NOTES

LIMITATIONS ON INSURANCE COVERAGE FOR FERTILITY TREATMENT: ARGUMENTS FOR & AGAINST CAPPING THE AGE & RESTRICTING THE MARITAL STATUS

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"There is nothing more basic to human beings than the desire to have a family."[1]

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*J.D. Candidate 2013, Albany Law School. I would like to express my gratitude to Professor Rosemary Queenan and Jim Foster for their guidance, encouragement, and motivation throughout the entirety of my law school career. I would also like to thank my parents and my sister for all their uncompromised support and faith in me. I could not have done this without each of you.

[1] 145 Cong. Rec. E1749-04 (daily ed. Aug. 4, 1999) (statement of Hon. Anthony D. Weiner).

I. INTRODUCTION

Jody had been put on this earth to be a mother. She was married at age twenty-four, had a career as a microbiologist, and was ready to have children at age twenty-six. But her dream started to shatter after having her first miscarriage. She did not give up hope, and by age twenty-eight, she was ready again. However, she had another miscarriage. Still holding on to her dream, she tried again at age thirty, and had a third miscarriage. Jody was losing sight of her dream. She, like many women, was infertile.

The American Society for Reproductive Medicine and the American College of Obstetricians and Gynecologists have recognized infertility as a disease.[2] It is not an inconvenience or just an "unfair" part of life. It is an inability to bear children. In the United States, this disease affects approximately 2.1 million couples (approximately one in eight couples),[3] which is about 7% of the reproductive-age population.[4] The members of this group

[2] Helen Lippman, *Pay or Pass on Elective Surgery? Surgery Defined for Insurance Coverage*, 19 BUS. & HEALTH 43 (2001).

[3] FERTILITY, FAMILY PLANNING, AND REPRODUCTIVE HEALTH OF U.S. WOMEN: DATA FROM THE 2002 NATIONAL SURVEY OF FAMILY GROWTH, CTRS. FOR DISEASE CONTROL & PREVENTION, 22, 108 (2005), *available at* http://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf.

[4] *Id.* at 22; ASSISTED REPRODUCTIVE TECHNOLOGY: SUCCESS RATES, NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS, NAT'L CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, 3 (2009), *available at* http://www.cdc.gov/

have little in common, medically.[5] Some women have had cancer treatments in which their ovaries have been removed, some have genetic problems with their reproductive systems, and some are allergic to their husband's sperm.[6] Others are much older when they begin reproducing, and some simply have problems with ovulation and their reproductive systems.[7] Men, too, have their share of infertility problems—some suffer from low sperm count, or have had exposure to chemical toxins; others are older or have problems with their reproductive system.[8] Some of these men and women have no discernible medical problems at all, but simply cannot conceive.[9] Regardless of the cause, there are millions of couples affected by infertility, and while it is not a life threatening disease,[10] it can become a curse, an overwhelming obsession, and can overwhelm a couple with despair and anguish.

While couples always have the option of adoption, many want a child with their own genetics. In 1981, the United States began using assisted reproductive technology (ART) to assist women in becoming pregnant with their *own* genetics, the most common form being in vitro fertilization (IVF).[11] In 2009, IVF treatment cost, on average, about $12,000, and if more assisted reproductive technologies were needed, the cost would be higher.[12] Such additional costs include: injecting a sperm directly into an egg, costing from $1,000 to $1,500 more; genetic testing of embryos (PGD) costing about $3,000 more; using an egg donor, which costs anywhere from $25,000 to $30,000 for one cycle; or using a sperm donor, which costs anywhere from $13,000 to

art/ART2009/PDF/ART_2009_Full.pdf.

[5] DEBORA L. SPAR, THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION 2 (Harvard Bus. Press 2006).

[6] *Id.*

[7] *Id.*; *Infertility: Frequently Asked Questions*, U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE ON WOMEN'S HEALTH, 2 (2009), http://www.womenshealth.gov/publications/our-publications/fact-sheet/infertility.pdf.

[8] SPAR, *supra* note 5, at 2.

[9] *Id.*

[10] Emily McDonald Evens, *A Global Perspective on Infertility: An Under Recognized Public Health Issue*, 18 CAROLINA PAPERS INTERNATIONAL HEALTH, 6, 12 (2004), http://cgi.unc.edu/uploads/media_items/a-global-perspective-on-infertility-an-under-recognized-public-health-issue.original.pdf.

[11] *What is Assisted Reproductive Technology?*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/art (last updated Feb. 12, 2013).

[12] Rachel Gurevich, *How Much Does IVF Cost?*, ABOUT.COM (Aug. 16, 2011), http://infertility.about.com/od/ivf/f/ivf_cost.htm.

$17,000.[13] According to the Centers for Disease Control, more than 1% of all children born in the United States are conceived through ART.[14]

Not only is there mental anguish, but couples are also forced to struggle financially in an attempt to conceive their own children. Even given the cost, couples are willing to go through great lengths to conceive a child of their own. They will pay whatever they have to, however they have to—"mortgage their house[], sell their car[], deplete their family savings."[15]

Often couples will turn to their insurance provider to assist in the coverage of their fertility treatments, given that the cost of such treatments are so high.[16] However, the California legislature found that "[i]nsurance coverage for infertility is uneven, inconsistent, and frequently subject to arbitrary decisions that are not based on legitimate medical considerations."[17] This is evidenced by the fact that most states do not even have laws that require or mandate coverage by insurance companies for the cost of fertility treatment.[18] Many insurance companies do not feel coverage is required, because "IVF does not treat [the] illness because it does not cure the underlying infertility, or by claiming that infertility is not [even an] illness" and as such, should not be covered.[19] While there may be some truth to that rationale, what really accounts for the underlying reasoning for exclusion of coverage is the "raw perception of its cost and its dispensability."[20]

Though insurance coverage throughout the United States is inconsistent, since about 1980, an increasing number of states have passed laws that require insurers to either cover or offer coverage for infertility diagnosis and treatment, including:

[13] *Id.*

[14] *What is Assisted Reproductive Technology?*, *supra* note 11.

[15] SPAR, *supra* note 5, at 4.

[16] *See id.* at 2–3 (describing the often untold obstacle of those seeking aid in fertility treatment in light of the high cost of fertility clinics).

[17] CHARLES P. KINDREGAN, JR. & MAUREEN MCBRIEN, ASSISTED REPRODUCTIVE TECHNOLOGY: A LAWYER'S GUIDE TO EMERGING LAW AND SCIENCE 223 (Am. Bar Ass'n Publ'g 2d ed. 2011); *see also* 1989 Cal. Legis. Serv. 734 § 1(4) (West).

[18] Note, *In Vitro Fertilization: Insurance & Consumer Protection*, 109 HARV. L. REV. 2092, 2095 (1996).

[19] *Id.* at 2096.

[20] Maura A. Ryan, THE ETHICS AND ECONOMICS OF ASSISTED REPRODUCTION: THE COST OF LONGING 19 (2001). Cost was the reason given to lobbyists in support of including coverage for assisted reproductive technologies at the time when the Clinton Administration was drafting legislation for the benefits package. *Id.* at 19 & 38 n.14.

Arkansas, California, Connecticut, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas, and West Virginia.[21] Evidence of the inconsistency is demonstrated by the fact that of the fifteen states that offer or require insurance coverage, four require that the individual be married,[22] and four others have placed a cap on the age of the individual who may be covered.[23]

While state laws may mandate insurance with respect to fertility treatment, these laws would only apply to plans that are fully insured, rather than self-insured.[24] Therefore, even in a

[21] *State Laws Related to Insurance Coverage for Infertility Treatment*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/insurance-coverage-for-infertility-laws.aspx (last updated Mar. 2012). *See also* ARK. CODE ANN. §§ 23-85-137 (West 2011), 23-86-118 (West 2012); CAL. HEALTH & SAFETY CODE § 1374.55 (West 2012); CAL. INS. CODE § 10119.6 (West 2012); CONN. GEN. STAT. § 38a-536 (2013); HAW. REV. STAT. § 431:10A-116.5(a) (2012); MASS. GEN. LAWS ANN. ch. 175, § 47H (West 2010), 176A § 8K (West 2010), 176B § 4J (West 2010), 176G § 4 (West 2011); MD. CODE ANN., INS. § 15-810 (West 2012); MONT. CODE ANN. § 33-31-102 (West 2011); N.J. STAT. ANN. § 17B:27-46.1x (West 2001); N.Y. INS. LAW §§ 3221(k)(6), 4303(s) (McKinney 2012); OHIO REV. CODE ANN. § 1751.01 (West 2012); R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2012); TEX. INS. CODE ANN. art. 1366.005 (West 2005); W. VA. CODE § 33-25A-2 (2010).

[22] *State Mandated Insurance Coverage*, Fertility LifeLines, http://www.fertilitylifelines.com/payingfortreatment/state-mandatedinsurancelist.jsp (last visited Feb. 17, 2013) (stating within the statute that the "patient's eggs must be fertilized with her spouse's sperm"). *See, e.g.,* ARK. CODE ANN. §§ 23-85-137 (West 2011), 23-86-118 (West 2012); HAW. REV. STAT. § 431:10A-116.5(a) (2012); MD. CODE ANN., INS. § 15-810 (West 2000); TEX. INS. CODE ANN. art. 1366.005 (West 2005) (providing examples of state statutes requiring insurance coverage for in vitro fertilization).

[23] *See* CONN. GEN. STAT. § 38a-536 (2013); N.J. STAT. ANN. § 17B:27-46.1x (West 2001); R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2012) (Connecticut covers those under the age of forty; New Jersey covers those under the age of forty-six; and Rhode Island covers those between the ages of twenty-five through forty-two.).

[24] *See* 29 U.S.C. § 1144 (Supp. 2009). There has been movement in the Senate to amend the Public Health Service Act, Employee Retirement Income Security Act of 1974 ("ERISA"), and chapter 89 of title 5, United States Code, to require coverage for the treatment of infertility. S. 1258, 111th Cong. (1st Sess. 2009); H.R. 2892, 110th Cong. (1st Sess. 2007). ERISA is a federal law, which supersedes any state laws that "relate to" an employee benefit plan – which includes health care coverage. 29 U.S.C. § 1144. Given this, any state law that relates to an employee benefit plan is void and ineffective. *Id.* Within the statute, however, there is a savings clause, which saves the state law that is pre-empted by ERISA *only if* it regulates insurance—which ultimately only effects plans that are fully insured and not self- insured. *Id.*; *see also* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985); FMC Corp. v. Holliday, 498 U.S. 52 (1990) (exemplifying situations where state law controls insurance or is preempted by ERISA).

state that mandates insurance coverage, there may be individuals who are not able to receive insurance coverage for fertility treatment, regardless of age or marital status so long as they are covered under a self-insured plan.[25] In the event Congress were to amend federal laws concerning healthcare benefits to require coverage for the treatment of infertility—all states and all plans (fully or self-insured) would be mandated to cover costs of treatment.[26] It should be noted that the proposed legislation of federally mandated fertility coverage *does not* place any restrictions on age or marital status of the covered individual.[27] However, "federally mandated coverage is an unlikely prospect in the near [future]."[28]

Given that a federally imposed requirement to cover costs for fertility treatment will likely not occur in the near future, this note discusses the various state insurance statutes that have capped the age and have restricted the coverage based on an individual's marital status concerning fully insured plans.

Part II examines the legislative intent with respect to state statutes that impose coverage restrictions on the age or marital status, in particular insurance statutes in Hawaii, New York and Rhode Island. With the age limitations imposed, it is evident that legislatures were motivated by medical research and statistics that demonstrated that as the age of a woman increases, her ability to conceive decreases and risk of miscarriage increases.[29] Additionally, the risk of complications during and after pregnancy increase for both mother and child as the woman's age

[25] *See* 29 U.S.C. § 1144 (discussing state regulated employee benefit plans); *see also State Mandated Insurance Coverage*, *supra* note 22 ("Fully insured plans follow state law. Self insured plans follow federal law and are exempt from state law.").

[26] *See* S. 1258, 111th Cong. § 2(a) (1st Sess. 2009); H.R. 2892, 110th Cong. § 2(a) (1st Sess. 2007) (proposing required coverage for infertility).

[27] *See* S. 1258, 111th Cong. § 2(a); H.R. 2892, 110th Cong. § 2(a) (discussing limitations on coverage, which do not include age or marital status).

[28] *Employer Experience with, and Attitudes Toward, Coverage of Infertility Treatment*, MERCER HEALTH & BENEFITS (May 31, 2006), http://familybuilding.resolve.org/site/DocServer/Mercer_Resolve_Final_Report.pdf?docID=4361; *see also* Testimony from the Haw. Dep't of Commerce & Consumer Affairs on S. Bill No. 615 – Relating to Fertility Procedures to S. Comm. on Judiciary & Labor & Health (Feb. 4, 2011), http://www.capitol.hawaii.gov/session2011/testimony/SB615_TESTIMONY_HTH-JDL_02-04-11.pdf (forwarding the testimony of those in the medical field on the proposed legislation to the appropriate Senate committee).

[29] *See* discussion *infra* Part II-A.

at conception increases.[30] Ultimately, it appears the legislature took into account the fact that the cost for IVF treatment will likely increase the older a woman is—as she may have to go through more cycles or she and/or the child may have to receive additional medical treatment after conception as a result of a high risk pregnancy.[31] With respect to the marital restrictions, at the time when many of these statutes were drafted, it appears that there was a stigma attached to a single parent household.[32] More recent legislators have accepted the non-traditional family and have begun taking steps to address and amend their state statutes accordingly.[33]

Part III addresses the policy arguments in support of and against the regulation of fertility treatment by insurance companies with respect to age. Arguments in support of restricting the age seem to be based mainly upon the increase in medical risks associated with a pregnancy later in life, in addition to a greater risk of parental death before a child reaches the age of majority.[34] These risks ultimately increase the costs to insurance providers in addressing the possible physical and mental difficulties that arise with such risks.[35] An argument against age restrictions is that a woman who has a child later in life has established herself and her career and is ultimately more competent to care for a child with a greater understanding of life.[36] Additionally, a woman and her treating physician should arguably be the only ones concerned with whether she is physically and mentally able to have a child later in life—not an insurance company.[37]

Part IV discusses the arguments for and against the regulation of fertility treatment by insurance companies with respect to marital status. Arguments in support of restricting the marital status, as mentioned above, stem mainly from the stigma that society has attached to a voluntary single parent home.[38] Additionally, studies suggest that there appear to be greater mental and emotional problems in children who have grown up

[30] *See* discussion *infra* Part II-A.
[31] *See infra* pp. 16–17.
[32] *See* discussion *infra* Part II.B.
[33] *See* discussion *infra* Part II.B.
[34] *See* discussion *infra* Part III.A, C.
[35] *See* discussion *infra* Part III.C.
[36] *See* discussion *infra* Part III.D.
[37] *See* discussion *infra* Part III.B, D.
[38] *See* discussion *infra* Part IV.A–B.

in single parent households and the treatment of these issues ultimately increase costs to insurance companies.[39] Arguments against restricting the marital status demonstrate that the problems a child faces in single parent households do not necessarily stem from the absence of both parents.[40] If a parent is able to provide for a child emotionally and financially and is made aware of and understands the risks that may arise with a child living in a single parent household—that is a concern for the parent; not a concern for an insurance company.

The right to raise a child in the manner a parent chooses is a fundamental right, recognized by the Supreme Court.[41] Part V questions whether, in light of the right to conceive and to become a parent, insurance policies and companies should be allowed to inhibit that right.

II. CAPPING THE AGE & RESTRICTING THE MARITAL STATUS: LEGISLATIVE INTENT

A. Capping the Age

Connecticut, New Jersey, New York, and Rhode Island all have statutes that place a cap on the age of the individual for which insurance companies will cover costs of fertility treatment.[42] In particular, New York's statute reads: "[c]overage shall be provided for persons whose ages range from *twenty-one through forty-four* . . .[43] Coverage shall be provided for persons whose ages range from *twenty-one through forty-four years* . . . ."[44]

Insurance companies in New York first began covering fertility treatment in 2002.[45] The law was passed by Senate Bill S7359, which would require insurers to provide coverage for accepted

[39] *See* discussion *infra* Part IV.A.

[40] *See* discussion *infra* Part IV.B.

[41] *See* discussion *infra* Part V.

[42] R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2007) (Rhode Island's statute reads in part "coverage . . . of infertility for women between the ages of twenty-five (25) and forty-two (42) years."); CONN. GEN. STAT. § 38a-536 (1989) (Connecticut's statute reads in part "[s]uch policy may: (1) [l]imit such coverage to an individual until the date of such individual's fortieth birthday[.]"); N.J. STAT. ANN. § 17B:27-46.1x (West 2001) (New Jersey's statute reads in part "cover[age] . . . shall be limited to . . . [a person who] is 45 years of age or younger."); N.Y. INS. LAW §§ 3221(6) & 4303(s) (McKinney 2012).

[43] N.Y. INS. LAW § 4303(s)(C)(3)(A) (McKinney 2012) (emphasis added).

[44] *Id.* § 3221(6)(c)(i) (emphasis added).

[45] *See id.* § 3221 (introducing legislation on coverage of fertility treatment began in 2002 with this statute).

diagnoses and treatment of infertility problems and expanded coverage that would only apply to individuals between the ages of 21 and 44.[46] In discussing the rational behind the legislation, the bill's sponsors stated that:

> Medical science has advanced to a point where treatment is available to increase fertility and allow in many cases individuals to realize their dream of having children. However, the high cost of infertility treatment has often been a primary barrier to obtaining these health care services. This legislation will assist many of these individuals by assuring that they are not denied coverage for surgical and medical procedures which would correct malformation, disease or dysfunction resulting in infertility and that they are provided coverage for prescription drugs approved by the FDA for use in the diagnosis and treatment of infertility.[47]

However, the legislative history does not specifically mention the age restriction and the motives behind the restriction.[48]

Rhode Island's statute provides "coverage . . . of infertility for women between the ages of *twenty-five (25) and forty-two (42) years*."[49] Similar to New York, in Rhode Island, the cut off age was initially 40 years old (passed in 2006), however Senate Bill S0453A, introduced by Sen. William A. Walaska and passed in 2007, increased the age from 40 to 42 years old.[50] Senator Walaska stated "that [the] age cut-off at 42 was chosen as a result of information provided by a number of physicians . . . [and] [t]hat material indicated that age cut-off limits do make sense, given the reasonable pregnancy rates in women in their early 40s, when fertility in women begins to decline significantly."[51] He went on to state that "[t]he age that was chosen was an effort to ensure that women in their early 40s have the opportunity to obtain covered diagnoses and treatment for infertility, balanced with financial concerns."[52]

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[46] *See* S. Bill S7359, at 2 (N.Y. 2002) (clarifying the obligations put on insurers through the new legislation).

[47] Sponsors Memo, S. Bill S7359 (N.Y. 2002).

[48] The bill jacket of the statute is the only legislative history available, and while it does not refer to the age limit, it does cite the individualized aspect of the insurance. *See* N.Y. BILL JACKET, L. 2002 A.B. 9759, ch. 82, at 1, 3.

[49] R.I. GEN. LAWS § 27-41-33 (2007) (emphasis added).

[50] *Compare* 2006 R.I. Pub. Laws ch. 06-246, art. 34, *with* Act Relating to Insurance, 2007 R.I. Pub. Laws ch. 07-411, secs. 1, 4 (showing the change in age restriction); s*ee also* Press Release, R.I. Gen. Assemb., Bill Hikes Women's Infertility Treatment Coverage to Age 42 (Apr. 17, 2007), http://webserver.rilin.state.ri.us/News/pr1.asp?prid=4052.

[51] Press Release, R.I. Gen. Assemb., *supra* note 50.

[52] *Id.*

Studies prior to the enactment of many of these statutes revealed the likelihood of live birth rates based upon age.[53]

> In 1985, the Society for Assisted Reproductive Technologies (SART) . . . established a voluntary reporting system for clinics . . . to collect data[.] . . . [The] [r]esults are compiled annually by the Centers for Disease Control and Prevention (CDC). According to the CDC's 2007 Assisted Reproductive Technology Success Rates Report, national norms of live birth rates per cycle were *40 percent* in women younger than 35 years of age, *31 percent* in women 35-37, *21 percent* in women aged 38-40, *12 percent* in women aged 41-42 years of age, and *5 percent* in women aged 43-44 years.[54]

There was also a study done in Boston around the same time involving 1263 women over the age of 40, which observed that even for the woman who did become pregnant with fertility procedures, the miscarriage rate per cycle was 24% for 40 year olds, 35% for 43 year olds, and 54% for 44 year olds.[55]

The data collected by SART, the results compiled by the CDC, and the study done in Boston report that a woman's odds of becoming pregnant decline sharply as she ages, while the risk of miscarriage increase substantially.[56] Because the chance of becoming pregnant decreases with age, while the risk of miscarriage increases,[57] presumably, older women may have a

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[53] CONNECTICUT MANDATED HEALTH INSURANCE BENEFITS REVIEWS: VOLUME II, UNIV. OF CONN., 88 (2010), www.ct.gov/cid/lib/cid/2010_CT_Mandated_Health_Insurance_Benefits_Reviews_-_General_Overview.pdf. The most recent study the CDC has conducted reveals that those percentages are about the same with was known in 1985. ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES, NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS, *supra* note 4, at 38, 61. "Percentages of ART cycles that result in pregnancies [and] live births . . . decline with each year of age and are particularly low for women aged 40 or older . . . . The average chance for pregnancy was 27% among women age 40; the percentage of ART cycles resulting in live births for this age was about 19% . . . . All percentages dropped steadily with each 1-year increase in age. Among women older than 44, percentages of live births . . . [were] less than 2%. Women aged 40 or older generally have much higher percentages of live births using donor eggs." *Id.* at 30.

[54] CONNECTICUT MANDATED HEALTH INSURANCE BENEFITS REVIEWS, *supra* note 53, at 88 (emphasis added).

[55] Salynn Boyles, *After Age 44, Fertility Successes Are Few: High-Tech Infertility Rx 'Reasonable' Until Mid-40's*, WEBMD HEALTH NEWS (Aug. 25, 2005), http://www.webmd.com/infertility-and-reproduction/news/20050825/after-age-44-fertility-successes-are-few.

[56] *See id.* (discussing the increasing difficulty of getting pregnant and the increasing possibility of miscarriages as women get older); *see* discussion *infra* Part III-A (discussing the increasing difficulty of getting pregnant and the increasing possibility of miscarriages as women get older).

[57] Boyles, *supra* note 55.

greater need for more fertility treatment cycles. Accordingly, the potential cost to insurance companies, which are making the payments for the treatments, increases.[58] Additionally, the cost to employers may provide health insurance benefits to their employees may increase, as well as the cost of premiums individuals, who are covered by such plans, will be required to pay. At least that appears to be the debate.[59]

While one may argue that those who are over the age-requirement (or under, in some states) are being discriminated against on the basis of age—absent some reasonable purpose (rational basis) for age restrictions, the Supreme Court will not recognize these limitations as discriminatory.[60] Medical complications related to age,[61] and increased costs to insurance companies[62] would be considered a rational basis for imposing age restrictions, therefore, the insurance laws may stand.

B. Restricting the Marital Status

Arkansas, Hawaii, Maryland, Rhode Island, and Texas all have statutes that restrict the coverage of fertility treatment based on the marital status of the individual.[63] In particular, Hawaii's

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[58] *See infra* text accompanying note 213 (mentioning that insurance companies believe fertility treatment will increase insurance costs).

[59] *Contra Employer Experience with, and Attitudes Toward, Coverage of Infertility Treatment*, *supra* note 28, (contrasting employer's perception of coverage costs with a more likely cost estimation).

[60] 29 U.S.C. § 623(f)(2) (Supp. 2009); *see also* Mass. Bd. of Ret. v. Murgia, 427 U.S. 307, 314–16 (1976) (showing that potential age discrimination is decided using the rational-basis test).

[61] *See* discussion *infra* Part III.A–B (describing medical complications); *see also* Vance v. Bradley, 440 U.S. 93, 103–04, 108–09, 111–12 (1979) (demonstrating that laws which may be viewed as discriminatory based upon age, are capable of withstanding a rational-basis analysis).

[62] *See* discussion *infra* Part IV (illustrating the difficult financial situation of many women); *see also* Dandridge v. Williams, 397 U.S. 471, 477–81, 483–86 (1970) (finding that a welfare cap irrespective of family size is rationally connected to the legitimate basis of conserving scarce welfare resources.)

[63] *See* HAW. REV. STAT. § 432:1-604 (2003); MD. CODE ANN., INS. § 15-810 (2000); R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2007); TEX. INS. CODE ANN. § 1366.005 (2005) (Maryland's statute reads in part "[t]he patient's oocytes are fertilized with the patient's spouse's sperm[.]" Rhode Island's statute reads in part "[f]or the purpose of the section, 'infertility' means the condition of an otherwise healthy married individual who is unable to conceive . . ." Texas's statute reads in part "the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse[.]" Hawaii's statute reads in part "[t]he patient's oocytes are fertilized with the patient's spouse's sperm[.]"); *see also* ARK. CODE ANN. §§ 23-85-137 (West 2011), 23-86-118 (West 2012).

statute reads: "The patient's oocytes are fertilized with the *patient's spouse's sperm*[.]"[64]

Currently, in Hawaii, amendments have been proposed to the current law to remove the requirement that an infertility patient be married.[65] The American Society of Reproductive Medicine stated in its letter to the State Senate, in response to the proposed amendments, that "[t]oday's society has come to not only accept, but embrace the fact that not all parents are married. ASRM does not believe that treatments for infertility should be restricted to married individuals."[66]

Based on this, it appears that the intent of the legislature in drafting the original statute in 1987 reflected the way in which society viewed single parents at that time. Many people believe that single parenthood, as a result of non-marital childbearing, as opposed to single parenthood as a result of divorce or separation, is a serious social problem, and as such, policymakers have expressed special concern for children born to unmarried mothers.[67] It appears that this concern stems from a variety of reasons, including disapproval for out-of-wedlock childbearing for religious purposes, a high risk of poverty and welfare dependency for unwed mothers, and greater costs to taxpayers.[68]

Additionally, studies done in the 1980s revealed that during that time, most of society believed that "fatherless families" tended to produce children with various "social 'pathologies' [including] juvenile delinquency and sex-role ambiguity."[69] Not only that, but there appears to be a stigma of "immoral behavior" attached to a single-parent family.[70]

When Americans link family change to a breakdown in 'traditional'

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64 HAW. REV. STAT. § 431:10A-116.5(a)(3) (2012) (emphasis added).

65 S.B. 615 (NS), 2011 Leg., 26th Sess. (Hi. 2011); Testimony of the Am. Soc'y of Reprod. Med. Submitted to Haw. State Legislature (Feb. 3, 2011), http://www.capitol.hawaii.gov/session2011/testimony/SB615_TESTIMONY_HTH-JDL_02-04-11.pdf (discussing the society's opinion of the state's proposed legislation).

66 Testimony of the Am. Soc'y of Reprod. Med.*, supra* note 65.

67 SARA MCLANAHAN & GARY D. SANDEFUR, GROWING UP WITH A SINGLE PARENT: WHAT HURTS, WHAT HELPS 64–65 (1994).

68 *Id.* at 65.

69 Robert John, Book Review, 6 MID-AM. REV. OF SOC. 131, 133 (1981) (reviewing ANDREW J. CHERLIN, MARRIAGE, DIVORCE, REMARRIAGE (1981)).

70 David T. Ellwood & Christopher Jencks, *The Spread of Single-Parent Families in the United States Since 1960*, HARVARD UNIV., JOHN F. KENNEDY SCH. OF GOV'T, 5 (Oct. 2002), http://www.hks.harvard.edu/inequality/Seminar/Papers/ElwdJnck.pdf.

> moral norms, they usually emphasize the spread of premarital sex, out-of-wedlock births, and divorce. Those who see such behavior as immoral often claim that it has costly social consequences . . . . The proportion of Americans who view these issues in moral terms has clearly declined over the past generation, but for those who continue to see the problem in moral terms these changes in public opinion serve as further evidence that the nation faces a moral crisis.[71]

While most of the current generation does not attach a stigma to single parent households, there continues to be an older generation of people who *do* associate corrupt behavior with nontraditional families and view the fact that the younger generation does not see this trend in moral terms as simply more evidence of social corruption.[72] While there are studies that report a greater chance for psychological and financial difficulties in children growing up in a single-parent household,[73] recent studies, due to the widespread increase in single-parent families,[74] have demonstrated there are a multitude of factors and a collection of circumstances that are attributed to problematic behavior in children and the "costly social consequences," other than simply the lack of both parents.[75]

While the view of single parents has been changing since the studies were done in the early 1980s, today, over twenty-five years after the original statute was passed in Hawaii,[76] still only about one-third of Americans think single parenthood is acceptable.[77] As a result, it has led to legislation requiring a

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[71] *Id.* at 5–6.

[72] *See id.* (discussing the fact that the portion of the population that views single parent families as morally wrong is declining).

[73] *See* discussion *infra* Part IV.A (discussing studies that have revealed a higher risk of psychiatric and psychological problems in children who grow up in single-parent homes).

[74] Ellwood & Jencks, *supra* note 70, at 2. "In 1964, when Lyndon Johnson declared a war on poverty, only 30 percent of poor families with children were headed by single mothers. Since the late 1970s the figure has been about 60 percent." *Id.* (citing calculations from U.S. Census Bureau material). Clearly the views upon single-parent households have changed over time, evidenced by the increase in such non-traditional families. *See* discussion *supra* Part II.B.

[75] *See* MCLANAHAN & SANDEFUR, *supra* note 67, at 2 (noting that "[g]rowing up with a single parent is just one among many factors that put children at risk of failure" and discussing how it is not necessarily the root of the problem).

[76] HAW. REV. STAT. § 431:10A-116.5(a) (2003).

[77] *See* Rich Morin, *The Public Renders a Split Verdict On Changes in Family Structure*, PEW RESEARCH CTR., 1 (Feb. 16, 2011), http://www.pewsocialtrends.org/files/2011/02/Pew-Social-Trends-Changes-In-Family-Structure.pdf ("About a third generally accepts the changes; a third is

patient to be married in order to receive fertility treatment.[78]

Ultimately, unless the legislature expressly prohibits discrimination in the state on the basis of marital status,[79] the insurance law that restrict the receipt of benefits to married individuals will likely stand.

III. ARGUMENTS IN SUPPORT OF & AGAINST CAPPING THE AGE

Statistics have demonstrated that on account of the low probability of infertility, the optimal age for a woman to become pregnant is between twenty and twenty-four.[80] However, few women actually conceive at this age.[81] The U.S. Bureau of Labor Statistics reported in October 2010, 68.1% of 2010 high school graduates were enrolled in colleges or universities, and, of the 2010 graduates, the college enrollment rate was 74% for young women and 62.8% for young men.[82] Not only are women attending undergraduate college but "[i]n each year since 1988, women have made up more than half of postbaccalaureate enrollment, and in 2009, postbaccalaureate enrollment was 59% female."[83]

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tolerant but skeptical; and a third considers them bad for society.").

[78] *See supra* Part II.B (discussing various statutes that restrict the insurance coverage of fertility treatments based on the patient's marital status).

[79] "In states in which medical antidiscrimination laws are either silent or ambiguous with respect to marital status or sexual orientation as protected categories, unmarried individuals may face impregnable barriers to access . . . [and] even if state law does prohibit discrimination on the basis of marital status or sexual orientation, presumably a[n] [insurance] provider could argue that [assisted reproductive technology] services are not 'medical services' as defined by the relevant statutes, and thus not covered services." Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18, 44 (2008).

[80] *Chart: The Effect of Age on Fertility*, BABYCENTER LLC, http://www.babycenter.com/0_chart-the-effect-of-age-on-fertility_6155.bc (last visited Feb. 17, 2013) (noting that between the ages of twenty though twenty-four women have an 86% chance of becoming pregnant and only a 3% chance of infertility).

[81] *See, e.g.,* Sylvia Ann Hewlett, *Executive Women and the Myth of Having It All*, HARV. BUS. REV., Apr. 2002, at 1, 5–6 ("So this is the difficult position in which women find themselves. According to Lisa Benenson, former editor of *Working Woman* and *Working Mother* magazines, '[t]he signals are very clear. Young women are told that a serious person needs to commit to her career in her 20s and devote all her energies to her job for at least ten years if she is to be successful.'").

[82] *College Enrollment and Work Activity of 2010 High School Graduates*, U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS (2011), http://www.bls.gov/news.release/archives/hsgec_04082011.pdf.

[83] THE CONDITION OF EDUCATION, U.S. DEP'T OF EDUC., NAT'L CTR. FOR EDUC.

A. Medical Considerations: For

Women are actively pursuing higher education and are on a quest to established themselves independently.[84] By the time they reach age twenty-four, many have just finished their college education and are working to establish their careers; many have not even considered having a child at this point in their life. As a result, women have begun bearing children at a later age.[85] Unfortunately, the increase in age is coupled with more medical risks.

Understanding the fact that the biological clock does exist is important when considering the time to conceive children. Ages beyond thirty-five appear to be when most women begin experiencing heightened risks of medical complications during and after pregnancy.[86] As a woman ages, her ovaries do not respond as well to the hormones that are responsible for helping the ovaries ovulate, which causes the ovaries to be less likely to produce mature eggs for ovulation, and also increases the chances of genetic problems, such as Down syndrome and autism.[87] Other risks for the female include gestational diabetes,

STATISTICS, 36 (May 2011), http://nces.ed.gov/programs/coe/pdf/coe_gre.pdf.

[84] *See* Tamar Lewin, *The New Gender Divide: At Colleges, Women Are Leaving Men in the Dust*, N.Y. TIMES (July 9, 2006), http://www.nytimes.com/2006/07/09/education/09college.html (discussing the correlation between female participation in higher education and the break from traditional gender roles).

[85] *National Vital Statistics Reports, Estimated Pregnancy Rates by Outcome for the United States, 1990–2004*, CTRS. FOR DISEASE CONTROL & PREVENTION, 3 (Apr. 14, 2008), http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_15.pdf ("In recent years, pregnancy rates fell steadily for teenagers and women in their early twenties; rates for women in their late twenties stabilized, and rates for older women rose.").

[86] *See* Rachel Gurevich, *Getting Pregnant After 35*, ABOUT.COM (last updated Jan. 9, 2012), http://infertility.about.com/od/causesofinfertility/a/pregnantafter35.htm (discussing the increased risk for miscarriages and birth defects); *see also Getting Pregnant – Pregnancy After Thirty-Five: Healthy Moms Healthy Babies*, MAYOCLINIC.COM (July 23, 2011), http://www.mayoclinic.com/health/pregnancy/PR00115 (listing seven health risks associated with pregnancy over the age of thirty-five.); *Age and Fertility: A Guide for Patients*, AM. SOC'Y FOR REPROD. MED. 1, 6–7 (2003), http://www.sart.org/uploadedFiles/ASRM_Content/Resources/Patient_Resources/Fact_Sheets_and_Info_Booklets/agefertility.pdf.

[87] *Getting Pregnant – Pregnancy After Thirty-Five*, *supra* note 86; *Age and Fertility: A Guide for Patients*, *supra* note 86, at 6 (indicating that by the age of thirty five women have a 1/378 chance of bearing a child with Down syndrome and a 1/192 chance of bearing a child chromosomal abnormalities; by the age of forty-five women have a 1/30 chance of bearing a child with Down syndrome and a 1/21 chance of bearing a child with a chromosomal abnormality.); Sandra

an increased chance of developing high blood pressure, the need for a caesarean section, an increased chance of miscarriage, uterine fibroids and endometriosis.[88] In 1999, a study was conducted by the Department of Maternal and Child Health, School of Public Health at the University of Alabama, "[t]o estimate whether achieving pregnancy beyond maternal age of [fifty] years compromises fetal well-being and survival."[89] The results were as follows:

> A total of 539 deliveries among older mothers (aged 50 and above) were documented (four per 100,000) . . . . [T]he risks for low birth weight, preterm, and very preterm were tripled among older mothers, whereas the occurrence of very low birth weight, small size for gestational age, and fetal mortality were approximately doubled compared with those for young mothers. Older mothers also had greater risks for fetal morbidity and mortality than their immediate younger counterparts (40-49 year olds) . . . . [Overall] compared with young mothers, older mothers had significantly higher risks of low birth weight, very low birth weight, very preterm, and small size for gestational age. Older mothers also had higher risk estimates for multiples than 40-49-year-old . . . in terms of all fetal morbidity and mortality indices.[90]

The study concluded that "[p]regnancy beyond age 50 was associated with increased risks for the fetus . . . [and] suggest[ed] that this age group is a distinct obstetric high-risk entity that requires special counseling before and after conception."[91]

With such risks to the fetus related to increased maternal age, it seems reasonable that insurance companies are capping the age for fertility treatment. The cost to insurance companies, employers and/or individuals increases dramatically as a result of potential medical complications and emotional difficulties when a woman chooses to conceive much later in life.[92]

Gordon, *Pregnancy in Your 20's, 30's and 40's*, BABYZONE.COM (2011) http://www.babyzone.com/pregnancy/your-body-during-pregnancy/20s-30s-40s-pregnancy_71393.

[88] *Age and Fertility: A Guide for Patients*, *supra* note 86, at 7; *Getting Pregnant After 35*, *supra* note 86.

[89] Hamisu M. Salihu et al., *Childbearing Beyond Maternal Age 50 and Fetal Outcomes in the United States*, 102 OBSTETRICS & GYNECOLOGY 1006, 1006 (2003); *see* David Banh et al., *Reproductive Beyond Menopause: How Old is Too Old for Assisted Reproductive Technology?*, J. ASSISTED REPROD. & GENETICS 365, 367 (2010) (discussing the main objectives from the University of Alabama Department of Maternal Health study).

[90] Salihu et al., *supra* note 89, at 1006.

[91] *Id.*

[92] *See* Adara Beamesderfer & Usha Ranji, *U.S. Health Care Costs*, KAISER

Additionally, because of the increased risk of miscarriage, as well as the increase in fetal mortality, the number of times a woman will go through assisted reproductive treatment potentially increases, thus costing insurance companies more as a result of multiple treatments.[93]

This restriction is unfair given that, for example in New York, a woman is able to receive fertility treatments until the age of forty-four, but beyond that insurance will not cover it.[94] Take for instance a woman who is in fantastic health, extraordinary physical condition, and emotionally stable, and desires to conceive a child at age forty-five—her insurance will not cover the costs of her treatment.[95] An insurance company should not have the power to restrict a woman's ability to bear children based upon age alone.

B. Medical Considerations: Against

While there are risks involved with children who are conceived by women older than the age of thirty-five, studies demonstrate that there are risks regardless of what age a woman is at the time of conception.[96] It is the responsibility of the physician treating his or her patient to inform the individual of the risks to

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FAMILY FOUND., http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (last updated Feb. 2012) ("In contrast to most other nations where the government finances health care for the majority of its residents, private, employer-sponsored insurance is the primary source of insurance in the United States, covering more than 60% of Americans. This system is costly and complex, resulting in a complicated array of players, including insurance companies, employer, and regulators."). "Health expenditures in the United States neared $2.6 trillion in 2010, over ten times the $256 billion spent in 1980. The rate of growth in recent years has slowed relative to the late 1990s and early 2000s, but is still expected to grow faster than national income over the foreseeable future." *Id.* (internal citations omitted).

[93] *See* Christopher J. Brower & Adam H. Balen, *The Adverse Effects of Obesity on Conception and Implantation*, 140 REPROD. 347, 349 (indicating that the increased risk of miscarriage among obese women leads to higher rates of assisted reproductive treatment); *see State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* note 21 (showing that the costs associated with assisted reproductive treatment are quite high).

[94] N.Y. INS. LAW §§ 3221(6) & 4303(s) (McKinney 2012).

[95] *Id.*

[96] *See* William M. Callaghan & Cynthia J. Berg, *Pregnancy-Related Mortality Among Women Aged 35 Years and Older, United States, 1991–1997*, 102 OBSTETRICS & GYNECOLOGY 1015, 1016–17 (2003) (implying that there is risk with pregnancy at ages younger than thirty-five, although it is less than the risk associated with pregnancy after age thirty-five).

herself and her child, regardless of whether she is twenty, thirty, forty or older.[97] "Physicians are bound by ethics to uphold the principles of beneficence and nonmaleficence."[98] Beneficence is to provide a benefit to the patient, and nonmaleficence is to prevent harm to the patient.[99] In the case of a late pregnancy, it is the physician's responsibility to provide, to the best of his or her ability, what the patient desires, as well as to act in the best interests of both the mother and the child and consider the well-being of both parties.[100] It is the responsibility of the physician treating the mother to "gauge whether the benefits of motherhood and childrearing outweigh the risks of childbearing to the mother and whether such risks may also endanger the welfare of the child."[101] "When evaluating older patients for IVF services, physicians should consider the rights of the patients, [as well as] their physical and mental well-being . . . to ensure that they are truly acting not just in the best interests of the parents, but also those of the children."[102]

Given the responsibility of the treating physician—it makes sense that a physician treating a woman who is considering pregnancy later in life would know *better* than an insurance company what age is suitable for her to conceive. For instance, in New York, a woman who was in very poor health and physical condition, and therefore is susceptible to more risks during pregnancy, but is under the age of forty-five, would receive insurance coverage for the costs of fertility treatment.[103] While another woman in perfect physical and mental health, who is less likely to suffer risks during the pregnancy, but is forty-five, will not have insurance coverage for the costs.[104] In this scenario, it should be in the treating physician's discretion, based on his or her medical background and expertise, to determine the risks to the mother and the child based on the patients' individual

[97] *See* Banh et al., *supra* note 89, at 367–68 (discussing that physicians have a duty to act in the patients best interests, thereby implying that if a procedure will harm the patient that the doctor has a duty to inform the patient of that harm).

[98] *Id.* at 367.

[99] *Id.*

[100] *See id.* at 368 (discussing a physician's role in treating both mother and child).

[101] *Id.*

[102] *Id.*

[103] N.Y. INS. LAW §§ 3221(k)(6) & 4303(s)(3) (McKinney 2012).

[104] *See id.* § 3221(k)(6) (outlining the age restrictions for insurance coverage of fertility treatments).

situation viewed in its entirety and not simply based on an isolated factor such as age.

Women that voluntarily trust their doctor to "determine [their] physical ability to experience a . . . pregnancy [later in life]," may feel that it is a decision that a doctor is "better able than [a patient] to make."[105] The doctor should be there to examine her physical condition and whether she is *able* to bear a child, not whether she *should* bear a child.[106] The determination of a woman's ability to bear a child later in life should be based upon the knowledge and expertise of a treating physician and the decision to have a child should ultimately be made by the woman herself.

Additionally, women are living longer than they had years ago. As one fertility physician points out:

> "The 40 and 45-year-old of today is not the 40-year-old of the past; the 50-year-old [today] is not the same of the past," said Dr. John Jain, a physician at the Santa Monica (California) Fertility Clinic who has treated age-related infertility for 15 years. "They're eating healthy. A woman who is 45 is barely halfway through [her] life."[107]

Age is merely a number, even more so today.[108] If a physically, emotionally, and mentally healthy forty-five year old wants to conceive, that should be *her* choice.

C. Best Interests of the Child: For

Maria del Carmen Bousada died nearly three years after she had given birth to twin boys at the age of sixty-six using IVF.[109] "She lied to a California fertility clinic to skirt its age limit, and later pointed to her mother's longevity as a reason to expect she'd be around to care for her kids."[110] According to the Centers for Disease Control's most recent publication of life tables, a fifty-one

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[105] LYNDA B. FENWICK, PRIVATE CHOICES, PUBLIC CONSEQUENCES: REPRODUCTIVE TECHNOLOGY AND THE NEW ETHICS OF CONCEPTION, PREGNANCY, AND FAMILY 21 (Dutton 1998).

[106] *Id.* (emphasis added).

[107] Breeanna Hare, *Should You Get Pregnant If You're 50 or Older?*, CNN.COM (July 19, 2009, 5:08 PM), http://www.cnn.com/2009/LIVING/07/17/older.women.pregnancy/index.html.

[108] *See id.* (demonstrating that scientific procedures can enable even an older woman to become pregnant).

[109] Daniel Woolls, *Maria del Carmen Bousada, World's Oldest New Mother Who Gave Birth at 66 Reported Dead*, HUFF POST WORLD (July 15, 2009, 8:49 PM), http://www.huffingtonpost.com/2009/07/15/worlds-oldest-new-mother_n_233040.html.

[110] *Id.*

year old female can expect to live about thirty more years, until she is about eighty years old.[111] The publication found that a sixty-eight year old can expect to live another seventeen years, but predisposing factors may limit her life expectancy.[112] Based on these statistics, if a woman were to have a child at age sixty-eight, she would likely die before the child reaches the age of eighteen, which is traditionally the "legal cutoff for self-sufficiency in the United States."[113]

While the best interests of a child are normally an issue raised in custody, guardian, and adoption cases, these issues arguably should also be considered in the case where an older woman is attempting to conceive through assisted reproductive technologies. As discussed in the previous section,[114] a physician owes a duty not only to the mother, but also to the child.[115] Therefore, in a case where a woman is bearing children much later in life, a child's interests should also be taken into consideration.[116] The child's welfare and best interests should be taken into consideration, especially if a mother has a less than ideal life-expectancy. As noted in the Supreme Court case, *Troxel v. Granville*, in 2000:

The phrase "best interests of the child" appears in no less than [ten] current Washington state statutory provisions governing determinations from guardianship to termination to custody to adoption . . . [with language including] "best interests of the child are served by a parenting arrangement that best maintains a child's emotional growth, health and stability, and physical care."[117]

Certainly, with the advances in technology, there should be no reason to restrict the 'best interests of a child' standard from assisted reproductive technology. Courts have established factors

111 Banh et al., *supra* note 89, at 366.

112 *Id.* (explaining that "[w]omen of advanced reproductive age are particularly at risk of heart disease, cancer, cerebrovascular disease, and dementia").

113 *Id.*

114 *See supra* Part III-B.

115 *See* Banh et al., *supra* note 89, at 365 (discussing the special considerations needed to balance the interests of the mother and child in the proliferation of assisted reproductive technology).

116 *Id.* at 368.

117 Troxel v. Granville, 530 U.S. 57, 84 n.5 (2000) (Stevens, J., dissenting); WASH. REV. CODE ANN. § 26.09.240(6) (West 1996) (enumerating eight factors courts may consider in evaluating the best interests of a child).

to be considered in determining the "best interests of a child."[118] In New York, such factors include:

> The quality of the home environment and the parental guidance the custodial parent provides for the child, the ability of each parent to provide for the child's emotional and intellectual development, the financial status and ability of each parent to provide for the child, [and] the relative fitness of the respective parents . . . .[119]

As noted above, Maria del Carmen Bousada died leaving behind two twins boys who were not yet even three years old.[120] They are now forced to go through life without their birth mother, because she was sixty-six when she decided to conceive.[121] According to numerous studies, children who suffer the loss of a parent are at greater risk for depression, stress, dramatic feelings of fear, anxiety and loss, psychiatric problems or even suicidal thinking—all mental conditions affecting the emotional and intellectual development of a child.[122]

Given the fact that the risk of death increases with age, a potential caretaker may be needed for a child who was conceived later in a woman's life.[123] The social support system for women bearing children at such a late time in life should be established, in the event that the mother or father passes when their child is still young.[124] However, because those who are older may not have family or friends who are capable of assisting them, especially if it is their first child, the support system is diminished in correlation to the parent's age at conception.[125] "There is no U.S. law regulating the age of in vitro candidates, but [one physician] said his clinic won't take older women because [he] 'would like the mother . . . to basically survive until

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[118] *E.g.,* Ekstra v. Ekstra, 912 N.Y.S.2d 592, 594 (App. Div. 2010).

[119] *Id.* at 990 (quoting Salvatore v. Salvatore, 893 N.Y.S.2d 63, 65 (App. Div. 2009)).

[120] Woolls, *supra* note 109.

[121] *Id.*

[122] *See* Janis Kelly, *Parental Death Has Major Impact on Depression Risk in Youth*, MEDSCAPE MEDICAL NEWS (2009), available at http://www.medscape.com/viewarticle/706384 (explaining types of grief that children experience after the loss of a parent, and the need to intervene); Banh et al., *supra* note 89, at 365–67 (stating that providing the child with a guardian or caretaker immediately after the parent's passing may be necessary to ensure the stability of the child's psychological development).

[123] Banh et al., *supra* note 89, at 367.

[124] *Id.* at 369.

[125] *See id.*

the kids reach 18.'"[126] This poses the question, who is to care for the child if one or both parents die before the child reaches the legal age of eighteen?

The death of a parent early on in a child's life costs insurance companies more because they are required to cover psychological problems of a child, which may surface later in life.[127] For example, New York' s Insurance Law § 4235—Group accident and health insurance, provides:

> psychiatric or psychological services or for the diagnosis and treatment of *mental, nervous, or emotional disorders or ailments*, however defined in such policy, a subscriber to such policy shall be entitled to reimbursement for such *psychiatric or psychological services* or diagnosis or treatment whether performed by a physician, psychiatrist or a certified and registered psychologist when the services rendered are within the lawful scope of their practice, and when such policy or any certificate issued thereunder is delivered or issued for delivery without this state by an authorized insurer, covered persons residing in this state shall be entitled to reimbursement for such diagnosis and treatment by a physician, psychiatrist or a certified and registered psychologist as hereinabove provided . . . .[128]

Additionally, in 2008, Congress passed the Mental Health Parity and Addiction Equity Act, which "requires private health insurance plans to provide equal coverage for mental and physical health services" and allows for "adults and children suffering from mental health disorders, such as anxiety and depression" to obtain the necessary coverage.[129] In addition, as a result of the new health care coverage passed by President Obama, more children who have mental and psychological problems are now covered by insurance companies.[130] In light of this legislation, it appears that insurance companies would cover the costs for psychological treatment for children who are potentially affected by the death of a parent.[131]

Not only are children psychologically affected by the loss of a

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[126] *World's Oldest New Mom Dies, Leaves 2 Toddlers*, NBCNEWS.COM (July 15, 2009, 6:01 PM), http://www.nbcnews.com/id/31921390/ns/health-womens_health.

[127] N.Y. INS. LAW § 4235(f)(4)(G) (McKinney 2012).

[128] *Id.*

[129] *Mental Health Insurance under Party Law*, AMERICAN PSYCHOLOGICAL ASS'N (2011) http://www.apa.org/helpcenter/federal-parity-law.aspx.

[130] *State Children's Health Insurance Program (SCHIP)*, MENTAL HEALTH AMERICA (2011) http://www.nmha.org/go/schip.

[131] *Id.*; N.Y. INS. LAW § 4235(f)(4)(G) (McKinney 2012).

parent at such a young age,[132] these children may also be financially affected. Women who are older and have a desire to conceive a child are likely nearing retirement, and as such their disposable income diminishes.[133] With substantially less disposable income than at a time when working full time, it becomes much more difficult to support and provide for a child.

While these factors have some weight in determining whether a couple or individual should conceive later in life, it is not a decision that insurance companies should decide for potential parents. This should be left to the discretion of the mother who is attempting to conceive.

D. Best Interests of the Child: Against

"'People feel that it's not fair to the child because you may not live long enough,'" said Dardick, a mother who conceived her first child at age fifty-one in Florida.[134] "But as someone who lost a father as a teenager, she knows '*there are no guarantees in life*.'"[135] Dardick and her husband understand that their age is not ideal.[136] However, they are taking the necessary precautions by adjusting financially and tightening bonds with their extended family in the event anything happens to either of them.[137]

If women are made aware of and consult a physician regarding their life expectancy, the financial impact of having a child, and other risk factors when considering a pregnancy later in life, there should be no reason for an insurance company to inhibit that right. After being informed by their physician of the potential risks and other factors that should be taken into account, women should be able to plan accordingly *themselves*. It is up to the treating physician to inform his or her patient of the potential risks and it is for the patient to decide herself, based on that information, whether to conceive. It is not for insurance companies to impose their opinions, through statutory provisions, on the age at which a woman *should* have a child—making "her

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[132] *See* Kelly, *supra* note 122 (describing a number of psychological issues that accompany parental deaths).

[133] *Retirement Planner: Full Retirement Age*, SOC. SEC. ADMIN., http://www.ssa.gov/retire2/retirechart.htm (last modified Oct. 18, 2012).

[134] Hare, *supra* note 107.

[135] *Id.* (emphasis added).

[136] *Id.*

[137] *Id.*

feel even guiltier about not having attempted childbirth at a younger age."[138]

As previously discussed, the most obvious reason women are waiting to bear children is their desire to establish themselves independently by attending undergraduate school and/or obtaining a postbaccalaureate degree.[139] In all likelihood, a woman who has focused on her career and has established stability in her life is mature and financially able to care for a child.[140] Women who bear children later in life have likely established their careers and have the ability to "begin working [at] home or negotiate for more flexible hours in the office, allowing for more time" to spend with their newborn.[141]

The older a woman is before becoming pregnant, the more time she has had to get to know herself and is more able to approach motherhood with a mature perspective and greater self-awareness.[142] Older women have much more wisdom, and may have a deeper understanding of who they are and the kind of parent they want to be, rather than falling into the same pattern of parenting as their own parents.[143]

In addition to the fact that women can be made aware of the possible risks,[144] are able to plan accordingly and are likely stable enough to do so,[145] women are also living longer than they were years ago.[146] The forty-year-olds of today are not the forty-year-olds of thirty years ago.[147] The life expectancy of a woman (at birth) for the total population is up from 49.2 years about 100 years ago to a record-high life expectancy for white females,

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138 *Older Women Pregnancy: CHR Special Contribution*, CTR. FOR HUMAN REPROD. (last updated Oct. 12, 2011), http://www.centerforhumanreprod.com/older_women_pregnancy_are_we_ready.html.

139 *See* Part III-A; NAT'L CTR. FOR EDUC. STATISTICS, *The Condition of Education 2012*, 36, U.S. DEP'T OF EDUC. (May 2012), *available at* http://nces.ed.gov/pubs2012/2012045.pdf (showing increasing rates of enrollment of women in postbaccalaureate programs).

140 *Tips for Parents: Older Parents*, THE LEARNING CMTY., http://www.thelearningcommunity.us/Portals/0/Tips%20for%20Parents/Tips%20for%20Parents_Older%20Parents.pdf (last visited Feb. 26, 2012).

141 Ginny Butler, *Motherhood at Any Age*, PREGNANCY AND NEWBORN MAG. (Nov. 7, 2011), http://www.pnmag.com/motherhood/motherhood-at-any-age-2.

142 *Id.*

143 *Id.*

144 Banh et al., *supra* note 89, at 369.

145 Butler, *supra* note 141.

146 *See* Hare, *supra* note 107 (explaining that many women now live well into their eighties).

147 *Id.*

reaching 80.5 years, and black females reaching 76.1 years.[148] In light of these statistics—it is reasonable to assume that if a woman conceives a child at age fifty, she will live to see the child reach the age of thirty, which is well beyond the age of majority.

Whether we are 25 or 45 when our children arrive, all moms have a shared goal: raising a happy, healthy child.[149] It is simply being aware of what you are choosing in order to give your child the best care and support you are able, and this is not a decision for an insurance company to make on behalf of mothers wanting to conceive later in life.[150]

IV. ARGUMENTS FOR & AGAINST RESTRICTING THE MARITAL STATUS

As noted in Part II, in Rhode Island a woman who has a desire to conceive a child must be *married* in order for insurance to cover the costs of fertility treatment.[151] This is also true in Arkansas, Hawaii, Maryland, as well as Texas.[152] Rhode Island's statute reads:

> (a) Any health maintenance organization service contract plan or policy delivered, issued for delivery, or renewed in this state, except a contract providing supplemental coverage to Medicare or other governmental programs, which includes pregnancy related benefits, shall provide coverage for medically necessary expenses of diagnosis and treatment of *infertility* for women between the ages of twenty-five (25) and forty-two (42) years . . . .
>
> (b) For the purpose of this section, "infertility" means the condition of an otherwise healthy *married individual* who is unable to conceive or sustain a pregnancy during a period of one year.
>
> (c) The health insurance contract may limit coverage to a lifetime cap of one hundred thousand dollars ($100,000).[153]

There is a trend of single parents raising children in the United States— "'[l]ove, marriage, and the baby carriage have

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[148] Laura B. Shrestha, *Life Expectancy in the United States*, CRS REPORT FOR CONGRESS, CRS-15 (2006), *available at* http://aging.senate.gov/crs/aging1.pdf.

[149] *See* Butler, *supra* note 141 (explaining the benefits and risks of pregnancy at any age).

[150] *See id.* (discussing the virtues of motherhood at an older age).

[151] *See supra* Part II-B; R.I. GEN. LAWS ANN. §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2012).

[152] ARK. CODE ANN. §§ 23-85-137 (West 2011), 23-86-118 (West 2012); HAW. REV. STAT. § 431:10A-116.5(a) (2012); MD. CODE ANN., INS. § 15-810 (West 2000); TEX. INS. CODE ANN. art. 1366.005 (West 2005).

[153] R.I. GEN. LAWS § 27-41-33 (emphasis added).

become unhitched.'"[154] Statistics have demonstrated that "21 percent of American households are married with children . . . down from approximately 24 percent in 2000 and 43 percent in 1950."[155] More and more Americans are less likely to say that a child needs a mother and a father living together to grow up happily.[156] Today, nearly a quarter of the seventy-five million children under age eighteen are living in a single-mother family.[157]

Experts state that because children born between 1981 and 2000 (the "Millennial Generation") grew up in nontraditional families—with half siblings, stepparents, stepsiblings, etc.—they believe that family is comprised of immediate family, extended family, as well as friends, rather than exclusively people who share the same DNA or are bonded by marriage.[158] Additionally, experts believe that "people are asking themselves about their hopes and dreams and applying them to their life *as they see fit*, whether it means being a single parent or having a baby with a partner you are committed to but haven't married[]"—arguably a more selfish generation.[159]

Some consider it unfair to force a child to grow up without a father because a woman is willing to forgo the traditional path in raising a child and instead resort to assisted reproductive technologies. Children with single parents are arguably emotionally and financially affected by a single parent household.[160] Such considerations may have been examined by insurance companies in drafting legislation.

A. Best Interests of the Child: For

A study from Sweden,[161] released in 2003, revealed that

[154] Elizabeth Foy Larsen, *The New American Family*, PARENTS MAG., (Oct. 2011), http://www.parents.com/ parenting/dynamics/family-statistics.

[155] *Id.*

[156] *Id.*

[157] MARK MATHER, POPULATION REFERENCE BUREAU, U.S. CHILDREN IN SINGLE-MOTHER FAMILIES 1, 1 (2010), *available at* http://www.prb.org/pdf10/single-motherfamilies.pdf.

[158] Larsen, *supra* note 154.

[159] *Id.* (emphasis added).

[160] *See* MATHER, *supra* note 157, at 2 (highlighting statistics that show that the majority of poor children in the United States come from single-mother households).

[161] Gunilla Ringbäck Weitoft et al., *Mortality, Severe Morbidity, and Injury in Children Living with Single Parents in Sweden: A Population-Based Study*, The LANCET 361, 289–95 (2003), *available at* http://www.lancet.com/

"children in one-parent homes are twice as likely as those in two-parent families to develop serious psychiatric problems and addictions later in life."[162] While there were elements of this study unaccounted for, such as "inner family details" including whether the parent was a widow, a divorcee, or a parent who never married,[163] it remains the largest, most intensive study done to date on the subject.[164] In particular a *father's* absence may produce "feelings of abandonment and stress" and, as such, it should not be a surprise that there is a higher prevalence of behavioral and psychological problems in children that grow up without a father.[165] Such physiological problems found in single-parent families include more aggressive behavior, depression, engagement in sexual behavior at a much younger age, violence, substance abuse, anti-social behavior, low self-esteem and higher use of mental health services.[166] Even if there are no *outstanding* psychological or psychiatric problems, many children living with a single-parent will have many questions and recognize that their situation is much different from others, which will likely have some sort of lasting impression and impact on a child later in life.[167]

Researchers in the United States have also found that single-

journals/lancet/article/PIIS0140-6736(03)12324-0/abstract. "Children with single parents showed increased risks of psychiatric disease, suicide or suicide attempt, injury, and addiction. After adjustment for confounding factors, such as socioeconomic status and parents' addiction or mental disease, children in single-parent households had increased risks compared with those in two-parent households for psychiatric disease in childhood . . . . Boys in single-parent families were more likely to develop psychiatric disease and narcotics-related disease than were girls, and they also had a raised risk of all-cause mortality . . . . Growing up in a single-parent family has disadvantages to the health of the child. Lack of household resources plays a major part in increased risks. However, even when a wide range of demographic and socioeconomic circumstances are included in multivariate models, children of single parents still have increased risks of mortality, severe morbidity, and injury." *Id.*

162 Emma Ross, *Single-Parent Kids More At Risk*, CBS NEWS (2009), http://www.cbsnews.com/ stories/2003/02/04/health/main539283.shtml.

163 *Id.*

164 *Id.*

165 Wendy Sigle-Rushton & Sara McLanahan, *Father Absence and Child Well-Being: A Critical Review*, CENTER FOR RESEARCH ON CHILD WELLBEING 1, 10 (2002) *available at* http://www.policyarchive.org/handle/10207/bitstreams/21760.pdf.

166 *Id.* at 10–12.

167 *See* Cary Rector & Tonja Rector, *Someone's Missing: A Child Needs An Explanation For An Absent Parent*, FAMILY TIMES, Aug. 29, 2011 (discussing techniques for single parents to use in answering their child's questions after the child's observations of their nontraditional family setting).

parent families are a major factor contributing to the increase in child-poverty, along with a slew of potential other problems later in life.[168] Such problems:

> have been shown to go beyond economics, increasing the risk of children dropping out of school, disconnecting from the labor force, and becoming teen parents [and though] many children growing up in single-parent families succeed, others will face significant challenges in making the transition to adulthood . . . [especially those] in lower-income, single-parent families . . . .[169]

Children of a single-parent household are less likely to remain in high school or attain higher educational qualifications, and those who grow up in mother-only families are more likely to experience unemployment and show a greater tendency to rely on public assistance in the future.[170]

Many of these problems may be attributed to a decrease in available resources—such as lower income and a decrease in adult supervision.[171] It is evident that the income of a single-parent family will likely be less than that of a household with two working parents. In the United States it has been found that "[m]ost single-mother families have limited financial resources available to cover children's education, child care, and health care costs."[172] "In 1992 approximately 45 percent of families with children headed by single mothers were living below the poverty line, as compared with 8.4 percent of families with two parents."[173] Further, because a single-parent must adequately provide for their child, or at least try to adequately provide without the help of a second income, a single-parent must forego a certain amount of involvement and time in their child's life in place of working to provide for their child's well-being. The time spent away from their child gives rise to unsupervised behavior, which if problematic and left unaddressed, may have lasting effects on the child's life.[174]

Given the fact that a child born into a single-parent family is

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168 MATHER, *supra* note 157, at 2.

169 *Id.* at 1.

170 Sigle-Rushton & McLanahan, *supra* note 165, at 7, 15.

171 MCLANAHAN & SANDEFUR, *supra* note 67, at 1. A decrease in parental supervision, involvement, and stability explains most of the negative impact of single-parent homes, however most of the negative effects disappear when there is adequate supervision, involvement, income, and stability. *See infra* Part IV-B.

172 MATHER, *supra* note 157, at 2.

173 MCLANAHAN & SANDEFUR, *supra* note 67, at 23.

174 Sigle-Rushton & McLanahan, *supra* note 165, at 8.

likely to face more adversity—psychologically and financially—it is apparent that the cost of treating psychological issues in the future and the cost, in general, for society to assist those who are more apt to become teen parents or struggle when entering the labor force substantially increases.[175]

B. Best Interests of the Child: Against

Consider this situation: a woman who is not married but cohabiting and committed to another individual, and has a desire to conceive a child with that particular person. Insurance coverage for this individual would be denied[176] because of the potential problems with a child—financial and psychological[177]—that often arise when there is only *one* individual raising the child. Look at Marsha, for example, a thirty-three year old who lives in Maryland with her domestic partner,[178] and is currently experiencing infertility issues, though luckily, she has insurance that covers fertility treatment costs.[179] However, she was denied coverage based on her domestic partnership—she was not married; "[s]ingletons, it turns out, simply don't meet the criteria."[180] As mentioned in Part IV, Maryland, as well as Arkansas, Hawaii, Rhode Island, and Texas all have insurance provision that mandate insurance companies cover or offer fertility treatments *only* to married couples.[181] Marsha must now come up with the funds to pay for the treatments, which costs $1,260 for a "cycle of IUI;" if those fail, she will need to pay about $27,000 for a "'package' of six IVF cycles."[182] If neither work, she will need even more treatments.[183] In order to afford the costs,

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[175] *See id.* at 2 ("Single mother families in the United States have high rates of poverty and rely disproportionately on public assistance.").

[176] *See* ARK. CODE ANN. §§ 23-85-137 (West 2011), 23-86-118 (West 2012); HAW. REV. STAT. § 431:10A-116.5(a) (2012); MD. CODE ANN., INS. § 15-810 (West 2000); TEX. INS. CODE ANN. art. 1366.005 (West 2005)
(giving examples of states that mandate insurance companies cover in vitro services only for married couples).

[177] *See supra* Part IV-A.

[178] Sarah Wildman, *Not Married? Your Insurance Might Not Cover Fertility Treatments: One Woman's Quest to Avoid a Ring But Have a Baby*, SLATE (2010), *available at* http://www.slate.com/articles/double_x/doublex_health/2010/03/not_married_your_insurance_might_not_cover_fertility_treatments.html; MD. CODE ANN., INS. § 15-810.

[179] Wildman, *supra* note 178.

[180] *Id.*

[181] *See supra* Part IV.

[182] Wildman, *supra* note 178.

[183] *Id.*

she may have to consider getting married.[184] Though Marsha is in a committed relationship, financially stable, and dedicated to having a child with her partner, she would essentially be *forced* into getting married, so that insurance would cover her costs.[185] And the irony is, that while Marsha and her partner are not married, that child would grow up in a loving, financially stable home with *both* parents.

So there is one scenario, but take for instance a woman who does not cohabit with another individual, but still wants to conceive a child of her own. She would be denied coverage based solely on the fact that she is without a partner.[186]

Section III[187] explains that in New York, courts have established factors that are considered in determining the 'best interests of a child' including:

> The quality of the home environment and the parental guidance the custodial parent provides for the child, the ability of each parent to provide for the child's emotional and intellectual development, the financial status and ability of each parent to provide for the child, [and] the relative fitness of the respective parents . . . .[188]

Taking into consideration the best interests of a child, "[e]ven though the challenges of raising children alone are tough, the vast majority of kids *do not* have . . . severe problems" and "[r]oughly 9 out of 10 teens and young adults don't have addiction or psychiatric problems serious enough for hospitalization."[189] As a researcher at Cornell University points out: "What matter[s] *most . . .* is a mother's education and ability level and, to a lesser extent, family income and quality of the home environment."[190] Most experts would agree that the *quality of parenting* is one of the most important factors influencing a child's future financial

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184 *Id.*

185 *See id.*; MD. CODE ANN., INS. § 15-810 (2000).

186 *See* ARK. CODE ANN. §§ 23-85-137 (West 2011), 23-86-118 (West 2012); HAW. REV. STAT. § 431:10A-116.5(a) (2012); MD. CODE ANN., INS. § 15-810 (West 2000); TEX. INS. CODE ANN. art. 1366.005 (West 2005).

187 *See supra* Part III.C.

188 Ekstra v. Ekstra, 912 N.Y.S.2d 592, 592 (App. Div. 2010) (quoting Salvatore v. Salvatore, 893 N.Y.S.2d 63, 64 (App. Div. 2009)).

189 Ross, *supra* note 162 (emphasis added).

190 Susan S. Lang, *On Mother's Day, A Hopeful Finding For Single Mothers and Their Children From a Cornell Researcher*, CORNELL NEWS (May 6, 2004), http://www.news.cornell.edu/releases/May04/single.parents.ssl.html (emphasis added).

and psychological issues.[191]

Seemingly, it is not so much whether a woman has the financial means or the mere fact that she is raising a child without a partner, but rather, *her parenting*—her desire and commitment to being a parent and raising the child to the best of her ability. It makes sense that a woman who is having a child later in life is more mature, likely better educated, and more committed to the responsibilities that come with raising a child, and would in all likelihood provide the best conditions she is able.

Additionally, the Cornell researcher found consistent links between maternal attributes, such as "education . . . positive child expectations, along with social resources supportive of parenting" and a child's school performance and behavior.[192] What it really comes down to is the kind of parenting and how involved and dedicated one is in raising a child.[193] As one single mother points out:

> [P]arenting skills are one of the main solutions here . . . [and while it] is hard being a single parent because you've got to take on dual roles . . . as long as the children know where they stand and as long as they know they are loved, it's probably OK . . . I try to tell my girls every day that I love them.[194]

While there have been studies to show that living with just one parent increases the risk of negative outcomes in children:[195]

> [I]t is not the only, or even the major, cause of them. Growing up with a single parent is just one among many factors that put children at risk of failure, just as lack of exercise is only one among many factors that put people at risk for heart disease.[196]

It seems as though having a child as a single parent is becoming less taboo as "[o]ver the past 20 years single-parent families have become even more common than the so-called 'nuclear family' consisting of a mother, father and children. Today we see all sorts of single parent families: headed by mothers, headed by fathers, headed by a grandparent raising their grandchildren."[197] Even the media has portrayed single

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[191] *See* Ross, *supra* note 162 (describing experts' views on the causes of children's issues).

[192] Lang, *supra* note 190.

[193] *See* Ross, *supra* note 162 (discussing the strong association between the quality of a parent and the development of the child).

[194] *Id.*

[195] *See supra* Part IV-A.

[196] MCLANAHAN & SANDEFUR, *supra* note 67, at 2.

[197] *Single Parenting and Today's Family*, AM. PSYCHOL. ASS'N, http://www.apa.org/helpcenter/single-parent.aspx (last visited Feb. 15, 2013).

parent families in a positive light.[198] Jennifer Aniston in a recent film, The Switch, portrays a single woman who chooses to conceive through assisted reproductive technologies.[199] Aniston stated she was happy science has allowed more options for women who have a desire to conceive later in life, and perhaps without a partner.[200]

While there are greater chances of adverse psychological and financial effects with children growing up in single-parent households,[201] the key to mitigating such adversity lies in simply informing single-parent families of the potential risks and ensuring the parents understand such risks.[202] As long as an individual is made aware and has an appreciation of *possible* effects, the options science has allowed for, as Aniston mentioned,[203] should not be obstructed.

Insurance companies should not be allowed to limit the options that science has so remarkably made available to women. *Everyone* has the right to be a parent. Whether twenty-five or fifty-five; whether married or single; whether Caucasian, African-American, or Asian—it is *our right*, a gift really, embedded in the Constitution of the United States, to bear and raise children in the manner we so choose.[204]

V.14TH AMENDMENT ISSUES—RIGHT TO BE A PARENT & COST SAVINGS FOR INSURANCE COMPANIES

In 1923, the United States Supreme Court held that a parent's right to direct upbringing of one's children is a fundamental

198 THE SWITCH (Miramax 2010).

199 *Id.* Aniston, commenting on the movie, stated that she does not feel that there are any restrictions on what type of family can raise a healthy child and that "[t]he point of the movie is, what is it that defines family? It isn't necessarily the traditional mother, father, two children and a dog named Spot . . . [l]ove is love and family is what is around you and who is in your immediate sphere." Parimal M. Rohit, *Film Review: 'The Switch' A modern Romantic Movie That Perhaps Probes Deeper Than Others*, BUZZINEFILM.COM (Aug. 19, 2010), http://www.buzzinefilm.com/reviews/film-review-switch-08202010.

200 Kay S. Hymowitz, *Just What Are "Choice Mothers" Settling For?*, THE EXAMINER (Aug. 18, 2010), http://www.manhattan-institute.org/html/miarticle.htm?id=6462.

201 *See supra* Part III-A

202 MCLANAHAN & SANDEFUR, *supra* note 67, at 144–45.

203 *See* Hymowitz, *supra* note 200 (citing Aniston's comment referring to the reproductive options available to single middle aged women).

204 *See* Meyer v. Nebraska, 262 U.S. 390, 399–400 (1923) (finding a liberty interest in the right to "bring up children").

liberty that is protected by the Constitution.[205] Underlying this right and decisional freedom of a parent in raising his or her child, as they see fit, is the presumption that a parent is in the best position to know what is in the best interests of his or her children.[206] The Supreme Court has explicitly stated that "the Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a 'better' decision could be made."[207] While this has been deemed a fundamental right, the Constitutional protections of parental rights will not be upheld where a parent has failed to adequately perform parental responsibilities.[208] As such, the Court has refused to extend their rights under the 14th Amendment *only* where a parent has failed to establish a relationship with the child, or provide emotional or financial support.[209] Given this, a parent should have at least a chance to create life before they are burdened with restrictions on insurance coverage.

This nation has recognized that there is a fundamental right for every individual to raise their children as they so choose and in the way they see fit; and that right, absent tenuous circumstances, should not be infringed upon.[210] Whether single or married, twenty-one or fifty-five, based on this fundamental right to raise a child, the decision to bear children whenever and however, should be up to the individual and not an insurance company. Insurance companies could arguably defend the legislation, reasoning that they are not inhibiting one's right to become a parent because individuals are still able to receive fertility treatments; however, for some who are without any sort of IVF coverage, the financial burdens of infertility treatments are too costly an option, thereby rending financial assistance from their insurance provider a *necessity*.[211] As such, an

[205] *Id.*

[206] Troxel v. Granville, 530 U.S. 57, 68–69 (2000) (citations omitted).

[207] *Id.* at 72–73.

[208] *See* Lehr v. Robinson, 463 U.S. 248, 261–63 (1983) (stating that more than a biological connection between a parent and child is required for Constitutional protection of parental rights).

[209] *See id.* at 267–68 (emphasis added) (explaining that the parent must effectively accept the responsibility of being a parent in order to receive protection).

[210] *Troxel*, 530 U.S. at 72–73.

[211] *See The Debate Marches On: Should Infertility Coverage Be Considered an "Essential" Health Benefit?* RESOLVE: THE NATIONAL INFERTILITY ASSOCIATION (Feb. 15, 2013, 11:08 PM), http://www.resolve.org/family-building-

argument by insurance companies that they are not "inhibiting" the fundamental right to become a parent seems entirely unfair.

Not only is it a fundamental right, embedded in the Constitution of the United States, but insurance companies may ultimately *save* money by including infertility treatment in their coverage provisions, which evidently appears to be the greatest concern for insurance companies.[212]

Insurance companies argue that the mandated coverage for infertility treatment will ultimately increase premiums; however studies have demonstrated that this belief is unfounded.[213] There was a study performed in Massachusetts which found that "[e]xpenditures for infertility services increased at a rate similar to or slower than inflation" and "[i]nfertility services accounted for [only] 0.41% of total expenditures within the . . . plan . . . [which was] approximately [a] $1.71 per contract [per] month [increase]" and as such the study concluded that "[m]andated infertility coverage was associated with increased use of ART *but not with excessive increases in consumer cost* for infertility insurance coverage."[214] Further studies have shown that 91% of employers, when asked if infertility treatment coverage resulted in "measurable, significant increase[s] in health plan cost[s]" said there were not significant increases.[215] Other studies have also demonstrated that "infertility coverage may actually reduce premium[s] . . . [by eliminating] unnecessary procedures such as tubal surgery . . .[216] [as well as] improv[ing] quality controls,

options/insurance_coverage/the-debate-marches-on-should-infertility-coverage-be-considered-an-essential-health-benefit.html (stating that infertility is considered a disease that requires medical treatment, and should be classed with other diseases covered by health insurance).

[212] *See supra* notes 20, 205–10 and accompanying text.

[213] Letter in support of Senate Bill No. 615–Relating to Infertility Problems from David Hood, to Comm. on Health, Judiciary and Labor (on file with Haw. Dep't of Commerce and Consumer Affairs), *available at* http://www.capitol.hawaii.gov/session2011/testimony/SB615_TESTIMONY_HTH-JDL_02-04-11.pdf (discussing studies that have shown insurance coverage for fertility may actually decrease premiums).

[214] Martha Griffin & William F. Panak, *The Economic Cost of Infertility-Related Services: An Examination of the Massachusetts Infertility Insurance Mandate*, 70 FERTILITY AND STERILITY 22, 22 (1998), *available at* http://www.fertstert.org/article/S0015-0282(98)00107-1/abstract (emphasis added).

[215] MERCER HEALTH & BENEFITS, EMPLOYER EXPERIENCE WITH, AND ATTITUDES TOWARD, COVERAGE OF INFERTILITY TREATMENT (2006).

[216] *See generally* WEBMD, *Fallopian Tube Procedures for Infertility* (Mar. 19, 2010), http://www.webmd.com/infertility-and-reproduction/fallopian-tube-procedures-for-infertility ("A fallopian tube blockage typically prevents

[which would potentially] reduce higher order multiple births and their accompanying costs."[217] Not only that, but "reproduction produces additional years of high-quality life[]"[218] in that child bearing will potentially restore the mental health of the infertile individual and additionally, assuming IVF treatment is successful and results in a healthy newborn.[219] Accordingly, it appears that covering fertility costs would ultimately *save costs*—and allow for more women and couples to pursue their fundamental right to become a parent.

VI. CONCLUSION

Jody, fortunately, did not have to resort to fertility treatment. She was able to have two healthy baby girls in her life. However, her tragic experiences throughout her late twenties and early thirties left a lasting impact on her. Today, she helps others reach their dreams of becoming parents. She works at a fertility clinic in Syracuse, New York—CNY Fertility. She has seen firsthand the great lengths couples, desperate to have children, will go through. She has seen the despair and mental anguish that comes with infertility.

Insurance companies should not have the authority to be making decisions on whether an individual is fit to be a parent based *solely* upon what age the individual is and what kind of marital status an individual has. To raise children in the manner one chooses is the right of the individual who is conceiving—not an insurance company, not the legislature, not the courts. It is not the job of insurance companies to impose their views on how they believe society should raise their children. While there are risks associated with pregnancy later in life, this decision is one meant for the woman conceiving, as it will impact her and the

successful passage of the egg to the sperm, or the fertilized egg to the uterus. Surgery can be used to try to correct this common cause of infertility. The specific type of surgery depends on the location and extent of the fallopian tube blockage.").

[217] *See* Letter in support of Senate Bill No. 615, *supra* note 213; Richard E. Blackwell & The William M. Mercer Actuarial Team, 182 AMERICAN J. OF OBSTETRICS & GYNECOLOGY 891, 895 (2000) (discussing that "under a well-managed infertility treatment program" hidden costs would not be as high, since couples would not seek out "shortcut" treatments which usually result in multiple births).

[218] David Orentlicher, *Discrimination Out of Dismissiveness: The Example of Infertility*, 85 IND. L.J. 143, 183 (2010).

[219] *Id.*

child she will be raising. To hinder a right so ingrained in our culture is indisputably unfair.

"'[O]f all the rights women possess, the greatest is to have a child."[220]

[220] Press Release, Dona Bertarelli-Spaeth, The Bertarelli Foundation, The Public Attitude to Infertility (May 7, 2001) (on file with PR Newswire Ass'n. Inc.) (quoting Lin Yutang).