

Lesbian Infertility: Queering Assisted Reproductive Technology and Examining Policy Impacts
on the LGBTQ Community

By:

Miranda Riley

University of Washington Bothell

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Purpose of Study:

Infertility affects one out of every ten couples attempting conceive. According to a recent study; “ten percent of women (6.1 million) in the United States ages 15-44 have difficulty getting pregnant and staying pregnant” (Center For Disease Control, 2018). Of these 10% of women in heterosexual relationships only about 1-2% are able to access Assisted Reproductive Technology (Katz, et. al, 2011). As recently at 2014 only about sixty percent of fertility clinics reported treating any same sex couples and only with the passage of federal marriage legislation in 2016 were clinics finally mandated to treat all married couples seeking fertility treatment. (Carpinello, 2016). This decision did not however extinguish all barriers for lesbian couples to use assisted reproductive technology to conceive a child. Some of these barriers are more difficult to recognize because they reinforce the status quo without restriction. For example, in most cases heterosexual couples in policy are referred to as a family, while most same sex relationship are conceived of as only a couple. This slight semiotic difference puts a burden of proof on lesbian couples wishing to begin the processes of family formation and it is only one way in which queer families are sent back when attempting to conceive. This paper will discuss economic and procedural barriers that disproportionately affect lesbian couples in their journey to parenthood through the utilization of assisted reproductive technology by centering the voices of those with person experience in these processes. By giving agency back to lesbian couples who have spent their life savings to start a family only to be given a psychological evaluation and dragged through the process of second parent adoption with allow for a clear sight line to the root of the problem, heteronormativity in reproductive practices.

Sexual reproduction in the United States has largely been framed as a heterosexual women’s issue. Through that lens the courts, both the U.S. Supreme court and various state courts, have ruled on regulating abortion, sterilization, pregnancy, surrogacy, reproductive insurance coverage, and the medical necessity of infertility diagnosis and treatment. However,

across this vast range, methods of assisted reproductive technology (ART) and the definition of infertility need to be challenged to encompass those beyond normative understandings of heterosexual family formation. This paper will focus on the ways in which LGBTQ populations, more specifically lesbian couples have been marginalized by current policies and procedures when accessing fertility services to create families, policies such as quarantining the sperm of a non-married donor, requiring psychological evaluations prior to services and the additional paperwork and cost of second parent adoption post after the arrival of a child. Each of these costly and unnecessary additional steps for lesbian parents demonstrates the inherent heteronormative nature of child creation and parenting policies and asks lesbian parents to go above and beyond the requirements of heterosexual couples. It is time that these policies change to be inclusive of all families. This paper will advocate and name these essential changes.

Background:

Assisted Reproductive Technologies (ART) are the processes and procedures that assist people in achieving pregnancy. Treatments include procedures for both men and women depending on the diagnosis of the couple. These treatments include but are not limited to the following:

- ovulation induction (OI) which stimulates ovulation with a follicle-stimulating hormone
- in-vitro fertilization (IVF) - the fertilization of an egg with semen outside of the body and then implanted into the uterus
- intra-cytoplasmic sperm injection (ICSI) a procedure generally for male infertility, such as low mobility, that is similar to IVF in that the egg is fertilized outside of the uterus.

However, this process is done with one viable sperm.

- intrauterine insemination (IUI) which takes a prepared semen sample and places it directly into the uterus
- gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) are two lesser utilized methods and both include full embryo transfer.

These fertilization procedures and other pharmaceutical methods all take place in a fertility clinic. Infertility is defined as “not being able to get pregnant after one year of trying (or six months if a woman is 35 or older) Women who can get pregnant but are unable to stay pregnant may also be infertile” (Women’s Health, 2018). Redefining the very foundation in which fertility is understood allows for a shift in the policies that privilege men and women in heterosexual relationships holding them up as the only couples worthy of assistance in family formation. Fertility or infertility is not just a woman problem or one that only effects heterosexual couples and our laws and policies that assist in regulating access to ART should reflect this understanding. Medical coverage for assisted reproductive technology should be mandatory at the federal level and with it a definition of infertility that allows for all couples regardless of race, gender or sexual orientation to access this coverage by utilizing the voices of the very group these laws exclude the most, lesbian couples.

Current litigation has shaped our understanding of the physical body, especially the female reproductive system, and those rulings that have governed our ideological ties to the social definitions of family. These frameworks have produced a definition of infertility that disproportionately effects same sex lesbian couples wishing to conceive. This paper will examine the litigation that has shaped our understandings of the physical body, especially the female reproductive system, and also those rulings that have governed our ideological ties to the social definitions of family. Furthermore, it will ground these arguments in practices of sterilization before and up to the eugenics era, during which black and brown bodies were

deemed less worthy of reproduction, and in abortion policy, which centers the the woman's body as a place to enact struggles of power.

An additional barrier for lesbian conception is the cost of reproductive procedures. While the cost of the procedure itself and the medication remain a constant regardless of sexuality there are two additional costly requirements for lesbian couples, a psychological evaluation pre reproductive attempt and a second parent adoption after birth. Even as ART has become more affordable in the last ten years, the average cost still is consistently reported at \$12,000 per cycle (monthly) not including medication. (Uffalussy, 2014). Considering that the Center for Disease Control estimates that ten percent of women and couples have difficulty conceiving and will require some sort of intervention to attain a viable pregnancy. (CDC, 2018) and that this number increases with the additional barrier of a same sex relationship it is time to redefine infertility so that these costs can be reduced. That only ten percent of those wishing to access fertility treatment in a heterosexual relationship can afford it and only about one to two percent are able to access ART to pursue parenthood regardless of sexual orientation (Katz, et. al, 2011) creates a barrier that most couples are not able to overcome without significant debt and spending. This has limited lesbian couples in their attempts at multiple children. The cost is so high that couples are usually waiting until later in life when their income increases to gain access to fertility treatment and since the viability of embryos is dependent on a woman's age women in lesbian relationships are often too old to conceive a second child by the time they can afford to do so. Again, these numbers of couples attempting to conceive in a fertility clinic do not include LGBT populations that are trying to conceive, yet; "in the United States an estimated 1.5 to 5 million lesbian mothers reside with their children" (Hequembourg and Farrel, 1999). It is time that our policies are representative of all populations of parents and that we make fertility coverage more accessible so that couples can start the process before their maternal clock expires.

LGBT parenting has shifted the landscape of fertility; “by gaining access to these interventions, lesbians have destabilized the dichotomy between heterosexual and homo-sexual experience and the institution of the family, the grounds upon which dichotomous gender is reinforced and maintained (Mamo, 2007). This paper aims to further this discourse by charting the changes medically and socially and not only as Laura Mamo articulates as the “transformation” of the fertility clinic, but also shifts this transformation into insurance coverage policy since the creation of the Affordable Care Act in 2010. (Mamo, 2013). Through expanding the ways we define the very nature of family which traditionally upholds heterosexism and situates gender in terms of binary opposition, the focus can shift and the problematic discourse around fertility can change. Utilizing data collected from 11 interviews with lesbian parents this study will highlight the current fertility landscape as it currently exists and from there advocate for changes that would present a more inclusive future.

Literature Review:

There is a long history of regulating fertility and child bearing in the United States. In 1927, Carrie Buck, was committed to the State Colony for Epileptics and Feeble Minded (SCEF) in the State of Virginia. The SCEF was ordered to perform the operation of salpingectomy for the purpose of making Ms. Buck sterile. (143 Va. 310). The sterilization was justified by utilizing the Sterilization Act of Virginia which as approved March, 20th, 1924 and “recites that the health of the patient and the welfare of society may be promoted in certain cases by the sterilization of mental defectives, under careful safeguard, and that the sterilization may be effected in males by vasectomy and in females by salpingectomy, without serious pain or substantial danger to life” (Sterilization Act, 1924). The Buck decision states, “it is better for all the world, if instead of waiting to execute degenerate offspring for a crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that

sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough” (143 Va. 310). Sterilization is justified through the potential crimes of future offspring and the location of the patient. Similarly in 1942, Jack Skinner was convicted of stealing chickens as a third offense in the state of Oklahoma which has a statute stating that “sterilization, by vasectomy or salpingectomy, of ‘habitual criminals’ — a habitual criminal being defined therein as any person who, having been convicted two or more times, in Oklahoma or in any other State, of ‘felonies involving moral turpitude,” (316 U.S. 535. 62 S.Ct. 1110; 86 L. Ed. 1655). However, unlike Carrie Buck the decision was overturned by the United States Supreme Court. In the opinion the Justices said, “there are limits to the extent to which a legislatively represented majority may conduct biological experiments at the expense of the dignity and personality and natural powers of a minority - even those who have been guilty of what the majority define as crimes. But this Act falls down before reaching this problem” (Skinner, 1942). Also in the appeal the US Supreme court stated, “marriage and procreation are fundamental to the very existence and survival of the race...He [who is sterilized] is forever deprived of this basic liberty” (Skinner, 1942). While Skinner stops short of sterilization and argues that the equal protections clause should not allow for forced sterilization the Buck decision allowed for the sterilization to occur. These two decisions frame the potential ideal candidate for reproduction under the definition of crimes of “moral turpitude” while deeming other types of crimes insufficient to enforce the penalty of sterilization. This example demonstrates the ways in which demotic differences in a family versus a couple can allow for drastic procedures to occur under the law.

Insurance companies have utilized three primary arguments to justify not covering issues related to fertility and specifically methods assisted reproductive technology. (1) infertility is not an illness, (2) ART treatment is not medically necessary; and (3) ART treatments are experimental. It is important to note that none of these arguments have been upheld by courts.

In 1987 in *Marsh v. Reserve Life Insurance Company*, Larry and Beverly Marsh were insured by Reserve Life Insurance Company. Before Beverly and her husband purchased this policy she had a tubal ligation voluntarily to make her infertile. Then two years later Mrs. Marsh decided she wanted to reverse the surgery. The procedure was not covered by her insurance and so litigation was brought by the Marsh couple. The insurer stated “the reversal of a voluntary tubal ligation did not result from an injury or sickness nor was it medically necessary are provided by the policy and, therefore, it was excluded from coverage” (516 So. 2d 1311 (La. Ct. App. 1987)). In this case Mrs. Marsh’s legal team argued that her inability to have children was a sickness which was not manifested until she desired children and the policy provides the following definition of an insured expense: “A charge which: a) results from an injury or sickness, b) is covered by the policy, c) is incurred while this policy is in force, d) is medically necessary, and e) is authorized by a physician or surgeon. [Also] injury is defined as: accidental bodily injury sustained, directly and independently of all other causes, from an accident occurring while this policy is in force. [And lastly] sickness is defined as: disease or illness which first manifests itself while this policy is in force... Including in the charges which are excluded from coverage under the policy in the exclusion section are those which: result from elective sterilization” (516 So. 2d 1311 (La. Ct. App. 1987)). Marsh argued that because her desire to have children did not occur until after she had purchased the insurance policy the procedure should be covered, which was originally dismissed by the court however, the “Louisiana Court of Appeals did not find that voluntary sterilization was an illness, it clearly distinguished between voluntary sterilization and other physical causes for the inability to have children” (Gilbert, 1996).

In *Witcraft v. Sundstrand Health and Disability Group Benefit Plan* the Iowa Supreme Court argued for the word illness, sickness and disease to be synonymous and that the definition, as related to health insurance, included “deviation from the healthy or normal condition of any of the function or tissues of the body” (*Witcraft v. Sundstrand Health and*

Disability Group Benefit Plan the Iowa Supreme Court, 1988). Since the natural function of the reproductive organs is to procreate, the court went on to declare that the inability of these functions and tissues to do so was an illness. The court also held that these medical procedures met the criteria of treatments for insurance purposes, and that since these treatments were not included in a list of specific exclusions in the plan, they were covered. (Witcraft v. Sundstrand Health and Disability Group Benefit Plan the Iowa Supreme Court, 1988). The decision in this case was additionally upheld by the Louisiana Court of Appeals. The Witcraft case does set precedence for future insurance coverage by persons wishing to use their insurance to conceive through assisted reproductive technology, however it does still require a diagnosis of infertility which is currently not an inclusive of all potential parents.

In Reilly v. Blue Cross and Blue Shield United of Wisconsin, the Reilly's undergo successful in vitro fertilization (IVF) and submit the claims to their insurance. Blue Cross denied coverage for the expenses incurred on the grounds that 1) IVF was an experimental procedure, which was excludable under the master contract's general provision excluding experimental procedures; and 2) the contract specifically excluded coverage for an IVF procedure. Blue Cross claimed that the IVF was experimental under the general exclusion because it had a success rate of less than 50%. The seventh Circuit court agreed with the plaintiff's contention that this logic was flawed and would allow denial of treatment for virtually all treatment for terminally ill patients, stating; "a decision to grant coverage based solely on a success rate per se may be arbitrary and capricious" (Reilly v. Blue Cross and Blue Shield United of Wisconsin, 1988). Utilizing the Kenzie rationale which states, "medically necessary was not adopted by the later cases of Egert, Ralston and Witcraft, which generally defined the term as 'service or supplies provided [which] are recommended by a physician and are essential for the necessary care and treatment of an insured or sickness and therefore, IVF qualifies as medically necessary

treatment because it is recommended by a physician and can be essential in the treatment of diseased reproductive organs” (Gilbert, 1996).

Additionally cases have tried to qualify for coverage under the American Disabilities Act (ADA). To qualify as disabled under the ADA, an individual must have either: (1) a physical impairment that substantially lists one or more of the major life activities of such individual, (2) a record of such an impairment, or must be (3) regarded as having such and impairment. An individual asserting protection under this provision must prove three elements: 1) suffer from a physical or mental impairment, 2) limited in one or more major life activities, and 3) the physical or mental impairment substantially limits the major life activity” (American Disabilities Act, 1990). In *Bragdon v. Abbott* the United States Supreme Court found that “reproduction is a major life activity under the American with Disabilities Act” (*Bragdon v. Abbott*, 118S.Ct. 2196, 1998). Each of these cases illustrate the ways that fertility coverage is being paid or denied in terms of insurance and the modes each side is utilizing to articulate their positions. From the long list mapping these cases, it is clear that this issue is being regulated in many ways at the state level, but it lacks a federal consensus. Additionally, these cases provide precedents to create federal legislation for mandating insurance coverage in terms of assisted reproductive technologies.

In addition to the medical diagnosis and clinical response to this issue, there is also a social component. The normative nuclear family is defined in terms of a heterosexual marriage, with kids, a house, maybe even a dog and a white picket fence and while this is not the reality for many Americans this is still the definition that is often used to measure the successes and failures of family formation. Litigation has reinforced this familial structure and expanded it. *Martha A. Field v. Compensated Surrogacy* stated that, “children are often associated with marriage, and those who marry often want to have children (89 Wash. L. Rev. 1155, 1169, 2014).

In the Obergefell v Hodges decision the court:

“held that the Due Process Clause of the Fourteenth Amendment guarantees the right to marry as one of the fundamental liberties it protects, and that analysis applies to same-sex couples in the same manner as it does to opposite-sex couples. Judicial precedent has held that the right to marry is a fundamental liberty because it is inherent to the concept of individual autonomy, it protects the most intimate association between two people, it safeguards children and families by according legal recognition to building a home and raising children, and it has historically been recognized as the keystone of social order” (Obergefell, 2015).

This ruling is crucial to constructing the idea of family that expands to include same sex couples under the law. Not only is this a substantive legal decision, but it is significant in that it changes the symbolic meaning of marriage. Additionally, this ruling makes clear that the definition of marriage has shifted from its original interpretation of two opposite sex partners. In line with this ideological shift the opinion in also states;

“The history of marriage is one of both continuity and change. Changes, such as the decline of arranged marriages and the abandonment of the law of coverture, have worked deep transformations in the structure of marriage, affecting aspects of marriage once viewed as essential. These new insights have strengthened, not weakened, the institution. Changed understandings of marriage are characteristic of a Nation where new dimensions of freedom become apparent to new generations” (Obergefell,2015).

The legal precedents for the Obergefell decision was established in part by another landmark case about the right to marry in Loving v. Virginia. This decision also relied upon the Due Process Clause of the Fourteenth Amendment. In this 1967 ruling; “the court also held that the Virginia law violated the Due Process Clause of the Fourteenth Amendment...under our Constitution the freedom to marry, or not to marry, a person of another race resides with the

individual, and cannot be infringed by the State” (Loving, 1967). The Loving case determined that restricting the right to marriage based on race took away a person’s individual choice, that marriage was part of the United States’ definition of liberty and freedom.

Lastly, and for my point most importantly, the Obergefell decision relied on *Pierce v. Society of Sisters* and the *United States v Windsor* cases to determine that;

“protecting the right to marry is [what] safeguards children and families and thus draws meaning from related right of childrearing, procreation, and education...Without the recognition, stability, and predictability marriage offers, children suffer the stigma of knowing their families are somehow lesser. They also suffer the significant material costs of being raised by unmarried parents, relegated to a more difficult and uncertain family life” (Obergefell, 2015).

The right to marriage for same-sex couples is a recent decision and we are already seeing some erosion in law. The *Masterpiece Cakeshop v. Colorado Civil Rights Commission*; *Charlie Craig*; and *David Mullins* case was decided June 4th, 2018. In this ruling the Supreme Court overturned a lower courts decision that refusing to make a cake for a same sex couple was unconstitutional. The Supreme Court reversed the decision 7-2 and “explained that while gay persons and same-sex couples are afforded civil rights protections under the laws and the Constitution, religious and philosophical objections to same-sex marriage are protected views and can also be protected forms of expression” (Masterpiece, 2018). This ruling has the potential to set precedents for further rulings that make legal the discrimination of gays and lesbians. It would benefit same-sex couples to have access to fertility and adoption insurance so that if for some reason the legality of same-sex marriage is in question in the near future children in these families will be insulated from the repercussions.

When a new patient enters a clinic they must go through a series of diagnostic tests before attempting any assisted reproductive technologies. This is the first level of stress in

which a woman or a couple must endure, questioning why pregnancy has not been achieved or why one might have been lost. Several studies in the *Journal of Counseling and Clinical Psychology* have noted “the negative effects that infertility has on psychological well-being” (Abbey, 1994) however the additional monetary stress that ART produces is not being researched adequately. In a report by Antonia Abbey, Frank Andres and Jill Halman examine infertility a step beyond by considering the psychological effects beyond conception asking the question, “Do the negative effects of infertility disappear after a child enters the family, or does some of the stress and negative affect persist to the detriment of the parenthood experience” (Abbey, 1994). Their research here most closely aligns to the experiences of the LGBT community in that the added pressure and monetary aspects of conception; “suggest that some previously infertile couples have difficulty acknowledging the unpleasant aspects of parenting (e.g. fatigue, less, leisure time) because they had idealized what parenthood would be like and feel that depressing negative affect ‘would make them appear ungrateful and less than perfect parents” (Abbey, 1994). The combination of postpartum psychological and monetary stressors are unnecessary and can be mitigated through the expansion of insurance coverage to reduce the financial burden that is unethically placed on families struggling with infertility and LGBT couples who must seek the medical interventions of a fertility clinic to conceive.

Second parent adoption is the proceedings by which a non-biological parent petitions to adopt the child of his or her partner. To clarify this means that a lesbian couple married or not that use donor sperm to conceive a child which one of the partners carries must be adopted by the non-biological parent to gain legal rights to the child conceived. During this process the couple must hire an attorney, pay a certified organization to conduct a home study, justify their ability to co-parent the child and validate that the adoption would be in the child’s best interest. This process is demeaning and requires that lesbian and gay couples jump through unnecessary hoops that heterosexual couples do not have to. This bias does not exist if donor

sperm is used to conceive in a heterosexual relationship. Equity across all family times is possible by simply changing birth certificate paperwork to read parent and parent and doing away with second parent adoption requirements to married LGBTQ couples. According to the Human Rights Campaign organizations the approximate cost of a second parent adoption nationwide is about \$6000. The cost of general adoption varies per state and method from under \$5000 to upwards of \$50,000 (HRC.org, 2018). “There are several common situations that may require a second parent adoption for unmarried same-sex adoptive parents: When one partner completed an adoption on their own, and the other partner wants to legalize their parent-child relationship with that adopted child. When a same-sex couple could not adopt jointly in the past but wants to protect the original non-adopting partner’s legal rights to their child. When an LGBT couple has a child through assisted reproductive technology and only one member of the couple is automatically the legal parent of a child (just being on the birth certificate is not enough to secure the non-biological parent’s rights)” (consideringadoption.com, 2018). The number of same sex couple with children has never been higher according to US census data which states that, “in 2010, there were 115,064 same sex couples with children in the United States” (United States Census, 2010). The visibility and representation of same sex parents is growing in the US, with the number of LGBTQ families interesting in adoption hovering around 2 million (hrc.org, 2018). The more ways the family formation is accessible the more children will have a lifelong loving place to call home.

Children in LGBTQ families deserve equal treatment under the law. There is not reason that a child should ever have to understand their family as lesser. While some adults may not consider this process a matter for children to comprehend many LGBTQ families are more open about where their children come from than heterosexual couples. It is obvious to children at a certain age who understand the process of conception to connect that because they have same sex parents they both did not carry and or produce them as biological children. There is no

reason that this process needs to exist for married same sex couples. This process undermines the integrity of that relationship between parent and child and institutions in the United States need to become more inclusive and aware of the toll these types of proceedings take on newly formed families. A majority of citizens have updated their understandings of queer families and are supportive of same sex marriage and family building, it is time for our legislation and representation to match these shifting views and make second parent adoption not required for married couples who conceive a child together.

Methodology:

This study utilized mixed methods beginning with consulting secondary literature and then data was collected from eleven lesbian couples who have utilized any method of assisted reproductive technology. Samples were collected through a snow ball sample based on beginning with immediate contacts. From there each couple recommended their own contact which contributed to the total number of interviews collected. Each couple was interviewed to record each their experiences with family formation as well as demographics including age, gender, and marital status. Following questions of these descriptive statistics each couple was asked to describe the factors that went into the decision to create a family and their processes in attempting to do so. After disclosing attempts at family formation each couple was then asked about potential insurance coverages. Contacts were invited to contribute to definitions of infertility and potential insurance coverage changes that would be more inclusive and would further a couple's ability to conceive without the financial barriers.

Questions were as follows:

1.) Descriptives:

- a.) Gender?
 - b.) Age?
 - c.) Relationship status?
 - d.) Married or Single?
 - e.) Ethnicity?
 - f.) annual income? (approximate)
- 2.) How did you meet?
 - 3.) When and what lead you to decide to have children?
 - 4.) Which assisted technology did you utilize to obtain pregnancy?
 - a.) How many cycles of each?
 - b.) Any additional medication or injections for fertility purposes?
 - 5.) Did you have a diagnosis of infertility prior to going to the fertility clinic?
 - a.) if so what with this process like?
 - b.) Did it require a referral from your primary care physicians?
 - 6.) What fees did you pay in order to conceive? (Break these down as much a possible per procedure and cycle)
 - 7.) In your own words can you define infertility?
 - a.) Do you find this definition to be problematic for any reason?
 - b.) Do you believe it is accessible as it is written to all couples?
 - 8.) Does insurance in your state/country cover any diagnosis or treatment for infertility?
 - a.) Do you believe it should? Why?
 - b.) Did you have any insurance coverage when attempting ART technologies?
 - 9.) What might you see as a pathway to increasing access to insurance for infertility?
 - a.) If insurance was available what would be the most helpful for it cover?
 - b.) Does this pathway work for all people wishing to conceive?
 - c.) In your vision who would benefit from this insurance coverage? Would there be any limitations?
 - 10.) In your opinion what role should the government play in funding family formation?
 - a.) Does a state single payer model appeal to you?
 - b.) Would you have utilized this type of coverage to conceive?
 - 11.) Who else should I talk to?

Questions were written based on existing statues for fertility coverage in these 19 states:

STATE	SUMMARY OF STATUTES
<p>ARKANSAS</p>	<p>Ark. Stat. Ann. § 23-79-510 specifies that the Arkansas Comprehensive Health Insurance Pool shall not include coverage for any expense or charge for in vitro fertilization, artificial insemination or any other artificial means used to cause pregnancy.</p> <p>Ark. Stat. Ann. § 23-85-137 and § 23-86-118 (1987, 2011) require accident and health insurance companies to cover in vitro fertilization. Services and procedures must be performed at a facility licensed or certified by the Department of Health and conform to the guidelines and minimum standards of the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. (2011 SB 213)</p>
<p>CALIFORNIA</p>	<p>Cal. Health & Safety Code § 1374.55 and Cal. Insurance Code § 10119.6 require specified group health care service plan contracts and health insurance policies to offer coverage for the treatment of infertility, except in vitro fertilization. The law requires every plan to communicate the availability of coverage to group contract holders. The law defines infertility, treatment for infertility and in vitro fertilization. The law clarifies that religious employers are not required to offer coverage for forms of treatment that are inconsistent with the organization's religious and ethical principles. The law was amended by 2013 Cal. Stats., Chap. 644 (AB 460) to specify that treatment of infertility shall be offered and, if purchased, provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.</p>

STATE	SUMMARY OF STATUTES
CONNECTICUT	<p>Conn. Gen. Stat. § 38a-509 and § 38a-536 (1989, 2005) require that health insurance organizations provide coverage for medically necessary expenses in the diagnosis and treatment of infertility, including in vitro fertilization procedures. Infertility, in this case, refers to an otherwise healthy individual who is unable to conceive or produce conception or to sustain a successful pregnancy during a one-year period. Amended in 2005 to provide an exemption for coverage that is contrary to the religious beliefs of an employer or individual.</p>
DELAWARE	<p>18 Del. C. §3556 (2018) requires all group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in the state of Delaware by any health insurer, health service corporation, or health maintenance organization and that provide for medical or hospital expenses shall include coverage for fertility care services, including in vitro fertilization services for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a pregnancy to live birth and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility.</p>
HAWAII	<p>Hawaii Rev. Stat. § 431:10A-116.5 and § 432.1-604 (1989, 2003) require all accident and health insurance policies that provide pregnancy-related benefits to also include a one-time only benefit for outpatient expenses arising from in vitro fertilization procedures. In order to qualify for in vitro fertilization procedures, the couple must have a history of infertility for at least five years or prove that the infertility is a result of a specified medical condition.</p>

STATE	SUMMARY OF STATUTES
ILLINOIS	<p>Ill. Rev. Stat. ch. 215, § 5/356m (1991, 1996) requires certain insurance policies that provide pregnancy-related benefits to provide coverage for the diagnosis and treatment of infertility. Coverage includes in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete sperm artificial intra-fallopian tube transfer, zygote intra-fallopian tube transfer and low tubal ovum transfer. Coverage is limited to four completed oocyte retrievals, except if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals are covered. (1996 Ill. Laws, P.A. 89-669)</p>
LOUISIANA	<p>La. Rev. Stat. Ann. § 22:1036 prohibits the exclusion of coverage for the diagnosis and treatment of a medical condition otherwise covered by the policy, contract, or plan, solely because the condition results in infertility. The law does not require insurers to cover fertility drugs, in vitro fertilization or other assisted reproductive techniques, reversal of a tubal ligation, a vasectomy, or any other method of sterilization. (2001 La. Acts, P.A. 1045)</p>

STATE	SUMMARY OF STATUTES
MARYLAND	<p>Md. Insurance Code Ann. § 15-810 (2000) amends the original 1985 law and prohibits certain health insurers that provide pregnancy-related benefits from excluding benefits for all outpatient expenses arising from in vitro fertilization procedures performed. The law clarifies the conditions under which services must be provided, including a history of infertility of at least a 2-year period and infertility associated with one of several listed medical conditions. An insurer may limit coverage to three in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000. The law clarifies that an insurer or employer may exclude the coverage if it conflicts with the religious beliefs and practices of a religious organization, on request of the religious organization. Regulations that became effective in 1994 exempt businesses with 50 or fewer employees from having to provide the IVF coverage. (2000 Md. Laws, Chap. 283; H.B. 350)</p> <p>Md. Health General Code Ann. § 19-701 (2000) includes family planning or infertility services in the definition of health care services.</p>

STATE	SUMMARY OF STATUTES
MASSACHUSETTS	<p>Mass. Gen. Laws Ann. ch. 175, § 47H, ch. 176A, § 8K, ch. 176B, § 4J, ch. 176G, § 4 and 211 Code of Massachusetts Regulations 37.00 (1987, 2010) require general insurance policies, non-profit hospital service corporations, medical service corporations and health maintenance organizations that provide pregnancy-related benefits to also provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization. This law was amended in 2010 to change the definition of "infertility" to be a condition of an individual who is unable to conceive or produce conception during a period of one year if the female is under the age of 35, or during a period of six months if the female is over the age of 35. If a person conceives but cannot carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six month period. (SB 2585)</p>
MINNESOTA	<p>Minn. Stat. Ann. § 256B.0625 specifies that medical assistance shall not provide coverage for fertility drugs when specifically used to enhance fertility.</p>
MONTANA	<p>Mont. Code Ann. § 33-22-1521 (1987) revises certain requirements of Montana's Comprehensive Health Association, the state's high-risk pool, and clarifies that covered expenses do not include charges for artificial insemination or treatment for infertility. (SB 310)</p> <p>Mont. Code Ann. § 33-31-102 et seq. (1987) requires health maintenance organizations to provide basic health services on a prepaid basis, which include infertility services. Other insurers are exempt from having to provide the coverage.</p>

STATE	SUMMARY OF STATUTES
NEW JERSEY	<p>N.J. Stat. Ann. § 17:48-6x, § 17:48A-7w, § 17:48E-35.22 and § 17B:27-46.1x (2001) require health insurers to provide coverage for medically necessary expenses incurred in diagnosis and treatment of infertility, including medications, surgery, in vitro fertilization, embryo transfer, artificial insemination, gamete intra-fallopian transfer, zygote intra-fallopian transfer, intra-cytoplasmic sperm injection and four completed egg retrievals per lifetime of the covered person. The law includes some restrictions as well as a religious exemption for employers that provide health coverage to fewer than 50 employees. (SB 1076)</p>

STATE	SUMMARY OF STATUTES
NEW YORK	<p>N.Y. Insurance Law § 3216 (13), § 3221 (6) and § 4303(1990, 2002, 2011) prohibit individual and group health insurance policies from excluding coverage for hospital care, surgical care and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility. The laws were amended in 2002 to require certain insurers to cover infertility treatment for women between the ages of 21 and 44 years. The laws exclude coverage for in vitro fertilization, gamete intra-fallopian tube transfers and zygote intra-fallopian tube transfers. The laws were amended again in 2011 by N.Y. laws, Chap. 598 to require every policy that provides coverage for prescription fertility drugs and requires or permits prescription drugs to be purchased through a network participating mail order or other non-retail pharmacy to provide the same coverage for prescription fertility drugs that are purchased from a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance to the same reimbursement amount and the same terms and conditions that the insurer has established for a network participating mail order or other non-retail pharmacy. The policy is prohibited from imposing additional fees, co-payments, co-insurance, deductibles or other conditions on any insured person who elects to purchase prescription fertility drugs through a non-mail order retail pharmacy. (2011 AB 8900)</p> <p>N.Y. Public Health Law § 2807-v (2002) creates a grant program to improve access to infertility services, treatments and procedures from the tobacco control and insurance initiatives pool.</p>

STATE	SUMMARY OF STATUTES
OHIO	<p>Ohio Rev. Code Ann. § 1751.01 (A)(1)(h) (1991) requires health maintenance organizations (HMOs) to provide basic health care services, which are defined to include infertility services, when medically necessary.</p>
RHODE ISLAND	<p>R.I. Gen. Laws § 27-18-30, § 27-19-23, § 27-20-20 and § 27-41-33 (1989, 2007) require any contract, plan or policy of health insurance (individual and group), nonprofit hospital service, nonprofit medical service and health maintenance organization to provide coverage for medically necessary expenses for the diagnosis and treatment of infertility. The law clarifies that the co-payments for infertility services not exceed 20 percent. Infertility is defined as the condition of an otherwise healthy married individual who is unable to conceive or produce conception during a period of one year. Rhode Island includes IVF coverage. Amended in 2007 to increase the age of coverage for infertility from forty (40) to forty-two (42) and redefines infertility to mean a woman who is unable to sustain pregnancy during a period of one year. (2007 R.I. Pub. Laws, Chap. 411, SB 453)</p>
TEXAS	<p>Tex. Insurance Code Ann. § 1366.001 et seq. (1987, 2003) requires that all health insurers offer and make available coverage for services and benefits for expenses incurred or prepaid for outpatient expenses that may arise from in vitro fertilization procedures. In order to qualify for in vitro fertilization services, the couple must have a history of infertility for at least five years or have specified medical conditions resulting in infertility. The law includes exemptions for religious employers.</p>

STATE	SUMMARY OF STATUTES
UTAH	<p>2014 Utah Laws, Chap. 353 (HB 347) amended § 31A-22-610.1, which requires insurers that provide coverage for maternity benefits to also provide an adoption indemnity benefit of \$4,000 for a child placed for adoption with the insured within 90 days of the child’s birth. The law was amended to allow an enrollee to obtain infertility treatments rather than seek reimbursement for an adoption. If the policy offers optional maternity benefits, then it must also offer coverage for these indemnity benefits under certain circumstances.</p>
WEST VIRGINIA	<p>W. Va. Code § 33-25A-2 (1995) amends the 1997 law and requires health insurers to cover basic health care services, which include infertility services. Applies to health maintenance organizations (HMOs) only.</p>

The data shows that insurance coverage for assisted reproductive technologies is minimal at the federal level and inaccessible to lesbian couples completely. Utilizing the state by state table these results are not only verified through my own research, but through the language of these laws which offer heterosexual couples varying degrees of coverage.

Currently, most states with the exception of 15 offer no coverage for reproductive medicine beyond the diagnosis of the cause of infertility and of those 15 states many have very strict guidelines that dictate the number of IVF attempts, don't cover certain types of treatments or require documentation of infertility for specified time periods. For example, Connecticut offers coverage that includes; “in vitro fertilization procedures” However, this is not without documented “natural” attempts to conceive for a one year period. Hawaii “requires certain insurance policies that provide pregnancy related benefits to provide coverage for the diagnosis and treatment of infertility. [including ART] but Hawaii Rev. Stat. 431:10A-116.5 only offers

coverage for “one time benefits, and the couple must have a history of infertility for at least five years or prove that the infertility is a result of a specified medical condition” (NCSL, 2018) In Illinois, “coverage is limited to four complete oocyte retrievals, except if a live birth follows a completed oocyte retrieval , then two more completed oocyte retrievals are covered” (NCSL, 2018). Maryland Insurance Code Ann. 15-810 states “an insurer may limit coverage to three in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000” (NCSL, 2018). Minnesota Stat. Ann 33-22-1521 “specifies that medical assistant shall no provide coverage for fertility drugs when specifically used to enhance fertility” (NSCL, 2018). Each legal definition of infertility is dependent on a woman’s ability to conceive.

Only one of the 15 states that offer some coverage for conception, California, have any language at all about LGBT couples. In 2013, Cal Stats. Chap. 644 was amended “to specify that treatment of infertility shall be offered and, if purchased, provided without discrimination own the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation” (NCSL, 2018). However, even with this amendment it is still not possible to document one year of infertility as stated in the common definition, “infertility is defined as the absence of conception after at least one year of regular, unprotected intercourse” (NSCL, 2018). Considering a same sex couple will never produce a pregnancy naturally these legal mandates for coverage cannot ethically address the desire of same sex couples to parent.

These fifteen states begin the conversation about fertility coverage in the United States, however even with the best examples lesbian couples wishing to conceive are still held outside of these mandates. Of the eleven couples interviewed none of these laws would have made fertility coverage possible. This demonstrates the heteronormative practices in current fertility ideology and practice.

Results and Discussion:

In order to facilitate a clearer interpretation of the laws and data collected from the interviews, the section below documents the procedures for a lesbian couple beginning fertility intervention. In this case the couple is starting the process at the fertility clinic and assuming no fertility complications or additional diagnosis have been provided to the couple. The timeline is an example of one case from sperm selection through legal parenthood post birth. As noted the specimen quarantine, psychological evaluations and second parent adoption policies for lesbian couples create an additional barrier for an already costly and stressful process.

When a lesbian couple to begin the process of starting a family they have many decisions to make. First, where will the sperm specimen come from. In this regard, there are really two choices, known or unknown donor, however if fresh sperm from a known donor is used an additional decision is required. The couple has to decide to take the risk and use the sperm fresh or to pay for storage, testing, and specimen preparation. If the donor is not married to the person wishing to conceive and the decision is made to take the specimen to a clinic for storage and preparation then there is a six month waiting period. This quarantine waiting period is mandatory even if the couple has already been trying at home with the same fresh sperm.

“We had our friends bank the sperm that we could ship it up here. So he had to go to the sperm bank in San Diego and make multiple visits and then like they did all these screenings and everything. And unfortunately there is, I don't know, there still is, but there was a rule that if you're not a couple, like a straight couple, the sperm had to be quarantined for six months. I mean for us, because they want to make sure that they're not infecting people with diseases. Um, but if we had been a married couple, they wouldn't have done that, which was really infuriating. Um, and felt very, um, discriminating, um, and slowed down our timeline and then had to have the sperm shipped here and um, kept at a facility at the u-dub down like that Seattle campus and their medical school and paid a whole bunch of money to do that” (Berliner, 2019). Sperm banks are both national and local. Washed sperm is necessary if you want to do an IUI. The washing process gets the specimen ready for the process of bypassing the cervix and

going straight into a uterus. Your clinic may or may not charge an additional fee for this process. If like the example above you know your donor, but do not live close to them, then storage and processing fees will apply if you wish to do an IUI in a clinic setting. There will also be a six month quarantine waiting period if the couple is not married.

Below is an example of what this choice might look like:

	Anonymous Donor	Open Donor	Known Donor
Sperm Bank 1: (Cost per vial)	\$865 washed \$775 unwashed	\$995 washed \$895 unwashed	Free if fresh and your donor agrees Storage and processing fees will apply if clinic is used
Sperm Bank 2: (Cost per vial)	\$795 washed \$795 unwashed	\$945 washed \$795 unwashed	Free if fresh and your donor agrees Storage and processing fees will apply if clinic is used

Storage Costs:

	One year storage	Three year storage
Sperm Bank 1: (Regardless of vials stored)	\$485	\$1085
Sperm Bank 2: (Regardless of vials stored)	\$375	\$1825

This process may have discounts for longer periods and it may be cost effective to purchase more vials at once, so then a decision must be made to consider the chances of getting pregnant before you run out of vials. There may also only be a certain number of vials available and the donor you select may not be interested in providing additional samples for future siblings or attempts. Most of the time clinics will not buy back vials that are not used or if anything they might buy them back at a discounted rate. At any rate, a decision must be made about the number of vials purchased, how long to store them, and where. Since shipping sperm

is also a cost it may be more cost effective to select a sperm bank near where you live if possible.

Shipping costs:

	Next Day Shipping	Two Day Shipping
Sperm Bank 1: (regardless of vials shipped)	\$295 (+\$80 processing fee)	\$235
Sperm Bank 2: (regardless of vials shipped)	\$250 (+\$100 processing fee)	\$205

Keeping in mind that ovulation is a window of time that is not always complete predictable without medical intervention. In that case your doctor will want to monitor ovulation with multiple ultrasounds around the approximate time of ovulation, which will require going to the clinic everyday and having a baseline ultrasound procedure.

Ultrasound:

	Ultrasound	Number of days monitored
Clinic 1:	\$300 per procedure	5
Clinic 2:	\$375 per procedure	6

Additionally before undergoing any type of artificial insemination many clinics will require a physiological evaluation. This may require multiple meetings with the clinic psychologist and at times for a lesbian couple the questions are off base and poorly worded. Questions may include anything from “Is it your intention to disclose sperm donation to your child?” to “Do you have a support system?” or even questions about stress management. Again, these services are not often covered by any form of insurance because they originate through a fertility clinic.

Psychology Screen:

	Intended parent consultation	Number of sessions
Clinic1:	\$250	2

	Intended parent consultation	Number of sessions
Clinic 2:	\$200	3

Upon determining you are fit to move forward with artificial insemination, the next part of the process is to start monitoring more closely to determine follicle size and really narrow down a window for the procedure bases on ovulation schedule.

Follicular Ultrasound:

	Ultrasound
Clinic 1:	\$250
Clinic 2:	\$285

Next, a determination is made by you and your provider about medication. This can be both very expensive and intensely mood altering. There are many different types of medication which achieve follicle stimulation, to assisting ovulation to full trigger of ovulation. Many come with health risks and increase chances of multiple births.

Some examples include but not limited to:

Medication	Price per cycle
Clomid (oral)	\$75
Letrozole (oral)	\$30
FSH (injection)	\$2000
HCG (trigger shot)	\$200
Ovidrel (trigger shot)	\$300

Side effects from clomid can be extreme include, hot flashes, abdominal discomfort, weight gain, mood swings, nausea and dizziness, abnormal menstrual bleeding, headaches, diarrhea, vomiting, and blurred vision or visual disturbances. The most commonly proscribed; "Clomid is an oral medication that can be used to stimulate ovulation. It works by blocking estrogen receptors at the hypothalamus, which is an important, 'hormonal control center' for the body.

When this happens, the hypothalamus is stimulated to release follicle stimulating hormone (FSH) and luteinizing hormone (LH)” (AIWHC, 2019). Many couple report the challenges with this type of medication,

“she put me on some medication, um, to see if that would help simulate things. And it just made me feel like shit and it didn't do anything cause I didn't get pregnant the next time or the next time” (Berliner, 2019).

However, if the pressure wasn't so high to get pregnant because of the excessive costs then perhaps this type of intervention would be less prevalent.

“But then, of course when you do a medicated cycle, there's like four additional associated ultrasounds to monitor your follicle growth, and there's the trigger shot, which caused \$150. And then, you know, there's some other costs the prescriptions itself. And so, um, so I was like, oh yeah, we'll try it with the Clomid. And then didn't realize until after I was like getting the bill, like, oh, you guys are expecting me to go from the cost of my vial of sperm, which is \$600. Um, you know, plus maybe one additional ultra sound to see if I've ovulated. And then the cost of the IUI itself too, then adding these additional daily ultrasound and this trigger shot. And so it went from being like \$1,000 a month that we can afford to like \$2,500 a month. Um, and of course none of that was covered by insurance” (Alloy, 2019).

IUI is the less expensive version of assisted reproduction, to provide some totals per cycle:

	1st round of IUI (without medication)	Each month after (Without medication)
Scenario 1:	\$2788	\$1753
Scenario 2:	\$2670	\$1800

Cost would reduce in this model per month for a short time if, you had purchased more than one vial of sperm, purchased a longer storage time frame or paid for upfront shipping. This total does not include any necessary medications and these are per month totals for and unmedicated IUI cycle. The costs would increase significantly when choosing an IVF cycle instead of IUI.

“There are five basic steps in the IVF and embryo transfer process: Step 1: Fertility medications are prescribed to stimulate egg production. Multiple eggs are desired because some eggs will not develop or fertilize after retrieval. A transvaginal ultrasound

is used to examine the ovaries, and blood test samples are taken to check hormone levels. Step 2: Eggs are retrieved through a minor surgical procedure that uses ultrasound imaging to guide a hollow needle through the pelvic cavity to remove the eggs. Medication is provided to reduce and remove potential discomfort. Step 3: The male is asked to produce a sample of sperm, which is prepared for combining with the eggs. Step 4: In a process called insemination, the sperm and eggs are mixed together and stored in a laboratory dish to encourage fertilization. In some cases where there is a lower probability of fertilization, intracytoplasmic sperm injection (ICSI) may be used. Through this procedure, a single sperm is injected directly into the egg in an attempt to achieve fertilization. The eggs are monitored to confirm that fertilization and cell division are taking place. Once this occurs, the fertilized eggs are considered embryos. Step 5: The embryos are usually transferred into the woman’s uterus three to five days following egg retrieval and fertilization. A catheter or small tube is inserted into the uterus to transfer the embryos. This procedure is painless for most women, although some may experience mild cramping. If the procedure is successful, implantation typically occurs around six to ten days following egg retrieval” (AmericanPregnancy.org/infertility/in-vitro-fertilization, 2019).

As noted above the additional costs of these procedures in IVF average about twelve thousand dollars per cycle (or attempt) and most if not all of either IVF or IUI in covered by insurance unless your employer has this added bonus in their private coverage (most do not).

The last procedure post birth for a lesbian couple is second parent adoption.

	Home Study	Attorney Fees
Agency #1	\$1100	\$1750
Agency #2	\$1200	\$1900

This process involves a home study worker evaluating your home for safety and space. As well as personal interviews about intricate details of your life over the course of three interviews to make sure the non-biological family member is fit to parent. Over and over again our courts have ruled that family is the foundation and a major building block by which we build our nation and it is time our health care system assisted to make this dream a reality for more couples regardless of their sexual orientation.

Conclusions:

In May, Senator Cory Booker (D-NJ) and Representative Rosa L. DeLauro (D-Conn) introduced legislation that would have required all private-sector health plans, plus the federal employees plan and the veterans health care system, to cover IVF. Finding 11 states, “The ability to have a family should not be denied to anyone on account of a lack of insurance coverage for medically necessary treatment” (S. 2960, 2018). The changes in this bill would make IVF and fertility treatments significantly more accessible to most American families seeking to conceive. Patricia Stapleton and Daniel Skinner write “the ACA could change the way fertility is understood medically as well as politically. These elements include the ACA’s essential health benefits (EHBs), the ACA’s impact on the state-level regulation of individual insurance markets, and the ACA’s prohibition of insurance coverage denials on the basis of pre-existing conditions” (Stapleton, 2015). The Affordable Care Act (ACA), the law has 3 primary goals: make affordable health insurance available to more people. Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. Support innovative medical care delivery methods designed to lower the costs of health care generally” (healthcare.gov). Every couple interviewed for this study would have benefited from a reduction to the cost of fertility treatment. In some cases these exorbitant costs meant that they could only have one child or tried more risky processes at home to try and conceive before attempting conception in a fertility clinic. Even more important however is the reduction of additional barriers for lesbian couple wishing to conceive. Psychological evaluations and second parent adoption proceedings need to be halted immediately and with it the erasure of the imaginary differences in heterosexual and queer parenting. A family is a family and love not biology should be enough to legally enforce parentage when a child is conceived via ART. Semiotic relationships between heterosexuality and family need to shift to allow a discourse that provides a more inclusive version of what it means to be a parent and lastly ART must become more affordable if the

United States wants to keep up with the promises the court made with the Obergefell v. Hodges decision in 2016 because family; “has historically been recognized as the keystone of social order” (Obergefell, 2015).

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