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## Cruel Dilemmas in Contemporary Fertility Care: Problematizing America's Failure to Assure Access to Fertility Preservation for Trans Youth

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CRUEL DILEMMAS IN CONTEMPORARY  
FERTILITY CARE:  
PROBLEMATIZING AMERICA’S FAILURE TO  
ASSURE ACCESS TO FERTILITY  
PRESERVATION FOR TRANS YOUTH

*Anna Reed\**

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## INTRODUCTION

Transgender youth are increasingly able to access gender-affirming healthcare.<sup>1</sup> Because gender-affirming care such as hormone therapy is clinically shown to reduce gender dysphoria and ease physical and social transition,<sup>2</sup> every major U.S. medical association recognizes that gender-affirming healthcare is medically necessary for the treatment of dysphoria.<sup>3</sup> However, an important dimension of gender-affirming care remains under-insured and overpriced: fertility preservation (FP).<sup>4</sup> Several studies indicate that hormone therapies and certain gender-affirming surgeries

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1. See Jae Puckett, *Trans Youth Are Coming Out and Living their Gender Much Earlier than Older Generations*, PHYS. ORG (Apr. 27, 2021), [https://perma.cc/L3NQ-KV3N].
  2. Gender dysphoria refers to “psychological distress that results from an incongruence between one’s sex assigned at birth and one’s gender identity.” Jack Turban, *What Is Gender Dysphoria?*, AM. PSYCHIATRIC ASS’N (Nov. 2020), [https://perma.cc/3J84-XERZ]. Gender-affirming care alleviates dysphoria by aligning a transgender person’s physical body and gender presentation with their gender identity. *See id.*
  3. *See Outlawing Trans Youth: State Legislatures and the Battle Over Gender-Affirming Healthcare for Minors*, 134 HARV. L. REV. 2163 (2021) [hereinafter *Outlawing Trans Youth*], citing Kellan E. Baker, *The Future of Transgender Coverage*, 376 NEW ENG. J. MED. 1801 (2017); *Professional Organization Statements Supporting Transgender People in Health Care*, LAMDA LEGAL (Sept. 17, 2018), [https://perma.cc/9V6A-DJVU].
  4. For the purposes of this paper, the term “fertility preservation” encompasses sperm cryopreservation and oocyte cryopreservation.

can have negative, long-term impacts on future fertility.<sup>5</sup> Although these impacts can be mitigated through approved FP methods such as sperm cryopreservation and oocyte cryopreservation,<sup>6</sup> such methods are rarely affordable for those who need them.<sup>7</sup>

These cost barriers largely exist because fertility care (including FP) remains excluded from most public and private insurance plans.<sup>8</sup> Even though states have the regulatory authority to remedy this, only seventeen have taken steps to do so.<sup>9</sup> This paper will demonstrate how the failure to provide coverage for fertility care forces young people into cruel dilemmas. Because gender-affirming care is, itself, expensive, paying additional out-of-pocket fees for FP is often not in the cards for many young people. Section I will delve into the landscape of FP coverage in the U.S. and the barriers that prevent people from accessing FP services. Section IV will then connect the lack of insurance coverage to a broader pattern of state efforts to withhold and eliminate child-bearing capacity, either directly or indirectly, from marginalized communities. Finally, Section III will offer legal and policy recommendations that could disrupt this history of reproductive oppression, and secure greater access to bodily autonomy for trans youth.

## I. BACKGROUND: FERTILITY CARE IN THE U.S.

According to the American Society for Reproductive Medicine, 6.7 million people in the U.S. are unable to have a child without some form

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5. Hormone therapy with estrogen or testosterone, for example, can prevent spermatogenesis and ovulation, respectively. Surgical gender affirmation can also compromise fertility, whether through the removal of gonadal tissue or the removal of the uterus. *See, e.g.*, Samuel Dubin, Megan Lane, Shane Morrison, Asa Radix, Uri Belkind, Christian Vercler & David Inwards-Breland, *Medically Assisted Gender Affirmation: When Children and Parents Disagree*, 46 J. MED. ETHICS, 295, 295 (2020); Shira Baram, Samantha A. Myers, Samantha Yee, & Clifford L. Librach, *Fertility Preservation for Transgender Adolescents and Young Adults: A Systematic Review*, 25 HUM. REPROD. UPDATE 694, 695 (2019).
  6. *See generally* Diane Chen & Lisa Simons, *Ethical Considerations in Fertility Preservation for Transgender Youth: A Case Study*, 6 CLINICAL PRAC. PEDIATRIC PSYCH. 93 (2018) (providing an overview of the ways in which sperm cryopreservation and oocyte cryopreservation mitigate the effects of gender affirming care on future fertility).
  7. *See infra* Section I.B. (providing an overview of cost barriers to fertility care in the United States).
  8. Gabriela Weigel, Usha Ranji, Michelle Long & Alina Salganicoff, *Coverage and Use of Fertility Services in the U.S.*, KAISER FAM. FOUND. (Sept. 15, 2020), [<https://perma.cc/176NK-E7R7>] [hereinafter Weigel et al.].
  9. *See infra* Section I.C. (providing an explanation of states' regulatory authority to mandate insurance coverage for fertility preservation).

of fertility treatment.<sup>10</sup> Over half of them describe struggling to conceive as the “most upsetting experience of their lives.”<sup>11</sup> The World Health Organization, the American Society for Reproductive Medicine, and the American College of Obstetricians and Gynecologists all recognize infertility as a serious health condition, and one with symptoms that go beyond simply not being able to reproduce.<sup>12</sup> A recent study found that people struggling with infertility feel “as anxious or depressed as those diagnosed with cancer, hypertension, and those recovering from a heart attack.”<sup>13</sup>

Most often, infertility is caused by a variety of individual and environmental health factors. However, for some, the inability to have a child is entirely avoidable. This is the case for many transgender adults who find themselves unable to conceive, either because they were not told about their fertility preservation options when they began transitioning, or because they could not afford the options that were presented to them.<sup>14</sup> Although it is sometimes possible to pursue FP after the initiation of gender-affirming care, the overwhelming majority of trans adults wish that they had pursued FP before transitioning.<sup>15</sup> This is especially true for adults who transition prior to puberty because the suppression of puberty with gonadotropin-releasing hormone agonist analogs (GnRHa) pauses the maturation of germ cells, which significantly reduces one’s fertility potential.<sup>16</sup> Although the effects of both testosterone and estrogen hormone therapies are potentially reversible, the extent is unclear.<sup>17</sup> Gender-affirming surgery that includes hysterectomy and oophorectomy in trans men or orchiectomy in trans women results in permanent sterility.<sup>18</sup> It is therefore essential that transgender patients be counseled on their fertility options prior to transitioning. However, less than five percent of trans

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10. Soc’y of Reprod. Surgeons, *Quick Facts About Fertility*, AM. SOC’Y REPROD. MED. (last accessed May 1, 2021), [<https://perma.cc/9J5U-A7QR>].

11. See Madeline Curtis, *Inconceivable: How Barriers to Infertility Treatment for Low-Income Women Amount to Reproductive Oppression*, 25 GEO. J. ON POVERTY L. & POL’Y 323, 324 (2018).

12. See *id.* at 325.

13. See *id.* at 324.

14. See Joshua Sterling & Maurice M. Garcia, *Fertility Preservation Options for Transgender Individuals*, 9 TRANSLATIONAL ANDROLOGY & UROLOGY S215, S220–21 (2020).

15. See *id.*

16. See Philip J. Cheng, Alexander W. Pastuszak, Jeremy B. Myers, Isak A. Goodwin & James M. Hotaling, *Fertility Concerns of the Transgender Patient*, 8 TRANSLATIONAL ANDROLOGY AND UROLOGY 209, 211 (2019).

17. *Id.*

18. *Id.*

youth pursue FP.<sup>19</sup> Although some trans youth forgo FP because they do not wish to have biological children in the future, structural barriers such as the lack of gender-affirming care,<sup>20</sup> parental involvement laws,<sup>21</sup> and the unavailability of insurance coverage<sup>22</sup> prevent many trans youth from accessing FP.

*A. Catch-22s: Problematizing Parental Involvement & Insurance Gaps in the Context of Fertility Preservation*

Most people encounter significant financial obstacles when seeking FP services.<sup>23</sup> However, transgender minors face a uniquely challenging set of financial obstacles. A 2017 survey of trans youth receiving gender-affirming care found that financial cost was the most significant access barrier standing between them and FP.<sup>24</sup> This is because of a variety of factors, including the fact that they often rely on their parents (who may or may not be supportive of their transition) for financial support and health insurance, and because insurance rarely covers fertility care.<sup>25</sup>

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19. Diane Chen, Lisa Simons, Emilie K. Johnson, Barbara A. Lockart & Courtney Finlayson, *Fertility Preservation for Transgender Adolescents*, 61 J. ADOLESCENT HEALTH, 120, 123 (2017); Lyne Noelle Chiniara, Christine Viner, Mark Palmert & Herbert Bonifacio, *Perspectives on Fertility Preservation and Parenthood Among Transgender Youth and their Parents*, 104 ARCHIVES DISEASE CHILDHOOD 739, 744 (2019); Leena Nahata, *Low Fertility Preservation Utilization Among Transgender Youth*, 61 J. ADOLESCENT HEALTH 40–44 (2017).
  20. Diane Chen, Moira A. Kyweluk, Afiya Sajwani, Elisa J. Gordon, Emilie K. Johnson, Courtney A. Finlayson & Teresa K. Woodruff, *Factors Affecting Fertility Decision-Making Among Transgender Adolescents and Young Adults*, 6 LGBTQ HEALTH 107, 109 (2019).
  21. See generally Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDISC. L. J. 179, 187 (2016).
  22. See *infra* Sections II.A.–B. for discussion of how the lack of insurance coverage prevents trans youth from accessing fertility preservation.
  23. *US Women Go into Debt for IVF*, KENNEDY INST. OF ETHICS (Jan. 15, 2018), [https://perma.cc/84SY-SWFJ].
  24. See Ann & Robert H. Lurie Children's Hospital of Chicago, *Transgender Youth Face Major Barriers to Fertility Preservation*, SCI. DAILY (Mar. 29, 2017), [https://perma.cc/8M9X-444C].
  25. See ALEXANDER CHEN & ASAFF ORR, TRANS YOUTH HANDBOOK, HARV. L. SCH. LGBTQ+ ADVOC. CLINIC 2 (last accessed Oct. 12, 2021), [https://perma.cc/T7LH-HEU7].

### 1. Parental Consent Laws Prevent Youth from Accessing the Care they Need

All states require parental consent for most medical care provided to minors,<sup>26</sup> and many courts adopt the view that a minor cannot consent to medical or surgical treatment.<sup>27</sup> The most widely recognized set of medical guidelines and protocols pertaining to the treatment of trans youth, the World Professional Association for Transgender Health (WPATH),<sup>28</sup> specifies that “when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians [must] have consented to the treatment and [be] involved in supporting the adolescent throughout the treatment process.”<sup>29</sup> In her article, *Overcoming the Parental Veto*, Emily Ikuta explains that WPATH’s parental consent requirement is not rooted in best practices for promoting adolescent health, but rather, primarily aims to “protect health professionals from liability.”<sup>30</sup> Most states have parental consent laws, and WPATH likely included the requirement to shield themselves from lawsuits for violation of these laws.<sup>31</sup>

This thicket of medical and legal requirements forces trans youth to involve their parents or guardians—who may or may not be supportive of their identity—in their decision-making process. This system is problematic for a variety of reasons. First, there is the reality that many parents will not provide consent for transition care or FP because they do not accept that their child is transgender.<sup>32</sup> Therefore, not only does family rejection have a significant negative impact on the mental and social health of trans youth,<sup>33</sup> but it can also have a life-altering effect on their

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26. See Ikuta, *supra* note 21, at 187.

27. *Id.*

28. *Id.* at 189.

29. Eli Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, 13 INT’L J. TRANSGENDERISM 165, 167 (2007).

30. See Ikuta, *supra* note 21, at 190.

31. See WILBURTA Q. LINDH, MARILYN S. POOLER, CAROL D. TAMPARO, BARBARA M. DAHL & JULIE A. MORRIS, DELMAR’S COMPREHENSIVE MEDICAL ASSISTING: ADMINISTRATIVE AND CLINICAL COMPETENCIES 120 (5th ed. 2013).

32. 57% of trans youth experience significant family rejection. See JAIME M. GRANT, ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY, NAT’L CTR. FOR TRANSGENDER EQUAL. 7 (2016), [<https://perma.cc/92NK-HWLR>].

33. See CAITLYN RYAN, *HELPING FAMILIES SUPPORT THEIR LESBIAN, GAY, BISEXUAL AND TRANSGENDER (LGBT) CHILDREN*, GEO. UNIV. CTR. FOR CHILD & HUM. DEV. (2009), [<https://perma.cc/H8JG-P6DF>].

fertility. Second, transition-related care already comes at significant financial cost for families. In fact, many people face as much as \$100,000 in out-of-pocket costs.<sup>34</sup> By requiring families to pay for FP rather than providing mandatory coverage, states force young people to depend on their parents to bankroll their transition care and FP. Even if the young person does have the support of their parent(s), paying for both gender-affirming treatment and FP is often not an option for parents.

## 2. High Out-of-Pocket Costs & the Unavailability of Insurance Coverage Force Youth to Forgo Fertility Preservation

Cost barriers are the most significant reason why trans youth are unable to access FP. Almost all of the participants in a 2019 study on trans youth fertility decision-making referenced financial considerations as a factor that shaped their course of treatment.<sup>35</sup> One participant shared: “The most important [thing] is being aware of costs.”<sup>36</sup> Another participant shared “I would not be doing [hormones] without freezing my sperm so I can have a biological child of my own if financial issues weren’t in play.”<sup>37</sup> Other participants highlighted the potential for emotional distress that stems from knowing FP exists but is unaffordable: “You don’t want to bring someone’s hopes up and then crash them down...it’d be pointless to get their hopes up and then find out they won’t be able to afford it cause it’s just worse for them.”<sup>38</sup> This study is consistent with others in this area, that all identify cost as a significant, if not the most significant, structural barrier to FP for trans youth.<sup>39</sup>

The high out-of-pocket costs for both gender-affirming care and FP make it so that trans youth and their families have to make hard decisions about what they can afford.<sup>40</sup> Trans youth will often prioritize gender-

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34. See Alyssa Jackson, *The High Cost of Being Transgender*, CNN (July 31, 2015), [<https://perma.cc/7NPP-HL3P>].

35. Chen, *supra* note 20, at 111.

36. *Id.*

37. *Id.*

38. *Id.*

39. See, e.g., Lurie Children’s Hospital, *supra* note 24; Chen, *supra* note 20, at 123; Kenneth C. Pang, Angus J. S. Peri, Hsu En Chung, Michelle Telfer, Charlotte V. Elder, Sonia Grover & Yasmin Jayasinghe, *Rates of Fertility Preservation Use Among Transgender Adolescents*, 174 JAMA PEDIATRICS 890 (2020).

40. See *infra* Section I.B. for more in-depth analysis of both FP costs and coverage gaps.

affirming care—which will provide immediate relief for gender dysphoria—over FP.<sup>41</sup> This trend may reflect the reality that many young people don't know if they will want children in the future—in fact, a recent study found that “nearly half of transgender youth indicated that their desire to have a biological child might change in the future.”<sup>42</sup> Therefore, when faced with the decision of having to choose between paying for gender-affirming healthcare or for fertility preservation, many prefer to invest in care they know they need now, rather than preserve their ability to receive care they might want in the future.<sup>43</sup> Thus, high out-of-pocket costs force youth to choose which type of care to prioritize: transitioning or preserving their ability to have children.<sup>44</sup> This problem could be addressed if insurance plans were required to cover fertility care. However, very few are. The following section will provide an overview of fertility care coverage in the U.S., and possible explanations for its scarcity.

B. *Background: Contemporary Landscape of Fertility Care Coverage in the U.S.*

Currently, only seventeen states have passed laws that require insurers to either cover or offer coverage for infertility diagnosis and treatment.<sup>45</sup> New York has the first and only state Medicaid program to cover any fertility treatment,<sup>46</sup> but its coverage remains limited to only certain infertility medications and excludes many of the procedures and services that trans people need, such as fertility preservation, in vitro fertilization

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41. See Kristin Samuelson, *Transgender Youth Faced With Tough Decision to Freeze Sperm or Eggs*, NW NOW (Apr. 15, 2019), [<https://perma.cc/TLY6-KEH6>].

42. Eva Feigerlova, *Fertility Desires and Reproductive Needs of Transgender People: Challenges and Considerations for Clinical Practice*, 91 CLINICAL ENDOCRINOLOGY 10, 16 (Jul. 2019).

43. See Diane Chen, Lisa Simons, Emilie K. Johnson, Barbara A. Lockart, & Courtney Finlayson, *Fertility Preservation for Transgender Adolescents*, 61 J. ADOLESCENT HEALTH, 120, 123 (2017); see also Cheng, *supra* note 16 at 211; Samuelson, *supra* note 42.

44. See Amanda Almendrala, *Transgender People Often Have to Choose Between their Fertility and their Transition*, CCRM FERTILITY (Oct. 31, 2018), [<https://perma.cc/G5Y5-59GB>].

45. These states include Arkansas, California, Connecticut, Delaware, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Montana, New Hampshire, New Jersey, New York, Ohio, Rhode Island, Texas, and West Virginia. See NAT'L CONF. STATE LEGISLATURES, STATE LAWS RELATED TO INSURANCE COVERAGE FOR INFERTILITY TREATMENT (Mar. 12, 2021), [<https://perma.cc/3E3J-F8CA>].

46. Legis. Assemb. A-2817, Reg. Sess. 2019–2020 (N.Y. 2019).

(IVF), or intrauterine insemination (IUI).<sup>47</sup> The dearth of state-mandated FP coverage, as well as the uneven coverage that is available in the states where there are such mandates, has continued because no federal law requires states to incorporate fertility care within their definition of “family planning benefits”<sup>48</sup>—a mandatory benefit under the Affordable Care Act.<sup>49</sup> Therefore, if people want to undergo FP, most must pay out of pocket, which simply is not an option for the vast majority of Americans.<sup>50</sup> The following section will provide an overview of the costs of fertility care, and then address possible explanations for state reluctance to mandate coverage on private and public insurance plans.

### 1. Costs and Coverage for Fertility Preservation

Fertility care is prohibitively expensive in the United States. In order to freeze and store sperm in the U.S., there is an initial cost of \$2,500, as well as an annual storage cost that ranges from \$150 to \$400, depending on the facility.<sup>51</sup> Harvesting and freezing eggs usually costs between \$8,000 and \$12,000 for the extraction, followed by an additional annual \$500 storage fee.<sup>52</sup> Then, because implanting preserved gametes will always require some artificial reproductive technology (ART), there are inevitably additional (and often very high) out-of-pocket costs that come later on, once the person has made the decision to conceive.<sup>53</sup> Research indicates that a \$500 surprise expense would put most Americans into

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47. See Weigel et al., *supra* note 8; see also Resolve Staff, *#Access2Care Win in New York, RESOLVE* (Apr. 12, 2019), [<https://perma.cc/4NX2-K34Z>] (“For both IVF and Fertility Preservation, the law also leaves out people who are covered by Medicaid in New York.”).

48. See Jenna Walls & Kathy Gifford, *Medicaid Coverage of Family Planning Benefits: Results from a State Survey*, KAISER FAM. FOUND. 17 (Sept. 2016) (“There are no federal requirements for state Medicaid programs to cover fertility testing or treatment such as medications, intrauterine insemination, or in-vitro fertilization for individuals enrolled in Medicaid.”). See also Louise Norris, *Does the ACA Require Infertility Treatment to be Covered by Health Insurance?*, HEALTH INSURANCE (Oct. 26, 2020), [<https://perma.cc/VZ5L-6WPQ>].

49. See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, § 1302, 124 Stat. 119 (2010) [hereinafter *Affordable Care Act*].

50. See Brant Deboer-Undark, *Most Americans Can't Afford Fertility Treatments Anymore—So They're Going Abroad*, POPULAR SCI. (Aug. 24, 2020), [<https://perma.cc/BNM2-RQR6>].

51. See Sterling & Garcia, *supra* note 14, at S221.

52. See *id.*

53. See *id.*

debt.<sup>54</sup> This means that the average American cannot afford FP if they need it.

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54. See, e.g., Maggie McGrath, *63% of Americans Don't Have Enough Savings to Cover a \$500 Emergency*, FORBES (Jan. 6, 2016), [<https://perma.cc/VM6D-JPJ4>]; Aimee Picchi, *A \$500 Surprise Expense Would Put Most Americans Into Debt*, CBS NEWS (Jan. 12, 2017), [<https://perma.cc/8AGY-KUFS>]; Jill Cornfield, *Bankrate Survey: Just 4 in 10 Americans Have Savings They'd Rely On In an Emergency*, BANKRATE (Jan. 12, 2017), [<https://perma.cc/2MKT-JH5K>].

**TABLE 1: FERTILITY PRESERVATION OPTIONS & COSTS FOR TRANSGENDER WOMEN<sup>55</sup>**

Patient population	Method	Patient requirements	Pregnancy requirements	Cost
Post pubertal transwomen before or after initiation of GAHT	Sperm cryopreservation	Established technique. Masturbatory or surgical retrieval options available. GAHT should be stopped prior to specimen retrieval but is not necessary	<i>Male partner:</i> needs donor oocyte and surrogate  <i>Female partner:</i> IUI or IVF/ICSI	Sperm banking—\$2,500 + 150–400 annual fee; IUI—\$500–\$2,500 + consultation fee; IVF—\$12,000–14,000 per attempt; ICSI and embryo implantation—\$18,000; egg donation and surrogacy—\$40,000; IVM—cost unknown
Pre and post pubertal transwomen at any point in their transition	Testicular tissue cryopreservation	Experimental not clinically available. No need to stop GAHT. Can be done concurrently with gender affirming surgery	<i>Male partner:</i> IVM then donor oocyte and surrogate  <i>Female partner:</i> IVM then IUI or IVF/ICSI	

IUI, intrauterine insemination; IVF, in vitro fertilization; ICSI, intracytoplasmic sperm injection; IVM, in vitro maturation.

**TABLE 2: FERTILITY PRESERVATION OPTIONS & COSTS FOR TRANSGENDER MEN<sup>56</sup>**

Patient population	Method	Patient requirements	Pregnancy requirements	Cost
Post pubertal transmen before and after initiation of GAHT	Embryo cryopreservation	Established practice. Should stop GAHT and undergo controlled ovarian stimulation with transvaginal oocyte retrieval. Need donor sperm at time of harvest	<i>Male partner:</i> can use partners sperm for fertilization. Need surrogate to carry embryo to term  <i>Female partner:</i> sperm donor for fertilization, transplantation of embryo into partners uterus	Egg freezing—\$8,000–12,000 + \$500 annual fee; IVF and embryo transfer—\$12,000–14,000; Surrogacy fees—\$30,000
Post pubertal transmen before and after initiation of GAHT	Oocyte cryopreservation	Established practice. Should stop GAHT and undergo controlled ovarian stimulation with transvaginal oocyte retrieval	<i>Male partner:</i> use partners sperm for fertilization. Need surrogate to carry embryo to term  <i>Female partner:</i> sperm donor for fertilization, transplantation of embryo into partners uterus	Egg freezing—\$8,000–12,000 + \$500 annual fee; IVF and embryo transfer—\$12,000–14,000; Surrogacy fees—\$30,000
Pre and post pubertal transmen at any point in their transition	Ovarian tissue cryopreservation	Experimental not clinically available. No need to stop GAHT. Can be done concurrently with gender affirming surgery	<i>Male partner:</i> IVM, use partners sperm for fertilization. Need surrogate to carry embryo to term  <i>Female partner:</i> IVM, sperm donor for fertilization, transplantation of embryo into partners uterus	Egg freezing—\$8,000–12,000 + \$500 annual fee; IVF and embryo transfer—\$12,000–14,000; Surrogacy fees—\$30,000; IVM—cost unknown

IVM, in vitro maturation.

## 2. Costs and Coverage of Artificial Insemination

Fertility preservation is only one element of the care that is necessary for trans people to have access to family building. As mentioned above,

55. Sterling & Garcia, *supra* note 14 at S215–S226.

56. *Id.*

using preserved gametes inevitably requires some form of later ART, often either Intrauterine Insemination<sup>57</sup> or In Vitro Fertilization (IVF).<sup>58</sup> The American Pregnancy Association sets the cost of a single cycle of IVF at up to \$17,000—more than half of the *annual* income of someone receiving Medicaid.<sup>59</sup> The astonishing price of treatment, when not covered by insurance, forces 70% of people who pursue IVF into debt, regardless of their income.<sup>60</sup>

### C. *Why the Reluctance to Cover Fertility Care?*

The systemic failure of insurers to cover fertility care might be attributable to the popular misconception that it is a luxury that only certain privileged individuals—namely wealthy white women—need and should be able to access.<sup>61</sup> The history behind this harmful mythology will be elaborated upon below, but it is important to first engage with, and challenge, the other explanations that exist for denying coverage. The following sections will demonstrate that neither financial nor legal barriers stand between a state expanding coverage.

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57. At the less expensive end of the cost spectrum, intrauterine insemination ranges from \$500 to \$2,500 per attempt. See Sterling & Garcia, *supra* note 14, at S221.

58. See *id.*

59. AM. PREGNANCY ASS'N, IN VITRO FERTILIZATION: IVF - IN VITRO FERTILIZATION, [<https://perma.cc/DGZ6-6UEA>]; see also AM. COUNCIL ON AGING, MEDICAID ELIGIBILITY: 2022 INCOME, ASSET & CARE REQUIREMENTS FOR NURSING HOMES & LONG-TERM CARE, [<https://perma.cc/689R-DMGC>].

60. US WOMEN GO INTO DEBT FOR IVF, KENNEDY INST. OF ETHICS (Jan. 15, 2018).

61. See, e.g., Rosario Ceballo, Erin T. Graham & Jamie Hart, *Silent and Infertile: An Intersectional Analysis of the Experiences of Socioeconomically Diverse African American Women with Infertility*, 39 PSYCH. WOMEN Q. 497, 505 (2015) (finding that the misperception that infertility only affects wealthy white women contributes to social isolation and shame among African-American women who are experiencing infertility); Alexia Fernández Campbell, *Five Myths About Women of Color, Infertility and IVF Debunked: We Discover Just How Much this is Not Just a Rich, White Woman's Issue*, ATLANTIC (Sept. 3, 2015), [<https://perma.cc/CD74-E83U>]; Usha Lee McFarling, *For Black Women, the Isolation of Infertility is Compounded by Barriers to Treatment*, STAT (Oct. 14, 2020), [<https://perma.cc/NA28-P654>].

## 1. States Have Legal Authority to Mandate Fertility Coverage on Individual, Group, and Medicaid Plans

### i. States Have Authority to Provide Fertility Care on Individual and Group Plans

States can legally require individual and group plans to cover infertility treatment.<sup>62</sup> The existence of seventeen states that have coverage mandates for infertility treatment proves this. Regulating public health has long been encompassed within the police power of states.<sup>63</sup> It is true that under the ACA, states must defray the costs of coverage mandates directed at individual and group plans,<sup>64</sup> which can be administratively and financially burdensome. However, this is not an insurmountable barrier. It is clear from the experience of states that have mandated fertility coverage on individual and group plans that the defrayal costs are ultimately worthwhile because coverage mandates save administrative and financial expenditures in other areas.<sup>65</sup>

### ii. States Have Authority to Provide Fertility Care as Part of the Medicaid Family Planning Benefit

States are free to include fertility care under their definition of “family planning services.” This is clear from the most recent edition of the State Medicaid Manual, the official medium by which the Center for Medicare & Medicaid Services (CMS) issues mandatory policies and procedures to the Medicaid state agencies.<sup>66</sup> It states that “the term ‘family planning services’ is not defined in the law or in regulations [...] [The state] may choose to include in [its] definition of Medicaid family planning services [...] services for the treatment of infertility.”<sup>67</sup> States are therefore acting within the bounds of their regulatory authority when

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62. *See infra* Section I.C.1.ii.

63. *See generally* Santiago Legarre, *The Historical Background of the Police Power*, 9 U. PA. J. CONST. L. 745 (2007).

64. *See* Affordable Care Act § 18031(d)(3)(B)(ii); 45 C.F.R. § 155.170.

65. *See infra* Section I.C.2.

66. STATE MEDICAID MANUAL, CTR'S. FOR MEDICAID & MEDICARE SERVICES, §4270.B(1), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927> (last visited Apr. 30, 2021) [hereinafter STATE MEDICAID MANUAL, CTR'S. FOR MEDICAID & MEDICARE SERVICES].

67. *Id.*

they choose to include fertility services within the scope of Medicaid-covered family planning services. New York, for example, has successfully incorporated some fertility care, such as coverage for certain medications,<sup>68</sup> within the scope of its Medicaid family planning benefit.<sup>69</sup>

It is worth noting that while there is a strong case for including FP under Medicaid plans, there may be administrative roadblocks to consider. For example, the State Medicaid Manual lists the types of services entitled to the enhanced federal match (90%).<sup>70</sup> This list includes “infertility treatment and sterilization reversals,” but does not explicitly include fertility preservation.<sup>71</sup> This could theoretically present an administrative barrier to mandating coverage, because there is no guarantee that services covered under a state Medicaid mandate would be reimbursed at the high rates that are necessary to keep costs manageable at the state level. However, given that insurance providers may not discriminate on the basis of sex,<sup>72</sup> which the Supreme Court has interpreted to encompass gender identity,<sup>73</sup> there is a strong constitutional argument for why a Medicaid fertility mandate would have to include FP. Indeed, the failure to cover FP would have a discriminatory impact on fertility care-seekers who need it, such as transgender people and people who need medical treatments (such as certain forms of cancer treatment) that render them infertile.<sup>74</sup> It is also the case that a state’s Medicaid definition must be “consistent with overall state policy and regulation regarding the provision of family planning services.”<sup>75</sup> Some individual and group plans do include FP in their coverage mandates.<sup>76</sup> Because Medicaid coverage must be consistent with

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68. Weigel et al., *supra* note 8.

69. NAT’L CONF. STATE LEGISLATURES, STATE LAWS RELATED TO INSURANCE COVERAGE FOR INFERTILITY TREATMENT (Mar. 12, 2021), [<https://perma.cc/8Q3L-HWPU>].

70. STATE MEDICAID MANUAL, CTRS. FOR MEDICAID & MEDICARE SERVS., § 4270(B)(1), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927>.

71. *Id.*

72. *See* Nondiscrimination in Health Programs and Activities, 45 C.F.R. 92 (May 18, 2016).

73. *See* *Bostock vs. Clayton County*, 590 US \_\_ (2020).

74. This is sometimes referred to as “iatrogenic” infertility and includes those at risk of infertility due to radiation or chemotherapy treatment for cancer, surgery for endometriosis, gender reassignment surgery or treatment, or other medically indicated reasons. Extend Fertility Staff, *New York’s Fertility Coverage Mandate*, EXTEND FERTILITY (Jan. 17, 2020), [<https://perma.cc/WZ8V-SCYV>].

75. *Id.*

76. Nine states currently mandate coverage for fertility preservation on private plans. Colorado, Connecticut, Delaware, Illinois, Maryland, New Hampshire, New Jersey, New York, and Rhode Island mandate coverage for both IVF and fertility preservation. *See*

the state policy for individual and group plans, FP could not be excluded from the scope of a Medicaid mandate in any of the states that mandate FP coverage on private individual or group plans.

## 2. Mandating Coverage of Infertility Treatment is Cost Effective

Fertility care is expensive. But so is denying coverage. The failure to cover fertility care ends up causing many people to take both financial and health risks that drive up healthcare costs in other domains.<sup>77</sup> For example, denying coverage causes many to attempt transferring more than one embryo at each in vitro insemination.<sup>78</sup> This significantly increases the risk of a multiple-birth, which is a leading source of morbidity and mortality for both the birthing person and fetus.<sup>79</sup> Multiple births tend to correlate with prematurity, low birth weight, cesarean delivery, increased risk of prolonged hospital stay for both the birthing person and the fetus, disability, or death.<sup>80</sup> Therefore, by denying coverage, states increase the need for pre-term and long-term care associated with multiple births, which costs between two and five times more than it would have cost to cover IVF in the first place.<sup>81</sup>

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Benjamin J. Peipert, *Analysis of State-Mandated Insurance Coverage for Infertility Treatment and Fertility Preservation in the United States*, 114 FERTILITY & STERILITY E4, E4 (2020).

77. See, e.g., Robert Klitzman, *How Much is a Child Worth? Providers' and Patients' Views and Responses Concerning Ethical and Policy Challenges in Paying for ART*, 12 PLOS ONE E0171939 (2017).
78. See Josephine Johnston & Michael K. Gusmano, *Why We Should All Pay for Fertility Treatment: An Argument from Ethics and Policy*, 43 HASTINGS CTR. REPORT 18, 18 (2013) (finding a strong correlation between the lack of insurance coverage and the number of multiple embryo implantations); See also AM. SOC. FOR REPROD. MED., *State Insurance Mandates Have a Positive Impact on Infertility Treatment Success*, SOC. FOR ASSISTED REPRODUCTIVE TECH. (Oct. 17, 2021), [https://perma.cc/PT5P-9JEN] (study that concluded that state insurance mandates reduce multiple embryo implantation, which in turn leads to more live births, which then reduces the need for further IVF cycles and the costs related to them).
79. See JOHNS HOPKINS MED., *Complications of Multiple Pregnancy*, [https://perma.cc/E5WU-P2WC].
80. See Sterling & Garcia, *supra* note 14, at S222, citing e.g. J. Reefhius, M. A. Honein, L. A. Schieve, A. Correa, C. A. Hobbs & S. A. Rasmussen, *Assisted Reproductive Technology and Major Structural Birth Defects in the United States*, 24 HUMAN REPROD. 360, 366 (2009); Sheena E. M. Lewis & R. John Aitken, *DNA Damage to Spermatozoa Has Impacts on Fertilization and Pregnancy*, 322 CELL TISSUE RES., 33-41 (2005); Sheena E. M. Lewis, Ishola Agbaje & Juan Alvarez, *Sperm DNA Tests as Useful Adjuncts to Semen Analysis*, 54 SYST BIOL REPROD MED., 111-25 (2005).
81. *Key Findings: Infertility Insurance Mandates and Use of Assisted Reproductive Technology*, CTR. FOR DISEASE CTRL. (April 2016), [https://perma.cc/G4W5-3D4H].

When states mandate coverage, it comes at little or no cost because of cost savings in pre-term and long-term perinatal care.<sup>82</sup> In Massachusetts, for example, the cost of infertility services as a percent of the total health care premium went *down* after a 1987 Massachusetts law mandated that all insurers provide coverage for “all non-experimental infertility procedures.”<sup>83</sup> Additionally, when Connecticut mandated infertility coverage (including IVF), premiums increased by less than 1% total to cover both basic and advanced treatments.<sup>84</sup> In Rhode Island, it is estimated that the infertility mandate costs \$1.29 per member per month.<sup>85</sup> Mandating coverage saves healthcare costs stemming from multiple births, and saves costs in other sectors, because families can achieve greater financial stability and spending power if they are not forced to empty their savings and rack up unpayable debt on their infertility treatment.

### 3. Alternative Explanations for Why States Don’t Cover Fertility Care: Popular Misconceptions About Infertility and Parenthood

So why *are* states so reluctant to mandate coverage if no real financial or legal risks are entailed? After invalidating the “lack of legal authority” and “cost ineffective” explanations, the most likely answer, it seems, is America’s popular misperception that infertility care is a luxury that only wealthy people deserve. “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.”<sup>86</sup> Poor people are perceived as having too many children for their own good, and their children are frequently viewed as unplanned and

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82. COALITION TO HELP FAMILIES STRUGGLING WITH INFERTILITY, *IVF Cost Fact Sheet*, RESOLVE (last visited Oct. 15, 2021), [https://perma.cc/3U24-ZZUT].

83. James Highland, *State-Mandated Health Insurance Benefits and Health Insurance Costs in Massachusetts*, COMPASS HEALTH ANALYTICS (January 2013), [https://perma.cc/RVL7-FLHB]; *Infertility Benefits*, 211 CMR 37.04 (2010).

84. See UNIV. OF CONN. CTR. FOR PUB. HEALTH & HEALTH POL’Y, CONNECTICUT MANDATED HEALTH INSURANCE BENEFITS REVIEWS 2010, at 10, (2011), [https://perma.cc/5MP4-F4VJ]; Conn. Gen. Stat. § 38a-536 (2012).

85. R. I. OFF. OF THE HEALTH INS. COMM’R, A REVIEW OF RHODE ISLAND’S MANDATED BENEFITS AND RECOMMENDATIONS FOR FUTURE REVIEWS, 22 (2014), [https://perma.cc/F8DN-N2RB].

86. Liza Mundy, *A Special Kind of Poverty*, WASH. POST (Apr. 20, 2003), [https://perma.cc/3BHS-C2JJ].

unwanted.<sup>87</sup> “People think: You’re breeders anyway. They think: You already have too many children,” says Sunyatta Amen, a Maryland-based doctor and fertility specialist.<sup>88</sup> The corollary of this myth is that infertility only plagues the rich. We imagine the prototypical fertility patient as a wealthy (probably white) working woman who chose to delay pregnancy just a little too long for the sake of her career. This vision of infertility makes coverage mandates seem 1) risky for the poor, and 2) unnecessary for the rich.

Young patients face additional cultural barriers to fertility preservation and the right to refuse it. Young people are routinely denied the ability to make their own healthcare decisions because they are dismissed by their parents, providers, and legislatures as unready or unable to navigate them.<sup>89</sup> As discussed in Section I, all states require parental consent for most medical care provided to minors, and many courts adopt the view that a minor child cannot consent to medical or surgical treatment.<sup>90</sup> These laws are a reflection of American culture, which routinely treats young people as mentally incompetent when it comes to decision-making about their bodies.<sup>91</sup> Research shows that parental involvement and consent laws for transition-related care do little to facilitate healthy or productive conversations about the young person’s healthcare decision-making.<sup>92</sup> Common rationales behind requiring parental involvement in the transition care of young people are that the person might change their minds later on about their gender identity or about their desire to have

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87. See *id.*; Georgia Aspinall, *Stop Telling People ‘You Shouldn’t Have Kids If You Can’t Afford to Feed Them’*, GRAZIA DAILY (Aug. 6, 2020), [<https://perma.cc/YRM5-TX4T>] (.

88. Mundy, *supra* note 86.

89. See, e.g., Ikuta, *supra* note 21, at 203 (describing the problems that arise when the parent of a trans youth refuses to provide consent to gender-affirming treatment for their child, and how minors can argue for the right to consent).

90. Doriane Lambelet Coleman & Philip M. Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 PEDIATRICS 786, 792 (2013).

91. Interesting parallels arise in the abortion and cancer treatment contexts. In each arena, legal advocates are challenging the paternalism embedded in parental involvement laws. See generally Sonia Adjroud, *Abortion and Parental Involvement Laws: A Threat to Young People’s Health and Safety*, ADVOC. FOR YOUTH (2019), [<https://perma.cc/EBV9-TVPM>] (describing the implications of requiring parental involvement in minors’ abortions); Gwendolyn P. Quinn, Devin Murphy, Caprice Knapp, Daniel K. Stearsman, Kathy L. Bradley-Klug, Kelly Sawczyn & Marla L. Clayman, *Who Decides? Decision Making and Fertility Preservation in Teens with Cancer: A Review of the Literature*, 49 J. ADOLESCENT HEALTH 337 (2011) (reviewing studies of cancer patients and their fertility decisions).

92. See generally Ikuta, *supra* note 21, at 187-9 (describing the problems that arise when the parent of a trans youth refuses to provide consent to gender-affirming treatment for their child, and how minors can argue for the right to consent).

children.<sup>93</sup> There is very little evidence to support the former.<sup>94</sup> While there is some evidence indicating that young people's attitudes surrounding future child rearing do evolve,<sup>95</sup> this phenomenon is not unique to young people. There is no way to predict—at any life juncture—how one will feel about having children for the rest of one's life. Laws and policies should therefore allow the person who has to live with the decision to have children to make it.

## II. FERTILITY CARE COVERAGE IS A COST-EFFECTIVE WAY TO IMPROVE HEALTH OUTCOMES AND ADVANCE EQUITY

America's failure to cover fertility care is therefore not evidence-based, nor is it the result of legal or administrative barriers. A different approach is possible. This section will outline the reasons why mandating insurance coverage for FP would improve public health and equity in the United States.

### A. *Public Health Promotion: Failure to Cover Fertility Care Drives Parents to Take Matters into Their Own Hands*

The financial stress of infertility treatment can drive people to take risks such as implanting multiple embryos at once because they can only afford one implantation procedure.<sup>96</sup> Perhaps more troublesome, however, is the burgeoning underground market for fertility drugs that is proliferating in private chat rooms, unregistered online pharmacies, and buyer-seller websites like [freegaragesale.org](http://freegaragesale.org), where private individuals can

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93. See *Outlawing Trans Youth*, *supra* note 3, at 2178.

94. A recent systematic research review found that less than 1% of transgender patients who underwent gender-affirming surgery in the United States regretted the decision. Valeria P. Bustos, Samyd S. Bustos, Andres Mascaro, Gabriel Del Corral, Antonio J. Forte, Pedro Ciudad, Esther A. Kim, Howard N. Langstein & Oscar J. Manrique, *Regret After Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence*, 9 PLASTIC & RECONSTRUCTIVE SURGERY GLOBAL OPEN e3477, e3477 (2021).

95. See Feigerlova, *supra* note 42, at 16.

96. Robert Stillman, *How Many Embryos Should You Transfer? eSET and In Vitro Fertilization*, SHADY GROVE FERTILITY (Oct. 1, 2014), [<https://perma.cc/4T3Q-R7SF>] (“It has been shown that patients who have insurance coverage for IVF or Donor Egg transfer fewer embryos per cycle since their fears of being unsuccessful and having to pay for another cycle are lessened.”).

post their leftover fertility medications at significantly reduced prices (often under \$500).<sup>97</sup>

While self-managing one's reproductive health can be very safe in some contexts,<sup>98</sup> there are some serious health risks involved when it comes to fertility drugs. First, most fertility medicines must be kept at regulated temperatures in order to be safe and effective.<sup>99</sup> There is no guarantee that private sellers have maintained the necessary safety conditions, creating risks of contamination or ineffectiveness for consumers. Second, the Alliance for Safe Online Pharmacies (ASOP) has flagged a trend in selling counterfeit, expired, or repackaged drugs.<sup>100</sup> Mandating coverage would likely eliminate such a market and the associated risks because if fertility planning is more accessible, there will be no need for individuals to seek cheaper, and potentially dangerous, alternatives.

#### B. *Health Disparity Reduction: Failure to Cover Fertility Care Perpetuates a Destructive History of Reproductive Oppression*

The U.S. government's failure to cover fertility care is consistent with America's troubling history of state-sponsored efforts to keep certain communities childless. Forced sterilization, family separation, and the denial of infertility treatment should be understood as existing on the same spectrum of state efforts to control who gets to parent. Denying infertility care coverage for people who cannot afford it out of pocket is rooted in the same misguided beliefs that have been used to justify targeting Black, Latinx and Indigenous people, as well as welfare recipients, people with disabilities, immigrants, and LGBTQIA+ people for sterilization.<sup>101</sup> These premises are that 1) the state has a role in deciding who can, or

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97. See Dana Elfin, *Costs, Coverage Issues Spur Black Market for Fertility Meds*, BLOOMBERG L. (June 29, 2018), [<https://perma.cc/FLP2-JS38>].

98. Self-managed abortion, for example, can be as safe as clinically-supervised abortion. See Heidi Moseson, Ruvani Jayaweera, Ijeoma Egwuatu, Belén Grosso, Ika Ayu Kristianingrum, Sybil Nmezi, Ruth Zurbriggen, Relebohile Motana, Chiara Bercu, Sofia Carbone & Caitlin Gerds, *Effectiveness of Self-Managed Medication Abortion with Accompaniment Support in Argentina and Nigeria (SAFE): A Prospective, Observational Cohort Study and Non-Inferiority Analysis with Historical Controls*, 10 LANCET e105, e105 (2020).

99. See Elfin, *supra* note 97.

100. See *id.*

101. See Maya Manian, *Immigration Detention and Coerced Sterilization: History Tragically Repeats Itself*, ACLU (Sept. 29, 2020), [<https://perma.cc/KE97-5LHS>] (“Over the course of this long history, both public and private actors in the U.S. targeted the poor, the disabled, immigrants, and racial minorities for forced sterilization.”).

should, become parents, and 2) certain groups don't deserve access to family building.

Spurred by the eugenics movement that emerged at the turn of the century, states began enacting laws as early as 1907 that authorized the sterilization of the “feebleminded.”<sup>102</sup> Approximately 70,000 coercive sterilizations were performed throughout the U.S. pursuant to these laws.<sup>103</sup> In *Buck v. Bell*, the Supreme Court authorized—and in doing so, legitimized—state-sponsored sterilization, holding that “[i]t is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.”<sup>104</sup> The case was considered a victory by America's eugenics movement, which “emphasized biological determinism” and designed policies meant to “breed out traits that were considered undesirable.”<sup>105</sup>

LGBTQIA+ status has historically been treated as one such trait. A century ago, LGBTQIA+ status was legally categorized, pathologized, and punished as a form of sexual deviance.<sup>106</sup> From the outset of the eugenics movement, doctors, legislators, and scientists sterilized young transgender individuals and other members of the LGBTQIA+ community in order to “condemn and control various forms of ‘sexually deviant’ conduct.”<sup>107</sup>

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102. Alexandra Minna Stern, *Eugenics, Sterilization, and Historical Memory in the United States*, 23 HISTÓRIA CIÊNCIAS, SAÚDE-MANGUINHOS 195, 196 (2016) (Braz.).

103. Adam Cohen, *The Supreme Court Ruling That Led To 70,000 Forced Sterilizations*, NPR (Mar. 7, 2016), [<https://perma.cc/NUX2-M6FT>].

104. See *Buck v. Bell*, 274 U.S. 200, 207 (1927).

105. Cohen, *supra* note 103.

106. See WENDY KLINE, BUILDING A BETTER RACE: GENDER, SEXUALITY, AND EUGENICS FROM THE TURN OF THE CENTURY TO THE BABY BOOM 34, 135 (2001) (“Strategies most effective in regulating female sexual and moral behavior—in particular, sterilization—gained legitimacy . . . and discharges [from institutions] were touted as scientific evidence of the efficacy of eugenics in negotiating a new, reproductive morality.”). For examples of primary sources documenting the link between sexual deviance and sterilization, see Everett Flood, *Notes on the Castration of Idiot Children*, 10 AM. J. PSYCH. 296, 297 (1899) (“Castration in cases of sexual perversion and for habitual criminals has been revived. . . .”); Jonathan Ostrowsky, *Evolving Public Attitudes: The Rise and Fall of Compulsory Sterilization of the Intellectually Disabled in the United States* (May 2013) (B.A. thesis, Brandeis University) (on file with Brandeis University Library system) [<https://perma.cc/3SRS-7Q5K>], (“[S]terilization [of sexual perverts] was done as a punishment rather than for any special good for society.”) (quoting *Sterilizing at Girls’ School Raises a Stir*, ASSOC. PRESS, Oct. 23, 1937).

107. See Jon Ostrowsky, *Birth Certificate Gender Corrections: The Recurring Animus of Compulsory Sterilization Targeting Transgender Individuals*, 27 UCLA WOMEN’S L. J. 273, 280 (2020) (citing Peter Boag, *Same-Sex Affairs: Constructing and Controlling Homosexuality in the Pacific Northwest* 206–16 (2003) (describing the punitive and stigmatic purpose of sterilization laws targeting gay men)); see also MARK A. LARGENT, BREEDING

In fact, the term “feeble-minded,” as used in many of the eugenics laws of the twentieth century, regularly referred to indecent or “sexually promiscuous behavior.”<sup>108</sup> Dressing and living in accordance with one’s self-identified gender rather than the one that was assigned at birth was criminalized as indecent or promiscuous behavior in many states—a reality that is reflected in cross-dressing bans of the era.<sup>109</sup>

Laws authorizing the sterilization of transgender people were justified by the eugenically-motivated rationale that it would not be in the best interest of children to have a trans parent.<sup>110</sup> Eugenicist R. W. Shufeldt, for example, reasoned that the United States would “continue to breed millions of sexual perverts and inverts—psychopathic types—just so long as any ignorant priest, justice of the peace or other party, is permitted to give people permission to breed them.”<sup>111</sup> This disturbing statement illustrates both the eugenics movement’s commitment to eliminating people it deemed sexually deviant by preventing them from having children, as well as the belief that this was within the state’s purview.

Some legal scholars, like Jon Ostrowsky, argue that the laws that targeted LGBTQ individuals sought to advance two goals that are “each distinct from the hereditary rationale of the eugenics movement.”<sup>112</sup> First, Ostrowsky argues that the “laws sought to deny, punish, and stigmatize LGBTQ individuals. . . .”<sup>113</sup> Second, he argues that the laws permitting sterilization tried to deter, incentivize, and control sexual conduct.<sup>114</sup>

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CONTEMPT: THE HISTORY OF COERCED STERILIZATION IN THE UNITED STATES 20–21 (2008) (describing methods of coerced sterilization); Ostrowsky, *Evolving Public Attitudes*, *supra* note 106.

108. Ostrowsky, *Birth Certificate Gender Corrections*, *supra* note 107, at 279 (2020) (citing ADAM COHEN, *IMBECILES: THE SUPREME COURT, AMERICAN EUGENICS, AND THE STERILIZATION OF CARRIE BUCK* 16 (2016) (“In the case of young women, [feeble-minded] often meant exhibiting what was regarded as an excessive or inappropriate interest in sex.”). Comstock laws also revealed states’ desire to regulate sexual conduct and ethics—what one scholar called “a media sensation . . . targeting feminists in a culture war over obscenity and birth control.” Annalee Newitz, *The 19th-Century Troll Who Hated Dirty Postcards and Sex Toys*, N.Y. TIMES (Sept. 20, 2019), [<https://perma.cc/B8KY-8YLT>].
109. Marc Stein, *Historical Landmarks and Landscapes of LGBTQ Law*, in *LGBTQ AM.: A THEME STUDY OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER HISTORY*, 19-1, 19-4 (Megan E. Springate ed., 2016).
110. A. J. Lowik, *Reproducing Eugenics, Reproducing While Trans: The State Sterilization of Trans People*, 14 J. GLBT FAM. STUD. 425, 426 (2018).
111. Hugh Ryan, *How Eugenics Gave Rise to Modern Homophobia*, WASH. POST (May 28, 2019), [<https://perma.cc/M79Z-AGF9>] (describing eugenicists who “taught people that homosexuality existed and that they should despise it.”).
112. See Ostrowsky, *Birth Certificate Gender Corrections*, *supra* note 107, at 279 (2020).
113. *Id.* at 279-80 (citing Ryan, *supra* note 111).
114. *Id.* at 280.

While it is important to recognize the particularities of different groups' experiences of state-sponsored sterilization, caution should be used when drawing lines that separate the state rationales that justified them. There is a danger of disregarding the intersectional dimensions of this violence, and the reality that many people of color were targeted because of overlapping and compounding forms of discrimination, both on the basis of LGBTQIA identity *and* because of their race. People of color were disproportionately targeted under public indecency laws, and still are.<sup>115</sup> Rather than drawing rhetorical lines between the rationales behind state-sponsored sterilization campaigns that targeted different groups, it seems more useful to focus on the core logic that permeated all such campaigns: that the U.S. government has routinely adopted the view that it can intervene, and interrupt, the reproduction of groups whom it deems unfit to parent.

This troubling line of reasoning is still enshrined in U.S. law. Even though the Supreme Court's 1942 decision in *Skinner v. Oklahoma* rejected eugenic sterilization as a valid state interest and recognized that procreation as a fundamental right,<sup>116</sup> *Buck v. Bell* was never expressly overruled. Its spirit remains, lurking behind policies that perpetuate reproductive oppression on marginalized people. It is within this context that we must understand the reluctance to protect the bodily and reproductive autonomy of young trans people. Failing to convey to trans youth the full range of their fertility preservation options, and denying them financial access to them, is simply one more iteration of the same, disturbing belief that they are not entitled to this care. America's lethargy in making fertility care affordable for everyone cannot be innocent in this context; it stands on the shoulders of centuries of reproductive oppression. Mandating fertility coverage and counseling is therefore essential if we hope to disrupt this history and achieve meaningful health equity in family building.

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115. Stein, *supra* note 109, at 19-6; *see also* Timothy Stewart-Winter, *Queer Law and Order: Sex, Criminality, and Policing in the Late Twentieth-Century United States*, 102 J. OF AM. HIST., 61, 70 (2016) (describing the disproportionate effects of anti-LGBTQ policing on gay Black and Latino activists).

116. Ostrowsky, *Birth Certificate Gender Corrections*, *supra* note 107, at 280 (2020) (citing *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942)).

### III. RECOMMENDED ACTIONS: MANDATING COVERAGE, COUNSELING, AND PROVIDER TRAINING

#### A. *Mandate Coverage for Fertility Care on All Individual, Group, and Medicaid Plans*

For healthcare to be financially accessible for everyone, available services must be comprehensive and covered regardless of one's insurance plan. Therefore, an important first step that states should take toward increasing access to care is to include fertility care (including FP and access to ART) and counseling within the scope of "family planning services" for all individual, group, and Medicaid plans. CMS guidance indicates that states have broad authority to do this and can be reimbursed by the federal government for 90% of the costs.<sup>117</sup> Mandating coverage is therefore not only ethical, but also a cost-effective measure that would expand access to coverage for many people who need it. Coverage should also be available regardless of one's gender and sexual orientation, which means that the mandate should include coverage for fertility preservation, infertility diagnosis, medications, ovarian stimulation, intrauterine insemination, IVF, surrogacy, and cryopreservation. Such comprehensive coverage would be transformative for transgender youth, not to mention the general population of people seeking fertility care.

#### B. *Develop a Comprehensive Guide for People Seeking Fertility Care*

Increased coverage will only lead to enhanced access if people understand what their options are. Funding must also be allocated toward an online, comprehensive, and youth-friendly guide to fertility care in each state. Young people need to be able to access information about their care options on their own terms and in private, and an online resource of this nature would allow them to learn about FP without engaging their parents in the process or needing to visit a doctor's office. To be effective, these guides must be federally mandated but developed in partnership with communities at the state level. This way, all states will be required to disseminate FP information, and this information can be responsive to the needs and care options that are available in each of them. Because trans youth are best situated to understand the needs of other trans youth

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117. See Ctrs. for Medicare and Medicaid Servs., Guidance Letter on Medicaid Family Planning Services and Supplies (June 14, 2016), [<https://perma.cc/BD45-A4SP>].

seeking this information, they should be the ones leading the writing and design process. The guides should include medically accurate information about local fertility care options that is explained in accessible, gender-inclusive language, and should be translated into multiple languages. Each guide should also provide a local directory of fertility care providers, noting which accept Medicaid and which provide FP counseling to trans youth. These guides could also provide an opportunity for communities to rate and review local providers as a new accountability mechanism for offering respectful and gender-affirming care.

*C. Reform Age of Consent, Parental Involvement  
Laws, and WPATH Guidance*

Requiring parental consent for transition care (including FP) prevents youth who cannot obtain it from getting the care they need. Many parents do not support their children's gender identity and refuse to help them throughout their transition and FP journey. Refusal or delay of gender-affirming care can have serious consequences, such as anxiety, depression and high-risk substance use, and suicide.<sup>118</sup> Thus, requiring parental consent for this care can be harmful, physically dangerous, and/or restrict the young person's ability to receive it.<sup>119</sup> Requiring young people to involve parents who have made it clear that they do not support their child's gender identity can be unsafe (physically and/or emotionally) for trans youth. It is therefore unethical to force youth to obtain parental consent for FP and transition care. Parental involvement laws and WPATH guidance on parental consent should be repealed.

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118. Samuel Dubin, Megan Lane, Shane Morrison, Asa Radix, Uri Belkind, Christian Vercler & David Inwards-Breland, *Medically Assisted Gender Affirmation: When Children and Parents Disagree*, 46 J. MED. ETHICS, 295, 298 (2020); See also Scott Leibowitz & Cynthia Telingator, *Assessing Gender Identity Concerns in Children and Adolescents: Evaluation, Treatments, and Outcomes*, 14 CURRENT PSYCHIATRY REP. 111, 119 (2012) (explaining research outcomes and treatment options for gender nonconforming youth); Sari L. Reisner, Ralph Vettes, M. Leclerc, Shayne Zaslow, Sarah Wolfrum, Daniel Shumer & Matthew J. Mimiaga, *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, 56 J. ADOLESCENT HEALTH 274 (2015) (describing negative mental health consequences among transgender youth as compared to that of cisgender youth).

119. See *Outlawing Trans Youth*, *supra* note 3, 2167-72.

#### D. *Invest in Provider Training Programs*

Many young people don't pursue FP simply because they never received fertility preservation counseling.<sup>120</sup> Thus, one important measure that is necessary in order to improve the landscape of FP access is to require that reproductive healthcare providers receive training on how to provide FP counseling. This training should be mandatory for all physicians who provide gender-affirming care and fertility preservation. Some transgender individuals cite the lack of affirming or culturally aware providers as a reason why they forgo FP.<sup>121</sup> It is therefore essential to develop more gender-affirming, trauma-informed, and culturally safe<sup>122</sup> counseling practices. Trans youth are those who will be most impacted by this training and are uniquely situated in terms of understanding where the current gaps exist, so it is essential to engage them as leaders in the development of the curriculum.

#### IV. CONCLUSION

The right to have a family, or “familial association,” has been described by our highest court as “perhaps the oldest of the fundamental liberty interests recognized by [the Supreme] Court.”<sup>123</sup> It does not belong to the rich, nor should it. All people—regardless of their income or identity—are capable of wanting and parenting a child and are potentially affected by an inability to conceive one. By mandating insurance coverage

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120. See Leena Nahata, Lisa T. Campo-Engelstein, Amy Tishelman, Gwendolyn P. Quinn & John D. Lantos, *Fertility Preservation for a Transgender Teenager*, 142 PEDIATRICS, Sept. 2017, at 1, 4 (“[M]any transgender teenagers report they had never been counseled by their doctors about FP.”).

121. See generally Ella Vermeir, *Improving Healthcare Providers' Interactions with Trans Patients: Recommendations to Promote Cultural Competence*, 14 HEALTHCARE POL'Y 11 (2018) (suggesting changes to patient care to improve trans healthcare experiences).

122. “Culturally safe care” refers to healthcare that is delivered in a manner that is cognizant of, and responsive to, power imbalances inherent in the healthcare system—notably those stemming from structural racism. *Culturally Safe Care*, PROVINCIAL HEALTH SERVS. AUTH., B.C. CTR. FOR DISEASE CTRL., [<https://perma.cc/3W4Q-9KE9>] “Indigenous cultural safety is the process of making spaces, services and organizations safer and more equitable for Indigenous people by considering current and historical colonial impact and seeking to eliminate structural racism and discrimination.” *Id.*

123. *Troxel v. Granville*, 530 U.S. 57, 65 (2000); see also *Kraft v. Jacka*, 872 F.2d 862, 871 (9th Cir. 1989) (finding intimate associational rights to be a fundamental liberty encompassed in the fourteenth amendment); *IDK, Inc. v. Clark Cnty.*, 836 F.2d 1185, 1191 (9th Cir. 1988) (protecting the right to “enter into and maintain certain intimate human relationships” within the freedom of association).

for all fertility care, ensuring access to information about care options and coverage, and consistently providing adequate FP counseling, states can radically transform access to FP for trans youth, and for everyone. ✿