

SAME-SEX MARRIAGE AND THE BABY CARRIAGE: A POST-*OBERGEFELL* ANALYSIS OF ART FUNDING FOR SAME-SEX COUPLES IN THE UNITED STATES

Charmaine Mech*

TABLE OF CONTENTS

I. INTRODUCTION 344

II. BACKGROUND 345

 A. *Anfertility Treatments and ART*..... 345

 B. *The Cost of Assisted Reproduction*..... 347

 C. *Same-Sex Couples and ART* 347

III. ANALYSIS..... 349

 A. *The United Kingdom* 349

 B. *The United States* 351

 1. *Obergefell v. Hodges* 352

 2. *The Present State of U.S. Infertility Statutes*..... 356

 i. *Statutes with Spousal Language*..... 363

 ii. *Statutes with Broad Definitions of Infertility*..... 368

 iii. *Statutes Without a Definition of Infertility* 371

 3. *The U.S. Government and ART*..... 373

IV. CONCLUSION 375

* J.D., University of Georgia School of Law, 2017.

I. INTRODUCTION

The Supreme Court's landmark case, *Obergefell v. Hodges*, provided unprecedented legal recognition for homosexual couples across the United States by extending the "fundamental right to marry" to same-sex couples.¹ The marriage equality decision divided more than just the Justices.² *Obergefell* spurred a national debate over the expanding nature of lesbian, gay, bisexual and transgender (LGBT) rights.³ News of the controversial ruling quickly took social media by storm. Millions of Twitter users, including the former U.S. President Barack Obama, expressed support for the *Obergefell* decision using the viral hashtag #LoveWins.⁴

The legal recognition of same-sex couples' right to marry left both sides of the debate wondering what the future would hold for LGBT rights. This Note proposes that the familiar childhood song, "first comes love, then comes marriage, then comes baby in the baby carriage," offers useful insight. As *Obergefell* ushers in a new era of marriage equality, it will be imperative to determine what form the "baby-carriage" will take for same-sex couples in the United States.⁵

Using the United Kingdom as a model, this Note speculates that the *Obergefell* decision will initiate an expansion of homosexual couples' access to infertility treatments and to the growing area of assisted reproductive technology (ART) in the United States. In the U.K., legal recognition and

¹ *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015).

² See *id.* at 2611–26 (Roberts, C.J., dissenting) (arguing the majority ignored the constitutional, historical, and precedent-based limitations on judicial review in favor of philosophical and fairness-based reasoning); *id.* at 2629 (Scalia, J., dissenting) (suggesting that the unelected Supreme Court bypassed the democratic process and used the *Obergefell* decision to engage in "super-legislative" law-making, invading a role constitutionally reserved for the legislature); *id.* at 2631–40 (Thomas, J., dissenting) (objecting to the majority's definition of liberty that includes entitlement to particular governmental benefits, which he argues is at odds with the historical intent of the framers of the Constitution); *id.* at 2640–43 (Alito, J., dissenting) (finding that the majority's opinion undermined an essential principal of federalism, by removing the possibility of state experimentation); see also Adam Liptak, *Gay Marriage Arguments Divide Supreme Court Justices*, N.Y. TIMES (Apr. 28, 2015), http://www.nytimes.com/2015/04/29/us/supreme-court-same-sex-marriage.html?_r=0.

³ See Daniel Burke, *The Next Battle over Gay Rights*, CNN (June 29, 2015), <http://www.cnn.com/2015/06/26/living/next-battle-same-sex/>.

⁴ Approximately 6.2 million tweets used the hashtag #LoveWins to discuss the marriage equality decision. Kerry Flynn, *How #LoveWins on Twitter Became the Most Viral Hashtag of the Same-Sex Marriage Ruling*, INT'L BUS. TIMES (June 26, 2015), <http://www.ibtimes.com/how-lovewins-twitter-became-most-viral-hashtag-same-sex-marriage-ruling-1986279>.

⁵ Daniel Sperling argues that the right to parent is "one of the primeval and most elementary interests a person may have" regardless of sexual orientation. See Daniel Sperling, *'Male and Female He Created Them': Procreative Liberty, its Conceptual Deficiencies and the Legal Right to Access Fertility Care of Males*, 7 INT'L J. L. CONTEXT 375, 375–77 (2011).

popular support for LGBT rights preceded any significant expansion of fertility treatment and ART services to same-sex couples.⁶ U.S. healthcare policy reform has historically followed a similarly responsive position to both legal and social changes. Therefore, it may reasonably be predicted that the *Obergefell* decision will have far-reaching legal and social implications that go beyond constitutional rights into the healthcare industry.

This Note begins its discussion by providing a brief overview of the history and development of ART around the world. This Note then looks to the United Kingdom for an example of expanding ART services to homosexual couples before assessing the present state of the law in the United States. The U.S. analysis is introduced by a close reading of the *Obergefell* decision, highlighting the narrowness of the Court's holding while also exploring the opinion's breadth. This Note then analyzes the position of fourteen existing state statutes that mandate coverage of infertility diagnosis and treatment. Using a variety of statutory interpretation tools, this Note contemplates how *Obergefell's* national recognition of same-sex marriage may change the interpretation and application of these preexisting state statutes.

It is the position of this Note that *Obergefell* renders preexisting state statutes that require insurers to cover infertility treatments and ART convoluted and unworkable. Ambiguous and discriminatory statutory language must be redrafted to account for *Obergefell* and shifting cultural norms. Therefore, this Note anticipates that the United States will expand insurance coverage for infertility treatments and ART to include same-sex couples affected by infertility by tailoring existing state insurance mandates.

II. BACKGROUND

A. Infertility Treatments and ART

Infertility is a pervasive medical and social issue that increasingly affects women and men in every country around the world. Recognizing this, both the World Health Organization (WHO) and the Centers for Disease Control identified infertility as a public health issue.⁷ Further, the WHO and the

⁶ Following the Civil Partnership Act of 2004 and the Marriage (Same-Sex Couples) Act of 2013, the U.K. National Health Service extended same-sex couples equal rights to IVF as heterosexual couples. See *Fertility Treatment for Same Sex Couples*, UKHEALTHCARECENTER, <http://www.healthcentre.org.uk/fertility-treatment/fertility-same-sex-couples.html> (last visited Oct. 17, 2015); see also Joan Mahoney, *Great Britain's National Health Service and Assisted Reproduction*, 35 WM. MITCHELL L. REV. 403, 409–10 (2009).

⁷ Marie-Eve Lemoine, *Toward a Public Health Approach to Infertility: The Ethical Dimensions of Infertility Prevention*, 6 PUB. HEALTH ETHICS 3, 287 (2013).

World Bank estimate “infertility to be the 5th largest cause of disability for people under 60.”⁸ This high profile coverage illustrates that the international community considers infertility a universal and growing issue.

However, diagnosing infertility can be difficult. There is not always a conclusive medical test to diagnose infertility. Thus, modern definitions of infertility increasingly look to a practical, results-based diagnosis rather than a traditional medical test. The WHO provides a good example, defining infertility in terms of an individual or a couple’s inability to conceive over a specified period of time. The WHO defines the term “infertility” as “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.”⁹ A majority of states with fertility coverage mandates rely on similar results-based standards to determine infertility.

Though diagnosis can be difficult, there are numerous treatment options for infertility. Those that involve external means of conception are typically categorized as assisted reproductive technology (ART).¹⁰ *In vitro* fertilization (IVF) is a well-known example of ART. IVF combines a female’s eggs and a male’s sperm outside the female’s body and then deposits the fertilized egg in the uterus.¹¹ These modern medical and technological advances provide infertile couples with a newfound capacity to procreate biologically. Since the first successful *in vitro* fertilization in 1978, the international demand for and use of ART measures has continued to grow rapidly.¹² For couples struggling to conceive, ART boasts impressive

⁸ Siri Tellier & Josephine Obel, *Infertility*, GLOBAL HEALTH MINDERS 2 (2015), <http://www.globalhealthminders.dk/wp-content/uploads/2015/05/GHM-Infertility-Brief.pdf>.

⁹ *Id.* at 1.

¹⁰ Infertility treatment options that are not classified as ART include but are not limited to: prescription medications, hormone therapy, and intrauterine insemination (a procedure wherein a prepared male’s sperm is inserted into the mother’s uterus, often referred to as artificial insemination). See *Infertility FAQs*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/reproductivehealth/infertility/> (last updated Apr. 14, 2016). ART is generally considered to include *in vitro* fertilization, zygote intrafallopian transfer (a procedure similar to IVF wherein the fertilized egg is placed inside the fallopian tube), gamete intrafallopian transfer (a procedure wherein eggs and sperm are transferred to the fallopian tube, where the fertilization takes place), and intracytoplasmic sperm injection (a procedure wherein a single sperm is injected into a single egg). *Id.*

¹¹ *Id.*

¹² Paul R. Brezina & Yulian Zhao, *The Ethical, Legal, and Social Issues Impacted by Modern Assisted Reproductive Technologies*, 2012 OBSTETRICS & GYNECOLOGY INT’L 1, 1–7 (estimating the usage of ART in developed countries is increasing at an annual rate of 5%–10%); *State Laws Related to Insurance Coverage for Infertility Treatment*, NAT’L CONF. ST. LEGIS. (June 1, 2014), <http://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx> (revealing that more than 1% of all U.S. births are conceived via ART, totaling 61,600 children born via ART in 2008 alone).

success rates of 40% in cases where the mother is less than thirty-five years of age.¹³ However, numerous restrictions still inhibit the widespread use of ART, most notably soaring costs.

B. The Cost of Assisted Reproduction

The financial cost of ART remains one of the most restrictive factors preventing access to alternative reproduction measures. The average cost of one IVF cycle in 2009, accounted for approximately 15%–18% of individuals' annual disposable income in the U.K. and 44%–50% in the United States.¹⁴ In response, many developed countries adopted varying approaches designed to shift the financial burden away from the individual and on to third-party insurers, national healthcare schemes, or some combination of the two.¹⁵

Historically, such cost-shifting programs focused on providing relief to traditional families composed of heterosexual couples affected by medically diagnosed infertility. As a result, many countries limited access to third-party ART funding by imposing qualification requisites that frequently excluded single women and same-sex couples. In light of the international community's recent recognition of an array of LGBT legal rights, many ideologically based restrictions, such as exclusions due to an individual's sexual orientation, are now under fire.

C. Same-Sex Couples and ART

Numerous factors can affect an infertile couple's access to ART regardless of the couple's sexual orientation. However, the historical discrimination of the LGBT community marginalized homosexuality, and in consequence same-sex couples and homosexual individuals continue to face unique obstacles in the family planning arena.¹⁶ The arduous development of adoption protocols

¹³ CENTERS FOR DISEASE CONTROL, *supra* note 10.

¹⁴ Georgina M. Chambers, Elizabeth A. Sullivan, Osamu Ishihara, Michael G. Chapman & G. David Adamson, *The Economic Impact of Assisted Reproductive Technology: A Review of Selected Developed Countries*, 91 FERTILITY & STERILITY 6, 2281, 2289 (2009).

¹⁵ For a comparative analysis of international ART financing, *see id.* at 2281–94.

¹⁶ For example, the American Psychiatric Association classified homosexuality as a mental disorder until 1973, and as ego-dystonic homosexuality until 1986. Gregory M. Herek, *Facts About Homosexuality and Mental Health*, U. CAL. DAVIS, http://psychology.ucdavis.edu/rainbow/html/facts_mental_health.html (last visited Oct. 26, 2016). These classifications of homosexuality as pathological contributed to widespread stigmatization and discrimination towards homosexuals. *Id.* This negative stigma continued within American society long after the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders and still affects the lives of numerous LGBT persons today.

for homosexuals provides an example of the LGBT community's struggle to gain legal and social validation in this space. It was not until the 1990s that most states began to permit homosexual persons and couples to adopt.¹⁷ Given the complex history of LGBT rights, it is important to insulate this Note's discussion of the issue of same-sex couples' access to infertility treatments and ART from ideological debates about homosexuality.

There are two principal ways to challenge a program where access to fertility treatment funding depends on the sexual orientation of the applicant.¹⁸ One argument advocates for the establishment of a positive right to procreate; the other challenges differences in health insurance coverage and funding depending on an individual's sexual orientation.¹⁹

The first approach turns on the controversial recognition of a couple's right to procreate regardless of sexual orientation.²⁰ By this argument, legal distinctions based on sexual orientation impose disproportionate financial burdens on same-sex couples that cannot afford unfunded ART measures. Without funding, large numbers of same-sex couples may be excluded from parenting a biological child, which for many may result in severe economic and social costs.²¹ This practice can be challenged as discriminatory because such a program denies to certain individuals the ability to parent a biological child on the basis of their sexual orientation.²² A challenge structured in this way implicitly relies on the acknowledgement of a universal right to parent biological offspring. This is problematic because no positive right to procreate has been legally recognized, even for heterosexual couples.²³

The second approach does not necessitate the recognition of a positive legal right to procreate, but rather examines the discriminatory effect of distinguishing healthcare coverage due to a patient's sexual orientation.²⁴

¹⁷ In the United States, the question of who may adopt is largely a matter of state law, and thus the standards vary from state to state. See *Overview of Lesbian and Gay Parenting, Adoption and Foster Care*, AM. CIV. LIBERTIES UNION, <https://www.aclu.org/fact-sheet/overview-lesbian-and-gay-parenting-adoption-and-foster-care?redirect=overview-lesbian-and-gay-parenting-adoption-and-foster-care> (last visited Oct. 27, 2015).

¹⁸ See Sperling, *supra* note 5, at 375–77.

¹⁹ *Id.*

²⁰ Expanding upon John Robertson's classic principal of procreative liberty, Sperling argues persons of all sexual orientations may share the "primeval" desire to parent biological children. However, Sperling also identifies numerous "conceptual difficulties" associated with identifying a formal right to procreate. *Id.*

²¹ The economic and social costs associated with infertility and childlessness can affect people at the "individual and societal levels." Tellier & Obel, *supra* note 8, at 2.

²² Sperling, *supra* note 5, at 375–77.

²³ *Id.*

²⁴ See *id.* at 384–95 (noting the shortfalls of courts that merely establish a procreative liberty right and advocating for a comprehensive legal scheme that serves to eliminate discrimination based on moral judgments).

Under this framework, the denial of funding arguably results in a significant and quantifiable financial obstacle unique to homosexual couples.²⁵ These financial burdens disproportionately amplify what many consider to be the “first and most far-reaching barrier” to ART.²⁶ While it is true that, without third-party funding, same-sex couples are not prevented from biological procreation, the practical effect of restricting funding dramatically reduces the participation of homosexuals in alternative reproduction methods. This second characterization of the issue provides for a more focused and successful analysis of the relevant issues. By narrowly tailoring the legal analysis to concrete factual inquires such as the financial burdens resulting from the alleged discrimination, the inquiry is strategically insulated from the many ideological debates surrounding LGBT rights.

Further, by framing the question of access as one of potential discrimination, the issue of homosexual access to ART funding more closely mirrors the language of *Obergefell*. In that case, the majority expressed concern over widespread practices that primarily function to “disrespect and subordinate gays and lesbians.”²⁷ This Note uses the second framing, identifying the issue of same-sex couples’ access to infertility treatments and ART as one of arbitrary line drawing and discrimination.

III. ANALYSIS

A. *The United Kingdom*

The U.K. has been a leader in the medical development of infertility treatments and ART services ever since it welcomed the first baby born via IVF conception, Louise Brown, in Oldham, England on July 25, 1978.²⁸ Therefore, analyzing the U.K.’s development of increasing access to ART, legal recognition of LGBT rights, and the intersection of the two, provides an interesting case study. This Note positions the U.K. as a model from which a similar expansion of access rights to ART for same-sex couples in the United States may be predicted. The international comparison provides a useful

²⁵ *Id.*

²⁶ *Id.* at 396.

²⁷ See *Obergefell v. Hodges*, 135 S. Ct. 2584, 2590–91 (2015) (recognizing the intersection of the Equal Protection Clause and the Due Process Clause, the Court acknowledged that laws infringing on the liberty of same-sex couples and “abridged central precepts of equality,” which was especially problematic for the Court in light of “a long history of disapproval of [same-sex] relationships”).

²⁸ *Louise Brown Biography*, BIO. (Apr. 2, 2014), <http://www.biography.com/people/louise-brown-95420722>.

framework due to the numerous cultural and legal similarities between the U.K. and the United States.

In 1982, the British Government sought to comprehensively address the potential benefits, risks, and implications of widespread use of ART services by establishing a multi-disciplinary committee to explore the medical and ethical questions facing the emerging field of assisted reproductive technologies.²⁹ This committee generated the Warnock Report, which recommended that the National Health Service (NHS) should provide fertility treatment including IVF.³⁰ The Report proposed that fertility treatments be extended to heterosexual couples, regardless of whether the couple was married.³¹ Following this Report, the committee's recommendations were enacted into law in 1990 via the Human Fertilization and Embryology Act (HFEA), which permitted, though did not require, the use of ARTs to treat infertility by the NHS and licensed private providers.³²

The 2000s ushered in an era of prolific social change for the LGBT movement in the U.K. and initiated a series of groundbreaking legislative acts, beginning with the passing of the Civil Partnership Act in 2004.³³ The Civil Partnership Act provided same-sex couples legal recognition equivalent to married heterosexual couples.³⁴ The government amended the HFEA regulations four years later to include lesbian couples and to permit a mother's female partner to be legally recognized as the child's second parent.³⁵ Ultimately, the passage of the Marriage (Same-Sex Couples) Act of 2013 granted full marriage rights to same-sex couples in England and Wales, which then led Scotland to pass similar legislation in 2014.³⁶

²⁹ Mahoney, *supra* note 6, at 404–05.

³⁰ *Id.* at 405.

³¹ *Id.* at 406.

³² *Id.* at 407.

³³ England and Wales extended to same-sex couples the opportunity to register for a civil partnership on religious premises in 2011. *Civil Partnership Review (England and Wales): A Consultation*, 8, DEP'T FOR CULTURE MEDIA & SPORT (Jan. 2014), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/274449/140122_CP_con_doc_pdf_docx.pdf (revealing that over 16,000 couples registered for civil partnerships within the first year, and an average of 6,000 same-sex couples annually entered into civil partnerships after the first year).

³⁴ *Id.*

³⁵ Mahoney, *supra* note 6, at 409–10.

³⁶ No such same-sex marriage right has been established in Northern Ireland. Joseph Patrick McCormick, *Thousands Call for End to Northern Irish Gay Marriage Ban at Belfast Pride* (Aug. 7, 2016, 1:10 AM), <http://www.pinknews.co.uk/2016/08/07/thousands-call-for-end-to-northern-irish-gay-marriage-ban-at-belfast-pride/> (identifying Northern Ireland as the last place in the British Isles without marriage equality). However, Northern Ireland authorizes non-religious civil partnerships and recognizes same-sex marriages that are legally performed in other states.

Presently in the U.K., the same alternative reproductive opportunities are available to same-sex couples as to heterosexual couples. Marriage is not a prerequisite to ART services for either heterosexual or same-sex couples. Covered procedures include both IVF and artificial insemination.³⁷ While NHS does not extend ART services to all, the eligibility criteria apply evenly to homosexual and heterosexual couples. A healthcare provider may consider the applicant's body mass index, whether the applicant already has children, and whether previous ART attempts have been unsuccessful in determining whether to extend ART and other infertility procedures.³⁸ Critics of the NHS's discretionary approach argue subjective standards can result in unequal access to infertility treatments.³⁹ Nevertheless, the alleged disparate access is not based on sexual orientation but rather on differences in doctor discretion.

It is noteworthy that the historical development of alternative reproductive and fertility access in the U.K. closely followed the recognition of same-sex couples' rights to civil partnerships and marriage. This suggests that the principles of marriage equality were linked to the subsequent development of non-discriminatory family planning and procreative rights. It is the position of this Note that the present state of ART access in the U.K. is both reflective of and responsive to the expanding legal status of same-sex couples, and it is specifically tied to the right to same-sex marriage.

B. *The United States*

The United States welcomed its first baby born via ART in 1981.⁴⁰ Since then, the practice has grown dramatically. The United States presently

³⁷ England provides infertile women with up to three cycles of IVF and intra-cytoplasmic sperm injection. Comparable regulations are in place in Scotland, Wales, and Northern Ireland. See *NHS Fertility Treatment*, HUMAN FERTILIZATION & EMBRYOLOGY AUTH., <http://www.hfea.gov.uk/fertility-treatment-cost-nhs.html> (last updated Jan. 6, 2015); see also *Fertility Treatment for Same Sex Couples*, *supra* note 6.

³⁸ *NHS Fertility Treatment*, *supra* note 37.

³⁹ Joan Mahoney highlights the problems presented by a permissive approach to ART as opposed to a mandatory universal coverage requirement. Mahoney laments that the structure of the NHS—in which the national government divides the country into local Primary Trusts that retain a large amount of discretion over the allocation and issuance of medical resources and services—frequently results in disparate access. Mahoney, *supra* note 6, at 407–08. See also Sperling, *supra* note 5, at 385–86 (raising concern over the delegation of ART regulation to the HFEA whose Code of Practice requires primary care givers to consider the “welfare of the future child” when making eligibility determinations, a system which arguably permits “moral judgments” of the individual seeking ART to be determinative).

⁴⁰ *National ART Surveillance*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/art/nass/index.html> (last updated Aug. 2, 2016).

features approximately 440 fertility clinics that provide ART services.⁴¹ In 2008, an estimated 61,600 children were born via non-donor ART services.⁴² Comparatively, the CDC reported 190,773 ART cycles were performed in 2013, meaning that ART accounted for approximately 1.5% of all children born in the United States during that year.⁴³

Cost and financing concerns, similar to those seen in the U.K., prohibit the widespread use of ART in the United States.⁴⁴ Historically, insurance coverage for infertility was not subject to governmental regulation in the United States.⁴⁵ However, a number of state legislatures have recognized the obstacle of cost and have responded by mandating infertility coverage by third-party insurers in their jurisdictions. Evidence of the legislative purpose can be glossed from the statutory text. For example, West Virginia's Health Maintenance Organization Act of 1977 cited "mounting costs" as a motivating factor for the state government to intervene in the insurance market.⁴⁶ A primary goal of state legislation was to make ART more readily available to the general population so that an infertile patient's choice to parent a biological child would not be dependent on the financial status of the individual or couple.⁴⁷

1. *Obergefell v. Hodges*

Before analyzing the existing state insurance mandates, it is necessary to first recognize the narrow scope of *Obergefell*. Understanding the decision's limitations helps to dispel some of the common misconceptions associated with the Supreme Court's decision. *Obergefell* did not establish a general

⁴¹ *Id.*

⁴² Lemoine, *supra* note 7.

⁴³ *ART Success Rates*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/art/reports/index.html> (last updated Aug. 26, 2015).

⁴⁴ Chambers, Sullivan, Ishihara, Chapman & Adamson, *supra* note 14, at 2288 (revealing that the average cost of a single cycle of IVF in 2009 was \$12,513, representing approximately 44% of disposable income).

⁴⁵ This structural distinction is representative of the United States' preference for principals of federalism and adherence to a market-based healthcare system as opposed to the U.K.'s centralized authority under a national healthcare scheme. However, the U.S. federal government has not been entirely absent from the healthcare market; it has occupied a limited regulatory role in the interest of public health through agencies such as the U.S. Food and Drug Administration. *See also* Sperling, *supra* note 5, at 390.

⁴⁶ W. VA. CODE ANN. § 33-25A-1 (LEXIS through Acts of the 2016 First Extraordinary Session 2016).

⁴⁷ The West Virginia statute further provides that it was enacted "with a view toward achieving greater efficiency, availability, distribution and economy" by providing "basic healthcare services" to "eliminate legal barriers to the establishment of prepaid health care plans accountable to consumers for the health care services they provide. *Id.*

cause of action for discrimination based on sexual orientation. The majority was very careful to limit its holding to the specific issue at hand: “whether the Constitution protects the right of same-sex couples to marry.”⁴⁸ Thus, the *Obergefell* precedent has the force of law only with respect to same-sex marriage.

Despite its narrow holding, *Obergefell* provides strong language to support the trend of expanding constitutional protections for discrimination against the LGBT community. One area in which this theme is explored is in the majority’s discussion of the Fourteenth Amendment’s Due Process and Equal Protection Clauses:

The Due Process Clause and the Equal Protection Clause are connected in a profound way, though they set forth independent principles. Rights implicit in liberty and rights secured by equal protection may rest on different precepts and are not always co-extensive, yet in some instances each may be instructive as to the meaning and reach of the other. In any particular case one Clause may be thought to capture the essence of the right in a more accurate and comprehensive way, even as the two Clauses may converge in the identification and definition of the right . . . This interrelation of the two principles furthers our understanding of what freedom is and must become.⁴⁹

This language implies that discriminatory treatment of same-sex couples may be inconsistent with a larger constitutional ideal of freedom. The *Obergefell* majority interestingly does not pinpoint a specific constitutional clause at issue but instead suggests there is an amalgamated liberty right “promised by the Fourteenth Amendment” generally.⁵⁰ Though this portion of the opinion is largely undeveloped and somewhat vague, it highlights the Court’s inclination to broadly promote certain homosexual liberty interests. This language suggests the Court supports the recent trend of striking down legal and social practices that are discriminatory on the basis of sexual

⁴⁸ *Obergefell*, 135 S. Ct. at 2606.

⁴⁹ *Id.* at 2602–03.

⁵⁰ *Id.* at 2602–05. The *Obergefell* majority’s language mirrored that used in the 2013 case, *United States v. Windsor*. *United States v. Windsor*, 133 S. Ct. 2675, 2693 (2013) (providing that “[t]he Constitution’s guarantee of equality ‘must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot’ justify disparate treatment of that group”).

orientation.⁵¹ This language could serve as ammunition for more expansive legal recognition of LGBT rights, particularly in the reproductive sphere.

The *Obergefell* majority was more specific in its discussion of the value of family. The Court repeatedly compared the fundamental right of same-sex couples to marry to other arenas that have historically been afforded Constitutional protection, such as parental and family rights.⁵² The majority builds its argument by drawing similarities to other recent Equal Protection and Due Process cases, which have tackled controversial topics of family planning such as abortion and contraception. The Court poignantly acknowledges that the decision to marry, like questions of contraception and family relationships, is private and solely between the couple. This recognition arguably works to insulate not only same-sex marriage discrimination, but also other “intimate” decisions such as the decision to reproduce and establish a family from overzealous governmental intervention and discrimination on the basis of sexual orientation.⁵³

In this same vein, the Court included powerful *dicta* that further intertwined the relationship between the fundamental right to same-sex marriage and the emerging legal rights of parents. The Court identified children’s need for protection as one of the primary arguments in support of its national recognition of same-sex marriage.⁵⁴ It further explained this connection by pointing out the negative effects that discriminatory marriage policies have on children.⁵⁵ The Court recognizes that the stigmatization of gay and lesbian parents in the family context can be debilitating both legally and socially. The limits of *Obergefell*’s language here, however, are important. The majority does not state that same-sex couples have any positive right to parent children, and as discussed earlier, the legal recognition of any such positive right to procreate is unlikely. The ideas

⁵¹ See *Windsor*, 133 S. Ct. at 2696 (holding the Defense of Marriage Act, DOMA, was unconstitutional in violation of the Fifth Amendment because it served “no legitimate [governmental] purpose”).

⁵² “Like choices concerning contraception, family relationships, procreation, and childrearing, all of which are protected by the Constitution, decisions concerning marriage are among the most intimate that an individual can make.” *Obergefell*, 135 S. Ct. at 2589.

⁵³ *Id.*

⁵⁴ “A third basis for protecting the right to marry is that it safeguards children and families and thus draws meaning from related rights of childrearing, procreation, and education.” *Id.* at 2590. This language also echoes that of *Windsor*, which shared similar concerns over the effect on children. See *Windsor*, 133 S. Ct. at 2694.

⁵⁵ “Excluding same-sex couples from marriage thus conflicts with a central premise of the right to marry. Without the recognition, stability and predictability marriage offers, their children suffer the stigma of knowing their families are somehow lesser.” *Obergefell*, 135 S. Ct. at 2600.

explored by the Court in this section of the opinion are nevertheless particularly significant to this Note for two reasons.

First, the Court expressly and unambiguously acknowledges that same-sex couples can be equally capable and loving as parents as can heterosexual couples.⁵⁶ The Court's recognition of the equal capacity of same-sex parents to provide loving and stable homes may be used as further ammunition against discriminatory legal practices aimed at same-sex parents. *Obergefell* thus stands for the principle that, in particular contexts, the negative social effects of discrimination can be so severe that they support the recognition of a fundamental constitutional right: the national right to same-sex marriage.⁵⁷

Secondly, this generalized statement against homosexual discrimination has also contributed to an expansion of popular support for same-sex couples. The societal impact of the *Obergefell* decision far exceeds the text of the decision alone. The nationwide flood of same-sex marriages arguably reinforced the Supreme Court's decision. Through the formation of countless same-sex unions, a significant portion of U.S. society relied on the *Obergefell* decision and therefore established a cultural precedent for same-sex marriage.⁵⁸ This "reliance interest" provides a strong argument that the *Obergefell* decision will not be overruled, due to the mutual desire of the judiciary and the general population for legal and cultural consistency.⁵⁹ Accordingly, this Note presumes the *Obergefell* precedent will not be

⁵⁶ As all parties agree, many same-sex couples provide loving and nurturing homes to their children, whether biological or adopted . . . Most States have allowed gays and lesbians to adopt, either as individuals or couples, and many adopted and foster children have same-sex parents. This provides powerful confirmation from the law itself that gays and lesbians can create loving, supportive families.

Id.

⁵⁷ The Court acknowledges the Constitution is a living text and that, as such, it should account for changes in public opinion and culture: "[R]ights come not from ancient sources alone. They rise too, from a better informed understanding of how constitutional imperatives define a liberty that remains urgent in our own era." *Id.* at 2602. This language provides support for expansion of same-sex couples' rights in the area of parenting.

⁵⁸ For further explanation of the "reliance interest" principal see Hillel Y. Levin, *A Reliance Approach to Precedent*, 47 GA. L. REV. 1035 (2013). Levin argues that "restrictive" court decisions (for example, *Baker v. Nelson*, where the Supreme Court dismissed a case challenging a Minnesota marriage law due to lack of a federal question) provide less persuasive arguments for precedent because those cases are "not like the sort [of cases] upon which people organize their lives." *Id.* at 1071. However, the decision in *Obergefell* is distinguishable: "[i]n contrast, opinions that expand protections of liberty, like a case requiring recognition of same-sex marriage, are much less easily undone because of the reliance—and consequent investment—they induce." *Id.*

⁵⁹ *Id.*

overturned and predicts that marriage equality will spark an expansion of LGBT rights in the United States.

2. *The Present State of U.S. Infertility Statutes*

A survey of the state statutes mandating some measure of infertility coverage shows a wide range of coverage mandates with varied available treatment options and restrictions on access.⁶⁰ Fourteen U.S. states attempted to shift the costs of infertility and ART services by passing laws requiring insurance companies to either mandate coverage or offer policyholders coverage for these services.⁶¹ The majority of these statutes mandate that insurers cover certain infertility treatments. All of these state mandates are subject to some limitation, though the limitation varies.

For purposes of this Note, the fourteen existing state statutes mandating insurance coverage have been divided into three categories: statutes with spousal language, statutes with broad definitions of infertility, and statutes

⁶⁰ See *State Infertility Insurance Laws*, AM. SOC. FOR REPROD. MED., <https://www.asrm.org/insurance.aspx> (last visited Oct. 12, 2016).

⁶¹ The fourteen states are: Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas and West Virginia. For an overview see *State Infertility Insurance Laws*, *supra* note 60. For full statutory texts see ARK. CODE ANN. § 23-85-137 (West, Westlaw through the end of the 2016 Third Extraordinary Sess. of the 90th Ark. Gen. Assemb. & the Nov. 8, 2016 election); CAL. HEALTH & SAFETY CODE § 1374.55 (Deering, LEXIS through all 2016 legis. & propositions); CAL. INS. CODE § 10119.6 (Deering, LEXIS through all 2016 legis. & propositions); CONN. GEN. STAT. ANN. § 38a-509 (West, Westlaw through enactments of the 2016 Feb. Reg. Sess., the 2016 May Spec. Sess., & the 2016 Sept. Spec. Sess.); HAW. REV. STAT. ANN. §§ 431:10A-116.5, 432:1-604 (LEXIS through the 2016 Second Spec. Sess.); 215 ILL. COMP. STAT. ANN. 5/356m (West, Westlaw through P.A. 99-920 of the 2016 Reg. Sess.); MD. CODE ANN. INS. § 15-810 (LEXIS through Jan. 1, 2017 & all chapters of the 2016 Reg. Sess. of the Md. Gen. Assemb.); MASS. GEN. LAWS ch. 175, § 47H (Westlaw through Chapter 375 of the 2016 2nd Ann. Sess.); MONT. CODE ANN. § 33-31-102 (West, Westlaw through the 2015 sess.); N.J. STAT. ANN. § 17:48E-35.22 (West, Westlaw with laws effective through L.2016, c. 83 & J.R. No. 11); N.Y. INS. LAW § 3221 (West, McKinney through L.2016, chapters 1-519); OHIO REV. CODE ANN. § 1751.01 (West, Westlaw through Files 144, 146, 147, 149, 152, 153, 157, 161 to 163, 167, 172, 174 and 175 of the 131st Gen. Assemb.); 27 R.I. GEN. LAWS ANN. §§ 27-41-33, 27-19-23 (West, Westlaw through Chapter 542 of the Jan. 2016 sess.); TEX. INS. CODE ANN. § 1366 (West, Westlaw through the end of the 2015 Reg. Sess. of the 84th Legis.); W. VA. CODE ANN. 33-25A-2 (LEXIS through Acts of the 2016 First Extraordinary Session 2016). Louisiana's statutory scheme also addresses infertility but in a limited way that does not pertain to this Note. See LA. STAT. ANN. § 22:1036 (Westlaw through the 2016 First Extraordinary, Reg., & Second Extraordinary Sess. (forbidding providers to deny otherwise covered diagnosis and treatment because they may result in infertility). New York has a similar requirement at N.Y. INS. LAW § 3221(6)(A) (West, McKinney through L.2016, chapters 1-519).

without a definition of infertility. *Table 1* provides a brief overview of the state statutes that are discussed in further detail throughout this Note.

Table 1

State:	Category:	Key Language:
Arkansas	No definition of infertility	All accident and health insurance companies doing business in this state shall include, as a covered expense, in vitro fertilization. ARK. CODE ANN. § 23-85-137 (West, Westlaw through the end of the 2016 Third Extraordinary Sess. of the 90th Ark. Gen. Assemb. & the Nov. 8, 2016 election).
California	Broad definition of infertility	For purposes of this section, “infertility” means either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon 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. CAL. HEALTH & SAFETY CODE § 1374.55 (Deering, LEXIS through all 2016 legis. & propositions).
Connecticut	Broad definition of infertility	For purposes of this section, “infertility” means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period. CONN. GEN. STAT. ANN. § 38a-509 (West, Westlaw through enactments of the 2016 Feb. Reg. Sess., the 2016 May Spec. Sess. & the 2016 Sept. Spec. Sess.).
Hawaii	Specific spousal language	(a) All individual and group accident and health or sickness insurance policies which provide pregnancy-related benefits shall include in

		<p>addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures performed on the insured or the insured's dependent spouse; provided that:</p> <p>(3) The patient's oocytes are fertilized with the patient's spouse's sperm;</p> <p>(4) The:</p> <p>(A) Patient and the patient's spouse have a history of infertility of at least five years' duration; or</p> <p>(B) Infertility is associated one of the following medical conditions . . .</p> <p>[and]</p> <p>(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 . . .</p> <p>(b) For the purposes of this section, the term "spouse" means a person who is lawfully married to the patient under the laws of the State.</p> <p>HAW. REV. STAT. ANN. § 431:10A-116.5 (LEXIS through the 2016 Second Spec. Sess.).</p>
<p>Illinois</p>	<p>Broad definition of infertility</p>	<p>(c) For purpose of this Section, "infertility" means the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to</p>

		<p>conceive after an individual is diagnosed with a condition affecting fertility, or the inability to sustain a successful pregnancy. 215 ILL. COMP. STAT. ANN. 5/356m (LEXIS through the 2016 Second Spec. Sess.).</p>
<p>Maryland</p>	<p>Specific same-sex spousal language</p>	<p>(b) An entity subject to this section that provides coverage for infertility benefits other than in vitro fertilization may not require as a condition of that coverage, for a patient who is married to an individual of the same sex:</p> <ul style="list-style-type: none"> (1) that the patient’s spouse’s sperm be used in the covered treatments or procedures; or (2) that the patient demonstrate infertility exclusively by means of history of unsuccessful heterosexual intercourse . . . <p>[Regulations about benefits apply if:]</p> <p>(d) (2) for a patient whose spouse is of the opposite sex, the patient’s oocytes are fertilized with the patient’s spouse’s sperm, unless:</p> <ul style="list-style-type: none"> (i) the patient’s spouse is unable to produce and deliver functional sperm; and (ii) the inability to produce and deliver functional sperm does not result from: <ul style="list-style-type: none"> 1. a vasectomy; or 2. another method of voluntary sterilization;

		<p>(3)(i) the patient and the patient's spouse have a history of involuntary infertility, which may be demonstrated by a history of:</p> <ol style="list-style-type: none"> 1. if the patient and the patient's spouse are of opposite sexes, intercourse of at least 2 years' duration failing to result in pregnancy; or 2. if the patient and the patient's spouse are of the same sex, six attempts of artificial insemination over the course of 2 years failing to result in pregnancy; or <p>(ii) the infertility is associated with any of the following medical conditions:</p> <ol style="list-style-type: none"> 1. endometriosis; 2. exposure in utero to diethylstilbestrol, commonly known as DES; 3. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or 4. abnormal male factors, including ligospermia, contributing to the infertility. <p>MD. CODE ANN. INS. § 15-810 (LEXIS through Jan. 1, 2017 & all chapters of the 2016 Reg. Sess. of the Md. Gen. Assemb.).</p>
Massachusetts	Broad definition of infertility	For purposes of this section, "infertility" shall mean the

		<p>condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35.</p> <p>MASS. GEN. LAWS ch. 175, § 47H (Westlaw through Chapter 375 of the 2016 2nd Ann. Sess.).</p>
New Jersey	Broad definition of infertility	<p>For purposes of this section, “infertility” means the disease or condition that results in the abnormal function of the reproductive system such that a person is not able to: impregnate another person; conceive after two “infertility.” Presently, four st the female partner is under 35 years of age, or one year of unprotected intercourse if the female partner is 35 years of age or older or one of the partners is considered medically sterile; or carry a pregnancy to live birth.</p> <p>N.J. STAT. ANN. § 17:48E-35.22 (West, Westlaw with laws effective through L.2016, c. 83 & J.R. No. 11)</p>
New York	Broad definition of infertility	<p>The determination of “infertility” in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;</p> <p>The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine.</p>

		N.Y. INS. LAW § 3221 (West, McKinney through L.2016, chapters 1-519).
Ohio	No definition of infertility	<i>See</i> OHIO REV. CODE. ANN. § 1751.01 (West, Westlaw through Files 144, 146, 147, 149, 152, 153, 157, 161 to 163, 167, 172, 174 and 175 of the 131st Gen. Assemb.).
Rhode Island	Broad definition of infertility	For the purposes of this section, 'infertility' means the condition of an otherwise presumably healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year. 27 R.I. GEN. LAWS ANN. § 27-41-33 (West, Westlaw through Chapter 542 of the Jan. 2016 sess.).
Texas	Specific spousal language	The coverage offered . . . is only required if: <ol style="list-style-type: none"> (2) the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse; (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: <ol style="list-style-type: none"> (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 group health benefit plan. TEX. INS. CODE ANN. § 1366 (West, Westlaw through the end of the 2015 Reg. Sess. of the 84th Legis.).
West Virginia	No definition of infertility	See W. VA. CODE ANN. 33-25A-2 (LEXIS through Acts of the 2016 First Extraordinary Session 2016).

Three states—Maryland, Hawaii, and Texas—include specific spousal requirements in their statutes. Maryland’s language is unique because it expressly addresses same-sex married couples. Seven states—California, Connecticut, Illinois, Massachusetts, New Jersey, New York, and Rhode Island—broadly define the term “infertility.”⁶² Four states—Arkansas, Montana, Ohio, and West Virginia—mandate providers cover basic enumerated services expressly including infertility but do not provide a statutory definition of the term “infertility.”

i. Statutes with Spousal Language

Of the fourteen states that mandate some measure of infertility coverage, Maryland alone expressly addresses same-sex couples. Maryland’s statute provides a useful starting point for the analysis portion of this Note for a number of reasons. First, Maryland provides support for this Note’s general presumption that statutory reform of infertility legislation is likely to follow the legalization of same-sex marriage.⁶³ The state legislature’s prompt

⁶² Instead of defining the term “infertility” in its statute, New York looks to the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine (ASRM). See N.Y. INS. LAW § 3221 (West, McKinney through L.2016, chapters 1-519). Nevertheless, New York fits within this category because the ASRM defines the term “infertility” broadly as

the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. The duration of unprotected intercourse with failure to conceive should be about 12 months before an infertility evaluation is undertaken, unless medical history, age, or physical findings dictate earlier evaluation and treatment.

Infertility, AM. SOC. FOR REPROD. MED., <https://www.asrm.org/topics/detail.aspx?id=36> (last visited Oct. 12, 2016).

⁶³ The Civil Marriage Protection Act of 2012 permitted same-sex marriage in Maryland and went into effect on January 1, 2013. *Maryland Approves Gay Marriage in Historic ‘Question 6’ Vote*, HUFFINGTON POST (Nov. 7, 2012, 12:29 AM), http://www.huffingtonpost.com/2012/11/07/maryland-question-6-results-2012_n_2050830.html. Within two years, the legislature

response to address the new state of the law following legalization of gay marriage is comparable to the timeline that occurred in the United Kingdom. Second, Maryland exemplifies a possible response that other states could adopt to redraft their existing statutes to account for the same-sex marriage decision. However, this Note will demonstrate that expressly restricting same-sex couples access may raise problems of interpretation and discrimination.

Pursuant to the 2016 statute, Maryland insurers must provide same-sex couples certain fertility treatments but are not required to cover ART, including IVF.⁶⁴ The legislature draws on a broad interpretation of “infertility” that expressly includes same-sex couples. The Maryland statute may therefore be characterized as inclusive. The Act also recognizes that same-sex couples, like heterosexual couples, can be affected by infertility and the inability to parent biological children. Accordingly, the statute mandates insurers cover heterosexual and same-sex couples’ infertility treatments including IVF.

Maryland’s statute was amended to include language that specifically addresses same-sex couples. The 2016 language provides:

(b) Impermissible requirements. An entity subject to this section that provides coverage for infertility benefits other than in vitro fertilization may not require as a condition of that coverage, for a patient who is married to an individual of the same sex:

- (1) that the patient’s spouse’s sperm be used in the covered treatments or procedures; or
- (2) that the patient demonstrate infertility exclusively by means of history of unsuccessful heterosexual intercourse.⁶⁵

The 2016 text calls attention to prior coverage restrictions that were inherently limited to heterosexuals, such as the condition that patients use their spouse’s sperm for infertility treatment and exclusionary definitions of infertility. The 2014 version of the Maryland Act did not expressly address infertility coverage of homosexual couples and thus was open to multiple interpretations. The ambiguous 2014 language could be read to the

amended the state’s existing infertility coverage statute to account for the change. *See* MD. CODE ANN. INS. § 15-810 (LexisNexis 2015); MD. CODE ANN. INS. § 15-810 (LexisNexis 2014).

⁶⁴ *See* MD. CODE ANN. INS. § 15-810 (LexisNexis 2016).

⁶⁵ *Id.*

exclusion of homosexual couples or in a way that would provide equal coverage for all couples. The amendment, by contrast, is considerably less uncertain.⁶⁶

To qualify for coverage, the statute requires that a patient show a “history of involuntary infertility.”⁶⁷ Heterosexual married couples may provide evidence of “intercourse of at least 2 years failing to result in pregnancy,” while same-sex married couples meet this requirement through “six-attempts of artificial insemination over the course of 2 years failing to result in pregnancy.”⁶⁸ Alternately, a married couple of any sexual orientation may demonstrate infertility associated with enumerated medical conditions including endometriosis, DES, and oligospermia.⁶⁹ Thus, there remain distinct differences between Maryland’s access requirements for heterosexual and same-sex married couples.

The 2016 Maryland statute initially appears to be inclusive and expansive, but in practice it may present more of a barrier to homosexual access than its predecessor.⁷⁰ On the one hand, the legislature expressly disapproves of certain inherently discriminatory interpretations of infertility. On the other hand, however, the amended language means undiagnosed same-sex married couples must bear the cost of six attempts of artificial insemination to demonstrate the necessary history of infertility to qualify for covered IVF. These substantial cost differences between couples seeking

⁶⁶ Courts often interpret textual changes to an act to be intentional and thus significant. *See, e.g., Tenn. Valley Auth. v. Hill*, 437 U.S. 153, 182 (1978) (exemplifying a case in which the Court’s majority opinion relied heavily on legislative context and history in parsing the meaning of the statutory text in question and concluded changes in the statutory language were “very significant”).

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ For a legislative amendment to be enacted into law, a proposed bill must pass through both houses. This process theoretically subjects the law to critical analysis by numerous and politically diverse legislators. As a result, U.S. courts have established several interpretative presumptions. These include assumption that the legislature carefully chose the text, accounted for its practical application, and understood how the act would interact with preexisting laws on the subject. Despite the fact that many of these presumptions rely largely on legal fictions, the underlying idea that the legislature acts rationally and with foresight remains important. *See, e.g., United States v. Costello*, 666 F.3d 1040, 1044 (7th Cir. 2012) (“One can properly attribute to legislators the reasonable minimum intention to say what one would ordinarily be understood as saying, given the circumstances in which it is said.”); *Sekhar v. United States*, 133 S. Ct. 2720, 2724 (2013) (“Where Congress borrows terms of art . . . it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken and the meaning its use will convey to the judicial mind unless otherwise instructed.” (quoting *Morissette v. United States*, 342 U.S. 246, 263 (1952))).

infertility coverage based on sexual orientation have given rise to discrimination challenges.⁷¹

Like Maryland, Hawaii and Texas also condition coverage of fertility treatments upon marriage.⁷² However, both of these states' statutory requirements rely on heterosexual conceptions of marriage that cannot be reconciled with the new definition of "spouse" following the legalization of same-sex marriage. The Texas statute provides:

The coverage offered under Section 1366.003 is only required if:

- (2) the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse;
- (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:
 - (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 group health benefit plan.⁷³

Texas implements a variety of restrictions in their statutes. These range from obvious limitations, such as the requirement that a patient must be a member

⁷¹ Kimberly Leonard, *Who Has the Right to Build a Family?*, U.S. NEWS & WORLD REP. (Aug. 15, 2016, 12:01 AM), <http://www.usnews.com/news/articles/2016-08-15/same-sex-infertility-case-exposes-lack-of-access-to-reproductive-treatment> (discussing a lawsuit brought by two lesbian couples against the New Jersey insurance commissioner, arguing for equal access to infertility treatments).

⁷² The language used in these statutes is almost identical to that of Maryland's 2014 statutory requirements. *Cf.* MD. CODE ANN. INS. § 15-810 (LexisNexis 2014).

⁷³ TEX. INS. CODE ANN. § 1366.005 (West, Westlaw through the end of the 2015 Reg. Sess. of the 84th Legis.). Hawaii's statute features very similar language but defines the term "spouse" as "a person who is lawfully married to the patient under the laws of the State." HAW. REV. STAT. ANN. § 431:10A-116.5 (LEXIS through the 2016 Second Spec. Sess.). Homosexual married couples fall squarely within the statutory meaning of the term "spouse" because Hawaii legalized same-sex marriage in 2013. *See Hawaii Governor Signs Bill Legalizing Gay Marriage*, DAILY NEWS (Nov. 13, 2013), <http://www.nydailynews.com/news/politics/hawaii-governor-signs-bill-legalizing-gay-marriage-hawaii-article-1.1515772>.

of the health plan, to medically specific qualifications such as requiring a couple to demonstrate a history of infertility.⁷⁴ Many of these restrictions equally affect same-sex and heterosexual couples.⁷⁵ However, the condition that “the fertilization or attempted fertilization of the patient’s oocytes is made only with the sperm of the patient’s spouse” proves problematic.⁷⁶ This provision highlights a tension between the text and the post-*Obergefell* state of affairs. The statute assumes that married couples seeking infertility treatment are composed of one male and one female. However, the undefined term “spouse” should be interpreted to reflect *Obergefell* and incorporate same-sex married couples.

Absent a statutory definition, courts engage in statutory interpretation to parse a term’s meaning. Generally, the first step looks to the plain meaning of the term.⁷⁷ Often courts seek to interpret the term in the manner in which it was understood when the law was passed.⁷⁸ However, here *Obergefell* expanded the legal meaning of the term “spouse” as a matter of federal law. Thus, the Supreme Court’s interpretation controls in every state.⁷⁹ The contemporary dictionary and ordinary meaning should reflect this change accordingly.⁸⁰ Therefore, a court would interpret the term “spouse” to mean

⁷⁴ See Ins. § 1366.005 (Westlaw); § 431:10A-116.5 (LEXIS).

⁷⁵ These provisions ask that “the patient and the patient’s spouse have a history of infertility of at least five continuous years,” and “the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments.” Ins. § 1366.005 (Westlaw).

⁷⁶ Ins. § 1366.005 (Westlaw). Hawaii similarly requires that “the patient’s oocytes are fertilized with the spouse’s sperm.” § 431:10A-116.5 (LEXIS).

⁷⁷ See, e.g., *United States v. Gayle*, 342 F.3d 89, 92 (2d Cir. 2003) (“Statutory construction begins with the plain text and, if that text is unambiguous, it usually ends there as well.”); *United States v. Costello*, 666 F.3d 1040, 1043 (7th Cir. 2012) (“[I]t is true that the words used, even in their literal sense, are the primary, and ordinarily the most reliable, source of interpreting the meaning of any writing: be it a statute, a contract, or anything else.”).

⁷⁸ See, e.g., *Univ. of Tex. Southwestern Med. Ctr. v. Nassar*, 133 S. Ct. 2517, 2529 (2013) (finding a reading of a statutory text that was inconsistent with the “design and structure of the statute as a whole” to be problematic and against the rule of statutory interpretation that “[j]ust as Congress’ choice of words is presumed to be deliberate, so too are its structural choices”).

⁷⁹ The distinction that Hawaii passed state legislation legalizing same-sex marriage prior to *Obergefell*, but Texas did not proves inconsequential to the interpretation of the term “spouse.” Hawaii’s statutory definition of spouse as “a person who is lawfully married to the patient under the laws of the State” raises comparable inconsistencies. § 431:10A-116.5 (LEXIS). In addition, the majority in *Obergefell* pointed out, “[i]t is of no moment whether advocates of same-sex marriage now enjoy or lack momentum in the democratic process” when the issue is one of a constitutionally protected right. *Obergefell*, 135 S. Ct. at 2606.

⁸⁰ The argument that the ordinary meaning of the term “spouse” includes same-sex couples is supported by evidence of reliance interest. Contemporary dictionary definitions further support such a reading. Merriam-Webster defines the term “spouse” to mean “someone who is married”; this definition is neutral and may be applied equally to heterosexual or

legally recognized married couples including both heterosexual and same-sex couples.

Requiring that fertilization “only” occur by use of the spouse’s sperm effectively excludes same-sex couples from the statute’s class of eligible spouses, which in turn excludes same-sex couples from obtaining similar insurance coverage for *in vitro* fertilization. The inconsistency between the post-*Obergefell* meaning of the term “spouse” and the statute’s presumption that all married couples are heterosexual exhibits an implicit contradiction that leaves the fate of infertile same-sex couples in limbo.

The spousal conditions on coverage are defined by the statutory enumerated restrictions that are not based on financial concerns of the provider or particularized medical conditions of the patient. Rather, the requirement that *in vitro* fertilization must use the spouse’s sperm unambiguously excludes all married couples of the same sex. It is often true that healthcare requires that a line be drawn somewhere, if only for financial reasons. However, drawing the line in a way that unambiguously excludes all same-sex married couples from medical treatments that are provided for similarly situated heterosexual couples discriminates on the basis of sexual orientation.

The three state statutes discussed above apply *Obergefell* in the most direct and obvious way because of their express treatment of marriage and spouses as a means of restricting coverage for enumerated infertility treatments. These states—Hawaii, Maryland, and Texas—demonstrate the myriad ways that existing statutory schemes relying on spousal language are difficult to reconcile with *Obergefell*. In addition, this section’s analysis highlights the complexities of drafting coherent and comprehensive statutes that establish necessary limits on coverage for infertility treatment but that do not discriminate against same-sex married couples.

ii. Statutes with Broad Definitions of Infertility

Seven states—California, Connecticut, Illinois, Massachusetts, New Jersey, New York, and Rhode Island—broadly mandate that third-party insurers provide diagnosis of and treatment for infertility.⁸¹ Unlike Hawaii,

homosexual married couples. *Spouse*, MERRIAM-WEBSTER (Nov. 23, 2015), <http://www.merriam-webster.com/dictionary/spouse>.

⁸¹ See CAL. HEALTH & SAFETY CODE § 1374.55 (Deering, LEXIS through all 2016 legis. & propositions); CAL. INS. CODE § 10119.6 (Deering, LEXIS through all 2016 legis. & propositions); CONN. GEN. STAT. ANN. § 38a-509 (West, Westlaw through enactments of the 2016 Feb. Reg. Sess., the 2016 May Spec. Sess., & the 2016 Sept. Spec. Sess.); ILL. COMP. STAT. ANN. 5/356m (West, Westlaw through P.A. 99-920 of the 2016 Reg. Sess.); MASS. GEN. LAWS ch. 175, § 47H (Westlaw through Chapter 375 of the 2016 2nd Ann. Sess.); N.J. Stat.

Maryland, and Texas, these seven states do not limit insurance coverage by reference to express marriage or spousal language. This may lead some to argue that *Obergefell* need not be applied to them. Yet analyzing these statutes in light of *Obergefell* is nevertheless valuable because it shows the range of existing state statutory schemes and their treatment of same-sex married couples.

California, Connecticut, Illinois, Massachusetts, New Jersey, New York, and Rhode Island's infertility statutes may all be read in a way that is inclusive for same-sex couples. For example, Massachusetts's "Coverage for Medically Necessary Expenses of Diagnosis and Treatment of Infertility" statute provides in pertinent part, "[f]or purposes of this section, 'infertility' shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35."⁸² A literal reading of the Massachusetts definition may reasonably include homosexual couples.⁸³ Homosexual individuals and couples will not "conceive or produce conception" during a one-year period (or any period)

Ann. § 17:48E-35.22 (West, Westlaw with laws effective through L.2016, c. 83 & J.R. No. 11); N.Y. INS. LAW § 3221 (West, McKinney through L.2016, chapters 1-519); 27 R.I. GEN. LAWS ANN. § 27-41-33 (West, Westlaw through Chapter 542 of the Jan. 2016 sess.).

⁸² Ch. 175, § 47H (LEXIS). Cf. HEALTH & SAFETY § 1374.55 (LEXIS) ("For purposes of this section, 'infertility' means either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon 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."); § 38a-509 (West) ("For purposes of this section, 'infertility' means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period."); ch. 215 § 5/356m (LEXIS) (For purpose of this Section, 'infertility' means the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to sustain a successful pregnancy."); INS. § 17:48E-35.22 (Westlaw) ("For purposes of this section, 'infertility' means the disease or condition that results in the abnormal function of the reproductive system such that a person is not able to: impregnate another person; conceive after two years of unprotected intercourse if the female partner is under 35 years of age, or one year of unprotected intercourse if the female partner is 35 years of age or older or one of the partners is considered medically sterile; or carry a pregnancy to live birth."); INS. § 3221 (McKinney) ("The determination of 'infertility' in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine."); and ch. 27 § 27-41-33 (Westlaw) ("For the purposes of this section, 'infertility' means the condition of an otherwise presumably healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year.").

⁸³ Courts interpret terms consistent with the statutory definition even if it differs from the ordinary meaning or dictionary definition. *Stenberg v. Carhart*, 530 U.S. 914, 942 (2000) ("When a statute includes an explicit definition, we must follow that definition, even if it varies from that term's ordinary meaning.").

without assisted reproductive measures. The California statute's qualification requirements for couples seeking ART are more specific than Massachusetts.⁸⁴ Yet, the California statute still lends itself to a possible inclusive reading, that a homosexual couple engaging in unprotected sex for the specified period of time will be unable to conceive, and therefore, under a strict literal application of the text, may qualify for coverage of fertility treatment.

Though theoretically plausible, this same-sex friendly interpretation likely would not stand in a court of law. It is a general rule of statutory interpretation that the plain meaning of statutory text is king, but it is also true that a statute cannot be read in a manner fundamentally at odds with its original intent and purpose.⁸⁵ Here the legislature clearly did not intend for the statutory definition of 'infertility' to apply to same-sex couples.

The language and context logically lends itself to an alternative interpretation. Conditioning infertility coverage on the couple's inability to conceive implicitly requires that the couple in question engage in sexual intercourse between two members of the opposite sex. California's use of the telling phrase "regular sexual relations without contraception" indicates that the intercourse should be reasonably calculated to result in conception.⁸⁶ Otherwise, the express requirement that the couple forgo contraception would serve no purpose. This would create a possible violation of the statutory rule of construction against reading laws in a way that renders language superfluous.⁸⁷

If a court were to read the text literally to include same-sex couples, a provision that was clearly intended to serve as a limitation on coverage would result in the opposite effect. Reading the provision to include same-sex couples would, in effect, offer unlimited infertility treatment coverage to all same-sex couples in the plan because all same-sex couples engaging in sexual intercourse would not conceive during the specified period. Comparatively, only those heterosexual couples that demonstrate the requisite history of infertility during the specified time period would be afforded equal fertility coverage. Contrary to the clear legislative intent,

⁸⁴ Compare HEALTH & SAFETY § 1374.55 (LEXIS), with LAWS ch. 175 § 47H (LEXIS).

⁸⁵ See, e.g., *Bob Jones Univ. v. U.S.*, 461 U.S. 574, 586 (1983) ("It is a well established canon of statutory construction that a court should go beyond the literal language of a statute if reliance on that language would defeat the plain purpose of the statute.").

⁸⁶ HEALTH & SAFETY § 1374.55 (LEXIS).

⁸⁷ See *Varity Corp. v. Howe*, 516 U.S. 489, 522 (1996) (stating the "well-settled rule of statutory construction" that "courts should disfavor interpretations of statutes that render language superfluous").

such an expansive reading of the term “infertility” would serve little to no restrictive function.

A close reading of the statutes in California, Connecticut, Illinois, Massachusetts, New Jersey, New York, and Rhode Island reveal that all of these statutes employ heterosexually exclusive methods of determining the requisite history of infertility. The use of such broad definitions of the term “infertility” raises possible discrimination problems comparable to statutes that used spousal language. If the broad, intercourse-based definitions of infertility were redrafted so that they only applied to heterosexual persons, the statute would need to provide a comparable test for homosexual individuals to show the requisite history of infertility. As shown by the Maryland example, requiring homosexual individuals to demonstrate a history of infertility via artificial insemination could have the unintended effect of imposing disproportionately higher costs. Alternately, the statutory language could be redrafted to require that same-sex couples show a diagnosis of infertility including for example, endometriosis, DES, or oligospermia. However, one of the reasons the medical community adopted the alternate results-based tests for infertility was precisely because diagnosis through traditional medical tests was difficult. Such a plan would unambiguously exclude infertile homosexual individuals that did not fit within the limited forms of diagnosable infertility while providing heterosexual individuals other means of demonstrating the requisite infertility.

iii. Statutes Without a Definition of Infertility

The integration of the *Obergefell* decision is least problematic when applied to existing state statutes that do not define the term “infertility.” Presently, four states—Arkansas, Montana, Ohio, and West Virginia—require all insurers to provide a minimum level of coverage for certain basic enumerated health services including infertility. For example, the Montana statute simply provides that “infertility” falls within the meaning of “basic healthcare services.”⁸⁸ Montana’s statutory text does not express further

⁸⁸ Compare MONT. CODE ANN. § 33-31-102 (West, Westlaw through the 2015 sess.), with ARK. CODE ANN. § 23-85-137 (West, Westlaw through the end of the 2016 Third Extraordinary Sess. of the 90th Ark. Gen. Assemb. & the Nov. 8, 2016 election), OHIO REV. CODE ANN. § 1752.01 (West, Westlaw through Files 144, 146-47, 149, 152-53, 157, 161-63, 167, 172, 174-75 of the 131st Gen. Assemb.), and W. VA. CODE ANN. 33-25A-2 (LEXIS through Acts of the 2016 First Extraordinary Session 2016).

qualifying restrictions on who may or may not receive coverage, nor does it limit which treatment options for infertility should be made available.⁸⁹

On their face, these statutes appear neutral and largely unaffected by *Obergefell*. However, if we view *Obergefell* and its subsequent effect on other state insurance mandates as a catalyst for legal and social change, even seemingly neutral statutory schemes like those of Arkansas, Montana, Ohio, and West Virginia may be impacted.

It will be necessary for third-party insurers to interpret the term “infertility” to define the scope of their policies. The simple act of defining the term “infertility” restricts access to infertility treatments, including ART. Thus, insurers in these states face similar problems of interpretation as their counterparts in states governed by statutes that define infertility through spousal language or a history of infertility demonstrable through intercourse that does not result in conception.

It is in the best financial interest of insurance companies to interpret infertility narrowly. The more treatments an insurance company covers, the more money it must pay out to healthcare providers such as hospitals. The financial implications, however, do not stop simply with the insurance companies. With increased insurance coverage can come higher premiums for policyholders. Thus, insurance companies need to strike a careful balance.

Defining the term too narrowly could also exclude classes of persons that have historically been extended ART coverage. For example, one means by which states could limit the class of persons eligible for ART coverage would be to restrict access to treatment to only those persons who can be diagnosed with infertility by way of conditions such as endometriosis, DES, or oligospermia. From a statutory interpretation perspective, the neutral language would not raise obvious problems of discrimination on the basis of sexual orientation. However, as discussed earlier, such an approach would likely be too restrictive as infertility is inherently difficult to diagnose. In addition, this policy may result in the exclusion of women who have waited to have children because of lifestyle choices. Though there is evidence that female infertility declines with age, large numbers of women wait until their thirties or even their forties before conceiving for a variety of personal reasons, including financial considerations and career initiatives. It has been a longstanding practice for many U.S. states and insurance companies to extend ART and fertility coverage to women under these circumstances, though insurers will often impose an age limit. For example, the Connecticut

⁸⁹ The Arkansas statute, by contrast, mandates that providers include in vitro fertilization as a covered expense. *See* § 23-85-137 (Westlaw).

statute allows insurers to limit coverage to policyholders under forty, and the Rhode Island law allows a limit at forty-two.⁹⁰ An interpretation that excludes all couples without a diagnosable medical condition identified with infertility may thus be unpopular with many U.S. women.

3. *The U.S. Government and ART*

The U.S. government has historically played only a limited role in the area of medical insurance. This is largely due to federalism concerns and the constitutional divisions between state and federal areas of regulation. Traditionally, healthcare has been reserved to the individual states under their Tenth Amendment police power.⁹¹

The Patient Protection and Affordable Care Act (Affordable Care Act) marked a decisive shift in the federal government's historically hands-off approach to regulation of the national private insurance market.⁹² President Barack Obama signed this seismic piece of legislation into law on March 23, 2010, despite vehement political, public, and legal opposition.⁹³ Through the Affordable Care Act, the federal government took an unprecedented regulatory role in the private health insurance market.⁹⁴ One of the Act's key objectives was to expand medical insurance on a national scale.⁹⁵ The resulting restructuring of the U.S. healthcare system impacted not only

⁹⁰ See CONN. GEN. STAT. ANN. § 38a-509 (West, Westlaw through enactments of the 2016 Feb. Reg. Sess., the 2016 May Spec. Sess., & the 2016 Sept. Spec. Sess.); 27 R.I. GEN. LAWS ANN. § 27-41-33 (West, Westlaw through Chapter 542 of the Jan. 2016 Sess.).

⁹¹ Historically, states have been the primary regulators of the insurance industry. The 1945 McCarran-Ferguson Act provided that, in the context of antitrust law, health insurance falls within the meaning of "interstate commerce" and therefore is subject to federal regulation in areas where the states have not asserted their primary regulatory power. See McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1945).

⁹² Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

⁹³ See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (upholding a constitutional challenge of the Affordable Care Act's individual mandate). For an example of the continuing public healthcare debate, see Robert Pear, *Many Say High Deductibles Make Their Health Law Insurance All But Useless*, N.Y. TIMES (Nov. 14, 2015), <http://www.nytimes.com/2015/11/15/us/politics/many-say-high-deductibles-make-their-health-law-insurance-all-but-useless.html?r=0>.

⁹⁴ For a summary of the primary initiatives of the Affordable Care Act, see Assistant Secretary for Public Affairs, *About the Law*, HHS, <http://www.hhs.gov/healthcare/about-the-law/index.html#> (last visited Aug. 13, 2015).

⁹⁵ The Affordable Care Act had other objectives, including cost shifting. This spurred one of the Act's most controversial provisions, the individual mandate, which required all Americans to purchase a minimum coverage insurance plan or pay a fee. The Supreme Court upheld this provision as a valid exercise of the federal government's enumerated power of tax and spending in a sharply divided 5-4 opinion. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2574 (2012).

public government programs such as Medicaid but also the private insurance market.⁹⁶

The Affordable Care Act requires that all health insurance companies provide coverage for the Act's expansive list of "essential health benefits." Infertility was not included. Accordingly, the Affordable Care Act reserved the choice to mandate infertility coverage to the states. Third-party insurers' obligation to extend coverage for infertility turns on whether a state considers infertility coverage to be an "essential health benefit."⁹⁷ However, recently proposed Health and Human Services (HHS) legislation suggests that the federal government no longer wishes to leave the regulation to individual state discretion.

HHS recently proposed a new rule for the anti-discrimination clause of the Affordable Care Act, Section 1557, which proposes that discrimination on the basis of sex include discrimination based on gender identity.⁹⁸ The rule seeks to address discrimination against transgender persons. However, it also clarifies that HHS "support[s] banning discrimination in health programs and activities . . . on the basis of sexual orientation."⁹⁹ HHS acknowledges that current law is "mixed" on whether Title IX discrimination "on the basis of sex" prohibits sexual orientation discrimination but highlights a recent EEOC decision reaching this conclusion.¹⁰⁰ Thus, HHS takes a strong and expansive position against health program discrimination on the basis of sex, including on the basis of sexual orientation and potentially gender identity.

HHS's proposed rule expresses concerns similar to those espoused by the majority in *Obergefell*. Both advance the idea that discriminatory treatment on the basis of sexual orientation violates certain fundamental and profound American principles of equal treatment. HHS parallels *Obergefell*'s novel discussion of a penumbral constitutional right that is implied by the intersection of the Fourteenth Amendment's Due Process and Equal Protection Clauses.¹⁰¹ Both the HHS rule and *Obergefell* are evidence of the

⁹⁶ Assistant Secretary for Public Affairs, *supra* note 94.

⁹⁷ See Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010); Katie Falloon & Philip M. Rosoff, *Who Pays? Mandated Insurance Coverage for Assisted Reproductive Technology*, 16 JAMA ETHICS 63–69 (2014).

⁹⁸ For the full text of the proposed rule, see *Nondiscrimination in Health Programs and Activities*, 80 Fed. Reg., 54,174 (Sept. 8, 2015) (defining the term "gender identity" as "an individual's internal sense of gender, which may be different from an individual's sex assigned at birth").

⁹⁹ *Id.* at 54,176.

¹⁰⁰ *Id.*

¹⁰¹ See *Obergefell v. Hodges*, 135 S. Ct. 2584, 2602–03 (2015).

social and legal trend against discriminatory treatment of the LGBT community, including same-sex couples.

In addition, the proposed legislation provides support for this Note's proposition that, following *Obergefell*, the legal protections of the LGBT community will expand rather than contract or remain stagnant. Further, the rule advances this Note's argument that the U.S. expansion will be comparable to the U.K. precedent, where reform of the healthcare industry promptly followed recognition of same-sex marriage. Finally, the proposed HHS rule indicates that state legislators and health care facilities will be held to increasingly strict standards against discrimination.¹⁰²

The HHS initiative and the larger legal trend it represents raise serious questions over whether states and healthcare insurers may provide disparate coverage of infertility services for heterosexual couples and same-sex couples. As the HHS proposal acknowledges, the law is inconclusive on whether discrimination on the basis of sex includes sexual orientation discrimination. Thus, it remains unclear whether limiting insurance coverage for infertility treatments and ART to same-sex couples constitutes Title IX discrimination. However, the HHS proposed rule provides further incentive for states and healthcare insurers with ambiguous and potentially discriminatory infertility coverage requirements to redraft their requirements in a manner that does not arbitrarily discriminate on the basis of sexual orientation.

IV. CONCLUSION

This Note demonstrates that the fourteen existing state health insurance mandates for infertility treatment and ART are largely unworkable in post-*Obergefell* America. Even the clearest application of *Obergefell* to statutes with spousal restrictions requires complicated statutory interpretation. Similarly, statutes that broadly define infertility or do not define infertility at all each raise difficult questions of where state legislators should draw the line. This Note's attempt to reconcile existing statutory language, much of which relied on presumptions of heterosexuality, with *Obergefell* ultimately results in convoluted and inconsistent statutory schemes. Accordingly, states should redraft their infertility legislation, and health insurance companies should reinterpret the scope of infertility coverage.

This Note also highlights recent developments in the social and legal realms, which lay the groundwork for more expansive protections of homosexual individuals and same-sex couples. *Obergefell* discusses the

¹⁰² *Nondiscrimination in Health Programs and Activities*, 80 Fed. Reg. at 54, 176.

possibility of a combination right against discrimination arising from the Fourteenth Amendment's Due Process and Equal Protection Clauses. HHS similarly expresses support for an interpretation of Title IX's notion of discrimination on the basis of sex which extends to sexual orientation discrimination as well. These examples suggest that increasing popular support for the LGBT community may initiate heightened legal protections against discrimination on the basis of sexual orientation.

This Note predicts that the *Obergefell* decision will initiate an expansion of homosexual couples' access to infertility treatments and the growing area of ART in the United States. The ambiguities in the existing statutory scheme and increasing social and legal support for homosexual rights call for anti-discrimination protections. State legislation and health insurance policies that exclude same-sex couples from infertility and ART coverage will be neither socially acceptable nor legally solid.

Therefore, states should extend substantially the same infertility and ART treatment options to homosexuals as they presently do for heterosexual individuals and couples. States may continue to restrict access in ways that do not depend on a policyholder's sexual orientation. Many existing statutes already impose limitations such as limits on age or number of treatment cycles per policyholder. Increased coverage requirements naturally give rise to cost considerations because increased coverage mandates directly affect the prices of insurance premiums for the public. However, the U.K. provides a compelling example of both an inclusive and an expansive coverage system that extends to a wide range of social groups. The U.K. provides restrictions similar to those seen in existing U.S. statutes, such as limiting the number of treatment cycles available to a particular couple and offering preference to childless couples or individuals, would allow for equal access by all classes of persons, including married couples and single women of all sexual identities, while managing runaway costs. A similar scheme could strike the necessary financial balance because evidence suggests that while ART is expensive for individuals, ART does not account for a large portion of national healthcare expenditures.¹⁰³ This Note's approach effectively protects against discrimination on the basis of sexual orientation, while remaining financially viable.

¹⁰³ Chambers, Sullivan, Ishihara, Chapman & Adamson, *supra* note 14 (explaining that this is evidenced by the fact that the average cost of one IVF cycle in 2009 accounted for 15%–18% of individuals' annual disposable income in the U.K. and 44%–50% in the United States; yet, nationally ART accounted for less than 0.25% of total healthcare expenditures in all countries, with the U.S. national outlay on ART services revealed to be the lowest percentage of total healthcare expenditure of all the countries surveyed, at just 0.06%).