Georgetown Journal on Poverty Law and Policy
Volume XXV, Number 2, Winter 2018

Inconceivable: How Barriers to Infertility Treatment for Low-Income Women Amount to Reproductive Oppression

Madeline Curtis*

* J.D. Candidate, Georgetown University Law Center (2019); B.S., Georgetown University, Healthcare Management and Policy. The author wishes to thank Jill Morrison, Danielle Curtis, Mike Rosenblatt, and the staff of the *Georgetown Journal on Poverty Law and Policy* for their invaluable advice and suggestions for this Note.

I. INTRODUCTION

If told that treatment for one of the most common diseases for people between the ages of twenty and forty-five costs several thousands of dollars, is usually not required to be covered by insurance companies in the United States, and is inaccessible to most low-income women, many Americans would be incredulous. This, however, is the case.[1] Although not often discussed or made public, infertility affects millions of Americans each year.[2] According to the American Society for Reproductive Medicine, infertility is the result of a disease of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.[3] Affecting between ten and fifteen percent of couples,[4] about one-third of infertility cases are attributed to the female partner, one-third are attributed to the male partner, and one-third are caused by a combination of problems in both partners or unexplained reasons.[5]

To many, having a child is central to attaining the American dream, standing alongside life goals like finding a partner and owning a home.[6] As a district court noted in *Pacourek v. Inland Steel Co.*, "[m]any, if not most, people would consider having a child to be one of life's most significant moments and greatest achievements, and the inability to do so, one of life's greatest disappointments."[7] The loss of this ability, coupled with the uncertain success of different treatment options, can lead to an enormous psychological toll that is similar to grief felt after significant loss.[8] Those struggling to have a baby may experience feelings of grief, shock, numbness, anger, and shame.[9] One study of couples seeking treatment at a fertility clinic found that half of the women and fifteen percent of the men said that struggling to conceive was the most upsetting experience of their lives.[10] Another study found that women with infertility felt as anxious or depressed as those diagnosed with cancer or hypertension or recovering from a heart attack.[11]

---

1. AM. SOC'Y FOR REPROD. MED., DEFINING INFERTILITY (2014), http://www.reproductivefacts.org/globalassets/rf/news-and-publications/bookletsfact-sheets/english-fact-sheets-and-info-ooklets/defining_infertility_factsheet.pdf; *Insurance Coverage in Your State*, RESOLVE, http://resolve.org/what-are-my-options/insurance-coverage/coverage-state/ (last visited Jan. 15, 2018).

2. ANJANI CHANDRA ET AL., INFERTILITY SERVICE USE IN THE UNITED STATES: DATA FROM THE NATIONAL SURVEY OF FAMILY GROWTH, 1982–2010 (2014), https://www.cdc.gov/nchs/data/nhsr/nhsr073.pdf.

3. *Infertility*, AM. SOC'Y FOR REPROD. MED., http://www.reproductivefacts.org/topics/topics-index/infertility/ (last visited Jan. 15, 2018).

4 . *Infertility*, MAYO CLINIC, http://www.mayoclinic.org/diseases-conditions/infertility/home/ovc-20228734 (last visited Jan. 15, 2018); *see also* AM. SOC'Y FOR REPROD. MED., *supra* note 1.

5. *Infertility*, NAT'L INSTS. OF HEALTH, https://medlineplus.gov/infertility.html (last visited Jan. 15, 2018).

6. *See* LIFESTORY RESEARCH, THE AMERICAN DREAM: A STATE OF MIND 15–16 (2015), http://lifestoryresearch.com/wp-content/uploads/2015/05/Lifestory_Research_2015_American_Dream_Report.pdf.

7. Pacourek v. Inland Steel Co, 916 F. Supp. 797, 804 (N.D. Ill. 1996).

8. *The Psychological Impact of Infertility and Its Treatment*, HARV. HEALTH PUBL'NS (2009), http://www.health.harvard.edu/newsletter_article/The-psychological-impact-of-infertility-and-its-treatment (last visited Jan. 20, 2018).

9. *Id.*

10. *Id.*

11. *Id.*

The World Health Organization, the American Society for Reproductive Medicine, and the American College of Obstetricians and Gynecologists all recognize infertility as a disease.[12] However, treatment for this disease is not routinely covered by health insurance, and in states where insurance does cover some or all infertility treatments, barriers often exist that make it difficult for all who wish to have children to access care.[13] Given that many therapies to assist those struggling with infertility can cost thousands of dollars, this lack of insurance coverage can be a dead end for many who want to become parents, especially low-income women.[14]

This Note will demonstrate how low-income women may have a higher risk of infertility and how the combination of the high cost of treatment, a lack of routine insurance coverage, and the existence of societal barriers to treatment disproportionately affects those with a low socioeconomic status.[15] Further, it will argue that because the Supreme Court has recognized the right to reproduce as one fundamental to American values, lack of access to infertility therapies today amounts to discriminatory reproductive oppression.[16]

II. THE LANDSCAPE OF INFERTILITY

A. The Types of Fertility Treatments

According to the Centers for Disease Control and Prevention's (CDC) National Survey of Family Growth, about twelve percent of women aged fifteen through forty-four experience problems in either becoming pregnant or carrying a pregnancy to term.[17] The American Society for Reproductive Medicine recommends that those trying to conceive should seek the care of a specialist if they are unable to achieve pregnancy after twelve months of unprotected intercourse and the woman is under the age of thirty-five or after six months if the woman is over thirty-five.[18] There are many causes of infertility, including problems with ovulation, blocked fallopian tubes, abnormal sperm, and age.[19] The types of services available to those struggling with infertility are as numerous and varied as the underlying reasons for infertility.

---

12. Fernando Zegers-Hochschild et al., *International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) Revised Glossary of ART Terminology*, 92 FERTILITY & STERILITY 1520, 1522 (2009); Samantha Pfeifer et al., *Definitions of Infertility and Recurrent Pregnancy Loss: A Committee Opinion*, 99 FERTILITY & STERILITY 63, 63 (2012).

13. *See infra* Part IV.

14. *See infra* Part IV Section B.

15. *See infra* Part IV.

16. *See infra* Part V.

17. *Key Statistics from the National Survey of Family Growth: I Listing*, NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nsfg/key_statistics/i.htm (last visited Jan. 15, 2018).

18. AM. SOC'Y FOR REPROD. MED., INFERTILITY: AN OVERVIEW 3 (2012), http://www.reproductivefacts.org/globalassets/rf/news-and-publications/bookletsfact-sheets/english-fact-sheets-and-info-booklets/booklet_infertility_an_overview.pdf.

19. *Id.* at 6–14.

Twelve percent of women aged fifteen to forty-four (7.3 million) or their husbands or partners sought infertility services from 2006 to 2010.[20] The first step for a couple experiencing infertility is for each partner to undergo a physical examination to determine their general state of health.[21] If this examination does not reveal the cause of infertility, medical professionals recommend additional tests that analyze a woman's body temperature and reproductive organs and a man's semen.[22] Once infertility is diagnosed, many treatment options are available based on the underlying cause of the infertility.[23] As of 2014, about half of those who seek an infertility evaluation undergo fertility treatment.[24]

For men, treatment options include altering lifestyle and behavioral factors like reducing consumption of harmful substances, establishing regular exercise, and improving frequency and timing of intercourse.[25] Medical professionals may recommend medications to improve a man's sperm count or increase testicular function, including sperm production and quality.[26] Some conditions may require surgery to reverse sperm blockage or repair a varicocele,[27] a condition that is a common cause of low sperm production and decreased sperm quality.[28] Sperm retrieval techniques may also be appropriate when there are problems with ejaculation or when there is no sperm present in the ejaculated fluid.[29]

For women, infertility treatment can include prescription drugs that stimulate or regulate ovulation.[30] Surgeries like hysteroscopies, laparoscopies, and micro-surgeries may also be appropriate to treat endometriosis, fibroids, and blocked fallopian tubes.[31] For women with cervical factor infertility, artificial insemination, also known as intrauterine insemination, may be used to process and concentrate sperm prior to placement in the uterus.[32]

Most cases of infertility (between eighty five and ninety percent) can be treated with therapies like drug treatment or surgery.[33] However, when these treatments

---

20. CHANDRA ET AL., *supra* note 2, at 9.

21. *FAQs About Infertility*, *Q03: How Is Infertility Diagnosed?*, AM. SOC'Y FOR REPROD. MED., http://www.reproductivefacts.org/faqs/frequently-asked-questions-about-infertility/03-how-is-infertility-diagnosed/ (last visited Jan. 15, 2018).

22. *Id.*; *see also* AM. SOC'Y FOR REPROD. MED., DIAGNOSTIC TESTING FOR FEMALE INFERTILITY FACT SHEET (2012), http://www.reproductivefacts.org/globalassets/rf/news-and-publications/bookletsfact-sheets/english-fact-sheets-and-info-booklets/diagnostic_testing_for_female_infertility_factsheet.pdf.

23. *Infertility Treatment*, MAYO CLINIC, http://www.mayoclinic.org/diseases-conditions/infertility/diagnosis-treatment/treatment/txc-20228794 (last visited Jan. 15, 2018).

24. Kate Devine et al., *The Affordable Care Act: Early Implications for Fertility Medicine*, 101 FERTILITY & STERILITY 1224, 1224 (2014).

25. *Infertility Treatment*, *supra* note 23.

26. *Id.*

27. *Id.*

28. *Varicocele, Definition*, MAYO CLINIC, http://www.mayoclinic.org/diseases-conditions/varicocele/basics/definition/con-20024164 (last visited Jan. 15, 2018).

29. *Infertility Treatment*, *supra* note 23.

30. *Id.*

31. *Fertility Treatments 101*, HRC FERTILITY, http://www.havingbabies.com/infertility-treatment/fertility-treatments-101/ (last visited Jan. 15, 2018).

32. *Id.*

33. *FAQs About Infertility*, *Q04: How Is Infertility Treated?*, AM. SOC'Y FOR REPROD. MED., http://www.reproductivefacts.org/faqs/frequently-asked-questions-about-infertility/q04-how-is-infertility-treated/ (last visited Jan. 20, 2018).

are either unavailable or unsuccessful, many turn to assisted reproductive technology (ART).[34] ART includes all fertility treatments in which both the eggs and the embryos are handled.[35] Usually this means surgically removing eggs from a woman's ovaries, combining those eggs with sperm in a laboratory, and then returning the fertilized embryos to the woman's body or donating them to another woman who will act as a surrogate.[36] CDC estimates that ART accounts for slightly less than two percent of total US births,[37] but since 1985 more than one million babies have been born from ART procedures performed in the United States.[38]

In vitro fertilization (IVF) is the most common and most effective form of ART, but the success of the procedure depends on several factors including age, cause of infertility, and number of embryos transferred.[39] The IVF process is complex, takes several weeks to complete, and women often need multiple cycles in order to become pregnant.[40] Data from the CDC shows that about 36% of IVF cycles result in pregnancy and 29.4% result in live births.[41] IVF is commonly discontinued after three or four unsuccessful cycles, yet a recent study found that the success rate after six cycles jumps to 65.3%, with variations by age and treatment type.[42] The costs of the procedure, however, often prohibit women from becoming pregnant.

B. Costs of Fertility Treatments and Current Insurance Coverage

Lower cost and less complex interventions like advice (29%), testing (27%), and ovulation medications (20%) account for the majority of common medical services received by women with fertility problems.[43] More complicated and expensive procedures like intrauterine insemination (7%), surgery for blocked

---

34. *See* Sarah Elizabeth Richards, *Skipping Baby Steps*, SLATE (Nov. 20, 2007), http://www.slate.com/articles/health_and_science/medical_examiner/2007/11/skipping_baby_steps.html.

35. *Assisted Reproductive Technology, What is Assisted Reproductive Technology?*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/art/whatis.html (last visited Jan. 15, 2018).

36. *Id.*

37. CTRS. FOR DISEASE CONTROL & PREVENTION, ASSISTED REPRODUCTIVE TECHNOLOGY NATIONAL SUMMARY REPORT 7 (2014), https://www.cdc.gov/art/pdf/2014-report/art-2014-national-summary-report.pdf.

38. Press Release, Am. Soc'y for Reprod. Med., SART Data Release: 2015 Preliminary and 2014 Final (May 1, 2017), http://www.reproductivefacts.org/news-and-publications/news-and-research/press-releases-and-bulletins/SART_Data_Release_2015_Preliminary_and_2014_Final/.

39. *In Vitro Fertilization*, MAYO CLINIC, http://www.mayoclinic.org/tests-procedures/in-vitro-fertilization/home/ovc-20206838 (last visited Jan. 15, 2018); *Success Rates*, SOC'Y FOR ASSISTED REPROD. TECH., http://www.sart.org/SART_Success_Rates/ (last visited Jan. 15, 2018).

40. *ART: Step-By-Step Guide*, SOC'Y FOR ASSISTED REPROD. TECH., http://www.sart.org/ART_Step-by-Step_Guide/ (last visited Jan. 15, 2018); Ellie Kincaid, *The Success Rates of 'Test Tube Babies' Are Nowhere Near What People Think*, BUSINESS INSIDER (May 28, 2015, 6:34 PM), http://www.businessinsider.com/in-vitro-fertilization-ivf-success-rates-2015-5.

41. Kincaid, *supra* note 40.

42. Andrew D.A.C. Smith et al., *Live-Birth Rate Associated with Repeat In Vitro Fertilization Treatment Cycles*, 314 JAMA 2654, 2654 (2015).

43. CTRS. FOR DISEASE CONTROL & PREVENTION, NATIONAL PUBLIC HEALTH ACTION PLAN FOR THE DETECTION, PREVENTION, AND MANAGEMENT OF INFERTILITY 5 (2014), https://www.cdc.gov/reproductivehealth/infertility/pdf/drh_nap_final_508.pdf.

tubes (3%), and ART (3%) are less commonly used.[44] The cost of hormone therapy can range from $200 to $3,000 per cycle, while tubal surgery costs about $10,000 to $15,000.[45] IVF is very expensive, with the average cost of one cycle totaling about $10,000 to $20,000 with just a thirty percent chance of success.[46] A survey reported in the *Wall Street Journal* found that about seventy percent of women who turn to IVF go into debt.[47] Medical side effects coupled with the financial stress of paying for infertility treatment and the emotional anxiety of the uncertainty of success can lead to emotional, physical, and financial exhaustion.[48]

Because the costs of infertility treatment, especially IVF, are so high, many turn to their insurance company to cover the cost of treatment. Insurance coverage of infertility diagnosis and treatment, however, varies widely based on what state the individual lives in and what type of insurance plan he or she has.[49] Because infertility treatment is not considered an "Essential Health Benefit" that plans must cover under the Affordable Care Act,[50] it is up to states to decide whether or not to mandate insurance coverage of treatment.[51] Fifteen states currently have laws requiring insurance coverage for infertility treatment, but the scope of this coverage varies greatly, ranging from coverage of fertility testing alone to coverage of multiple cycles of IVF.[52] Some of these states only require that insurance companies *offer* policies that cover infertility treatment, while others *require the inclusion* of infertility treatment as a benefit in every plan offered.[53] Several of the states that mandate insurance coverage of infertility treatment do not require religious organizations, small businesses, or employers who self-insure to offer coverage.[54] A study conducted in 2013 found that sixty-five percent of businesses with more than 500 employees will pay for an initial evaluation by a fertility specialist and forty-one percent will cover drug therapies, while just twenty-seven percent cover IVF.[55]

---

44. *Id.*

45. Marianne P. Bitler & Lucie Schmidt, *Utilization of Infertility Treatments: The Effects of Insurance Mandates* 8 (Nat'l Bureau of Econ. Research, Working Paper No. 17668, 2011), http://www.nber.org/papers/w17668.pdf.

46. Jennifer Gerson Uffalussy, *The Cost of IVF: 4 Things I Learned While Battling Infertility*, FORBES (Feb. 6, 2014, 3:00 PM), https://www.forbes.com/sites/learnvest/2014/02/06/the-cost-of-ivf-4-things-i-learned-while-battling-infertility/; *US Women Go into Debt for IVF*, KENNEDY INST. OF ETHICS, https://bioethics.georgetown.edu/2015/05/us-women-go-into-debt-for-ivf/ (last visited Jan. 15, 2018); Kincaid, *supra* note 40.

47. *US Women Go into Debt for IVF*, *supra* note 46.

48. *Preparing for IVF: Emotional Considerations*, SOC'Y FOR ASSISTED REPROD. TECH., http://www.sart.org/Preparing_for_IVF_Emotional_Considerations/ (last visited Jan. 15, 2018).

49. *FAQs About Infertility*, *Q08: Do Insurance Plans Cover Infertility Treatment?*, AM. SOC'Y FOR REPROD. MED., http://www.reproductivefacts.org/faqs/frequently-asked-questions-about-infertility/q08-do-insurance-plans-cover-infertility-treatment/ (last visited Jan. 15, 2018).

50. Uffalussy, *supra* note 46.

51. *The Affordable Care Act and Infertility*, RESOLVE, http://web.archive.org/web/20170710044517/http://www.resolve.org/get-involved/the-center-for-infertility-justice/public-policy/the-affordable-care-act-and-infertility.html (last visited Jan. 15, 2018).

52. *Insurance Coverage in Your State*, *supra* note 1.

53. Bitler & Schmidt, *supra* note 45, at 8–9.

54. *Insurance Coverage in Your State*, *supra* note 1.

55. Tara Siegel Bernard, *Insurance Coverage for Fertility Treatments Varies Widely*, N.Y. TIMES (July 26, 2014), https://nyti.ms/2lO50aX.

The states that mandate insurance coverage for infertility treatment all have varying requirements that a patient seeking to have a baby must meet in order to qualify for coverage.[56] For example, most states define infertility by specifying how long a woman must have been having unprotected sexual intercourse without conceiving before she qualifies for coverage of treatment.[57] In states like New York, this amounts to one year for patients under thirty-five and six months for patients over thirty-five, while in states like Texas the requirement is five years; other states do not specify a time period.[58] Several states require that the patient be married and that the patient's eggs be fertilized with her spouse's sperm.[59] Others specify certain medical conditions that must be the cause of the infertility in order for treatment to be covered or require that patients pay out of pocket for failed attempts at artificial insemination before other treatments are covered.[60] Many states place an age limit on infertility treatment, only providing coverage to women under the age of forty, forty-four, or forty-six.[61]

These various limitations, coupled with the high costs of IVF and other treatments, disproportionately affect those in poverty. This Note will explore how these requirements, as well as numerous other barriers to infertility care, disproportionately affect low-income women.

III. LOW-INCOME WOMEN AND THE CUMULATIVE EFFECT

Compounding the burden of the high cost of treatment, the poor may be more likely to be infertile.[62] While there is no direct evidence that those with a lower socioeconomic status are more likely to be infertile, there is evidence that, controlling for age, infertility rates decline with increased educational attainment—and because socioeconomic status tends to correlate with education levels, populations with higher educational attainment often have higher incomes.[63] Other evidence suggests that more affluent states have a lower percentage of infertile women as compared to less affluent states.[64] Further, both Hispanic and African-American women are more likely to experience infertility than white women.[65] Because minority families are more likely to be low-income,

56. *Insurance Coverage in Your State*, *supra* note 1.

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*; Bernard, *supra* note 55.

61. *Insurance Coverage in Your State*, *supra* note 1.

62. *See generally* ANN V. BELL, MISCONCEPTION: SOCIAL CLASS AND INFERTILITY IN AMERICA (2014); Liza Mundy, *A Special Kind of Poverty*, WASH. POST MAG., Apr. 20, 2003.

63. U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, INCOME AND POVERTY IN THE UNITED STATES: 2014 16 (2015), https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf; Marianne Bitler & Lucie Schmidt, *Health Disparities and Infertility: Impacts of State-Level Insurance Mandates*, 85 FERTILITY & STERILITY 858, 861 (2006).

64. Bitler & Schmidt, *supra* note 45, at 8.

65. *Id.*

these populations are doubly at risk for infertility and often bear more of the burdens associated with seeking infertility treatment.[66]

This discrepancy in infertility rates may be due to the "cumulative effect" of infertility. Underlying medical conditions and environmental circumstances put women at risk for infertility, and without consistent access to high-quality health care, these issues may be untreated and cumulatively result in the inability to conceive a child.[67] Infertility has a myriad of causes, with medical, environmental, and genetic factors all playing a role. Low-income and minority women are more likely to be exposed to many of these factors and, as a result, experience infertility.[68]

A. Underlying Medical Conditions

Several underlying medical conditions that contribute to infertility are prevalent in low-income women. According to the CDC, polycystic ovary syndrome (PCOS) is the leading cause of infertility for women.[69] Research has found that women who had a low socioeconomic status during childhood were at an increased risk of PCOS.[70] While PCOS affects women of all races, obese women are more likely to develop PCOS,[71] and data shows that low-income women are more likely to experience obesity.[72] In addition to body weight affecting a woman's risk of developing PCOS, body weight can affect both estrogen levels and the pituitary gland, leading to problems with ovulation.[73] According to the American Society for Reproductive Medicine, twelve percent of infertility cases are caused by the woman being overweight or underweight.[74] Obese women are also more likely than women of normal weight to experience a miscarriage.[75] Because low-income women are more likely to engage in adverse health behaviors like lack of physical activity and consuming a diet of poor

66. DEBORAH POVICH ET AL., THE WORKING POOR FAMILIES PROJECT, LOW-INCOME WORKING FAMILIES: THE RACIAL/ETHNIC DIVIDE 1 (2015), http://www.workingpoorfamilies.org/wp-content/uploads/2015/03/WPFP-2015-Report_Racial-Ethnic-Divide.pdf.

67. *See infra* Part III Sections A–B.

68. *See id.*

69. *Infertility FAQs*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/infertility/ (last visited Jan. 15, 2018).

70. Sharon Stein Merkin et al., *Socioeconomic Status and Polycystic Ovary Syndrome*, 20 J. WOMEN'S HEALTH 413, 415–18 (2011).

71. *Polycystic Ovary Syndrome*, WOMENSHEALTH.GOV, https://www.womenshealth.gov/a-z-topics/polycystic-ovary-syndrome (last visited Jan. 15, 2018).

72. Eric Zuehlke, *For Women in the U.S., Obesity Links to Socioeconomic Status and Poor Diet*, POPULATION REFERENCE BUREAU (Apr. 2010), http://www.prb.org/Publications/Articles/2010/usobesity.aspx.

73. Amy Marturana, *The Top 7 Causes of Infertility in Women*, SELF (Mar. 3, 2016), http://www.self.com/story/top-causes-of-infertility-in-women; *Weight*, AM. SOC'Y FOR REPROD. MED., http://www.reproductivefacts.org/topics/topics-index/weight/ (last visited Jan. 15, 2018).

74. *FAQ Quick Facts About Infertility*, SOC'Y OF REPROD. SURGEONS, http://connect.asrm.org/srs/about/new-item9 (last visited Jan. 16, 2018).

75. *Weight and Fertility*, AM. SOC'Y FOR REPROD. MED., http://www.reproductivefacts.org/news-and-publications/patient-fact-sheets-and-booklets/fact-sheets-and-info-booklets/weight-and-fertility/ (last visited Jan. 20, 2018).

nutritional quality, they are more likely to be obese,[76] and therefore, more likely to experience infertility.[77]

Infections and growths in the reproductive system also affect fertility. Sexually transmitted diseases (STDs) like gonorrhea and chlamydia, when untreated, can cause damage to the fallopian tubes, uterus, and surrounding tissues, which can lead to infertility.[78] Data shows that low-income people are at a higher risk for contracting STDs.[79] In its *Sexually Transmitted Disease Surveillance Report* from 2015, the CDC suggests that this may be due to the fact that "people who struggle financially are often experiencing life circumstances that potentially increase their risk for STDs."[80] Uterine fibroids and other growths like polyps and cysts can also affect fertility.[81] Black women are nearly three times as likely to have fibroids as white women.[82] Considering poverty rates are particularly high for women of color, fibroids disproportionately affect low-income women.[83]

B. Environmental Factors

In addition to being at a higher risk of experiencing a medical condition that may affect fertility, low-income women are also more likely to experience environmental factors that put them at risk for infertility. Although more research is needed in the field, studies suggest that exposure to particular toxins like lead and the chemicals found in pesticides can negatively affect fertility.[84] Fertility specialists suggest taking measures to limit exposures to these chemicals like purchasing organic foods with less pesticide exposure, minimizing exposure to toxins in the workplace, and avoiding homes with lead-based paint.[85] However, for many low-income women, it is extremely difficult to evade contact with these toxins because low-income women are more likely than their well-off counterparts to work in a job where they are regularly exposed to chemical contaminants like

---

76. *See* Zuehlke, *supra* note 72.

77. *See* Eden R. Cardozo et al., *Knowledge of Obesity and Its Impact on Reproductive Health Outcomes Among Urban Women*, 38 J. COMMUNITY HEALTH 261 (2013).

78. *STDs & Infertility*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/std/infertility/default.htm (last visited Jan. 15, 2018).

79. Guy Harling et al., *Socioeconomic Disparities in Sexually Transmitted Infections Among Young Adults in the United States: Examining the Interaction Between Income and Race/Ethnicity*, 40 SEXUALLY TRANSMITTED DISEASES 575 (2014).

80. CTRS. FOR DISEASE CONTROL & PREVENTION, SEXUALLY TRANSMITTED DISEASE SURVEILLANCE 2015 69 (2015), https://www.cdc.gov/std/stats15/STD-Surveillance-2015-print.pdf.

81. *Fibroids and Polyps Overview*, FERTILITY AUTHORITY, https://www.fertilityauthority.com/fertility-issues/fibroids-polyps-symptoms-diagnosis-and-treatment (last visited Jan. 15, 2018).

82. Vanessa L. Jacoby et al., *Racial and Ethnic Disparities in Benign Gynecologic Conditions and Associated Surgeries*, 202 AM. J. OBSTETRICS & GYNECOLOGY 514, 514 (2010).

83. JASMINE TUCKER & CAITLIN LOWELL, NAT'L WOMEN'S L. CENT., NATIONAL SNAPSHOT: POVERTY AMONG WOMEN & FAMILIES, 2015 5 (2015), https://nwlc.org/wp-content/uploads/2016/09/Poverty-Snapshot-Factsheet-2016.pdf.

84. *Environmental and Occupational Factors Affecting Female Fertility*, INTERNET HEALTH RESOURCES, http://www.ihr.com/infertility/causes-of-female-infertility/environment-and-infertility.html (last visited Jan. 15, 2018).

85. Shona Murray, *Environmental Toxins' Effect on Fertility*, UNIV. OF COLO. ADV. REPROD. MED. (Sept. 29, 2014), https://arm.coloradowomenshealth.com/doctors-blog/environmental-toxins-affect-fertility.

formaldehyde and organic solvents that may adversely affect fertility.[86] Further, low-income women likely cannot afford to purchase organic foods with less pesticides or to live in a home that is not contaminated with lead paint.[87] In fact, a 2002 study found that thirty-five percent of all low-income housing had lead-based paint hazards, while only nineteen percent of households with incomes greater than or equal to $30,000 per year had lead hazards.[88]

Emerging research shows that stress can negatively affect fertility.[89] One study found that women who reported feeling more stressed than usual during their ovulatory window were forty percent less likely to become pregnant that month.[90] Women living in poverty are more likely to experience stress than those who are not. One study found that women living in poverty-stricken areas were over sixty percent more likely to have anxiety than women in wealthier areas.[91] This is due to many factors, including exposure to crime and violence, discrimination, inadequate housing, dangerous neighborhoods, and financial uncertainties.[92] Additionally, stress may be even more burdensome for low-income women who often work long hours and lack a strong support system.[93]

Smoking negatively impacts almost all aspects of female fertility, including problems with the fallopian tubes, a decrease in the number of eggs a woman has in her ovaries, and an increased risk of miscarriage.[94] Further, when women smoke during their pregnancy, the future fertility of their fetus is also put at risk.[95] Smoking is much more prevalent in low-income populations, with 26.1% of those living below the poverty level identifying as current smokers compared to 13.9% of those at or above the poverty level.[96] Additionally, people with low socio-

86. Kyung-Taek Rim, *Reproductive Toxic Chemicals at Work and Efforts to Protect Workers' Health: A Literature Review*, 8 SAFETY & HEALTH WORK 143, 147 (2017).

87. *See* Phuong Cat Le, *Poor Are Priced Out of Healthful Eating*, SEATTLE PI (Jan. 28, 2007), http://www.seattlepi.com/lifestyle/food/article/Poor-are-priced-out-of-healthful-eating-1226707.php.

88. David E. Jacobs et al., *The Prevalence of Lead-Based Paint Hazards in U.S. Housing*, 110 ENVT'L HEALTH PERSP. 599, 601 (2002).

89. C.D. Lynch et al., *Preconception Stress Increases the Risk of Infertility: Results from a Couple-Based Prospective Cohort Study—the LIFE Study*, 29 HUMAN REPROD. 1067, 1072–74 (2014); Nicholas Bakalar, *Stress May Affect Fertility*, N.Y. TIMES: WELL (Mar. 24, 2014), https://nyti.ms/2mbnCFG.

90. Lila MacLellan, *'Just Relax and Let It Happen': More Scientific Evidence to Annoy Stressed Out Women Who Want to Get Pregnant*, QUARTZ (Sept. 16, 2016), https://qz.com/782282.

91. Mary Elizabeth Dallas, *Poverty May Be More Stressful for Women Than Men*, HEALTHDAY (May 9, 2017), https://consumer.healthday.com/mental-health-information-25/anxiety-news-33/poverty-may-be-more-stressful-for-women-than-men-722397.html.

92. Deborah Belle, *Poverty and Women's Mental Health*, 45 AM. PSYCHOLOGIST 385, 385 (1990).

93. *See Fact Sheet: Women and Socioeconomic Status*, AM. PSYCHOLOGICAL ASS'N, http://www.apa.org/pi/ses/resources/publications/women.aspx (last visited Jan. 15, 2018); NAT'L P'SHIP FOR WOMEN & FAMILIES, DETOURS ON THE ROAD TO EMPLOYMENT (1999), http://www.nationalpartnership.org/research-library/more/economic-security/detours-road-employment.pdf; Soo Oh, *Many Americans Are Working More Hours to Make the Same Wages*, VOX (Apr. 3, 2017), https://www.vox.com/policy-and-politics/2017/4/3/15115758.

94. Rachel Gurevich, *What You Need to Know About Smoking and Getting Pregnant*, VERYWELL (Nov. 29, 2016), https://www.verywell.com/female-fertility-and-smoking-1960254.

95. Richard M. Sharpe & Stephen Franks, *Environment, Lifestyle and Infertility—An InterGenerational Issue*, NATURE CELL BIOLOGY & NATURE MED. 33, 38 (2002).

96. *Current Cigarette Smoking Among U.S. Adults Aged 18 Years and Older*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-states.html (last visited Jan. 15, 2018).

economic status tend to smoke cigarettes more heavily and are more likely to suffer from diseases caused by smoking than smokers with higher incomes.[97] Second-hand smoke exposure, which also negatively impacts fertility, is higher among people living below the poverty level.[98] Because tobacco use disproportionately affects people in low-income communities, they are more likely to experience infertility resulting from such exposure.

C. Lack of Access to Health Care

Those with a low socioeconomic status are less likely to have health insurance and less likely to access health care.[99] As a result, underlying conditions that can contribute to infertility often go untreated. As previously mentioned, STDs, which often contribute to infertility, especially when untreated, [100] are more prevalent in low-income populations.[101] Further, the poor often experience morbid obesity and diabetes, which can create hormonal imbalances that lead to infertility.[102] Without regular access to preventative care and annual physicals, these conditions are unlikely to be detected or treated.[103] Even if these conditions were to be detected, low-income women may lack the insurance or resources to pay for treatments like antibiotics.[104] This lack of access to health care exacerbates the underlying medical conditions and environmental factors that low-income women are more likely to suffer from and be exposed to, and causes increased infertility in this population.[105]

IV. BARRIERS TO INFERTILITY TREATMENT FOR LOW-INCOME WOMEN

In addition to being more susceptible to infertility due to the prevalence of underlying medical conditions, the increased chance of exposure to environmental risks, and the lack of access to health care, low-income women face several barriers in obtaining treatment for infertility. The combination of the high cost of treatment, the lack of widespread insurance coverage for treatment, discriminatory insurance requirements, and societal barriers like judgement and mistrust of the medical

97. *Cigarette Smoking and Tobacco Use Among People of Low Socioeconomic Status*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/tobacco/disparities/low-ses/index.htm (last visited Jan. 15, 2018).

98. *Id.*

99. Anna Maria Barry-Jester & Ben Casselman, *33 Million Americans Still Don't Have Health Insurance*, FIVETHIRTYEIGHT (Sept. 28, 2015), https://fivethirtyeight.com/features/33-million-americans-still-dont-have-health-insurance/.

100. *STDs & Infertility*, *supra* note 78.

101. Harling et al., *supra* note 79.

102. Cynthia L. Ogden et al., *Obesity and Socioeconomic Status in Adults: United States, 2005–2008*, NAT'L CENT. HEALTH STAT. DATA BRIEF, no. 50, Dec. 2010, https://www.cdc.gov/nchs/data/databriefs/db50.pdf; Mundy, *supra* note 62.

103. *See Preventative Health Care*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/PreventiveHealth.html (last visited Jan. 15, 2018).

104. Barry-Jester & Casselman, *supra* note 99.

105. *See infra* Part IV Sections A–B.

community, make it nearly impossible for low-income women to access fertility treatments.

A. Cost Barriers

Household income is a strong predictor of the use of fertility treatments, with higher socioeconomic status being associated with a greater use of treatment.[106] From 2006 to 2010, twenty-one percent of women whose household incomes were 400% or higher of the federal poverty level had ever used infertility services, compared with just thirteen percent of women whose household incomes were below the poverty level.[107] With the average cost of infertility treatment, including office visits, medication, and related expenses averaging about $5,000 and IVF totaling around $12,000, it is unsurprising that cost proves to be a barrier to low-income women hoping to access infertility treatments.[108] In addition to the challenge of being able to afford the treatments outright, the time-sensitive nature of infertility adds another barrier for low-income women, who often lack sufficient time to save up for treatments.

1. Unable to Afford

IVF and other infertility treatments are quite costly. With the annual median household income in America amounting to $55,775, it is difficult for many families to afford treatments like IVF that frequently exceed $12,000.[109] For low-income families, the high cost of IVF can be an automatic barrier to reproduction. A recent survey found that eighty-three percent of respondents who sought fertility treatment said that they were either concerned or very concerned about the cost of treatment.[110] The survey found cost to be the biggest factor in a woman's decision to delay treatment.[111] Almost eighty-two percent of women said the high cost of treatment played a role in their decision to postpone treatment.[112]

2. Unable to Save

Due to the time-sensitive nature of fertility treatment, women who do not have tens of thousands of dollars of disposable income rarely have time to save that money for treatment. Age is the most important factor in the success of IVF. In fact, data from the CDC show that the percentage of ART cycles resulting in live

106. James F. Smith et al., *Socioeconomic Disparities in the Utilization and Success of Fertility Treatments: Analysis of Data from a Prospective Cohort in the United States*, 96 FERTILITY & STERILITY 95, 99 (2011).

107. CHANDRA ET AL., *supra* note 2, at 6.

108. Genevra Pittman, *Average Out-of-Pocket Fertility Costs Top $5,000*, REUTERS (Sept. 17, 2013), http://reut.rs/19aZRLz.

109. KIRBY G. POSEY, U.S. CENSUS BUREAU, HOUSEHOLD INCOME: 2015 (2016), https://www.census.gov/content/dam/Census/library/publications/2016/demo/acsbr15-02.pdf.

110. Dan Mangan, *High Cost of Fertility Treatment Sends Many into Debt*, CNBC (May 20, 2015), http://cnb.cx/2EWGFZC.

111. *Id.*

112. *Id.*

birth decreases steadily with each one-year increase in age.[113] This is due to the lower chance of getting pregnant from the treatment as well as the higher risk of miscarriage with increasing age.[114] While women may be able to budget and save for fertility treatment, the longer they wait to undergo treatment, the less chance there is of it being successful. This may be one of the reasons that so many women go into debt while pursuing fertility treatment. Surveys show that seventy percent of women go into some sort of debt to pay for treatments, while forty-four percent of women seeking treatment accrue more than $10,000 in debt.[115]

B. Insurance Barriers

While staggering costs bar many women from accessing fertility treatments, women may be encouraged to discover that some insurance plans provide coverage for this type of care. Unfortunately, however, women with a low socioeconomic status are both less likely to have insurance that provides this type of coverage and less likely to meet the requirements for care that many companies stipulate. The combination of these factors amounts to another barrier for low-income women seeking fertility treatment.

1. Less Likely to Have Insurance

As previously discussed, fifteen states currently mandate that insurance companies either offer or cover some sort of fertility treatment. While the coverage provided in these states varies greatly, insurance helps many women to be able to afford and access care. Low-income women, however, are less likely to be able to benefit from insurance coverage of fertility treatment. The fifteen states currently mandating that insurance plans offer or cover some sort of infertility testing or treatment only apply this requirement to private insurance, not Medicaid.[116] Low-income workers are less likely to be offered private, employer-sponsored insurance (thirty percent) than workers in higher income households (seventy-eight percent).[117] This may be due to the high probability that these workers work part-time and hourly jobs that are not required to offer insurance.[118] Because of this, low-income women are less likely to be covered by private insurance plans that offer or cover fertility treatments.[119]

---

113. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 37, at 21.

114. *ART: Step-By-Step Guide*, *supra* note 40.

115. Mangan, *supra* note 110.

116. BELL, *supra* note 62, at 5.

117. MICHELLE LONG ET AL., KAISER FAMILY FOUND., TRENDS IN EMPLOYER-SPONSORED INSURANCE OFFER AND COVERAGE RATES, 1999–2014 2 (2016), http://files.kff.org/attachment/issue-brief-trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014-2.

118. GREGORY ACS & AUSTIN NICHOLS, URBAN INST., LOW-INCOME WORKERS AND THEIR EMPLOYERS: CHARACTERISTICS AND CHALLENGES 6 (2007), https://www.urban.org/sites/default/files/publication/46656/411532-Low-Income-Workers-and-Their-Employers.PDF; Anne Morrison & Katherine Gallagher Robbins, *Part-Time Workers Are Paid Less, Have Less Access to Benefits—and Two-Thirds Are Women*, NAT'L WOMEN'S LAW CTR. (Sept. 1, 2015), https://nwlc.org/resources/part-time-workers-are-paid-less-have-less-access-benefits%E2%80%94and-two-thirds-are-women/.

119. Morrison & Gallagher Robbins, *supra* note 118.

Not only do low-income women bear the burden of being less likely to have insurance that covers fertility treatment, some scholars suggest that insurance coverage of infertility treatment has led to higher costs for those who do not have insurance coverage. They hypothesize that doctors, unaware of their patient's financial circumstances, may be more likely to order expensive tests and procedures assuming they will be covered by insurance.[120] As a result, low-income women will bear higher out-of-pocket costs and may be forced to shoulder the costs of unnecessary tests or treatments that may be unlikely to improve fertility.

2. Lack of Medicaid Coverage

While many low-income people qualify for Medicaid, there are no federal requirements that state Medicaid programs cover fertility testing or treatment.[121] A 2016 survey from the Kaiser Family Foundation found that nine of the forty-one responding states cover fertility testing for women and men in their traditional Medicaid program, and six of the twenty-five states that expanded Medicaid under the Affordable Care Act cover fertility testing.[122] None of the responding states covered Intrauterine Insemination or IVF in their Medicaid program, and just one state, Nebraska, indicated that it provides women with fertility medications, although this is only when the infertility is a symptom of a separate medical problem.[123] This lack of Medicaid coverage creates an unequal distribution of fertility benefits based on social class.[124] Interestingly, Medicaid requires coverage of contraception, while private, employer plans are not required to offer this benefit. This has the effect of discouraging births among low-income women and encouraging births for wealthier women.[125]

3. Discriminatory Insurance Requirements

Even in the states that mandate some sort of insurance coverage of infertility testing or treatment, there is evidence to suggest that differences in utilization of treatment based on socioeconomic status still exist.[126] More-educated, higher-income women are shown to increase utilization as a result of a mandate, while less-educated, lower-income women do not increase their use of the services as significantly.[127] This may be due to the fact that lower-income women are less

120. BELL, *supra* note 62, at 93.

121. JENNA WALLS ET AL., KAISER FAMILY FOUND., MEDICAID COVERAGE OF FAMILY PLANNING BENEFITS: RESULTS FROM A STATE SURVEY 17 (2016), http://files.kff.org/attachment/Report-Medicaid-Coverage-of-Family-Planning-Benefits-Results-from-a-State-Survey.

122. *Id.*

123. *Id.*

124. *See* Joy Moses, *The Facts About Americans Who Receive Public Benefits*, CENT. FOR AM. PROGRESS (Dec. 16, 2011, 9:00 AM), https://www.americanprogress.org/issues/economy/reports/2011/12/16/10767/the-facts-about-americans-who-receive-public-benefits/.

125. BELL, *supra* note 62, at 5.

126. CHANDRA ET AL., *supra* note 2, at 2.

127. Bitler & Schmidt, *supra* note 45; Randy Dotinga, *Wealthier Women More Likely to Use Fertility Services: CDC*, HEALTHDAY (Jan. 22, 2014), https://consumer.healthday.com/public-health-information-

likely to be offered private insurance that is subject to the mandate.[128] This may also be due to the fact that many low-income women face societal barriers in accessing fertility treatments. This will be more fully explored later in this piece.

Further, low-income women may be less likely to meet the requirements set out by the state to qualify for coverage of treatment. For example, many states require that a woman be married in order for her fertility treatments to be covered by insurance.[129] Low-income women are less likely to be married than their higher-income counterparts.[130] Other states specify that small companies with few employees are not required to offer fertility coverage. According to the Urban Institute, forty-two percent of low wage workers work in small firms with fewer than ten employees. Among all workers, twenty percent are employed in small firms.[131] Additionally, low-income women may not have been able to afford to exhaust alternative treatment options, as some states require, before treatment is covered by the insurance company.

4. Employment Barriers

Even in states where insurance coverage is not mandated, some employers may choose to offer insurance coverage of fertility treatments. In fact, a survey by the International Foundation of Employee Benefit Plans found that twenty-four percent of large employers offered coverage of fertility services, nineteen percent included coverage for IVF, and twelve percent paid for fertility medications.[132] However, only four percent of employers with fewer than fifty workers included fertility coverage in their plans.[133] As noted previously, low-income workers are far more likely to be employed by a small employer than their higher-wage counterparts.[134] The firms that do offer fertility benefits are typically in highly competitive fields like technology, investment banking, and consulting.[135] Low-income workers are unlikely to be employed by these firms, both because they are unlikely to have the education and training required for these jobs and because if

---

30/economic-status-health-news-224/wealthier-women-more-likely-to-use-fertility-services-cdc-684087.html.

128. *Id.*

129. *Coverage By State*, NAT'L INFERTILITY INST., https://resolve.org/what-are-my-options/insurance-coverage/coverage-state/ (last visited Jan. 15, 2018); *see also* Sarah Wildman, *Not Married? Your Insurance Might Not Cover Fertility Treatments*, SLATE (Mar. 17, 2010), http://www.slate.com/articles/double_x/doublex_health/2010/03/not_married_your_insurance_might_not_cover_fertility_treatments.html; Bernard, *supra* note 55.

130. Lindsey Cook, *For Richer, Not Poorer: Marriage and the Growing Class Divide*, U.S. NEWS & WORLD REPORT (Oct. 26, 2015), https://www.usnews.com/news/blogs/data-mine/2015/10/26/marriage-and-the-growing-class-divide.

131. ACS & NICHOLS, *supra* note 118.

132. Press Release, Int'l Found. of Emp. Benefit Plans, Survey Report: Family-Friendly Benefits Gain Popularity in the Workplace (Aug. 9, 2016), https://www.ifebp.org/aboutus/pressroom/releases/Pages/Survey-Report-Family-Friendly-Benefits-Gain-Popularity-in-the-Workplace.aspx.

133. *Id.*

134. *See* ACS & NICHOLS, *supra* note 118.

135. Ann Carrns, *Tech Companies Get High Marks for Covering Infertility Treatment*, N.Y. TIMES: YOUR MONEY (Nov. 18, 2017), https://nyti.ms/2hD0b7m; Valentina Zarya, *These Are the Companies with the Most Generous Fertility Benefits*, FORTUNE (Nov. 15, 2016), http://for.tn/2fQwgCc.

they did work at these companies, they would likely be paid well and would not be classified as low-income.

Even if a low-income woman were able to finance infertility treatment, she may have difficulty taking off work in order to undergo the extensive testing or treatments often necessary to conceive.[136] Higher-income women are more likely to have job flexibility that allows them leave time in order to attend appointments.[137] All of these factors create an unfortunate situation for low-income women who are less likely to be able to afford the treatment, less likely to have insurance, and, even if they do have insurance, less likely to be offered a plan that offers fertility treatment.

C. Societal Barriers

In addition to facing cost and insurance barriers to accessing fertility treatment, low-income women face several societal barriers that make it difficult for them to access care. Low-income women have less familiarity with the medical community and may, as a result, be unaware of the treatment options available to them or unwilling to fully trust doctors with treating their fertility.[138] Further, low-income women report feeling negatively judged by society in their quest to become a parent, and therefore, are less likely to attempt to treat their infertility.[139]

1. Unfamiliarity with and Distrust of the Medical Community

Because low-income women are less likely to have health insurance and access to health care, they may be less familiar with the medical community.[140] For a multitude of reasons, including this unfamiliarity, low-income patients often do not trust the health care system.[141] In fact, research shows that working-class women tend to reject medical control over their bodies, particularly in relation to reproductive processes.[142] One study found that low-income patients feel health care professionals see them as "less than."[143] These patients reported feeling that

---

136. BELL, *supra* note 62, at 92.

137. EILEEN APPELBAUM ET AL., CTR. FOR AM. PROGRESS, THE ECONOMIC IMPORTANCE OF WOMEN'S RISING HOURS OF WORK 4–5 (2014), https://cdn.americanprogress.org/wp-content/uploads/2014/04/WomensRisingWorkv2.pdf.

138. *See infra* Section 1.

137. *See infra* Section 2.

140. *See* KAISER FAM. FOUND., HEALTH COVERAGE AND ACCESS CHALLENGES FOR LOW-INCOME WOMEN: FINDINGS FROM THE 2001 KAISER WOMEN'S HEALTH SURVEY (2004), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/health-coverage-and-access-challenges-for-low-income-women.pdf.

141. Chris C. Duke & Christine Stanik, *Overcoming Lower Income Patients' Concerns About Trust and Respect from Providers*, HEALTHAFFAIRS (Aug. 11, 2016), http://www.healthaffairs.org/do/10.1377/hblog20160811.056138/full/; Vanessa B. Sheppard et al., *Providing Health Care to Low-Income Women: A Matter of Trust*, 21 FAMILY PRACTICE 484 (2004); Nicholas C. Arpey et al., *How Socio-economic Status Affects Patient Perceptions of Health Care: A Qualitative Study*, 8 J. PRIMARY CARE & CMTY. HEALTH 169 (2017); *see also* Robert J. Blendon et al., *Public Trust in Physicians – U.S. Medicine in International Perspective*, 371 NEW ENGLAND J. MED. 1570 (2014).

142. BELL, *supra* note 62, at 86.

143. Duke & Stanik, *supra* note 141.

they were treated with less respect because of their income, insurance, status, and race, and therefore, have "widespread distrust of the health care system."[144] These feelings seem to be prevalent. A study published in the *New England Journal of Medicine* found that low-income adults are significantly less trusting of doctors and less satisfied with their medical care than those with a higher socioeconomic status.[145]

Low-income women may also be less informed about available infertility treatments, especially because utilization among their peers is so low.[146] Because there is a lack of familiarity with these treatments in low-income communities, women may not be encouraged to seek help once they realize they are struggling to become pregnant. The authors of a study published in *Fertility and Sterility* suggest that the disparity in utilization of infertility services may be due to several factors, including those with higher incomes having "increased access to healthcare through knowledge of healthcare options" and "a greater likelihood of belonging to social networks that help to identify optimal treatments."[147]

2. Social Judgement

Conscious and unconscious class-based ideas about who deserves to be a mother may impact whether low-income women seek treatment for infertility.[148] In her article *A Special Kind of Poverty*, Liza Mundy explores the bias many low-income women encounter, saying "the myth is that the less money a person has, the more babies a person has: that the poor are unstoppably fertile, popping out baby after baby that they cannot afford to clothe or educate or feed."[149] However, as this Note has explored, the poor may have more trouble conceiving than wealthier women do.

Ann Bell explores these ideas in her book *Misconception: Social Class and Infertility in America*. In interviewing low-income women struggling with infertility, Bell found that women of low socioeconomic status feel that they are discriminated against by health care providers due to their low income and often due to their marital status, and that these providers may actively dissuade them from having children.[150] One women described her interaction with her doctors by saying, "they just seem like they just didn't want me to have any kids at all . . . they scared me into even trying to have any more."[151] Many other low-income women note that during their annual visit to the gynecologist, the doctor is more

144. *Id.*

145. *Americans Mistrust Medical Profession but Like Their Own Doctors*, HARV. T.H. CHAN SCH. OF PUB. HEALTH, https://www.hsph.harvard.edu/news/hsph-in-the-news/americans-mistrust-medical-profession-but-like-their-own-doctors/ (last visited Jan. 15, 2018).

146. J. Farley Ordovensky Staniec & Natalie J. Webb, *Utilization of Infertility Services: How Much Does Money Matter*, 42 HEALTH SERVS. RES. 971, 984 (2007).

147. Smith et al., *supra* note 106.

148. Lynn K. White et al., *Explaining Disparities in Treatment Seeking: The Case of Fertility*, 85 FERTILITY & STERILITY 853, 854 (2006).

149. Mundy, *supra* note 62.

150. BELL, *supra* note 62, at 97, 100.

151. *Id.* at 97.

likely to steer the conversation towards STDs and birth control than to reproductive options.[152]

These feelings of judgment and sometimes active dissuasion regarding a low-income woman's desire to become a parent combined with the low-income community's distrust of the medical system leads many low-income women to refrain from seeking infertility treatment.[153]

V. THE RIGHT TO PARENT

Whether or not society and the medical community intend this result, the discrimination against and judgment of low-income women who want to have children that discourages them from seeking treatment amounts to reproductive oppression for low-income women. In order to ensure reproductive justice is achieved, steps should be taken to reduce the barriers that low-income women face when dealing with infertility.

A. A Legal History of the Right to Parent

While the Constitution does not directly address whether there is an American "right to bear children," the Supreme Court has held that the right to procreate is protected.[154] In the landmark case of *Skinner v. Oklahoma*, the Court examined whether an Oklahoma statute that enabled the state to sterilize "habitual criminals" who had been convicted of two or more felonies violated the Constitution.[155] The Court found the statute to be unconstitutional and in violation of the Equal Protection Clause, noting "we are dealing here with legislation which involves one of the basic civil rights of man."[156] Later, in *Eisenstadt v. Baird*, the Court expanded this right to unmarried persons, saying "if the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[157] The Court further held in *Carey v. Population Services* that "the decision whether or not to beget or bear a child is at the heart of this cluster of constitutionally protected choices."[158] Legal scholars understand this galaxy of cases as recognizing a broad right to procreate, whether single or married.[159]

The Supreme Court has not yet directly addressed whether or not there is a right to procreate through ART, including IVF.[160] Professor John Robertson has

152. Tanzina Vega, *Infertility, Endured Through a Prism of Race*, N.Y. TIMES (Apr. 26, 2014), https://nyti.ms/2mHYYcM.

153. BELL, *supra* note 62, at 83–111.

154. *See* John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 414 (1983).

155. Skinner v. Oklahoma, 316 U.S. 535, 541 (1942).

156. *Id.*

157. Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

158. Carey v. Population Servs., 431 U.S. 678, 685 (1977).

159. Catherine DeLair, *Ethical, Moral, Economic and Legal Barriers to Assisted Reproductive Technologies Employed by Gay Men and Lesbian Women*, 4 DEPAUL J. HEALTH CARE L. 147, 178 (2000).

160. Robertson, *supra* note 154.

argued that the right to decide when to have children extends to persons who would need the assistance of ART in order to conceive, saying "because fertile married persons have the right to add children to the family, infertile married persons must have it as well: a legal distinction based on the natural lottery of physical equipment is not reasonable."[161] Indeed, a federal district court held that the right to procreate encompasses the right to use technologies like IVF, stating, "it takes no great leap of logic to see that within the cluster of constitutionally-protected choices that includes the right to have access to contraceptives, there must be included within that cluster the right to submit to a medical procedure that may bring about, rather than prevent pregnancy."[162]

Some argue, however, that because the Supreme Court has only heard cases in this field that concern the right to contraception, abortion, and freedom from sterilization, this precedent stands for the negative right to prevent or terminate pregnancy, not a positive right to procreate with assistance.[163] A negative right is a liberty right that protects a person from governmental intrusion, while a positive right gives a person a claim to an entitlement or benefit.[164] While the Court has recognized a liberty right in choosing when to become pregnant, it has not explicitly found a positive right to assistance in becoming pregnant or terminating a pregnancy.[165] For example, in *Maher v. Roe* and *Harris v. McRae*, the Supreme Court held that while women had the right to access an abortion, they did not have the right to government assistance in financing the procedure.[166] Extending this reasoning to infertility would mean that everyone has a right to access infertility treatments like IVF, but not a right to have the government pay for it.

B. Current Barriers to Fertility Treatment Amount to Reproductive Oppression

While it is unclear whether or not individuals have a positive right to the financial assistance needed to become a parent, the Court could recognize this right in order to ensure that reproductive justice is realized and all Americans who wish to bear children are able to actualize their dreams of becoming a parent. The current landscape surrounding infertility treatment unfairly discriminates against low-income Americans and violates the recognized right to freedom from governmental intrusion in determining when to bear children. As discussed previously, infertility is a disease. In fact, in *Bragdon v. Abbott*, the Supreme Court held that reproduction was a major life activity, and therefore ruled that infertility should be considered a disability.[167] The fact that barriers exist for treatment of a

161. *Id.*

162. Lifchez v. Hartigan, 735 F. Supp. 1361, 1377 (N.D. Ill. 1990).

163. *See* Carter J. Dillard, *Rethinking the Procreative Right*, 10 YALE HUM. RTS. & DEV. L.J. 1, 50 (2007); *see also* Laura Shanner, *The Right to Procreate: When Rights Claims Have Gone Wrong*, 40 MCGILL L.J. 823, 839–40 (1995).

164. *See* Shanner, *supra* note 163, at 839–40.

165. *See id.* at 843.

166. Maher v. Roe, 432 U.S. 464, 474 (1977); Harris v. McRae, 448 U.S. 297, 316 (1980).

167. Bragdon v. Abbott, 524 U.S. 624, 641 (1998). *But see* SAUL SPIGEL, CONN. OFFICE OF LEGISLATIVE RESEARCH, INFERTILITY: CAUSES, TREATMENT, INSURANCE AND DISABILITY STATUS (2005), https://www.cga.ct.gov/2005/rpt/2005-R-0145.htm (noting that subsequent court cases have held that "a

disease that enables people to become parents—which the Court has ruled to be a fundamental protected right—oppresses the reproductive rights of vulnerable citizens.

Through both intentional and unintentional barriers that make it more difficult for low-income women to access fertility treatments, society is making judgments about who should be allowed to reproduce and raise the next generation. The insurance, cost, and societal barriers low-income women face when dealing with infertility are discriminatory and amount to reproductive oppression. According to the Asian Communities for Reproductive Justice, depriving certain communities of the ability to control their reproduction is a "strategic pathway to regulating entire populations."[168] By limiting low-income women's access to these treatments, our country is making a statement that it does not value these women's right to become mothers.

The resources that exist to assist some women in accessing fertility treatments should not be limited based on the social characteristics of those trying to access them. As Dorothy Roberts said: "Reproductive health policy affects the status of entire groups. It reflects which people are valued in our society; who is deemed worthy to bear children and capable of making decisions for themselves. Reproductive decisions are made within a social context, including inequalities of wealth and power."[169]

All Americans should be valued in society, not just those who are able to access and afford fertility treatments. While changing deeply held biases about who deserves to be a parent will be difficult, steps must be taken to ensure that low-income women no longer face discriminatory barriers that oppress their ability to have children. In order to reach the ideals of American equality, low-income women should have every opportunity to become mothers.

VI. CONCLUSION

Treatment for infertility, one of the most common and heart-wrenching diseases in America, is inaccessible to millions of Americans due to a variety of barriers, including high cost of treatment, insurance requirements, and societal norms. These obstacles disproportionately affect low-income women, who also happen to have a higher risk of infertility. Because American jurisprudence recognizes the right to procreate and defines it as a major life activity, barriers to infertility treatment that disproportionately affect low-income women are discriminatory and amount to reproductive oppression. In order to achieve reproductive justice, these obstacles must be overcome so that *all* Americans have the ability to pursue parenthood.

---

person is not considered disabled under the act if the disability can be overcome by mitigating or corrective measures").

168. ASIAN CMTYS. FOR REPROD. JUSTICE, A NEW VISION FOR ADVANCING OUT MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE JUSTICE 1 (2005), https://forwardtogether.org/wp-content/uploads/2017/12/ACRJ-A-New-Vision.pdf.

169. *Id.* at 4.