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The Socioeconomic Gap of Infertility: Medicaid Coverage of Infertility Treatments in West Virginia

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THE SOCIOECONOMIC GAP OF INFERTILITY: MEDICAID COVERAGE OF INFERTILITY TREATMENTS IN WEST VIRGINIA

ABSTRACT

Infertility treatments have become more accessible and widely used in the last 20 years. As more couples look to these treatments in their struggle to start a family, health insurers are lagging behind in coverage for these options. For the majority of women in the country, paying for infertility treatment out-of-pocket is unrealistic. Not all states have approached this issue but those who have vary in their approach. Some are utilizing either mandate-to-cover for private insurers or Medicaid coverage to attempt to make treatments and diagnosis more accessible. Without policy solutions, the inequality of access between socioeconomic statuses will remain. This Note will analyze the current statutes and proposed legislation and recommend what lawmakers should propose to solve this disparity in access. With West Virginia’s rate of Medicaid use, expansion of coverage through Medicaid would be the most beneficial to women suffering with infertility in the state. This Note will argue that infertile women with low socioeconomic status are receiving unequal treatment since they are prohibited the opportunity to start a family due to the exorbitant costs of fertility treatments and lack of mandated coverage by insurance, and that a limited coverage of fertility drugs by Medicaid would help to alleviate this burden.

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I. INTRODUCTION

A woman, in her forties, is in a serious relationship with a man that she has known for years. They become engaged and both feel that they have finally found the love of their lives. They both have children from prior relationships, but they want so badly to have children together to continue to build their family. Fortunately, she is able to afford to go through eight months of in vitro fertilization (“IVF”) with two egg retrievals during that time. Ultimately, however, they are unsuccessful in their attempts at becoming parents again.

Another woman is in her thirties and has been trying to have a child with her husband for a year. The woman goes to the gynecologist and learns that she would likely need to undergo infertility treatment to become pregnant. The couple saves up money so that they are able to afford the treatment. They can only afford to do one singular round of IVF and when it does not work, they are left with drained finances and no child.

Although both of these women had the same disheartening result from IVF, they were left in two very different situations. The first woman is Kourtney Kardashian, who has a net worth of $65 million, and her husband, Travis Barker, who has a net worth of $50 million. The couple likely spent over $200,000 out-of-pocket on their infertility treatments, and when they stopped the IVF treatments, it was due to health reasons and not finances. The second woman is based on the experience of April Barsby who lives in Norman, Oklahoma.

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2 See Marissa Conrad, How Much Does IVF Cost?, FORBES HEALTH (Aug. 14, 2023, 7:04 AM), https://www.forbes.com/health/family/how-much-does-ivf-cost/ (The amount that Kourtney Kardashian and Travis Barker spent on their infertility treatment is not public information. She has confirmed that she went through eight months of IVF with two egg retrievals. She has not publicized how many rounds of IVF she went through. A typical round takes about three weeks.); see also Mayo Clinic Staff, In Vitro Fertilization (IVF), MAYO CLINIC (Sept. 10, 2021), https://www.mayoclinic.org/tests-procedures/in-vitro-fertilization/about/pac-20384716#:~:text=During%20IVF%20%20%C2%B0mature%20eggs%20are%20fertilized%20in%20vitro%20and%20implanted%20in%20the%20uterus%20at%208%20to%2010%20days%20after%20ovulation%20(nearly%20three%20weeks%20from%20the%20initial%20ovulation%20cycle%20in%20women%20with%20regular%20cycles)%20and%2014%20days%20after%20the%20first%20day%20of%20the%20luteal%20phase%20(%20the%20second%2014%20to%2021%20days%20of%20the%20menstrual%20cycle%20in%20women%20with%20regular%20cycles)%20and%20%20the%20uterine%20lining%20is%20fully%20prepared%20for%20implantation%20of%20the%20embryo.)

is low-income and her insurance does not cover IVF. The procedure drained her and her husband’s finances after just one round that likely cost around $20,000.4

The inequality between the socioeconomic statuses is stark when it comes to the ability to afford infertility treatment. Due to the prohibitive cost of treatments, many more women5 are in a situation like April Barsby than Kourtney Kardashian. This inequality in treatment has led to a growing gap between those that are able to access infertility treatments, with or without help from their insurance, and those who are not. Women that are on Medicaid are offered no solution to their infertility problems since Medicaid, in all states but one, does not cover any infertility treatments; it only covers a diagnosis of the problem.6 This leaves women with an answer but no solution. Women in West Virginia are particularly vulnerable to this because the state has the highest number of people on Medicaid per capita.7 Coverage by Medicaid of some infertility treatments would allow for people suffering from infertility to have a chance of achieving parenthood, regardless of their financial status.

Part I of this Note will explore what fertility treatments are available, why they may be needed, and the prohibitive cost of those treatments. Part II of the Note will describe the law as it is across various states focusing on Medicaid coverage. States approach this issue very differently with varying results. Recognizing the unique challenges West Virginia women face, Part III of this Note will explain why people with low-socioeconomic status are in need of coverage of infertility treatments. Part IV of this Note will explain why the alternatives to legislation are inadequate to make change in this area of the law. Finally, Part V of this Note will propose recommendations for legislation in West Virginia for Medicaid to cover infertility treatments.

II. BACKGROUND

The first baby born via in vitro fertilization was in 1981.8 Her name was Elizabeth Carr and she was born to a couple that was told they would never be able to have children.9 After three ectopic pregnancies that resulted in

4 Id.; see also Conrad, supra note 2.
5 Throughout this Note, I will use “women” to describe the people suffering from infertility. This term is used for ease of reading the Note, but I would like to acknowledge that people of all gender identities born with a female reproductive system are harmed by these policies and can be helped by the solutions in this Note.
6 See discussion infra Part II.A.
9 Id.
Elizabeth’s mother, Judy, losing her fallopian tubes, the couple was able to participate in IVF trials and successfully have a baby girl. Since then, over 8 million children have been born through IVF. IVF is now considered one of the most successful treatments for infertility. IVF has become safer and more successful in the forty years since its inception, and it has become much more common for everyday people who are struggling with infertility to consider.

There are many steps to achieving pregnancy that can go wrong and lead to infertility. For a pregnancy to occur the man must make healthy sperm and the woman must have healthy eggs. The woman must be able to ovulate, where the egg is released from the ovary and moves to the fallopian tube where it can be fertilized. The fallopian tubes must be open to allow sperm to reach the egg. The sperm must be able to fertilize the egg and that fertilized egg must implant into the uterus and become a healthy embryo. In this Note, the focus will be on the female side of conception.

Infertility is defined as “not being able to get pregnant (conceive) after one year (or longer) of unprotected sex.” Nineteen percent of heterosexual women between the ages of 15 and 49 fall under this definition of infertility. Infertility is caused by conditions affecting the ovaries, fallopian tubes, and uterus. Conditions affecting the ovaries include any disruption in ovarian function. Disruption in ovulation can have many causes that without diagnosis...
could cause serious harm to the patient.\textsuperscript{23} A condition that affects the fallopian tubes would be considered a fallopian tube obstruction. There are many risk factors for this condition, including history of pelvic infection, a ruptured appendix, some bacterial sexually transmitted diseases, or prior abdominal surgery.\textsuperscript{24} Uterine conditions that affect fertility can include fibroids, intrauterine adhesions, endometrial polyps, or congenital anomalies.\textsuperscript{25}

Along with these conditions, female fertility declines between 30–39 years of age.\textsuperscript{26} As of 2022, the median age for women to give birth is 30 years old.\textsuperscript{27} This age has gradually been increasing for years and will likely continue to increase as more women chose to have children later in life.\textsuperscript{28} Other factors that cause a decline in fertility include smoking; excessive alcohol use; being overweight, obese or underweight; extreme weight gain or loss; and excessive physical or emotional stress.\textsuperscript{29} Infertility is one of the few diseases that is still prevalent and has treatments with high success rates, but nonetheless the sheer cost of such treatments makes them unattainable for so many.

IVF and other fertility treatments have become widely more accessible in recent years. About 2\% of all births in the United States are the result of assisted reproductive treatments.\textsuperscript{30} However, this access to treatment is not equal across the U.S. Those with the highest use of fertility treatments are the higher educated, higher income population.\textsuperscript{31} Forty-eight percent of people with family incomes of $75,000 and higher have been exposed to fertility treatment, by either knowing someone who has undergone treatment or undergoing the treatment.

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\textsuperscript{23} See id. These conditions include polycystic ovary syndrome, diminished ovarian reserve, functional hypothalamic amenorrhea, improper function of the hypothalamus and pituitary glands, and premature ovarian insufficiency.).
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\textsuperscript{24} Id.
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\textsuperscript{25} See id.
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\textsuperscript{26} See id. ("About 1 in 5 (22\%) married couples in which the woman is 30–39 have problems conceiving their first child, compared to about 1 in 8 (13\%) married couples in which the woman is younger than 30\.").
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\textsuperscript{28} See id. (The decision to have children later in life has been motivated by college-educated women investing in their education and careers so they could be better off financially when they have children, as well as working class women’s desire to have financial stability before motherhood.).
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\textsuperscript{30} Gretchen Livingston, \textit{A Third of U.S. Adults Say They Have Used Fertility Treatments or Know Someone Who Has}, \textit{PEW RSCH. CTR.} (July 17, 2018), https://www.pewresearch.org/fact-tank/2018/07/17/a-third-of-u-s-adults-say-they-have-used-fertility-treatments-or-know-someone-who-has/.
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\textsuperscript{31} See id.
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themselves, compared to 19% for those with a family income of $30,000 or less.\textsuperscript{32} Access to fertility treatments and usage of those treatments is directly related to income.\textsuperscript{33}

Infertility treatments can have many different forms depending on the patient’s cause of infertility, age, and personal preferences.\textsuperscript{34} This Note will focus on infertility treatments in women. These treatments include fertility drugs, surgery, intrauterine insemination (“IUI”), and assisted reproductive technology (“ART”) such as in IVF.\textsuperscript{35}

\textbf{A. Infertility Treatments}

The first step in treating infertility is a diagnosis, which includes a general physical and gynecological exam with some specific fertility tests to determine what treatment will be most effective.\textsuperscript{36} These tests include blood tests and, if needed, more invasive tests.\textsuperscript{37} These blood tests will determine whether or not the patient is ovulating, and also examine other ovulatory hormones and pituitary hormones.\textsuperscript{38} A hysterosalpingography is an x-ray of the uterus that evaluates the condition of the uterus and fallopian tubes.\textsuperscript{39} This would be ordered to see if the fallopian tubes are partly or fully blocked or to evaluate the scarring of the uterus.\textsuperscript{40} Ovarian reserve testing is done to determine the quality of eggs available for ovulation.\textsuperscript{41} Pelvic ultrasounds are also done to look for uterine and ovarian disease that can contribute to infertility.\textsuperscript{42} In rare cases doctors will request a hysteroscopy, which includes the insertion of a thin, lighted device into the uterus, or a laparoscopy, which is a minimally invasive surgery where a device is inserted to examine the fallopian tubes, ovaries, and uterus.\textsuperscript{43} This

\textsuperscript{32} Id.
\textsuperscript{33} See id.
\textsuperscript{34} Infertility, MAYO CLINIC (Sept. 1, 2022), https://www.mayoclinic.org/diseases-conditions/infertility/diagnosis-treatment/drc-20354322 [hereinafter Infertility Mayo Clinic].
\textsuperscript{35} Id.
\textsuperscript{36} Id.
\textsuperscript{37} See id.
\textsuperscript{38} Id.
\textsuperscript{39} Id.
\textsuperscript{40} Hysterosalpingography (HSG), THE AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (Apr. 2023), https://www.acog.org/womens-health/faqs/hysterosalpingography#:~:text=Hysterosalpingography%20(HSG)%20is%20an%20X,a%20normal%20size%20and%20shape.
\textsuperscript{41} Infertility Mayo Clinic, supra note 34.
\textsuperscript{42} Id.
\textsuperscript{43} Id.
would be used to investigate the symptoms or problems causing the infertility and to diagnose the conditions that cause infertility. Women differ on if they need one or many different types of treatment to achieve pregnancy based on the cause and severity of their infertility. Infertility drugs are the first and main treatment used to treat infertility. These drugs, follicle-stimulating hormone and luteinizing hormone, mimic natural hormones that trigger ovulation. Assisted reproductive technology (“ART”) is defined as “any fertility treatment in which the egg and sperm are handled.” The most common form of ART is IVF, a process in which hormones are used to stimulate egg growth before a retrieval of the eggs is performed. Those eggs are then fertilized outside of the body. The embryo that forms from fertilization is then transferred into the woman’s uterus and hopefully implants causing pregnancy to begin. In addition to being a treatment for infertility, ARTs are also used to help same-sex couples achieve pregnancy.

B. The Cost of Infertility Treatments

Although IVF and other infertility treatments have become widely used, the cost is still prohibitive for vast sections of the country. The cost of a single cycle of IVF depends on various factors, such as location in the country, the center performing the IVF, and the patient’s individual needs, ultimately ranging

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44 Hysteroscopy, NAT’L HEALTH SERV. (Feb. 16, 2023), https://www.nhsinform.scot/tests-and-treatments/non-surgicalprocedures/hysteroscopy#:~:text=A%20hysteroscopy%20is%20a%20procedure,can%20see%20inside%20your%20womb.
45 Infertility Mayo Clinic, supra note 34.
46 Id. (infertility drugs regulate or induce ovulation).
47 See id. (explaining that the common fertility drugs include Clomiphene citrate, Gonadotropins, Metformin, Letrozole, and Bromocriptine).
48 Id.
49 Id.
50 Id.
51 Id.
Clinics usually have a base fee for IVF that covers appointments, bloodwork, egg retrieval, and the additional care. Additionally, the injectable hormones can cost more than $6,000, and clinic fees for additional treatments can add costs. Some women must go through multiple cycles of IVF, which escalates the cost. The use of a sperm donor, egg donor, or surrogate can add on additional hundreds to thousands of dollars. Other costs can include anesthesia, costing around $725, donor sperm, costing from $300 to $1,600, intracytoplasmic sperm injection, costing around $2,000, and mock embryo transfer, costing around $240 to $500.

One of the reasons fertility treatments are so expensive is the lack of coverage by insurers. Most private insurance plans cover diagnosis of infertility at the gynecology appointment, but there is very little coverage available for treatment services such as intrauterine insemination (“IUI”), which is the commonly used type of artificial insemination, and IVF. About 71% of women that went through infertility treatment in 2018 did not have fertility treatment coverage. These treatments can easily become tens of thousands of dollars that patients end up paying out of pocket. There are only a few states that require private insurers to cover infertility treatments and those take very different forms. Due to the lack of coverage many families go into debt or deplete their savings due to the cost of their infertility treatments. Employers are likely to be the best resource for women to have coverage of infertility treatment. Some major companies have added fertility benefits to their coverage and some companies have additionally offered egg freezing services. In 2020, 42% of

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54 Conrad, supra note 2.
55 Id.
56 Id.
57 Id. (Commonly, the couples using donations or surrogacy are same-sex couples making the fertility process more inaccessible to this specific population. Use of a surrogate includes legal fees and medical expenses which can cost between $60,000 and $150,000.).
58 Id.
59 Weigel, supra note 53.
61 Weigel, supra note 53.
62 See id.
63 See id. (“Over half of women, 52%, who were planning to undergo IVF this year say they will pay for treatment with a credit card, according to a poll of 776 women from Student Loan Hero.”).
64 See id.
65 Id.
Although this is a clear step in the right direction, infertility coverage is still lacking for millions of Americans without health insurance, with insufficient health insurance plans, or employers that do not cover treatments.

III. INFERTILITY TREATMENT COVERAGE LEGISLATION

Since the development of infertility treatments, specifically IVF, 17 states have passed laws that require insurers to cover diagnosis and treatments for infertility. These laws vary state to state. Some cover very minimal treatment while others cover much more. Fifteen of these states require certain insurance plans to cover treatment while two of these states, California and Texas, require all insurance companies to offer coverage for infertility treatment.

A. Variations and Limitations on Infertility Coverage

States have imposed varying levels of limitations on infertility treatment coverage. Connecticut and Rhode Island have similar laws that require health

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69 Id.

70 See CONN. GEN. STAT. ANN. §§ 38a-509, -536 (West 2023) (effective Jan. 1, 2018) (“[E]ach group health insurance policy... shall provide coverage for the medically necessary expenses for the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer.”) (amended 2023 Conn. Legis. Serv. P.A. 23-117 (West)).

71 Any health insurance contract, plan, or policy delivered or issued for delivery or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs,... shall provide coverage for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (40) years.

insurers to provide coverage for only medically necessary expenses. Medically necessary is defined by most insurers as services that are clinically appropriate and considered effective for the treatment of the illness, injury, or disease of the patient, not just the convenience of the patient or the physician.\textsuperscript{72} Delaware\textsuperscript{73} is one of the states mandating that, for coverage, the individual must suffer from a disease or a condition resulting in infertility. This causes the exclusion of LGBTQ families seeking to use these services. Conversely, Maryland’s statute explicitly requires that a patient who is in a same-sex marriage does not have to demonstrate infertility by only unsuccessful heterosexual intercourse.\textsuperscript{74} Instead, same-sex couples can qualify for coverage under the statute by showing failure to achieve pregnancy through attempts at artificial insemination.\textsuperscript{75} California\textsuperscript{76} explicitly specifies that coverage of infertility treatments should be provided

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\textsuperscript{73} ‘Infertility’ means a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth . . . . This section applies to every group or blanket policy or contract of health insurance, or certificate issued thereunder . . . that requires an insured, participant, policyholder, subscriber or beneficiary to designate a participating primary care provider. Del. Code Ann. tit. 18, § 3556 (West 2023).  \\
\textsuperscript{74} An entity subject to this section that provides coverage for infertility benefits other than in vitro fertilization may not require as a condition of that coverage, for a patient who is married to an individual of the same sex: . . . that the patient demonstrate infertility exclusively by means of a history of unsuccessful heterosexual intercourse. See Md. Code Ann., Ins. § 15–810 (West 2023).  \\
\textsuperscript{75} [F]or a married patient, the patient and the patient’s spouse have a history of involuntary infertility which may be demonstrated by a history of: . . . if the patient and the patient’s spouse are same sex, three attempts of artificial insemination over the course of 1 year failing to result in pregnancy. See Md. Code Ann., Ins. § 15–810 (West 2023).  \\
\textsuperscript{76} See Cal. Ins. Code § 10119.6 (West 2023) (“[C]overage for the treatment of infertility shall be offered and, if purchased, provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.”).
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without discrimination on the basis of sexual orientation. Hawaii\textsuperscript{77} and Texas\textsuperscript{78} both require a period of infertility for five years before coverage of infertility services would start. This is substantially longer than the medical definition of one year.\textsuperscript{79}

Some states have imposed limits through which type of insurer is required to cover the treatment. In California\textsuperscript{80} all health care service plan contracts that are not HMOs are required to offer coverage of treatment, with the

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\textsuperscript{77} All individual and group accident and health or sickness insurance policies which provide pregnancy-related benefits shall include in addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures performed on the insured or the insured’s dependent spouse; provided that: . . . [p]atient and the patient’s spouse have a history of infertility of at least five years’ duration. See Haw. Rev. Stat. Ann. §§ 431:10A-116.5(a)(4)(A), 432:1-604 (West 2023).

\textsuperscript{78} Subject to this subchapter, an issuer of a group health benefit plan that provides pregnancy-related benefits for individuals covered under the plan shall offer and make available to each holder or sponsor of the plan coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures. See Tex. Ins. Code Ann. § 1366.003(a) (West 2023). “The coverage offered . . . is required only if . . . the patient and the patient’s spouse have a history of infertility of at least five continuous years’ duration . . . .” Id. § 1366.005(3).

\textsuperscript{79} See Infertility Johns Hopkins, supra note 14.

\textsuperscript{80} See Cal. Ins. Code § 10119.6 (West 2023) (“Every health care service plan contract that is issued, amended, or renewed that covers hospital, medical, or surgical expenses on a group basis, where the plan is not a health maintenance organization . . . shall offer coverage for the treatment of infertility, except in vitro fertilization.”).
exemption of IVF coverage. West Virginia, Massachusetts, and Montana all require HMOs to cover some infertility services. Massachusetts requires coverage of medically necessary expenses while West Virginia and Montana do not include a definition of “infertility services.” Most states that allow IVF coverage have a limit based on how many attempts will be covered. Maryland allows entities to limit their coverage to three rounds of in vitro fertilization per live birth without exceeding a lifetime benefit of $100,000. Some states have restrictions based on age limitations for female patients. For example, Rhode Island restricts female patients under age 25 and over age 42 from coverage of fertility treatment, and New Jersey restricts women over age 46 from receiving coverage for treatment.

According to Healthcare.gov, a Health Maintenance Organization (HMO) is:

[A] type of insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won’t cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Christ Chambers, Americans Largely Satisfied with Own Health Care, and HMO Users Only Slightly Less Satisfied Than Those with Other Forms of Health Care Coverage, GALLUP (Sept. 20, 2000), https://news.gallup.com/poll/2533/americans-largely-satisfied-own-health-care-hmo-users-only.aspx (This is only one type of insurance coverage so a law requiring coverage through HMOs leaves out many people. Only 34% of the population of Americans with insurance, which is 88% of the population, are covered by HMOs).

See W. VA. CODE ANN. § 33-25A-2 (West 2023) (“Basic health care services’ means . . . infertility services . . . .” The law is very vague and does not include a definition of infertility services.)

See, e.g., MASS. GEN. LAWS ANN. ch. 175 § 47H (West 2023) (“Any blanket or general policy of insurance . . . shall provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility to persons residing within the commonwealth.”).

See MONT. CODE ANN. §§ 33-31-102, -115 (West 2023) (“‘Basic health care services’ means . . . infertility services . . . .” Similar to West Virginia law, this statute is very vague in its definition of infertility services.)

MD. CODE ANN., INS. § 15-810 (West 2023) (“An entity subject to this section may limit coverage of the benefits for in vitro fertilization required under this section to three in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.”).

Any health insurance contract, plan, or policy delivered or issued for delivery or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, . . . shall provide coverage for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (40) years.


Some states have laws that show a more unique approach to limiting coverage for infertility treatment. Uniquely, Utah requires that an insurer that provides coverage for maternity benefits must also provide an indemnity benefit for adoption or infertility treatments.\textsuperscript{88} Both Louisiana\textsuperscript{89} and New York\textsuperscript{90} do not allow the exclusion of coverage for a medical condition solely because the condition results in infertility. Minnesota does not cover fertility drugs when they are specifically used to enhance fertility.\textsuperscript{91} Most states with laws covering infertility treatments provide coverage for in vitro fertilization, but some have not extended their statutes to include this successful procedure.\textsuperscript{92} However, as briefly touched on before, California\textsuperscript{93} and Louisiana\textsuperscript{94} specifically exclude

\textsuperscript{88} If an insured has coverage for maternity benefits on the date of an adoptive placement, the insured’s policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child’s birth. . . . An insurer may comply with the provisions of this section by providing the $4,000 adoption indemnity benefit to an enrollee to be used for the purpose of the enrollee obtaining infertility treatments rather than seeking reimbursement for an adoption in accordance with terms designated by the insurer. Utah Code Ann. § 31A-22-610.1 (West 2023).

\textsuperscript{89} La. Stat. Ann. § 22:1036 (2023) (“Any health insurance policy, contract, or plan . . . shall not exclude coverage for diagnosis and treatment of a correctable medical condition otherwise covered by the policy, contract, or plan solely because the condition results in infertility.”). This plan however does not require coverage of fertility treatment. Id. (“This Section shall not be construed to require coverage of the following: (a) Fertility drugs; (b) In vitro fertilization or any other assisted reproductive technique . . . .”

\textsuperscript{90} Every policy which provides coverage for hospital care shall not exclude coverage for hospital care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility. Every policy which provides coverage for surgical and medical care shall not exclude coverage for surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility.

N.Y. Ins. Law § 3216(13)(A), (B) (McKinney 2023).

\textsuperscript{91} Minn. Stat. Ann. § 256B.0625 (West 2023) (“Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility . . . .”).

\textsuperscript{92} See NCSL, supra note 67.

\textsuperscript{93} See Cal. Health & Safety Code § 1374.55 (“Every insurer issuing, renewing, or amending a policy of disability insurance that covers hospital, medical, or surgical expenses on a group basis shall offer coverage of infertility treatment, except in vitro fertilization . . . .”).

\textsuperscript{94} See La. Stat. Ann. § 22:1036 (2023) (“This Section shall not be construed to require coverage of the following: (b) in vitro fertilization or any other assisted reproductive technique.”).
coverage of IVF. Although many states have made progress on coverage of treatment, there is only one state that currently has any coverage under Medicaid.

B. Coverage of Infertility Treatments by Medicaid

Although the coverage of infertility by private insurers is a substantial step into making infertility treatment more universally accessible, it does not address the clear exclusion that exists of women without infertility coverage through their employers. Medicaid covers almost 90 million Americans.\(^95\) Without coverage by Medicaid, these Americans are again excluded from the potential use of infertility treatments, perpetuating the economic gap that exists in who can afford treatment.

Medicaid is a federal and state funded welfare program for low-income Americans, pregnant women, elderly adults, and people with disabilities.\(^96\) In 2018, Medicaid covered the healthcare in any given month for 32 million children, 28 million adults, six million seniors, and nine million people with disabilities.\(^97\) Medicaid is considered an “entitlement program,” meaning that anyone eligible has a right to enroll in coverage.\(^98\) States are guaranteed federal financial support for the cost of their Medicaid programs.\(^99\)

1. Mandatory and Optional Provisions

There are both mandatory and optional provisions in the federal law for eligibility, benefits, and program administration.\(^100\) There are certain populations that are considered mandatory to be covered.\(^101\) These are children through age 18 with income below 138% of the poverty line, people who are pregnant and have income below 138% of the poverty line, certain parents or caretakers with very low income, most seniors, and people with disabilities who receive cash

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\(^98\) Id.

\(^99\) Id.

\(^100\) See BARRY R. FURROW, HEALTH LAW CASES, MATERIALS, AND PROBLEMS 833 (7th ed. 1987).

assistance through Social Security. These populations must be covered for the state to receive federal funding. A state can also receive federal funding to cover optional populations. These include people in the mandatory populations that exceed the income limits, seniors, people with disabilities that are below the poverty line, those who have income that exceeds the state’s regular Medicaid eligibility limit but who have high medical expenses that reduce their income below the eligibility limit, and others who need long-term services and support. The Affordable Care Act grants inclusion to non-disabled adults with income below 138% of the poverty line, including those without children. Not all states have implemented this ACA Medicaid Expansion. In these states, generally no adults over 21 are eligible for Medicaid regardless of how low their incomes are unless they are pregnant, caring for children, elderly, or have a disability.

There are also mandatory benefits that federal law requires states cover through Medicaid. These include services such as inpatient and outpatient hospital services, and early and periodic screening, diagnostic, and treatment services. Additionally, Medicaid provides for mandatory coverage of some more specific services, including but not limited to family planning services, birth center services, and midwife services. None of these services include infertility treatment. There are also optional services that states can choose to implement. These include prescription drugs, dental care, vision services, and personal care services for seniors and people with disabilities.

2. Medicaid in West Virginia

West Virginia is one of the 39 states that has expanded their Medicaid program. Expansion allows for the federal government to pay all costs of expansion for the first three years, and then 90% of the costs on a permanent

103 Id.
104 Id.
106 Id.
107 Id.
108 Id.
109 Id.
110 Id.
111 Id.
basis. The federal government contributes at least $1 in matching funds for each $1 that a state spends on its Medicaid program. In West Virginia, every $100 spent by the state on Medicaid services will be matched up to $298 by the federal government. As a result, Medicaid does not cost West Virginia a significant amount of money but it covers almost a third of its population’s healthcare.

Over 564,000 West Virginians, 29% of the population, are covered by Medicaid as of 2020. One in 13 women of childbearing age are uninsured, and half of births in West Virginia are covered by Medicaid. Of the women who are enrolled in Medicaid, two-thirds are in their reproductive years. Women that are of childbearing age are heavily covered by Medicaid in West Virginia and thus are very likely not able to afford infertility treatments unless they are covered by Medicaid. West Virginia’s current infertility treatment law requires HMOs to cover infertility treatments, however, a large portion of the population would not be helped by this law because it only requires HMOs to cover infertility treatments and the majority of people in West Virginia are not covered by an HMO. To actually make a significant change in the gap of economic availability for infertility treatment in West Virginia, it is essential that the state include infertility treatment coverage as an optional benefit for Medicaid.

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114 Id.
115 Id.
116 West Virginia Bureau for Medical Services, Medicaid 101: 2021 Edition, W. VA. DEP’T OF HEALTH & HUM. RES. (2021), https://dhhr.wv.gov/bms/BMSPUB/Documents/Medicaid_101_Manual_2021_Edition.pdf (The federal share of the cost of Medicaid is determined by the Federal Medical Assistance Percentages (FMAP) which is calculated annually using a formula set forth in the federal statute. It is inversely proportional to a state’s per capita income relative to the U.S. average which means that the lower the state’s income, the higher the federal match will be. The FMAP in 2020 was 74.9% which means that the federal government bears that same percentage of the costs for eligible Medicaid services. The remaining is covered by the state. In essence, the FMAP acts as a multiplier for state spending.).
In contrast, New York’s Medicaid scheme allows for at least some coverage of infertility treatments. Currently, New York is the only state that provides any coverage of infertility treatment by Medicaid.\textsuperscript{122} The law, enacted in 2020, mandates that any large-group insurance plans cover IVF.\textsuperscript{123} However, the coverage in New York is limited.\textsuperscript{124} The Medicaid benefits include “medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such for individuals 21 through 44 years of age experiencing infertility.”\textsuperscript{125} The infertility benefits include office visits, hysterosalpingograms, pelvic ultrasounds, blood testing, and ovulation enhancing drugs.\textsuperscript{126} These benefits are limited to coverage of three cycles per lifetime.\textsuperscript{127} IVF and IUI are not covered by this law.\textsuperscript{128} Additionally, for this purpose, New York has defined infertility as a condition characterized by “the incapacity to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse for individuals 21 through 34 years of age, or after six months for individuals 35 through 44 years of age.”\textsuperscript{129} Through Medicaid’s fee-for-service, the claims must be submitted with an infertility diagnosis.\textsuperscript{130} This New York law shows that state legislation is a viable route for expansion of infertility coverage.

IV. WHY LOW-INCOME PEOPLE NEED COVERAGE OF INFERTILITY TREATMENTS

The primary population that is covered by Medicaid is low-income people.\textsuperscript{131} As mentioned in Part I, Medicaid covers a third of West Virginia’s population, making it one of the largest healthcare providers in the state.\textsuperscript{132} To exclude those covered by Medicaid from insurance coverage of infertility treatment would exclude a significant portion of women of child-bearing age.

\textsuperscript{122} See N.Y. INS. LAW § 3216 (McKinney 2023).
\textsuperscript{124} Id.
\textsuperscript{126} Id.
\textsuperscript{127} Id.
\textsuperscript{128} See id.
\textsuperscript{129} Id.
\textsuperscript{130} Id.
\textsuperscript{131} Policy Basics: Introduction to Medicaid, supra note 97.
\textsuperscript{132} Medicaid’s Role in West Virginia, supra note 117.
from access to treatment.\textsuperscript{133} Infertility is prevalent at similar rates among women of all different walks of life.\textsuperscript{134} About 12.5\% of women in a 2019 study from the University of Michigan reported that they were unable to conceive for one year— the medical definition of infertility.\textsuperscript{135} Of those in the study making less than $25,000 a year, only one-third of women sought infertility treatment.\textsuperscript{136} Two-thirds of women who made $100,000 or more a year sought fertility treatment.\textsuperscript{137}

“Women with less education, lower incomes, non-citizens and women without health insurance and without access to physician offices did not see their doctors as often for help with fertility,” said Dr. James Dupree, assistant professor of obstetrics and gynecology.\textsuperscript{138} There are a number of barriers that cause this distinction including “patient lack of awareness, geographic access to specialists, financial burdens, and time burdens.”\textsuperscript{139} Financial burdens are not the only reason that many women do not seek treatment.\textsuperscript{140} However, with coverage of these treatments more women may learn about and become motivated to find a treatment for their condition.

\textit{A. The Likelihood of Infertility in Low-Income Women}

There is no direct evidence that women who are lower income are more likely to be infertile.\textsuperscript{141} However, there are numerous factors that place low income women at a higher risk of infertility.\textsuperscript{142} Many of the common causes of infertility are concerned with ovulation problems.\textsuperscript{143} Some other causes of fertility problems include other aspects of the female reproductive system, which

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\textsuperscript{133} See Data for West Virginia, supra note 118.
\textsuperscript{135} Id.
\textsuperscript{136} Id.
\textsuperscript{137} Id.
\textsuperscript{138} Id.
\textsuperscript{139} Id.
\textsuperscript{140} See generally Madeline Curtis, \textit{Inconceivable: How Barriers To Infertility Treatment For Low-Income Women Amount to Reproductive Oppression?}, XXV \textit{C. J. ON POVERTY L. & POL’Y} 323, 329 (2018) (explaining that various state IVF qualifications such as meeting unprotected sexual intercourse duration criteria, marriage mandates, requiring underlying medical conditions, and age limits also create barriers to women’s ability to seek IVF treatment).
\textsuperscript{141} Id.
\textsuperscript{142} Id.
\textsuperscript{143} \textit{Infertility}, \textit{OFFICE ON WOMEN’S HEALTH} (Feb. 22, 2021), https://www.womenshealth.gov/a-z-topics/infertility [hereinafter \textit{Infertility Women’s Health}].
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can be very costly to treat. There are many other environmental factors that can cause a woman to have a difficult time conceiving. These factors include age, smoking, excess alcohol use, stress, poor diet, being overweight or underweight, and untreated sexually transmitted diseases. Almost all of these factors are more prevalent in low-income women than in women with a higher socioeconomic status. Cumulatively, these factors can lead to higher risks for infertility and without access to adequate healthcare these can lead to the inability to conceive naturally.

Smoking is much more common for women below the poverty level with 22.7% of women versus 12.3% of women above the poverty level. These numbers correlate with lower education levels. People with low socioeconomic status are more likely to smoke and less likely to have access to the resources to be able to quit. Excess alcohol use and substance abuse are also more prevalent in low-income Americans. Specifically, those with a stable income are less likely to have addiction than someone who has no financial security. Often there is a culture of issues with excess drinking in neighborhoods with lower socioeconomic status. This can be more powerful of an environmental factor than just actual access to the substance. These environmental factors can lead to behaviors that are not the fault of the women who are influenced but due to the influence of the environment that they were raised in or live in, and these behaviors can lead to a decreased chance of fertility later in life.

Particularly relevant to West Virginia is the factor of weight. West Virginia is a state with an obesity rate of approximately 40.9%—the highest in}

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144 Id. These include blocked fallopian tubes, uterine problems, and uterine fibroids.
145 Id.
146 Curtis, supra note 140, at 331–33.
147 Id. at 333.
149 Id. Historically, the tobacco industry has targeted women and low-income communities.
151 See Addiction and Low-Income Americans, ADDICTION CENTER (Apr. 17, 2023), addictioncenter.com/addiction/low-income-americans.
152 Id.
the United States. However, this statistic does not manifest itself among only women of extreme poverty. Lower and middle-income women are both more likely to be overweight than wealthy women. There are many causes of obesity that are more typically associated with the lifestyle of a lower socioeconomic person, such as less physical activity, poor diet due to either financial constraints or lack of access to healthy foods, and lack of access to healthcare.

Most sexually transmitted infections (“STIs”) can lead to infertility if they are left undiscovered or untreated. Due to the opioid crisis in West Virginia, STI outbreaks have become more common and are considered an epidemic. Due to the limited healthcare access of people with lower socioeconomic status, this population is less likely to discover these infections and they are able to progress to a point that can cause serious problems in the future with fertility. There are higher rates of sexually transmitted diseases (“STDs”) among those in poverty, unemployed, or with low education levels. These communities are also less likely to have access to sexual health education or providers that they trust to help with an issue as personal as an STI.

Heightened stress is also characteristic of low-income populations. 8.7% of people under the poverty level report severe psychological distress. These factors can lead to some of the other risk factors discussed here such as

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156 Cynthia L. Ogden et al., Morbidity and Mortality Weekly Report, CDC (Dec. 22, 2017), cdc.gov/mmwr/volumes/66/wr/mm6665a1.htm.
158 Id.
160 Id.
162 See Curtis, supra note 140, at 331.
164 Id.
166 Id.
substance or alcohol abuse, high blood pressure, and obesity.\textsuperscript{167} Long-term stress is likely to occur from prolonged exposure to poverty, and these responses can lead to long-term physical consequences.\textsuperscript{168} Along with the more likely high levels of stress, low-income people are less likely to have access to mental health services to help treat these issues because of insurance coverage or lack of access to care for people living in rural areas.\textsuperscript{169}

B. Environmental Hazards Affecting Fertility Make Low-Income Women More At Risk for Infertility

These factors taken together suggest that low-income women in West Virginia are more at-risk—due to environmental factors—to struggle to conceive. Additional environmental factors such as pollution and air quality can also lead to a decrease in fertility.\textsuperscript{170} Exposure to pesticides, toxins, and lead has been found to negatively affect fertility.\textsuperscript{171} Indeed, fertility specialists recommend avoiding these toxins when trying to conceive.\textsuperscript{172} Low income women are more likely to be exposed to these toxins because they are more likely to have jobs where they regularly come in contact with these chemicals such as farm and greenhouse work; healthcare; nail, beauty, and hair salons; and manufacturing.\textsuperscript{173}

There are other environmental hazards that are not linked to employment but also show up more often in low-income families. Lead-based paint is more likely to be found in houses owned or rented by low-income families.\textsuperscript{174} A 2002 study showed that 35\% of low-income housing has lead-based paint, while only 19\% of households with incomes greater than $30,000 had lead-based paint.\textsuperscript{175} Harmful pesticides are more likely to be present on non-organic food.\textsuperscript{176} These


\textsuperscript{168} \textit{Low-Income, supra note 165.}

\textsuperscript{169} Id.


\textsuperscript{171} Curtis, \textit{supra note 140}, at 331.

\textsuperscript{172} Id.

\textsuperscript{173} Id. at 331–32.

\textsuperscript{174} Id. at 332.

\textsuperscript{175} Id.

\textsuperscript{176} Id.
foods tend to be cheaper and more accessible to people with low-incomes, so they are more likely to be consumed and potentially harm fertility.\textsuperscript{177}

\textbf{C. Societal Opinions on Low-Income Women and Fertility}

Although rates of infertility are relatively similar for low-income and high-income women, historically low-income women have been seen as “hyper fertile” and having too many children.\textsuperscript{178} This view has led to the misconception that fertility is a “rich women problem” and disregards that low-income women also may desire to use infertility treatments to achieve a family.\textsuperscript{179} This view can be seen in the current lack of coverage for low-income women’s infertility treatments. The difference in treatment and societal view of low-income women is shown in the example of how large employers that offer high salaries are starting to provide fertility benefits, while Medicaid in most states covers zero fertility treatments but a variety of contraceptive devices.\textsuperscript{180}

Many free clinics, like Planned Parenthood, are able to provide contraception or abortion and regular gynecologic services but do not provide any type of infertility treatment.\textsuperscript{181} In most states, Medicaid will cover diagnosis of infertility through gynecologic services, but then a woman is left with a diagnosis and nowhere to turn to treat the medical issue.\textsuperscript{182} For most other diagnoses, this would be seen as egregious treatment of a person, to cover diagnosis but require a hefty sum for any chance at treatment. For example, this would be like going to the doctor and being diagnosed with a sinus infection but when you went to get your antibiotics, they would cost $5,000. Most people would be in shock if this situation happened to them, however, this is the only outcome for all low-income women who deal with infertility.

\textbf{D. Adoption as An Option for Low-Income Women Suffering from Infertility}

Low-income women who want children are no different than high-income women who want children; however, high-income women have more options. There is an inequality of options. A common counterpoint to infertility

\textsuperscript{177} See id.
\textsuperscript{178} *ANN V. BELL, MISCONCEPTION: SOCIAL CLASS AND INFERTILITY IN AMERICA* 41–2 (Anita I. Garey et al. eds. 2014).
\textsuperscript{179} *Id.*
\textsuperscript{181} *Id.*
\textsuperscript{182} See Weigel, *supra* note 53.
treatments is adoption. However, that too is an unreliable alternative and not as accessible to low-income families as is to high-income families due to the cost. Families suffering from infertility may be encouraged to become foster parents or adopt through private agencies. Many people do not foster children because there is a strong chance that throughout the court process the children will be given back to their birth parents and that possibility can be too emotionally devastating for some people to risk.

Additionally, private adoption agencies are very selective in who is able to adopt a child. Income is factored into the decision and a family on Medicaid due to their income level, is unlikely to qualify to adopt. Private adoption agencies typically allow for the birthmothers to pick the families the child will go to and often the birth mother would prefer that the child go to a well-off family. Adoption is also a large upfront cost. Adoptions can cost upwards of $15,000 and close to $40,000 in some cases. Adopting a child requires involvement of attorneys, social workers, physicians, and typically involves agency fees and potentially adoption costs to the prospective birth mother. Independent adoptions are not allowed in every state and most states require that both parties have attorneys, which can become expensive. The adoption option is much more feasible for women with high-incomes than it is for low-income women. Beyond this, women of all socioeconomic status may just simply want to have their own children and that is the real injustice of the gap in access to infertility treatment.

E. More Access to Treatment Encourages Safer Procedures in Treatment

There are additional medical risks, specifically with IVF, that can be motivated by the cost of treatment. The number of embryos transferred depends on the quality of the embryo and the age of the woman, but typically more than

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186 See id.
187 Id.
188 Id.
189 See id.
one is transferred to optimize the chance of pregnancy.\textsuperscript{191} This can result in multi-fetal pregnancies at a higher incidence than with natural conception.\textsuperscript{192} These pregnancies, although seen as a success, can lead to potentially dangerous outcomes for both babies and mother.\textsuperscript{193} There are no federal laws that limit the amount of embryos that can be transferred and physicians are incentivized to implement more to maximize the investment of their patients.\textsuperscript{194} A successful pregnancy occurs only 40–50\% of the time that an embryo is transferred and success rates increase as more embryos are implanted.\textsuperscript{195}

These pregnancies often result in preterm births of two, three, or four babies.\textsuperscript{196} Preterm births are dangerous to both the mother and the babies and become more likely with each added embryo.\textsuperscript{197} Single birth pregnancies result in preterm births 9.4\% of the time, twin births 14\% of the time, and triplets 41\% of the time.\textsuperscript{198} Preterm birth is associated with low birth weights and can often result in complications in both the short-term and long-term.\textsuperscript{199} This can lead to developmental delays and long-term health needs.\textsuperscript{200} Preterm births are also costly, at an average of $51,000 per infant.\textsuperscript{201} There are additional long-term costs in the form of additional care, long-term treatment, and potential long-term mental or physical disability care.\textsuperscript{202} For the mother, gestational diabetes and preeclampsia are more likely to occur.\textsuperscript{203}

Insurance coverage that assists with the cost of infertility treatments would likely encourage parents and doctors to avoid this risky practice. In the

\textsuperscript{192} Id.
\textsuperscript{193} Id. at 151.
\textsuperscript{194} Id.
\textsuperscript{196} Davidson, supra note 190, at 150.
\textsuperscript{197} Id. at 147.
\textsuperscript{198} Greg Alexander, Michael Kogan, Joyce Martin & Emile Papiernik, \textit{What Are The Fetal Growth Patterns of Singletons, Twins, And Triplets In The United States?}, 41 CLINICAL OBSTETRICS & GYNECOLOGY 115 (1998).
\textsuperscript{199} Id.
\textsuperscript{200} Id.
\textsuperscript{201} Davidson, supra note 190, at 148.
\textsuperscript{203} Id.
countries that do provide insurance coverage for IVF, there are lower rates of multi-fetal pregnancies from multiple embryo implantations.\textsuperscript{204} Physicians are no longer incentivized to implant more embryos because with insurance coverage they will be reimbursed for more rounds.\textsuperscript{205} Additionally, parents would be less likely to request multiple implantations if they knew the risks and had more chances to get pregnant. Without coverage, women who want to get treatment are unlikely to be able to afford more than one round.\textsuperscript{206} They are, literally, putting all of their eggs in one basket. With coverage, this dangerous practice would be no longer incentivized and would likely cost less to the insurance companies and government in the long run.

\textbf{F. Importance of Inclusion of LGBTQ Low-Income People in Coverage of Infertility Treatments}

The definition that most states use to define infertility is inherently based on heterosexual couples and natural conception.\textsuperscript{207} This results in an ambiguity in the current language in most statutes if LGBTQ couples are covered by insurance coverage for assisted reproduction. There is ongoing litigation and debate in different states about whether LGBTQ couples are included.\textsuperscript{208} Regardless, low-income LGBTQ couples are left with no option when they are not able to access assisted reproduction.

By allowing coverage of some less costly fertility treatments, such as intrauterine insemination, LGBTQ couples can be given a way to grow their families.\textsuperscript{209} Procedures like this are not as costly as IVF but are still cost prohibitive for many low-income people.\textsuperscript{210} The barriers with adoptions for low-income LGBTQ couples are the same as those for heterosexual low-income people making adoption an unreliable and lengthy process for these couples. Wealthier LGBTQ couples are able to access a variety of different routes to achieve pregnancy, including sperm donations, IVF, surrogacy, and intrauterine insemination, giving these couples the opportunity to have their own biological children.\textsuperscript{211} Meanwhile, low-income LGBTQ couples are prohibited from

\textsuperscript{204} Davidson, supra note 190, at 149.
\textsuperscript{205} Id. at 150.
\textsuperscript{206} Id. at 150–51.
\textsuperscript{208} See id. at 468–72.
\textsuperscript{209} See id. at 460–61.
\textsuperscript{210} See generally IUI or “Artificial Insemination”, FERTILITY IQ, https://www.fertilityiq.com/iui-or-artificial-insemination/the-cost-of-iui (last visited Nov. 7, 2023) (explaining that a typical cycle of IUI costs $500 to $4,000 depending on the type of medication, the monitoring and bloodwork and if there will be more than one insemination).
\textsuperscript{211} See Weigel, supra note 53.
biological children by cost. Providing minimal insurance coverage of these treatments and broadening the definition of infertility in the law, as some states already have done, can allow low-income couples the same chance of becoming families as middle or high-income LGBTQ couples.

V. INADEQUATE ALTERNATIVES TO LEGISLATION

There are alternatives to proposing policy that may be considered when attempting to include infertility treatments in insurance coverage; however, a change in policy is likely the best avenue toward change. Litigation has proven unsuccessful here since it is unreliable and unestablished in this area.\(^\text{212}\) Currently, private agencies provide funding for medical care for some patients that want to undergo fertility treatments; however, that funding is very limited and also unreliable.\(^\text{213}\) In the last few decades, more employers have started to include coverage of infertility treatments for their employees; however, most of these employers are already paying higher salaries, which just continues to exacerbate the gap of access between socioeconomic status.\(^\text{214}\)

A. Litigation

First, litigation is unlikely to bring about change in this area. There is very little case law across the country on the issue of infertility treatment inequality.\(^\text{215}\) There are some cases that have been brought on the issue of gender inequality and the Pregnancy Discrimination Act. In *Saks v. Franklin Covey Co.*,\(^\text{216}\) a female employee with infertility brought an action against her employer under the Americans with Disabilities Act (ADA) and the Pregnancy Discrimination Act (PDA) from denial of her claim for benefits for her surgical impregnation procedures.\(^\text{217}\) The Second Circuit held that the exclusion of the benefits did not violate the PDA because infertility is not a condition unique to women, so the exclusion of the treatment was not discrimination on the basis of “pregnancy and related medical conditions.”\(^\text{218}\) Another case, *Bragdon v. Abott*,\(^\text{219}\) established that reproduction falls within the definition of “major life

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\(^{212}\) See infra Part IV.A.

\(^{213}\) See infra Part IV.B.

\(^{214}\) See infra Part IV.C.

\(^{215}\) This is based off a Westlaw search using the terms “fertility treatments” and an additional search of “fertility treatments” and “Medicaid.”

\(^{216}\) 316 F.3d 337 (2d Cir. 2003).

\(^{217}\) Id. at 341.

\(^{218}\) Id. at 351.

activity” as defined by the ADA. This holding does establish a ground for which the argument for expansion of infertility coverage can be based, but is unlikely to be interpreted broadly enough since the holding here was narrowed to the language of the ADA. These cases can only take this issue so far without a change to policy and they do not address the specific issue of coverage by Medicaid.

Additionally, litigation is an unreliable way to bring about change in Medicaid policy due to the slow speed of litigation. It would likely be faster and more lasting for a state legislature to include the policy change. All significant change in those states that have mandated coverage of infertility treatment in different forms has been through their state legislatures. A proposed policy such as the law that West Virginia has adopted for coverage by HMOs, which has been approved in a state legislature, can be attractive to a legislature in a state where there is a clear need for the change. In West Virginia, the infertility coverage that is state mandated was done through the legislature and not through litigation. This shows that the legislature has shown interest in a policy change similar to this and there is legislative history to show that the state is receptive to change in this area.

B. Private Agencies

Private agencies are currently one of the most available resources for helping people who are unable to afford fertility treatment. Many agencies give scholarships and grants to those that meet certain requirements. Based on these requirements, grants come in different categories: There are national grants, patient specific, state specific, and clinic specific. The information for these scholarships are available on the internet and on fertility specific sites such as resolve.org and fertilityiq.com which provide education and resources for people who are struggling with infertility, however they are limited in resources. There are some grants such as from The Gift of Parenthood, which can be used to cover any expenses that are associated with reproduction such as IUI, IVF,

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220 Id. at 638.
221 See id.
222 See discussion supra Part II.A.
224 Id.
227 Id.
There are other grants that are more specific to treatment such as the International Council on Infertility Information Dissemination (“INCIID”), which provides IVF scholarships at certain national clinics. These only are provided once a month. Although these scholarships do provide a resource for those who may not be able to afford an infertility treatment, they are extremely limited in resources, with some of the grants only being afforded once a year, or being capped at an amount of money that will not cover a substantial amount of treatment.

Some patient specific grants include grants specific to veterans, cancer survivors, Jewish families, and low-income families. These specific grants include the Bob Woodruff Foundation, providing $5,000 to veterans and the Samfund, providing up to $4,000 to cancer survivors. The Jewish charities give slightly more monetary support with Hasidah, offering between $5,000 and $15,000, Making Miracle Babies which provides loans for up to $18,000, and Tree of Life which is regional specific grant that provides $10,000 to those Jewish families that are earning under $100,000 a year. There are state specific grants that are available to residents that show need, however, not every state has the resources of these nonprofits. Reliance on agencies again disenfranchises those that are in poorer states. Some universities allow for periodic free rounds of IVF or discounted treatments for people meeting certain requirements.

Although some of these charities are granting scholarships of a substantial amount of money, in the world of fertility treatment these scholarships will not make a large difference. On average one round of IVF is between $12,000–$20,000, and many women need more than one round to achieve pregnancy. There are many more nonprofits than just the ones that were specifically mentioned here, but there simply are not enough resources to go around and it takes significant energy and resources just to find and apply to these agencies, which is likely to be more difficult for low-income and working class couples. Additionally, insurance is historically a problem that was handled within the government and accordingly, it is unrealistic and unreliable to continue to rely on the private sector to bridge the gap in equality that the public sector has left.
C. Employer Coverage of Infertility Benefits

Another alternative to insurer mandated coverage policies is employers choosing to supply fertility benefits. There has been a trend in the last couple of years for large companies to offer family building benefits.238 Employers are free, regardless of what state they are in, to offer coverage of infertility benefits to their employees.239 Overall, large employers are more likely to include coverage of fertility treatments than small employers.240 56% of employers with 500 or more employees will cover some fertility services but not all treatments.241 Employers that offer higher salaries are also more likely to cover more extensive types of treatment like IVF, IUI, or egg freezing.242 Nevertheless, employers have been slow to include infertility treatment in their insurance plans but the number is rising.243 This may be due to the fading of some of the taboos around infertility, a more competitive job market, and the issue becoming one about corporate diversity and less about a stereotype of career driven women waiting too late into their careers to achieve parenthood.244

Almost 800 large companies and employers have implemented or enhanced their family-building benefits (including fertility, adoption, or foster).245 These companies are not only the traditionally generous industries like technology, banking, and consulting.246 BP and Starbucks both now offer comparable benefits to those in the historically generous industries.247 Different companies offer different amounts of coverage, for example Starbucks offers around $25,000 for IVF, Walmart offers around $20,000, and Adobe offers $60,000 for a lifetime.248 Some companies allow unlimited coverage like Chanel,

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239 Id.
240 Id.
241 Weigel, supra note 53.
242 Id.
244 Id.
246 Id.
247 Id.
the fashion giant, Bain and Company, the management consulting company, and Spotify, the music streaming service.\textsuperscript{249}

This rise in employer coverage of fertility benefits has been enormously beneficial to women in their access of treatments.\textsuperscript{250} However it does not address many of the issues that we have discussed in this Note. Primarily, the companies that are offering these benefits are already higher paying jobs, with the exclusion of some companies such as Starbucks or Walmart.\textsuperscript{251} The companies that offer the best benefits are ones where the employees are likely making higher salaries.\textsuperscript{252} It is more likely that these people could afford a fertility treatment with just their salary. The people that are employed in lower paying jobs have a higher need for the additional benefits since their salaries are unlikely to be able to cover the cost of the treatments on their own.

Recently, there has been an increase in the reduction of benefits overall.\textsuperscript{253} In 2021, there were reductions in benefits by employers with the most generous benefits and this showed a move by these companies to cover more costly fertility treatments like surrogacy.\textsuperscript{254} Although coverage of more expensive treatments is a good outcome that helps to benefit a broader set of people hoping to grow their families, this reduction in benefits exemplifies how reliance on employers can lead to unreliability in coverage. Legislation in this area would allow for people to be able to plan ahead and know which treatments and how many treatments will be covered. By continuing to rely on private employers and their decision to include fertility treatments in their benefits package, the families are at the whim of their employer’s decisions and their impact on how or when they can try to grow their families.

Along with this there are some employers that are not incentivized to start to offer benefits to employees.\textsuperscript{255} There will always be those fields in which employee recruitment is more important to the employer and the employers are able to see a clear reason why they should include these benefits.\textsuperscript{256} On the other hand, there will also always be fields where the employees have less power in choosing who to work for and which benefits are better for them. Many people will not be able to choose their just job based on coverage of infertility benefits.

\textsuperscript{249} Id.
\textsuperscript{250} See id.
\textsuperscript{251} Id.
\textsuperscript{253} 2021 Fertility IQ Workplace Index, supra note 237.
\textsuperscript{254} Id.
\textsuperscript{256} See id. at 6.
The companies that are covering infertility benefits are mostly very large companies which typically do not have locations in more rural areas.\textsuperscript{257} Continuing to rely on employers to make the slow crawl to covering fertility benefits would likely result in a plateauing of the rates.\textsuperscript{258} Accordingly, this does still leave a gap with low-income Americans and their need for coverage since many smaller sized businesses will be unlikely to cover infertility treatments any time in the near future.\textsuperscript{259}

VI. RECOMMENDATIONS FOR LEGISLATION IN WEST VIRGINIA

In the 2022 Regular Session, a bill was introduced that considered substantially expanding the coverage of infertility treatments in West Virginia.\textsuperscript{260} This bill did not go any further than being referred to a committee.\textsuperscript{261} However, this still shows that there is interest in the state for coverage to be expanded.\textsuperscript{262} The findings clause of the proposed bill states:

it is in the public interest to make medical treatment for infertility and related conditions affordable for West Virginia residents and employers, so as to attract and retain young families, expand the state’s health care resources, reduce overall health care costs, and improve health outcomes for the resulting children.\textsuperscript{263}

In this bill fertility treatment is given a broad definition of a service or a product with the intent to achieve a pregnancy.\textsuperscript{264} Infertility is defined without any year limitations.\textsuperscript{265} The treatment is required to be medically necessary

\textsuperscript{257} \textit{Surve}, supra note 255, at 11; \textit{see generally} \textit{Making Sense, Map: These Cities Are Home to the Nation’s Biggest Companies}, PBS (Nov. 13, 2018, 2:58 PM), https://www.pbs.org/newshour/economy/making-sense/amazon-map-cities-home-nation-biggest-companies
\textsuperscript{258} \textit{Surve}, supra note 255, at 11.
\textsuperscript{259} \textit{Id.}
\textsuperscript{261} \textit{Id.}
\textsuperscript{262} \textit{See id.}
\textsuperscript{263} \textit{Id.}
\textsuperscript{264} \textit{Id.} (“‘Fertility treatment’ means health care services or products provided with the intent to achieve a pregnancy that results in a live birth with healthy outcomes.”).
\textsuperscript{265} \textit{Id.} (“‘Infertility’ means a disease, caused by an illness, injury, underlying disease, or condition, where an individual’s ability to become pregnant or to carry a pregnancy to live birth is impaired, or where an individual’s ability to cause pregnancy and live birth in the individual’s partner is impaired.”).
which is similar to most of the language in other state’s statutes.\textsuperscript{266} The proposed bill requires that diagnosis of infertility be covered.\textsuperscript{267} The proposed bill requires coverage for medically necessary fertility treatment including evaluation, laboratory assessments, medications, and treatments associated with the procurement of donor eggs, sperm, and embryos.\textsuperscript{268} The proposed bill would also provide benefits for the medical and hospital expenses for fertility preservation for a person who is about to undergo medical treatment that causes a risk of impairment of fertility.\textsuperscript{269}

Since this bill was proposed, it is clear that there is an interest in the state of expanding access to infertility care. However, since the bill was not passed some key changes may need to be considered to make it more reasonable. One change is the inclusion of some limitation to usage like that in the New York legislation. The New York bill only requires coverage of three rounds of treatment.\textsuperscript{270} This is a reasonable number considering one round of treatment only is successful 46\% of the time for women under 30.\textsuperscript{271} Three rounds of treatment is enough to make the system a little fairer to women at the extreme lower end of the socioeconomic spectrum.

A law very similar to the New York law would likely be the best option for a state like West Virginia. The explicit inclusion of Medicaid recipients in the bill would allow for less discretion by interpretation as there has been in New

\textsuperscript{266} Id. ("‘Medically necessary’ means health care services or products provided to an enrollee for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease . . . ‘").

\textsuperscript{267} Id. ("Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for the diagnosis of the etiology of infertility.").

\textsuperscript{268} Id. ("Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for medically necessary fertility treatment. Enrollees shall be provided coverage for evaluations, laboratory assessments, medications, and treatments associated with the procurement of donor eggs, sperm, and embryos.").

\textsuperscript{269} Id. ("Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for fertility preservation when a person is expected to undergo surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment of fertility. Coverage under this section shall include coverage for standard fertility preservation service, including the procurement and cryopreservation of embryos, eggs, sperm, and reproductive material determined not to be an experimental infertility procedure. Storage shall be covered from the time of cryopreservation for the duration of the policy term. Storage offered for a longer period of time, as approved by the health carrier, shall be an optional benefit.").


York. Instead of the three rounds of treatment that New York allows, a more attractive bill in West Virginia would include two rounds of treatment. This would allow for families to have more than one chance but is still restrictive enough that there will not be excess spending. By offering coverage of two rounds of treatment some of the issues with multiple embryos and worries of multiple children could be taken away as some of the less risky treatment like ovulation enhancing drugs would be covered earlier on. This could give parents the opportunity to attempt to have one biological child. If additional rounds are needed those could come out of pocket and the cost would be lessened to low-income West Virginians because they would have the first few rounds covered.

The bill should include a provision for LGBTQ individuals as the proposed legislation did and allow for some minimal treatment to allow an opportunity for those families. Even without coverage for IVF and just coverage of infertility drugs there is a better opportunity for low-income Americans. There will always be a gap between the rich and the poor when it comes to medical treatments, but this bill could substantially help low-income women in West Virginia who prior to this had no options. A bill of this nature could attempt to bridge the gap between high-income and low-income West Virginians allowing for more equality for couples suffering from infertility in the state.

VII. CONCLUSION

Infertility treatments in the United States are more accessible now and are widely used. More people than ever before are using infertility treatments as a means to get pregnant. However, as this technology has become more commonplace, the price has not correspondingly gone down. For those of higher economic status, infertility treatments are a cost they are willing to bear, and they will not be substantially disadvantaged by the cost. This system leads to the disparity between women like Kourtney Kardashian, who easily can afford eight months of IVF treatments, and women in rural Appalachia who cannot even consider IVF due to its cost.

To effectively contribute to the goal of greater accessibility to infertility treatment, West Virginia needs to include those who are on Medicaid. In the 2022 Session of the West Virginia Legislature, a bill was proposed that was similar to New York’s law. This bill would have required a broad coverage of infertility diagnosis, medications, and treatments. The bill would have applied to women using Medicaid as well. Since the bill did not make it out of committee, a narrower bill may be more effective. A bill with some of the limits that have been used in other states could allow coverage to be extensive enough and more

appealing to a legislature but will still allow some help to low-income couples who are suffering from infertility.

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