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**Title:** Reproductive Health Insurance Coverage

**Introduced by:** Nicklas Bara for the Medical Student Section

**Original Author:** Bori Lesser-Lee and Alice J. Liu

**Referred To:** Reference Committee A

**House Action:** **APPROVED AS AMENDED**

Whereas, infertility affects 20 percent of married women of reproductive age, with 12.2 percent of women having ever received infertility treatment in 2019, and

Whereas, 42 percent of American adults claim to have used fertility treatments or personally know someone who has, and

Whereas, 31 percent of lesbians with insurance seek fertility and reproductive services, compared to 10 percent of heterosexual individuals, and

Whereas, the collective clinical definitions of infertility among several health organizations (i.e., the Centers for Disease Control, World Health Organization, and American College of Obstetricians and Gynecologists) can be summarized as "failure to become pregnant after 1 year of regular, unprotected sexual intercourse," and

Whereas, social infertility explores the relational or biographical factors, such as being single or in a same-sex relationship, limit one's ability to conceive, and

Whereas, the aforementioned clinical definitions, which serve as a basis for infertility diagnoses and subsequent access to care, endorse a physiological basis, though fail to recognize that infertility and the inability to conceive have both biological and social roots, and

Whereas, while recognizing infertility as a medical diagnosis has broadened heterosexual couples' access to fertility care and insurance coverage, the majority of patients undergoing in-vitro fertilization (IVF) pay out of pocket, as many insurance policies regularly exclude fertility care, only cover an infertility diagnosis, or do not cover IVF, and

Whereas, insurance companies offering IVF coverage only do so after patients reach an infertility diagnosis defined as "failing to conceive after six or twelve months of receiving fertility treatment" (i.e., IUI), thereby necessitating out of pocket payments for those navigating social infertility before gaining access to fertility insurance coverage, and

Whereas, the median price of IVF in the United States is \$19,200 for one cycle, with the full course of treatment costing significantly more, and

Whereas, transgender and gender diverse individuals undergoing hormonal therapy or surgical treatment risk impaired fertility as potential side effects, and

50           Whereas, In Michigan, there is no state mandate requiring insurers to offer coverage for  
51 fertility care or preservation, and

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53           Whereas, insurance coverage in Michigan is dependent on the insurance carrier and an  
54 employer's discretion to purchase an insurance rider for fertility diagnosis and treatment, and

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56           Whereas, Nebraska is the only state to offer Medicaid coverage of infertility treatments,  
57 though this is only available to patients with an underlying medical problem, thus excluding same-  
58 sex couples and single individual, and

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60           Whereas, even states that mandate coverage for fertility services, such as Utah, New York,  
61 New Jersey, Delaware, Connecticut, Rhode Island, Maine, and New Hampshire, continue to exclude  
62 same-sex couples and unmarried individuals from the definition of infertility required to qualify for  
63 fertility service coverage, and

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65           Whereas, Colorado, Illinois, Washington D.C., and Maryland are the only states that  
66 mandate coverage for fertility services for all individuals, including same-sex couples and single  
67 individuals attempting to access fertility services, and

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69           Whereas, the American Society of Reproductive Medicine (ASRM), in October 2023, issued  
70 an expanded infertility definition to incorporate "the need for medical intervention, including, but  
71 not limited to, the use of donor gametes or donor embryos in order to achieve a successful  
72 pregnancy either as an individual or with a partner" alongside traditional definitions, and

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74           Whereas, the World Professional Association for Transgender Health recommends health  
75 care providers offering gender-affirming care to transgender and gender diverse individuals should  
76 ensure they receive timely information about fertility preservation services prior to undergoing  
77 treatment, and

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79           Whereas, acknowledging both the physiological and social causes of infertility through a  
80 formal definition legitimizes access to care and treatment, regardless of relationship status or  
81 sexual orientation; therefore be it

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83           RESOLVED: That MSMS formally recognizes the concept and experiences of social infertility  
84 amidst the American Society of Reproductive Medicine's (ASRM) recently expanded infertility  
85 definition that incorporates "the need for medical intervention, including, but not limited to, the  
86 use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an  
87 individual or with a partner;" and be it further

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89           RESOLVED: That MSMS supports established definitions of infertility, etiologies of infertility,  
90 and evidence-based medicine recommended by the American Society for Reproductive Medicine  
91 and American College of Obstetrics and Gynecology for insurance coverage of fertility treatment  
92 and preservation.

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95           WAYS AND MEANS COMMITTEE FISCAL NOTE: \$16,000-\$32,000

**Relevant MSMS Policy** - None

## Relevant AMA Policy

### Preserving Access to Reproductive Health Services D-5.999

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

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