
LESBIANS, GAYS, AND PEOPLE LIVING WITH HIV: FACING AND FIGHTING BARRIERS TO ASSISTED REPRODUCTION

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Numerous discriminatory barriers limit the ability of gays, lesbians, and people living with HIV to participate in assisted reproduction. Many of these barriers are created by laws and regulations, such as state laws criminalizing sperm donation by people living with HIV, and insurance regulations that are interpreted to limit infertility coverage to persons who have engaged in unprotected heterosexual intercourse that has not resulted in pregnancy. Other barriers are rooted in policies or practices of individual entities or individuals. For example, a gay man in Florida and a lesbian in California denied fertility services due to their sexual orientation have been the subject of recent civil rights proceedings brought by Lambda Legal Defense and Education Fund (“Lambda Legal”), a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work. This article explains some of the discriminatory barriers affecting equal access to assisted reproduction currently faced by lesbians, gays, and people living with HIV and discusses legal strategies that have been used to attack those barriers.

I. INTRODUCTION

Assisted reproduction is a matter of particular importance to lesbians and gays. If they wish to have genetically related children, lesbians and gays generally turn to assisted reproduction to make that feasible. Lesbians use artificial insemination in order to conceive and gays use surrogates to bear children using their sperm.¹ In addition, some gay men donate their sperm, without desiring to play a parental role in any resultant child’s life, so that women—known or unknown to them—can use it to conceive. In their efforts to use assisted reproductive technologies, lesbians and gays face the burdens encountered by

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¹ See, e.g., Justyn Lezin, *(Mis)conceptions: Unjust Limitations on Legally Unmarried Women’s Access to Reproductive Technology and Their Use of Known Donors*, 14 HASTINGS WOMEN’S L. J. 185, 188 (2003) (many lesbians choose/desire to conceive via assisted reproductive technologies); see also Catherine DeLair, *Ethical, Moral, Economic and Legal Barriers to Assisted Reproductive Technologies Employed by Gay Men and Lesbian Women*, 4 DEPAUL J. HEALTH CARE L. 147, 148 (2000).

others seeking such services, such as high costs and paucity of qualified service providers.² Moreover, because marriages of same-sex couples are not allowed or even legally recognized in most of the United States, barriers to assisted reproduction based on marital status³ fall especially heavily on lesbians and gays. A different set of barriers arises specifically because of the sexual orientation of lesbians and gays. In addition, people who have the human immunodeficiency virus—HIV—face special barriers to using assisted reproductive technologies, irrespective of their sexual orientation.⁴

This article provides an overview of major limitations on access to assisted reproduction that are based on sexual orientation or HIV status and discusses some of the legal strategies that have been used to challenge such limitations.⁵ Part II of this article provides brief background on assisted reproductive technologies and related medical issues of particular relevance to lesbians, gays, and people living with HIV. Part III discusses the following restrictions on access to assisted reproduction by members of those communities: federal and state restrictions on sperm donations by gay men and men living with HIV, limitations on insurance coverage for assisted reproductive services, and denial of access to lesbians, gays and people living with HIV due to provider bias and/or religious beliefs. Part IV discusses some legal bases that might be used to challenge denials of services to lesbians, gays, and people living with HIV, and illustrates such challenges with information about two matters in which Lambda Legal has represented clients denied fertility services due to their sexual orientation.⁶

² See, e.g., DeLair, *supra* note 1, at 151-63.

³ See, e.g., Holly J. Harlow, *Paternalism Without Paternity: Discrimination Against Single Women Seeking Artificial Insemination by Donor*, 6 S. CAL. L. & WOMEN'S STUD. 173 (1996) (discussing restrictions posing difficulties for unmarried/single women); see also Lezin, *supra* note 1, at 188.

⁴ The term "HIV" is commonly used to refer not only to the virus itself, but also to "HIV infection" or "HIV disease." See, e.g., Centers for Disease Control and Prevention ("CDC"), *Living with HIV/AIDS*, <http://www.cdc.gov/hiv/resources/brochures/livingwithhiv.htm#q2> (last modified June 21, 2007). The diagnosis of "acquired immunodeficiency syndrome" (or "AIDS") typically is used to refer to an advanced stage of HIV infection, but the terms "HIV" and "AIDS" are often used interchangeably and are sometimes referred to as "HIV/AIDS." *Id.*

⁵ This article does not address restrictions on the availability of assisted reproduction that impact everyone seeking such services, such as state laws regulating surrogacy arrangements, although such restrictions may be particularly problematic for gays or lesbians due to their need for assisted reproduction in order to have genetically-related children. Nor does this article attempt to provide a comprehensive survey of all laws, regulations, and practices which limit access to assisted reproduction for lesbians, gays, and people living with HIV. Also not addressed here are the implications for adoption, child custody, and other family law matters of lesbians and gays becoming parents through the use of assisted reproduction. See, e.g., John A. Robertson, *Gay and Lesbian Access to Assisted Reproductive Technology*, 55 CASE W. RES. L. REV. 323, 355-59 (2004); Richard F. Storrow, *The Bioethics of Prospective Parenthood: In Pursuit of the Proper Standard for Gatekeeping in Infertility Clinics*, 28 CARDOZO L. R. 2283, 2299-308 (2007).

⁶ Some of the barriers discussed in this article also impact bisexuals and/or transgender people. For example, limitations on sperm donations by men who have had sex with men will impact some bisexuals, transgender people are especially likely to encounter bias in the medical profession, and limitations affecting people with HIV will impact some bisexuals and transgender people. However, this article does not specifically address barriers faced based on transgender or bisexual status.

II. BACKGROUND

Assisted reproduction has been defined as “the use of non-coital technologies to conceive a child and initiate pregnancy.”⁷ This very definition illustrates the relevance of assisted reproduction to lesbians and gays, who do not wish to engage in sexual intercourse with a person of the opposite sex. The assisted reproductive technology of most relevance to lesbians is artificial insemination, through which semen—whether from a known or anonymous sperm donor—is introduced into a woman’s vagina or uterus by a method other than sexual intercourse.⁸ A gay man seeking genetic offspring may seek the services of a surrogate mother, with the egg(s) being fertilized by his sperm and the surrogate inseminated by means of artificial insemination.⁹ A woman serves as a surrogate mother by carrying to term a child conceived using her own egg—oocyte—or an egg donated from another woman which has been fertilized in vitro and then implanted in her; in the former situation, she is referred to as a traditional surrogate and in the latter, she is referred to as a gestational surrogate.¹⁰ In vitro fertilization involves combining an egg and sperm in a laboratory dish to achieve fertilization and then transferring the resulting embryo into a woman’s uterus.¹¹ Sperm used in these technologies may be “fresh”—i.e., recently ejaculated—or thawed “frozen” or “cryopreserved” sperm.¹² Lesbian couples seeking to have a child who is genetically linked to both of them may try to combine—through artificial insemination or in vitro fertilization—egg(s) from one of them with sperm from a male relative of the other; similarly, gay couples may use sperm from one and eggs from a female relative of the other.¹³

Assisted reproduction technologies also have a special relevance for HIV-positive individuals. Unprotected sexual intercourse with a partner who has HIV poses the risk that the person with HIV will transmit the virus to his or her sexual partner.¹⁴ Artificial insemination allows a woman living with HIV to have children

⁷ Robertson, *supra* note 5, at 324.

⁸ See, e.g., DeLair, *supra* note 1, at 149.

⁹ *Id.* at 149-50, 163 n.140; see also Robertson, *supra* note 5, at 359.

¹⁰ See DeLair, *supra* note 1, at 149-50; see also American Society for Reproductive Medicine (“ASRM”), *Assisted Reproductive Technologies: A Guide for Patients*, 12 (2008), available at <http://www.asrm.org/Patients/patientbooklets/ART.pdf>.

¹¹ See ASRM, *supra* note 10, at 20; see also DeLair, *supra* note 1, at 150 n.23 (noting the benefits and disadvantages for gay men of using a traditional or gestational surrogate).

¹² See, e.g., Lezin, *supra* note 1, at 192-93; see also ASRM, *supra* note 10, at 11.

¹³ See, e.g., John A. Robertson, *Procreative Liberty and Harm to Offspring in Assisted Reproduction*, 30 AM. J. LAW & MEDICINE 7, 37 (2004).

¹⁴ See, e.g., CDC, *Fact Sheet: HIV and Its Transmission* 1, 4 (July 1999), available at <http://www.cdc.gov/hiv/resources/factsheets/PDF/transmission.pdf> (identifying sexual contact with a person who has HIV as a means of transmission of HIV and noting the effectiveness of condom use in preventing pregnancy and transmission of HIV); see also CDC, *Condoms and STDs: Fact Sheet for Public Health Professionals* 2 (last updated Mar. 26, 2009), <http://www.cdc.gov/condomeffectiveness/latex.htm> (discussing effectiveness of condoms in preventing HIV transmission and specifically noting epidemiological studies showing that “consistent use of latex condoms provides a high degree of protection” from transmission of HIV from one sexual partner to the

without risking infecting her sexual partner.¹⁵ The risk that a woman with HIV will transmit HIV to her child during pregnancy or labor and delivery has been almost eliminated in the United States, largely through the use of HIV treatment and with some additional risk reduction through delivery by caesarian section.¹⁶

HIV has been found in the semen of men who have HIV; semen is the fluid in which the male reproductive cells—spermatozoa—are located.¹⁷ Artificial insemination allows the female partner of a man living with HIV to have children using a sperm donor, thus avoiding any risk of HIV infection.¹⁸ Sperm to be used in artificial insemination technologies is tested for the presence of HIV in most situations.¹⁹ To avoid the risk of transmitting HIV through donated sperm obtained from sperm banks, most sperm is frozen and quarantined for six months.²⁰ Before the frozen sperm is released for use, a new sperm sample is obtained from the donor and tested for infectious diseases, including HIV.²¹

Although HIV is present in semen, some researchers believe that it is not present in spermatozoa and that “sperm washing” can reduce or possibly eliminate the presence of HIV, while permitting spermatozoa to remain alive and potent.²²

other).

¹⁵ See, e.g., Eric S. Daar & Judith F. Daar, *Human Immunodeficiency Virus and Fertility Care: Embarking on a Path of Knowledge and Access*, 85 FERTILITY & STERILITY 298, 298 (2006); see also The Ethics Committee for the ASRM, *Human Immunodeficiency Virus and Infertility Treatment*, 77 FERTILITY & STERILITY 218, 219 (2002), available at <http://www.asrm.org/Media/Ethics/hivethics.pdf>. There is some risk that a man will contract HIV infection during vaginal intercourse with a woman who has HIV, though that risk is much less than the risk to a woman if her male partner has HIV. See, e.g., CDC, *HIV/AIDS Fact Sheet: HIV/AIDS Among Women* 4 (Aug. 2008), available at <http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/women.pdf>.

¹⁶ See, e.g., CDC, *HIV/AIDS Fact Sheet: Mother-to-Child (Perinatal) HIV Transmission and Prevention* 3 (Oct. 2007), available at <http://www.cdc.gov/hiv/topics/perinatal/resources/factsheets/pdf/perinatal.pdf>; see also The Ethics Committee for the ASRM, *supra* note 15, at 219; Howard Minkoff & Nanette Santoro, *Ethical Considerations in the Treatment of Infertility in Women with Human Immunodeficiency Virus Infection*, 342 NEW ENG. J. MED., 1748-750 (2000).

¹⁷ See CDC, *Fact Sheet: HIV and Its Transmission*, *supra* note 14, at 1; Marcos Meseguer et al., *Comparison of Polymerase Chain Reaction-Dependent Methods for Determining the Presence of Human Immunodeficiency Virus and Hepatitis C Virus in Washed Sperm*, 78 FERTILITY AND STERILITY 1199 (2002); ASRM, *supra* note 10, at 21-22 (explaining terms “semen” and “sperm”).

¹⁸ This is especially important because sexual intercourse with men currently poses the greatest risk of new HIV infection among women. See, e.g., CDC, *HIV/AIDS Fact Sheet: HIV/AIDS Among Women*, *supra* note 15, at 1.

¹⁹ See, e.g., 21 C.F.R. § 1271.85(a) (2008) (FDA regulation requiring testing of donated human cells, tissues, and cellular and tissue-based products for HIV); see also *infra* Part III.A.

²⁰ See ASRM, *supra* note 10, at 11; see also 21 C.F.R. § 1271.60(a) (2008); *id.* § 1271.3(q) (2008) (defining “quarantine” to mean “the storage or identification of [human cells, tissues, and cellular and tissue-based products], to prevent improper release, in a physically separate area clearly identified for such use, or through use of other procedures, such as automated designation.”).

²¹ See ASRM, *supra* note 10, at 11; see also 21 C.F.R. § 1271.85(d) (2008).

²² See, e.g., Valerie Savasi et al., *Safety of Sperm Washing and ART Outcome in 741 HIV-1-Serodiscordant Couples*, 22 HUM. REPROD. 772-77 (2007); Louise U. Kim et al., *Evaluation of Sperm Washing as a Potential Method of Reducing HIV Transmission in HIV-Discordant Couples Wanting to Have Children*, 13 AIDS 645-51 (1999); Meseguer et al., *supra* note 17, at 1199-202; see also Lynn M. Zuchowski, *The Americans with Disabilities Act—Paving the Way for Use of Assisted Reproductive Technologies for the HIV-Positive*, 36 SUFFOLK U. L. REV. 185, 191-92, n. 42 (2002) (discussing greater

Sperm washing involves techniques of spinning and washing, designed to “purify” spermatozoa by separating those cells from the non-sperm cells, including semen.²³ Some studies have demonstrated substantial reduction in the risk of HIV transmission after sperm washing,²⁴ but studies also show that the risk is not eliminated.²⁵ Standardized means for evaluating success however, have not yet been developed.²⁶ The Ethics Committee of the American Society for Reproductive Medicine (“ASRM”) has cautioned that “[m]ore data are needed to demonstrate the complete efficacy of these sperm preparation techniques. Until then, couples must still be cautioned about the potential risk of HIV transmission to the uninfected partner and to their offspring.”²⁷

III. RESTRICTIONS ON ACCESS TO ASSISTED REPRODUCTION FOR LESBIANS, GAYS AND PEOPLE LIVING WITH HIV

A. Restrictions on Sperm Donations by Gay Men and Men Living with HIV

1. FDA Regulations and Guidance Regarding Sperm Donations

The federal Food and Drug Administration—FDA—has established requirements relating to sperm donor eligibility and use of donated sperm, intended “to prevent the introduction, transmission, and spread of communicable diseases.”²⁸ Of primary relevance to gay men and men living with HIV are the restrictions on donor eligibility.

Establishments subject to the FDA regulations are required to make donor-eligibility determinations for sperm donors, based on donor screening and testing for specified communicable disease agents and diseases, except in a few specified situations.²⁹ Potential sperm donors must be screened, by reviewing the donor’s medical records for clinical evidence of “communicable disease agents and

acceptance of sperm washing in Europe).

²³ *Id.*

²⁴ *See, e.g.,* Savasi et al., *supra* note 22; Kim, *supra* note 22; Meseguer, *supra* note 17.

²⁵ *See, e.g.,* Meseguer et al., *supra* note 17, at 1201 (noting that risk of contamination exists despite sperm washing); Kim et al., *supra* note 22, at 648-50 (reporting substantial reductions).

²⁶ *See, e.g.,* Daar & Daar, *supra* note 15, at 299.

²⁷ The Ethics Committee for the ASRM, *supra* note 15, at 219.

²⁸ 21 C.F.R. § 1271.1 (2008). These regulations, related to human cells, tissues, and cellular and tissue-based products (“HCT/Ps”), are set forth in Part 1271 of Title 21 of the Code of Federal Regulations. These regulations do not apply to all facilities that use human sperm. *See id.* §§ 1271.10, 1271.15, 1271.20. For example, the regulations contained in 21 C.F.R. Part 1271 do not apply to an establishment that “does not recover, screen, test, process, label, package, or distribute, but only receives or stores HCT/P’s solely for implantation, transplantation, infusion, or transfer within [its] facility” or “only recovers reproductive cells or tissue and immediately transfers them into a sexually intimate partner of the cell or tissue donor.” *Id.* §§ 1271.15(d), (e).

²⁹ *Id.* § 1271.45 (setting forth general requirements); *id.* § 1271.90 (setting forth exceptions to requirements).

diseases”—a term which includes HIV³⁰—and “risk factors” for such agents and diseases.³¹ A would-be donor is ineligible if he is identified as having such clinical evidence or such a risk factor.³² In addition to donor screening, the FDA also requires that the sperm be tested for several communicable disease agents, including HIV.³³ A donor is ineligible to donate sperm if his sperm specimen tests positive for, *inter alia*, HIV.³⁴

However, the sperm from a donor who is determined to be ineligible based on screening and/or testing may be used if the donor is a directed reproductive donor.³⁵ A “directed reproductive donor” is defined as a person who donates his or her reproductive cells or tissue to a specific recipient who knows the donor and whom the donor knows.³⁶ Moreover, none of these requirements for screening, testing, and eligibility determination apply if the sperm is donated by “a sexually intimate partner of the recipient for reproductive use.”³⁷

The regulations impose a re-testing requirement for anonymous sperm donors: not only must the initially donated sperm be tested for, *inter alia*, HIV, but at least six months later, a new sperm specimen must be obtained and tested for the same communicable disease agents.³⁸ Until that re-testing is done, the donor’s sperm must be “quarantined”—i.e., stored or identified so as to prevent its use.³⁹ However, this re-testing requirement does not apply to directed reproductive donors.⁴⁰

Thus, under the FDA regulations, a man who has HIV is ineligible to donate sperm unless he is donating to someone he knows and who knows him, or he is the

³⁰ 21 C.F.R. § 1271.3(r)(1)(i)(A) (2008) (defining “communicable disease or disease agent” to include “human immunodeficiency virus, types 1 and 2”).

³¹ *Id.* § 1271.75(a).

³² *Id.* §§ 1271.50(b), 1271.75(d); *see generally* 21 C.F.R. Part 1271 (2008).

³³ 21 CFR § 1271.80 (2008) (setting forth general testing requirements); *id.* § 1271.85(a) (requiring, *inter alia*, HIV testing with all donors).

³⁴ *Id.* § 1271.80(d); *see also id.* § 1271.50(b).

³⁵ *Id.* § 1271.65(b)(1)(ii).

³⁶ 21 C.F.R. § 1271.3(l) (2008) (defining term “directed reproductive donor”). The term “directed reproductive donor” is defined as not encompassing a sexually intimate partner. *Id.*

³⁷ *Id.* § 1271.90(a)(2).

³⁸ *Id.* § 1271.85(d).

³⁹ *Id.* § 1271.60(a); *see also* 21 C.F.R. § 1271.3(q) (2008) (defining the term “quarantine”).

⁴⁰ *Id.* § 1271.85(d) (exempting directed reproductive donors from retesting requirement). The FDA had proposed imposing the six-month retesting requirement on sperm donations from directed reproductive donors also, unless the donor and recipient were “sexually intimate partners.” *See* Suitability Determination for Donors of Human Cellular and Tissue-Based Products, 64 Fed. Reg. 52696, 52723 (Sept. 30, 1999) (text of proposed 21 C.F.R. §§ 1271.85(d)), 1271.90(a)(2)). Following a public comment period, the FDA revised the regulations to allow all recipients of directed donations to use fresh sperm, regardless of whether they have been sexually intimate with the directed donors. *See* Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products, 69 Fed. Reg. 29786, 29800 (May 25, 2004). In deciding to exempt directed reproductive donors from the retesting requirement, the FDA commented that “[b]ecause of the variability in whether a particular donor’s sperm will survive the freeze/thaw process, a requirement for quarantine could defeat the intentions of the directed reproductive donor and intended recipient who have made a joint decision for the recipient to conceive a child.” *Id.*

sexually intimate partner of the sperm recipient. But a man who is gay, bisexual, or otherwise has sex with men is not categorically ineligible to donate sperm, even as an anonymous donor. The FDA's regulations do not impose any sperm donation restrictions based on the donor's sexual orientation or sexual conduct.⁴¹

The FDA has issued nonbinding recommendations for establishments charged with making donor eligibility determinations, which do specify risk factors that could serve as bases for excluding anonymous sperm donors.⁴² The guidance document specifically recommends that sperm banks treat as ineligible any man who has had sex with another man within the past five years.⁴³ In contrast to that recommendation, the FDA suggests that persons who have engaged in such high-risk activities as having sex with someone known to have HIV, or getting a tattoo or piercing with a contaminated instrument should be excluded for only one year after engaging in that activity.⁴⁴

The recommendation for a five-year blanket exclusion of all men who have had sex with other men has been objected to on the grounds, *inter alia*, that it is discriminatory, lacks a sound scientific basis, and does not treat similar risks similarly.⁴⁵ The five-year exclusion far exceeds the actual period during which a donor with HIV might nonetheless test negative for HIV: a person exposed to HIV typically develops detectable antibodies within the first two to three months after infection, if not earlier.⁴⁶ The testing, six-month quarantine period, and subsequent re-testing—required by the FDA regulations—are more than ample to address

⁴¹ See *id.* In response to the proposed regulations published in 1999, the FDA received some comments suggesting that it should abandon the requirement for screening based on risk factors, allowing establishments to rely on testing without screening. 69 Fed. Reg. 29786, 29806 (May 25, 2004) (to be codified at 21 C.F.R. pt. 1271). In issuing its final revised regulations in 2004, the FDA refused to do so, stating “based on the current state of testing and current knowledge about disease transmission, it is necessary to screen for risk factors as well as to test for diseases such as HIV.” *Id.*

⁴² U.S. Department of Health and Human Services, Food and Drug Administration (“FDA”), *Guidance for Industry: Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps)* (Aug. 2007), available at <http://www.fda.gov/cber/gdlns/tissdonor.pdf>. The Guidance “do[es] not establish legally enforceable responsibilities . . . and should be viewed only as recommendations, unless specific regulatory or statutory requirements are cited.” *Id.* at 1.

⁴³ *Id.* at 14. The Guidance also recommends that any male donor who exhibits physical evidence of anal intercourse should be determined to be ineligible. *Id.* at 24.

⁴⁴ *Id.* at 15-16.

⁴⁵ See, e.g., Letter from Jonathan Givner, Staff Attorney, Lambda Legal, to FDA Division of Dockets Management (Aug. 23, 2004), available at <http://www.fda.gov/ohrms/DOCKETS/dailys/04/aug04/083004/04d-0193-c00017-vol1.pdf> (submitting comments on Draft Guidance for Industry: Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products, on behalf of Lambda Legal, the Gay and Lesbian Medical Association, the Human Rights Campaign, and the National Center for Lesbian Rights).

⁴⁶ See, e.g., CDC, *HIV Testing: Questions and Answers*, http://www.cdc.gov/hiv/topics/testing/resources/qa/be_tested.htm#wait (last modified Jan. 22, 2007) (stating that most people develop antibodies to HIV within two to eight weeks after exposure); CDC, *Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients*, 50 MORBIDITY AND MORTALITY WEEKLY REPORT, No. RR-5 11-12 (Apr. 27, 2001), available at <http://www.cdc.gov/mmwr/PDF/rr/rr5005.pdf>.

concerns that an HIV infection may not be detectable at the time of donation.⁴⁷ To exclude men who have sex with other men for five years while persons who engage in other high-risk activity are excluded for only one year—a much shorter period—appears arbitrary and clearly discriminatory.⁴⁸ Despite such objections, the FDA has refused to modify this nonbinding recommendation.⁴⁹

2. State Laws Restricting Use of HIV-Infected Tissues and Criminalizing Sperm Donation by Men who Have HIV

Many states have enacted laws imposing HIV screening requirements for sperm donors and prohibiting the use of sperm, semen, or other tissue infected by HIV in most situations.⁵⁰ For example, Illinois requires that all sperm and tissue banks test all “donors of semen for the purposes of artificial insemination” for “evidence of exposure to [HIV] and any other identified causative agent of [AIDS]” at the time of donation or prior to the semen being made available for use.⁵¹ The law also criminalizes the intentional, knowing, reckless, or negligent use of semen of a donor who has tested positive for HIV.⁵²

Several states have laws criminalizing the donation of semen by men who have HIV.⁵³ Some of these laws criminalize any donation of semen if the man knows that he has HIV.⁵⁴ Others limit criminal liability to situations in which the semen donor both knows that he has HIV and had been informed that by donating human tissue he could transmit HIV to another person.⁵⁵ Several states allow

⁴⁷ See, e.g., 69 Fed. Reg. 29786, 29800 (May 25, 2004) (to be codified at 21 C.F.R. pt.1271) (“The requirement to retest the donor was intended to provide an important added measure of protection by addressing the ‘window period’ between the time of infection and the presence of detectable levels of antigens and/or antibodies to communicable diseases and agents such as HIV.”).

⁴⁸ Letter from Givner, *supra* note 45, at 5.

⁴⁹ See FDA, *supra* note 42, at 14. In response to comments, the FDA did eliminate its previous requirement that directed reproductive donors be subject to screening for risk factors. See, e.g., 69 Fed. Reg. 29786, 29805-9806 (May 25, 2004) (to be codified at 21 C.F.R. pt.1271) (responding to comments that risk screening should be eliminated and noting that FDA has limited the screening requirement to anonymous donors).

⁵⁰ See, e.g., CAL. HEALTH & SAFETY CODE § 1644.5; ILL. COMP. STAT. 231/2310-325, 2310-330; LA. REV. STAT. ANN. § 1062.1; VA. CODE ANN. § 32.1-45.3.

⁵¹ ILL. COMP. STAT. 231/2310-330(b).

⁵² *Id.* at 231/2310-330(c).

⁵³ See generally Lambda Legal, *State Criminal Statutes on HIV Transmission* (last updated Aug. 2008), available at http://data.lambdalegal.org/publications/downloads/fs_state-criminal-statutes-hiv-transmission.pdf (providing a summary of provisions of state statutes criminalizing acts specifically due to an alleged risk of transmitting HIV).

⁵⁴ See CA. HEALTH & SAFETY CODE § 1621.5(a); GA. CODE ANN. § 16-5-60(c) (providing that it is a felony offense for someone, knowing that he is “HIV infected,” to donate any “body fluid” without disclosing his HIV status); IDAHO CODE § 39-608 (making it a felony for a person who knows he has HIV to give semen for purposes of transfer to another person); IND. CODE § 35-42-1-7, § 16-41-14-17 (criminalizing the reckless, knowing, or intentional donation of semen that contains HIV or HIV antibodies for purposes of artificial insemination); MO. REV. STAT. § 191.677 (providing that it is a felony for someone who knows he is infected with HIV to be, or attempt to be, a sperm donor); S.C. CODE ANN. § 44-29-145 (making it a felony for someone who knows he is infected with HIV to knowingly donate semen).

⁵⁵ FLA. STAT. ANN. § 381.0041(11)(b) (providing that a felony has been committed if a person who

directed donation by donors with HIV if the sperm recipient knows that the donor has HIV and that sperm can transmit HIV.⁵⁶

Recently, California ameliorated the harsh consequences of criminalizing all sperm donations by men who know they have HIV. In 1997, the California legislature amended the State's prohibition on use of sperm from a donor who was infected by hepatitis B, hepatitis C, or syphilis to allow sperm donation if the sperm recipient consents to therapeutic insemination or other reproductive use of the sperm and the donor is the spouse of, partner of, or designated donor for the sperm recipient.⁵⁷ Ten years later, the legislature expanded that exception to include donors who test positive for HIV, provided that certain other specified conditions are met.⁵⁸ The author of the 2007 bill sought to address the law's discriminatory exclusion of sperm donors living with HIV in light of advances in sperm-washing techniques for reducing the risk of HIV transmission.⁵⁹ California's law now allows a man living with HIV to donate his sperm and have it used for assisted reproduction by his spouse, partner, or designated donor, if:

(1) the physician advises the donor and the recipient of the potential medical risks from using sperm from someone with HIV and obtains documentation that each of them understands those risks and gives consent;⁶⁰

(2) where the recipient has tested negative for HIV, the sperm "has been effectively processed to minimize the infectiousness of the sperm for that specific donation" and informed, mutual consent has been obtained;⁶¹

(3) the facility that performs the sperm processing complies with regulations of the California Department of Health, once adopted, and follows guidelines developed by the ASRM until the Department adopts regulations;⁶²

(4) the physician informs the sperm recipient that sperm processing may not eliminate all risks of HIV transmission, that sperm may be tested to determine

knows he has HIV "has been informed that by donating blood, organs or human tissues he or she may communicate HIV to another person and with this knowledge donates blood, organs, plasma, skin or human tissue"); KY. REV. STAT. ANN. § 311.990(24)(b) (same); VA. CODE ANN. § 32.1-289.2 (same).

⁵⁶ See 720 ILL. COMP. STAT. § 5/12-16.2 (providing that a person who knows he is infected with HIV and provides his semen for administration to another person commits a felony, but that it is an affirmative defense if the person exposed to the semen "knew the infected person was infected with HIV, knew the action could result in infection, and consented with that knowledge."); IOWA CODE § 709C.1 (same); S.D. CODIFIED LAWS §§ 22-18-31, 22-18-33 (same); TENN. CODE ANN. § 39-13-109 (same).

⁵⁷ 1997 Cal. Stat. ch. 511, § 1 (amending CAL. HEALTH & SAFETY CODE § 1644.5).

⁵⁸ 2007 Cal. Stat. ch. 207, § 1 (amending CAL. HEALTH & SAFETY CODE § 1644.5). One of the provisions added to Section 1644.5 of the Health and Safety Code in 2007 was slightly modified in 2008. See 2008 Cal. Stat. ch. 347, § 1 (modifying requirement related to treatment of sperm donor for his HIV infection).

⁵⁹ See Cal. Senate Health Committee Analysis for Bill No. SB 443 (2007), at 3-5, available at http://info.sen.ca.gov/pub/07-08/bill/sen/sb_0401-0450/sb_443_cfa_20070326_171507_sen_comm.html.

⁶⁰ CAL. HEALTH & SAFETY CODE § 1644.5(c)(2) (2008).

⁶¹ *Id.* § 1644.5(c)(3)(B)(i).

⁶² *Id.* § 1644.5(c)(3)(B)(ii).

whether it is free of HIV, and what potential adverse effects testing may have on the processed sperm;⁶³

(5) the physician provides appropriate prophylactic treatments to the recipient to reduce the risk of infection, verifies that a physician is managing the donor's HIV to minimize the risk of transmission, and takes specified actions related to followup testing and monitoring;⁶⁴ and

(5) the recipient is informed of appropriate treatments—including treatments or procedures that may reduce the risk of transmission to her offspring—if the recipient tests positive for HIV after the assisted reproductive technique has been used.⁶⁵

Also, a man living with HIV can donate his sperm for use in assisted reproduction by his spouse, partner, or designated donor if the recipient previously has been documented as having HIV an informed, mutual consent has been obtained.⁶⁶ In any of these situations, a man who knows he has HIV can donate his sperm without incurring criminal liability.⁶⁷

B. Limitations on Insurance Coverage for Assisted Reproductive Services

The high cost of assisted reproductive services is a practical barrier preventing many lesbians and gays—as well as straights—from accessing those services.⁶⁸ That barrier is reduced in a few states, which mandate insurance coverage for some assisted reproductive services.⁶⁹ However, lesbians, gays, and people living with HIV may face particular challenges in establishing that they are entitled to coverage under some statutory mandates. Some mandates for coverage of in vitro fertilization services require fertilization of a patient's oocytes with the sperm of the patient's spouse, a requirement that is likely to disproportionately burden gays and lesbians, while also excluding straight unmarried people.⁷⁰ Of particular concern to lesbians and people living with HIV are limitations on

⁶³ *Id.* § 1644.5(c)(3)(B)(iii).

⁶⁴ *Id.* § 1644.5(c)(3)(B)(iv).

⁶⁵ *Id.* § 1644.5(c)(3)(B)(v).

⁶⁶ CAL. HEALTH & SAFETY CODE § 1644.5(c)(3)(B)(vi) (2008).

⁶⁷ *Id.* § 1644.5(c)(4).

⁶⁸ See Robertson, *supra* note 5, at 361 (noting that “[i]n the end, the lack of resources to pay for [assisted reproductive procedures] may be a greater barrier for gays and lesbians seeking medical assistance to reproduce than is the law.”).

⁶⁹ For example, Arkansas generally mandates that health insurers that cover maternity services cover the cost of in vitro fertilization. See ARK. CODE ANN. §§ 23-85-137, 23-86-118 (2008); see generally ASRM, *State Infertility Insurance Laws*, <http://www.asrm.org/Patients/insur.html> (summarizing state infertility coverage mandates in Arkansas, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Jersey, Ohio, Rhode Island, and West Virginia). A few states mandate that coverage be offered. See CAL. HEALTH & SAFETY CODE § 1374.55 (2008) (requiring offer of coverage for infertility treatment, excluding in vitro fertilization services); TEX. INS. CODE ANN. § 1366.003 (2008) (requiring offer of coverage for in vitro fertilization services).

⁷⁰ See, e.g., HAW. REV. STAT. §§ 431:10A-116.5, 432:1-604 (2008); MD. CODE ANN., INS. § 15-810 (2008); 054-00-001 ARK. CODE R. §5(B) (Weil 2008).

coverage for infertility services resulting from requirements that they demonstrate infertility by engaging in unprotected sexual intercourse for a specified period.

Illinois, for example, mandates coverage for the diagnosis and treatment of infertility by all group accident and health insurance policies and health maintenance organization group contracts that cover more than twenty-five employees and provide pregnancy related benefits.⁷¹ For purposes of this requirement, “infertility” is defined as “the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.”⁷² The Division of Insurance’s regulations amplify that definition by stating that:

[i]n the event a physician determines a medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments, the one year requirement shall be waived.⁷³

The state regulations define “unprotected sexual intercourse” as “sexual union between a male and a female, without the use of any process, device or method that prevents conception”⁷⁴

Lambda Legal has heard from several lesbians who, despite an inability to conceive, have been denied coverage for infertility services, apparently because their insurance company was interpreting this infertility definition as requiring a demonstration that they had been unable to conceive after engaging in unprotected sexual intercourse.⁷⁵ Even though an inability to conceive can be shown just as effectively by lack of success using other methods, such as artificial insemination, some insurers have interpreted the definition as allowing them to deny coverage for infertility services if a female policyholder has not engaged in at least a year of actual, unprotected sexual intercourse with a male partner, even if she has been diagnosed as infertile and has a documented medical need for infertility coverage.⁷⁶

⁷¹ 215 ILL. COMP. STAT. 5/356m(a) (2008) (group policies of accident and health insurance); *id.* at 125/5-3 (health maintenance organizations); 50 ILL. ADMIN. CODE tit. 50, § 2015.20 (2008). As is typical of state laws mandating coverage of infertility services, the Illinois statute limits which infertility services must be covered. *See* 215 ILL. COMP. STAT. 5/356m(a), (b) (2008).

⁷² 215 ILL. COMP. STAT. 5/356m(c) (2008).

⁷³ 50 ILL. ADMIN. CODE tit. 50, § 2015.30 (2008).

⁷⁴ *Id.*

⁷⁵ Telephone interview with Christopher Clark, Senior Staff Attorney, Lambda Legal (Jan. 14, 2009).

⁷⁶ Lambda Legal recently advocated with Abbott Laboratories for coverage for an infertile Illinois lesbian under Abbott Laboratories’ health care plan language specifying that eligibility for infertility services coverage is predicated, *inter alia*, on being unable to conceive or to maintain pregnancy after a year of unprotected sexual intercourse with a partner of the opposite sex. Telephone interview with Christopher T. Clark, Senior Staff Attorney, Lambda Legal (Jan. 14, 2009). Through that advocacy, Lambda Legal learned that Abbott Laboratories applies that criterion to confirm the presence of a covered medical condition, not to preclude coverage of infertility services for same sex couples. *Id.*

Interpreting Illinois law and regulation to require actual sexual intercourse with a male serves to discriminatorily exclude from coverage lesbians who have been diagnosed as infertile and have a documented medical need for infertility coverage. Such differential treatment is not medically justified, because artificial insemination is as—or more—likely to result in pregnancy in a fertile woman as unprotected sexual intercourse.⁷⁷ The irrationality of such an interpretation is further demonstrated by Illinois' statutory recognition that artificial insemination is a valid, alternate means of reproduction and parenthood.⁷⁸

Moreover, requiring unprotected sexual intercourse in order to qualify for coverage of infertility services could encourage risky sexual behavior, which would be poor public health policy. As discussed in Part II, *supra*, unprotected sexual intercourse poses a risk of transmission of HIV if one of the sexual partners has HIV.

In contrast, other states that mandate infertility coverage have avoided the risks and discrimination problems posed by the wording of Illinois' law by clearly defining “infertility” in a more inclusive way. For example, Massachusetts requires that health maintenance organizations and insurance companies that cover pregnancy-related benefits also cover the cost of medically necessary expenses for infertility diagnosis and treatment.⁷⁹ For those purposes, “infertility” is defined as “the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.”⁸⁰

C. Denials of Access to Assisted Reproductive Services Due to Service Provider Bias or Religious Beliefs

In general, physicians in the United States—including those providing assisted reproductive services—are allowed to choose whether or not to accept someone as a patient, as long as they do not discriminate against a prospective

⁷⁷ See, e.g., John C. Peek et al., *Estimation of Fertility and Fecundity in Women Receiving Artificial Insemination by Donor Semen and in Normal Fertile Women*, 91 BRIT. J. OBSTETRICS & GYNAECOLOGY, 1019 (1984).

⁷⁸ See 750 ILL. COMP. STAT. 40/1 *et seq* (2008).

⁷⁹ MASS. GEN. LAWS ch. 175, § 47H (2008); *id.* ch. 176A, § 8K; *id.* ch. 176B, § 4J; *id.* ch. 176G, § 4.

⁸⁰ See MASS. GEN. LAWS ch. 175, § 47H (2008); *id.* ch. 176A, § 8K; *id.* ch. 176B, § 4J; *see also*, CONN. GEN. STAT. §§ 38a-509, -536 (2008) (mandating coverage of infertility services in both individual and group plans, using same definition of infertility as Massachusetts, with the additional alternative qualifying condition of being unable to sustain a successful pregnancy); CAL. HEALTH & SAFETY CODE § 1374.55 (2008) (requiring some insurers to offer coverage for infertility diagnosis and treatment and defining “infertility” as either “(1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception”); *but see* R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2008) (requiring that insurers and health maintenance organizations that cover pregnancy services also cover the cost of medically necessary diagnosis and treatment of infertility for women between the ages of twenty-five and forty-two years, but defining “infertility” as “the condition of an otherwise healthy *married* individual who is unable to conceive or sustain a pregnancy during a period of one year” (emphasis added)).

patient on a basis prohibited by law.⁸¹ Clinics providing assisted reproductive services screen potential patients based on many factors, including, but by no means limited to, physiological and psychological screening.⁸² As discussed above, in many situations, providers of assisted reproductive services are required to screen for HIV and must exclude individuals with HIV from services in some circumstances.⁸³ An additional criterion for screening, sanctioned by the ASRM, is child-rearing ability.⁸⁴

Some providers refuse to provide services to lesbians and/or gays. The bases for such unwillingness vary, but include objections to providing services to unmarried individuals, religious objections to providing services to lesbians and gays, personal moral objections to lesbians and gays, and other biases.⁸⁵ Commentators have noted that sex-based stereotypes about child-rearers and/or prejudices concerning gay parenting may cause some providers to refuse services to gays or lesbians.⁸⁶

As the Ethics Committee of the ASRM stated in a 2006 Committee Report,

Fertility programs often receive requests to treat single persons and lesbian and gay-male couples, but they vary in their willingness to accept them as patients. Some programs think that it is never acceptable to treat unmarried persons, whether heterosexual or gay or lesbian. Other programs that do treat single women and lesbian couples, however, choose not to assist single men or gay-male couples to have children.⁸⁷

In a 2004 article, Professor John Robertson stated that about eighty percent of clinics providing assisted reproductive services in the United States provided such services to single women and lesbian couples, “while only about [twenty percent] provide[d] services to male individuals or couples.”⁸⁸ In a 1998 survey of policies

⁸¹ See e.g., Storrow, *supra* note 5, at 2285-288; Robertson, *supra* note 5, at 353-54; Susan B. Apel, *Access to Assisted Reproductive Technologies*, 12 MICH. ST. U. J. MED. & L. 33, 41-42 (2008); DeLair, *supra* note 1, at 150.

⁸² See, e.g., Judy E. Stern et al., *Access to Services at Assisted Reproductive Technology Clinics: A Survey of Policies and Practices*, 184 AM. J. OBSTETRICS & GYNECOLOGY 591 (2001); Andrea D. Gurmankin, Arthur L. Caplan, & Andrea M. Braverman, *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 FERTILITY & STERILITY 61, 67 (2005); see also Storrow, *supra* note 5, at 2285-293; Apel, *supra* note 81, at 41-42; DeLair, *supra* note 1, at 150-51.

⁸³ *Supra* Part III.A.

⁸⁴ See, e.g., The Ethics Committee for the ASRM, *Child-Rearing Ability and the Provision of Fertility Services*, 82 FERTILITY & STERILITY 564 (2004), available at <http://www.asrm.org/Media/Ethics/childrearing.pdf>; Gurmankin et al., *supra* note 82, at 63; Storrow, *supra* note 5, at 2287.

⁸⁵ See, e.g., The Ethics Committee for the ASRM, *Access to Fertility Treatment by Gays, Lesbians, and Unmarried Persons*, 86 FERTILITY & STERILITY 1333 (2006), available at http://www.asrm.org/Media/Ethics/fertility_gaylesunmarried.pdf; DeLair, *supra* note 1, at 154-56.

⁸⁶ See, e.g., Robertson, *supra* note 5, at 352; DeLair, *supra* note 1, at 156-60; see also The Ethics Committee for the ASRM (2006), *supra* note 85, at 1334-35 (refuting arguments of opponents to child-rearing by gays and lesbians).

⁸⁷ The Ethics Committee for the ASRM (2006), *supra* note 85, at 1333.

⁸⁸ Robertson, *supra* note 5, at 353.

and practices at some assisted reproductive technology clinics, seventy-four percent of the clinics responded that they treated lesbian couples.⁸⁹

In its recent Statement addressing the ethics of denying access to assisted reproductive services on the basis of sexual orientation, the Ethics Committee of the ASRM stated: “[a]s a matter of ethics, we believe that the ethical duty to treat persons with equal respect requires that fertility programs treat single persons and gay and lesbian couples equally with married couples in determining which services to provide.”⁹⁰ The statement concludes that, absent concerns that would disqualify them even if they were married or heterosexual, there is “no sound ethical basis for licensed professionals to deny reproductive services to unmarried or homosexual persons.”⁹¹

People living with HIV have special difficulty accessing assisted reproductive services. As Nanette Elster has reported, “[h]istorically, couples affected by HIV have been denied access to infertility services as a result of a range of health and safety concerns.”⁹² Unwillingness to provide assisted reproductive services to people living with HIV has stemmed in part from concerns about HIV transmission to sexual partners, sperm or egg recipients, and/or offspring and about the shortened lifespan of the parent or parents living with HIV.⁹³ Advances in medical treatment of people living with HIV and in methods to limit the risk of HIV transmission to partner, sperm recipient, or offspring led the ASRM to revise its ethical guidelines concerning patients with HIV several years ago.⁹⁴ ASRM’s Ethics Committee’s revised guidelines discuss methods for safely providing infertility treatments if a male or female involved in the treatments has HIV and state that “[u]nless health care workers can show that they lack the skill and facilities to treat HIV-positive patients safely or that the patient refused reasonable testing and treatment, they may be legally as well as ethically obligated to provide requested reproductive assistance.”⁹⁵ Similarly, a recent Opinion of the Committee on Ethics of the American College of Obstetricians and Gynecologists states that “[t]here is an emerging consensus that indications for assisted reproductive technology use should not vary with HIV serostatus; therefore, assisted

⁸⁹ Stern et al., *supra* note 82, at 596; see Apel, *supra* note 81, at 44. A 1987 survey of physicians regularly providing artificial insemination found fifteen percent of the physicians reporting that they considered a prospective patient unsuitable if the patient was “homosexual.” U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, OTA-13P-BA-48, ARTIFICIAL INSEMINATION: PRACTICE IN THE UNITED STATES: SUMMARY OF A 1987 SURVEY, 9 (1988), available at <http://www.princeton.edu/~ota/disk2/1988/8804/8804.PDF>.

⁹⁰ The Ethics Committee for the ASRM (2006), *supra* note 85, at 1335.

⁹¹ *Id.*

⁹² Nanette R. Elster, *HIV and ART: Reproductive Choices and Challenges*, 19 J. CONTEMP. HEALTH L. & POL’Y 415, 416 (2003); see also Mark V. Sauer, *American Physicians Remain Slow to Embrace the Reproductive Needs of Human Immunodeficiency Virus-Infected Patients*, 85 FERTILITY & STERILITY 295, 295 (2006).

⁹³ See, e.g., The Ethics Committee for the ASRM (2002), *supra* note 15, at 218.

⁹⁴ *Id.*; see also Elster, *supra* note 92, at 418-19.

⁹⁵ The Ethics Committee for the ASRM (2002), *supra* note 15, at 221.

reproductive technology should be offered to couples in which one or both partners are infected with HIV.”⁹⁶

Despite these recognized medical advances and the ASRM’s revised guidelines, people living with HIV are still turned away by assisted reproductive services providers. In 2006, Dr. Mark Sauer of Columbia Presbyterian Medical Center reported that apparently “still fewer than 10 [assisted reproductive services centers in the United States] admit[ted] to actively treating men with HIV.”⁹⁷ When presented in 2001 with hypothetical scenarios of possible candidates for their services, fifty-nine percent of the surveyed directors of assisted reproductive technology programs responded that they were “very or extremely likely” to turn away a woman if she had HIV.⁹⁸ In the 1998 survey of directors of assisted reproductive technology clinics in the United States, eighty-one percent reported that they would not treat women with HIV and another twelve percent were not sure if they would.⁹⁹

IV. CHALLENGES TO RESTRICTIONS ON BEHALF OF LESBIANS, GAYS AND PEOPLE LIVING WITH HIV

A. Legal Bases for Challenging Denials to Lesbians, Gays, and People Living with HIV

Federal law prohibits discrimination in the provision of public accommodations—including discriminatory denials of access to medical services—based on disability. The Americans with Disabilities Act—ADA—prohibits discrimination in the provision of public accommodations by public entities and by private businesses.¹⁰⁰ The Rehabilitation Act of 1973 prohibits discrimination in programs and activities receiving federal financial assistance or conducted by a federal executive agency.¹⁰¹ Service establishments, including hospitals and offices of health care providers, are subject to these prohibitions.¹⁰² These laws define “disability” as a “physical or mental impairment that substantially limits one or more of the major life activities” of the individual, having “a record of such an

⁹⁶ American College of Obstetricians and Gynecologists Committee on Ethics, *ACOG Committee Opinion: Human Immunodeficiency Virus* 4 (2007), available at http://www.acog.org/from_home/publications/ethics/co389.pdf; see also Minkoff & Santoro, *supra* note 16 (discussing considerations in treating infertility in women with HIV and concluding that “[a]ccess to . . . infertility should no longer be contingent on HIV status.”).

⁹⁷ Sauer, *supra* note 92, at 295; see also Daar & Daar, *supra* note 15, at 299-300 (discussing indications of very limited access in United States).

⁹⁸ Gurmankin et al., *supra* note 82, at 63.

⁹⁹ Judy E. Stern, et al., *Attitudes on Access to Services at Assisted Reproductive Technology Clinics: Comparisons with Clinic Policy*, 77 FERTILITY & STERILITY 537, 539 (2002).

¹⁰⁰ 42 U.S.C. §§ 12131-2134, 12141-2150, 12161-2165 (2006) (Title II, applicable to public entities); *id.*, §§ 12181-2189 (2006) (Title III, applicable to private businesses).

¹⁰¹ 29 U.S.C. § 794 (2007).

¹⁰² 42 U.S.C. § 12181(7)(F) (2006); 22 C.F.R. § 142.62 (2008).

impairment,” or “being regarded as having such an impairment.”¹⁰³ HIV has been recognized to be a disability within the meaning of these antidiscrimination laws.¹⁰⁴ In the seminal case *Bragdon v. Abbott*,¹⁰⁵ the United States Supreme Court found that even asymptomatic HIV infection is a physical impairment and that the plaintiff had a disability because she was substantially limited in the major life activity of reproduction due to the impact of her HIV infection on her ability to reproduce and bear children.¹⁰⁶

Of potential relevance in the context of restrictions on access to assisted reproductive technologies based on HIV status is the “direct threat” defense. Under the ADA and the Rehabilitation Act, an individual may be excluded from a public accommodation if the individual’s participation would pose a direct threat to the health or safety of others.¹⁰⁷ “Direct threat” is defined to mean “a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.”¹⁰⁸ As Nanette Elster noted, using sperm from a man who has HIV may pose risks to the sperm recipient, to the resulting child, and to lab personnel who handle the sperm samples, although each of those risks can be eliminated or greatly reduced.¹⁰⁹

State laws also prohibit discrimination in public accommodations based on disability, using various definitions of “public accommodations”¹¹⁰ and “disability.”¹¹¹ State prohibitions on discrimination in public accommodations typically apply to places that provide services and are open to the public and therefore apply to medical service providers. Some statutes specifically define the term “public accommodation” to include medical service providers.¹¹² Where facilities and individuals providing health care services are prohibited from discrimination, those prohibitions apply to fertility clinics, other assisted

¹⁰³ 42 U.S.C. § 12102(2)(A-C) (2006); 29 U.S.C. § 705(9)(B) (2007).

¹⁰⁴ See, e.g., *Bragdon v. Abbott*, 524 U.S. 624 (1998).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 632-37, 640-42.

¹⁰⁷ See 42 U.S.C. § 12182(b)(3) (2006); 28 C.F.R. § 36.208(b) (2008).

¹⁰⁸ 42 U.S.C. § 12182(b)(3) (2006).

¹⁰⁹ Elster, *supra* note 92, at 421-23.

¹¹⁰ See, e.g., 775 ILL. COMP. STAT. 5/5-101(A)(6) (2009); N.H. REV. STAT. ANN. § 354-A:2(XIV) (2008); N.J. STAT. ANN. § 10:5-5(l) (2009); N.Y. EXEC. LAW § 292(9) (2008); WASH. REV. CODE § 49.60.040(10) (2008).

¹¹¹ See, e.g., CAL. GOV. CODE § 12926.1 (2008); CAL. CIV. CODE § 51 (2008); FLA. STAT. ANN. § 413.08-1(b) (2008); WIS. STAT. §§ 106.50, 106.52 (2008).

¹¹² See, e.g., 775 ILL. COMP. STAT. 5/5-101(A)(6) (2009) (defining “public accommodation” to include a “professional office of a health care provider” and “hospital”); N.H. REV. STAT. ANN. § 354-A:2(XIV) (2008) (defining “place of public accommodation” to include any “health care provider”); N.J. STAT. ANN. § 10:5-5(l) (2009) (defining “place of public accommodation” to include clinics and hospitals); N.Y. EXEC. LAW § 292(9) (defining “place of public accommodation” to include clinics and hospitals) (2008); WASH. REV. CODE § 49.60.040(10) (2008) (defining places of public accommodation to include any place “where medical service or care is made available”).

reproduction facilities, and physicians providing assisted reproductive services.¹¹³ Definitions of “disability” in some states mirror the federal definition; some state statutes specify that HIV infection is a disability.¹¹⁴

Unlike the federal laws prohibiting discrimination in public accommodations, several states also prohibit discrimination on the basis of sexual orientation.¹¹⁵ For example, California’s Unruh Civil Rights Act (“Unruh Act”) provides that:

All persons within the jurisdiction of this state are free and equal, and no matter what their sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status, or sexual orientation are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever.¹¹⁶

For purposes of that law, “sexual orientation” is defined to mean “heterosexuality, homosexuality, and bisexuality.”¹¹⁷ Some local communities also prohibit discrimination based on sexual orientation.¹¹⁸

Several commentators, while acknowledging that a constitutional right to access assisted reproductive services has not been established, have discussed constitutional rights that might be implicated by State-imposed restrictions on such access.¹¹⁹ The following rights have been suggested as possible bases for lesbians

¹¹³ See *infra* Part IV.B (discussing claims that providers of assisted reproductive services violated a prohibition on discrimination in places of public accommodations); see also Harlow, *supra* note 3, at 204-13 (discussing protections under state public accommodations laws and challenges brought in 1995 in Minneapolis and Boston).

¹¹⁴ See, e.g., CAL. GOV. CODE § 12926.1 (2008) (defining “disability” more broadly than the ADA and specifying that “disabilities” include “HIV/AIDS”); CAL. CIV. CODE § 51 (2008) (incorporating definitions of disability from CAL. GOV. CODE §§ 12926, 12926.1 into law prohibiting discrimination in public accommodations); FLA. STAT. ANN. § 413.08-1(b) (2008) (defining an “individual with a disability” as “a person who is deaf, hard of hearing, blind, visually impaired, or otherwise physically disabled.”); WIS. STAT. §§ 106.50, 106.52 (2008) (defining “disability,” for purposes of public accommodations anti-discrimination law, as “a physical or mental impairment that substantially limits one or more major life activities, a record of having such an impairment or being regarded as having such an impairment.”).

¹¹⁵ CAL. CIV. CODE § 51(b) (2008); CONN. GEN. STAT. § 46a-81d (2008); D.C. CODE ANN. § 2-1402.31 (2009); HAW. REV. STAT. § 489-3 (2008); 775 ILL. COMP. STAT. 5/5-102, 5/1-103(Q) (2009); MD. ANN. CODE art. 49B, § 5 (2008); MASS. GEN. LAWS ch. 272, § 98 (2008); MINN. STAT. § 363A.11 (2008); ME. REV. STAT. ANN. tit. 5, § 4552 (2008); N.H. REV. STAT. ANN. § 354-A:17 (2008); N.J. STAT. ANN. § 10:5-4 (2009); N.M. STAT. ANN. § 28-1-7(F) (2008); N.Y. EXEC. LAW § 296(2) (2008); R.I. GEN. LAWS § 11-24-2 (2008); VT. STAT. ANN. tit. 9, § 4502 (2007); WASH. REV. CODE § 49.60.030(1) (2008).

¹¹⁶ CAL. CIV. CODE § 51(b) (2008).

¹¹⁷ CAL. CIV. CODE § 51(e)(6) (2008) (incorporating definition in CAL. GOV. CODE § 12926 (2008)); CAL. GOV. CODE § 12926(q) (2008).

¹¹⁸ E.g., compare Code of the City of Orlando, Title II, § 57.08(1) (2008) (prohibiting discrimination in places of public accommodation based on “race, color, religion, national origin, marital status, age, sex, sexual orientation or handicap”) with FLA. STAT. ANN. § 760.08 (2008) (prohibiting discrimination in places of public accommodation based on “race, color, national origin, sex, handicap, familial status, or religion.”).

¹¹⁹ See Lezin, *supra* note 1, at 197-203, Robertson, *supra* note 5, at 326-32, 349-52, Storrow, *supra* note 5, at 2295-99, DeLair, *supra* note 1, at 180-82.

and/or gays to challenge such restrictions: the right to privacy, as a right to reproduce;¹²⁰ the right to privacy, as an associational right;¹²¹ and equal protection.¹²²

B. Legal Challenges to Denials of Fertility Services Brought by Lambda Legal

1. Discriminatory Denial of Fertility Services in the *Barros* Matter

Dennis Barros—an Orlando, Florida veterinarian—experienced discrimination based on his sexual orientation when he sought to use fertility services.¹²³ Dr. Barros and his partner planned to have a child through a surrogate mother, who consented to carry an egg fertilized by Dr. Barros’s sperm.¹²⁴ In early 2006, Dr. Barros called the offices of Dr. Frank C. Riggall in Orlando, to obtain fertility services: specifically, to have his sperm inseminate an egg from a known egg donor, with the fertilized egg to be carried by a gestational surrogate.¹²⁵ Dr. Barros indicated to Dr. Riggall’s clinic that he wanted these services so that he and his male partner could have a child.¹²⁶ Dr. Riggall’s office scheduled an appointment for late March 2006.¹²⁷ But by letter dated March 20, 2006, Dr. Riggall’s office informed Dr. Barros that the appointment was cancelled and that Dr. Riggall refused to provide fertility services to him.¹²⁸ The letter cited “recent changes in FDA regulations and risk screening criteria.”¹²⁹

Dr. Barros obtained Lambda Legal as legal counsel. On May 23, 2006, Lambda Legal wrote Dr. Riggall’s office, explaining that FDA regulations do not prohibit gay men from donating sperm generally, and specifically allow a “directed” donation—that is, a donation where the donor is known to the recipient, who gives her informed consent for the donation.¹³⁰ Dr. Riggall’s office failed to respond to the letter or to reschedule Dr. Barros’s cancelled appointment for services. In September 2006, Lambda Legal filed a complaint with the City of

¹²⁰ See Lezin, *supra* note 1, at 197-99 (discussing rights that might be asserted by lesbians and unmarried women), Robertson, *supra* note 5, at 326-32, 349-52 (discussing rights that might be asserted by lesbians and/or gays), DeLair, *supra* note 1, at 177-80 (discussing rights that might be asserted by lesbians and/or gays); see also Storrow, *supra* note 5, at 2295-99 (discussing right to procreative liberty in context of assisted reproduction, irrespective of sexual orientation).

¹²¹ See Lezin, *supra* note 1, at 200-03.

¹²² *Id.* at 200-01; Robertson, *supra* note 5, at 329, 349; DeLair, *supra* note 1, at 180-82.

¹²³ See Complaint by Dr. Dennis Barros filed with City of Orlando Office of Human Relations (received Sept. 13, 2006), available at http://data.lambdalegal.org/in-court/downloads/barros_fl_20060913_complaint.pdf (alleging discrimination in public accommodations) (hereinafter “Barros Complaint”).

¹²⁴ *Id.* at 2.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.* at 3.

¹²⁸ *Id.* Barros Complaint, *supra* note 123, at 2.

¹²⁹ *Id.*

¹³⁰ Letter from Gregory R. Nevins, Senior Staff Attorney, Lambda Legal, to Susan Russell, Office Manager for Dr. Riggall, (May 23, 2006), available at <http://data.lambdalegal.org/pdf/731.pdf>.

Orlando Office of Human Relations on behalf of Dr. Barros.¹³¹ The complaint alleges that Dr. Riggall denied Dr. Barros services because of his sexual orientation, in violation of Chapter 57 of the Code of the City of Orlando.¹³² Section 57.08(1) of the Code prohibits sexual orientation discrimination in public accommodations.¹³³ As of this writing, the Complaint is still pending before the Office of Human Relations.¹³⁴

During the Office of Human Relations' investigation, Dr. Riggall asserted three main defenses: (1) his medical office is not a place of public accommodation subject to the prohibitions of Chapter 57 of the Code of the City of Orlando; (2) FDA guidelines required him to freeze the sperm of a gay male donor for six months—a service he does not provide; and (3) he provides services to lesbians.¹³⁵ Consistent with interpretations of “place of public accommodation” under federal and state anti-discrimination laws, the agency investigator concluded that Dr. Riggall's medical offices are a place of public accommodation under the Code.¹³⁶

The FDA regulations and guidelines relevant to Dr. Barros's situation are those applicable to “directed reproductive donors,” because, as he informed Dr. Riggall, the services he sought involved a specific known sperm recipient.¹³⁷ As discussed in Part III.A, *supra*, FDA regulations require that sperm from an anonymous sperm donor be frozen for six months before use, but that requirement does *not* apply to directed reproductive donors.¹³⁸ No delay in use of the directed reproductive donor's sperm is suggested.¹³⁹ Moreover, the FDA regulations do not impose any requirements specific to the sperm from gay men.¹⁴⁰ Nonbinding FDA guidance on screening sperm donors—in draft form at the time Dr. Barros was refused services and issued in final form in August 2007—recommends that clinics

¹³¹ See Barros Complaint, *supra* note 123.

¹³² *Id.* at 2.

¹³³ Subsection (1) of Section 57.08 states, “It shall be an unlawful discriminatory practice to discriminate or separate on the basis of race, color, religion, national origin, marital status, age, sex, sexual orientation or handicap, any place of public accommodation in the City.” Code of the City of Orlando, Title II, § 57.08(1) (2008).

¹³⁴ In June 2008, the Office issued a finding that there was no reasonable cause to believe discrimination had occurred. E-mail from Gregory R. Nevins, Supervising Senior Staff Attorney, Lambda Legal to Bebe Anderson, HIV Project Director, Lambda Legal (Jan. 13, 2009) (on file with author). Dr. Barros sought review of that finding and a hearing was held before the Orlando Review Board in October 2008, resulting in the Board ordering the Office of Human Relations to re-do its investigation. *Id.*

¹³⁵ *Id.*

¹³⁶ See Code of the City of Orlando, Title II, § 57.08(2) (2008) (specifying that “[a] place of public accommodation within the meaning of this Section shall include, *but not be limited to*, the following establishments which serve the public,” followed by list which does not explicitly reference physician's offices) (emphasis added); see also, e.g., 42 U.S.C. § 12181(7)(F) (2008) (defining “public accommodation” under Title III of the Americans with Disabilities Act to include “professional office of a health care provider, hospital, or other service establishment.”).

¹³⁷ See 21 C.F.R. § 1271.3(1) (2008) (defining “directed reproductive donor”).

¹³⁸ See 21 C.F.R. §§ 1271.85(d), 1271.60(a) (2008); see generally *supra* Part III.A.

¹³⁹ See *supra* note 40.

¹⁴⁰ See 21 C.F.R. Part 1271 (2008).

refuse donations from men who have had sex with men in the past five years.¹⁴¹ However, those draft, nonbinding recommendations were inapplicable to sperm from directed reproductive donors, such as Dr. Barros; the FDA specifies in its regulations that although such donors are subject to HIV testing and screening for risk factors, their sperm can be used even if they are found “ineligible.”¹⁴² As the FDA clearly stated in a Question and Answer document explaining its regulations and then-draft guidance, when the donor and recipient know each other, the donation of fresh sperm is allowed, and no freezing is required:

Directed semen donors must be tested at the time of donation, but do not have to be retested 6 months later (as do anonymous semen donors) [citing 21 C.F.R. §1271.85(d)]. Directed donation of fresh semen is allowed. The term “directed reproductive donor” means a reproductive donor who knows and is known by the recipient before donation [citing 21 C.F.R. §1271.3(l)].¹⁴³

Thus, FDA regulations did not prohibit, nor did the agency recommend against, the use of Dr. Barros’s fresh sperm with someone he knew.

Dr. Riggall’s argument that his refusal to treat gay men cannot be a violation of the City ordinance because he treats lesbians is also without merit. It is well established that discrimination against a subgroup of a protected class is still actionable discrimination.¹⁴⁴ In 1971, the Supreme Court held that employment discrimination against women with pre-school-age children was actionable, even though the overwhelming majority of the employees hired for the position sought by the plaintiff were women.¹⁴⁵ The same year, the Seventh Circuit held that a subgroup of married women had a sex discrimination claim against United Airlines for its policy against married female flight attendants.¹⁴⁶ More analogous to the discrimination here, the Fifth Circuit—which then included Florida—issued a landmark decision in 1980 holding that black women stated a claim for discrimination even if black men—or white women—were treated fairly.¹⁴⁷ This principle has been reaffirmed repeatedly by courts across the country.¹⁴⁸

¹⁴¹ See FDA, *supra* note 42, at 14. At the time Dr. Barros was discriminated against, the same screening recommendations were in draft form. See *id.*, at 2.

¹⁴² 21 C.F.R. § 1271.65(b)(1)(ii) (2008).

¹⁴³ FDA, QUESTIONS AND ANSWERS FOR ROLL-OUT OF DONOR ELIGIBILITY FINAL RULE AND DRAFT GUIDANCE (2005), available at <http://www.fda.gov/cber/rules/suitdonorq&a.htm>.

¹⁴⁴ See, e.g., Phillips v. Martin Marietta Corp., 400 U.S. 542, 543 (1971) (*per curiam*) (“Section 703(a) of the Civil Rights Act of 1964 requires that persons of like qualifications be given employment opportunities irrespective of their sex. The Court of Appeals therefore erred in reading this section as permitting one hiring policy for women and another for men—each having pre-school-age children.”).

¹⁴⁵ *Id.*

¹⁴⁶ Sprogis v. United Air Lines, Inc., 444 F.2d 1194, 1198 (7th Cir. 1971); see also Arnett v. Aspin, 846 F. Supp. 1234, 1240 (E.D. Pa. 1994) (holding actionable discrimination against women over age forty and stating “[t]he point behind the establishment of the sex-plus discrimination theory is to allow Title VII plaintiffs to survive summary judgment when the defendant employer does not discriminate against *all* members of the sex.”) (emphasis in original).

¹⁴⁷ Jefferies v. Harris County Cmty Action Ass’n, 615 F.2d 1025, 1034 (5th Cir. 1980) (stating that when it is alleged “that an employer discriminates against black females, the fact that black males and

2. Discriminatory Denial of Fertility Services in the *Benitez* Case

Guadalupe “Lupita” Benitez and Joanne Clark, after eleven years creating a home together, decided to become parents by having Benitez become pregnant.¹⁴⁹ Unfortunately, over time they discovered that Benitez had an infertility problem that made becoming pregnant extremely difficult.¹⁵⁰ When Benitez tried to address that problem, she encountered discrimination based on her sexual orientation, which started her on a legal battle that has now lasted for over seven years.¹⁵¹ Benitez’s case went all the way to the California Supreme Court, and as of this writing is back in the lower court for trial.¹⁵² Lambda Legal is lead counsel for Benitez.

Benitez tried to become pregnant by self-insemination without professional medical assistance, but the efforts were unsuccessful.¹⁵³ Fortunately, her health insurance covered fertility treatment, but it limited her to only one source for that treatment: the North Coast Women’s Care Medical Group, Inc. (“North Coast”).¹⁵⁴ Benitez and Clark met with Dr. Christine Brody, an obstetrician and gynecologist employed by North Coast, and during that meeting Benitez mentioned to Dr. Brody that she was a lesbian.¹⁵⁵ Dr. Brody informed Benitez that she objected for religious reasons to directly assisting a lesbian to become pregnant and therefore would not perform a medical insemination—intrauterine insemination—for Benitez.¹⁵⁶ However, Dr. Brody volunteered that she would prescribe fertility medications, perform various tests, advise Benitez on her attempts at self-

white females are not subject to discrimination is irrelevant and must not form any part of the basis for a finding that the employer did not discriminate against the black female plaintiff.”).

¹⁴⁸ See, e.g., *Lam v. Univ. of Hawai’i*, 40 F.3d 1551, 1562 (9th Cir. 1994) (stating that Asian women “may be targeted for discrimination ‘even in the absence of discrimination against [Asian] men or white women.’”); *Graham v. Bendix Corp.*, 585 F. Supp. 1036, 1047 (N.D. Ind. 1984) (stating “[t]he duty not to discriminate is owed *each* minority employee, and discrimination against one of them is not excused by a showing the employer did not discriminate against all of them, or there was one he did not abuse.”) (emphasis in original).

¹⁴⁹ Opening Brief on the Merits of Plaintiff and Real Party in Interest Guadalupe T. Benitez at 4 (Sept. 20, 2008), *North Coast Women’s Care Medical Group*, 189 P.3d 959 (Cal. 2008) (No. S142892), available at <http://data.lambdalegal.org/pdf/legal/benitez/benitez-opening-brief.pdf> (hereafter “Benitez’s Opening Br. to Cal. Sup. Ct.”).

¹⁵⁰ *Id.*

¹⁵¹ See *North Coast Women’s Care Med. Group, Inc. v. San Diego County Superior Court*, 189 P.3d 959 (Cal. 2008).

¹⁵² *Id.*

¹⁵³ *Id.* at 962.

¹⁵⁴ *Id.*; *North Coast Women’s Care Medical Group, Inc. v. Superior Court*, 40 Cal. Rptr. 3d 636, 639 (Cal. Ct. App. 2006).

¹⁵⁵ *North Coast Women’s Care Medical Group*, 189 P.3d at 963.

¹⁵⁶ *Id.* The parties dispute the basis for the physicians’ religious objections to providing the medical services to Benitez. Defendants claim that the physicians’ religious objections were to performing intrauterine insemination (IUI) for an unmarried woman and therefore their refusal to perform IUI on Benitez was based on her marital status rather than her sexual orientation. *Id.* at 963 n.1; see also 40 Cal. Rptr. at 642-47. Defendants contend that discrimination on the basis of marital status was not prohibited by the civil rights law at the relevant time. See 40 Cal. Rptr. at 642-47.

insemination at home, deliver the baby, and provide post-natal care.¹⁵⁷ She further promised Benitez that another North Coast physician would perform intrauterine insemination for Benitez if she failed to become pregnant with the medication and self-insemination.¹⁵⁸ Brody formulated a treatment plan that called for intrauterine insemination if the medication was ineffective and Benitez had not become pregnant after three months of trying at home.¹⁵⁹

By the summer of 2000, after almost eleven months of unsuccessful home attempts, it was clear that Benitez needed to be medically inseminated if she was to become pregnant.¹⁶⁰ At this point, Dr. Douglas Fenton, North Coast's Medical Director, intervened and told Benitez that she should seek treatment at another facility, since so many of North Coast's staff refused to provide that medical service to Benitez because of their religious objections to treating lesbians.¹⁶¹ Benitez was shocked and devastated at the abrupt termination of the treatment relationship.¹⁶² As a result, she was unable to obtain this needed medical service from the only provider of that service in her health plan.¹⁶³ To obtain the fertility treatment she needed, she was forced to see a physician outside her health plan, at a considerable distance from her home and work, and fully at her own expense.¹⁶⁴ Fortunately—through services of the out-of-plan physician—she was able to become pregnant and gave birth to a healthy boy.¹⁶⁵ Nevertheless, she suffered deep pain and humiliation, as well as the out-of-pocket costs, and the need to repeat much of the testing and treatment she had endured during the prior year, due to North Coast's refusal to complete her treatment plan because of her sexual orientation.¹⁶⁶

Benitez filed suit against North Coast, Dr. Brody, and Dr. Fenton in San Diego Superior Court in July 2001, alleging, inter alia, that the medical providers had violated California's Unruh Act, which forbids discrimination by business establishments—including medical clinics—based on sexual orientation.¹⁶⁷ The

¹⁵⁷ See *North Coast Women's Care Medical Group*, 189 P.3d at 963; Benitez's Opening Br. to Cal. Sup. Ct., *supra* note 149, at 4.

¹⁵⁸ Benitez's Opening Br. to Cal. Sup. Ct., *supra* note 149, at 4.

¹⁵⁹ See *id.* at 4-5.

¹⁶⁰ See *North Coast Women's Care Medical Group*, 189 P.3d at 963-64; *North Coast Women's Care Medical Group*, 40 Cal. Rptr. at 639-40.

¹⁶¹ *North Coast Women's Care Medical Group*, 189 P.3d at 964; *North Coast Women's Care Medical Group*, 40 Cal. Rptr. at 640-41.

¹⁶² Benitez's Opening Br. to Cal. Sup. Ct., *supra* note 149, at 5.

¹⁶³ *North Coast Women's Care Medical Group*, 189 P.3d at 964; Benitez's Opening Br. to Cal. Sup. Ct., *supra* note 149, at 4.

¹⁶⁴ *North Coast Women's Care Medical Group*, 189 P.3d at 964; see also First Amended Complaint for Damages and Petitions for Injunctive Relief, *Benitez v. North Coast Women's Care Medical Group*, 2001 WL 35919623, ¶ 36 (Cal. Super. Ct. Dec. 7, 2001) (hereinafter "Benitez's First Am. Compl.>").

¹⁶⁵ *North Coast Women's Care Medical Group*, 189 P.3d at 964; see also *North Coast Women's Care Medical Group*, 40 Cal. Rptr. 3d at 641.

¹⁶⁶ See Benitez's Opening Br. to Cal. Sup. Ct., *supra* note 149, at 5.

¹⁶⁷ CAL. CIV. CODE § 51. During the time period relevant to this case, subsection (b) of California Civil Code Section 51 stated: "all persons within the jurisdiction of this state are free and equal, and no

case initially was dismissed, based on the defendants' argument that Benitez's state law claims—including her discrimination claim under the Unruh Act—were preempted by the federal Employee Retirement Income Security Act—ERISA—because she received her infertility treatments under an employee health benefit plan.¹⁶⁸ In March 2003, the California Court of Appeal for the Fourth District reversed that ruling, allowing the suit to proceed.¹⁶⁹ In a unanimous decision, that appellate court ruled that ERISA, which regulates employee benefit plans, does not shield health care providers from liability for civil rights violations, such as discriminatory refusals to provide medical treatment based on sexual orientation.¹⁷⁰

Defendants asserted various defenses, including claiming that they were exempt from liability because they were exercising constitutionally protected rights of religion and speech.¹⁷¹ Benitez filed for summary adjudication of the physicians' constitutional rights defenses, and in October 2004, the trial court ruled in her favor.¹⁷² The trial court found that the physicians' religious freedom rights under the state and federal constitutions do not permit them to violate California's civil rights law.¹⁷³ After the doctors asked the appellate court to review that question before trial, the Court of Appeal for the Fourth District ruled that the trial court should not have dismissed those defenses at that stage of the case and that the physicians were entitled to an opportunity to testify at trial about their religious reasons for refusing to provide medical services to Benitez.¹⁷⁴ Benitez appealed that decision to the California Supreme Court, which agreed to review the religious defense.¹⁷⁵ In August 2008, the Court ruled unanimously in favor of Benitez,

matter what their sex, race, color, religion, ancestry, national origin, disability, or medical condition are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever." CAL. CIV. CODE § 51(b) (2000), amended by 2005 Cal. Stat. ch. 420. The Unruh Act also had been construed as prohibiting sexual orientation discrimination, *see North Coast Women's Care Medical Group*, 189 P.3d at 965, and Benitez maintained that it ought to be read as prohibiting discrimination based on marital status as well. *See* Petition for Review of Real Party in Interest Guadalupe T. Benitez at 30-31 (Apr. 24, 2008), *North Coast Women's Care Medical Group*, 189 P.3d 959 (Cal. 2008) (No. S142892), available at <http://data.lambdalegal.org/pdf/661.pdf>. In 2005, the California Legislature amended the Act to expressly prohibit both sexual orientation and marital status discrimination. *See id.*; 2005 Cal. Stat. ch. 420, § 2(c) (declaring the Legislature's view that the bill codified existing law rather than changing the law). Benitez also asserted contract and tort claims against defendants. *See* Benitez's First Am. Compl., *supra* note 164; *see also North Coast Women's Care Medical Group*, 40 Cal. Rptr. 3d at 642 n.4.

¹⁶⁸ Benitez v. North Coast Women's Care Medical Group, Inc., 131 Cal. Rptr. 2d 364, 368 (Cal. Ct. App. 2003).

¹⁶⁹ *Id.* at 364.

¹⁷⁰ *Id.* at 372-74.

¹⁷¹ *See North Coast Women's Care Medical Group*, 189 P.3d at 964.

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *North Coast Women's Care Medical Group*, 40 Cal. Rptr. 3d 636.

¹⁷⁵ *Benitez*, 139 P.3d 1 (Cal. 2006) (granting review). The case generated great interest and sixteen amicus briefs were filed with the California Supreme Court: thirty leading health care, community health policy, civil rights groups, and the Attorney General of California participated in seven amicus briefs in support of Benitez and sixteen conservative religious and legal groups joined in ten amicus briefs supporting the defendants. Many of the amicus briefs in support of Benitez, as well as other filings with the Supreme Court in this case, are available on Lambda Legal's website. *See* Lambda

rejecting the physicians' religious freedom affirmative defense and making it clear that California's state law prohibiting discrimination must be followed.¹⁷⁶

The Court held that physicians' constitutional rights to free exercise of religion do not exempt them from the requirement that they act in accord with the requirements of California's civil rights law and, specifically, that those religious rights do not give physicians a right to deny infertility treatment because of the sexual orientation of their patients.¹⁷⁷ Writing for the court, Justice Kennard stated:

Defendant physicians contend that exposing them to liability for refusing to perform the [intrauterine insemination] medical procedure for plaintiff infringes upon their First Amendment rights to free speech and free exercise of religion [under the United States Constitution]. Not so. As we noted earlier, California's Unruh Civil Rights Act imposes on business establishments certain antidiscrimination obligations, thus precluding any such establishment or its agents from telling patrons that it will not comply with the Act.¹⁷⁸

Similarly, the Court held that the physicians were not exempt from the Unruh Act's prohibitions on discrimination based on their exercise of religious rights guaranteed by the state constitution.¹⁷⁹ Without deciding which standard of review it must apply to a religious exemption challenge under the state Constitution, the Court found that even if it applied strict scrutiny and the civil rights act's prohibition of sexual orientation discrimination would substantially burden the physicians' religious beliefs, the physicians still must comply with the Unruh Act.¹⁸⁰ The Court held that "[t]he Act furthers California's compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation, and there are no less restrictive means for the state to achieve that goal."¹⁸¹ By its rulings, the California Supreme Court made clear that lesbians, gays, bisexuals, and transgender people in California have a right to receive equal access to assisted reproductive services.

V. CONCLUSION

Assisted reproductive technologies are of tremendous importance to lesbians, gays, and people living with HIV. For lesbians and gays, such technologies

Legal, Benitez v. North Coast Women's Care Medical Group available at <http://www.lambdalegal.org/our-work/in-court/cases/benitez.html> (providing links to copies of numerous court filings).

¹⁷⁶ The Court denied the defendants' petition for rehearing on October 28, 2008. *North Coast Women's Care Medical Group*, 189 P.3d at 959. The case is currently pending in the San Diego County Superior Court.

¹⁷⁷ *Id.* at 965-69.

¹⁷⁸ *Id.* at 967.

¹⁷⁹ *Id.* at 968-69.

¹⁸⁰ *Id.* at 968.

¹⁸¹ *North Coast Women's Care Medical Group*, 189 P.3d at 968.

generally must be used in order for them to have genetically related children. For people living with HIV, assisted reproduction avoids the risk of transmission associated with unprotected sexual intercourse. But lesbians, gays and people living with HIV face special barriers—beyond those applicable to everyone seeking use of those technologies—which prevent or limit their access.

Some of those barriers—such as restrictions on sperm donation by men who have HIV—are based on medical considerations. Yet those restrictions often do not keep pace with medical advances, thus unjustifiably limiting access. Other restrictions—such as restrictive interpretations of entitlement to infertility insurance coverage—may differentially impact lesbians, gays, or people with HIV. Deliberate refusals to provide services because of sexual orientation or HIV status undoubtedly occur, but the extent of such refusals is difficult to gauge given the broad discretion afforded medical care providers to choose patients. Where bias based on sexual orientation or HIV status does result in denial of services, laws prohibiting discrimination in public accommodations on the basis of sexual orientation or disability can provide legal recourse.