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WHO SHOULD REPRODUCE? PERPETUATING ARCHAIC VALUE JUDGMENTS OF PROCREATION IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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I. INTRODUCTION

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) into law.[1] The PPACA withstood a constitutional challenge before the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius*, and has now been implemented across the United States.[2] The PPACA is lauded by some as a key step toward achieving a universal health care system in the United States,[3] and demonized by others as "socialized medicine."[4]

A large portion of PPACA is devoted to newly developed Essential Health Benefits (EHBs).[5] EHBs are categories of benefits that each non-grandfathered health insurance plan must cover to be sold in the insurance exchanges created by the PPACA.[6] The U.S. Department of Health and Human Services (HHS) developed and promulgated rules for the EHBs based on recommendations from the non-profit Institute of Medicine (IOM).[7] Based on recommendations from IOM, HHS mandated that female contraceptives, such as hormonal birth control pills, be covered by insurers without cost-sharing as part of women's preventive

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.).

2. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. __, 132 S. Ct. 2566, 2600 (2012) (upholding the individual mandate for Americans to acquire health insurance coverage by January 1, 2014 under Congress' taxing authority, while simultaneously limiting the expansion of Medicaid to cover all individuals up to 138 percent of the Federal Poverty Level).

3. *See, e.g.*, ALAN G. RAYMOND, MASSACHUSETTS HEALTH CARE REFORM: A FIVE-YEAR PROGRESS REPORT 3 (2011) (describing the goals and successes of Massachusetts' efforts to gain universal health care, and highlighting that 98.1 percent of Massachusetts residents have health care coverage because of the reforms). It is worth noting that the PPACA was based in large part on the Massachusetts health care insurance program. *See* Elizabeth Hartfield, *Romneycare in Massachusetts, Six Years Later*, ABC NEWS (June 21, 2012), http://abcnews.go.com/Politics/romneycare-massachusetts-years/story?id=16614522.

4. *See, e.g.*, Michael McAuliff, *Obamacare is Socialism: Reps. Louie Gohmert, Steve King Attack*, HUFFINGTON POST (Mar. 27, 2012), http://www.huffingtonpost.com/2012/03/27/ obamacare-socialism-louie-gohmert-steve-king_n_1383973.html (describing the political demonization of healthcare reform as "socialized medicine").

5. John K. Iglehart, *Defining Essential Health Benefits—The View from the IOM Committee*, 365 NEW ENG. J. MED. 1461, 1461 (2011).

6. *Id.*; *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVICES, http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html (last visited Nov. 7, 2013).

7. Iglehart, *supra* note 5 ("The DHHS, in turn, asked the Institute of Medicine (IOM) to recommend a process for defining and updating the EHB package—but notably, not to develop a specific list of benefits. In a report released on October 7, the IOM recommended that the initial EHB package be equivalent in scope to what could be purchased by the average premium that a small business would pay on behalf of an employee [ ].").

care EHBs.[8] Excluded from the EHBs, however, is coverage for infertility treatment.[9] Including contraceptive coverage in the EHBs of the PPACA, while failing to include infertility treatment, unintentionally reinforces existing racial and economic disparities in procreation.[10]

This Article critically assesses the racial and economic realities of reproductive policies in the United States. First, the Article briefly discusses prior racial and economic disparities in U.S. reproductive health law.[11] Second, this Article addresses the PPACA's anticipated impact on reproductive health.[12] Third, the Article addresses the influence of state law mandates to cover infertility services, as permitted by the savings clause of the Employee Retirement Income Security Act (ERISA).[13] Finally, this Article examines the legal and ethical implications of failing to include infertility treatment as an EHB and argues that infertility treatment should be included as an EHB.[14]

II. UNITED STATES REPRODUCTIVE POLICY: A TENSION BETWEEN PRONATALISM AND ANTINATALISM

Reproductive policies in the United States have been politicized throughout this country's history.[15] Moreover, debates over reproductive policies have often been contentious due to the competing interests of

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8. Adam Sonfield, *The Religious Exemption to Mandated Insurance Coverage of Contraception*, 14 AM. MED. ASS'N J. ETHICS 137, 137 (2012); *see also* Julie Appleby, *Five Questions About the Health Law's Mandate to Cover Birth Control*, Kaiser Health News (Feb. 27, 2012), http://www.kaiserhealthnews.org/stories/2012/february/27/five-questions-health-law-mandate-birth-control.aspx (discussing a HHS decision that contraceptive mandate under PPACA *only* applies to female FDA approved contraceptives).

9. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 5–8 (2011).

10. *See* Baris Ata & Emre Seli, *Economics of Assisted Reproductive Technologies*, 22 CURRENT OPINION IN OBSTETRICS & GYNECOLOGY 183, 184 (2010) (providing an international assessment of government coverage for ARTs and out-of-pocket spending). The study notes that among developed countries, the difference between usage of ARTs may depend on whether the government subsidizes such services. *Id.* For example, many in the United States must rely on out-of-pocket spending in order to access ART services, and thus usage tends to be lower than other countries where the government reimburses citizens for using ART services. *Id.* at 184 fig.1; *see also* KAISER FAMILY FOUNDATION, HEALTH COVERAGE BY RACE AND ETHNICITY: THE POTENTIAL IMPACT OF THE AFFORDABLE CARE ACT 5 (2013), *available at* http://www.kff.org/minorityhealth/upload/8423.pdf (finding that twenty-one percent of non-elderly blacks and thirty-two percent of non-elderly Hispanics are uninsured, compared to thirteen percent of non-elderly whites).

11. *See infra* Part II.

12. *See infra* Part III.

13. *See infra* Part IV.

14. *See infra* Part V.

15. *See generally* HELEN LEFKOWITZ HOROWITZ, REREADING SEX: BATTLES OVER SEXUAL KNOWLEDGE AND SUPPRESSION IN NINETEENTH-CENTURY AMERICA (2002) (dis-

encouraging procreation in some groups, while discouraging procreation in others.[16] These competing interests continue to shape the evolution of reproductive rights in the United States, both for better and for worse.[17]

Generally, pronatalist policies support increasing certain segments of the population, either through incentives such as tax breaks for families with children, or through policies that restrict access to contraceptive and abortion services.[18] In contrast, antinatalist policies discourage procreation.[19] At different points in its history, the United States has embraced both pronatalist and antinatalist policies.[20] Pronatalist and antinatalist reproductive policies have been aimed at different groups, sometimes concurrently.[21]

A. *The Population Race*

The United States has an undeniable history of racism and sexism that has greatly influenced reproductive policies at both the state and national level.[22] White, Protestant men of Anglo-Saxon descent have traditionally dominated the American political and social hierarchy.[23] Many reproductive policies in the United States have been structured to maintain this social hierarchy. This is especially true of policies developed during the Comstock Era.[24] The Comstock Era references the hundred year span

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cussing tensions between anti-obscenity reformer Anthony Comstock and reproductive rights advocate Victoria Woodhull in the 1800s).

16. *See infra* Part II.A.

17. *See infra* Part II.A.

18. *See* Leslie King, *Demographic Trends, Pronatalism, and Nationalist Ideologies in the Late Twentieth Century*, 25 ETHNIC & RACIAL STUDIES 367, 371–72 (2002) (describing pronatalist policies aimed at increasing certain segments of the population through incentives like tax breaks and policies that restrict access to contraceptives and abortion services).

19. *See, e.g.*, Susan L. Thomas, *Race, Gender, and Welfare Reform: The Antinatalist Response*, 28 J. OF BLACK STUDIES 419, 430 (1998) (discussing statements by policy makers that discourage procreation among black women).

20. *See infra* Part II.A.

21. *See infra* Part II.A.

22. *See, e.g.*, PAULA S. ROTHENBERG, RACE, CLASS, AND GENDER IN THE UNITED STATES: AN INTEGRATED STUDY 5–7 (6th ed. 2004) (describing underlying racism and sexism in American society).

23. *See* Nicola Beisel & Tamara Kay, *Abortion, Race, and Gender in Nineteenth-Century America*, 69 AM. SOC. REV. 498, 500–03 (2004) (describing the dominance of white, Protestant men of Anglo-Saxon descent in U.S. culture and their influence on reproductive policies in order to maintain their dominance in the United States).

24. *See* Martha J. Bailey, *"Momma's Got the Pill": How Anthony Comstock and* Griswold v. Connecticut *Shaped U.S. Childbearing*, 100 AM. ECON. REV. 98, 104–07 (2010) (explaining the scope of Comstock Era obscenity laws, including the states that criminalized the sale of contraceptives and abortion).

following enaction of the Comstock Act of 1873.[25] The Comstock Act outlawed the mailing of materials classified as "obscene," including contraceptives and abortion information.[26] The Comstock Era also coincided with a time of state-imposed sterilization of certain groups, such as the mentally disabled.[27]

Many of the Comstockian policies were inherently pronatalist.[28] The most pronatalist policies of the era encouraged childbirth in general, but were specifically targeted toward promoting childbirth among married couples.[29] The preference for marital birth is reflected in the poor treatment of non-marital children under the law during the Comstock Era.[30] In addition to implementing policies that encouraged marital birth, policy makers during the Comstock Era also placed a great deal of emphasis on restricting procreation along economic, class, and racial lines.[31] These restrictive policies were inherently antinatalist, and were rooted in the eugenics movement that originated in the late 1800s and early 1900s.[32]

One of the strongest supporters of the eugenics movement was President Theodore Roosevelt.[33] President Roosevelt advocated that white, Protestant women of Anglo-Saxon descent reproduce in order to outpopulate immigrant communities.[34] Many of the immigrant communities

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25. *Id.* at 104.

26. *See id.* at 104–07 (detailing activities outlawed by the Comstock Act).

27. Buck v. Bell, 274 U.S. 200, 207–08 (1927) (upholding a Virginia law that mandated sterilization of the mentally disabled to prevent them from procreating, and infamously declaring "[t]hree generations of imbeciles are enough").

28. *See* Marcia A. Ellison, *Authoritative Knowledge and Single Women's Unintentional Pregnancies, Abortions, Adoption, and Single Motherhood: Social Stigma and Structural Violence*, 17 MED. ANTHROPOLOGY Q. 322, 325 (2003) (discussing how Comstock Era laws banned contraceptives and criminalized abortion, resulting in an increased birth rate).

29. *See* Sara L. Zeigler, *Wifely Duties: Marriage, Labor, and the Common Law in Nineteenth-Century America*, 20 SOC. SCI. HIST. 63, 64–65 (1996) (describing social and legal power of marriage in the late nineteenth century, coinciding with the Comstock Era).

30. *See* Richard F. Storrow, *"The Phantom Children of the Republic": International Surrogacy and the New Illegitimacy*, 20 AM. U. J. GENDER SOC. POL'Y & L. 561, 568–71 (2012) (describing mistreatment of "illegitimate" children under common law).

31. Kathleen E. Powderly, *Contraceptive Policy and Ethics: Illustrations from American History*, 25 HASTINGS CTR. REP. S9, S9 (1995) (describing the push for limiting procreation of immigrant and lower class women).

32. *See* PAUL A. LOMBARDO, THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT AND BUCK V. BELL, at xi (2008) (asserting *Buck v. Bell* was part of an "elaborate campaign to win judicial approval for eugenic sterilization laws").

33. *See* Thomas C. Leonard, *Retrospectives: Eugenics and Economics in the Progressive Era,* 19 J. ECON. PERSP. 207, 209–10 (2005) (comparing Theodore Roosevelt's support for eugenics with Darwin's "survival of the fittest" theory).

34. *See id.* at 209 (displaying Roosevelt's fear of "race suicide," a term describing reproduction by those of white, Anglo-Saxon descent being severely outpaced by "less desirable" offspring).

with which early twentieth century American eugenicists were concerned are now included in the modern race of "white," including, for example, Italian and Irish immigrants.[35] In the early twentieth century, these immigrant communities were perceived as people of "racially inferior stock" who were outpopulating people of Anglo-Saxon descent, who were of "racially superior stock."[36] This population fear, or "race suicide," influenced President Roosevelt to publically advocate that white middle- and upper-class women of Anglo-Saxon ancestry reproduce as their "civic duty."[37]

Supported by academics, medical practitioners, and politicians, the American eugenics movement of the early 1900s was very powerful.[38] Biologist Charles Benedict Davenport, an elite member of the American scientific community, established the Eugenics Record Office in 1910.[39] The Eugenics Record Office offered detailed statistical research and educational materials supporting the field of eugenics.[40] The office published family pedigree charts that tracked conditions such as "epilepsy, feeblemindedness, insanity, alcoholism, syphilis, sexual immorality, and an impulse to 'nomadism' or aimless wandering," because they were thought to be hereditary traits.[41] These charts were meant to support policies, such as forced sterilization and institutional segregation, which would prevent certain populations from procreating.[42]

Twentieth-century policies restricting procreation, such as the Virginia law that mandated sterilization of the mentally disabled, for example,

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35. *See id.* at 208 (distinguishing the modern concept of race from the early twentieth century understanding).

36. *See id.* at 209 (defining the early twentieth century concept of race suicide, in which a race seen as superior is outpopulated by one seen as inferior).

37. *See* Ellison, *supra* note 28 (framing female reproduction in terms of public service as a common occurrence throughout much of U.S. history); *see also* Kathy J. Cooke, *Duty or Dream? Edwin G. Conklin's Critique of Eugenics and Support for American Individualism*, 35 J. HIST. BIOLOGY 365, 365–66 (2002) (explaining that women, generally, were expected to bear and raise children that would be "good Americans who could make use of the political, social, and economic opportunity in America").

38. Ana Romero-Bosch, *Lessons in Legal History – Eugenics and Genetics,* 11 MICH. ST. U. J. MED. & L. 89, 98–99 (2008).

39. *See* Oscar Riddle, *Biographical Memoir of Charles Benedict Davenport; 1866–1944,* 25 NAT'L ACAD. OF SCI. BIOGRAPHICAL MEMOIRS 75, 83 (1947) (detailing establishment of the Eugenics Record Office).

40. *See* Paul A. Lombardo, *"The American Breed": Nazi Eugenics and the Origins of the Pioneer Fund,* 65 ALB. L. REV. 743, 755 (2001) (emphasizing the role of Eugenics Record Office's scientific research in the eugenics movement).

41. LOMBARDO, *supra* note 32, at 35–36.

42. *See id.* at 31 (explaining how research into people's medical history would help eugenic legislation to prevent "idiots, low imbeciles, incurable and dangerous criminals from having children").

perpetuated a value judgment as to what types of people should reproduce.[43] In the infamous case *Buck v. Bell*,[44] the Supreme Court of the United States upheld Virginia's mandatory sterilization law for the "feeble-minded."[45] Justice Oliver Wendell Holmes, writing for the majority, upheld the substance of the law, declaring, "Carrie Buck 'is the probable potential parent of socially inadequate offspring, likewise afflicted, that she may be sexually sterilized without detriment to her general health and that her welfare and that of society will be promoted by her sterilization . . . .'"[46]

In addition to Virginia, several other states passed similar mandatory sterilization laws for the mentally disabled that are still in effect.[47] Other types of sterilization laws from the era, however, were struck down as unconstitutional.[48] In 1942, when the U.S. eugenics movement was starting to weaken, the Supreme Court declared an Oklahoma law mandating the sterilization of individuals convicted of two or more crimes unconstitutional.[49] The Supreme Court found that Oklahoma's sterilization mandate interfered with "one of the basic civil rights of man."[50] Unfortunately, in *Skinner*, the Supreme Court did not explicitly overrule

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43. *See id.* at 60-61 (describing Virginia statutes in the early 1900s giving institutional physicians discretion to sterilize "women of child bearing age" to prevent them from having children). Many of these women were considered "insane," "defective," or "weak minded," all traits that were thought to be hereditary. *Id.*; *see also* Paul A. Lombardo, *Eugenic Sterilization Laws*, EUGENICS ARCHIVE, http://www.eugenicsarchive.org/html/eugenics/essay8text.html (last visited Oct. 20, 2013) (stating Virginia's sterilization law was a strategy to relieve the tax burden on the state because publicly-funded mental institutions were becoming overpopulated).

44. *Buck*, 274 U.S. at 200.

45. *Id.* at 206.

46. *Id.* at 207.

47. *See, e.g.*, ARK. CODE ANN. § 20-49-205 (West 1971) (permitting court-ordered sterilization of mentally incompetent individuals). There are several states with either statutes or case law still supporting sterilization of those with mental illness or developmental disabilities. *See* Gail Rodgers, Comment, *Yin and Yang: The Eugenic Policies of the United States and China: Is the Analysis That Black and White?*, 22 HOUS. J. INT'L L. 129, 148-50 (1999) (noting a number of states still have some form of involuntary sterilization).

48. *See* Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535, 536 (1942) (declaring restriction of procreation based on an individual's "habitual criminal activity" to be "a sensitive and important area of human rights").

49. *See id.* at 538 (distinguishing the Oklahoma case from *Buck v. Bell* by stating that the accused is not given a chance to be heard as to whether he will produce "undesirable offspring").

50. *See id.* at 541 (asserting marriage and procreation are a necessity for our existence and a fundamental right of all people).

Bell, but it is unlikely that forced sterilization laws could withstand judicial scrutiny now.[51]

The eugenics movement of the early twentieth century fell from the mainstream procreation views shortly after World War II.[52] Although overt eugenics policies are generally "unpalatable" today,[53] there are modern incidences of similar practices.[54] Along with specific instances of judicial action, there are some legislative policies that perpetuate many of the value judgments the eugenics movement had on race and class.[55] For example, a potential state law that conditions receipt of welfare benefits by single mothers—many of whom are women of color—on whether these women take contraceptives exhibits an inherent value judgment about who should reproduce.[56]

B. *Choosing Parenthood: Support for Procreative Liberty and Reproductive Justice*

Current U.S. law supports a "procreative liberty framework."[57] The procreative liberty framework supports an individual's desire to become a

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51. ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 814 (3d. ed. 2006).

52. *See* Rodgers, *supra* note 47, at 167 (stating eugenics is deemed unfavorable in many countries, except in China).

53. *See* CHEMERINSKY, *supra* note 51, at 815 (noting Nazi attempts in creating a master race played a role in the eugenics movement's demise).

54. *See* Rory Riley, Comment, *A Punishment That Does Not Fit the Crime: The Use of Judge-Ordered Sterilization as a Condition of Probation*, 20 QUINNIPIAC PROB. L.J. 72, 72 (2006) (describing a 2005 case in which a judge allowed a single mother to avoid jail time for shaking her baby to death if she agreed to serve five years of probation and sterilization).

55. *See, e.g.*, Jillian T. Stein, Comment, *Backdoor Eugenics: The Troubling Implications of Certain Damages Awards in Wrongful Birth and Wrongful Life Claims*, 40 SETON HALL L. REV. 1117, 1117 (2010) ("Wrongful birth and wrongful life actions are unlike other prenatal torts because of such lawsuits' discriminatory treatment of the disabled. When a state recognizes such causes of action without limitation or restrictions on damages awards, the state is engaging in eugenics."); *see also* David S. Coale, *Norplant Bonuses and the Unconstitutional Conditions Doctrine*, 71 TEX. L. REV. 189, 192–93 (1992) (arguing bonuses for welfare recipients taking contraceptives violates the Unconstitutional Conditions Doctrine, which states "whatever the Constitution forbids government to do directly, it equally forbids the government to do indirectly"). Because the Constitution affords women the right to refuse to take contraceptives, the government should be barred from forcing women to take contraceptives. *Id.* If a woman takes a contraceptive "because she does not want to be worse off financially than the women around her, the government has affected a right protected by the Constitution that it could not do directly." *Id.*

56. Kimberly A. Smith, *Conceivable Sterilization: A Constitutional Analysis of A Norplant/Depo-Provera Welfare Condition*, 77 IND. L.J. 389, 408 (2002).

57. The procreative liberty framework supports the right of individuals to become parents, to choose not to become a parent, and to parent the children they create. *See*

parent, to avoid parenthood, and to parent one's own children.[58] "Liberty" in the procreative liberty framework is a negative right, meaning that there is "no moral duty . . . [to make] a procreative choice, and that other persons have a duty not to interfere with that choice."[59] In terms of constitutional law, procreative liberty is a right against state interference in the decision to procreate or not procreate.[60] However, with the enactment of the PPACA, the understanding of procreative liberty is changing.[61]

Several Supreme Court cases decided in the mid-twentieth century definitively signaled the end of the eugenics movement and ushered in a new era of reproductive rights in U.S. constitutional law.[62] Along with *Skinner*, which struck down a bluntly eugenic law that mandated sterilization of habitual criminals,[63] the Supreme Court case *Loving v. Virginia*[64] attacked the core of the eugenics movement. In *Loving*, the Supreme Court found a Virginia law banning interracial marriage unconstitutional, because there was no legitimate state interest in the miscegenation law at issue, only racial discrimination.[65] These cases and their progeny support a negative constitutional right to reproduce.

In the same era, the Supreme Court tackled the right to avoid parenthood through either contraception or abortion. In *Skinner*, the Supreme Court found that the Equal Protection Clause of the Fourteenth

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JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 22–42 (1994).

58. *See generally id.* (detailing the procreative liberty framework). Constitutionally, the U.S. Supreme Court has supported the notion that there is a fundamental right to reproduce, to terminate a pregnancy within certain restrictions, and to parent their progeny. *See* Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535, 541 (1942) (declaring the restriction of procreation based on an individual's "habitual criminal activity" to be a "a sensitive and important area of human rights"); Roe v. Wade, 410 U.S. 113, 151 (1973) (establishing the right of woman to choose to have an abortion within certain state restrictions); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992) (reaffirming the constitutional right to an abortion and reframing state restrictions in terms of fetal viability, instead of a trimester framework); Lassiter v. Dep't of Soc. Servs. of Durham Cnty., 452 U.S. 18, 33–34 (1981) (holding indigent parents have a right to counsel in parental termination hearings).

59. *See* ROBERTSON, *supra* note 57, at 23 (establishing what procreative liberty entails and further defining the concept of a "negative right").

60. *Id.*

61. *See infra* Part III.

62. *See* CHEMERINSKY, *supra* note 51 (discussing *Skinner* and its impact on Constitutional jurisprudence).

63. *Skinner*, 316 U.S. at 545 (holding the right to have offspring is a fundamental right and the government must have a compelling interest to interfere with said right).

64. Loving v. Virginia, 388 U.S. 1 (1967).

65. *Id.* at 11.

Amendment protected the right to procreate.[66] In contrast, the Supreme Court found the right to *avoid* procreation is protected under the privacy right that exists within the "penumbras" of the Bill of Rights.[67] In various cases, the Supreme Court held the right to privacy from state intrusion on an individual's reproductive choices allows for the procurement of contraceptives, as well as early-term abortions.[68]

In *Maher v. Roe*, the Supreme Court affirmed that the right to procure an abortion is a negative right.[69] In *Maher*, the Supreme Court denied the Equal Protection claim of an indigent Connecticut woman seeking a non-therapeutic abortion.[70] The Supreme Court held that although Connecticut Medicaid covered expenses for pregnancy, its denial of coverage for an indigent woman's abortion was constitutional.[71] The Supreme Court left open the option for federal coverage for non-therapeutic abortions; but that same year, Congress passed the Hyde Amendment, which prohibits such coverage.[72]

Although the negative right to avoid parenthood—through either procurement of contraceptives or an abortion—was upheld in various cases throughout the mid- to late-twentieth century,[73] there is still a strong political movement to eliminate this right.[74] The movement to restrict abor-

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66. *Skinner*, 316 U.S. at 545.

67. Griswold v. Connecticut, 381 U.S. 479, 484 (1965).

68. *Id.*; Roe v. Wade, 410 U.S. 113, 154 (1973); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

69. Maher v. Roe, 432 U.S. 464, 464 (1977); *see also* ROBERTSON, *supra* note 57, at 23 (defining further the concept of negative rights). "It means that a person violates no moral duty in making a procreative choice, and that other persons have a duty not to interfere with that choice . . . However, the negative right to procreate or not does not imply the duty of others to provide the resources or services necessary to exercise one's procreative liberty despite plausible moral arguments for governmental assistance." ROBERTSON, *supra* note 57, at 23.

70. *Maher*, 432 U.S. at 480.

71. *Id.* at 480–81.

72. *See* Jeannie I. Rosoff, *The Hyde Amendment and the Future*, 12 FAM. PLAN. PERSP. 172, 172 (1980); *see generally* Harris v. McRae, 448 U.S. 297 (1980) (upholding the Hyde Amendment because it does not *per se* prevent a woman from obtaining an abortion, solidifying the right to access and abortion as a negative right in American law).

73. Griswold v. Connecticut, 381 U.S. 479, 484 (1965); Roe v. Wade, 410 U.S. 113, 154 (1973); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

74. *See, e.g.*, Rachel Benson Gold & Elizabeth Nash, *Troubling Trend: More States Hostile to Abortion Rights as Middle Ground Shrinks*, 15 GUTTMACHER POL'Y REV. 14 (2012) (describing increasingly radicalized state anti-abortion policies from 2000 through 2012); Mariel Puryear, *Hardline Ideology Stymies Real Results: Texas Lawmakers' Battle Over Family Planning Leaves Texas Women Unprotected*, 15 SCHOLAR 829, 832 (noting Texas lawmakers' politicization of reproductive health has left women in Texas with fewer choices and lower quality of care).

tion rights has been quite successful, particularly at the state level.[75] For example, to restrict access, states have placed heavy regulatory burdens on abortion providers, often framing them as medical safety precautions to promote women's health and safety.[76] This tactic appears to be working, with a record number of abortion clinics losing due to burdensome regulations.[77] Although increased medicalization of abortion services is restricting access, the increased medicalization of contraception has expanded access in the United States.[78] While there are general concerns over the increased medicalization of contraceptives and pregnancy, at least health insurance coverage is available for these services.[79]

However, the creation of the EHBs in the PPACA, and the mandate that all health insurance plans cover contraceptives without cost sharing,

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75. Gold & Nash, *supra* note 74.

76. B. Jessie Hill, *Legislative Restrictions on Abortion*, 14 VIRTUAL MENTOR: AM. MED. ASS'N J. ETHICS 133, 135 (2012) (outlining various TRAP laws that have been implemented around the country aimed at decreasing availability of abortion services). "TRAP" is defined as "targeted regulations of abortion providers." *Id.* Requiring abortion providers to have hospital admitting privileges is a relatively new and highly effective type of TRAP law, as shown by recent challenges to Mississippi's sole abortion clinic. *See* Laura Bassett, *Mississippi's Only Abortion Clinic Fights to Stay Open*, HUFFINGTON POST (Nov. 28, 2012, 5:26 PM), http://www.huffingtonpost.com/2012/11/28/mississippi-abortion-clinic_n_2205153.html ("The lone abortion clinic in Mississippi [faced closure] in early January [2013] if a federal judge allow[ed] a state law to go into effect that would regulate the clinic out of existence."). A federal court issued an order allowing the clinic time to comply with the law without additional interference from the state. Laura Bassett, *Mississippi's Only Abortion Clinic Fights to Stay Open*, HUFFINGTON POST (Nov. 28, 2012, 5:26 PM), http://www.huffingtonpost.com/2012/11/28/mississippi-abortion-clinic_n_2205153.html. However, constitutionality of the state's actions has not been addressed. Laura Bassett, *Mississippi's Only Abortion Clinic Fights to Stay Open*, HUFFINGTON POST (Nov. 28, 2012, 5:26 PM), http://www.huffingtonpost.com/2012/11/28/mississippi-abortion-clinic_n_2205153.html. North Dakota and Alabama followed Mississippi in 2013, passing similar laws requiring physicians to have admitting privileges at a local hospital in order to perform abortions in the state. *See* Abby Ohleheiser, *Fate of Alabama's Abortion Clinics Could be Decided by New Rules*, SLATE (Apr. 3, 2013), http://www.slate.com/blogs/the_slatest/2013/04/03/alabama_passes_restrictive_admitting_privileges_abortion_law.html (discussing "restrictive abortion laws that could cause [Alabama's] five abortion-providing clinics to close . . . [which] prompt[ed] a legal challenge from clinics and organizations who want to keep abortion access in the state").

77. *See* Laura Bassett, *Anti-Abortion Laws Take Dramatic Toll on Clinics Nationwide*, HUFFINGTON POST (Aug. 26, 2013, 8:30AM), http://www.huffingtonpost.com/2013/08/26/abortion-clinic-closures_n_3804529.html (noting providers in twenty-seven states have closed or stopped providing abortion services).

78. *See* Andrea Tone, *Medicalizing Reproduction: The Pill and Home Pregnancy Tests*, 49 J. OF SEX RES. 319, 320 (2012) (describing medicalization of contraception since the Food and Drug Administration's approval of oral contraceptives).

79. *See* Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 371–72 (1998) (describing American private insurance coverage trends for different types of contraceptives for men and women).

deviates from the long tradition of reproductive rights categorized as negative rights.[80] For the first time, at least one prong of procreative liberty is a positive right, with an essential right to access prescription contraceptives.[81]

At the same time contraceptives became medicalized, infertility treatments also received increased attention from the medical community. Prior to the introduction of Assisted Reproductive Technologies (ARTs), infertility was generally thought to be an incurable condition, with limited assistance and treatment available.[82] However, as the medical community garnered a greater understanding of the mechanics behind procreation, researchers began searching for solutions to infertility.[83] The introduction of ARTs changed the perception of infertility from an incurable affliction to a medically treatable condition.[84] Today, treating medical infertility is a multi-billion dollar industry.[85]

"Infertility" is defined as the inability of a woman under the age of thirty-five to conceive after one year of unprotected sex with a male partner.[86] For women over the age of thirty-five, the timeframe is six months.[87] If a woman fails to conceive within the medically prescribed timeframe, she and her partner can seek infertility treatment.[88] Diagnosing infertility is divided into three phases: (1) diagnostic testing; (2) "standard" treatments; and (3) high-cost, low-success treatments.[89] Diagnostic testing includes traditional measures, such as checking semen mobility and ova permeability.[90] The "standard" treatments address an underlying cause of infertility, such as prescribing the drug Metformin to address

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80. ROBERTSON, *supra* note 57, at 28–30.

81. *Id.* at 35–38.

82. *See* ELIZABETH ANN REEDY, AMERICAN BABIES: THEIR LIFE AND TIMES IN THE 20TH CENTURY 143–44 (2007) (describing general hopes of a couple to conceive and how, prior to the twentieth century, women were usually blamed for failing to conceive).

83. *Id.* at 144.

84. *See* Elizabeth Heitman, *Infertility as a Public Health Problem: Why Assisted Reproductive Technologies Are Not the Answer*, 6 STAN. L. & POL'Y REV. 89, 96 (1995) (describing the growing public health concern of infertility after the introduction of ARTs).

85. DEBORA L. SPAR, THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION 3 (2006).

86. Nizan Geslevich Packin, Comment, *The Other Side of Health Care Reform: An Analysis of the Missed Opportunity Regarding Infertility Treatments*, 14 SCHOLAR 1, 11 (2011).

87. *Id.*

88. *Id.* at 11, 18.

89. Solomon Leftin, *Insurance Coverage of Infertility Treatments and Procedures*, 19 COLO. LAW. 663, 663 (1990).

90. *See* Mohamed A. Aboulghar et al., *Diagnosis and Management of Unexplained Infertility: An Update*, 267 ARCHIVES OF GYNECOLOGY & OBSTETRICS 177, 177 (2003) (describing general tests for diagnosing unexplained infertility).

insulin levels in women with Polycystic Ovary Syndrome (PCOS), which is one of the leading causes of female infertility.[91] High cost, low success treatments involve many noncoital reproductive treatments such as *in vitro* fertilization (IVF).[92]

The medical category of ART, in which IVF belongs, is considered the "wild west" of medicine.[93] The industry is essentially unregulated by government entities, relying instead on voluntary regulatory bodies like the American Society of Reproductive Medicine.[94] Diagnosis and treatment of infertility is an expensive endeavor, often not covered by health insurance plans.[95] In 2004, infertility patients in the United States spent $1,038,528 on IVF procedures, $1,331,860 on fertility drugs, and $374,900 on diagnostic tests.[96] The enormous cost of infertility treatment prevents many infertile individuals from obtaining treatment, or even a diagnosis.[97]

III. SUCCESSES OF THE PPACA: EXPANDING WOMEN'S HEALTH AND REPRODUCTIVE RIGHTS

The American health care system was in disarray when Congress first debated health care reform in 2009.[98] The overwhelming cost of American medical care, totaling over $2.7 trillion in 2009, coupled with the large number of uninsured or underinsured citizens, created a "paradox of ex-

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91. Emre Seli & Antoni J. Duleba, *Treatment of PCOS with Metformin and Other Insulin-sensitizing Agents,* 4 CURRENT DIABETES REPS. 69, 69 (2004).

92. SPAR, *supra* note 85, at 55.

93. *See* Alexander N. Hecht, Comment, *The Wild Wild West: Inadequate Regulation of Assisted Reproductive Technology*, 1 HOUS. J. HEALTH L. & POL'Y 227, 228–29 (2001) ("Unfortunately [the Assisted Reproductive Technology] industry remains widely unregulated. The near absence of federal and state law combined with ineffective and unheeded industry guidelines leads to a lawless free-for-all. In the 'Wild Wild West' of ART, doctors fraudulently impregnate their patients, fertility researchers use their patient's genetic samples without valid consent, and clinics fail to safely screen potential donors.").

94. *Id.* at 253.

95. *See* Jessie R. Cardinale, *The Injustice of Infertility Insurance Coverage: An Examination of Marital Status Restrictions Under State Law*, 75 ALB. L. REV. 2133, 2137 (2012) (discussing various reasons insurers deny coverage for infertility treatments, and explaining why federal attempts to enforce mandates that insurers cover infertility treatments have failed).

96. SPAR, *supra* note 86.

97. *See* Packin, *supra* note 85, at 19–20 ("Infertility treatments, and in particular IVF treatments, are very expensive. The average cost for one IVF cycle in the United States is about $12,400 . . . therefore . . . an all inclusive infertility treatment cycle is valued at about $21,000 per couple.").

98. *See* Denis Cortese & Jeffrey O. Korsmo, *Health Care Reform: Why We Cannot Afford to Fail*, 28 HEALTH AFFAIRS w173, w173 (2009) (discussing the poor state of health care in 2007 and the Mayo Clinic Health Policy Center's efforts to correct these issues).

cess and deprivation."[99] Women, in particular, experienced discrimination in the health care system based solely on their gender.[100] The PPACA successfully addressed many gender inequalities in access to health insurance, creating equity in health insurance rates and coverage for women.[101] Furthermore, the mandate for health insurance plans to cover contraceptives without cost sharing as part of the preventive health EHBs set a new standard for women's reproductive health.[102]

A. *Prior Gender Inequalities in Health Insurance*

For decades, women were faced with unequal access to health insurance benefits in comparison to their male counterparts.[103] In the public benefit sphere, programs such as Medicaid required women to have children of a certain age in order to obtain coverage.[104] Private insurers in both individual and employer-based plans often charged different premiums for women that were based solely on their gender.[105] Additionally,

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99. *See* Theodore Marmor & Jonathan Oberlander, *The Patchwork: Health Reform, American Style*, 72 SOC. SCI. & MED. 125, 125 (2011) ("Fifty-one million Americans[—]nearly [seventeen percent] of the population[—]go without health insurance at any given time . . . . Another twenty-five million American adults are "underinsured," covered by insurance policies that inadequately protect them against the high costs of medical care . . . .").

100. *See* Marcia Greenberger & Lisa Codispoti, *What Health Reform Means for Women*, 37 HUM. RTS. 5, 5–7 (2010) (asserting that women "faced unique challenges within [the American] health care system" due to gender rating, discrimination, and denials in coverage based on factors such as a prior caesarian section or undergoing IVF).

101. *See infra* Part III.A.

102. *See infra* Part III.B.

103. *See* Susan L. Waysdorf, *Fighting for Their Lives: Women, Poverty, and the Historical Role of United States Law in Shaping Access to Women's Health Care*, 84 KY. L.J. 745, 757–59 (1996) (describing health issues disproportionally plaguing women as they age, considering women's increasing life expectancy).

104. Prior to PPACA, many states denied Medicaid benefits to childless adults. KEAVNEY KLEIN & SONYA SCHWARTZ, NAT'L ACAD. FOR ST. HEALTH POL'Y, STATE EFFORTS TO COVER LOW-INCOME ADULTS WITHOUT CHILDREN 1 (2008), *available at* http://www.nashp.org/sites/default/files/shpmonitor_childless_adults.pdf?q=files/shpmonitor_childless_adults.pdf. Although PPACA was written to allow all Americans falling under 138 percent of the Federal Poverty Level to benefit from Medicaid programs regardless of their family status, the Supreme Court decision in *NFIB v. Sibelius* threatens that goal because it permits states to opt out of the Medicaid expansion. James F. Freeley III, *National Federation of Independent Business v. Sebelius: The Constitutionality of Health Care Reform and the Spending Clause*, 45 CONN. L. REV. CONNTEMPLATIONS 19, 29 (2013); MARTHA HEBERLEIN, ET AL., GEORGETOWN UNIV. HEALTH POL'Y INST., MEDICAID COVERAGE FOR PARENTS UNDER THE AFFORDABLE CARE ACT 2 (2012), *available at* http://ccf.georgetown.edu/wp-content/uploads/2012/08/Medicaid-Coverage-for-Parents.pdf.

105. *See* NAT'L WOMEN'S LAW CTR., TURNING TO FAIRNESS: INSURANCE DISCRIMINATION AGAINST WOMEN TODAY AND THE AFFORDABLE CARE ACT 14 (2012), *available at* http://www.nwlc.org/resource/report-turning-fairness-insurance-discrimination-against-

insurers rejected women from coverage for previously undergoing IVF, or having a caesarean section.[106] The PPACA banned many of these practices, providing greater gender equity in health insurance coverage and premiums.[107]

Another way the PPACA attempts to eliminate gender and sex discrimination is through the Act's prohibition on "gender rating."[108] Prior to the adoption of the PPACA, women were charged significantly higher insurance premiums than men of the same age, with the same health status.[109] This practice was prohibited by several states prior to the PPACA.[110] Now, the PPACA prohibits gender rating for all qualified health insurance plans.[111]

The PPACA also prohibits insurers from denying coverage based on a pre-existing condition, which allows women greater access to health insurance.[112] Some common conditions associated purely with women's health were previously used by insurers to disqualify women from obtaining insurance. Insurance companies would classify these issues—caesarean section births or surviving gynecological cancer, for example—as pre-existing conditions in order to deny coverage.[113] If the goals of the PPACA are fully realized, there will no longer be gender or sex discrimination in health insurance coverage.[114]

B. *The Contraceptive Coverage Mandate*

One of the most controversial elements of the PPACA is the inclusion of contraceptive coverage as an EHB under the preventive care category.[115] An Institute of Medicine report released in July 2011 highlighted

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women-today-and-affordable-care-ac ("Individual and small group health plans are specifically precluded from using gender to determine premiums.").

106. Greenberger & Codispoti, *supra* note 100, at 7.

107. *See* NAT'L WOMEN'S LAW CTR., *supra* note 105, at 3 (explaining how PPACA prohibitions, fully enacted by 2014, will provide better access to health care to women for these specific women's health issues).

108. *Id.* at 14.

109. *Id.* at 7.

110. *See id.* at 8, 10–11, 18 (listing the thirteen states banning gender rating in the small group market before the implementation of the PPACA).

111. *Id.* at 5.

112. James Comstock & Sloane Kuney Rosenthal, *Health Care Access: Access After Health Care Reform*, 12 GEO. J. GENDER & L. 667, 684–85 (2011).

113. *See id.* (noting new exceptions will prevent insurers from continuing discrimination against women based on pre-existing conditions that only apply to women).

114. *See id.* (explaining the existence of gender discrimination in the healthcare system and the PPACA's attempt to resolve this problem).

115. *See* Vincent J. Samar, *Religion/State: Where the Separation Lies*, 33 N. ILL. U. L. REV. 1, 2, 58–60 (2012) (describing the controversy created by the PPACA contraceptive mandate and its intersection with the Establishment Clause and certain religious entities).

the preventive health measures most important to women.[116] As a result, the Institute recommended that healthcare reform legislation "include a fuller range of contraceptive education, counseling, methods, and services so that women can better avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes."[117] Based on the Institute's recommendation, the Department of Health and Human Services declared that all FDA-approved contraceptive devices will be included as an EHB without cost sharing.[118] This declaration was slightly narrowed by the Department's proposed rules in early 2013, which outlined ways for religious non-profits and institutions of higher education to possibly receive exemptions from the mandate.[119]

Insurance coverage for contraceptives, at least in part, is not a new phenomenon.[120] Twenty-eight states previously mandated insurance companies to cover FDA-approved contraceptives, with cost sharing permitted in some instances.[121] Twenty of those states that mandate contraceptive coverage allow certain employers, mostly religious organizations, to refuse to comply with the state insurance mandate.[122]

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116. INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 1–2 (July 2011), *available at* http://www.iom.edu/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf.

117. *Id.* at 2.

118. NAT'L WOMEN'S LAW CTR., CONTRACEPTIVE COVERAGE IN THE NEW HEALTH CARE LAW: FREQUENTLY ASKED QUESTIONS 1 (2011), *available at* http://www.nwlc.org/sites/default/files/pdfs/contraceptive_coverage_faq_11.9.11.pdf; Teresa B. Gibson et al., *The Effects of Prescription Drug Cost Sharing: A Review of the Evidence*, 11 AM. J. MANAGED CARE 730, 731 (2005) (defining "cost sharing" as an insurance practice in which the insurer covers a portion of the procedure or drug cost, while leaving a certain amount, known as a co-payment, for the insured to pay out of pocket). It is worth noting lower or no cost sharing for medical services correlates with higher utilization of those services, including prescription drugs. *See* Avi Dor & William Encinosa, *How Does Cost-Sharing Affect Drug Purchases? Insurance Regimes in the Private Market for Prescription Drugs*, 19 J. ECON. & MGMT. STRATEGY 545, 549 (2010) (showing increased prices of medical services and prescriptions results in a decreased number of patients who will purchase these services or drugs).

119. *See* News Release, U.S. Dep't of Health & Human Servs., News Div., Administration Issues Notice of Proposed Rulemaking on Recommended Preventive Services Policy (Feb. 1, 2013), *available at* http://www.piersystem.com/go/doc/2430/1696291 (summarizing exceptions to the contraceptive coverage mandate for religious organizations).

120. *See* GUTTMACHER INST., INSURANCE COVERAGE OF CONTRACEPTIVES 1 (2013), *available at* http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf (noting that, prior to the adoption of the PPACA, many states already required insurance policies to cover FDA-approved contraceptives).

121. *Id.* at 2.

122. *Id.*

In addition to state mandates, many employers already cover contraceptives in their health plans.[123] This is likely because it is significantly cheaper for an insurer to cover contraceptives than to cover the entire cost of a pregnancy.[124] For example, a non-profit representing the interests of large employers on health policy issues estimated a fifteen to seventeen percent savings for employers that covered contraceptives in their health insurance plan, compared to employers that did not cover contraceptives.[125] Generally, the only employers that forgo this opportunity to save costs by covering contraceptives are those with religious-based objections to such coverage.[126]

Dozens of lawsuits have been filed since HHS announced the contraceptive mandate.[127] Some lawsuits involve religiously affiliated institutions—such as the University of Notre Dame—that oppose the contraceptive coverage mandate on religious liberty grounds.[128] Notre Dame, along with several other religiously-affiliated universities, argue that the mandate violates their Constitutional right to exercise their religion free from governmental interference, and that the mandate to provide contraceptive coverage violates their religious principles.[129] In addition to educational institutions, several private corporations have claimed that the mandate violates their religious freedom.[130] For example, craft retailer Hobby Lobby challenged the mandate for violating the religious beliefs of company CEO David Green.[131]

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123. *See* Alina Salganicoff & Usha Ranji, *Insurance Coverage of Contraceptives*, KAISER FAMILY FOUNDATION (Feb. 21, 2012), www.kff.org/2012/february/insurance-coverage-of-contraceptives.aspx (asserting that eighty-five percent of large firms already cover some prescription contraceptives).

124. *See* NAT'L WOMEN'S LAW CTR., COVERING PRESCRIPTION CONTRACEPTIVES IN EMPLOYEE HEALTH PLANS: HOW THIS COVERAGE SAVES MONEY 1 (2012), *available at* http://www.nwlc.org/sites/default/files/pdfs/Contraceptive%20Coverage%20Saves%20Money%20Aug%202009.pdf (presenting the costs of an employee's pregnancy to employers, including both the direct and indirect costs of an unwanted pregnancy).

125. *Id.*

126. Ethan Bronner, *A Flood of Suits Fights Coverage of Birth Control*, N.Y. TIMES, Jan. 26, 2013, www.nytimes.com/2013/01/27/health/religious-groups-and-employers-battle-contraception-mandate.html?pagewanted=all.

127. *Id.*

128. Univ. of Notre Dame v. Sebelius, No. 3:12CV325RLM, 2012 WL 6756332, at *2 (N.D. Ind. Dec 31, 2012).

129. *Id.* at *1, *2.

130. *See* Hobby Lobby Stores, Inc. v. Sebelius, 870 F. Supp. 2d 1278, 1296–97 (W.D. Okla. 2012) *rev'd and remanded*, 723 F.3d 1114 (10th Cir. 2013) (denying the stores Hobby Lobby and Mardel—private, for-profit entities—an injunction against the contraceptive mandate in the PPACA).

131. *Id.* at 1284–85.

Under the 2013 Department of Health and Human Services' regulation, universities such as Notre Dame will likely be exempted from the mandate.[132] Private corporations like Hobby Lobby, however, are unlikely to be successful, because private, for-profit entities are not entitled to free exercise of religion as contemplated by the Constitution.[133] Despite these challenges to the contraceptive mandate, the majority of health insurance policies will still provide contraceptives without cost-sharing measures under the PPACA.

IV. Patchwork Health Insurance Policies: State Regulation Power Under ERISA

Employer-sponsored health insurance plans drove the U.S. health care system for many years prior to the PPACA.[134] Initially, employer-sponsored health insurance plans were considered perks given by a company to entice employees to choose to work for it rather than for a competitor.[135] Because health care was inexpensive and relatively easy to access during the early twentieth century, the core benefits that many workers sought from an employer were retirement benefits, often in the form of a defined pension.[136]

In the mid-1900s, many workers enjoyed traditional pension plans in which an employer defined the benefits available for an employee's retirement, as long as the employee worked for the company for a certain

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132. *Univ. of Notre Dame*, 2012 WL 6756332, at *9.

133. Conestoga Wood Specialties Corp. v. Sebelius, 917 F. Supp. 2d 394, 408 (E.D. Pa. 2013) ("Therefore, we conclude that the nature, history and purpose of the Free Exercise Clause demonstrate that it is . . . [a] 'purely personal' right[ ] . . . and as such, is unavailable to a secular, for-profit corporation."). *But see* John K. DiMungo, *The Affordable Care Act's Contraceptive Coverage Mandate*, 25 Cal. Ins. L. & Reg. Rep. 1, 4 (2013) (asserting corporations historically did not enjoy personal constitutional rights, but that recent Supreme Court decisions such as *Citizens United v. Federal Election Commission,* which recognize free speech rights for corporations, now place that longstanding legal principle into question).

134. *See, e.g.*, Kaiser Family Found. & Health Research & Educ. Trust, Employer Health Benefits: 2002 Annual Survey 1 (2002), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/04/3251.pdf (noting nearly two-thirds of Americans have employer-provided health insurance).

135. *See* Karen Seccombe, *Employer Sponsored Medical Benefits: The Influence of Occupational Characteristics and Gender*, 34 Sociological Q. 557, 557–58 (1993) (noting employer-provided benefits, including health insurance, are benefits typically classified as "fringe" benefits, because they are benefits that employees accept in place of additional taxable wages they could earn).

136. *See* Jeffrey R. Houle, *ERISA-Qualified Pension Plans As Property of the Bankruptcy Estate: A Survey of Creditors' Rights to Participants' Pension Assets Pre- and Post-Patterson v. Shumate,* 29 Hous. L. Rev. 763, 767 (1992) ("ERISA's primary purposes are to encourage and protect accumulated savings for retirement years . . . .").

period of time.[137] These employer promises went largely unregulated until a major manufacturing company in Indiana closed and was consequently unable to pay the pension benefits to most of its workers.[138] To protect against future similar incidents, Congress instituted the Pension Benefit Guarantee Corporation to insure defined benefit plans and passed the Employee Retirement Income Security Act (ERISA).[139]

Although ERISA focuses primarily on retirement benefit plans, it also regulates "employee welfare benefit plans."[140] Some welfare benefit plans provide employees with health insurance.[141] Employer-sponsored health insurance plans are governed by ERISA; thus, it is important to explore the interplay between the PPACA and ERISA.

A. *Power of State Insurance Regulation Through ERISA's Savings Clause*

Prior to PPACA's enactment, individual states primarily regulated the types of benefits included in employer-sponsored health insurance plans.[142] Outside of the EHBs of the PPACA, states retain the power to regulate health insurance under ERISA.[143] In general, ERISA preempts state laws that "relate to" any ERISA plan, including pensions, retirement plans, and other welfare benefit plans.[144] The major exception to federal preemption is found in § 1144(b)(2)(A) of ERISA. This section

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137. *See* JOHN BROADBENT ET AL., THE SHIFT FROM DEFINED BENEFIT TO DEFINED CONTRIBUTION PENSION PLANS – IMPLICATIONS FOR ASSET ALLOCATION AND RISK MANAGEMENT 3–4 (2006), *available at* http://www.bis.org/publ/wgpapers/cgfs27broadbent3.pdf (defining a traditional or "defined benefit" pension plan).

138. Katherine A. McAllister, *A Distinction Without A Difference? ERISA Preemption and the Untenable Differential Treatment of Revocation-on-Divorce and Slayer Statutes*, 52 B.C. L. REV. 1481, 1484 n.23 (2011).

139. Mark Daniels, *Pensions in Peril: Single Employer Pension Plan Terminations in the Context of Corporate Bankruptcies*, 9 HOFSTRA LAB. L.J. 25, 31–32 (1991). ERISA is a federal law protecting private, employer-sponsored benefits like pensions, health insurance, and education benefits. *Id.*

140. Michael Serota & Michelle Singer, *Maintaining Healthy Laboratories of Experimentation: Federalism, Health Care Reform, and ERISA*, 99 CALIF. L. REV. 557, 576–77 (2011).

141. *Id.*

142. *See State Health Insurance Mandates and the PPACA Essential Benefits Provisions*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx#Understanding (last updated Oct. 31, 2013) (noting states already have nearly 2,000 laws in place pertaining to welfare benefit plans).

143. *See id.* (quoting code sections of PPACA allowing state provision of additional healthcare benefits).

144. 29 U.S.C. § 1144(a) (2006). Unfortunately, ERISA's text does not provide any guidance on what it means for a state law to "relate to" ERISA. *Id.* In its broadest reading of the ERISA "relate to" doctrine, the Supreme Court found that any law with "a

saves a state law "which regulates insurance" from preemption.[145] This clause, known as the "savings clause," grants a state the power to regulate insurance markets within its own state—including the health insurance market.[146]

Courts assess several factors when determining whether a state law regulates insurance.[147] These factors include: (1) whether the law affects transferring or spreading policy holder risk; (2) whether the law is integral in the policy relation between an insured individual and the insurer; and (3) whether the law is limited to insurance industry entities.[148] A common type of state law that falls within the insurance regulation exception is a mandate of specific insurance benefits. In *Metropolitan Life Insurance Company v. Massachusetts*,[149] the Supreme Court held that state laws mandating specific benefits in private insurance plans fit squarely into the insurance regulation exception. Thus, such mandates are protected from federal preemption.[150]

B. *Inconsistent Coverage: State Mandates for Providing Insurance Coverage of Infertility Treatment*

Every state has laws mandating the minimum levels of benefits required in health insurance plans;[151] however, states vary on what types of services must be covered and the level of benefits that must be provided.[152] Most states mandate that employers cover standard medical treatments, such as diabetes treatments and preventive health screenings.[153]

The EHBs established in the PPACA mostly coincide with existing state-mandated benefits for health insurance, making the transition of plans theoretically simple.[154] Some states already mandated contraceptive coverage in healthcare plans, and in 2010, eighty-five percent of large

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connection with or reference to" a plan would be saved from preemption. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 97 (1983).

145. 29 U.S.C. § 1144(b)(2)(A).

146. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 733 (1985).

147. Union Labor Life Ins. Co. v. Pinero, 458 U.S. 119, 120 (1982).

148. *Id.*

149. *Metro. Life Ins. Co.*, 471 U.S. at 733.

150. *See id.* (upholding a Massachusetts law mandating that health insurers provide a minimum level of mental health benefits in the insurance plans).

151. NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 142.

152. *Id.*

153. VICTORIA CRAIG BUNCE, COUNCIL FOR AFFORDABLE HEALTH INS., TRENDS IN STATE MANDATED BENEFITS, 2011, at 2 (2012), *available at* www.cahi.org/cahi_contents/resources/pdf/PolicyTrendsMandatedbenefits2011.pdf.

154. *See* NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 142 (describing interplay between state and federal healthcare mandates).

employers offered prescription contraceptive coverage as part of their most comprehensive health insurance plans.[155] Unlike contraceptive coverage, which is usually very inexpensive for insurers to cover,[156] diagnosing and treating infertility can be very costly and is rarely covered by health insurance plans.[157] While insurers often cover some basic diagnostic tests for infertility,[158] high-cost, low-success treatments are almost never covered by private health insurance plans.[159] Given the high cost of diagnosing and treating infertility, insurers rarely cover infertility diagnosis and related treatment, absent a state mandate.[160] To create greater access to infertility treatment, several states enacted mandates for insurers to either offer or provide coverage for infertility treatment.[161]

Approximately fifteen states mandate some form of insurance coverage for infertility treatment.[162] Even among states that provide insurance coverage for infertility treatment, the range of benefits provided varies drastically.[163] For example, Maryland statutorily requires every private insurance plan cover up to $100,000 of IVF treatments.[164] The benefits are limited, however, to married couples using their own gametes.[165] While the law helps increase use and access to IVF for some married couples, it does not help same sex couples or unmarried individuals access treatment.

In contrast, Massachusetts provides coverage for up to three rounds of IVF treatments without limitations on marriage or gamete usage.[166] Other states, like Texas, only mandate that insurers offer the option of a

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155. *Insurance Coverage for Contraceptives Laws*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/insurance-coverage-for-contraception-state-laws.aspx (last updated Feb. 2012).

156. NAT'L WOMEN'S LAW CTR., *supra* note 124.

157. *See* Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things*, 13 WIS. WOMEN'S L.J. 119, 159, 172–73 (1998) (detailing insurer coverage of infertility diagnosis and treatments, as well as the underlying reasons for not covering most infertility treatments).

158. *Id.* at 172–73.

159. *Id.*

160. *Id.* at 147.

161. *Id.*

162. *See State Laws Related to Insurance Coverage for Infertility Treatment*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/insurance-coverage-for-infertility-laws.aspx (last updated Mar. 2012) (asserting only fifteen states mandate or offer health insurer coverage of infertility treatment).

163. *See id.*

164. MD. CODE ANN., INS. § 15–810 (West 2011).

165. *Id.* § 15–810(c)(2).

166. MASS. GEN. LAWS ch. 176A, § 8K (West 2013); 211 MASS. CODE REGS. 37.05 (2013) (requiring insurer coverage of infertility treatments, including IVF).

plan with infertility treatment coverage.[167] Regardless of the type of mandate, states with an insurance mandate to cover or offer coverage of infertility treatment see higher utilizations of the technology by those seeking to have children.[168]

V. Perpetuating Inequality: The Impact of Not Including Infertility Treatment as an Essential Health Benefit in the PPACA

In *Bragdon v. Abbott*, the Supreme Court determined that reproductive capacity is a major life activity.[169] In spite of this determination, there is little legal support for a universal mandate that requires health insurance carriers to cover infertility treatments.[170] Thus, the reproductive options for some individuals who are unable to conceive through traditional methods might be limited. Despite irregularities in the types of infertility coverage mandated by states, the states that mandate some insurance assistance for infertility treatment see greater use of these services.[171] Excluding infertility treatment from the PPACA's EHBs forces many patients to pay for such treatment out-of-pocket, thereby limiting access to treatment to those with economic means.[172] This section will first explore the implications of this policy based on economic status, particularly for middle-income Americans.[173] Then, it will focus on the racial disparities associated with health insurers failing to cover infertility

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167. Tex. Ins. Code Ann. § 1366.003 (West 2010).

168. *See* Tarun Jain et al., *Insurance Coverage and Outcomes of In Vitro Fertilization*, 347 New Eng. J. Med. 661, 666 (2002) (finding state mandated insurance coverage of IVF lead to higher utilization of services with lower numbers of embryo transfers, resulting in fewer pregnancies with multiples). *But see* Marianne Bitler et al., *Health Disparities and Infertility: Impacts of State-Level Insurance Mandates*, 85 Fertility & Sterility 858, 862 (2006) (finding no statistically significant link between state insurance mandates and increase of access to IVF services).

169. *See* Bragdon v. Abbott, 524 U.S. 624, 638–39 (1998) (concluding childbearing is a "major life activity").

170. *See* Saks v. Franklin Covey Co., 316 F.3d 337, 349 (2d Cir. 2003) (affirming a lower court ruling that an employer-sponsored health insurance plan that did not include infertility treatment coverage did not violate the Americans with Disabilities Act, Pregnancy Discrimination Act, or Title VII).

171. *See, e.g.*, Martha Griffin & William F. Panak, *The Economic Cost of Infertility-Related Services: An Examination of the Massachusetts Infertility Insurance Mandate*, 70 Fertility & Sterility 22, 28 (1998) (finding "[m]andated infertility coverage was associated with increased use of ART" in Massachusetts).

172. *See* Ata & Seli, *supra* note 10 (noting many in the United States rely on out-of-pocket spending to access services and that state coverage of services leads to higher utilization in other countries).

173. *See infra* Part V.A.

treatment.[174] Finally, this section argues that infertility diagnosis and low-cost, high-success infertility treatments should be included as an EHB under the PPACA.[175]

A. *Failing to Provide Infertility Treatment as an EHB Limits Access Based on Income*

For the infertile, having a child can be an expensive endeavor.[176] Conservatively, one cycle of IVF treatment costs approximately $12,400.[177] Generally, only 44.6 percent of single IVF cycles result in a pregnancy and only 38.7 percent result in a live birth.[178] While the Federal Tax Code outlines tax credits for infertile couples who adopt children, there is no support for use of ARTs to create a child genetically related to at least one of the intended parents.[179]

Despite the high cost of infertility treatment, many middle-income Americans try to access these services in order to have a genetically related child, or the pregnancy experience.[180] Some seeking a genetically related child turn to private financing to cover the costs of the infertility treatment, incurring great debt to gain the opportunity to conceive.[181] In fact, obtaining private funding to cover the costs of infertility treatment is a common choice for middle-income Americans whose insurers do not cover such treatments.[182] While these private loans are easy to obtain,

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174. *See infra* Part V.B.

175. *See infra* Part V.C.

176. *See* SPAR, *supra* note 85 (highlighting the cost of gametes, IVF, surrogacy, and adoption in the United States).

177. Glenn Cohen & Daniel L. Chen, *Trading-Off Reproductive Technology and Adoption: Does Subsidizing IVF Decrease Adoption Rates and Should It Matter?*, 95 MINN. L. REV. 485, 492 (2010).

178. U.S. DEP'T OF HEALTH AND HUMAN SERVS., ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES, 94, 221 (2009), *available at* http://www.cdc.gov/art/art2007/ pdf/complete_2007_art.pdf.

179. *See* Melissa B. Jacoby, *The Debt Financing of Parenthood*, 72 LAW & CONTEMP. PROBS. 147, 151–53 (2009) (discussing tax support given to families seeking adoptions and fertility treatments).

180. *See* Maurizio Macaluso et al., *A Public Health Focus on Infertility Prevention, Detection, and Management*, 93 FERTILITY & STERILITY 16.e1, 16.e1–16.e3 (2010) (describing strong desire to have genetic children and socioeconomic barriers some face in having genetic children).

181. *See* Jim Hawkins, *Financing Fertility*, 47 HARV. J. ON LEGIS. 115, 142 (2010) (describing the often unseen costs of infertility treatment, even when full rebate programs offered by some clinics are utilized).

182. *See* Jacoby, *supra* note 179, at 148 (acknowledging the need for private lending because most insurance policies do not allow for infertility treatment).

they have extremely high interest rates, and there is no guarantee that treatment will be successful.[183]

For example, Capital One Fertility offered a "forty-two-year-old woman of modest means . . . a $20,000 . . . installment loan at 25.99 [percent] interest for a [single] round of . . . [IVF] and the eggs of a younger woman."[184] A forty-two year old woman seeking IVF services has only a 10.8 percent chance of a live birth based from a single round of IVF.[185] While a rational consumer may be dissuaded from procuring a loan to cover a procedure with a low chance of success, such a utilitarian view discounts the emotional need some have to procreate.[186] In their attempt to fulfill this need, some find themselves facing bankruptcy.[187]

If these middle-income Americans had insurance coverage to defray a portion of the cost, it is likely that they would not have incurred such debt and financial ruin. Including infertility treatment as an EHB will increase access for those currently dissuaded by cost alone and ease the economic burden among middle-income Americans.[188]

B. *Including Infertility Treatment as an EHB will Help Increase Access to Racial Minorities*

Non-white, infertile individuals experience additional barriers to infertility services other than economic means.[189] For example, there is an unfortunate, yet pervasive, stereotype that "[p]oor Black women . . . [are] highly (and uncontrollably) fertile and unfit to be mothers[,] with images of the welfare queen, crack babies, and teen mothers reinforcing this depiction, whereas middle- and upper-class white women are commonly portrayed as infertile with successful higher order multiple births."[190] In

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183. *Id.*

184. *Id.* at 147.

185. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 178, at 161.

186. *See* Michael Pawson, *The Battle with Morality and the Urge to Procreate*, *in* INCONCEIVABLE CONCEPTIONS: PSYCHOLOGICAL ASPECTS OF INFERTILITY AND REPRODUCTIVE TECHNOLOGY 60, 60–61 (2003) (describing the need for physician understanding and empathy with the emotional pain caused by infertility and the desire to procreate).

187. Jacoby, *supra* note 179, at 159.

188. *See id.* (highlighting the extreme financial burden pursuing infertility treatments can place on a family household).

189. *See generally* Ann V. Bell, *"IT'S WAY OUT OF MY LEAGUE": Low-Income Women's Experiences of Medicalized Infertility*, 23 GENDER & SOC'Y 688, 700–04 (2009) (describing the experiences of low-income minority women in accessing infertility treatment).

190. *Id.* at 689. An example of the continued misconception on fertility of minority communities occurred when former Florida Governor Jeb Bush asserted "immigrants are more fertile" during a 2013 speech on immigration policy. *See* Bill Chappell, *'Immigrants are more Fertile,' Jeb Bush Says in Reform Speech*, NPR (June 14, 2013), http://www.npr

reality, though, Hispanic and black women have higher rates of infertility.[191] Despite a higher prevalence of infertility, racial minorities are less likely to seek infertility treatment, likely due to social cues including lack of spousal support or a general distrust of medical institutions.[192]

Failing to include infertility treatments as an EHB under the PPACA unintentionally perpetuates the procreative value judgments rooted in the U.S. eugenics movement.[193] The lack of insurance coverage for infertility issues leaves lower-income Americans facing infertility with limited options. Furthermore, the pervasive stereotypes about minorities and childbearing make infertile women in that community reluctant to seek infertility treatments. Consequently, white, wealthy women have the widest access to infertility treatments. The lack of coverage for infertility treatments under the PPACA unintentionally discounts the infertility troubles of non-whites, who often lacked health insurance prior to the enactment of the PPACA.[194] While the PPACA will greatly expand health insurance coverage to these groups, without infertility treatment as an EHB, many of these populations will not have access to infertility treatment services, despite having higher rates of infertility.[195]

Currently, states that have mandated insurance coverage for infertility treatment still see racial disparities in accessing services.[196] However, these studies focus purely on the economic feasibility of accessing infertility treatment, instead of addressing the underlying racial narratives surrounding infertility. Insurance coverage for infertility treatment alone will not fully eliminate racial disparities in accessing the treatments, but it is a necessary step in addressing reproductive stratification based on race.[197] Including infertility treatment as an EHB normalizes the condition, framing it as a condition that can affect anyone, regardless of race. It is a small step in a larger strategy to de-stratify reproduction in the United States, dispelling racialized images of motherhood.

.org/blogs/thetwo-way/2013/06/14/191776099/immigrants-are-more-fertile-jeb-bush-says-in-reform-speech.

191. Arthur L. Greil et al., *Race-Ethnicity and Medical Services for Infertility: Stratified Reproduction in a Population-based Sample of U.S. Women*, 52 J. OF HEALTH & SOC. BEHAV. 493, 494–95 (2011).

192. *Id.* at 495–502.

193. *See supra* Part II.A.

194. *See* KAISER FAMILY FOUND., *supra* note 10 (finding twenty-one percent of non-elderly blacks and thirty-two percent of non-elderly Hispanics are uninsured, compared to thirteen percent of non-elderly whites).

195. Greil et al., *supra* note 191, at 494.

196. *Id.*

197. *See* Karen McCormack, *Stratified Reproduction and Poor Women's Resistance*, 19 GENDER & SOC'Y 660, 661 (2005) (describing political and social reinforcements of stratified reproduction in the United States).

C. *Reproductive Justice and Balance: The Scope of an Infertility EHB*

Similar to the concept of procreative liberty, the reproductive justice movement supports "the right to have children, not have children, and to parent the children [an individual has] in safe and healthy environments."[198] As this article previously established, categorizing contraception as an EHB under the PPACA makes avoiding procreation a positive right for the first time in American law.[199] The PPACA, however, fails to create an equivalent positive right to have a child. The failure to include infertility as an EHB unintentionally perpetuates old value judgments on procreation, giving more weight to avoiding parenthood and making access to infertility treatment dependent on the socioeconomic status of the infertile. The simplest remedy to this inequality is for infertility treatment to be included as an EHB.

Pragmatically, an infertility EHB should be relatively limited in scope. Because of cost and prevalence of infertical couples, it would be impractical to mandate IVF coverage for all.[200] Instead, the federal EHB for infertility treatment should be limited to diagnosis and "standard" treatments that tend to be relatively low-cost, high-success treatments.[201]

As with other EHBs, each state retains the power to provide greater coverage than the minimum EHB.[202] This approach would also mirror the scope of coverage to avoid parenthood, which is currently limited to relatively inexpensive and non-invasive treatments, such as oral contraceptives, instead of more invasive treatments like abortion.[203] This solution would help increase access to infertility services by minorities and

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198. *See Why is Reproductive Justice Important to Women of Color*, SISTER SONG, http://www.sistersong.net/index.php?option=com_content&view=article&id=141&Itemid=81 (last visited Apr. 6, 2013). The right to parent one's own children, although important, is outside the scope of this Article. This Article only discusses the right to reproduce and the right to avoid procreation.

199. *See supra* Part II.B.

200. *See* Marianne Bitler & Lucie Schmidt, *Utilization of Infertility Treatments: The Effects of Insurance Mandates*, 49 DEMOGRAPHY 125, 129–32 (2006) (asserting IVF accounts for only five percent of infertility treatments); M. KATE BUNDORF ET. AL, NAT'L BUREAU OF ECON. RESEARCH, MANDATED HEALTH INSURANCE BENEFITS AND THE UTILIZATION AND OUTCOMES OF INFERTILITY TREATMENTS 3–4 (2007), *available at* http://web.econ.uic.edu/health/ health.10102007.pdf (describing the moral hazard of providing unrestricted health insurance coverage for IVF).

201. *See supra* Part II.B.

202. *See* Christopher C. Jennings & Katherine J. Hayes, *Health Insurance Reform and the Tensions of Federalism*, 362 NEW. ENG. J. MED. 2244, 2244–45 (2010) (discussing state powers in policy choices under the PPACA).

203. Roy G. Spece, Jr., *The Purpose Prong of Casey's Undue Burden Test and Its Impact on the Constitutionality of Abortion Insurance Restrictions in the Affordable Care Act or Its Progeny*, 33 WHITTIER L. REV. 77, 88–105 (2011).

those with a low socio-economic status, while having a near negligible impact on health insurance premiums overall.[204]

VI. CONCLUSION

American reproductive policies are historically rife with eugenic undertones, particularly on the lines of class and race. The PPACA, once in full effect, should provide greater access to healthcare for all Americans. This includes greater support for some reproductive choices, specifically in delaying or avoiding procreation through prescription contraceptives.[205] The law, however, fails to assist infertile individuals seeking treatment.

This dichotomy unintentionally perpetuates old racist and classist views of reproduction, especially that minorities of low socio-economic status are hyperfertile and without need of infertility treatment.[206] Including a limited level of infertility treatment as an EHB will help minorities and impoverished Americans access care.[207] This inclusion comes at minimal cost to the overall population, while enabling an infertile individual have a genetic child and, in some cases, the pregnancy experience.

204. *See* Griffin & Panak, *supra* note 171, at 22 (asserting coverage for infertility services, including IVF, only raised premiums by "$0.26, or less than 0.1 [percent] of the total health care premium in the typical family health care benefits plan").

205. *See* Spece, *supra* note 203 (describing exclusion of abortion coverage in the PPACA).

206. Bell, *supra* note 189, at 689.

207. *See supra* Part II.B.