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William C. Cole

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Infertility: A Survey of the Law and Analysis of the Need for Legislation Mandating Insurance Coverage

Infertility is a serious prevalent problem in the United States. It is believed that one in six couples is infertile, and that there are over two million infertility related medical visits per year. While there are numerous treatments with high success rates, the cost of infertility treatment can be expensive. Although infertility is a common problem, health insurance coverage is erratic. Some insurance companies only cover specific types or certain portions of the treatment, while other insurance companies do not provide any coverage at all.

This Comment addresses two central issues. First, it discusses the current state of the law for infertility coverage. Second, it analyzes whether health insurance companies should be required to offer infertility treatment coverage as an option, or whether they should be required to provide infertility treatment automatically as part of the policy coverage.

Part I of this Comment presents background information to facilitate a general understanding of infertility and insurance coverage. Part II surveys the law regarding insurance coverage of infertility treatments. This survey includes existing case law, current and proposed state legislation, and proposed federal legislation. The focus of this Comment is on state legislation, with identification and analysis.
of the different general types of existing legislation. Part III analyzes whether infertility legislation is necessary. More specifically, Part III presents arguments opposing and supporting legislation to conclude that infertility legislation is necessary. Part IV presents guidelines for model state legislation for infertility treatment insurance coverage. Part V concludes that at a minimum, states should require health insurance companies to offer infertility coverage, but ideally states should require health insurance companies to provide infertility coverage.

I. UNDERSTANDING INFERTILITY

According to the standard medical definition of infertility, "[a] couple is infertile if neither spouse is surgically sterile and if they have had at least 12 months of unprotected intercourse without a pregnancy." In 1982, approximately 2.4 million married couples between the ages of fifteen and forty-four years of age were considered infertile. Also in 1982, it was estimated that approximately fourteen percent (one out of seven) of all married couples of childbearing age were infertile. Although a United States Department of Health and Human Services survey has not been performed since 1982, it is believed that currently approximately seventeen percent (one out of six) of all married couples of childbearing age are infertile. Based on these statistics, ten million Americans are defined as involuntarily infertile.

Although infertility is prevalent in the United States, there are several treatment options available. Authorities suggest that infertile couples should begin with counseling from their primary care physician concerning pinpointing ovulation and timing intercourse in relation to ovulation. If such counseling is unsuccessful, the couple should undergo a series of diagnostic tests to identify breakdowns in the reproductive process, and if repairable, to determine the appropriate means to correct the problem. Once the specific problem is identified, a variety of sophisticated procedures are available to correct it. These methods generally include surgery to repair anatomical

8. W. Mosher & W. Pratt, supra note 6, at 3 (not including surgically sterile couples).
9. Desperately Seeking Baby, supra note 1, at 58.
10. Id.
damage, fertility drugs to enhance ovulation and sperm function, artificial insemination, and in vitro fertilization (IVF). Most authorities agree that of the methods listed above, including counseling and excluding IVF, the combined success rate is 70 to 85 percent. The success rate for IVF alone is considerably lower at 20 to 30 percent.

While the average success rate of these procedures is high, the potential costs are also high. A complete diagnostic workup can cost $3000; fertility drug treatments approximately $3000; artificial insemination approximately $400; and in vitro treatments between $4500 and $6000 per cycle. However, these expensive procedures are not always required. Often, the problem can be corrected fairly inexpensively through counseling or through preliminary testing of the husband's semen.

Assuming a couple cannot correct their infertility at the counseling stage or through preliminary testing, resolution of the problem will cost a minimum of $2500 to $3000 for complete diagnostic testing, plus the added cost of treatment. However, the actual average cost for infertility treatment is estimated to be only $200 per couple. Insurance coverage of infertility treatment is erratic: some insurance companies cover treatment, while many others do not. Additionally, of the insurance companies that do cover infertility treatment, many exclude specific types or certain portions of the treatment.

13. G. Sher, V. Marriage & J. Stoess, supra note 5, at 5. In 1987, "IVF was undertaken by less than 1 percent of the estimated number of infertile couples in the United States who sought treatment." Congress of the U.S. Office of Technology Assessment, Infertility: Medical and Social Choices Summary 9 (1989) [hereinafter Infertility: Medical and Social Choices Summary].
17. Frey, Stenchever & Warren, supra note 11, at 22. Counseling usually involves pinpointing of ovulation and the timing of intercourse in relation to ovulation. Id. Counseling may help between one-fourth and one-half of infertile couples. Id.
18. Desperately Seeking Baby, supra note 1, at 60. "A $50 test of the husband's semen may reveal a shortage of healthy sperm, a problem sometimes cured by antibiotics or just a cutback in alcohol consumption." Id.
20. Fuchs & Perreault, Expenditures for Reproduction-Related Health Care, 255 J.A.M.A. 30 (1986). This is a true average, including inexpensive procedures such as counseling and preliminary testing as well as expensive procedures such as IVF. This low average cost indicates to this writer that a majority of cases are resolved prior to resorting to expensive procedures.
21. Desperately Seeking Baby, supra note 1, at 63.
22. Some insurance plans exclude IVF as experimental. Id. Some insurance com-
II. SURVEY OF THE LAW

A. Existing Case Law

Existing case law has addressed insurance coverage for infertility treatment in four general categories. First, courts have analyzed whether infertility is an illness. Second, they have analyzed whether infertility treatment is a medically necessary procedure. Third, they have analyzed whether IVF is "experimental" and thus subject to exclusion. And fourth, they have analyzed whether sterilization reversals merit coverage. This section will address each of these four categories, and will also address the insurance companies' response to a successful California class action settlement and to an Iowa Supreme Court decision forcing coverage of infertility treatment. As a result of these cases, insurance companies began to specifically exclude infertility treatment from coverage.

companies pay for the portion of IVF involving fertility hormone shots, ultrasound examinations, and the egg retrieval process, but "will not pay laboratory work, the fertilization process, or the embryo transfer." G. SHER, V. MARRIAGE & J. STOESS, supra note 5, at xviii (1988). "Treatment related to IVF is specifically excluded from coverage by the majority of health plans, but substantial reimbursement occurs for the various components of IVF treatment (e.g. hormonal stimulation)." INFERTILITY MEDICAL AND SOCIAL CHOICES SUMMARY, supra note 13, at 9.

23. Witcraft v. Sundstrand Health and Disability Group Benefit Plan, 420 N.W.2d 785 (Iowa 1988) (holding that denial of coverage for artificial insemination was improper because infertility is an illness); see infra notes 30-40 and accompanying text.

24. Kinzie v. Physician's Liability Ins. Co., 750 P.2d 1140 (Okla. Ct. App. 1987) (holding that denial of coverage for IVF was proper because it was not a "medically necessary" service within the meaning of the insurance policy); see infra notes 41-48 and accompanying text.

25. Reilly v. Blue Cross and Blue Shield, 846 F.2d 416 (7th Cir. 1988) (holding that there were disputed material issues of fact as to the basis for the insurance company's decision to exclude IVF as experimental and that there were disputed material issues of fact as to whether the insurance company's decision was arbitrary, capricious, or motivated by bad faith.); see infra notes 50-60 and accompanying text; see also Thiebaud v. Kaiser Foundation Health Plan, Cox, Insurers Being Forced To Pay for Fertility Right, Nat'l L.J., Apr. 11, 1988, at 14, col. 2 (Cal. Super. Ct. filed May 1985) (out of court settlement of a breach of contract action for insurance company's refusal, under an experimental techniques exclusion, to pay for in vitro fertilization); see infra notes 61-63 and accompanying text.


29. See Cox, supra note 25.
1. Infertility As An Illness

In *Witcraft v. Sunstrand Health and Disability Group Benefit Plan,* the plaintiffs, an infertile couple, underwent two unsuccessful attempts at artificial insemination, and then attempted a more sophisticated form of artificial insemination. The plaintiffs submitted their claim to their health insurance provider, but the company denied the claim. The issue before the court was whether infertility was an illness within the meaning of the plan. The specific policy provision stated "[i]f a covered individual incurs outpatient expenses relating to injury or illness, those expenses charged . . . are covered expenses under the provisions of [the plan]." Four factors supported the court's decision. First, the evidence showed that the plaintiffs suffered from dysfunctional reproductive organs, which, in a broad sense, the procedure did help to reverse. Second, the court stated "that insurance language should be interpreted from the viewpoint of an ordinary person," and that "[t]he plan's language suggests to the average reader that any expenses incurred because of, rather than as treatment for, the infertility problem of the couple are covered." Third, the court noted that the plan neither excluded ar-

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30. 420 N.W.2d 785 (Iowa 1988).
31. Id. at 786.
32. Id. at 788. The trial court had determined that although improper functioning of reproductive organs "may be an illness, the condition of not being pregnant is not an illness. Therefore, any procedure, *i.e.* artificial insemination, used to change that condition is not compensable under the terms of the plan." Id. (quoting the trial court).
33. Id. at 778.
34. Id. at 786.
35. Id. at 789-80.
36. The court agreed with the trial court's decision that "the natural function of the reproductive organs is to procreate." Id. at 788 (quoting the trial court), and that "[t]he mere fact that the treatment may occur outside the body of one or the other or in the subsequent course of insemination is not material because it is the natural function of the organs, reproduction, which is in fact treated." Id. at 789 (quoting the trial court). "As for Thomas, the procedure alleviates the problem of low sperm count and low sperm motility. As for Jill, the procedure allows the sperm to be injected directly into the uterus at the time she is ovulating, a condition that must be induced by fertility drugs because of its irregularity." Id. at 790.
37. Id. at 790 (citing Benzer v Iowa Mut. Tornado Ins. Ass'n 216 N.W.2d 385, 388 (Iowa 1974)).
38. Id. The defendant argued that artificial insemination is not a treatment and therefore is not within the terms of the policy. However, because "the language in the plan does not speak in terms of 'treatment of an illness or injury,'" but instead "covers
tificial insemination, nor limited the term "illness." Finally, the court believed that the insurance company had already interpreted the coverage language in this manner because the company had paid for prior infertility treatments of the plaintiffs.

2. Infertility Treatment As a Medically Necessary Procedure

In contrast to Witterraft, Kinzie v. Physician’s Liability Ins. Co. held that IVF was not a “medically necessary” service within the meaning of the plaintiff’s health insurance policy. That policy provided that the insurance company would pay “reasonable and customary charges for medically necessary services.” The issue before the court was whether IVF was medically necessary. The court determined that the term medically necessary was unambiguous, and therefore, that it “should be interpreted in the way it would be understood by the average person.” The court found that IVF “was not . . . contemplated by either of the parties at inception of the contract.” The court reasoned “that in vitro fertilization was not a medically necessary service because it was elective and was not required to cure or preserve Mrs. Kinzie’s health.” The court noted that although the conception of a child is important, it is not within the terms of the policy because it is “not ‘medically necessary’ to the physical health of the insured.” The court also found that the insurance company was not estopped from denying coverage, even though the insurance company had approved payment of prior surgery to correct the plaintiff’s infertility. The court concluded that the insurance company did not lead the plaintiff to believe they would cover in vitro fertilization.

‘expenses relating to injury or illness,’ ” this broader interpretation is appropriate. Id.

39. Id.

40. Id. “Before it denied payment for the Protocol I procedure, Sundstrand paid for semen analysis, sperm counts, ultrasound . . . , fertility drugs to induce ovulation in Jill, and the less expensive washed intrauterine insemination procedure.” Id.; see also supra text accompanying note 32.


42. Kinzie, 750 P.2d at 1141.

43. Id. at 1142.

44. Id. (citing Safeco Ins. Co. of America v. Davis, 44 Wash. App. 161, 721 P.2d 550 (1986)).

45. Id.

46. Id. at 1141. It was not medically necessary because it did not “physically alleviate or correct a serious illness, disease or affliction.” Mrs. Kinzie’s infertile condition was not corrected by IVF because the condition was not reversed or cured. Id. at 1142.

47. Id. at 1142.

48. Id. at 1142-43. The court cursorily dismissed this argument stating that there
3. In Vitro Fertilization Excluded As Experimental

Another means by which insurance companies have denied, or have attempted to deny, infertility treatment coverage is by classifying IVF as experimental and, therefore, as falling within the experimental procedures exclusion clause of the insurance policy. In *Reilly v. Blue Cross and Blue Shield*, the plaintiffs were covered under a health plan subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). Blue Cross, the defendant insurance company, attempted to exclude IVF through both a general provision excluding experimental procedures and through a specific provision excluding IVF. The plaintiffs brought suit against Blue Cross, alleging that Blue Cross had denied their insurance claim arbitrarily and capriciously. Because the specific provision was added after the procedure had been performed on plaintiffs, the district court held that the insurance contract did not specifically exclude IVF. Accordingly, the district court analyzed the case solely under the general provision excluding experimental procedures. The district court granted the defendant's motion for summary judgment, finding that the procedure was still experimental and holding, therefore, that there were no material questions of fact as to whether the defendant had acted arbitrarily, capriciously, or in bad faith in refusing to pay the plaintiffs' claim for IVF.

The court of appeals reversed as to this issue, holding that there were "clearly disputed material issues of fact as to whether the defendant's decision and whether it was arbitrary, capricious or motivated by bad faith." The *Reilly* court reached this decision for several reasons. First, the plaintiffs introduced evidence that IVF was not experimental at the time the coverage was denied. Second,
Blue Cross did not provide expert testimony that in 1984 IVF was experimental, "and no comparison with the plaintiffs' experts' testimony was made."\(^{59}\) Third, Blue Cross' rationale for denying coverage—the success rate of IVF—was not reviewed by the district court.\(^{60}\) Finally, the Reilly court held that there were numerous other open issues not addressed by the district court.\(^{61}\)

In Thiebaud v. Kaiser Foundation Health Plan,\(^{62}\) a California class action suit for breach of contract, the defendant insurance company also attempted to exclude IVF under a general experimental procedure exclusion clause. The case did not reach final disposition, but instead was settled for up to $50,000 each for an estimated 5000 women.\(^{63}\) Subsequent to the settlement, the defendant insurance company conceded that in vitro fertilization is not experimental.\(^{64}\)

### 4. Sterilization Reversals

Two courts have addressed whether sterilization reversals are covered by medical insurance policies.\(^{65}\) In both cases the courts upheld denial of coverage. First, both courts concluded that the exclusion section of the policy excluded charges for elective sterilization, and therefore, by extension, excluded charges for sterilization reversals as well.\(^{66}\) Second, they held that the surgery was neither medically necessary, nor "the result of sickness or injury as those terms were defined by the policy."\(^{67}\) Third, the Ruess court concluded that the procedure was not within the "covered charges" because it was not "usual, customary, and necessary."\(^{68}\)

\(^{59}\) Id. at 423.

\(^{60}\) Id.

\(^{61}\) Id. at 424. Open issues included: "(1) Who made the ultimate decision . . . that IVF is experimental? (2) What are their qualifications and on what basis was that decision made? (3) How many IVF procedures were analyzed to make this conclusion? (4) What other evidence was reviewed by the decision makers which suggested that it was not experimental?" Id.

\(^{62}\) See Cox, supra note 25.

\(^{63}\) Id.

\(^{64}\) L.A. Times, Sept. 30, 1987, § 1, at 3, col. 5.


\(^{66}\) See Marsh, 516 So.2d at 1315; see also Ruess, 177 Ga. App. at 673, 340 S.E.2d at 626.

\(^{67}\) Marsh, 516 So.2d at 1315; see also Ruess, 177 Ga. App. at 673, 340 S.E.2d at 626.

\(^{68}\) Ruess, 177 Ga. App. at 673, 340 S.E.2d at 626.
5. Movement by Insurance Companies to Specifically Exclude Infertility Treatment

As a result of Thiebaud and Witcraft, insurance companies began to explicitly exclude infertility treatment.69 The Witcraft court held that because the plan did not specifically exclude artificial insemination or limit the broad term “illness,” the procedures were covered by the plan,70 implying that had artificial insemination been specifically excluded, or “illness” limited to exclude artificial insemination, the denial of coverage would have been proper. Similarly, in Marsh v. Reserve Life Insurance Co., the court denied coverage because the procedure was excluded by clear and unambiguous language.71 Realizing that the courts may enforce coverage of infertility treatment in the absence of specific exclusions, insurance companies began to exclude such coverage explicitly.72 For example, Kaiser Foundation Health Plan, the defendant in Thiebaud, has now “reworded policies to state explicitly that in vitro fertilization is ‘not a customary procedure required to save a life or cure a disease.’”73

B. State Legislation

In response to the movement by insurance companies to exclude infertility treatment, a considerable number of states have passed legislation requiring financial coverage for infertility treatments,74 and other states are currently discussing similar legislation.75 Al-
though the legislation in each state varies in scope and application, it can be classified into one of two general categories: imposition of a requirement that health insurance companies offer coverage (mandate to offer), or imposition of a requirement that health insurance companies actually provide coverage (mandate to provide). This section presents the type of coverage that each of these states require, and briefly discusses the application, scope and variations among the states that have enacted such legislation.

1. Mandate to Offer

California enacted legislation which became effective on January 1, 1990 requiring group insurance plans to offer infertility treatment coverage. The law applies to health care service plans, health maintenance organizations, nonprofit hospital service plans and disability insurance policies which cover, on a group basis, "hospital, medical or surgical expenses." The scope of coverage for this man-

Ohio, In Vitro Fertilization Bill Passes, UPI, Columbus, Ohio, June 29, 1989 (available on Nexis) (this pending legislation would expand the scope of Ohio's existing infertility legislation); Nevada, UPI, Carson City, Nev., March 21 1989 (available on Nexis); Alaska, Alaska Small Business Owners Mount Campaign to Oppose Health Insurance Bills, Business Wire Inc, Juneau, Alaska, April 11, 1988 (available on Nexis); Oregon, UPI, Salem, Ore., Feb. 28, 1989 (available on Nexis). Due to the great difficulty in researching pending legislation of the various states, it is likely that other states which this writer has not been able to identify are also considering infertility coverage legislation.
date includes treatment for infertility except IVF. Treatment for infertility is defined as "procedures consistent with established medical practices in the treatment of infertility by licensed physicians including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer." IVF is defined as "the laboratory medical procedures involving the actual in vitro fertilization process."

Connecticut recently enacted infertility legislation similar to California's mandate to offer, requiring group insurance plans to offer infertility treatment coverage. The legislation applies to "[a]ny insurance company, hospital service corporation or medical service corporation authorized to do the business of health insurance in this state." It requires these entities to offer to their group insureds "a group hospital or medical service plan or contract providing coverage for the medically necessary expenses of the diagnosis and treatment of infertility."

This law also provides an exemption from offering coverage for treatment of infertility in a manner inconsistent with a religious organization's religious and ethical principles to any employer which is a religious organization or insurer which is a subsidiary of an entity whose owner or corporate member is a religious organization. The reasoning behind the exclusion for IVF is inconsistent with the aims of the bill. The legislature found that infertility is a significant health problem in California, that it is a medical illness, and that because "insurance coverage for infertility is uneven, inconsistent, and frequently subject to arbitrary decisions which are not based on legitimate medical considerations," this mandate was required.

The IVF exclusion is quite narrow in scope and excludes only "the laboratory medical procedures involving the actual in vitro fertilization process." This exclusion suggests that all other IVF procedures not involving the actual fertilization will be covered by this mandate.
of infertility, including in vitro fertilization.\textsuperscript{87} The scope of coverage is broader than California's because it includes IVF. However, because of the vagueness of the qualification of "medically necessary expenses," it is possible that the scope of coverage will be restricted.\textsuperscript{88}

Texas also enacted legislation requiring insurers to offer coverage for IVF related expenses.\textsuperscript{89} This legislation applies to:

- all insurers, nonprofit hospital and medical service plan corporations, . . .
- health maintenance organizations, . . . and all employer, multiple employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plans, programs, or arrangements that either issue group health insurance policies, enter into health care service contracts or plans, or provide for group health benefits, coverage, or services in this state for hospital, medical, or surgical expenses incurred as a result of accident or sickness.\textsuperscript{90}

The scope of coverage of this statute is much narrower than any of the legislation previously discussed. The statute only pertains to IVF, and does not include other infertility treatments. The Texas statute also imposes several conditions before the offer to make the coverage available must be made.\textsuperscript{91}

\textsuperscript{87} CONN. GEN. STAT. ANN. § 89-120 (West 1989). Infertility is defined as "the condition of a presumably healthy individual who is unable to conceive or produce conception, or retain a pregnancy during a one-year period." Id.

\textsuperscript{88} If there is any future infertility treatment insurance coverage litigation in Connecticut, it likely will focus largely on defining "medically necessary expenses." A contributing factor may well include the development of new technologies. A new medically recognized technique, which presumably would have a higher success rate, may also be more expensive, thus providing incentive for insurers to exclude it as not being "medically necessary," because older, cheaper, technologies achieve some success in inducing pregnancies even if at a lower success rate than that achieved by the newer technology.

\textsuperscript{89} TEx. INS. CODE ANN. art. 3.51-6, § 3A (Vernon Supp. 1990).

\textsuperscript{90} Id. § 3A(a). Like California and Connecticut, this statute does not cover individual insurance contracts. This statute also provides an exemption for any entity within its scope that is part of or directly affiliated with a bona fide religious denomination holding views against in vitro fertilization. Id. § 3A(f).

\textsuperscript{91} Section 3A(e) states:

The offer to make the coverage available is required only under the following conditions:

1. the patient for the in vitro fertilization procedure is an insured, enrollee, subscriber, member, or otherwise covered employee or person under the policy, contract, plan, program, or arrangement;
2. the fertilization or attempt at fertilization of the patient's oocytes is made only with the patient's spouse's sperm;
3. the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with one of the following conditions:
   A. endometriosis
   B. exposure in utero to diethylstilbestrol (DES);
   C. blockage of or surgical removal of one or both fallopian tubes; or
   D. oligospermia;
4. the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy, contract, plan, program, or arrangement; and
2. Mandate To Provide

Massachusetts’ infertility legislation is the broadest in the United States, because there are no controls, restrictions, or limits on the number of attempts at becoming pregnant.\textsuperscript{92} The law applies to any blanket or general insurance policy,\textsuperscript{93} any accident and sickness insurance policy,\textsuperscript{94} any employees’ health and welfare fund,\textsuperscript{95} any individual or group medical service agreement,\textsuperscript{96} and all health maintenance organization contracts.\textsuperscript{97} The scope of coverage of these statutory provisions includes all “medically necessary expenses of diagnosis and treatment of ‘infertility.’”\textsuperscript{98}

Ohio’s infertility legislation applies only to health maintenance organizations (HMOs).\textsuperscript{99} As a condition to the issuance of a certificate of authority, an HMO must “provide or arrange for the provision of basic health care services.”\textsuperscript{100} Basic health care services include “preventative health services, including . . . infertility services.”\textsuperscript{101} The scope of the statute is not clear. However, because infertility services are classified as a “preventative health service,” the statute is probably limited to covering procedures consistent with prevention, such as examination, diagnosis, counseling, and minimal treatment

\(\textit{id.} \, \S \, 3A\text{(a)}\).

\textsuperscript{92} For example, unlike Texas, Massachusetts does not make coverage dependant upon statute of use conditions. \textit{Cf. supra} note 91 and accompanying text. Furthermore, unlike Hawaii, Massachusetts does not limit coverage to one IVF attempt. \textit{Cf. infra} note 122 and accompanying text.

\textsuperscript{93} MASS. GEN. LAWS ANN. ch. 175, \S 47H (West Supp.1990). However, this legislation does not apply to “a blanket or general policy of insurance which provides supplemental coverage to medicare or other governmental programs . . . which provides hospital expense or surgical expense insurance.” \textit{id.}

\textsuperscript{94} \textit{Id.}

\textsuperscript{95} \textit{Id.}

\textsuperscript{96} \textit{Id.} ch. 176B, \S 4J. However, this legislation does not apply to any subscription certificates under an individual or group medical service agreement “which provide supplemental coverage to medicare or other governmental programs.” \textit{id.}

\textsuperscript{97} MASS. GEN. LAWS ANN. ch. 175, \S 47H (West Supp. 1990); \textit{id.} ch. 176B, \S 4J; \textit{id.} ch. 176G, \S 4 (designating coverage as set forth in chapter 175, \S 47H). Infertility is defined as “the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.” \textit{id.} Like Connecticut, defining “medically necessary expense” may be a focus of future litigation. \textit{Cf. supra} note 88.

\textsuperscript{99} OHIO REV. CODE ANN. \S 1742 (Baldwin 1986).

\textsuperscript{100} \textit{id.} \S 1742.05(C).

\textsuperscript{101} \textit{id.} \S 1742.01(A)(6).
for infertility rather than also including such advanced infertility
treatment procedures as artificial insemination or IVF.

West Virginia's infertility legislation is almost identical to Ohio's.
This legislation applies only to HMOs, and it makes the issuance of
a certificate of authority conditional upon the provision of basic
health care services. Basic health care services entail "preventative
services including . . . infertility services." Like Ohio's legislation,
the scope of coverage is not clear.

Arkansas' legislation requires coverage for IVF. The law applies
to all disability insurance companies doing business in the state,
including group and blanket disability insurers. The scope of this
legislation is limited to IVF. Additionally, it provides that "after
conducting appropriate studies and public hearings, the insurance
commissioner shall establish minimum and maximum levels of cover-
age to be provided by the disability insurance companies."

Maryland's legislation applies to each non-profit health service
plan group or individual medical contract or certificate, each
group or blanket health insurance policy, and each hospital or ma-
ajor medical insurance policy. Like the Texas statute, the scope
of coverage is narrower than other infertility legislation. The statute
only pertains to IVF, does not mandate coverage for other types of
infertility treatment, and imposes several conditions before coverage
is provided.

103. Id. § 33-25A-2.
105. Id. § 23-85-137(a).
106. Id. § 23-86-118(a) (chapter 86 applies to group and blanket disability
insurance).
108. Id. §§ 23-85-137(c), 23-86-118(c).
110. Id. § 477EE.
111. Id. § 470W.
112. See supra note 90 and accompanying text.
113. The entities the Maryland legislation applies to "may not exclude benefits for
all outpatient expenses arising from in vitro fertilization procedures." MD. INS. CODE
114. The affected entities:
may not exclude benefits . . . provided that:
(1) Benefits under this section shall be provided to the same extent as benefits
provided for other pregnancy-related procedures;
(2) The patient is a subscriber or covered dependent of the subscriber;
(3) The patient's oocytes are fertilized by the patient's spouse's sperm;
(4)(i) The patient and the patient's spouse have a history of infertility of at
least 5 years' duration; or
(ii) The infertility is associated with 1 or more of the following medical
conditions:
1. Endometriosis;
2. Exposure in utero to diethylstilbestrol, commonly known as DES; or
3. Blockage of, or surgical removal of, 1 or both fallopian tubes (lateral or
Hawaii’s infertility legislation applies to “[a]ll individual and group health insurance policies which provide pregnancy-related benefits.”\(^{116}\) and to “[a]ll individual and group hospital or medical service plan contracts which provide pregnancy-related benefits.”\(^{116}\) The scope of this legislation is limited. It pertains exclusively to IVF,\(^{117}\) and it only requires insurers to provide coverage for one IVF attempt.\(^{118}\) As in Texas\(^ {119}\) and Maryland,\(^ {120}\) Hawaii’s legislation imposes several conditions precedent to coverage.\(^ {121}\)

(5) The patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the contract or certification; and

(6) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Id. 115. HAW. REV. STAT. § 431:10A-116.5 (Supp. 1989). 116. Id. § 432:1-604. 117. Id. §§ 431:10A-116.5, 432:1-604. 118. The entities these statutes apply to “shall include in addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures.” Id. The logic of this restriction is not clear. The Hawaii Legislature believes that infertility is a serious enough problem to merit a mandate, but it is not serious enough to require coverage after a failed attempt. The seriousness of the problem does not decrease just because of a failure. When infertility is severe enough that IVF is required, it often takes several attempts to achieve a successful pregnancy. Desperately Seeking Baby, supra note 5, at 63.

119. See supra note 91 and accompanying text. 120. See supra note 114 and accompanying text. 121. The entities this legislation applies to:

shall include . . . a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures . . . provided that:

(1) Benefits under this section shall be provided to the same extent as benefits provided for other pregnancy-related benefits;

(2) The patient is the insured or covered dependent of the insured;

(3) The patient’s oocytes are fertilized by the patient’s spouse’s sperm;

(4) The:

(A) Patient and the patient’s spouse have a history of infertility of at least five years’ duration; or

(B) Infertility is associated with one or more of the following medical conditions:

(i) Endometriosis;

(ii) Exposure in utero to diethylstilbestrol, commonly known as des;

(iii) Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

(iv) Abnormal male factors contributing to the infertility.

(5) The patient has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available under the insurance contract; and

(6) The in vitro fertilization procedures are performed at medical facilities that
Rhode Island's infertility legislation applies to any accident and sickness health insurance contract, plan or policy; any non-profit hospital service contract, plan or insurance policy; any non-profit medical service contract, plan or insurance policy; and any health maintenance organization service contract, plan, or policy which include pregnancy-related benefits. The scope of coverage of this legislation includes all "medically-necessary expenses of diagnosis and treatment of infertility." However, the entities to which this legislation applies may require subscriber co-payment up to twenty percent “for those programs and/or procedures the sole purpose of which is the treatment of infertility.”

C. Proposed Federal Legislation

At the federal level, United States Representative Patricia Schroeder, Democrat from Colorado, is currently sponsoring legislation entitled the “Federal Employee Family-Building Act of 1989” that would require all health insurance plans covering federal employees to provide coverage for infertility treatments. This bill requires that any carrier offering obstetrical benefits under the health benefits program for federal employees must also provide benefits relating to certain “family building procedures.” These benefits include reimbursement for medical procedures necessary to overcome

conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

(7) The term 'spouse' means a person who is lawfully married to the patient under the laws of the State.


122. R.I. GEN. LAWS § 27-18-30 (1989). However, this legislation does not apply to “contracts providing supplement coverage to Medicare or other governmental programs.” Id.

123. Id. § 27-19-23. However, this legislation does not apply to "contracts providing supplemental coverage to Medicare or other governmental programs." Id.

124. Id. § 27-20-20. However, this legislation does not apply to "contracts providing supplemental coverage to Medicare or other governmental programs." Id.

125. Id. § 27-41-33. However, this legislation does not apply to contracts “providing supplemental coverage to Medicare or other governmental programs.” Id.

126. As may occur in Connecticut and Massachusetts, future litigation to define “medically necessary expense” may be anticipated. See supra notes 88 and 98 and accompanying text.

127. R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (1989). Infertility is defined as “the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of one (1) year.” Id.


129. H.R. 2860, 101st Cong., 1st Sess. (1989). This is a mandate to provide proposal. See supra note 77.

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III. ANALYSIS OF THE NEED FOR INFERTILITY INSURANCE LEGISLATION

As indicated above, many states have enacted infertility legislation.132 Should other states follow suit? This section analyzes the need for infertility insurance legislation for all types of infertility treatments, including IVF. Part A of this section presents the arguments opposing such legislation, and Part B presents the arguments supporting such legislation. Both Part A and Part B address infertility legislation in general, including arguments common to both mandates to offer and mandates to provide, as well as arguments specific to mandates to provide. Part C of this section concludes with this writer’s belief that infertility legislation is necessary.

A. Arguments Opposing Infertility Legislation

Several arguments opposing infertility legislation are common to both mandates to offer and mandates to provide. First, opponents argue that infertility is not an illness, and that treatment only circumvents the condition without correcting the cause of the infertility.133 Second, it is argued that infertility treatment is not medically necessary. For example, in Kinzie v. Physician’s Liability Ins. Co.,134 the defendant insurance company successfully argued that treatment for infertility was not medically necessary, and therefore coverage was not required.135 Third, insurance companies have also attempted

131. Id.
132. See supra notes 79-128 and accompanying text.
133. But see Witcraft v. Sunstrand Health and Disability Group Benefit Plan, 420 N.W2d 785 (Iowa 1988) (holding that denial of coverage for artificial insemination was improper because infertility is an illness). See also supra notes 30-40 and accompanying text.
134. 750 P.2d 1140 (Okla. Ct. App. 1987) (holding that because IVF is elective and is not required to preserve or cure a person’s health, it is not medically necessary); see supra notes 41-48 and accompanying text; see also L.A. Times, Sept. 30, 1987, § 1, at 3, col. 5 (stating that several insurance companies contend that infertility treatment “is no more worthy of coverage than other elective therapies, such as cosmetic surgery.”). A Blue Cross/Blue Shield attorney stated in a letter that became part of the Theibaud lawsuit, that “[s]moothing the wrinkles, bobbing the nose or conceiving a child may have a tremendously positive psychological effect but it does not enhance or diminish the individual’s health.” Id.
135. Kinzie, 750 P.2d 1140 (Okla. Ct. App.). This argument can also be restated as “infertility treatment addresses individual desires and not medical needs.” ASSEMBLY BILL ANALYSIS, supra note 75, at 6.
to exclude IVF by classifying it as experimental. Finally, it can be argued that it is not necessary for legislators to force insurance companies to offer or provide coverage because the marketplace will respond to infertile couples' needs for infertility insurance coverage. In other words, the natural forces of supply and demand will ensure that coverage is provided.

In addition to the arguments against infertility legislation common to both types of mandates, there are arguments specific to mandates to provide. The biggest concern is that health care costs will increase, which will ultimately make health insurance too expensive for certain segments of our society. Opponents also contend that IVF does not merit coverage because it has a "relatively low success rate compared with the high cost of" the procedure. It is also argued that it is unfair for other individuals in the insurance pool to have to pay for the treatment of those infertile individuals in the pool.

B. Arguments Supporting Infertility Legislation

Several arguments in support of infertility legislation are common to both mandates to offer and mandates to provide. First, proponents of infertility legislation argue that infertility has a devastating effect on a significant percentage of the population. Infertility is a significant health problem, affecting approximately seventeen percent (one out of six) of all married couples. Infertility adversely affects an individual's perception of self. In addition to the effect on self esteem, infertile couples may have to contend with family

136. See supra notes 49-64 and accompanying text.
137. Assembly Bill Analysis, supra note 75, at 6; see also Boston Globe, Mar. 30, 1989, Metro/Region, at 25 (city ed.) (Blue Cross/Blue Shield proposed a rate increase of 50% in Massachusetts, of which 6% was attributable to chiropractic treatment, infertility treatment, preventive services for children, and certain nutritional supplements).
138. According to a study by the National Center for Policy Analysis, as many as 9.3 million people, 25% of all people without health insurance, lack health insurance because of state government regulations which increase insurance costs. This increase in cost is a direct result of state legislative mandates. Various states have mandated coverage for chiropractors, acupuncture, naturopaths (herb specialists), alcoholism, drug abuse, mental health, in vitro fertilization, aids, heart transplants, liver transplants, hairpieces. Lack Of Health Insurance Due To Regulations, PR Newswire, Dallas, Tx., Nov. 2, 1988 (available on Nexis).
140. See Assembly Bill Analysis, supra note 75, at 6; Spiegel & Nelson, supra note 139.
141. Assembly Bill Analysis, supra note 75, at 5.
142. See supra note 9 and accompanying text.
143. Infertility: Medical and Social Choices Summary, supra note 13, at 1.
disharmony. The "[s]exual behavior for both partners experiencing the stress of infertility may change radically and induce marital strife." Most importantly though, "[i]nfertility frustrates one of the most basic human desires—that is, to have children." The resolution of infertility is necessary for the physical and emotional well being of millions of Americans.

Second, it is argued that infertility is an illness, and health insurance companies can no longer exclude treatment from coverage claiming that it is not. For example, the California Legislature found that "[i]nfertility is a medical illness or condition similar to other illnesses or conditions that is created by the malfunction of other bodily organs, and thus is no different than other illnesses or conditions and should be treated for purposes of insurance the same as any other body dysfunction." Likewise, the Witcraft court held that infertility was an illness. Furthermore, assuming arguendo that infertility is not technically an illness, and that treatment only circumvents the condition, there are many similar medical procedures which are covered by insurance. For example, cardiac bypass surgery only circumvents the patient's condition, but it is covered by insurance.

Third, proponents assert that IVF can also no longer be considered an experimental procedure. Insurance companies have attempted to exclude coverage for IVF by classifying it as experimental. However, the Reilly decision and the Thieband result reject the ex-

144. Id.
145. Id.
146. Id.
148. Witcraft v. Sundstrand Health and Disability Group Benefit Plan, 420 N.W.2d 785 (Iowa 1988) (holding that denial of coverage for artificial insemination was improper because infertility is an illness); see also supra notes 30-40 and accompanying text.
150. A. Ghitman, supra note 149, at 27.
151. See supra notes 49-64 and accompanying text.
152. Reilly v. Blue Cross and Blue Shield, 846 F.2d 416 (7th Cir. 1988) (holding that there were disputed material issues of fact as to the basis for the insurance company's decision to exclude IVF as experimental and that there were disputed material issues of fact as to whether the insurance company's decision was arbitrary, capricious, or motivated by bad faith); see supra notes 50-61 and accompanying text.
153. Thieband v. Kaiser Foundation Health Plan, Cox, supra note 25 (class action
perperimental argument as applied to IVF. Furthermore, the effort to exclude infertility treatment is arguably analogous to the history of insurance coverage for heart and liver transplants. Initially, heart and liver transplants were not covered by insurance because they were considered elective or experimental. However, now that those procedures are more common, they are covered by insurance. Additionally, "[t]he American Fertility Society, many doctors, clinics and insurance companies have made statements to the effect that IVF is an established and controlled procedure with consistent and continually improving techniques."

Fourth, it is argued that states have enacted mandates for other illnesses and conditions. For example, California currently mandates: treatment of alcoholism; acupuncture benefits; diabetic day care self-management education programs; home health care; comprehensive preventative care of children; and prenatal diagnosis of genetic disorders of the fetus. If these illnesses and conditions merit a legislative mandate, certainly a condition as prevalent and serious as infertility does also.

Finally, proponents contend that the natural forces of supply and demand do not ensure that insurance coverage is provided. Theoretically, the contention by opponents of infertility legislation that the natural forces of supply and demand will ensure that coverage is provided, is correct. However, in actuality, this is not the case. The California legislature found that currently, "insurance coverage for infertility is uneven, inconsistent, and frequently subject to arbitrary decisions which are not based on legitimate medical considerations." Consequently, many states have found it necessary to enact infertility legislation to ensure availability of coverage.

In addition to the arguments supporting infertility legislation common to both types of mandates, there are arguments specific to mandates to provide. The primary argument against coverage is the fear of increased health care costs. However, the average cost per couple for infertility treatment, including IVF, is actually estimated out of court settlement); see supra notes 62-64 and accompanying text.

154. See Johnson, supra note 149, at 24, col. 1.
155. A. Ghtman, supra note 149, at 28; see also supra note 58.
157. Id. § 1373.10.
158. Id. § 1367.5.
159. Id. § 1374.10.
160. Id. § 1367.3.
161. Id. § 1367.7.
162. 1989 Cal. Stat. 734 § 1(4) (legislative finding); see also supra notes 21-22 and accompanying text.
163. See also supra note 74 and accompanying text.
164. See supra notes 137-38 and accompanying text.
to be very low, at $200 per couple.\textsuperscript{165} Experience in Maryland indicates that the incremental total cost increase to insurance companies resulting from such legislation was nominal and far less than estimated.\textsuperscript{166} It is also argued that insurance coverage for infertility treatment is reasonable from an economic standpoint because infertility affects over six percent of the population, yet the annual cost of infertility therapy only "comprises about 1/10 of 1\% of the United States health care budget."\textsuperscript{167} Proponents also argue that advances in medical technology will almost certainly reduce infertility treatment costs in the future. New drugs have been developed and are being developed to prevent some of the causes of infertility, to "enhance the quality of ovulation and expedite pregnancy," and to eliminate the need for surgery for fibroids and endometriosis.\textsuperscript{168} Additionally, IVF is often a much cheaper and safer alternative to laparotomy, a type of surgery used to repair damaged tubes. Significantly, laparotomy is not classified as an infertility treatment, despite the fact that it is often used to treat infertility, and is therefore normally covered by the general provisions of health insurance.\textsuperscript{169} Furthermore, "[m]icrosurgery and laser surgery through the laparoscopy, verses the laparotomy, reduce anesthesia time, recovery and hospital time, and time away from work."\textsuperscript{170} Additionally, new diagnostic procedures may prevent unnecessary or useless treatment.\textsuperscript{171} Finally, "[r]esearch and develop-
ment in IVF technology has led to advances which both enhance other procedures, and lower the expenses involved in IVF itself.172

Proponents of infertility legislation also argue that providing coverage would alleviate the intangible costs to society associated with infertility. Infertility often results in absenteeism, depression, and other psychological problems which affect society through decreased productivity, and damaged or failed marriages.173 Where the treatment is successful, some of these costs will be eliminated.

Finally, it is argued that allowing insurance companies to exclude infertility procedures is contrary to the principle of group insurance, as well as unfair to the infertile couple. The principle of group insurance is to pool money to pay for health care. Under group insurance, many people pay for coverage which they do not use. For example, all individuals covered by a health insurance plan will pay into the insurance pool, yet only a select number of individuals in the pool will ever require coverage for cancer treatment. For infertile couples, it is especially unfair to require payment of a family rate for health insurance coverage which "is calculated to take into account childbearing and potential fetal health problems"174 while denying them access to those benefits: "infertile couples never get to use their benefits. Instead, infertile individuals pay for others' maternity benefits."175 Similarly, under a typical general health insurance policy, infertile couples pay for other reproductive services they will not use, such as abortion and sterilization.176

C. Conclusion: Infertility Legislation Is Necessary

After evaluating the arguments on both sides of this issue, this writer is convinced that infertility legislation is necessary. Most importantly, infertility has a devastating effect on a significant percentage of the population.177 Furthermore, insurance companies can no longer exclude coverage claiming that infertility is not an illness,178 nor can they exclude IVF as experimental.179 Additionally, state legislatures have enacted mandates for other illnesses or conditions, and infertility is equally as deserving of legislative attention.180

172. Id.
173. Id. at 26.
174. Id. at 27.
175. Id.
176. UPI, Salem, Ore., February 28, 1989 (available on Nexis).
177. See supra notes 141-46 and accompanying text.
178. See supra notes 147-50 and accompanying text. Furthermore, that insurance companies began to explicitly exclude infertility treatment (see supra note 69 and accompanying text) demonstrates that insurance companies recognize that infertility cannot be excluded by claiming that it is not an illness.
179. See supra notes 151-55 and accompanying text.
180. See supra notes 156-61 and accompanying text.
legislation is necessary because the market place has failed to ensure the availability of coverage.\textsuperscript{181}

At the very least, states without infertility legislation should enact mandates to offer. The primary argument against infertility legislation is the fear of increased health care costs. However, under a mandate to offer, the insureds pay optional additional rates to secure infertility coverage, thus cost increases will be isolated solely to individuals in the insurance pool desiring the coverage. Yet, a mandate to offer is not sufficient: states should go one step further and enact mandates to provide.

Even though costs will increase as a result of a mandate to provide, infertility is a serious problem in our society, and the costs for treatment are low enough that insurance companies should be forced to provide coverage for treatment. Not only is the average cost of treatment very low,\textsuperscript{182} but advances in medical technology will continue to reduce this cost.\textsuperscript{183} Additionally, coverage will alleviate the intangible costs that infertility imposes upon society.\textsuperscript{184} Finally, coverage is consistent with the principle of group insurance and will eliminate the unfairness inherent in forcing infertile couples to subsidize the childbearing costs of fertile couples.\textsuperscript{185}

IV. GUIDELINES FOR MODEL LEGISLATION

The states which have enacted infertility legislation have adopted one of two types of legislation: mandates to offer or mandates to provide.\textsuperscript{186} This section proposes guidelines for model legislation which will ensure fair and workable infertility coverage. As discussed above, a mandate to provide is the preferred type of legislation. However, recognizing that states may not wish to go this far, this section will propose guidelines for both mandates to offer and mandates to provide.

\textsuperscript{181} See supra notes 162-63 and accompanying text.
\textsuperscript{182} See supra note 165 and accompanying text.
\textsuperscript{183} Just like any type of new technology, the costs for new infertility treatments will initially be more expensive than the technology then in existence; however, once the new treatment is accepted and refined, the cost for such treatment will decrease. E.g. supra notes 168-72 and accompanying text.
\textsuperscript{184} See supra note 173 and accompanying text.
\textsuperscript{185} See supra notes 174-76 and accompanying text.
\textsuperscript{186} See supra notes 76-77 and accompanying text.
A. Mandate to Offer

Mandate to offer legislation should consist of a hybrid of several of the state laws currently enacted, plus additional modifications. The application of the legislation should be as broad as possible, and should apply to all forms of health insurance, both group and individual.\textsuperscript{187} Borrowing from the California Act, the legislation should define infertility as “either (1) [t]he presence of a demonstrated condition recognized by a licensed medical physician as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.”\textsuperscript{188}

Model legislation should require that coverage be offered for all expenses of diagnosis and all forms of infertility treatment, including IVF. Because IVF is occasionally the only way infertile couples can conceive a child, and since under a mandate to offer the cost will be borne solely by an insurance pool of infertile individuals desiring the additional coverage, IVF should not be excluded. For the safety of the insured, as well as for efficient use of resources, model legislation should include the California definition of “treatment of infertility.” Accordingly, infertility treatment should be restricted to “procedures consistent with established medical practices in the treatment of infertility by licensed physicians.”\textsuperscript{188} This approach to defining “treatment of infertility” will also decrease the possibility of litigation which exists in states which have adopted the “medically necessary expenses” approach.\textsuperscript{189}

As discussed above, several states make operation of their statutes conditional upon several elements.\textsuperscript{190} Model legislation should incor-

\textsuperscript{187} Model legislation should apply to health care service plans, health maintenance organizations, non-profit hospital service plans, disability insurance policies, hospital service corporations, medical service corporations, self-funded or self-insured welfare or benefit plans, and all other forms of health insurance policies or contracts. The application of this legislation should be as broad as possible because the rationale for infertility legislation applies equally well to all entities and types of insurance policies, both group and individual.

\textsuperscript{188} \textsc{cal. health & safety code} § 1374.55(b) (west 1990), \textsc{cal. ins. code} §§ 10119.6(b), 11512.28(b) (west supp. 1990). If an individual has a demonstrated condition which causes infertility, there is no logical reason that the individual should have to wait a year before coverage is offered; therefore, the California definition of infertility should be adopted.

\textsuperscript{189} \textsc{cal. health & safety code} § 1374.55(b) (west 1990), \textsc{cal. ins. code} §§ 10119.6(b), 11512.28(b) (west supp. 1990). Due to rapid advances in medical technology, “established medical practices” is not clearly definable at any given point in time. Additionally, just like any legal term, definition of “established medical practices” will emerge through case by case litigation involving a parade of medical community experts produced to convince the triers of fact that a given treatment is an “established medical practice.”

\textsuperscript{190} See supra notes 88, 98, and 126 and accompanying text.

\textsuperscript{191} These states include Texas (see supra note 91 and accompanying text), Maryland (see supra note 114 and accompanying text) and Hawaii (see supra note 121 and
porate several of these conditions while specifically rejecting several others. First, for the protection of the insurer, the patient must be a covered individual "under the policy, contract, plan, program, or arrangement." Second, the patient must have "been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy." The basis for this requirement is efficiency. Often infertility can be treated fairly inexpensively at a preliminary stage of the diagnostic and treatment process. The success rate of the procedures normally used prior to IVF is very high and these procedures are often much more economical than IVF, the most expensive of the advanced forms of treatment. Therefore, to minimize the cost to the other individuals in the insurance pool, less costly treatments must be attempted as a condition precedent to coverage for more advanced forms of treatment. Third, in cases where IVF is necessary, the IVF procedures must be "performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization." The purpose of this requirement is to protect the health of individuals using such procedures.

While adopting the three conditions set forth above, model legislation should specifically reject other conditions currently found in some state statutes. First, no limit should be placed on the number of IVF attempts. Infertility is a serious enough problem to merit a mandate. The seriousness of the problem does not decrease just because of a failed attempt. When infertility is severe enough that IVF is required, it often takes several attempts to achieve a successful pregnancy.

Second, model legislation should not restrict fertilization of the
patient's oocytes only to use of the patient's spouse's sperm. This restriction should not be adopted in order to ensure the right of a fertile woman to conceive a child in cases where the husband's sperm is defective or inadequate. Moreover, an infertile woman's right to conceive a child should not be conditional upon marriage. Such a condition would discriminate against unmarried infertile women who wish to have children, and therefore should not be adopted.

Third, model legislation should not require the existence of a statutorily specified medical condition as a condition precedent to insurance coverage. Coverage should not be dependent upon whether the cause of the infertility fits into one of a list of statutorily specified conditions, because listed conditions are unlikely to be exhaustive of all of the known causes of infertility. With the exception of reversals of voluntary sterilizations, the cause of the infertility should be irrelevant to insurance coverage of treatment. Infertility is a serious problem and coverage should be provided regardless of the cause.

Finally, model legislation should not require a history of continuous infertility for a specified number of years before eligibility for coverage. Such a requirement is extreme, and these guidelines' definition of the term "infertility" is adequate to ensure that an individual is in need of treatment. Additionally, a lengthy temporal requirement reduces the possibility of pregnancy, because after the age of twenty-four, as a woman ages the possibility of becoming pregnant decreases. This is especially significant in modern society where more couples are waiting longer to start families. Furthermore, infertility imposes such a severe psychological and emotional burden upon individuals that a several year waiting period is unduly burdensome.

B. Mandate to Provide

For the policy and practical reasons discussed above, a mandate to provide is the preferred form of legislation. Model mandate to provide legislation should be identical to the guidelines for model man-

199. See generally id. at 60-61.
200. In the event that sterilization costs are covered by health insurance, it can be argued that it is unfair for all insureds to pay for both the sterilization costs and the costs for reversal of sterilization. Accordingly, this might be an appropriate limitation on coverage.
201. See supra note 188 and accompanying text.
203. Desperately Seeking Baby, supra note 1, at 58.
date to offer legislation, except for the requirement that insurers provide coverage to all insureds. Like the model mandate to offer legislation above, model mandate to provide legislation should apply to all forms of health insurance, both group and individual. It should also include the California definition of infertility. The scope of coverage should include all expenses of diagnosis and treatment of infertility, and covered individuals should be described as above. Furthermore, model mandate to provide legislation should also specifically reject other conditions currently found in some state statutes.

V. CONCLUSION

Infertility is a serious and prevalent health problem in the United States; however, there are numerous treatments with high success rates. Until recent court decisions, insurance companies had excluded infertility treatments from coverage either by claiming that infertility was not an illness or that IVF, an important and costly option in infertility treatment, was experimental and, therefore, excluded. Reacting to judicial interpretations requiring coverage in the absence of explicit exclusionary language in policies, insurance companies began to explicitly exclude infertility coverage. As a result of this movement to exclude coverage, several states enacted mandatory legislation which either require insurance companies to offer or require insurance companies to provide coverage for infertility treatment.

In light of the pervasiveness of infertility and its devastating effects upon individuals, the states which enacted legislation took the correct action. At a minimum, states without infertility legislation

204. See supra note 187 and accompanying text.
205. See supra note 188 and accompanying text.
206. See supra note 189 and accompanying text. Like model mandate to offer legislation, model mandate to provide legislation should include IVF as well as other forms of infertility treatment. However, unlike a mandate to offer, the costs are not borne exclusively by infertile individuals in the insurance pool, but rather are borne by all individuals in the insurance pool. Infertility is a serious enough problem in our society and treatment has a low enough cost to justify, consistent with the concept of group insurance, that all members in the insurance pool bear the cost. Additionally, in order to partially alleviate the valid argument that IVF has a relatively low success rate compared with the cost of the procedure (supra note 139 and accompanying text), IVF will only be performed after the patient has exhausted all less expensive treatment alternatives. See supra notes 193-96 and accompanying text.
207. See supra notes 192-97 and accompanying text.
208. See supra notes 198-203 and accompanying text.
should now move to require health insurance companies to offer coverage, but preferably these states should require health insurance companies to provide coverage. Under a mandate to offer, only the insureds desiring infertility treatment coverage pay additional rates to secure it, thus imposing no cost burden on others in the insurance pool. However, a mandate to offer is not sufficient, as infertility is a serious problem in our society, and the costs for treatment are sufficiently low that any rate increases under a mandate to provide would be minimal.

Either form of model legislation proposed by the guidelines in this Comment will ensure fair and workable infertility coverage. Both forms of model legislation should consist of a hybrid of several state statutes plus additional modifications. The application, scope, and definition of infertility included in model legislation should be broad. Moreover, for the safety of the insured, and in the interest of efficiency, treatment under model legislation should be limited to established medical procedures. Finally, for the protection of both the insurer and the consumer, model should be conditional upon the benefit recipient being covered under the policy, the exhaustion of less costly infertility treatments before more costly procedures are attempted, and the provision of IVF treatments only in certified facilities under specified conditions. Such legislation is needed to ensure that infertility treatment is available to the insured public.

WILLIAM C. COLE