

# **BARRIERS FOR ACCESS TO ASSISTED REPRODUCTIVE TECHNOLOGIES BY LESBIAN WOMEN: THE SEARCH FOR PARITY WITHIN THE HEALTHCARE SYSTEM**

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## I. INTRODUCTION

Most people take the ability to conceive and bear children for granted. In fact, our society focuses much of its concern about reproductive issues on trying to prevent “unwanted” pregnancy rather than trying to achieve conception and a full-term, healthy baby. We are constantly bombarded with messages about birth control, the rise in teen pregnancy, family planning, and responsible sexual behavior. Yet, according to the American Pregnancy Association, 6.1 million couples struggle with infertility each year.<sup>1</sup>

Infertility is typically defined as the “the failure to conceive after a year of regular intercourse without contraception.”<sup>2</sup> The definition can be further expanded to include primary infertility – where a pregnancy has never occurred, and secondary infertility – where a couple previously conceived, but is unable to conceive again.<sup>3</sup> Just over fifty years ago, adoption was the only real option for infertile women and couples. Technology has made such great advances that there are now a variety of options. Commonly known as assisted reproductive technologies, or ARTs, these options range from the minimally invasive (such as drug/hormone therapy)<sup>4</sup> to those requiring surgery<sup>5</sup>, alternative sources of gametes<sup>6</sup>, and/or surrogacy.<sup>7</sup> The desire for genetically related offspring is so strong that advances in reproductive technology have exploded on an exponential scale, producing a variety of options for infertile women.

### A. Types of ARTs

The definition of assisted reproductive technologies varies from

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<sup>1</sup> American Pregnancy Association, Statistics, <http://www.americanpregnancy.org/infertility/fertilityfaq.html> (last visited Dec. 14, 2008).

<sup>2</sup> MedicineNet.com, Definition of Infertility, *available at* <http://www.medterms.com/script/main/art.asp?articlekey=3977> (last visited Dec. 14, 2008).

<sup>3</sup> The Free Dictionary, Definition of Infertility, <http://medical-dictionary.thefreedictionary.com/infertility> (last visited Dec. 14, 2008).

<sup>4</sup> See *infra* note 9 at 4.

<sup>5</sup> *Id.* at 6.

<sup>6</sup> *Id.* at 11.

<sup>7</sup> *Id.* at 12.

one agency to another. The Centers for Disease Control and Prevention (CDC) defines ARTs as “[A]ll fertility treatments in which both eggs and sperm are handled. . . . They do NOT include treatments in which only sperm are handled. . . .”<sup>8</sup> The American Society for Reproductive Medicine has a similar definition, with in vitro fertilization (IVF) being the most common form of assisted reproductive technology used.<sup>9</sup> However, the term assisted reproductive technologies is also used in the lay literature to refer to the entire gamut of available techniques, invasive or not, to help infertile women conceive a genetically related child.<sup>10</sup>

The first step in fertility treatment is to run a series of tests to attempt to determine the cause of infertility.<sup>11</sup> The general causes of infertility can be considered within the framework of the couple as a whole or as causes affecting women only. When considering couples, the causes of infertility and percentages for each cause are as follows: 35% attributed to male infertility, 15% attributed to ovulatory dysfunction, 35% attributed to tubal dysfunction, 5% attributed to other (an inclusive category with a large variety of identifiable causes) and 10% unexplained.<sup>12</sup> When looking at the woman as an individual, the causes and percentages for infertility are as follows: 40% attributed to ovulatory dysfunction, 40% attributed to tubal dysfunction, 10% attributed to other causes, and 10% unexplained.<sup>13</sup>

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<sup>8</sup> Centers for Disease Control and Prevention, Assisted Reproductive Technology: Home, <http://www.cdc.gov/ART/> (last visited Dec. 14, 2008).

<sup>9</sup> See AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, ASSISTED REPRODUCTIVE TECHNOLOGIES: A GUIDE FOR PATIENTS (2008), <http://www.asrm.org/Patients/patientbooklets/ART.pdf> (stating that IVF is employed for many infertility causes from endometriosis to unexplained infertility).

<sup>10</sup> See Jessica Evert, MentalHelp.net, Infertility Treatments Continued, [http://www.mentalhelp.net/poc/view\\_doc.php?type=doc&id=11287&cn=65](http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=11287&cn=65) (last visited Sept. 25, 2009) (referring to ART as an “umbrella term” for many types of fertility treatments).

<sup>11</sup> See John C. Petrozza & Mary E. Sabatini, Assisted Reproduction Technology 3-4, *emedicine* from WebMD, <http://emedicine.medscape.com/article/263907-overview> (last visited Nov. 22, 2009)(classifying a physical examination and history as vital for treatment of an infertile couple).

<sup>12</sup> *Id.* at 3.

<sup>13</sup> *Id.*

Once a cause (or lack thereof, in unexplained cases of infertility) has been identified, the path for treatment generally becomes apparent. In the case of male infertility, there are several factors that are assessed, including semen volume, sperm concentration, sperm motility and morphology, and the presence of infection or physical obstruction.<sup>14</sup> With the explosion in technology, other, more sensitive, tests continue to be discovered to detect any form of dysfunction within the male.<sup>15</sup>

If male infertility is discovered to be the culprit, the treatment options include hormone therapy to improve semen conditions, treatment of any aggravating infections, and other medications to improve the production and motility of the sperm.<sup>16</sup> However, if these treatments prove unsuccessful, or if the cause of male infertility remains unexplained, in vitro fertilization (an invasive procedure for the woman) is the treatment of choice.<sup>17</sup>

Because the woman is the gestational incubator for the child, there are many more things that can go wrong and therefore many more treatment possibilities.<sup>18</sup> The male must only provide a sufficient and healthy sample of sperm for conception, but the female must have the right balance of hormones and healthy eggs, uterus, cervix and fallopian tubes in order to provide the right environment for conception and, ultimately, development of a fetus to occur.<sup>19</sup>

It is possible that the woman does not have enough healthy eggs (ovarian reserve), for example. However, this is usually not the case, and ovarian dysfunction is often a problem with the release of the

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<sup>14</sup> *Id.* at 4.

<sup>15</sup> *Id.*

<sup>16</sup> Petrozza and Sabatini, *supra* note 11, at 6.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at 4-9. (According to the authors, 55% of infertility cases in couples can be attributed to the woman, while only 35% can be attributed to the man and 10% remain unexplained. Further, treatments for male factor infertility are limited and often result in IVF anyway - an invasive procedure for the woman - whereas treatments for female factor infertility can include the use of drugs, hormone replacement therapy, and minor surgery, as well as IVF and other ARTs.)

<sup>19</sup> JAMES W. WOOD, DYNAMICS OF HUMAN REPRODUCTION: BIOLOGY, BIOMETRY, DEMOGRAPHY 483 (1994).

egg.<sup>20</sup> If this is the only dysfunction a woman experiences, it can typically be treated with cycles of drugs (the most common of which is known as Clomid) and hormones to encourage the release of one or more healthy eggs at an appropriate time for conception.<sup>21</sup> If, however, this is not successful after three to six cycles, it is usually recommended that another course of action be taken because the drugs used for this purpose are expected to work within this time frame for an otherwise healthy individual and they bear a low risk of ovarian tumors.<sup>22</sup> Thus, the failure of this treatment after so many cycles is an indication that there may be a further problem.

Tubal dysfunction is typically more of an obstructive cause of infertility.<sup>23</sup> If only one tube is dysfunctional, ovarian stimulation treatments may be effective in achieving conception by encouraging the ovary associated with the functional tube to produce eggs.<sup>24</sup> It is also possible that surgical procedures can correct any problems within the tubes.<sup>25</sup> However, in most cases of tubal dysfunction, the most effective treatment to achieve conception is in vitro fertilization.<sup>26</sup>

Within the "other" category of female infertility are lumped potential problems with the cervix, the uterus and the endocrine system (the system of the body responsible for hormone production).<sup>27</sup> Treatment for these conditions may consist of hormone replacement/enhancement therapy, surgical procedures to correct any physical deformities, and intrauterine insemination (IUI), which allows the doctor to bypass a dysfunctional cervix and insert semen directly into the woman's uterus.<sup>28</sup>

If less invasive techniques prove unsuccessful, there are additional technologies that may help the woman achieve conception.

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<sup>20</sup> Petrozza and Sabatini, *supra* note 11, at 7.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> *Id.* at 5.

<sup>24</sup> *Id.* at 7.

<sup>25</sup> Petrozza & Sabatini, *supra* note 11, at 8.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 4-5.

<sup>28</sup> *Id.* at 8.

IVF is the most common option and involves stimulating the ovaries to produce eggs, which are then removed through the vagina, fertilized in culture, and replaced a few to several days later once they have begun to divide and develop.<sup>29</sup>

Another lesser-known and rarely used procedure is gamete intrafallopian transfer, or GIFT.<sup>30</sup> GIFT starts similarly to IVF in that the woman's ovaries are stimulated to produce eggs, and the eggs are then removed through the vagina.<sup>31</sup> However, in the case of GIFT, the retrieved eggs are then replaced into the woman's fallopian tubes along with the male sperm to allow fertilization within the woman's body.<sup>32</sup> This practice is sometimes considered more acceptable to those who have a religious objection to IVF because the actual fertilization still takes place within the mother's body.<sup>33</sup>

Finally, the techniques of zygote intrafallopian transfer (ZIFT) and tubal embryo transfer (TET) are alternatives to IVF and GIFT. As in the other two techniques, the ovaries are stimulated and eggs removed from the woman.<sup>34</sup> The eggs are then fertilized in culture; however, they are returned to the woman's fallopian tubes rather than her uterus (as in IVF) and must make their way down and implant in the uterus on their own.<sup>35</sup> The type of technique, whether ZIFT or TET, is simply determined by the time frame and stage of development, at which the fertilized eggs are returned to the woman's body.<sup>36</sup> These techniques are used much less frequently than IVF; however, "[w]ith the development of enhanced culture media, the success rates for IVF are now comparable, if not better, to those of GIFT and ZIFT, and IVF is less invasive than GIFT and ZIFT."<sup>37</sup>

If these options fail, or if the woman does not have viable eggs,

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<sup>29</sup> *Id.* at 9.

<sup>30</sup> Petrozza & Sabatini, *supra* note 11.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> Petrozza & Sabatini, *supra* note 11, at 9.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

there are two other options available: donor eggs or surrogacy—the two techniques may be combined if necessary.<sup>38</sup> These techniques, referred to as “third party reproduction,” include both the donation of eggs or embryos, and the use of biological surrogates and gestational surrogates.<sup>39</sup> Biological surrogates not only carry the child, but also provide the genetic material (the egg) for the conception process, whereas gestational surrogates have no genetic link to the child produced and simply carry the child to term.<sup>40</sup> These procedures tend to be more complex than “standard” fertility treatments, incite more controversy and legal issues, and also tend to be much more expensive than fertility treatments.<sup>41</sup>

## B. The “Typical” Infertile Person

Typically, when we think of infertile people, we think of the heterosexual, married woman who is unable to conceive—regardless of whether the problem is due to the husband’s or wife’s reproductive system. However, that model is shifting as more single women and lesbian couples desire to raise a genetically related child.<sup>42</sup> These two populations face the difficulty of being infertile by means of their lifestyle and lack of access to the necessary starting blocks for conception—commonly referred to as social infertility.<sup>43</sup> Single women may choose celibacy and prefer to avoid sexual contact with a man, they may choose to concentrate on their career rather than a relationship, they may be unable to find a man who meets their expectations, or they may feel that they are growing older and running out of time to

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<sup>38</sup> AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, *THIRD PARTY REPRODUCTION: A GUIDE FOR PATIENTS (SPERM, EGG, AND EMBRYO DONATION AND SURROGACY)* 3 (2006), <http://www.asrm.org/Literature/patient.html>, scroll down to the middle of the page and click on the link for “Third party reproduction” (Sperm, egg, and embryo donation and surrogacy) (last visited Dec. 14, 2008).

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* at 3–4.

<sup>42</sup> Maurice Rickard, *Is It Medically Legitimate to Provide Assisted Reproductive Treatments to Fertile Lesbians and Single Women?*, Research Paper 23 2000-01, 8 (2000), Parliament of Australia, <http://www.apf.gov.au/library/pubs/rp/2000-01/01RP23.htm> (last visited Dec. 15, 2008).

<sup>43</sup> *Id.* at 1.

have a child in the “traditional” way.<sup>44</sup> Lesbian women do not desire intercourse with a man, but may also feel some of the time and career pressures that are experienced by single, heterosexual women. Whatever the reasons for not engaging in intercourse with a male partner, these two groups do not have access to sperm in the traditional sense, and are unable to conceive, thereby rendering them infertile.

The range of ARTs currently available can provide those starting blocks and create the possibility of a genetically related child for single women and lesbians without requiring sexual intercourse with a man. However, ARTs are not as readily available for single women and lesbians as they are for married, heterosexual couples.

This comment will focus on the various barriers to access within the bounds of a committed lesbian relationship. This will include a comparison with heterosexual couples, and whether or not the barriers against lesbians are valid. There will be a special focus on how these barriers impact the availability of insurance coverage for ARTs both in the general population and, more specifically, for lesbian couples. Ultimately, the discussion will focus on the inequality of restricting access to these services and how equality should be addressed for all populations seeking to reproduce.

## II. ACCESS BARRIERS TO ARTS FOR THE LESBIAN COUPLE

Lesbian couples in particular face many barriers to accessing assisted reproductive technologies.<sup>45</sup> Barriers to ARTs for homosexual couples include religious objections, moral and ethical determinations, limited financial resources, limited insurance coverage or a complete lack of insurance coverage, discrimination, and legal barriers.<sup>46</sup>

### A. Religious Barriers

There is no doubt that the lesbian lifestyle causes controversy

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<sup>44</sup> *Id.*

<sup>45</sup> Catherine DeLair, *Ethical, Moral, Economic and Legal Barriers to Assisted Reproductive Technologies Employed by Gay Men and Lesbian Women*, 4 DEPAUL J. HEALTH CARE L. 147, 148 (2000).

<sup>46</sup> *Id.*



and is considered “wrong” by many. This “wrongness” is often based upon religious beliefs and a particular religion’s definition of the traditional family.

Each religion has its own perspective on marriage, the family and children. While there are a large variety of world religions, the focus of moral values in the developed world often comes from one of four primary religious groups: Catholics, Muslims, Jews, or Protestants.

Catholicism tends to provide the most restrictive view of family and the use of assisted reproductive technologies due to the belief that procreation should only occur within the married heterosexual relationship.<sup>47</sup> Not only do strict Catholics believe that the homosexual lifestyle is immoral,<sup>48</sup> there is a belief that medical interventions for procreation are unacceptable for heterosexual couples as well.<sup>49</sup> While this view is highly restrictive, it at least demonstrates a level of equality by restricting fertility treatments for anyone, regardless of sexual orientation.

Islam, as practiced in Iran, does not restrict access to ARTs that result in genetically related offspring for married, heterosexual couples.<sup>50</sup> However, Iranian law, which is inexorably linked to the religion of Islam, does not allow homosexuality and goes further to consider it a crime.<sup>51</sup> The laws of Iran define family as, “wife, husband and children.”<sup>52</sup> While the status of single parents—although undesirable—is accepted as inevitable in Iran for the welfare of the child, Iranian (and therefore, strict Islamic) law does not support the *creation* of

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<sup>47</sup> *Id.* at 154; see also Holly J. Harlow, *Paternalism Without Paternity: Discrimination Against Single Women Seeking Artificial Insemination By Donor*, 6 S. CAL. REV. L. & WOMEN’S STUD. 173, 191-92 (1996).

<sup>48</sup> DeLair, *supra* note 45, at 154.

<sup>49</sup> *Id.* See also Harlow, *supra* note 47, at 192.

<sup>50</sup> Reza Omani Samani, Ahmad Vosough Taghi Dizaj, Mohammad Reza Rezania Moalem, Seyed Taha Merghati, and Leila Alizadeh, *Access to Fertility Treatments for Homosexual and Unmarried Persons, through Iranian Law and Islamic Perspective*, 1 IRANIAN J. OF FERTILITY AND STERILITY 127, 129 (2007).

<sup>51</sup> *Id.* at 129.

<sup>52</sup> *Id.* at 128.

a child without a man and woman involved.<sup>53</sup> Therefore, assisted reproductive technologies are not available in Iran to either homosexual couples or single women.<sup>54</sup>

The Jewish faith is accepting of some forms of ARTs within the confines of a marriage in an effort to procreate and multiply.<sup>55</sup> The use of these techniques for the single or lesbian woman, however, is looked down upon and, in some cases, the resultant children are considered illegitimate.<sup>56</sup>

The Protestant denominations vary widely from conservative to much more liberal. Therefore, there is a range of opinions regarding what is and is not acceptable. The more conservative views follow along the same lines as those from the Jewish and Catholic faiths in that marriage exists only between a man and a woman and that certain ARTs—specifically those that require donor sperm or eggs—are unacceptable.<sup>57</sup> However, there are Protestants who feel that all ARTs are acceptable within the confines of a marriage.<sup>58</sup> Additionally, some Protestants go even further by sanctioning and performing marriages between same-sex couples.<sup>59</sup> It is therefore likely that these denominations would view the use of ARTs within these same-sex marriages as an acceptable means of procreation.

Some providers (clinics or individual doctors) may refuse to provide fertility services to homosexual couples based on these religious values.<sup>60</sup> The providers in these cases typically claim a First Amendment right to the free exercise of religion when denying these patients access. The practice has become synonymous with the conscience clause objections of some pharmacists to provide birth control or emergency contraception at all, or to certain populations of wom-

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<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> DeLair, *supra* note 45, at 155.

<sup>56</sup> DeLair, *supra* note 45, at 155. See also Harlow, *supra* note 47, at 193.

<sup>57</sup> DeLair, *supra* note 45, at 156.

<sup>58</sup> *Id.*

<sup>59</sup> Laurie Goodstein, *Episcopal Bishops Give Ground on Gay Marriage*, N.Y. TIMES, July 15, 2009, <http://www.nytimes.com/2009/07/16/us/16episcopal.html> (last visited Nov. 22, 2009).

<sup>60</sup> DeLair, *supra* note 45, at 151.

en.

However, in April 2008, the Supreme Court of California issued a ruling in the case of *North Coast Women's Care Medical Group, Inc., et al. v. San Diego County Superior Court*, contradicting the concept of a conscience clause in the treatment of infertility.<sup>61</sup>

The case involved a lesbian woman, Guadalupe T. Benitez, and her partner, who were seeking fertility treatment at the North Coast clinic in order to conceive a genetically related child with the use of donor sperm.<sup>62</sup> After several unsuccessful attempts at self-insemination and a series of tests performed by her doctor, which resulted in a diagnosis of PCOS, or polycystic ovarian syndrome (a cause of infertility), Ms. Benitez was referred to the North Coast clinic to receive fertility treatment.<sup>63</sup>

The doctor, who initially treated Ms. Benitez at North Coast, claims that she informed Ms. Benitez that she and another doctor in the practice had a religious objection to performing intrauterine insemination for Ms. Benitez, and that if it came to that, she would be referred to two other physicians within the practice.<sup>64</sup> However, Ms. Benitez was ultimately denied treatment at North Coast by all of the doctors and was referred to a doctor outside of the clinic.<sup>65</sup>

Ms. Benitez sued the North Coast clinic for sexual orientation discrimination under California's Unruh Civil Rights Act, alleging that she was denied treatment at the clinic due to her sexual orientation.<sup>66</sup> The defendants made several claims, most pertinent of which were first, that the right to deny services to a client based on religious beliefs is protected by the First Amendment to the U.S. Constitution regardless of the California law, and second, that the religious objections to treating Ms. Benitez were based on grounds other than her

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<sup>61</sup> *N. Coast Women's Care Med. Group, Inc. v. San Diego County Superior Court*, 189 P.3d 959, 962 (2008).

<sup>62</sup> *Id.* at 963.

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *Id.* at 964.

<sup>66</sup> *Id.*

sexual orientation.<sup>67</sup>

The ruling of the appellate court against Ms. Benitez was ultimately reversed by the state supreme court and remanded to determine the actual basis for the religious objection to treating Ms. Benitez by the doctors at the North Coast clinic.<sup>68</sup> The court held that:

- (1) First Amendment right to free exercise does not guarantee right to deny fertility treatment to lesbian patients;
- (2) Physicians' inability to tell patients that they will not comply with Unruh Civil Rights Act does not violate their rights to free speech and free exercise;
- (3) Patient's motion for summary adjudication of physicians' constitutional affirmative defense did not violate physicians' First Amendment right to free speech;
- (4) State constitution right to free exercise does not guarantee right to deny fertility treatment to lesbian patients;
- (5) State power to burden right to free exercise is not limited to prohibiting acts that are licentious or inconsistent with peace or safety of State; but
- (6) Physicians could present evidence that they denied treatments due to patient's unmarried status rather than sexual orientation.<sup>69</sup>

The concurring opinion supported the majority opinion and reasoning in full but took it a step further to broaden the underlying principles behind that decision.<sup>70</sup> The concurrence states in part that "[C]alifornia has a compelling interest, furthered by the Unruh Civil Rights Act, 'in ensuring *full and equal access to medical treatment* irrespective of sexual orientation.'" <sup>71</sup> The concurring opinion further addressed the federal constitutional issue stating, "[A]ssuming that a strict scrutiny standard applies under the California Constitution, the

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<sup>67</sup> *Id.* at 967-68.

<sup>68</sup> *Id.* at 970-71.

<sup>69</sup> *Id.* at 959.

<sup>70</sup> *Id.* at 971.

<sup>71</sup> *Id.* (quoting the majority opinion) (original emphasis).

state's interest—here represented in a statute—must be balanced, in appropriate cases, against the fundamental *constitutional* right to the free exercise of religion.<sup>72</sup> [I]n the circumstances before us, the burden imposed on this constitutional right was not sufficient to overcome the state's interest."<sup>73</sup>

This case is pivotal in establishing equal rights and equal access to assisted reproductive technologies for lesbians. It demonstrates two very important rights – free speech and equal protection – in conflict, and it comes down on the side of equality for the masses. The question now is whether this case was an isolated incident or the beginning of a trend towards greater access to assisted reproductive technologies for lesbian couples. Is this case strong enough to establish a new standard of equality, or will the ruling be later overturned in light of the recent passage in California of a state constitutional amendment to ban homosexual marriage?

While access to medical services must be available to everyone, there are questions as to the necessity of services such as ARTs, which will be addressed when considering insurance coverage for these procedures.

## **B. Moral and Ethical Barriers**

Even outside the religious sphere, there are some who simply view the idea of a “single mother by choice”<sup>74</sup> as morally wrong. They feel that a child needs both a father and a mother in order to develop, both mentally and emotionally.<sup>75</sup> Proponents of this idea believe that the homosexual lifestyle is not conducive to raising healthy, happy children.<sup>76</sup> They argue that children raised in a same-

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<sup>72</sup> *Id.* (original emphasis).

<sup>73</sup> *Id.* (This is an important ruling not only for lesbian women seeking this type of treatment, but also for constitutional law in general due to the fact that the “compelling state interest” supported by the state’s supreme court is actually being used to protect civil rights rather than to deny them.)

<sup>74</sup> Harlow, *supra* note 47, at 174.

<sup>75</sup> Timothy J. Dailey, *Homosexual Parenting: Placing Children at Risk*, ORTHODOXTODAY.ORG (2002), at <http://www.orthodoxytoday.org/articles/DaileyGayAdopt.php> (last visited Dec. 14, 2008).

<sup>76</sup> *Id.*

sex household are more likely to become homosexual, to be exposed to domestic violence, and to be exposed to deviant sexual behavior.<sup>77</sup>

However, there are many studies that debunk the idea that same-sex marriages are harmful to children and some that even find benefits to children raised in lesbian households.<sup>78</sup> Several studies have shown that the benefits to children are greatest when there are two parents living in the same household—regardless of the gender of those two parents.<sup>79</sup> Further, a study by researchers Judith Stacey and Timothy J. Biblarz demonstrated that there are some differences in children raised by lesbians, but they are largely positive.<sup>80</sup> Some of these positives include less aggressive and more nurturing boys, more egalitarian parenting styles, less pressure for adolescents to fit specific gender roles, and better anger management within the parental relationship.<sup>81</sup>

### C. Legal Barriers

The most obvious legal barrier to ART access is the fact that in most states lesbian women are not allowed to marry. As will be seen when addressing the concerns over insurance coverage, this legal technicality lends itself to other barriers, primarily financial. Some states, such as Texas, go so far as to limit required insurance coverage to married couples for certain procedures.<sup>82</sup>

Another legal barrier to ARTs for lesbian couples is the issue of parentage. Many states have adopted the Uniform Parentage Act

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<sup>77</sup> *Id.*

<sup>78</sup> Gilien Silsby, *Sociology: Study examines gender roles of children with gay parents*, U. S. CAL. NEWS, May 30, 2001, available at <http://www.usc.edu/uscnews/stories/6908.html>.

<sup>79</sup> Daniel Goleman, *Studies Find No Disadvantage In Growing Up in a Gay Home*, N.Y. TIMES (Dec. 2, 1992), available at <http://query.nytimes.com/gst/fullpage.html?res=9E0CEEDC1131F931A35751C1A964958260> (quoting Dr. Julie Gottman, a clinical psychologist, "What mattered most for [the children's] adjustment was whether the mother had a partner in the home, whether male or female. If so, those children tended to do better than others in self-confidence, self-acceptance, and independence. But the sexual orientation of the lesbian mothers had no adverse effects.")

<sup>80</sup> Silsby, *supra* note 78.

<sup>81</sup> *Id.*

<sup>82</sup> See *infra* note 133.

(UPA), which was created with the noble intent of ensuring a legal bond between parent and child.<sup>83</sup> The UPA states in part:

a) If, under the supervision of a licensed physician and with the consent of her husband, a wife is inseminated artificially with semen donated by a man not her husband, the husband is treated in law as if he were the natural father of a child thereby conceived. The husband's consent must be in writing and signed by him and his wife. The physician shall certify their signatures and the date of the insemination, and file the husband's consent with the [State Department of Health], where it shall be kept confidential and in a sealed file. However, the physician's failure to do so does not affect the father and child relationship. All papers and records pertaining to the insemination, whether part of the permanent record of a court or of a file held by the supervising physician or elsewhere, are subject to inspection only upon an order of the court for good cause shown.

b) The donor of semen provided to a licensed physician for use in artificial insemination of a married woman other than the donor's wife is treated in law as if he were not the natural father of a child thereby conceived.<sup>84</sup>

As DeLair points out, the language in the UPA leaves open the possibility that the sperm donor has two possible avenues for asserting parental rights.<sup>85</sup> The first would be in the case of self-insemination. The UPA clearly requires the self-insemination to be "[u]nder the supervision of a licensed physician, . . ." opening the door to a possible parental challenge by the donor if the woman inseminated herself with the sperm rather than seeking medical assistance for the procedure.<sup>86</sup> This creates a further financial barrier if the woman is unable to afford artificial insemination by a physician. The second case would relate back to the issue of the marital status of the couple. This section of the UPA is riddled with the terminology of traditional marriage, discussing the relationship between *husband* and *wife* and the presumption that the legal husband of the woman

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<sup>83</sup> UNIF. PARENTAGE ACT § 5 (1973) [UPA].

<sup>84</sup> *Id.*

<sup>85</sup> DeLair, *supra* note 45, at 164-65.

<sup>86</sup> *Id.*

who was inseminated would be considered the father of the child.<sup>87</sup> A donor would have a second avenue for a parental rights challenge if the woman inseminated with the sperm was not married - as would be the case for the majority of lesbian women.<sup>88</sup>

#### **D. Financial Barriers**

Not surprisingly, assisted reproductive technologies can be quite expensive. The cost of obtaining sperm can be free (if obtained from a friend) or can cost hundreds of dollars if obtained through a sperm bank.<sup>89</sup> While self-insemination is possible, many women find greater success through physician-assisted insemination, which adds to the cost of the procedure. Additional costs are incurred if the insemination is not successful and multiple cycles of insemination are attempted.<sup>90</sup> If the insemination ultimately proves to be unsuccessful, some women may turn to other procedures such as the use of donor eggs or surrogates, which magnify the costs into the tens of thousands of dollars.<sup>91</sup>

Many people simply cannot afford to spend that amount of money. Married, heterosexual couples often have some insurance coverage, usually minimal, that may help defray some of the costs associated with infertility procedures. Lesbian couples, however, are unable to marry in most states, which limits access to insurance coverage for ARTs, especially if employers are unwilling to cover domestic partners.<sup>92</sup> Even if coverage is available, lesbian couples may not fit the definition of "medically infertile" and may be denied coverage for ARTs.<sup>93</sup> The following is a more in-depth discussion of insurance coverage for ARTs and the special barriers for lesbian couples.

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<sup>87</sup> UPA, *supra* note 83.

<sup>88</sup> DeLair, *supra* note 45, at 164-65.

<sup>89</sup> *Id.* at 160.

<sup>90</sup> *Id.*

<sup>91</sup> DeLair, *supra* note 45, at 160.

<sup>92</sup> *Id.* at 161.

<sup>93</sup> *Id.*



### III. GENERAL INSURANCE COVERAGE FOR ARTS

One of the biggest controversies surrounding assisted reproductive technologies is whether insurance companies should be required to provide coverage for fertility treatments. Proponents of coverage argue that infertility should be treated as a disease that requires medical intervention.<sup>94</sup> While no one will typically deny that at least for the heterosexual couple, individuals have the right to reproduce, there is an argument to be made that they do not have the right to require an insurance company to pay for the procedures if they are unable to conceive naturally.<sup>95</sup>

#### A. Medical Necessity v. Medical Legitimacy

In a market of limited resources for healthcare, many suggest that insurance companies should not be required to pay for infertility treatments while cutting back costs on treatments for other conditions such as cancer.<sup>96</sup> There are a limited number of dollars allocated to healthcare and medical expenses, and arguments have been made regarding the need to ration these scarce resources. Infertility treatments are viewed as optional (similar to cosmetic surgery) rather than necessary medical interventions.<sup>97</sup> This rationale is due in part to the fact that society does not view reproduction as a medical necessity for every person and in part to the fact that there are viable alternatives (such as adoption) to conceiving and raising a genetically related child. It is considered a privilege to be able to raise such a child, but it is not a guarantee and is not deemed necessary in order to live a healthy productive life.

Maurice Rickard outlines four basic and related concepts of medical legitimacy that are used to deny lesbians and single women access to fertility services.<sup>98</sup> These four concepts are as follows:

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<sup>94</sup> Tricha Shivas, *HIV-1, Reproduction, and Justice: What is Society's Obligation?*, AM. J. BIOETHICS, Winter 2003, at 63.

<sup>95</sup> *Id.*

<sup>96</sup> *Id.*

<sup>97</sup> Delair, *supra* note 45, at 161.

<sup>98</sup> Rickard, *supra* note 42, at 3.

**1. An intervention is medically appropriate only when it is the only effective option. It will not be legitimate when there are other effective non-medical options available.**

There are other such options through which lesbians and single women can address their childlessness. There is adoption, and, because they are still [apparently] medically fertile, there is also the option of intercourse with a man.

**2. The domains of medical responsibility and of personal responsibility are distinct. An intervention is only medically legitimate when it is not called upon to correct the foreseeable consequences of people's choices, or to compensate for life circumstances that have merely been a little unfavourable in certain ways.** Social infertility is either a foreseeable consequence of lifestyle choice, or else a predictable outcome of perhaps unfavourable, but not debilitating or out of the ordinary, life circumstances.

**3. The purpose of medical interventions is to repair conditions. Medical interventions correct problems in people's normal functioning. They do not enhance people's well-being or capacities beyond their level of normal functioning.** Lesbian couples do not, as a matter of their normal functioning, have a capacity to reproduce. Giving them that capacity would not be repairing a dysfunction as much as enhancing their lives. Strictly speaking, the inability of socially infertile single heterosexual women to conceive is not due to a dysfunction they have.

**4. Medical treatments are for medical conditions.** To act otherwise by recommending a physiological intervention to overcome a non-physiological cause of childlessness is to act outside the confines of sound medical practice.<sup>99</sup>

The problem with these concepts is that they are applied only to women who are deemed socially infertile: women who are either single or lesbian and choose to conceive a genetically related child without engaging in sexual intercourse with a male.<sup>100</sup> Rickard believes that if these concepts were applied universally, there would be many medical interventions that are considered "normal" and "acceptable"

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<sup>99</sup> Rickard, *supra* note 42, at 3-4.

<sup>100</sup> *Id.* at 1.

that would not meet the standard of medically legitimate.<sup>101</sup>

The first concept, that medical appropriateness is determined when a particular treatment is the only option, easily fails when applied universally.<sup>102</sup> In many cases, alternative treatments exist (for example radiation, chemotherapy, and surgery for the treatment of certain cancers).<sup>103</sup> The goal in these instances is to choose the treatment that will be most effective.<sup>104</sup> Treatment effectiveness is not only dependent upon the type of treatment being given, but also on the willingness of the patient to comply with the given treatment option.<sup>105</sup> The "best" treatment may not be the one that is deemed most medically effective, but the one that is medically effective *and* is compatible with the patient's needs and values.<sup>106</sup>

Maurice Rickard uses the example of obesity to illustrate this point.<sup>107</sup> Obesity can be treated through lifestyle changes such as diet and exercise (just as lesbians could engage in heterosexual intercourse to conceive a child).<sup>108</sup> However, there are times when the obese patient is unwilling or unable to make these changes and medication is prescribed or surgery is performed to correct the problem.<sup>109</sup> There is no argument over whether or not obesity can be treated through non-medical alternatives; however, society does not seem to mind the use of medical intervention in this case.<sup>110</sup> While adoption, self-insemination, and heterosexual intercourse are all options available to lesbian women, there are still barriers and possible negative consequences for such alternatives that lead these women to choose a medical treatment option.<sup>111</sup>

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<sup>101</sup> *Id.* at 15.

<sup>102</sup> *Id.* at 7.

<sup>103</sup> *Id.* at 6.

<sup>104</sup> Rickard, *supra* note 42, at 7.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Id.* at 6.

<sup>108</sup> *Id.*

<sup>109</sup> Rickard, *supra* note 42, at 6.

<sup>110</sup> *Id.* at 7.

<sup>111</sup> *Id.*

The second proposition of personal responsibility assumes that lesbian women have "chosen" their lifestyle and must therefore suffer the predictable consequences of that choice—childlessness.<sup>112</sup> There are two arguments against this proposition. The first is that of choice. According to the American Psychological Association (APA), while scientists have not found any one particular factor that determines sexual orientation, it does appear to be a product of both genetics and environment and has little to do with choice.<sup>113</sup>

The second argument is that even *if* homosexuality is a choice, people make choices on a daily basis for which they know the consequences and yet still expect to receive (and *do* receive) medical assistance.<sup>114</sup> Rickard gives the examples of boxing as well as that of self-harm or attempted suicide.<sup>115</sup> The people who engage in these activities are very aware that such activities can and do result in injuries requiring medical attention; yet, regardless of the fact that these are conscious choices, society still sees fit to provide medical services to the people who make these choices.<sup>116</sup> Therefore, the idea of personal responsibility and awareness of choice cannot be conclusive evidence that a medical treatment is not legitimate.<sup>117</sup>

The third proposition to consider medical treatments only as a means to correct conditions and return a person to normalcy also fails the test when applied universally.<sup>118</sup> First, treatments such as cosmetic surgery, while certainly discretionary in most cases, "arguably still would not count as an abuse of medicine nor would they be otherwise medically improper."<sup>119</sup> Second, this proposition assumes a

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<sup>112</sup> *Id.*

<sup>113</sup> American Psychological Association, Answers to Your Questions For a Better Understanding of Sexual Orientation & Homosexuality, <http://www.apa.org/topics/orientation.html> (last visited Dec. 14, 2008).

<sup>114</sup> Rickard, *supra* note 42, at 10.

<sup>115</sup> *Id.* at 13.

<sup>116</sup> *Id.*

<sup>117</sup> *Id.* at 13-14.

<sup>118</sup> *Id.* at 14.

<sup>119</sup> Rickard, *supra* note 42, at 16.

certain definition of “normalcy.”<sup>120</sup> The idea of normal is a function of society and values; therefore, it is a very fluid idea.<sup>121</sup> Normal can vary from one society to another, one time period to another, family to family, and person to person. It is impossible to define what makes any one individual “normal.”

The fourth and final concept used to deny ART services to single women and lesbians is the concept that medical treatments are solely to be used for medical conditions.<sup>122</sup> Since lesbians are not considered medically infertile (in most cases), this concept assumes that there is no need for medical treatment to provide a genetically related child to this population.<sup>123</sup> Like the other three propositions, however, when applied universally this concept also fails.<sup>124</sup> One argument against this concept can be found directly in the application and use of ARTs for heterosexual couples.<sup>125</sup> As the statistics have shown, approximately 10% of cases of infertility are unexplained.<sup>126</sup> There is no identifiable medical condition that is the cause of the infertility, yet there is no question that medical intervention is acceptable in these cases.<sup>127</sup> Further, Rickard points out that many medical treatments are not designed to treat the medical condition, but rather to treat the symptoms of that condition.<sup>128</sup> These treatments do not necessarily address the cause or condition but simply provide some form of relief for the symptoms that are manifested.<sup>129</sup>

Lesbian couples cannot marry in most states, and very few employers provide insurance coverage for domestic partners. Even when this coverage is made available to same sex couples, these couples do not necessarily meet the statutory or medical definition of in-

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<sup>120</sup> *Id.*

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at 17-18.

<sup>123</sup> *Id.* at 18.

<sup>124</sup> Rickard, *supra* note 42, at 18.

<sup>125</sup> *Id.*

<sup>126</sup> Petrozza & Sabatini, *supra* note 11.

<sup>127</sup> Rickard, *supra* note 42, at 18.

<sup>128</sup> *Id.*

<sup>129</sup> *Id.*

fertility. Ultimately, the question here is one of equality and justice: if insurance companies do cover assisted reproductive technologies for heterosexual couples, is it appropriate or ethical to deny coverage for these same fertility treatments to lesbian couples who also desire a genetically related child?

## **B. A Comparison of Insurance Coverage in the United States.**

Only fourteen states have passed laws that require insurers to offer coverage for infertility treatments in some form or fashion.<sup>130</sup> Those states include Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas, and West Virginia.<sup>131</sup> This note considers three states - Texas, California, and Connecticut - which provide a representative sample of the existing legislation on insurance coverage for fertility treatments.

### **1. Texas**

Texas Insurance Code section 1366.001 is the most restrictive of the statutes among the three states considered, allowing little room for interpretation. The law applies only to group health insurance plans that provide pregnancy benefits and requires that these policies also provide coverage for in vitro fertilization (IVF) expenses.<sup>132</sup> Coverage must be at the same level as pregnancy benefits.<sup>133</sup> For example, if a particular policy covers 80% of all pregnancy-related expenses, the plan must also cover at least 80% of in vitro fertilization expenses. There is an exception or waiver included in the statute for those benefit providers that are directly affiliated with a religious denomination that is opposed to infertility treatments.<sup>134</sup>

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<sup>130</sup> National Conference of State Legislatures, State Laws Related to Insurance Coverage for Infertility Treatment (2008), <http://www.ncsl.org/programs/health/50infert.htm> (last visited Dec. 14, 2008).

<sup>131</sup> *Id.*

<sup>132</sup> TEX. INS. CODE ANN. § 1366.001 (2005).

<sup>133</sup> *Id.* at § 1366.003.

<sup>134</sup> *Id.* at § 1366.006 (allowing certain issuers of health benefit plans directly associated with religious denominations to opt out of coverage for in vitro fertilization if the procedure is

This would seem to provide adequate coverage, at least for in vitro fertilization; however, the conditions and restrictions placed on access to coverage greatly reduce the number of people who can benefit from this law. In addition to actually being covered by the health plan in question and utilizing an appropriately accredited facility (one that has adopted the standards of the American Society for Reproductive Medicine), the conditions within the Texas code require that:

(2) the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the group health benefit plan.<sup>135</sup>

The one point of ambiguity within the statute is that it leaves some question as to whether both husband and wife must be covered or only the wife must be covered by the benefit plan.<sup>136</sup> There is no question, however, that the statute does not require coverage of assisted reproductive technologies for single parents or unmarried couples (which encompasses lesbians, since homosexual marriage is

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contrary to their beliefs).

<sup>135</sup> *Id.* at § 1366.005.

<sup>136</sup> *Id.* at §§ 1366.001-.005.

not recognized in the state of Texas).<sup>137</sup>

## 2. *California*

By contrast, California law requires coverage for fertility treatment, but specifically excludes in vitro fertilization (IVF) from group benefit plans. IVF may be covered by some providers, but they are not required to do so by law.<sup>138</sup> Covered fertility treatment is generally defined as, "diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer."<sup>139</sup> This list is inclusive and therefore not comprehensive, with IVF being the only procedure specifically not requiring coverage by law.

California has an additional statute that provides for limited fertility services to lower income families.<sup>140</sup> The coverage includes some limited diagnostic services, as well as family planning and fertility counseling to families with incomes at or below 200 percent of the federal poverty level.<sup>141</sup> This benefit appears to be unique to California.

Like Texas, the California statutes do allow an exception for those employers and providers whose religious affiliation includes moral objections to various infertility treatments.<sup>142</sup> This appears to be a common concession within all of the laws reviewed, obviously avoiding any possible constitutional battles over First Amendment violation claims.

A further distinction between the California and Texas statutes is that California specifically defines infertility within the statute. The definition includes, "(1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations

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<sup>137</sup> *Id.*

<sup>138</sup> CAL. HEALTH & SAFETY CODE § 1374.55(a)(2009). *See also* CAL. INS. CODE § 10119.6(a) (2009).

<sup>139</sup> CAL. HEALTH & SAFETY CODE § 1374.55(b)(2)(2009). *See also* CAL. INS. CODE § 10119.6(b)(2)(2009).

<sup>140</sup> CAL. WELF. & INST. CODE § 14132(aa)(1)(2009).

<sup>141</sup> *Id.* at § 14132(aa)(8).

<sup>142</sup> CAL. HEALTH & SAFETY CODE § 1374.55(f)(2009). *See also* CAL. INS. CODE § 10119.6(e)(2009).



without contraception.”<sup>143</sup> Unlike Texas, the California law does not limit coverage of services to married couples.

While the drafters of the legislation may not have intended to extend coverage to lesbian couples, it is conceivable that the language and definition may be construed to include such couples. This could be achieved either through the acceptance of homosexuality as a “recognized condition” that causes infertility or through the acknowledgement that “regular sexual relations” could include sexual interactions between two people of the same sex, which will obviously not result in conception.

### 3. *Connecticut*

Of the three states considered, the state of Connecticut appears to have to the most progressive law requiring insurance coverage for assisted reproductive technologies. The list of covered treatments for infertility covers the entire gamut of available reproductive technologies, including in vitro fertilization, various forms of insemination and gamete transfer, as well as the less expensive hormone and medication therapies.<sup>144</sup> Furthermore, while the Texas and California statutes only require coverage for group benefit plans, Connecticut requires coverage of assisted reproductive technologies for both group and individual policies.<sup>145</sup>

Like California, the Connecticut Code includes a very broad and ambiguous definition of infertility defining it as, “the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period.”<sup>146</sup> Furthermore, the words “produce conception” imply the possible inclusion of a male partner in the definition of the patient rather than the focus on the female as the patient that is explicit or implicit within both the Texas and California statutes.

Similar to the California statute, Connecticut’s law leaves room

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<sup>143</sup> CAL. HEALTH & SAFETY CODE § 1374.55(b)(West 2009). See also CAL. INS. CODE § 10119.6(b)(2009).

<sup>144</sup> CONN. GEN. STAT. § 38a-509(a) & 38a-536(a)(2009).

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

for interpretation to include a lesbian couple in the definition of infertility. Connecticut's definition includes no mention of sexual relations at all and could easily include homosexuality as a condition that would prevent a "presumably healthy individual" from conceiving.

Despite the liberality of the definition of infertility and infertility treatments within Connecticut's Code, there are some limitations placed on ARTs coverage that do not exist in either Texas or California. The Connecticut law includes an age restriction and limits the number of treatment cycles that must be covered by the insurer for various techniques, as follows:

- (1) Limit such coverage to an individual until the date of such individual's fortieth birthday;
- (2) Limit such coverage for ovulation induction to a lifetime maximum benefit of four cycles;
- (3) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of three cycles;
- (4) Limit lifetime benefits to a maximum of two cycles, with not more than two embryo implantations per cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as one cycle;
- (5) Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful;
- (6) Require that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;

(7) Limit coverage to individuals who have maintained coverage under such policy for at least twelve months; and

(8) Require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. Such disclosure shall be made on a form and in the manner prescribed by the Insurance Commissioner.<sup>147</sup>

These limitations on coverage for ARTs may provide further barriers to lesbians even if they are able to obtain general coverage under a health insurance plan. There may be a need for additional cycles of either intrauterine insemination or IVF, which would not necessarily be covered by the insurance plan. Furthermore, because the statute restricts access to ASRM accredited facilities, this could place an additional burden on lesbians who already have difficulty finding clinics that will serve the lesbian population.

### C. Coverage in Other Developed Countries

Insurance coverage for fertility treatments varies around the world; however, many countries with some form of national health insurance provide coverage for at least some ARTs. In the United Kingdom (UK), for example, the National Health Service (NHS) will provide funding for one cycle of in vitro fertilization to women within a certain age category who meet other eligibility criteria.<sup>148</sup> However, waiting lists for these treatments can be very long.<sup>149</sup> Women in the UK have the option of paying out of pocket at a private clinic where costs may vary widely.<sup>150</sup>

Germany has more comprehensive public funding for infertility treatments with coverage for "14 inseminations, 2 GIFT, and 4 IVF cycles. If [a] live birth [is] achieved, [the] same treatment options

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<sup>147</sup> CONN. GEN. STAT. § 38a-509(b) & 38a-536(b)(2009).

<sup>148</sup> Human Fertilisation & Embryology Authority, Funding, <http://www.hfea.gov.uk/en/1200.htm> (last visited Dec. 14, 2008).

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

[are] available for a further pregnancy.”<sup>151</sup> France also has generous public funding for fertility treatments providing 100% coverage for six rounds of insemination and four cycles of IVF.<sup>152</sup> These same options are also available for a subsequent pregnancy.<sup>153</sup>

There are many countries, however, that do not provide any publicly funded coverage for ARTs at all. These include Canada (except in Ontario), India, Israel, and Ireland.<sup>154</sup> It is clear that there is no international standard for funding or insurance coverage for assisted reproductive technologies.

### III. (RE)DEFINING INFERTILITY

The Merriam-Webster dictionary defines infertility as a condition rendering one, “incapable of or unsuccessful in achieving pregnancy.”<sup>155</sup> Most medical experts and texts further define infertility as “the failure to conceive after a year of regular intercourse without contraception.”<sup>156</sup> Primary infertility refers to a couple that has yet to achieve a successful pregnancy, whereas secondary infertility refers to a couple that has achieved at least one successful pregnancy, but is now experiencing difficulties.<sup>157</sup> None of the technical or medical definitions of infertility limit the concept to heterosexual couples. However, there is an underlying societal assumption that this is implied in the definition.

There are many possible causes of infertility in a person, including the age of the person, low sperm count or problems with egg development, hormonal imbalances, physical scarring or blockages, and

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<sup>151</sup> No Baby On Board, How does the US compare to the rest of the world for infertility coverage?, <http://www.nobabyonboard.com/worldcompare.html> (last visited Dec. 14, 2008).

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> Merriam-Webster Online, <http://www.merriam-webster.com/dictionary/infertility> (last visited Dec. 14, 2008).

<sup>156</sup> Medicinenet.com, *supra* note 2.

<sup>157</sup> The Free Dictionary, *supra* note 3.

past behaviors (drug, nicotine or alcohol use).<sup>158</sup> However, all of the causes of infertility are typically viewed from the framework of a married (or at least committed) heterosexual woman.

Opponents of providing coverage for fertility treatments to homosexual couples give several reasons for not requiring coverage that relate back to the various barriers to assisted reproductive technologies discussed previously. Some argue that lesbian couples either cannot get married or are not in a traditional relationship, which is considered “necessary” to successfully raise a child (i.e. two-parent family—one male, one female).<sup>159</sup> Others argue that lesbians are not actually medically infertile—or at least we do not know that they are, since they do not engage in intercourse with male partners.<sup>160</sup> However, lesbians will argue that they are technically infertile because there is no biological way for two women to conceive together without the advantage of medical intervention.<sup>161</sup> This concept is referred to as “relational infertility”.<sup>162</sup> This concept is similar to that of social infertility that was previously applied to both single women and lesbian women.<sup>163</sup>

The concept of relational infertility, if accepted and recognized, would provide a diagnostic basis for and legitimization of the infertility of lesbian couples.<sup>164</sup> This legitimization would hopefully increase access to services, health insurance coverage, and parental rights.<sup>165</sup>

Looking back to the statutes regarding mandatory coverage for infertility services in Texas, California and Connecticut, it is immediately obvious that the acceptance of relational infertility, in the gen-

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<sup>158</sup> Petrozza & Sabatini, *supra* note 11.

<sup>159</sup> Julien S. Murphy, *Should Lesbians Count as Infertile Couples?: Antilesbian Discrimination in Assisted Reproduction*, EMBODYING BIOETHICS: RECENT FEMINIST ADVANCES (NEW FEMINIST PERSPECTIVES), 103, 111-12 (Donchin & Purdy, eds., 1999).

<sup>160</sup> *Id.* at 107.

<sup>161</sup> *Id.* at 103-04.

<sup>162</sup> *Id.* at 103.

<sup>163</sup> Martyn Stafford-Bell, *Social Infertility*, SEXUAL FUNCTION & SEXUALITY, Spring 2006, at 25.

<sup>164</sup> Murphy, *supra* note 159, at 103.

<sup>165</sup> *Id.*

eral or medical definition of infertility, would still not provide access to insurance coverage for lesbian couples in all states. States such as Texas would still restrict access due to the fact that the procedures are limited to insemination by the spouse of the patient. This impacts lesbians first because same-sex marriage is not recognized within most states in the United States, and second, because the spouse (if same-sex marriage is allowed) is unable to provide the semen for the procedure—whether it is artificial insemination or in vitro fertilization.

However, there would be hope in the greater number of states that don't necessarily define the relationship through marriage or limit the donor semen to the spouse only. In states such as California and Connecticut, that incorporate a broad definition of fertility which can be construed outside of the marital relationship, the addition of relational infertility as a recognized condition would allow insurance coverage of infertility services for lesbian couples.

Even if this concept is accepted, there is an additional barrier for lesbian couples that must be overcome in order to access assisted reproductive technology through health insurance companies. Health insurance providers, whether group plans through employers or private, individual providers, must be willing to extend benefits to partners or married homosexual couples.

#### IV. CONCLUSION

The biological drive to reproduce and raise genetically related children is very strong. Women experience monthly cycles in which the body prepares itself for the potential pregnancy and then resets if fertilization does not occur. The surges in hormones that occur during these monthly phases not only prepare the body physically, but also affect the mental and emotional state of the woman.

Almost every woman experiences this phenomenon regardless of her sexual orientation. However, as has been demonstrated, millions of women are unable to conceive a child through "natural" means. This inability to conceive may be due to physical/physiological conditions, mental health/emotional conditions, sexual orientation, limitations arising from the age of the woman, or a lack of available and viable partners. Whatever the reason for this infertility, the biological

drive to conceive and raise a child still exists, causing mental anguish and frustration for those who are infertile.

Medical technology has expanded to provide the means to fulfill the desire for a genetically related child for the vast majority of these women. However, these assisted reproductive technologies (ARTs) are not without cost—great cost in some cases—and are therefore not readily available to all women desiring access. While insurance coverage for ARTs may be available to some women, coverage is not universally available. There are further barriers to access for certain populations, including single women and lesbians, based on society's view of what a child needs in order to grow up happy and healthy.

Lesbian women face the greatest barriers because their lifestyle is viewed as non-traditional and even morally wrong. They also lack the benefits of legal marriage that are available to heterosexual couples. These women face religious and moral objections to access by doctors as well as other providers of ARTs. Additionally, they face financial, insurance, and legal barriers to fertility treatments.

Yet, these are the kind of people that society should want to reproduce. People who are in a committed relationship and desperately want to provide a loving environment in which to raise a genetically related child. Contrast this to the heterosexual woman who is able to spend a single night with a man and conceive a child by "mistake," without the benefit of a committed relationship or a desire to raise the child. Lesbian women are willing to face and overcome these barriers in order to obtain what many heterosexual women take for granted.

By redefining infertility to include social (or relational) infertility and by removing some of the barriers to assisted reproductive technologies for lesbians, we can provide reproductive equality and ensure that children are being planned and conceived within the boundaries of committed relationships to people who truly desire children.