Last Updated: March 26, 2026

AN INITIATIVE OF
STATE INNOVATION EXCHANGE

Fertility Preservation and Beyond: State Policy Approaches to Increase Access to Fertility Treatments

Despite significant advances to fertility treatments, such as egg freezing and In Vitro Fertilization (IVF), access to and affordability of this care is severely lacking in the United States. Fertility treatments can be cost prohibitive, mainly because they are not often covered by health insurance plans. Because of the lack of private, state, and federal coverage, some states have passed legislation that provides some insurance coverage for fertility treatments. Additionally, although recent polls demonstrate that the majority of Americans believe people should have access to fertility treatments, like IVF, political and legal challenges increasingly threaten access to comprehensive reproductive healthcare.

IN THIS BRIEF

BACKGROUND

In June 2024, the Right to IVF Act, championed by Senators Tammy Duckworth (D-IL), Senator and Chair of the Senate Appropriations Committee Patty Murray (D-WA), and Senator Cory Booker (D-NJ), failed to advance to a full U.S. Senate vote. This bill has been blocked by Republican Senators twice. No federal legislation exists regarding fertility treatments, and insurance coverage for fertility treatments is limited and varies by insurance provider and state. Twenty-three states mandate some insurance coverage for fertility treatments; however, some state insurance mandates are more comprehensive than others.

Even though the U.S. Congress has been unable to pass legislation that guarantees the right to access In Vitro Fertilization (IVF) services, public support for IVF, the most common fertility treatment responsible for the birth of approximately 2.3% of babies born in the U.S. each year, is high. According to Pew Research 70% of adults believe that people having access to IVF is a "good thing" and a survey conducted by The Associated Press-NORC Center for Public Affairs Research found that about 6 in 10 adults favor protecting access to IVF, including 77% of Democrats and 56% of Republicans.[1] [2]

Fertility treatments are used by a variety of people: those who are single, in LGBTQ relationships, undergoing gender-affirming treatment, have genetic or other health concerns (e.g. cancer patients), people with disabilities, and/or people diagnosed with infertility, among others. Fertility treatments are also increasingly needed and used by people of reproductive age. According to a national survey, 13% of reproductive age women reported needing fertility services to become pregnant or prevent a miscarriage at some time in their lives; however, there are many barriers to accessing fertility treatments: cost, insurance coverage, provider availability, and time constraints. Cost is the leading reason women say that they could not access fertility treatments and 48% of women who have needed fertility treatments say it is difficult to get care in their state.[3]

The cost of fertility treatments remain high and cost prohibitive, mainly because they are not often covered by health insurance. For instance, the average cost of one egg freezing cycle in the U.S. is $11,000, with additional charges for hormone medication and storage. The U.S. Department of Health and Human Services estimates the cost for a single cycle of IVF can range from $15,000 to $20,000, and can exceed $30,000 if a donor egg is involved.[4] KFF's 2024 Employer Health Benefits Survey found that among firms with 200 or more employees that offer health benefits, only 27% provide coverage for IVF.[5] Because of the lack of private and federal coverage, some states have passed some sort of legislation that mandates some insurance coverage for fertility treatments.

---

[1] Gabriel Borelli. "Americans overwhelmingly say access to IVF is a good thing." Pew Research, 13 May 2024.
[2] "Most support protecting access to IVF." AP-NORC Center, 12 July 2024.
[3] Usha Ranji, Karen Diep, Brittni Frederiksen, Ivette Gomez, and Alina Salganicoff. "Access to Fertility Care: Findings from the 2024 KFF Women's Health Survey." KFF, 21 October 2024.
[4] "Fact Sheet: In Vitro Fertilization (IVF) Use Across the United States." U.S. Department of Health and Human Services, 13 March 2024.
[5] "2024 Employer Health Benefits Survey." KFF, 9 October 2024.

States with IVF and fertility preservation coverage mandates include California, Colorado, Connecticut, Delaware, Illinois, Massachusetts, Maryland, Maine, New Hampshire, New Jersey, New York, Rhode Island, and Utah.[6] Texas mandates coverage for fertility preservation and that infertility or IVF coverage are offered but not required. Kentucky and Oklahoma only mandate fertility preservation coverage while Louisiana and Montana have mandated fertility preservation and some infertility coverage. Arkansas only mandates that IVF be covered, and Ohio and West Virginia mandates some infertility coverage. [7] However, even states with the most comprehensive insurance mandates have some significant limitations, such as:

- Employers who self-insure are exempt from the requirements of the law.
- Employers with fewer than either 25 or 50 employees do not have to provide coverage.
- Exclusions for religious employers.
- Age restrictions (for example, IVF cycles might only be covered for women between the ages of 25 and 42).
- Caps on the number of IVF cycles.
- Exclusions on coverage for surrogacy and/or donor eggs.
- Storage costs are not included.

Additionally, Medicaid does not provide comprehensive fertility coverage in any state. Medicaid in New York provides 3 cycles of ovulation-enhancing drugs and monitoring while a few states cover fertility preservation procedures for iatrogenic infertility (infertility that is caused by medical treatments or procedures): Illinois, Maryland, Montana (cancer patients only), Oklahoma (cancer patients only), and Utah (cancer patients only). No state Medicaid program covers artificial insemination (IUI) or IVF. The lack of fertility coverage in Medicaid programs disproportionately impacts Black and Latinx communities since, among women of reproductive age, Medicaid programs cover 30% of Black women and 26% of Latinas compared to 15% of white women. Additionally, eligibility for Medicaid is based on low-income which means most people enrolled in Medicaid could not afford to pay for fertility treatments or related services out of pocket.[8]

[6] According to the U.S. Department of Health and Human Services, fertility preservation is the process of saving or protecting eggs, sperm, or reproductive tissue so that a person can use them to have biological children in the future.
[7] "Insurance Coverage by State." Resolve, 30 September 2024.
[8] "Coverage and Use of Fertility Services in the U.S." KFF, 15 September 2020.

Policy and Legal Landscape

The 2022 *Dobbs v. Jackson Women's Health Organization* decision exacerbated abortion restrictions and bans across the U.S., and has emboldened state courts to continue to drastically restrict people's rights to make personal decisions about their own sexual and reproductive health care and how they make a family. For example, in early 2024, the Alabama Supreme Court ruled, in *LePage v. Mobile Infirmary Clinic*, that frozen human embryos are "extrauterine children." The court ruled that someone who destroys embryos can be civilly sued for wrongful death under Alabama's Wrongful Death of Minors Act. What is particularly underhanded about the outcome of the case is that it was not brought by anti-abortion plaintiffs, but rather, by families who were pursuing IVF and lost their embryos due to alleged clinic negligence. However, anti-abortion justices on the Alabama Supreme Court weaponized the case to push their agenda.

The decision in *LePage* had an immediate and direct impact on Alabama residents' ability to become parents since several hospitals in the state halted its IVF services in response to the court case. Conservative state legislators passed a 'fix' bill later in 2024, but that legislation only provided protection against civil and criminal liability for IVF patients and providers. It did not address the dangerous embryonic personhood language in *LePage* or the sweeping pregnancy criminalization implications. It also leaves patients without any recourse in the case of any harm caused to them by fertility clinics if their embryos are destroyed through the clinic's negligence.

The *LePage* decision will have implications beyond Alabama's borders and is likely to encourage litigation involving IVF and other fertility treatments to be brought in other states, especially under the current post-*Dobbs* Trump administration, that may limit or eliminate access to fertility treatments. Moreover, abortion restrictions and the concept of fetal/prenatal personhood, a radical legal doctrine that seeks to endow fertilized eggs, embryos, and fetuses with full rights and legal protections, pose a threat to assisted reproduction. Seventeen states have already established fetal/prenatal personhood by law or judicial decision to apply to criminal and/or civil laws, and at least 24 states include personhood language in anti-abortion laws.[9]

In 2025, there were bills introduced in state legislatures that attempted to restrict access to fertility treatments by repurposing anti-abortion tactics, such as bills in Arkansas and Texas, that would impose medically unnecessary and burdensome reporting

[9] For more on fetal/prenatal personhood, see Unpacking Fetal Personhood: The Radical Tool That Undermines Reproductive Justice. Pregnancy Justice, 23 September 2024.

requirements on providers of fertility treatments as well as implement unnecessary reporting requirements about embryos that could potentially increase pregnancy criminalization. These Targeted Restrictions of IVF Provider (TRIP) bills use the same structure and have the same intent as Targeted Restrictions of Abortion Provider (TRAP) laws.[10] Fertility treatment advocates are also warning policymakers to be vigilant against misleading terms, such as "Ethical IVF," and "Restorative Reproductive Medicine" (RRM), which was used in Arkansas' Reproductive Empowerment and Support Through Optimal Restoration (RESTORE) Act, that could be used to promote ideologically driven restrictions that could limit patient care. RRM typically excludes IVF and related treatments on moral or religious grounds, not clinical evidence, and its proponents create a false narrative that standard fertility care skips proper diagnosis or healing.[11]

POLICY RECOMMENDATIONS

The example bills and initiatives below are a reference to be used within a collaborative governance model in order to secure and sustain meaningful racial, social, and economic justice outcomes. We invite values-aligned state legislators to partner with issue advocates and grassroots leaders. Together, they can commit to centering the people most impacted by systemic and structural oppression to transform the conditions of power at the state level.

Proactive Legislation

Fertility Preservation

Some bills about or that include fertility preservation in state insurance mandates are written narrowly and can miss including coverage for LGBTQ people by, for example, only requiring coverage for people who have received a cancer diagnosis. Ideally, any fertility preservation bill would cover fertility preservation for anyone who is expected to receive treatment that may directly or indirectly risk their fertility, including gender affirming treatments. The language in these insurance mandates should be inclusive and non-discriminatory in order to ensure the broadest access to fertility preservation and avoid the singling out of any specific reasons someone might be seeking it.

---

[10] "IVF Under Attack: Anti-Reproductive Freedom Fertility Doctrines," Center for Reproductive Rights, 11 June 2025.

[11] For more on "Ethical IVF" and "Restorative Reproductive Medicine" (RRM), see Just the Facts: "Restorative Reproductive Medicine" and "Ethical IVF" are Misleading Terms That Threaten Access. American Society For Reproductive Medicine Center for Policy & Leadership, May 2025.

The states that provide the most comprehensive state mandated insurance coverage for fertility preservation are Colorado, Connecticut, Delaware, Maryland, Maine, New Hampshire, New Jersey, New York, Rhode Island, Utah, and Washington D.C.. Colorado, Maine, Massachusetts, New Hampshire, and Washington D.C. can serve as a model for providing fertility preservation coverage to any person who is expected to receive treatment that may directly or indirectly risk their fertility, including those who are receiving gender-affirming treatments. These insurance mandates use similar language to define fertility preservation and include a reference to the guidelines published by American Society for Reproductive Medicine and the American Society of Clinical Oncology. The mandates generally define Standard fertility preservation services as "procedures that are consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology," and generally define fertility preservation as needed "when a person is expected to undergo surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment of fertility." Additionally, the cost of storage can be expensive and storage costs for preserved gametes (eggs or sperm) and embryos are rarely covered by insurance. New Hampshire's statute provides language for how to include storage costs into a law:

- New Hampshire: "Standard fertility preservation services means procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology. Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide coverage for...fertility preservation when a person is expected to undergo surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment of fertility. This includes coverage for standard fertility preservation services, including the procurement and cryopreservation of embryos, eggs, sperm, and reproductive material determined not to be an experimental infertility procedure. **Storage shall be covered from the time of cryopreservation for the duration of the policy term. Storage offered for a longer period of time, as approved by the health carrier, shall be an optional benefit.**"

Comprehensive Fertility Treatment Coverage

The states with the strongest and most comprehensive insurance mandates include Connecticut, Illinois , Massachusetts, New Jersey, New York (S719; A2817), and Rhode

Island. They can serve as examples for providing more comprehensive coverage as they include In Vitro Fertilization (IVF) coverage in their insurance mandates. Additionally, some states like Connecticut and New Jersey, for example, also include intrauterine insemination (IUI) in their insurance mandate.[12] The language of their mandates also uses a definition of infertility that aligns with The American Society for Reproductive Medicine's definition of infertility, and allows people with same sex partners and people without partners to qualify for infertility coverage.[13]

Some examples of the language used by states with more comprehensive insurance mandates include:

- **Illinois** mandates that companies that provide group health insurance, have 25 or more employees, and provide pregnancy related coverage must provide fertility treatment including, but not limited to: diagnosis of infertility; in vitro fertilization (IVF); embryo transfer; artificial insemination; gamete intrafallopian transfer (GIFT); and zygote intrafallopian transfer (ZIFT). Under the insurance mandate, each patient is covered for up to 4 egg retrievals; however, if a live birth occurs, two additional egg retrievals will be covered, with a lifetime maximum of six retrievals covered. The coverage mandate also applies to fertility preservation. These plans must provide coverage for medically necessary expenses for standard fertility preservation services when a necessary medical service may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

- **New Jersey** mandates that any insurance provider who provides pregnancy-related benefits must also cover infertility treatment and IVF costs. The law also requires health plans contracting to cover state employees and teachers

[12] Intrauterine insemination (IUI) is a procedure that places sperm into a woman's uterus around the time of ovulation. "Fact Sheet: INTRAUTERINE INSEMINATION (IUI)," ReproductiveFacts.org, 2021.

[13] The American Society for Reproductive Medicine defines ''infertility'' as a disease, condition, or status characterized by any of the following: 1) The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. 2) The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner. 3) In patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older. DEFINITION OF INFERTILITY: A COMMITTEE OPINION, ASRM, 2023.

must include the same infertility coverage. Under the coverage mandate, insurers must provide infertility treatment including, but not limited to: diagnosis and diagnostic tests; medications; IUI; in vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate; genetic testing; medical costs of egg or sperm donors; 4 completed egg retrievals and unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when recommended and deemed medically appropriate by a physician; standard fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility.

States could further increase access to fertility treatments for their constituents by the expansion of comprehensive fertility coverage into Medicaid. Legislative, provider, and patient advocacy to expand insurance coverage regardless of the insurance payor would expand access to fertility treatments and provide more people the ability to build their families.

SiX Policy Agenda

SiX's policy agenda provides model legislation and resources to improve access to reproductive healthcare, including two model bills related to fertility care: the Fertility Care Coverage Act and the Right to Fertility Treatment Act. Our model bills seek to center the autonomy of birthing people to make healthcare decisions for themselves and their families that best meet their needs, including access to healthcare when trying to conceive. We urge legislators to use the models as a starting point and to work closely with state advocates and community members to craft solutions specific to your state's needs.

STATE POLICY THREATS

Various bills were introduced in 2025 that include fetal/prenatal personhood language as well as bills that specifically targeted access to fertility treatments– attempting to restrict access to fertility care by repurposing anti-abortion tactics and using misleading terms, such as "Restorative Reproductive Medicine" (RRM) and "Ethical IVF." Below are some examples.

- Arkansas introduced HB 1554, which would require Arkansas fertility clinics to report detailed data on assisted reproductive technology (ART) procedures, such as the total number of embryos created, their outcomes, and the success rates of different ART procedures, with the Department of Health publishing an annual public report based on this data. This legislation would impose medically

unnecessary and burdensome reporting requirements on providers of fertility treatments as well as implement unnecessary reporting requirements about embryos that could possibly be used for pregnancy criminalization. Additionally, anti-abortion policymakers have seized on abortion reporting as an additional tool for restricting access and, with this bill, could do the same for IVF. These Targeted Restrictions of IVF Provider (TRIP) bills are repurposing anti-abortion tactics, and use the same structure and have the same intent as Targeted Restrictions of Abortion Providers (TRAP) laws. (Status: Withdrawn and Recommended for study in the Interim by the Committee on Public Health, Welfare and Labor Committee on 4/1/25)

- Arkansas introduced (HB 1142) and **enacted** (now Act 859) the Reproductive Empowerment and Support Through Optimal Restoration (RESTORE) Act, which uses the misleading term "**Restorative Reproductive Medicine**" (RRM) and promotes ideologically driven restrictions that will limit patient care. RRM typically excludes IVF and related treatments on moral or religious grounds, not clinical evidence. Its proponents create a false narrative that standard fertility care skips a proper diagnosis or healing. (Status: Became Public Law on 4/17/25)
- Indiana HB 1334 seeks to amend the Indiana Code concerning criminal law and procedure, with a focus on extending legal protections to unborn children. (Status: Referred to Committee on Courts and Criminal Code 1/13/25)
- Kansas introduced HB 2010, a total abortion ban that does not include an exception to save the life of the pregnant person despite the Kansas State Supreme Court reaffirming the proactive constitutional amendment passed in 2022. The legislation would give fertilized embryos and fetuses the same rights as people, potentially threatening access to fertility treatments like in vitro fertilization. (Status: Withdrawn from Committee on Interstate Cooperation; Rereferred to Committee on Health and Human Services on 3/17/26)
- North Dakota HB 1373 (North Dakota Century Code) aims to redefine the terms "human being" and "person" to include an "unborn child" in the context of murder, assault, and civil actions for wrongful death. (Status: House– Dead, 2/12/25 Second reading, failed to pass)
- Oklahoma SB 456 seeks to extend the definition of homicide to include the "killing of an unborn child," thereby repealing provisions that previously allowed for abortion. (Status: Failed in Committee - Judiciary 2/19/25)
- South Carolina HB 3537 defines life starting at fertilization in state law. (Status: Referred to Committee on Judiciary 1/14/25)
- Texas introduced HB 3132, which would require Texas fertility clinics to report detailed data on assisted reproductive technology procedures, such as the total number of embryos created, their outcomes, and the success rates of different ART procedures, with the Texas Health and Human Services Commission. Like Arkansas' HB 1554, this legislation would impose medically unnecessary and burdensome reporting requirements on providers of fertility treatments as well as implement unnecessary reporting requirements about embryos that could

possibly be used for pregnancy criminalization. Additionally, anti-abortion policymakers have seized on abortion reporting as an additional tool for restricting access and, with this bill, could do the same for IVF. (Status: Referred to the House Committee on Public Health 3/20/25)

RESOURCES

- SiX Webinar: Expanding Access to Fertility Care & Protecting Families: What Legislators Can Do Now
- Glossary: Terms Related to Fertility Treatments (SiX)
- ReproductiveFacts.org (ASRM)
- Resolve: The National Infertility Association
- Society for Assisted Reproductive Technology

CONTACT INFORMATION:

Please contact the State Innovation Exchange (SIX) Reproductive Rights team at reproductiverights@stateinnovation.org with questions or requests for more information.