jected shortage of more than 3 million long-term–care workers by 2040. Yet on each of the fronts where progress could be made to address this shortage, current federal policy runs counter to what evidence indicates is necessary: research funding is contracting, immigration enforcement poses threats to existing workers, and Medicaid cuts are expected to reduce reimbursement rates and wages. Meeting this challenge will require action on all three fronts. Substantial policy shifts are unlikely in the short term, but even small steps could begin to address the growing care needs of aging Americans. Absent policy changes in these areas, this gap will widen — resulting in fewer staffed beds, reduced access to home-based care, and inadequate quality of care for older Americans.

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1. National Academies of Sciences, Engineering, and Medicine. The national imperative to improve nursing home quality: honoring our commitment to residents, families, and staff. Washington, DC: National Academies Press, 2022 (https://www.nationalacademies.org/read/26526).
2. Jun H, Grabowski DC. Nursing home staffing: share of immigrant certified nursing assistants grew as US-born staff numbers fell, 2010–21. Health Aff (Millwood) 2024;43:108-17.
3. Grabowski DC, Gruber J, McGarry BE. Immigration, the long-term care workforce, and elder outcomes in the U.S. Am J Health Econ (in press).
4. Grabowski DC, Gruber J, McGarry BE. Is immigration good for health? The effect of immigration on older adult mortality in the United States. NBER Working Paper 34791. Cambridge, MA: National Bureau of Economic Research, February 2026 (https://www.nber.org/system/files/working_papers/w34791/w34791.pdf).
5. Almuhaisen A, Amuedo-Dorantes C, Furtado D. Immigration enforcement and the institutionalization of elderly Americans. J Health Econ 2024;94:102859.

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Mandated State-Level Surveillance of Assisted Reproductive Technology — An Emerging Threat in the United States

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In 2025, Arkansas became the first U.S. state to enact a "restorative reproductive medicine" (RRM) law. RRM emphasizes treating underlying causes of infertility with methods such as fertility awareness, lifestyle changes, and endometriosis surgery — an approach promoted by the Heritage Foundation, a conservative think tank with a "pro-life" agenda. Though RRM aims to "restore natural fertility," strict adherence to it can delay or limit patients' access to the full spectrum of proven interventions for infertility, such as in vitro fertilization (IVF). More than 6 months after the Arkansas law went into effect, stakeholders are still working to determine how it should be interpreted and implemented.

Although RRM captured the headlines, a less publicized yet equally consequential bill was introduced during the same session: Arkansas House Bill 1554 "To Create the Assisted Reproductive Technology Reporting Act." The bill, taken nearly verbatim from model legislation published by the Heritage Foundation, was halted in committee and recommended for interim study.[1] Strikingly similar bills have been introduced in Texas and Oklahoma.

Arkansas's proposed legislation asserts that assisted reproductive technology lacks oversight, outlining new guidelines for data that must be collected and reported to the state. The bill undermines established clinical definitions by introducing its own definitions of medical terms. Furthermore, language in the bill diminishes the experience of patients with infertility and casts doubt on the expertise of assisted reproductive care providers.

Proposals within this bill potentially lay the groundwork for future personhood-based legislation that could grant legal rights and protections to embryos created by means of IVF. Personhood legislation, in turn, may restrict patients' rights to make decisions about disposition of their embryos created using the IVF process and limit physicians' ability to provide standard-of-care infertility treatment, since it could impose legal repercussions for actions leading to damage or discarding of embryos.

The bill defines infertility as "a symptom of an underlying disease or condition," despite the modern medical consensus that infertility is a disease in itself. Characterizing infertility as a symptom contradicts globally accepted definitions endorsed by organizations including the American Society for Reproductive Medicine, the American Medical Association, and the World Health Organization.

Denying infertility's status as a disease trivializes the experience of affected patients, particularly those (up to 30%) in whom no underlying cause can be identified.

The bill's definition of assisted reproductive technology includes procedures such as artificial and intrauterine insemination, in conflict with established medical and regulatory definitions, which exclude procedures involving only the handling of sperm. In the context of the existing medical literature, redefining key terms creates ambiguity about which data should be collected and how outcomes should be measured. Legislative replacement of established medical terminology with alternative schema can lead to health care regulations motivated primarily by political, rather than clinical, concerns.[2]

The proposed legislation implicitly disparages reproductive health care professionals, claiming that "fertility clinics lack an adequate understanding of how assisted reproductive technology functions in the State of Arkansas." Reproductive health care professionals undergo extensive training to develop comprehensive expertise in the clinical, scientific, and ethical aspects of fertility care. State medical boards, professional medical accrediting bodies, and federal agencies all oversee assisted reproductive technology, which is one of medicine's most highly regulated fields.[3] Language suggesting otherwise can undermine trust in evidence-based fertility care, as lawmakers lacking medical expertise shape the relevant regulatory requirements.

The Alabama Supreme Court's 2024 decision in *LePage v. Center for Reproductive Medicine* demonstrated how rapidly personhood-based legal decisions can disrupt fertility care. Clinics paused procedures amid legal uncertainty, halting access to assisted reproductive technology. Granting personhood to embryos created by IVF could potentially result in punitive or criminal penalties for engaging in standard laboratory practices, such as discarding of nonviable or aneuploid embryos. The Arkansas bill and similar proposed legislation could produce the same effects by statutory, rather than judicial, means.

The bill sets the stage for establishing fertilized oocytes as legal entities. It states, "'Human embryo' means a distinct and living organism of the species Homo sapiens conceived either in the human body or produced in an artificial environment other than the human body, from the moment of fertilization, including the single-celled stage, until natural death, including such embryos that are in a state of cryopreservation or are otherwise unused." Omitting the terms "person" and "personhood" allows for incremental extension of legal protections for embryos. This approach creates a path for future expansion of embryo rights while potentially reducing immediate political, legal, or public backlash.

Similar definitions of a human entity as established at the time of fertilization or from the single-cell stage are found in other statutes, such as those limiting embryonic stem-cell research or restricting abortion access. This terminology attempts to impose a fixed legal status on what in reality is a biologic progression from gametes to viable fetus.

Specific mandated reporting parameters in the bill exceed both the federal requirements outlined in the 1992 Fertility Clinic Success Rate and Certification Act and information required for patient-safety monitoring. Examples include the annual numbers of embryos that are "negligently" destroyed, "intentionally" destroyed, donated to research, and remaining cryopreserved. Such information lacks the clinical nuances to accurately reflect the biologic reality of embryos in an assisted reproductive technology laboratory. For instance, no distinction is made between known euploid and aneuploid embryos. Furthermore, terms such as "negligent" and "intentional" force clinics to assign clinical activities legal rather than medical labels. The data may therefore be misleading, especially given the possible political motives at play.

Particularly concerning is proposed behavioral oversight requiring disclosure of patients' reasons for discarding their embryos. Mandated reporting of this sensitive information is intrusive, risks compromising patient confidentiality, subverts the patient–provider relationship, and can stigmatize standard-of-care procedures and personal decisions. Such surveillance provides another avenue for data collection on practices that personhood laws seek to deter. Although some states have enacted protections for assisted reproductive technology and specifically IVF, these measures merely guarantee the right to access or perform the procedures. They do not protect from potential consequences of legally designating in vitro embryos as persons.

Legislation like what has been proposed in Arkansas can have substantial effects on providers of and patients seeking infertility health care. It may be the first step of targeted regulation, following a sequential process that's been used before in women's health. Targeted regulation of abortion providers (TRAP laws) began with intrusive mandatory reporting re-

quirements under the guise of transparency. Subsequently introduced were punitive consequences for noncompliance and threats of revocation of licensure and facility credentials, framed as ensuring public safety. Non–medically indicated restrictions or bans on evidence-based medicine, using the previously collected data as justification, were ultimately instituted. Restrictions on abortion and assisted reproductive technology are part of a strategy aimed at establishing that a person with legal rights exists from the "moment" of fertilization.

If the Arkansas bill passes, we believe it will lead toward limits on evidence-based fertility care. Fearing restrictions on embryo disposition, patients may transfer their existing embryos or seek care entirely in a state with fewer constraints. Physicians may be forced to offer less effective treatments by minimizing the number of embryos created in an IVF stimulation cycle. The result will be additional financial, logistic, and emotional burdens for patients trying to build a family in a state where access to women's reproductive health care is already limited.

Legal regulation of medical care should be evidence-based and aim to improve safety and outcomes while preserving patient autonomy. The ethical principle of autonomy holds that patients with personhood-based views of embryos should have their beliefs respected and their medical care provided in accordance with their values, without imposing those beliefs on others. Lawmakers, health care professionals, and oversight agencies share the responsibility of ensuring that reproductive health care policy follows current medical standards and works within existing regulatory frameworks, rather than reshaping clinical practice by means of legislative overreach grounded in ideological and political agendas.

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1. Heritage Foundation. ART reporting requirements — state model legislation (https://www.heritage.org/model-legislation/art-reporting-requirements-state-model-legislation).
2. Peck MC, Scheffler RM. An analysis of the definitions of mental illness used in state parity laws. Psychiatr Serv 2002;53:1089-95.
3. American Society for Reproductive Medicine. Oversight of assisted reproductive technology (https://www.asrm.org/advocacy-and-policy/fact-sheets-and-one-pagers/oversight-of-art/).

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For Those Left Behind

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"You were the light of his life, honey, and your dad had a wonderful life," his octogenarian neighbor told me kindly in the days after he died.

"Too bad about his death," I blurted out. The words escaped before I could catch them, propelled by exhaustion and emotion. Luckily, she was hard of hearing.

Three weeks. That's all we had from diagnosis to death. He'd survived a heart attack in his 40s, bypass surgery in his 60s, colon cancer in his 70s, and a gauntlet of bowel obstructions. I thought we would have more time.

Advanced lung cancer, they said. I had brushed off his decline as a lingering winter respiratory illness or perhaps depression. He'd lost his wife unexpectedly a year earlier. When it became clear he couldn't live alone anymore, we moved him off the island where he'd lived for most of his life. Away from his friends, his routines, and the neighbors who looked out for him. We brought him closer so we could take care of him, and so he could spend more time with his grandchildren. It felt like the right thing to do. In retrospect, I wonder if it accelerated his decline. His world had already shrunk with grief; maybe we made it smaller still.

When hospice was mentioned, it seemed obvious. We'd bring him home to die. That's what most Americans say they want. And I believed it, too, that dying at home meant comfort, dignity, control. Soft music, family close by, a cozy blanket, and the quiet reassurance of hospice. Compared with the ICU, home seemed more humane.

I was wrong about what dying at home would require of us.

The hospital bed arrived before we did. Morphine came by FedEx. The hospice nurse showed up with a clipboard and a scripted list of state-mandated questions, delivered with the awkwardness of someone still new to the job. My father, once a proud, strong man,