

Maria's Law: Extending Insurance Coverage for Fertility Preservation to Cancer Patients in Massachusetts

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ABSTRACT

This Note addresses the issues related to fertility preservation treatments for cancer patients in the context of insurance coverage. As cancer survival rates improve, the ability to bear children after therapy is increasingly difficult and a concern for most patients. Currently, no states have laws requiring insurance coverage for fertility preservation treatments for cancer patients. Because it is not currently covered by either private or public insurance, only those who can pay for it on their own can use fertility preservation treatments. This Note proposes that Massachusetts, as having one of the most inclusive infertility health insurance mandates, should expand insurance coverage to those who may become infertile because of cancer treatments. Such an expansion would ensure that cancer patients can receive fertility preservation treatment prior to commencing chemotherapy or radiation. This Note argues that insurance coverage should be extended because it improves a cancer patient's quality of life, and will promote consistency, fairness, and equality. Further, this Note explores the constitutional implications of oncofertility.

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I. INTRODUCTION

“The prospect of making it through cancer and then not having children to share that with seemed a bit like a death—a cut-off from the future.” Maria, 28, Ovarian Cancer¹

At twenty-eight years old, Maria Arruda found out that cancer took her ability to have children too. After battling three years of aggressive ovarian cancer, Maria felt a sense of defeat; something treasured had been irretrievably lost, and there was nothing to be done about it. Prior to chemotherapy, her doctor informed her that she could undergo fertility preservation and freeze her eggs. Maria’s health insurance coverage was small and Massachusetts did not even consider covering medical costs for someone like her. On March 16, 2003, she found out she could not have children. Her husband could not look at her. She felt inside her somewhere, adjacent to or below the ailing heart, a hungry, thirsty, empty, sore, haunted sensation of being unfinished, random, and unattached, as if, even if the body were working perfectly, there was nothing there for it to run.

She found herself looking forward to the night time. Sleep came down so fast it was only in dreaming that she felt the peculiar new thing: motherly. She imagined a daughter, having her lips, nose, and chin, caressing each part of her as if she were a rose that a gardener paused to admire. Her skin was soft and bright. Her hair was blonde and curly, just like her mother’s. That little girl was part of her flesh—flesh that wept, laughed, and danced on bare feet in the grass. Her child, in reality, had no face, no form, no voice, and no odor. She was a simple presence in her mind, an all-embracing tenderness with strength and a promise of rest.

Cancer patients like Maria are more commonplace today than ever before. Clinical infertility—the failure to conceive after a year of trying—is particularly common among adults who receive pelvis radiation and a class of chemotherapy drugs called alkylating agents.² Over the years, advances in radiation and chemotherapy have improved survival rates, but have significantly impacted the

¹ Telephone interview with Maria Arruda (October 6, 2013) (on file with author).

² Anahad O’Connor, *After Cancer, Fertility is Often Within Reach*, THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES (Mar. 27, 2014, 3:22PM), <http://fertilitycenter-uconn.org/after-cancer-fertility-is-often-within-reach/>.

reproductive capability of cancer survivors.³ Certain cancer treatments induce infertility rates of eighty percent or more, and some treatments estimate that up to ninety percent of cancer patients in their reproductive years will be rendered infertile from treatment.⁴ However, no states currently have laws providing for insurance coverage for fertility preservation treatments for patients that had cancer.⁵ As a result, many patients are unable to have biologically natural children after surviving the aggressive disease.

This Note argues that Massachusetts, as the leading state with the most inclusive infertility coverage,⁶ should provide insurance coverage for fertility preservation treatments for cancer patients about to receive chemotherapy and radiation. Part II of this Note discusses cancer's unfortunate consequences on a patient's reproductive system and their options for treatment. Part III surveys the different issues regarding insurance coverage for cancer patient fertility preservation treatment. Lastly, Part IV discusses the current infertility law in Massachusetts and suggests that Massachusetts should amend its current mandate by adding a clause to cover people facing infertility due to cancer treatment.

II. THE FIGHT TO SAVE TWO LIVES

"I was shocked. Then devastated. Never warned or prepared about this possibility until after it happened. I think the infertility was worse than the cancer."
Marcia, 27, Ovarian Cancer⁷

A. The Emerging World of Oncofertility

Survival rates among young cancer patients have steadily increased each year over the past four decades because of the development of

³ Seema Mohapatra, *Oncofertility and Reproductive Justice*, HARV. J. ON RACIAL & ETHNIC JUST. (forthcoming 2014) (manuscript at 4) (on file with author).

⁴ Daniel Basco et al., *Insuring Against Infertility: Expanding State Infertility Mandates to Include Fertility Preservation Technology for Cancer Patients*, 38 J.L. MED. & ETHICS 832, 836 (2010).

⁵ Mohapatra, *supra* note 3 (manuscript at 1).

⁶ Basco, *supra* note 4, at 832.

⁷ *Marcia, Survivor Stories*, FERTILE HOPE (Mar. 26, 2010), <http://www.fertilehope.org/find-support/cancer-survivor-stories-details.cfm?SID=641>.

effective cancer treatments.⁸ Increased survival is due to factors such as earlier detection of disease, intensive radiation therapy, and new chemotherapies.⁹ Data collected by the National Cancer Institute (“NCI”) reveals that there are 630,000 young survivors of cancer, and that number is increasing each year.¹⁰ Twenty five percent of breast cancer patients are younger than forty years old, and over 12,400 adolescents under nineteen are diagnosed with cancer each year with a cure rate of seventy-five percent.¹¹ Further, survival rates for childhood cancer have increased from twenty percent to eighty-one percent over the last forty years.¹² Ultimately, as the NCI reports, one out of every 250 adults will be a survivor of childhood cancer by 2015.¹³ This increased rate of survival among cancer patients is largely attributable to the tremendous rise in cancer curing drugs. However, one of the main complications of these cancer-curing drugs—particularly for young men, women, and children—is the impact on future fertility.¹⁴

“Oncofertility” is a new discipline that bridges the gap between oncology and new medicine in order to discover and apply new fertility preservation options for young patients with cancer.¹⁵ Under the emerging field of oncofertility, medical researchers are

⁸ The Oncofertility Consortium, *About the Oncofertility Consortium*, NORTHWESTERN UNIVERSITY, <http://oncofertility.northwestern.edu/about-us> (last visited December 15, 2013).

⁹ Teresa K. Woodruff, *The Emergence of a New Interdiscipline: Oncofertility*, in ONCOFERTILITY: FERTILITY PRESERVATION FOR CANCER SURVIVORS 3, 3 (Teresa K. Woodruff & Karrie Ann Snyder eds., Springer 2007).

¹⁰ *Id.* at 4.

¹¹ *Id.*

¹² NAT’L CANCER INST., SEER CANCER STATISTICS REVIEW 1975–2005, at 31 tbl.I-3 (2008), available at http://seer.cancer.gov/archive/csr/1975_2005/results_merged/sect_01_overview.pdf.

¹³ Woodruff, *supra* note 9, at 4.

¹⁴ *See id.* at 3.

¹⁵ The Oncofertility Consortium, *About the Oncofertility Consortium*, NORTHWESTERN UNIVERSITY, <http://oncofertility.northwestern.edu/about-us> (last visited Mar. 27, 2014). Dr. Woodruff, the Professor of Obstetrics and Gynecology at Northwestern University, coined the term “oncofertility” in 2006 to incorporate life-after-cancer care with treating the disease. The goal of oncofertility is to meet an emerging urgent unmet need for young cancer patients: balancing life-preserving treatments with fertility-preserving options. *Id.*

investigating new approaches to preserve a cancer patient's reproductive options.¹⁶

In addition, oncofertility strives to close not only the gap between oncology and new medicine, but also the wide information gap that exists in today's society.¹⁷ This information gap consists of the lack of understanding that cancer patients have regarding the possibility of infertility resulting from their cancer treatment.¹⁸ Ultimately, many doctors and oncologists focus on saving the patient's life rather than discussing the future possibility of infertility.¹⁹ However, oncofertility stresses the importance of oncology providers to facilitate discussions about fertility preservation and post-cancer quality of life.²⁰ It is critical for clinicians to educate patients on their options for fertility preservation early in the process for cancer risk management.

B. Infertility: Casualty of Cancer Treatment

Decreased fertility after cancer treatment is mainly caused by the exposure to radiation and the alkylating agent chemotherapy.²¹ Infertility is an unfortunate and likely result for many cancer patients, with certain cancer treatments inducing infertility rates of eighty percent or more.²² Some treatments estimate that up to ninety percent of cancer patients in their reproductive years will be rendered infertile from treatment.²³ Rates of infertility vary according to cancer site, type of treatment, and the age of a patient.²⁴

There are many different fertility preservation options available to newly diagnosed cancer patients. First, there are traditional options, which include adoption and third-party reproduction.²⁵ Second,

¹⁶ See Gregory Dolin, *Medical Hope, Legal Pitfalls: Potential Legal Issues in the Emerging Field of Oncofertility*, 49 SANTA CLARA L. REV. 673, 674 (2009).

¹⁷ See Brigid K. Martz, *Learning to Bridge the Information Gap*, THE ONCOFERTILITY CONSORTIUM (Dec. 5, 2013), <http://blog.oncofertility.northwestern.edu/>.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ Dolin, *supra* note 16, at 673.

²² Basco, *supra* note 4, at 836.

²³ *Id.*

²⁴ G.P. Quinn et al., *Frozen Hope: Fertility Preservation for Women with Cancer*, 55 J. MIDWIFERY & WOMEN'S HEALTH 175, 175 (2010).

²⁵ Third-party reproduction consists of gamete donation and/or uterine surrogacy for cancer patients whose therapies diminished these functions. Dolin, *supra*

assisted reproductive technology provides new and advanced ways to preserve fertility.²⁶ Technology is significantly advancing in the area of fertility preservation after cancer treatment.²⁷

In men, cancer itself may be correlated with low sperm counts.²⁸ However, the primary threat for male cancer patients is a compromised sperm production, quality, motility, and DNA damage caused by exposure to chemotherapy and/or radiation.²⁹ The most proven and successful method of fertility preservation for men is semen cryopreservation, where patients provide semen samples which are frozen for later use.³⁰ Intrauterine insemination or intracytoplasmic sperm injection is extremely effective, as one single sperm may be sufficient to result in a pregnancy.³¹ The primary concern for male cancer patients is to reach a sperm bank in a timely manner, as sperm represent a ready and available source in large numbers and can be cryopreserved easily.³²

In women, cancer treatments pose a variety of reproductive risks including immediate infertility, premature menopause, and compromised ability to carry a pregnancy due to uterine or cervical damage.³³ Women who undergo chemotherapy or radiation during their reproductive years have a forty to eighty percent chance of losing fertility.³⁴ Chemotherapy and radiation can damage or destroy oocytes

note 16, at 683. These options are valuable means of forming a family, but do not fulfill a woman's or man's desire to have biological children. *See id.* at 684.

²⁶ *See Dolin, supra* note 16, at 684.

²⁷ *See Ina N. Cholst, Oncofertility: Preservation of Reproductive Potential*, 61 DEPAUL L. REV. 763, 763 (2012).

²⁸ FERTILE HOPE, CANCER AND FERTILITY: FAST FACTS FOR REPRODUCTIVE PROFESSIONALS 5 (2008), available at http://www.fertilehope.org/uploads/pdf/FH_RP_FastFacts_08.pdf.

²⁹ *Id.*

³⁰ *See Dolin supra* note 16, at 684. If the male cancer patient cannot obtain a semen sample by ejaculatory methods because of the nature of his condition, a surgical biopsy can be performed and mature sperm may be extracted. *Id.*

³¹ *See id.*

³² *Id.*

³³ FERTILE HOPE, CANCER AND FERTILITY: FAST FACTS FOR ONCOLOGY PROFESSIONALS 6 (2008) http://www.fertilehope.org/uploads/pdf/08_FH_Onc_FastFacts.pdf [hereinafter CANCER AND FERTILITY: FAST FACTS].

³⁴ Quinn, *supra* note 24, at 175. Infertility rates vary depending on many factors; including cancer site, type of treatment, and the patient's age. Infertility in cancer patients can be caused by the cancer or the type of cancer treatment that is involved. Exact infertility rates are not known because no valid measures exist

and follicles, which can cause either immediate or premature menopause years after treatment.³⁵ In addition, surgery to remove reproductive organs such as the ovaries, fallopian tubes, uterus, and cervix will reduce a woman's ability to become pregnant or carry a child.³⁶ In addition, radiation can damage the uterus and increase the risk of miscarriage or low-birth weight.³⁷

A number of treatments are available for infertility for women but are more limited than those available to men.³⁸ The most common fertility preservation procedure is in vitro fertilization ("IVF").³⁹ There are also experimental options available such as in vitro maturation or ovarian tissue freezing.⁴⁰ The most well-established treatment, however, is to undergo ovarian stimulation for maturation and retrieval of the eggs.⁴¹ The oocytes are fertilized on the day of egg retrieval and

for women to establish that fertility was present prior to treatment. However, women who undergo chemotherapy or radiation during their reproductive years have a forty to eighty percent chance of losing fertility. Treatments using the alkylating agents of cyclophosphamide, methotrexate, and fluorouracil produce the greatest risk for infertility. Further, total body radiation and external beam radiation also produces great risks for infertility. *Id.*

³⁵ CANCER AND FERTILITY: FAST FACTS, *supra* note 33, at 6.

³⁶ *Id.*

³⁷ *Id.*

³⁸ Dolin, *supra* note 16, at 684. Many techniques that are used, including embryo and oocyte cryopreservation, require hormonal stimulation, which is problematic and thus poses many limitations. Cancer treatment must be delayed when undergoing stimulation procedures, but it is imperative that a patient begin treatment immediately after cancer diagnosis. In addition, ovarian stimulation may elicit reactions from hormonally responsive cancers, such as breast and ovarian cancers. *See id.* at 685.

³⁹ CANCER AND FERTILITY: FAST FACTS, *supra* note 33, at 12. With IVF, doctors retrieve eggs from a woman's ovary after hormonal stimulation of the ovaries, fertilize the eggs with sperm in a petri dish, and transfer some of the embryos to the woman's uterus. The remaining embryos are frozen for future use. *See* David Orenlicher, *Discrimination Out of Dismissiveness: The Example of Infertility*, 85 IND. L.J. 143. 154.

⁴⁰ In vitro maturation involves removing immature oocytes and then maturing them in vitro. CANCER AND FERTILITY: FAST FACTS, *supra* note 33, at 12. Once matured, the oocytes can either be frozen or fertilized to create embryos and then frozen. Ovarian tissue freezing involves the removal, sectioning and freezing of an ovary. The ovarian strips can be transplanted later to restore hormonal function and for use with IVF. *Id.*

⁴¹ Sanjay K. Agarwal & R. Jeffrey Chang, *Fertility Management for Women with Cancer*, in ONCOFERTILITY: FERTILITY PRESERVATION FOR CANCER SURVIVORS,

the resultant embryos are cryopreserved.⁴² The embryos can be thawed and transferred into either the patient's own uterus, providing that her uterus is viable for pregnancy, or that of another woman as a gestational surrogate.⁴³ The success rates for these procedures are dependent upon the woman's age at the time the eggs were retrieved and fertilized.⁴⁴

Traditional infertility patients are often able to receive infertility treatment until they are able to conceive, which differs dramatically from cancer patients.⁴⁵ Cancer patients have only one substantial chance at preserving fertility because they are only able to receive fertility treatment before they begin cancer treatment.⁴⁶ Consequently, cancer patients typically undergo treatment immediately or shortly after their diagnosis, giving them a short period of time to utilize fertility preservation treatment.

C. Insurance Coverage for Fertility Preservation Treatments

Insurance companies do not typically cover fertility preservation treatments because they are commonly viewed as elective procedures rather than medically necessary.⁴⁷ Infertility resulting from radiation or chemotherapy is typically known as an iatrogenic condition.⁴⁸ Insurance companies generally cover treatment for iatrogenic conditions that result from cancer treatment, even though they do not

at 6 (2007), http://oncofertility.northwestern.edu/sites/default/files/uploadedfile/content/onco_chapter_2.pdf.

⁴² *Id.* at 6.

⁴³ *Id.*

⁴⁴ *Id.* at 7.

⁴⁵ Basco, *supra* note 4, at 834.

⁴⁶ *Id.*

⁴⁷ Lisa Campo-Englestein, *Insurance Coverage for Cancer Treatment Induced Conditions: Comparing Fertility Preservation to Breast Reconstructive Surgery*, 61 DEPAUL L. REV. 849, 854 (2012).

⁴⁸ *Id.* at 854. An iatrogenic condition is a negative side effect or adverse condition that is caused by the diagnosis, manner, activity, or treatment of a healthcare provider. *Id.* Specifically, in relation to cancer, we refer to infertility as a nonnegligent iatrogenic condition, which occurs when medically necessary treatments have unavoidable or unpredictable negative side effects. For example, this may occur when cancer treatment causes infertility, hair loss, or nausea in a patient. *Id.* at 850.

cover these same conditions when they are naturally occurring.⁴⁹ However, infertility treatment is typically not covered.⁵⁰

Most health-care plans will not reimburse patients or physicians for the cost of IVF or other technologies to assist reproduction, and even when insurance provides coverage, it typically is inadequate.⁵¹ Twelve states mandate insurance coverage for infertility treatments, and two states require that coverage be offered.⁵² However, it appears that no state currently provides insurance coverage specifically for fertility preservation treatment for cancer patients. When an insurance company denies fertility preservation coverage, there is a minimal amount of time to appeal.⁵³ Consequently, cost and lack of insurance coverage are major reasons why many female patients do not undergo fertility preservation treatment.⁵⁴

The costs of fertilization preservation treatments and procedures vary.⁵⁵ The price to receive information and advice about procedures

⁴⁹ *Id.* at 851.

⁵⁰ *Id.*

⁵¹ Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER, L. & JUST. 18, 22 (2009).

⁵² *Id.*

⁵³ Mohapatra, *supra* note 3 (manuscript at 3); Nat'l Conference of State Legislatures, *State Laws Related to Insurance Coverage for Infertility Treatment* (May 2009), <http://www.ncsl.org/programs/health/50infert.htm>.

⁵⁴ A study conducted from January 2011 to October 2012 surveyed reproductive aged women with cancer who were being counseled by a reproductive health clinic for fertility preservation. Patients completed surveys at four different points in time, including before and after a new patient consultation, at the time they made a decision about fertility preservation, and six to eight months after consultation. The possible reasons for not undergoing fertility preservation included: risks to fertility from cancer treatment, cost, lack of insurance coverage, age, delay of cancer treatment, and future pregnancy's effect on long term prognosis. Ninety-four women were surveyed, and fifty-two percent of women did not undergo FP, ninety percent of which identified cost and lack of insurance coverage as the reason for not undergoing treatment. *See* E.E. Niemasik, et. al., *It Comes Down to Money: Why Women Decide Not to Undergo Fertility Preservation*, 98 FERTILITY AND STERILITY S122 (2012); *see also* DEBORA L. SPAR, *THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION* 30 (2006) ("In this market, therefore, price acts harshly as a constraint on demand. The desire is there, as we know. So, increasingly, is the supply. Yet the price of this supply is still too high for many potential buyers, leaving supply and demand to meet at a point well below their full potential.").

⁵⁵ Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 300 (2005).

typically only cost the amount of a general office visit.⁵⁶ Further, the price of treatment intrauterine insemination is typically only a few hundred dollars.⁵⁷ However, estimates for IVF range from \$8,000 to \$10,000 per procedure, and patients usually must undergo more than one procedure during this process.⁵⁸ Below, in Table 1, is a summary of the average prices of the most common fertility preservation treatments.⁵⁹

Table 1: Summary Statistics of Fertility Preservation Prices

	Oocyte Cryopreservation	Embryo Cryopreservation	Sperm Cryopreservation	Sperm Storage
Avg. Price	\$6608	\$8285	\$244	\$381 annually

Many different views exist as to why insurance coverage is not extended to cancer patients. First, many of the most effective assisted reproductive technologies are deemed experimental and many insurers do not cover experimental procedures.⁶⁰ Further, insurance companies typically cover conditions that currently exist or conditions that are certain to occur, and infertility is not definite.⁶¹ Even after a patient undergoes fertility preservation procedures, the embryos, eggs, or ovarian tissue may not be used until some later time in the far future.⁶² Finally, insurance companies find that fertility preservation is vastly complex when compared to other side effects of cancer because it affects the patient's family and future offspring.⁶³ These views will be addressed and challenged thoroughly in Part IV.⁶⁴

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Fertility Preservation for Cancer Patients: Demographic Disparities in Counseling and Financial Concerns are Barriers to Utilization*, AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE (Oct. 23, 2013), http://www.socrei.org/Fertility_Preservation_for_Cancer_Patients_Demographic_Disparities_in_Counseling_and_Financial_Concerns_Are_Barriers_to_Utilization/.

⁶⁰ Mohapatra, *supra* note 3 (manuscript at 14).

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *See infra* Part IV.

Despite the criticism, oncofertility is making its way to the insurance sphere. Currently, Connecticut,⁶⁵ Hawaii,⁶⁶ New Jersey,⁶⁷ and California⁶⁸ have bills pending that deal with fertility preservation insurance coverage specifically for cancer patients. The California Bill, in particular, would require a health care service plan and a health insurer to provide, on a group and individual basis, coverage for medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility.⁶⁹ Further, the United States Congress also has a bill pending for a similar goal.⁷⁰ The Family Act of 2013 has been introduced into both the U.S. Senate and U.S. House of Representatives—S 881/HR 1851, respectively—and will provide critical financial support for young people with cancer, autoimmune disorders, and other conditions whose treatment may save their lives yet damage their ability to have children in the future.⁷¹ The Family Act will create a tax credit for eligible taxpayers to cover fifty percent of the cost of IVF and fertility preservation up to the maximum amount set by the ATC—\$12,970 this calendar year.⁷²

Further, in June 2013, the American Medical Association (AMA) adopted a policy that supports coverage by all insurance providers of fertility preservation treatment for cancer patients undergoing treatments “that may result in infertility”.⁷³ The AMA stated that

⁶⁵ A.B. 5644, Gen. Assembly Reg. Sess. (Conn. 2013).

⁶⁶ H.B. 2105, 26th Leg., Reg. Session (Haw. 2012).

⁶⁷ A.B. 2479, 215th Leg., 1st Session (N.J.2012).

⁶⁸ A.B. 912, Reg. Session (Cal. 2013-2014).

⁶⁹ *Id.* The fiscal effect of Bill AB 912 was found to result in approximately \$69,000 of additional costs to the California Public Employees' Retirement System for additional premiums and unknown costs, potentially greater than \$100,000, to the extent the fertility treatment preservation services exceed the Essential Health Benefits (EHB) of the Affordable Care Act (ACA). Quirk-Silva, *Bill Analysis for A.B. 912, Reg. Session (Cal. 2013-2014)* 1, available at http://leginfo.ca.gov/pub/13-14/bill/asm/ab_0901-0950/ab_912_cfa_20130624_135304_sen_comm.html.

⁷⁰ See H.R. 1851, 113th Cong., 1st Session (2013). S.B. 881, 113th Cong., 1st Session (2013).

⁷¹ *Id.*

⁷² *Id.*

⁷³ *AMA Adopts New Policies on First Day of Voting at Annual Meeting*, AMERICAN MEDICAL ASSOCIATION (June 17, 2013), <http://www.ama-assn.org/ama/pub/news/news/2013/2013-06-17-new-ama-policies-annual-meeting.page#>.

coverage for infertility treatments “should be an essential part of the management of [patients] cancer.”⁷⁴ This policy treats infertility as a side-effect of treatment or a negative condition created by cancer.⁷⁵ Consequently, it is slowly being recognized that the need for fertility preservation treatment is a result of a medical condition and not just a desired elective procedure.⁷⁶

III. CURRENT LAW: MASSACHUSETTS AND FERTILITY COVERAGE

“I am saddened that so many people not only have to go through cancer and the treatments required just to overcome this disease and be able to live, but also have to worry about whether or not they will ever become parents.” Thomas, 34, Testicular Cancer⁷⁷

In 1987, Massachusetts passed the Act Providing a Medical Definition of Infertility (“Infertility Act”).⁷⁸ RESOLVE, a national infertility advocacy group based in Massachusetts, began pushing for an insurance mandate.⁷⁹ This advocacy group wanted infertility to be labeled as a medical condition necessitating treatment, removing it from the sphere of a cosmetic problem to a medical problem.⁸⁰ Thus, the confluence of interests created a mandate to include insurance coverage requirements for infertility services at the same level as pregnancy-related services.⁸¹

In Massachusetts, infertility refers to the condition of an individual who is unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35.⁸² Under the mandate, all

⁷⁴ *Id.*

⁷⁵ Angela Krausfeldt, *Support for Fertility Preservation Now an AMA Policy!*, THE ONCOFERTILITY CONSORTIUM (June 28, 2013), <http://blog.oncofertility.northwestern.edu/2013/06/support-for-fertility-preservation-is-now-an-ama-policy/>.

⁷⁶ *Id.*

⁷⁷ *Thomas, Survivor Stories*, FERTILE HOPE (March 26, 2010), <http://www.fertilehope.org/find-support/cancer-survivor-stories-details.cfm?SID=626>.

⁷⁸ See K. Cullen, *Law Orders Coverage for Infertility*, BOSTON GLOBE, October 9, 1987.

⁷⁹ Basco, *supra* note 4, at 833.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² 211 C.M.R. § 37.03 (2012).

insurers providing pregnancy-related benefits shall provide for the diagnosis and treatment of infertility, including the following: artificial insemination; IVF; GIFT; sperm, egg, and/or inseminated egg procurement and processing; and banking of sperm of inseminated eggs, to the extent such costs are not covered by the donor's insurer.⁸³ Under the mandate, however, insurers are not required to cover, but are not prohibited from recovering, experimental infertility procedures, surrogacy, reversal or voluntary sterilization.⁸⁴ Further, Massachusetts insurance companies and HMPs must cover "the medically necessary expenses of diagnosis and treatment of infertility."⁸⁵ The statute further places limits to the same extent as they are provided for other pregnancy-related procedures and—subject to the other terms and conditions of the subscription certificate—coverage for medically necessary expenses of diagnosis and treatment of infertility.⁸⁶

Massachusetts' infertility mandate is one of the most inclusive health insurance mandates regulating coverage for infertility services in the United States.⁸⁷ The Massachusetts mandate creates a review system that allows for additional infertility services to be covered as medical technology advances and procedures move from experimental to routine.⁸⁸ Unlike other states, Massachusetts' mandate places few limitations on covered procedures.⁸⁹ However, the mandate still fails to include patients who face infertility due to cancer treatment.

The Affordable Care Act ("ACA") is unlikely to have a dramatic impact on infertility care and does not directly address infertility coverage.⁹⁰ However, the law does give states the power to determine the scope of insurance coverage for a variety of medical conditions

⁸³ See 211 MASS. CODE. REGS. § 37.05 (2013).

⁸⁴ 211 MASS. CODE. REGS. § 37.07 (2013).

⁸⁵ MASS. GEN. LAWS ANN. ch. 175, § 47H (West 2010).

⁸⁶ MASS. GEN. LAWS ANN. ch. 176B § 4J (West 2010).

⁸⁷ Basco, *supra* note 4, at 833.

⁸⁸ *Id.*

⁸⁹ See 211 MASS. CODE. REGS. § 37.09 (2013).

⁹⁰ Paul R. Brezina et. al., *How Obamacare Will Impact Reproductive Health*, 31 SEMIN REPROD MED. 189, 197 (2013), available at http://www.medscape.com/viewarticle/803528_5. There is no language in the ACA that explains how state-mandated infertility coverage will or will not be affected. Insurance companies will not be required to cover infertility services at a federal level. There is also no language in the ACA that will make public payers, such as Medicaid, to cover infertility. See *id.*

and procedures, including infertility.⁹¹ Consequently, ACA does little to standardize the state-mandated insurance policies dealing with the diagnosis and treatment of infertility.⁹² The ACA does require that health plans offered in the small group and individual markets cover Essential Health Benefits (“EHBs”) effective January 1, 2014, but this does not necessarily include infertility treatment.⁹³ As Massachusetts currently mandates coverage for infertility treatment, it also included the infertility mandate in its Benchmark plan.⁹⁴ Thus, in Massachusetts, infertility treatment is an essential benefit.⁹⁵ It might therefore be said that, because the ACA does not mandate infertility treatment, it does not pose an incredible disadvantage or even make a big difference in infertility treatment via insurance coverage.⁹⁶

Unfortunately, while extremely inclusive, the mandate primarily affects those who have health insurance and who meet the Massachusetts definition of infertility. The Massachusetts mandate essentially is designed for a “presumably healthy individual.”⁹⁷ Unfortunately, cancer patients are not included under the definition of infertility in Massachusetts because cancer patients are not considered physiologically or medically infertile at the time when fertility preservation treatment would take place.⁹⁸ Therefore, it is under the assumption that medicine is reactive, treating conditions that already

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.* EHBs are the medical services, supplies, or prescription drugs required to be covered in all small group and individual health plans, but it does not include the level of cost-sharing (copayments, deductibles, or coinsurance). *See id.* at 194.

⁹⁴ *See* Michael Cahill, *What the Affordable Care Act Does Wrong When it Comes to Infertility Treatment*, THE CENTER FOR INFERTILITY JUSTICE (Jul. 23, 2013), <http://www.resolve.org/get-involved/legislative-issues/blog/what-the-affordable-care-act-does-wrong.html>.

⁹⁵ *See id.*

⁹⁶ Brezina, *supra* note 90, at 195. The ACA could facilitate access to fertility treatments in mandated states. First, the ACA will make health insurance available to many individuals who would be otherwise uninsured. Second, insurers will be unable to use preexisting conditions to determine coverage eligibility. Consequently, this will significantly help individuals faced with infertility seeking insurance, particularly in states that mandate infertility coverage. *Id.*

⁹⁷ Basco, *supra* note 4, at 833.

⁹⁸ *Id.* at 836.

exist, rather than being proactive in preventing conditions from existing in the future.⁹⁹

Under existing state law, a cancer patient is considered part of the general population with regard to the class of persons protected by laws relating to infertility. This is problematic because cancer survivors have characteristics that set them apart from the general population intended to be addressed by fertility insurance law.¹⁰⁰ The language of the law itself attests to the non-applicability of its provisions to cancer patients, particularly young, unmarried men and women.¹⁰¹ Therefore, cancer survivors would have to wait until they met the clinical definition of infertility before attempting to use insurance benefits.¹⁰² This is unlikely because chemotherapy and radiation are prone to render a patient without viable sperm or eggs, and the most likely chance of success will come from the sperm or eggs harvested before the initiation of cancer treatment.¹⁰³

IV. SOLUTION: EXTENDING FERTILITY PRESERVATION COVERAGE TO CANCER PATIENTS

“Having breast cancer made me want children even more. When you are faced with your own mortality each day, you want to make sure you leave some sort of legacy behind.” Tonya, 21, Breast Cancer¹⁰⁴

A. Proposed Legislation and Implementation

Massachusetts should provide insurance coverage for fertility preservation procedures for cancer patients about to receive chemotherapy and radiation, both of which often cause infertility. Treatment to preserve fertility in men and women can be done before chemotherapy or radiation and can be used after the patient is free of cancer.¹⁰⁵ Particularly, Massachusetts should add a clause to its current

⁹⁹ *Id.*

¹⁰⁰ Gwendolyn P. Quinn et al., *State Laws and Regulations Addressing Third-Party Reimbursement for Infertility Treatment: Implications for Cancer Survivors*, 95 FERTILITY AND STERILITY 72, 74 (2011).

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Tonya, Survivor Stories*, FERTILE HOPE (Apr. 24, 2010), <http://www.fertilehope.org/find-support/cancer-survivor-stories-details.cfm?SID=651>.

¹⁰⁵ Quinn, *supra* note 100, at 72.

mandate extending fertility preservation insurance coverage to cancer patients. With this legislation, Massachusetts would create a separate and different definition of infertility for cancer patients and survivors. Thus, although cancer patients would not be able to meet the standard definition of infertility, they would be able to meet the separate definition of infertility set out in the amended mandate. The added clause may look as follows, as modeled by the California Bill A.B. 912¹⁰⁶:

(1) Every group or individual health care service plan that is issued, amended, or renewed on and after January 1, 2016, that provides hospital, medical, or surgical coverage shall include coverage for medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to an enrollee.

(2) For purposes of this section, the following terms have the following meanings:

(a) “Standard fertility preservation services” means procedures consistent with established medical practices and professional guidelines published by the American Society of Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional organizations.

(b) “May directly or indirectly cause” means treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional organizations.

The current Massachusetts mandate gives the Massachusetts Commissioner of Insurance the authority to establish a list of required and optional infertility benefits, along with the authority to oversee the process of adding new procedures to what would be covered.¹⁰⁷ In order for a new procedure to be added, an individual must petition the commissioner to recognize the procedure as fundamental or non-experimental.¹⁰⁸ This process has allowed for the mandate to evolve as medical technology advances without the need for further legislative steps.¹⁰⁹

¹⁰⁶ S.912, Gen. Assemb. Reg. Sess. (Cal. 2013).

¹⁰⁷ Basco, *supra* note 4, at 833.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

With the increase in survival rates and decrease in fertility due to new and advanced cancer-curing drugs, the commissioner may amend the existing mandate, as modeled above, to include cancer patients. The mandate would ultimately provide separate standards for cancer patients to meet the definition of infertility. This is an extremely beneficial and workable option, as it recognizes that cancer patients have limited time to preserve their fertility before beginning treatment that is likely going to render them infertile. Massachusetts should implement this flexible policy with the insurance mandate so that the mandate will evolve as technology advances. Thus, with medical technology and advances in cancer survival, it is plausible for Massachusetts to take this route and extend coverage for cancer patients in this way.

Further, health insurance mandates have become extremely popular in the United States, especially those specifically centered on cancer.¹¹⁰ From 2000 to 2003, an average of seventy six health insurance mandates were passed per year, which rose from fifty nine mandates per year during the 1990s.¹¹¹ Every state now has at least one health insurance mandate applying to cancer.¹¹² For example, all states now have legislation regulating coverage for breast reconstructive surgery after surviving breast cancer and many states also address coverage for diagnosing prostate cancer.¹¹³ As mandates are becoming more common place, it may be reasonable to predict that an addition to a mandate will be passed for cancer patients to receive infertility treatment insurance coverage.

B. Why Should Coverage Be Extended?

In one study of cancer survivors, seventy-six percent of those who were childless expressed a desire to have biological children in the future.¹¹⁴ Most fertility preservation treatments and procedures for cancer patients are not covered by insurance, even in Massachusetts which has mandated IVF coverage. Those who are unable to have children because of certain cancer treatments thus must pay out of

¹¹⁰ *Id.* at 837.

¹¹¹ *Id.*

¹¹² Basco, *supra* note 4, at 837.

¹¹³ *Id.*

¹¹⁴ L. R. Schover, *Motivation for Parenthood After Cancer: A Review*, 34 J. NAT'L CANCER INSTITUTE OF MONOGRAPHS 2, 5 (2005), available at <http://jncimono.oxfordjournals.org/content/2005/34/2.full.pdf>.

pocket for further treatment for infertility. As discussed more below, this section suggests that coverage for infertility preservation should be expanded to cancer survivors due to the issues of quality of life, fairness, consistency, equality, and certain constitutional considerations.

1. Quality of Life

The inability to reproduce, although not life-threatening or harmful, adversely affects a person's quality of life tremendously. Men and women typically do not expect to be infertile, and news of infertility comes as a severe shock.¹¹⁵ Consequently, infertility is extremely emotionally distressing. Psychological responses to infertility range from surprise, denial, anxiety, anger, guilt, low self-esteem, isolation, hopelessness, feelings of unfulfillment, social withdrawal, and depression.¹¹⁶ Those who experience infertility also experience changes to their perceptions of their lives. This can include feelings of an inability to plan the future, the inability to find meaning in life, and the overgeneralization of loss of control over reproduction to other aspects of life.¹¹⁷

Many studies have found that infertility patients also find infertility to be one of the most upsetting experiences of their lives.¹¹⁸ In addition to a cancer diagnosis, many people deal with infertility as they would a loss of a loved one.¹¹⁹ Infertility brings not only the loss of the ability to have children, but the loss of pregnancy, childbirth, and breastfeeding, and experiences of genetic continuity, parenthood, and relationships.¹²⁰ Ultimately, cancer patients may also deal with subsequent repercussions of infertility that require more extensive medical appointments, testing, medication, surgeries, physical pain, numerous unfortunate side effects, fear, grief, and psychological identity adjustment.¹²¹

¹¹⁵ Katherine T. Pratt, *Inconceivable? Deducting the Costs of Fertility Treatment*, 89 CORNELL L. REV. 1121, 1127 (2004).

¹¹⁶ Jody Lynee Madeira, *Woman Scorned? Resurrecting Infertile Women's Decision-Making Autonomy*, 71 MD. L. REV. 339, 370 (2012).

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 370–71.

¹¹⁹ *Id.* at 371.

¹²⁰ *Id.*

¹²¹ *Id.* at 372.

Mandating insurance coverage for fertility preservation thus has the power to transform the quality of life for cancer survivors.¹²² Without insurance coverage, patients may opt out of fertility preservation, which may result in high costs for the survivor years later when he or she is trying to build a family and create a life after cancer, and further enforce the feelings of anguish and grief that patients' experience.¹²³ If men and women have the option to preserve their fertility before undergoing treatment—and have the opportunity to afford it—they will not have to deal with these other devastating effects of cancer and their quality of life will improve greatly.

In terms of financial impact, expanding this coverage is only for a relatively small number of people during their reproductive years and will only minimally impact insurance premiums when spread out amongst all insured persons.¹²⁴ Without such coverage, patients are unable to afford this unexpected out-of-pocket expense, especially when facing other significant costs surrounding the cancer treatment itself.¹²⁵ A study conducted in 1998 revealed that mandated infertility coverage was associated with increased use of assisted reproductive technology, but there were no excessive increases in consumer cost for infertility insurance coverage.¹²⁶ While expanding coverage to include infertility treatment for cancer patients may increase demand because of the lower costs to patients, these increases would be small considering the limited number of people who are diagnosed with cancer at the heart of their reproductive age.¹²⁷ For example, one study demonstrated that if utilization of IVF rose to a high of three hundred

¹²² Madeira, *supra* note 117, at 372–73.

¹²³ *See id.* at 372.

¹²⁴ *California Bill AB 912: Mandated Fertility Preservation Coverage*, THE ONCOFERTILITY CONSORTIUM (Apr. 5, 2013), <http://blog.oncofertility.northwestern.edu/2013/04/california-bill-ab-912-mandated-fertility-preservation-coverage/>.

¹²⁵ *Id.*

¹²⁶ Martha Griffin & William F. Panak, *The Economic Cost of Infertility-Related Services: An Examination of the Massachusetts Infertility Insurance Mandate*, 70 FERTILITY AND STERILITY 22, 22 (1998). Cost data was obtained from the Massachusetts Department of Insurance Rate-Setting Commission and nine large group insurance plans for the period of 1986–1993 and examined the utilization and success rates of ART. *Id.* Infertility services amounted for 0.41% of total expenditures within the indemnity plan in 1993. *Id.*

¹²⁷ *Id.*

percent as a result of expansion, premiums would only increase about nine dollars per employee per year.¹²⁸

Further, although nontraditional parenting is becoming more prominent in today's society, the options of adoption and the use of donor gametes and surrogacy should not substitute extending insurance coverage all together. Cancer survivors face significant obstacles when dealing with non-biological parenting options.¹²⁹ Options such as these are costly, and adoption is typically restricted to young and healthy married couples.¹³⁰ In order to adopt a child, agencies frequently require documentation and proof that cancer survivors have been disease-free for at least five years.¹³¹ These options may provide an individual with the means of *forming* a family, but fail to fulfill the desire of many individuals to *making* a family. Thus, these options do not vastly improve a patient's quality of life.

2. Consistency and Fairness

Health care providers often provide for certain measures to prevent iatrogenic conditions from occurring.¹³² Almost every side effect of cancer and its treatment is covered by health insurance except for infertility.¹³³ First, insurance covers antiemetics for nausea and dental evaluations for osteoradionecrosis.¹³⁴ Other conditions resulting from cancer, such as hair loss, are also covered under insurance.¹³⁵ Scholars have compared infertility treatments to breast reconstruction procedures, which are also covered by insurance.¹³⁶ Covering infertility treatment for cancer patients with iatrogenic infertility ultimately creates consistency and fairness in policy coverage, rather

¹²⁸ Jessica L. Hawkins, *Separating Fact from Fiction: Mandated Insurance Coverage of Infertility Treatments*, 23 WASH. U. J.L. & POL'Y 203, 221 (2007).

¹²⁹ Clarisa R. Garcia & Jacqueline S. Jeruss, *Lives in the Balance: Women With Cancer and the Right to Fertility Care*, 31 J. CLINICAL ONCOLOGY 1, 2 (2013), available at <http://jco.ascopubs.org/cgi/doi/10.1200/JCO.2012.47.5798>.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² Basco, *supra* note 4, at 834.

¹³³ See *Triaging Fertility Preservation & the AMA*, TRIAGE CANCER (July 1, 2013), <http://triagecancer.org/blog/triaging-fertility-preservation-the-ama/>.

¹³⁴ Basco, *supra* note 4, at 834.

¹³⁵ Campo-Engelstein, *supra* note 47, at 856.

¹³⁶ *Id.* at 854. The Women's Health and Cancer Rights Act of 1998 mandated that if insurers covered mastectomy (breast removal), then they must also cover breast reconstruction. *Id.*

than treating infertility differently than other iatrogenic conditions that are covered.

Although insurance companies rarely cover experimental procedures, many fertility preservation treatments are no longer considered experimental by scientists.¹³⁷ The freezing of a woman's eggs has become increasingly ordinary, with seventy to ninety percent of eggs surviving the process.¹³⁸ Further, the technology of egg preservation and freezing is improving rapidly.¹³⁹ Most importantly, egg and ovarian tissue cryopreservation are the only options available for young or single women to be able to have a child in the future with someone without a sperm donor.¹⁴⁰ Fertility preservation options should be available for single women to have a biological child in the future with the person of their choice.

Although infertility cannot be calculated to an exact certainty—like hair loss or the loss of a breast—this should not preclude insurance coverage of the condition. For instance, insurance companies provide coverage for nausea, although it may not be absolutely certain to occur.¹⁴¹ They also cover storing one's blood as a prophylactic precaution in case there needs to be an emergency transfusion, which also cannot be predicted.¹⁴² Similarly, patients undergoing cancer treatment also may find themselves rendered infertile, and thus fertility preservation treatment, like blood storage, should be saved in that “just-in-case” scenario. This speaks to consistency and fairness, and Massachusetts should set the way for insurance to cover iatrogenic infertility.

Cancer patients are simply not responsible for their infertility, and not providing them insurance coverage for a medical implication out of their control promotes unfairness. However, for example, it is possible, albeit crass, to suggest that a woman who seeks fertility preservation treatment to address age-related infertility is responsible for her own condition because she *intentionally* delayed her child-bearing; yet this is covered by insurance.¹⁴³ It would be equally absurd to suggest that a patient with cancer—who is typically not “causally

¹³⁷ *Id.* at 856.

¹³⁸ Mohapatra, *supra* note 3 (manuscript at 15).

¹³⁹ Campo-Englestein, *supra* note 47, at 856.

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ Basco, *supra* note 4, at 836.

responsible” for his or her condition¹⁴⁴—who decides to have treatment that could result in infertility should not get insurance coverage for his or her condition. Rather, our present system forces a cancer patient to ultimately choose between two losses: the loss of life or the loss of fertility.¹⁴⁵ Because there is no causal responsibility, as it is out of a cancer patient’s control, and because insurance companies already cover other “possible” side effects, insurance companies should extend their own policies and extend coverage.

3. Equality

An insurance mandate that is extended to cancer patients can create a sense of equality in certain ways. First, anecdotal evidence from Massachusetts suggests that because the state recognizes same-sex marriages and gives equal insurance benefits regardless of marriage, coverage may be expanded to include same-sex couples and could expand to unmarried cancer patients.¹⁴⁶ Second, equality among men and women can be considered when dealing with extending the infertility mandate to cancer patients. Fertility preservation treatment is a lot cheaper for men than it is typically for women.¹⁴⁷ Thus, extending insurance coverage for cancer patients will allow women more affordable options for treatment that are closer in price to their male counterparts.

Inequality is not created by extending coverage because those who will never need infertility treatments have to pay for them. The purpose of health insurance, ultimately, is to pool risks in order to provide affordable health care for all members.¹⁴⁸ Those who are insured pay into the insurance pool, hoping they will never have to utilize it.¹⁴⁹ On the contrary, infertile couples or individuals must pay for others’ maternity and childbirth expenses that they are unable to use, diminishing any trace of unfairness or inequality.¹⁵⁰

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ Quinn, *supra* note 24, at 180.

¹⁴⁷ *Infra* Part II.C.

¹⁴⁸ See John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 312 (1997).

¹⁴⁹ See William C. Cole, *Infertility: A Survey of the Law and Analysis of the Need for Legislation Mandating Insurance Coverage*, 27 SAN DIEGO L. REV. 715, 736 (1990).

¹⁵⁰ *Id.* Insurance companies consider the costs of “childbearing and potential fetal health problems” when calculating insurance premiums. *Id.*

4. Constitutional Considerations

Finally, although the courts have not considered the issue of fertility preservation treatment and cancer directly, the rights to reproduce and bear children are rooted in American law and should be taken into consideration. The Supreme Court has recognized the ability to have children as a fundamental right.¹⁵¹ Further, the Supreme Court has established that reproduction is a central role in the lives of many individuals, and has also labeled reproduction as a major life activity.¹⁵² Cases involving the right to use contraceptives further demonstrate that the right to make decisions regarding sexual activities and reproduction is a substantive due process right, as the Supreme Court has protected a married couple's right to use contraceptives in *Griswold v. Connecticut*.¹⁵³ Thus, the Court described reproductive freedom as "intimate to the degree of being sacred."¹⁵⁴ The Court extended the protection beyond married couples to single individuals in *Eisenstadt v. Baird*, holding that the right to privacy encompasses the right of a single individual to make his or her own decisions as to whether "to bear or beget a child."¹⁵⁵ Taking it even further, in *Ohio v. Akron Center for Reproductive Health*, the Supreme Court extended this right to minors.¹⁵⁶

While no state explicitly protects a right to use assisted reproductive technology ("ART") or procedures such as IVF, both state and federal governments implicitly acknowledge that such a right exists.¹⁵⁷ As Massachusetts mandates insurance coverage for IVF, it necessarily recognizes the legality of ART to support citizens' access to these services.¹⁵⁸ Thus, some courts currently acknowledge that procreative liberty encompasses, subject to state and judicial

¹⁵¹ See *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) ("We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race.").

¹⁵² See *Bragdon v. Abbot*, 524 U.S. 624, 638 (1998) ("Reproduction falls well within the phrase 'major life activity.' Reproduction and the sexual dynamics surrounding it are central to the life process itself.").

¹⁵³ See *Griswold v. Connecticut*, 381 U.S. 479, 485–86 (1965).

¹⁵⁴ *Id.* at 486.

¹⁵⁵ *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

¹⁵⁶ *Ohio v. Akron Ctr. For Reprod. Health*, 497 U.S. 502, 506–07 (1990).

¹⁵⁷ Dolin, *supra* note 16, at 679.

¹⁵⁸ *Id.* at 678–79.

regulation, the right to use ART.¹⁵⁹ Not allowing cancer patients to undergo fertility preservation treatment under the current mandate therefore inhibits their right to reproduction, creating various constitutional concerns. Not being able to afford these procedures, a patient should therefore argue that this inhibits their substantive due process right to make decisions about reproduction.

5. Further Concerns and Comments

The area of oncofertility raises a number of moral and ethical questions. Among these concerns are the ethical implications of removing and freezing embryos; the question of who can consent to a procedure; property ownership of the reproductive material; and the control of the reproductive tissue if the patient has died.¹⁶⁰ Questions of financing, religious objections, and access must be considered.¹⁶¹ The emerging field of oncofertility creates new hope and possibilities for individuals whose fertility may be compromised by cancer treatment and it is a field that is still growing. The Oncofertility Consortium continues to expand their analysis on such legal and ethical implications, striving for patients to have the ability to have children and to exercise their freedom to make reproductive decisions in the most ethical and legal manner.¹⁶²

V. CONCLUSION

“I remember seeing a picture in my breast surgeon’s office that has a list of things that cancer cannot do. And I wanted that to include that it couldn’t take pregnancy away from us. Even if we never use the eggs or get pregnant on our own, it would be a blessing. I refer to my frozen eggs as my pocket full of sunshine.”
Michele Foust, 26, *Breast Cancer*¹⁶³

Advances in medicine and technology now allow young cancer patients the option of preserving their fertility, and it is important that these patients have the monetary tools necessary to do so. The

¹⁵⁹ See *id.* at 679–80.

¹⁶⁰ See Dolin, *supra* note 16, at 715–16.

¹⁶¹ *Id.*

¹⁶² See *id.* at 716.

¹⁶³ Emily Wax, *Saving Fertility Pre-Chemo options May Help Cancer Patients Who Still Want to Have Kids*, CHICAGO DAILY HERALD (Sep. 9, 2013).

technology exists that allows cancer patients to enter survivorship with the option to have a biological child, but is out of reach due to extensive costs.¹⁶⁴ As the emerging field of oncofertility continues to grow, insurance companies will be faced with how to handle infertility for cancer patients. Amending the Massachusetts infertility mandate to include cancer patients is an equitable and cost-effective solution to a foreseeable harm from medically necessary treatment. This amendment to the mandate not only symbolizes the importance of fertility preservation treatment and the severity of infertility as a disease, but also opens the door for more discussions between patients and providers about fertility preservation treatment. Further, the amendment would improve a patient's quality of life, and create a sense of fairness, consistency, and equality that is currently lost.

The success rates for infertility treatments continue to improve, and a more expansive insurance coverage is likely to lead to more effective treatments while lowering the risks of infertility associated with cancer. For an individual or a couple who receives news of possible infertility, it can be devastating. Indeed, there is a dark irony in the fact that medical technology exists to enable them to have a child, but health insurance does not provide coverage for them. Although Massachusetts provides infertility coverage to the general public, it is simply not enough, as it excludes cancer patients. The amendment to the mandate would include a tragically excluded population while keeping costs low. Most importantly, the amended mandate would enable cancer patients to fulfill one of the most basic and beloved human desires: creating a family.

After going through cancer and divorce battles, Maria now lives alone and constantly contemplates what life would be like if she never had cancer. She now lives in a society which indicated in every possible way that she was a broken woman, with thin hair and cracked eyebrows, with not a lash left on her eye. Her therapist suggested writing her thoughts down, and she decided to try, for she had nothing left to lose.

She sits on her porch, with great wounds, beginning to scratch in a notebook. The moon was about in the same position it was always in, and provided enough light on her notebook to write. With tired hands and wet eyes, she picked up a pen and began to write: "At twenty-eight years old, I found out that cancer took my ability to have children too."

¹⁶⁴ See Niemasik, *supra* note 54, at S122.