The Missing Piece in Infertility Policy: Integrating Mental Health into ART Care

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Infertility treatment can become a prolonged, high-stakes experience marked by grief, uncertainty, physical demands, difficult decision-making, financial strain, and psychological distress. For those who proceed with assisted reproductive technology (ART), those demands can intensify across repeated treatment cycles.

The psychological burden is well documented. Depression, anxiety, trauma-related symptoms, and infertility-specific distress are not rare outliers among people navigating infertility. Yet even as federal and state policymakers have increasingly focused on expanding access to infertility treatment and IVF, policy efforts have largely centered on procedural access and insurance coverage rather than the psychosocial care infrastructure surrounding treatment.

The result is a policy framework that increasingly funds the procedure while still ignoring much of the experience of the person undergoing it.

The clinical problem is broader than ART alone. Individuals may experience significant psychological distress across the infertility-care continuum, including during evaluation, non-ART treatment, pregnancy loss, decisions about whether or how to proceed with treatment, and treatment discontinuation. The psychosocial needs addressed in this paper are not limited to ART. ART instead offers a clear place to start: patients are already engaged in an intensive medical system, professional guidance already recognizes a role for mental health care, and policy is increasingly determining who can access and afford treatment.

Much of the existing infertility mental health literature has focused on women and heterosexual couples, limiting the extent to which prevalence estimates can be generalized across the full diversity of individuals and families accessing fertility care. Even with that limitation, the existing evidence consistently demonstrates that infertility and its treatment can carry clinically meaningful psychological consequences.

Quick Facts

- In a prospective U.S. fertility-treatment cohort of patients who did not achieve a successful child-related outcome during 18 months of follow-up, **39.1% of women and 15.3% of their male partners met criteria for major depressive disorder** (Holley et al., 2015).
- A 2023 systematic review and meta-analysis estimated the pooled **prevalence of depression among infertile men at 18.3%** (Kiani et al., 2023).
- Recent meta-analyses estimate **anxiety symptoms in approximately 41% of women with infertility and 21.4% of infertile men** (Hu et al., 2025; Simbar et al., 2024).
- In a 2026 mixed-methods online survey of women experiencing infertility-related traumatic events, **41% met questionnaire criteria for PTSD or complex PTSD** (Gameiro et al., 2026).

- In a study of insured U.S. women who discontinued IVF before achieving a live birth, **40.2% reported that further treatment was too stressful. Easy access to a mental health professional was identified by 39.4% as something that could have improved the treatment experience** (Domar et al., 2018).
- ASRM's minimum standards for practices offering ART include a mental health professional with expertise in fertility counseling and state that, when one is not employed by the program, a consultant mental health professional should be available (ASRM, 2021).

These findings matter regardless of whether psychosocial intervention changes reproductive outcomes.

Mental health care does not need to increase pregnancy or live-birth rates to have clinical value. Psychological suffering is, in and of itself, a meaningful health outcome.

Reproductive medicine already recognizes a role for specialized mental health care. What remains missing is the infrastructure that makes that care consistently available, accessible, and sustainable.

The gap isn't a lack of evidence. It's a lack of structure.

That structural gap operates across three interconnected areas:

POLICY: Infertility policy does not meaningfully integrate mental health into the ART care continuum.

WORKFORCE: Professional standards for specialized fertility counseling exist, but there is no standardized national workforce-development infrastructure for developing, supporting, and measuring the workforce needed to provide it.

PAYMENT: Mental health and reproductive medicine remain divided by reimbursement structures that do not consistently support collaborative, infertility-specific psychosocial care.

These gaps feed one another. Screening means very little if there is no qualified provider to call. Building the workforce means very little if patients cannot afford to see them. And coverage alone is not comprehensive care if mental health remains structurally separate from infertility treatment.

A meaningful policy response therefore has to address all three.

IDENTIFY → CONNECT → COVER

A comprehensive approach to integrating mental health into ART care can be organized around three interconnected policy goals:

IDENTIFY psychosocial needs through routine screening, education, and care planning.

CONNECT patients who need additional support with appropriately qualified infertility mental health professionals while building the workforce necessary to provide that care.

COVER clinically indicated psychosocial services so patients can realistically access the care to which they are referred.

Together, these components create a pathway from identifying a need to actually receiving care.

They also require an important ethical guardrail:

Mental health should support access, not determine eligibility.

A positive mental health screen should open a door to care, not close the door to ART.

From Clinical Guidance to Practice

Reproductive medicine does not need to start from zero.

ASRM already recognizes mental health professionals with fertility counseling expertise as part of ART practice and has established professional guidance regarding the qualifications and competencies required for fertility counseling (ASRM, 2021).

ESHRE's evidence-based guideline for routine psychosocial care in infertility and medically assisted reproduction provides an additional clinical foundation, offering extensive guidance regarding patient psychosocial needs and the responsibilities of fertility staff across treatment (Gameiro et al., 2015). ESHRE is currently developing updated guidance focused on integrating routine psychosocial care throughout medically assisted reproduction.

Together, this existing clinical guidance illustrates how psychosocial care can operate at different levels within infertility and ART care:

Tier 1: Routine Psychosocial Care

Fertility practices incorporate psychosocial awareness, patient education, routine identification of psychosocial needs, and basic supportive responses into care.

This level of support does not require every interaction to involve a specialized mental health professional. Fertility physicians, nurses, advanced practice clinicians, care coordinators, and other appropriately trained members of the fertility team can contribute to routine psychosocial care within their roles.

Tier 2: Specialized Infertility Mental Health Care

Patients whose needs exceed routine support have a clear pathway to appropriately qualified infertility mental health professionals for psychotherapy, grief support, couples or family work, decision-making support, crisis intervention, or other clinically indicated services.

Tier 3: Higher-Acuity Mental Health Care

Patients experiencing significant psychiatric symptoms, safety concerns, complex mental health conditions, or needs requiring specialty psychiatric treatment are connected with appropriate higher-acuity behavioral health or psychiatric care.

This tiered structure is one way to translate existing clinical guidance into practice. Psychosocial care can be part of routine fertility treatment without assuming every patient needs therapy—or that every fertility practice needs a full-time reproductive mental health professional on staff.

Why Policy?

If professional organizations already recognize psychosocial care as relevant to infertility treatment, why does policy need to be involved?

Because clinical guidelines and policy do different jobs.

Professional societies can establish clinical standards, define competencies, and develop implementation guidance. Fertility practices can integrate those standards into patient care. Mental health professionals can provide specialized treatment.

But clinical guidance cannot require insurers to reimburse that care. It cannot establish network requirements. It cannot fund workforce development. It cannot determine the benefit structure of employer-sponsored plans. And it cannot ensure that a referral actually leads to an available, affordable provider.

The screening protocol is clinical. The access problem is structural.

No single part of the health care system owns this problem. The responsibility is already spread across practices, mental health professionals, payers, employers, and policymakers. The problem is that those systems do not reliably connect.

Who Owns What?

Actor	Primary Role
Professional organizations	Define clinical standards, competencies, ethical guidance, and implementation principles.
Fertility practices	Implement routine psychosocial identification, patient education, supportive care, and referral pathways.
Mental health professionals	Provide specialized assessment, psychotherapy, consultation, and other clinically appropriate reproductive mental health services within their scope of practice.

Payers and health plans	Establish reimbursement mechanisms, network structures, and benefit designs that make clinically indicated care accessible.
State policymakers	Regulate state-governed insurance markets, establish applicable benefit requirements, and support state workforce initiatives.
Federal policymakers	Address federal benefit structures, ERISA-governed coverage, federal workforce investment, and other areas of federal jurisdiction.
Employers	Design infertility and psychosocial benefits within self-funded employer plans.

That is why no single actor can fix this alone. Each has a different piece of the solution.

Policy Vehicles: State and Federal

There isn't one policy vehicle that can solve this across the U.S. health insurance system.

State infertility coverage mandates remain an important policy vehicle. In states that regulate infertility benefits, policymakers could define comprehensive infertility coverage to include psychosocial identification and care planning, referral pathways to qualified infertility mental health professionals, and coverage for clinically indicated psychosocial services delivered within or alongside infertility treatment.

But state policy has an important limitation.

A substantial portion of workers with employer-sponsored insurance receive coverage through self-funded health plans. These plans established by private employers are generally exempt under the Employee Retirement Income Security Act of 1974 (ERISA) from state insurance requirements, including many state-mandated benefit laws. In 2025, 67% of workers covered by employer health benefits were enrolled in self-funded plans; among workers at firms with 200 or more employees, that figure was 80% (KFF, 2025).

State infertility mandates therefore cannot create universal access on their own.

Federal policy provides a complementary pathway. The Helping to Optimize Patients' Experience with Fertility Services Act, or HOPE with Fertility Services Act (H.R. 8119), introduced in March 2026, provides a current example of federal legislation using ERISA itself as a mechanism for infertility coverage requirements. The bill would establish infertility-treatment coverage requirements for certain group health plans and health insurance issuers offering group coverage. As of October 2026, the bill has been introduced and referred; it has not been enacted.

For this proposal, the importance of H.R. 8119 is structural. It shows that infertility coverage standards can be placed within ERISA rather than relying exclusively on state insurance mandates.

Self-funded employers also retain an important role because they may voluntarily design infertility and psychosocial benefits beyond what state law requires.

The policy architecture therefore has to work across jurisdictions. State policy can shape state-regulated insurance markets. Federal policy can address coverage within areas governed by federal law. Employers can voluntarily design more comprehensive benefits within self-funded plans. Professional societies can define clinical standards and implementation principles. Payers can create the benefit, network, and reimbursement structures that make those standards accessible in practice.

The mechanism may differ by jurisdiction. The goal does not.

IDENTIFY: Make Psychosocial Needs Visible

The first step is ensuring that fertility-care systems have a consistent way to identify when patients may need additional psychosocial support.

Infertility-related distress is not static. A patient who is coping effectively at the beginning of treatment may experience very different needs following unsuccessful cycles, pregnancy loss, a shifting prognosis, escalating financial strain, difficult treatment decisions, or years of prolonged treatment.

That means identification cannot be a one-time mental health screen at intake. Needs change as treatment changes.

ESHRE's psychosocial guidance provides a clinical foundation for incorporating assessment of patient psychosocial needs into routine fertility care. Other areas of medicine offer similar clinical precedent. The National Comprehensive Cancer Network's Distress Management framework, for example, has long incorporated systematic distress screening, assessment, and referral within cancer care.

The infertility-specific screening protocol itself should remain a matter of clinical guidance rather than being rigidly defined in statute.

What Policy Should—and Should Not—Do

Policy can establish an expectation that covered infertility and ART practices have a process for identifying and responding to psychosocial needs.

That process could include screening or psychosocial assessment at clinically appropriate points in treatment, patient education, staff training, clear referral pathways, and escalation procedures for higher-acuity needs.

And screening cannot simply become one more task added to an already busy fertility team. Practices need training, response protocols, and resources for what happens when a screen identifies an urgent or complex need.

Identifying distress without giving fertility teams the infrastructure to respond to it would simply relocate the access problem.

Policy does not need to prescribe a particular screening instrument, score, or rigid schedule. Those decisions should remain responsive to evolving clinical evidence and professional guidance.

Most importantly, screening must not become a suitability determination for routine fertility treatment.

A patient who honestly reports depression, anxiety, trauma symptoms, grief, relationship strain, or difficulty coping should not reasonably fear that disclosure will jeopardize access to ART.

A positive mental health screen should open a door to care, not close the door to ART.

Routine supportive screening must also remain distinct from psychological assessment or evaluation used for a separate clinical, ethical, or legal purpose in specific reproductive contexts, including some forms of third-party reproduction.

The purpose of IDENTIFY is to recognize psychosocial needs and connect patients with appropriate support. It is not to determine who deserves fertility treatment.

Screening is therefore only the first step. Once a need is identified, the system must be capable of responding to it.

That is where CONNECT begins.

CONNECT: Build the Workforce and the Pathway to Care

Identifying psychosocial need only improves care if there is somewhere for the patient to go next.

Existing professional guidance already provides a foundation for defining reproductive mental health competency. ASRM's guidance for fertility counselors describes recommended graduate education, clinical licensure, reproductive-medicine knowledge, post-licensure experience, supervision or consultation, and continuing education for mental health professionals working in reproductive medicine.

The problem is not that the field has no idea what specialized fertility mental health care requires.

The problem is whether patients can find it.

Contemporary reproductive-medicine literature identifies multiple barriers to mental health care in fertility settings, including cost, stigma, inadequate communication about available services, and limited availability of mental health professionals trained in reproductive medicine (Anderson et al., 2026).

At the same time, there is no standardized national infrastructure for developing, supporting, or measuring the infertility mental health workforce. We therefore cannot claim a precisely quantified national shortage when the workforce itself is not being systematically measured.

That absence of data is part of the infrastructure problem.

We cannot build a reliable referral pathway into a workforce we are not adequately developing, supporting, or even measuring.

A referral is not the same thing as a connection.

From Competency Standards to Workforce Development

Policy does not need to define a new national infertility mental health credential in order to begin addressing workforce capacity. Professional organizations should define clinical competency. Policy should make it possible to build and sustain the workforce that meets it.

Federal behavioral-health workforce programs provide a structural precedent for this type of investment. The Health Resources and Services Administration's Behavioral Health Workforce Education and Training program is designed to increase the supply and distribution of a well-trained behavioral health workforce through mechanisms including experiential training, interprofessional education, curriculum development, and support for clinical supervision.

A reproductive mental health workforce strategy could similarly support specialty training, supervision and consultation, and continuing or interdisciplinary education.

Maternal mental health provides another useful specialty-workforce precedent. The 2024 federal National Strategy to Improve Maternal Mental Health Care identifies training, expansion, and diversification of the perinatal mental health workforce as a national priority. Proposed legislation provides a more recent example: the Moms Matter Act (H.R. 8811), introduced in 2026, would establish grants to grow and diversify the maternal mental and behavioral health workforce. As of October 2026, the bill has not been enacted.

Telehealth can also expand geographic reach and should be part of the access conversation, but it cannot substitute for workforce development. Telehealth does not create trained clinicians, eliminate licensure barriers, guarantee network participation, or make out-of-network care affordable.

CONNECT does not require every fertility practice to employ a full-time mental health professional. It requires an infrastructure in which identifying a need can realistically lead somewhere.

Identifying a need is not meaningful access if the next step is a waitlist, an out-of-network provider, or no appropriately trained provider at all.

COVER: Build a Payment Pathway

Connecting patients with qualified mental health professionals only creates meaningful access if patients can afford to receive the care to which they are referred.

This is where the structural divide between fertility treatment and mental health reimbursement becomes particularly visible.

Psychosocial care may be clinically relevant to infertility treatment while still being financed through a separate mental health benefit, a separate provider network, different cost-sharing requirements, or a reimbursement structure that does not readily support collaboration with the fertility team.

The care may be recommended.

The provider may exist.

The referral may be made.

And the payment infrastructure may still not follow.

Patients should not have to get sicker before their mental health becomes worthy of care.

Infertility-related distress does not always fit neatly into the assumption that meaningful (and therefore reimbursable) mental health care begins only after a patient meets criteria for a major psychiatric disorder. Patients may experience significant grief, anxiety, trauma responses, decisional distress, relationship disruption, or difficulty coping with treatment without meeting full diagnostic criteria for a psychiatric condition.

Integrated Care Already Has Payment Precedent

Health policy already recognizes that payment systems sometimes need to be intentionally designed to support collaboration between medical and behavioral health care.

Medicare maintains separate payment mechanisms for Behavioral Health Integration services, including the Psychiatric Collaborative Care Model. State policies have also addressed reimbursement for integrated behavioral health. Illinois Public Act 101-0574 requires reimbursement for services provided through Psychiatric Collaborative Care and identifies applicable billing mechanisms. Louisiana law requires applicable health plans providing mental health or substance-use benefits to cover evidence-based integrated behavioral health models, including Collaborative Care.

These examples do not mean that the existing Psychiatric Collaborative Care Model should simply be transplanted into fertility clinics. Collaborative Care is a specific evidence-based clinical and billing model. Infertility and ART may require a different or adapted approach.

The precedent is therefore not the billing code itself. The precedent is that reimbursement policy can recognize and support integrated behavioral health care.

But none of these precedents answers one of the hardest payment questions in infertility care: How do we pay for clinically meaningful psychosocial care when a psychiatric diagnosis is neither present nor clinically appropriate?

We do not have a complete answer yet. That is part of the policy work still to be done.

This is not entirely unfamiliar territory within reproductive medicine. ASRM's Mental Health Professional Group and Coding Committee have addressed coding considerations for psychoeducational consultation in third-party reproduction.

That guidance is not a ready-made payment model. It does mean ASRM already has people with the reproductive mental health and coding expertise needed to start asking these questions.

What COVER Could Do

Policy could establish or support a defined reimbursement pathway for clinically indicated psychosocial care associated with infertility and ART, using existing mechanisms where appropriate and developing or adapting mechanisms where they are not.

Depending on the clinical setting and benefit structure, that could include individual, couples, or family mental health services associated with infertility treatment; care coordination; appropriate reimbursement across embedded and independent settings; telehealth; and network access to clinicians with reproductive mental health competency.

Specific coding, billing, benefit-design, and reimbursement mechanisms require additional evaluation by payer, coding, clinical, and policy experts. This proposal is not intended to prescribe a single billing model.

But when psychosocial care is clinically indicated as part of infertility treatment, financing should not treat that care as if it is unrelated to the medical experience in which the need arises.

The goal is to make sure that when clinically appropriate mental health care is part of infertility treatment, someone can actually pay for it.

Implementation and Ethical Guardrails

How we do this matters as much as whether we do it.

A poorly designed system could create new barriers while trying to solve existing ones.

The goal is not simply to add mental health to infertility policy. It is to integrate mental health in a way that improves access to care without creating new barriers to treatment.

Supportive Care Is Not Psychological Clearance

Routine psychosocial screening must remain distinct from psychological evaluation used for specific clinical, ethical, or third-party-reproduction purposes.

ASRM's fertility-counselor guidance recognizes multiple functions for reproductive mental health professionals, including supportive counseling, psychotherapy, grief counseling, decision-making support, psychoeducation, and third-party evaluation. Current ASRM guidance regarding gamete and embryo donation similarly distinguishes psychoeducational consultation for recipients from referral for independent evaluation when concerns arise that warrant additional assessment.

That distinction matters.

IDENTIFY is designed to recognize psychosocial needs and connect patients with support. It is not designed to determine patient suitability for routine ART.

Patients should be able to disclose depression, anxiety, trauma, grief, relationship strain, or difficulty coping without believing that honesty could threaten their access to treatment. Routine psychosocial screening should identify opportunities for support—not create another threshold patients must clear before receiving care.

This framework does not eliminate or replace psychological assessment when assessment serves a distinct clinical, ethical, or legally relevant purpose. It does require clarity about the function of that assessment, why it is being performed, and how the information will be used.

Mental health should support access, not determine eligibility.

Avoid Creating an Unfunded Mandate

Screening without referral capacity or reimbursement risks reproducing the very problem this framework is intended to solve.

IDENTIFY cannot operate independently from CONNECT and COVER.

If practices are expected to identify psychosocial needs, patients need somewhere appropriate to go next and the clinicians providing that care need a sustainable payment pathway.

Do Not Confuse Coverage with Access

A covered benefit is not necessarily an accessible benefit.

Network composition, reproductive mental health expertise, geography, licensure requirements, cost-sharing, and wait times all affect whether patients can actually use the care that exists on paper.

The relevant question is not simply whether a plan includes mental health professionals in its network. It is whether patients can access professionals with the competencies necessary for reproductive mental health care.

Protect Clinical Flexibility

Policy should establish expectations and infrastructure without freezing clinical practice in statute.

Screening tools, intervals, referral thresholds, and clinical protocols should remain responsive to evolving evidence and professional guidance. Policy can support specialty training and workforce development without asking legislators to define a new clinical specialty credential.

Preserve Patient Choice

Mental health integration should expand patients' options, not create another compulsory step in fertility treatment.

Except where a separate evaluation is required for a distinct clinical, ethical, or legal purpose, psychotherapy or mental health treatment should not become a prerequisite for receiving ART.

The measure of successful integration is not how many fertility patients enter therapy.

It is whether patients who need support can be identified, connected with appropriate care, and realistically access that care without mental health becoming another barrier they must overcome.

A Role for ASRM

Policy change alone will not determine whether integrated psychosocial care works in practice. Successful implementation will require collaboration among reproductive medicine clinicians, mental health professionals, payers, coding experts, and policymakers.

ASRM is uniquely positioned to help convene that work.

Rather than creating a new clinical standard from scratch, ASRM could bring together representatives from the Mental Health Professional Group, reproductive medicine clinical leadership, coding and reimbursement expertise, and policy stakeholders to develop consensus principles for integrating mental health into infertility and ART care.

That work could focus on several practical questions:

- What core competencies should define appropriately qualified infertility mental health professionals across different clinical roles?
- What should effective referral pathways between fertility practices and mental health professionals look like?
- How can routine supportive screening remain clearly distinct from evaluative psychological assessment?
- What reimbursement and coding barriers currently prevent collaborative care, consultation, and coordination?
- What principles should guide policymakers seeking to incorporate psychosocial care into infertility coverage without creating psychological gatekeeping or rigid clinical mandates?

The goal would not be for ASRM to prescribe a single model of mental health care or dictate insurance policy. It would be to establish interdisciplinary consensus around the clinical and implementation principles necessary for responsible integration.

Those principles could then inform clinical guidance, payer conversations, workforce initiatives, and model policy at both the state and federal levels.

The pieces already exist. ASRM has an opportunity to help bring them together.

Conclusion

Infertility policy is changing. Access to treatment is increasingly part of the conversation. But expanding access to a medical procedure without building the infrastructure to support the people undergoing it leaves the work unfinished.

We do not need to prove that infertility and ART can carry a significant psychological burden. We already know that. We do not need to invent clinical guidance recognizing psychosocial care as part of reproductive medicine. That already exists. And we do not need to build every policy mechanism from scratch. Across behavioral health, reproductive health, and other areas of medicine, there are already models for screening, workforce investment, integrated care, and reimbursement.

What is missing is the structure that connects them.

IDENTIFY psychosocial needs as part of routine infertility care—without turning screening into psychological clearance.

CONNECT patients who need additional support with appropriately qualified professionals—and build the workforce necessary to make that referral meaningful.

COVER clinically indicated psychosocial care so that access does not end when someone hands a patient a referral.

At its core, the proposal asks something much simpler:

When patients experience a mental health need in the context of infertility care, our health care system should be capable of responding to it.

For too long, mental health has been treated as adjacent to infertility care—important, perhaps, but ultimately separate from the medical treatment itself. Patients have been expected to absorb grief, uncertainty, repeated treatment failure, pregnancy loss, financial strain, difficult decision-making, and the psychological demands of ART, while the systems providing and financing their medical care often remain structurally disconnected from the systems expected to support their mental health.

We can do better than acknowledging that infertility is hard.

We can build care that responds accordingly.

That will require reproductive medicine, mental health professionals, payers, professional organizations, employers, and policymakers to work across boundaries that our patients are already forced to navigate.

It will also require those of us with expertise in infertility mental health to be willing to bring that expertise into rooms where decisions about reproductive health policy are being made.

The goal is not to make mental health another hurdle in fertility treatment.

The goal is to make sure patients do not have to get sicker before their mental health becomes worthy of care.

The evidence exists.

The clinical guidance exists.

The policy mechanisms exist.

The pieces already exist. Infertility policy simply has not brought them together.

And until it does, expanding access to IVF will remain only part of the work.

Access to IVF is not the same thing as access to comprehensive infertility care.

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