Mandated Insurance Coverage of Assisted Reproduction for LGBTQ Individuals: A Quest for Reproductive Equity

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Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals have historically faced discrimination in all areas of their lives, including healthcare. At a time when the rights to experiencing same-sex relationships and marriage comparable to heterosexual counterparts have just recently been reinforced in the United States with the Respect for Marriage Act, LGBTQ individuals still face significant barriers to establishing families. The quest for reproductive equity is important to many LGBTQ persons. Evidence shows that transgender and nonbinary individuals want to have children for the same reasons as cisgender and heteronormative persons, including closeness, nurturance, and family-building.\(^1\) Transgender and nonbinary parents demonstrate warmth, commitment, and attention to their children in the same way as cisgender and heteronormative parents.\(^2\) Despite comparable desires to create a family, given biological constraints, LGBTQ individuals may need to rely on assistive reproductive technologies (ARTs) to have biologically related children.\(^3\) These ARTs can include in-vitro fertilization (IVF), intrauterine insemination, gamete donation, surrogacy planning, and gamete preservation.\(^4\) There are significant constraints that preclude queer persons from utilizing formal healthcare options to facilitate

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2 Ethics Committee, *Fertility and Sterility*, 874-878.


contraception, including exorbitant cost barriers and mandatory provisional steps to access ARTs.\textsuperscript{5,6} While the number of same-sex female couples using donor insemination and IVF are increasing, the current medical definition of infertility and resultant lack of insurance coverage for LGBTQ individuals is discriminatory as viewed through a reproductive justice lens.\textsuperscript{7} Therefore, policy should be enacted to establish widespread insurance mandates for coverage of ARTs for LGBTQ persons.

The historical medical landscape for LGBTQ individuals has not been easy. Queer people report experiencing inequities in medical care including institutionalized discrimination, legal barriers to care, and intergenerational trauma/distrust of the medical system.\textsuperscript{8} There is a marked history of misunderstanding of this population, and pathologization of the queer community by medical professionals, including the treatment of transgender individuals as psychologically unwell. And the reproductive rights of queer persons have long been in jeopardy; even as recently as 2015, 24 countries in Europe required the sterilization of transgender individuals before changing their gender on legal documents.\textsuperscript{9} Queer people report experiencing challenges in receiving appropriate and culturally competent reproductive care specifically, emphasizing the presumed heteronormativity of the healthcare system.\textsuperscript{10} This exclusion from essential health spaces can manifest in a variety of ways such as gendered health environments (ie., posters/pictures/paint colors) and difficulties in making appointments for

\textsuperscript{5} Catherine Meads, “Why are the proportions of in-vitro fertilization interventions for same sex female couples increasing,” \textit{Healthcare} 9, no.1657 (2021): 1-9, accessed January 14, 2023, \url{https://doi.org/10.3390/healthcare9121657}


\textsuperscript{7} Catherine Meads, \textit{Healthcare}, 1-9.

\textsuperscript{8} Abirami Kirubarajan, \textit{Fertility and Sterility}, 1294-1301.


\textsuperscript{10} Abirami Kirubarajan, \textit{Fertility and Sterility}, 1294-1301.
necessary care (ex., pap smear access for transgender men).\textsuperscript{11} Patients on the queer and genderqueer spectrum have historically been denied access to ARTs, despite the American Medical Association’s policy position on LGBTQ issues explicitly opposing discrimination in healthcare.\textsuperscript{12}

Understanding how access to ARTs for LGBTQ persons is restricted in a discriminatory and prejudicial fashion hinges upon the medical definition of infertility. Infertility is reported to impact more than 186 million people worldwide.\textsuperscript{13} 12\% of women experience infertility with notable differences across racial and socioeconomic lines.\textsuperscript{14} The World Health Organization in 2009 defined infertility as a disease, “due to an impairment of function reflected through lack of pregnancy after 12 months of unprotected intercourse.”\textsuperscript{15,16} In the United States, the Center for Disease Control and Prevention utilizes a similar definition of infertility, emphasizing an inability to achieve pregnancy after one year of unprotected sex.\textsuperscript{17} However, these definitions in and of themselves include an underlying assumption of


\textsuperscript{12} Ethics Committee, Fertility and Sterility, 874-878.

\textsuperscript{13} Rachid Bezad, BMC Health Services Research, 1-12.


heteronormativity and cisgender status in which a cisgender man engages in sexual intercourse with a cisgender woman in order to procreate. A definition of infertility that centers on an inability to conceive following unprotected sex is, at its core, fundamentally exclusionary of LGBTQ individuals.\textsuperscript{18} When insurers utilize this definition of infertility to justify coverage of ARTs, such as IVF, LGBTQ individuals are unable to access coverage to the same extent as their heteronormative peers, resulting in financial gatekeeping of parenthood that discriminates against LGBTQ persons. Given the exorbitant costs of all forms of procreation for LGBTQ persons (ie., adoption, surrogacy, IVF, etc.), perhaps infertility needs to be viewed as not just a medical diagnosis, but a social condition.\textsuperscript{19}

In the United States, 85\% of infertility care is paid for out of pocket\textsuperscript{20} Infertile couples may incur catastrophic financial costs in order to finance ARTs that are not covered by insurance.\textsuperscript{21} One cycle of IVF may cost upwards of $19,000 – and one cycle alone may not be enough to establish pregnancy.\textsuperscript{22} Other forms of assisted reproduction, including gamete preservation in transgender and non-binary individuals are under-utilized because of the high costs associated with treatment.\textsuperscript{23} However, evidence demonstrates increased utilization of these services with increased insurance coverage.\textsuperscript{24}

\textsuperscript{18} Jennifer Kawwan, \textit{Fertility and Sterility}, 29-42.


\textsuperscript{21} Rachid Bezad, \textit{BMC Health Services Research}, 1-12.

\textsuperscript{22} Shira Stein, \textit{Bloomberg}.

\textsuperscript{23} Angela Leung, \textit{Fertility and Sterility}, 858-865.

\textsuperscript{24} Holly Cooper, “Fertility preservation in transgender and non-binary adolescents and young adults,” \textit{PLOS One} (2022): 1-11, accessed January 14, 2023, \url{https://doi.org/10.1371/journal.pone.0265043}.
companies can, and should, engage in the coverage of ARTs. There is also evidence that the per capita increase in cost to an insurer that covers ARTs is minimal, and that the cost is less than many other routinely covered interventions.\textsuperscript{25} In fact, Massachusetts mandates fertility treatment coverage with no lifetime financial cap. The state has reported that infertility treatment cost the state between 0.12 - 0.95\% of premium costs in 2016, which is minimal as compared to other costs of insurance coverage.\textsuperscript{26} The model of healthcare in the United States, equating health to a business transaction, should not dissuade from coverage for important health services for everyday people. Minimizing insurance coverage of ARTs may also serve, from a business perspective, to decrease the number of agencies and clinics in existence, perpetuating reduced access for persons in need.\textsuperscript{27} If insurance companies will not reimburse for ARTs, fewer clinics may offer, or may be able to afford to offer, this form of healthcare.

Not only is access to ARTs cost prohibitive for many, but LGBTQ couples report additional barriers in accessing ARTs that heterosexual couples are not faced with. These mandatory provisional steps may include meetings with social workers, counseling, and fertility tests, which patients report as frustrating and insulting.\textsuperscript{28} Perhaps more sickeningly, there is documented evidence that lesbian women have been exploited by fertility clinics into participating in ‘egg sharing’ for infertile heteronormative couples in a quid pro quo arrangement for reduced financial costs of their own IVF treatment.\textsuperscript{29} Egg retrieval is not a minor medical process. This form of agreement requires queer women to use their bodies as a tool for the procreation of others. It is largely exploitative, and should not be the price to pay

\textsuperscript{25} Jennifer Kawwan, \textit{Fertility and Sterility}, 29-42.

\textsuperscript{26} Shira Stein, \textit{Bloomberg}.

\textsuperscript{27} Jennifer Kawwan, \textit{Fertility and Sterility}, 29-42.


\textsuperscript{29} Catherine Meads, \textit{Healthcare}, 1-9.
for wanting children of one’s own. If we view the desire to raise children as a biological right, it becomes important to recognize that most anyone who could create a family at no cost or without medical intervention would choose to do so, and therefore facilitate reproduction for those who otherwise cannot reproduce.30

The definition of reproductive justice includes the ability to have children if so desired. 31 Fertility equality can only be achieved when one’s ability to have a family “is no longer determined by wealth, sexuality, gender, or biology.”32 The existence of ARTs is progress towards fertility equality, but access to ARTs for all people – LGBTQ, people of color, etc. – is what is required in order to achieve parity with white, cisgender, heteronormative reproduction. This idea is reinforced by the notion of procreative liberty, the “freedom to decide whether or not to have offspring and to control the use of one’s reproductive capacity.”33 In many countries, ARTs are considered a negative right, meaning that there is no ethical obligation on the part of society to help individuals achieve procreation via insurance coverage.34 In order to achieve reproductive justice and fully respect the rights of queer and genderqueer people who wish to be parents, access to ARTs must be considered an essential health right.35

In the United States as of 2020, there were 19 mandates in 19 states for coverage of infertility with varying terms and conditions.36 As previously discussed, under the current medical definition of

35 Shira Stein, *Bloomberg*.
infertility, LGBTQ persons may still be excluded from coverage in these states. The requirements for accessing IVF benefits frequently involve a number of failed home inseminations, which is exclusionary of lesbian couples. Furthermore, rarely are the costs of the donor sperm necessary to meet these requirements, and subsequently access benefits, covered by insurance.\(^3^7\) One couple, faced with this very obstacle, reported that their concern was that the language of their insurance policy seems to imply that a lesbian could conceive via heterosexual intercourse, but rather just chooses not to, which is discriminatory.\(^3^8\) By invoking heterosexual intercourse in the definition of infertility, there becomes a case based on sex discrimination.

In the spring of 2022, the Biden Administration considered utilizing an update to the Affordable Care Act to address the definition of infertility under Section 1557, which applies to fertility treatment. These changes would not apply to employer plans, which cover 67% of American workers.\(^3^9\) Section 1557 prohibits discrimination based on “race, color, national origin, sex, age, and disability in covered health programs or activities.” Following the Supreme Court ruling in *Bostock v. Clayton County* regarding firing an employee for being gay or transgender as a violation of Title VII of the Civil Rights Act of 1964, the Department of Health and Human Services could justify using an interpretation of ‘sex’ that includes sexual orientation and gender identity, such that Section 1557 would apply to LGBTQ individuals.\(^4^0\) Previously, under the Obama administration, this was always viewed to be the case, but the Trump administration reversed course.\(^4^1\) However, even these proposed changes would still leave gaps in

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\(^3^8\) Stephanie Fairyington, *New York Times*.

\(^3^9\) Shira Stein, *Bloomberg*.

\(^4^0\) Shira Stein, *Bloomberg*.

\(^4^1\) Shira Stein, *Bloomberg*.
coverage for many queer and genderqueer Americans. And even if an insurer or state were required to cover ARTs for LGBTQ persons, it would only cover persons in those specific states or under that insurer. There needs to be widespread mandates to improve access for all.

As a bisexual woman who is engaged to a woman, this issue has pertinent relevance to me, my relationship, and my future. My partner and I have spent the year since the overturning of Roe dreading the possible fall of Obergefell, devising contingencies plans for geographic relocation for our own safety and the safety of our future family. We recognize our privilege both in being straight-passing individuals and in having the means to relocate, if necessary, but it has been a frightening time. I experienced fear for the safety of our yet-to-be conceived children, to the point of suggesting to my partner that until there would be legislative protection for our impending marriage and the sanctity of a resultant family, we should abstain from having children, lest we put our future selves or future children at risk. Would we be able to engage in interstate travel if there were states that did not recognize our marriage? Would it allow for the possible involvement of Child Protective Services if we happened to drive through a state filled with hatred for us and all that our love represents? Would we face challenges in one of us being unable to pick up our children from school? And would our children be allowed to actually discuss their home life and their two mothers in class at school without fear of retribution?

Following the passage of the Respect for Marriage Act, we feel more protected and more optimistic about our future. Our hope for our marriage is bolstered, and with cautious optimism we continue to plan. Now, as we discuss our future, our conversations center around the financial feasibility of having children. By the time that we would start a family, we will both have doctorates in medical professions (I have a clinical Doctorate of Physical Therapy and my partner is completing a Doctorate of Nursing Practice program next year). Despite our high levels of education, our quality career prospects, and anticipated income, parenthood feels financially out of reach.

Adoption is expensive and even more so if looking to raise a child from infancy. It also comes with an important set of challenges (how do we raise a child to truly know themselves if they feel that
they don’t know where they come from? Is it a show of white saviorism to adopt a baby of color? Is it perpetuating racism to preference the adoption of a white child that would look more like it is genetically related to us, etc.) and is steeped in its own set of historical atrocities. Sperm donation is the most financially conservative option, but would mean that our children would only share the genetic material of one of us. While that is not our priority, for many queer and genderqueer individuals, genetic relation of their children is a primary concern. And for some, the idea of reciprocal IVF (in which one female partner carries a child conceived from an egg of the other partner) is romantic and creates a shared, familial experience that is more similar to the experience of parenthood for heterosexual couples. As queer women, I believe that my fiancé and I should have the ability to create a family in any way that feels most right for us. I watch as heterosexual couples become pregnant ‘on accident,’ are perhaps forced to start a family, or may have more children than they can afford to provide for, and I am struck by the seeming ease with which creation of a family can happen for some people (albeit, certainly not all). It seems prejudicial that because my love is devalued by society, I may not be able to afford to have a family, despite knowing that we could create a warm and loving home for our children. Therefore, I propose widespread mandates for insurance coverage for ARTs for LGBTQ individuals. I may never meet the medical definition of infertility, but I should still have a right to have a child.

There remain pressing concerns with creating widespread access for ARTs for all persons. For example, what amount of lifetime utilization of ARTs should be covered? How might access issues and discrimination of certain populations be perpetuated despite widespread insurance mandates given that there are people who are uninsured or underinsured? Should surrogacy benefits exist such that gay men with insurance that covers surrogacy would be able to offer their benefit coverage to their surrogate (there may be some established precedent for this in the area of living organ donation)? And in expanding the access to and utilization of ARTs, there remain questions that we need to grapple with centered around

the technology itself – how much control of gene selection is ethical (in order to avoid disability erasure or a neo-eugenics movement)? In the instance of gamete preservation for transgender or non-binary individuals, should children be able to autonomously consent to this care without the permission of their parents? This area remains rife with ethical dilemmas and questions, but there is no ethical basis for the gatekeeping of parenthood from queer and genderqueer persons.