THE INJUSTICE OF INFERTILITY INSURANCE COVERAGE:
AN EXAMINATION OF MARITAL STATUS RESTRICTIONS UNDER STATE LAW

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I. INTRODUCTION

Infertility is a disease of the reproductive system that impairs the conception of children. To date, it affects about 7.3 million people. Often described as one of the most painful and difficult life crises that an individual and couple can face, infertility creates feelings of anxiety, depression, and stress as it touches upon “every aspect of [one’s] life” ranging from his or her “sex life [to] relationships with friends and family [to] jobs.” Luckily, improvements in infertility treatments are making it possible for more infertile couples to experience the birth of a child.


I would like to thank Dean Alicia Ouellette for reviewing and providing thoughtful suggestions throughout the writing process. More importantly, I would like to thank her for serving as my mentor, which has proven to be an invaluable gift. I would also like to thank my family and friends for enduring lengthy conversations about infertility treatments and the complexities of state law. Finally, last but not least, thank you to the incredible staff of the Albany Law Review.

One obstacle that deters many from seeking these options is the high costs associated with infertility treatments. Despite both the American Society for Reproductive Medicine ("ASRM") and the American College of Obstetricians and Gynecologists ("ACOG") recognizing infertility as a disease in its disruption of the normal functioning of the reproductive system, the federal government has not yet acknowledged this condition as such. As a result, there is no mandate that health insurance companies include coverage of infertility treatments in their policies.

In the United States, only fifteen states mandate health insurance companies to provide some coverage for infertility treatment. Additionally, in five of these fifteen states, the law only requires coverage if the woman is married. Therefore, unmarried couples, same-sex couples, and single women are legally denied a health benefit that is available to others who pay the same premiums. Denial of coverage under these circumstances amounts to discrimination by state laws and by insurance providers who establish and enforce such policies. As federal law does not mandate such coverage, it is important to look to state law to determine whether this limitation on infertility insurance is permissible. It will be argued that these infertility insurance statutes are unconstitutional because they place an undue burden on an individual's right to privacy under state law.

Part II provides a brief overview of infertility, including costs associated with possible treatment options. Part III reviews the history of insurance coverage for infertility in the United States.

Part A focuses on the history of coverage in relation to the federal

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4 See id.
6 See Hawkins, supra note 5, at 204.
9 See infra Part II.
10 See infra Part III.
government through an evaluation of the Americans with Disabilities Act ("ADA") and the Pregnancy Discrimination Act ("PDA"). Next, Part B highlights two of the fifteen states (Hawaii and Rhode Island) to determine the constitutionality of their infertility insurance coverage that is limited to married women. These states were picked at random to illustrate the constitutionality of this restricted form of insurance coverage. First, Hawaii’s constitutional jurisprudence is examined to show that this state is likely to find its limitation unconstitutional as based on the Privacy Clause in its state constitution. Then, Rhode Island is evaluated to show that based on its constitutional jurisprudence, this state would also likely find its marital status restriction unconstitutional. For Rhode Island, however, it can also be argued that the statute may be deemed valid due to the absence of an express privacy clause in its state constitution and a lack of precedent on the matter.

Part IV argues that regardless of whether an individual has a right to coverage for fertility treatment under state or federal law; there are strong economic and social policy reasons for passing a legislative mandate. Moreover, a mandate would eliminate the problem of inconsistent and restrictive coverage under state law.

II. THE CONDITION OF INFERTILITY

Diagnosis of infertility, a disease that impairs the ability to conceive a child, occurs when one is unable to get pregnant (1) after one year of trying; (2) after six months of trying if the woman is thirty-five or older; or if (3) the woman can get pregnant but is unable to stay pregnant. This condition affects approximately twelve percent of women and their partners (7.3 million) in the United States ages fifteen to forty-four.

Infertility occurs equally in both men and women with male and female factors each accounting for about one-third of infertility problems. For the remaining one-third of infertile couples, this

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11 See infra Part III.A.
12 See infra Part III.B.
13 See infra Part III.B.1.
14 See infra Part III.B.2.
15 See infra Part IV.
17 See Quick Facts About Infertility, supra note 2.
condition is thought to be caused by a combination of problems in both partners. Additionally, in about twenty percent of the cases the cause is unknown.

Common causes of male infertility include problems with the production and delivery of sperm, while the predominant cause of female infertility is an ovulation disorder. It has also been alleged that environmental factors play a role in infertility, such as unhealthy body weight and the use of alcohol, tobacco, and illegal drugs. Another concern is structural infertility, which occurs when an individual or couple must find another means of reproducing “because of the social structure in which they self-identify.” This includes single individuals and same-sex couples. In these situations, the parties are unable to conceive a child biologically on their own and must access reproductive assistance to achieve parenthood.

To remedy this problem, infertility treatments have been made available. The type of treatment recommended, however, depends on the fertility issue. Less invasive therapies, for women, such as hormone therapy can range from $200–$3,000 per cycle, while tubal surgery can range from $10,000–$15,000 and requires a hospital stay as well as poses high risks of complications. Another option, assisted reproductive technologies (“ART”), is a procedure where both the egg and sperm are handled. In general, it “involve[s] surgically removing eggs from a woman’s ovaries, combining them with sperm in the laboratory, and returning them to the woman’s body or donating them to another woman.” A common form of ART includes in vitro fertilization (“IVF”) whereby fertilized eggs are transferred into a woman’s uterus. Costs range from $10,000–$18,000 per cycle. Today, over one percent of all infants born in

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19 Id.
20 Id.
21 Id.
22 Hawkins, supra note 5, at 206 (citing DIANE ABONSON, RESOLVING INFERTILITY 234, 242–46 (1999)).
24 Id.
25 Id.
28 Id.
29 Id.
the United States each year are conceived using ART and this number continues to rise steadily.\textsuperscript{31}

III. HISTORY OF INFERTILITY INSURANCE COVERAGE

A. Federal Law

Insurance coverage has become a key issue with the rising costs of infertility treatments. Currently, there is no federally mandated coverage and only fifteen states have laws requiring insurers to either cover or offer to cover some form of infertility diagnosis and treatment.\textsuperscript{32} Insurers did not begin to include infertility treatments until the 1990s.\textsuperscript{33} The three main arguments attributed to denying coverage included that, “1) infertility is not an ‘illness,’ 2) artificial insemination is not a ‘treatment,’ and 3) infertility treatment is not ‘medically necessary.’”\textsuperscript{34}

Although some argue that various federal laws require insurance protection for infertility treatment, attempts to enforce such arguments in the courts have failed.\textsuperscript{35} One avenue to mandate infertility insurance coverage is the ADA.\textsuperscript{36} Under this statute, an employer cannot “discriminate against a qualified individual with a disability” in the “terms, conditions, and privileges of employment.”\textsuperscript{37} The landmark decision of \textit{Bragdon v. Abbott}\textsuperscript{38} was

\textsuperscript{31} \textit{What is Assisted Reproductive Technology?}, supra note 27.

\textsuperscript{32} Insurance Coverage of Infertility Treatments, supra note 26.

\textsuperscript{33} James B. Roche, \textit{After Bragdon v. Abbott: Why Legislation is Still Needed to Mandate Infertility Insurance}, 11 B.U. Pub. Int. L.J. 215, 216 (2002). The first argument that infertility is not an illness was premised on the idea that “although improper function of ovaries or testicles may be an illness, the condition of being not pregnant is not an illness.” \textit{Id.} (quoting Witcraft v. Sundstrand Health & Disability Grp. Benefit Plan, 420 N.W.2d 785, 788 (Iowa 1988)). The contention that artificial insemination is not a “treatment” was based on the notion that infertility treatments do not constitute a cure for a disease. Roche, \textit{supra}, at 217 (citing \textit{Witcraft}, 420 N.W.2d at 787, 790). Moreover, the assertion that infertility treatment is not “medically necessary” is based on the idea that not being able to conceive is not a sickness. Roche, \textit{supra}, at 219 (citing Ralston v. Conn. Gen. Life. Ins. Co., 617 So. 2d 1379, 1382 (La. Ct. App.), rev’d 625 So. 2d 156 (La. 1993); Kinzie v. Physician’s Liab. Ins. Co., 750 P.2d 1140, 1141–42 (Okla. Civ. App. 1987)).

\textsuperscript{34} Roche, \textit{supra} note 33, at 216 (citing Pamela Prager, \textit{Insurance Coverage for Infertility Treatment}, INCIID, http://www.inciid.org/article.php?cat=benefits&id=16 (last updated May 10, 2002)).

\textsuperscript{35} See, e.g., David Orentlicher, \textit{Discrimination Out of Dismissiveness: The Example of Infertility}, 85 Ind. L.J. 143, 144 (2010) (arguing that infertility is a disability).


\textsuperscript{37} \textit{Id.} § 12112(a).

the first glimmer of hope for infertile couples hoping they would be afforded protection under the ADA.\(^3^9\) In this case, the plaintiff, living with HIV, brought suit under the ADA, claiming that a dentist discriminated against her when he refused to provide treatment in his office due to her HIV status.\(^4^0\) Here, the United States Supreme Court held that “even in the so-called asymptomatic phase, [HIV] is an impairment which substantially limits the major life activity of reproduction.”\(^4^1\) As a result, the plaintiff was afforded protection from discrimination as provided by the ADA.\(^4^2\)

Following *Bragdon*, many infertility rights advocates believed this decision would compel insurers to provide coverage for infertility.\(^4^3\) Unfortunately, this was not the result.\(^4^4\) In *Saks v. Franklin Covey Co.*, the plaintiff brought an action against defendant employer for its insurance plan’s lack of coverage for surgical impregnation procedures.\(^4^5\) Here, the court looked to its decision in *Bragdon* to determine whether coverage should be mandated as required by the ADA.\(^4^6\) It was held that the plaintiff’s “infertility ‘substantially limits’ her ability to reproduce—indeed, it appears to prevent it altogether, absent outside intervention of a very drastic nature.”\(^4^7\) Ultimately, the court decided that, though the plaintiff had a viable claim, the defendant’s failure to provide insurance coverage for infertility did not violate the ADA.\(^4^8\) The ADA claim failed for two reasons: (1) Franklin Covey’s insurance plan offered the same coverage to all employees (both fertile and infertile) and (2) Franklin Covey’s plan was not covered by the ADA.\(^4^9\)

The reasoning behind the *Saks* decision is arguably flawed. First, the court stated that insurance coverage was provided uniformly to

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\(^3^9\) See Roche, supra note 33, at 220 (citing Bonny Gilbert, *Infertility and the ADA: Health Insurance Coverage for Fertility Treatment*, 63 DEF. COUNS. J. 42, 46–57 (1996)).

\(^4^0\) *Bragdon*, 524 U.S. at 628–29.

\(^4^1\) *Id.* at 647.

\(^4^2\) *Id.* at 655.

\(^4^3\) Roche, supra note 33, at 221.

\(^4^4\) *Id.*

\(^4^5\) *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 320 (S.D.N.Y. 2000). This decision was followed in *Knight v. Hayward Unified School District*, where the California Court of Appeals held that the group health insurance policy provided by the school district to employees did not discriminate based on disability when in its lack of coverage for IVF. 132 Cal. App. 4th 121, 131 (Ct. App. 2005).

\(^4^6\) *Saks*, 117 F. Supp. 2d at 324.

\(^4^7\) *Id.*

\(^4^8\) *Id.* at 323–28.

\(^4^9\) *Id.* at 327.
all employees. However, the Saks court could have distinguished between fertile and infertile individuals. This argument was made in EEOC v. Staten Island Savings Bank, where the court was asked to differentiate between the short-term insurance coverage provided to those with mental disabilities and the long-term coverage provided to those with physical disabilities. In Staten Island Savings Bank, it was decided that insurance providers did not need to provide equal coverage for every disability and that employees under this plan still had meaningful access to mental disability coverage. Saks is distinguishable, however, in that infertile individuals had no access at all to treatment for their infertility.

Second, Franklin Covey was deemed exempt from the ADA as it ran a self-insured health-care plan. Nevertheless, even if it did not run its own health-care plan, the insurance provisions of the ADA still permit health insurers to determine their own coverage as long as the policies are sound. This protection is withdrawn, though, if the insurance provider is trying to evade the requirements of the ADA. Here, Franklin Covey’s insurance plan which excludes surgical impregnation procedures predates the 1991 enactment of the ADA and thus is not subject to this protection. Arguably, if the insurance plan was subject to the ADA, the plaintiffs would have had a stronger case as the court stated infertility was an impairment of a major life activity, and therefore subject to protection under the ADA. However, following Saks, infertile individuals have had little luck in securing mandated insurance coverage under the ADA.

Another avenue to mandate infertility insurance coverage is the Pregnancy Discrimination Act (“PDA”). Under this Act, an employer cannot discriminate “because of or on the basis of

50 Id.
51 EEOC v. Staten Island Sav. Bank, 207 F.3d 144 (2d Cir. 2000); see Orentlicher, supra note 35, at 178 (discussing Staten Island Sav. Bank).
52 Staten Island Sav. Bank, 207 F.3d at 146–47.
53 Id. at 150.
54 Orentlichter, supra note 35, at 179.
55 Id.
56 Id. (citing Americans with Disabilities Act, 42 U.S.C. § 12201(c)(1) (2012)).
57 Orentlichter, supra note 35, at 180.
59 Id. at 323–28.
60 See Bragdon v. Abbott, 524 U.S. 624, 654 (1998) (holding that reproduction is a major life event under the ADA).
pregnancy, childbirth, or related medical conditions." To date, the United States Supreme Court has not ruled on whether infertility is included under this statute and courts across the nation have had differing results.

In *Pacourek v. Inland Steel Co.*, the Northern District Court for the Seventh Circuit held that the broad language of the statute should include infertility. More specifically, it “stated that the term ‘related’ was a ‘generous choice of wording, suggesting that interpretation should favor inclusion rather than exclusion in the close cases.’” In contrast, in *Krauel v. Iowa Methodist Medical Center*, the United States Court of Appeals for the Eighth Circuit viewed the language more narrowly and determined it was only related to pregnancy and childbirth.

There is no real guidance under the ADA or the PDA in regards to insurance coverage for infertility treatments under the federal law. Therefore, parties seeking insurance coverage for infertility treatments must look to state law in the hopes of obtaining a better result.

B. State Law

In the United States, only fifteen states mandate health insurance companies to provide some coverage for infertility treatment. Additionally, coverage in four of these fifteen states is contingent upon fertility treatments being deemed “medically necessary,” or, in other words, an individual being diagnosed as infertile. Many times, one must prove that they have engaged in unprotected sex for a certain period of time (generally a year) to qualify for such diagnosis.

Furthermore, in five of these fifteen states, the law only requires
coverage if the woman is married. Additionally, of these five states, all but Arkansas and Rhode Island stipulate that coverage for in vitro fertilization will only be permitted if the husband’s sperm is used. Thus, these plans exclude unmarried heterosexual couples, same-sex couples, single individuals, and even married couples where the husband has defective sperm.

This paper argues that exclusions based on marital status may violate the laws of the states in which they are enacted. Focus will be placed on the states of Hawaii and Rhode Island to determine the constitutionality of insurance plans limiting coverage based on marital status. These states were chosen at random. It will be shown that the right to privacy arguably will not support the enactment of infertility insurance statutes that limit coverage based on marital status as these restrictions place an undue burden on an individual’s right to exercise his or her right to privacy in rendering decisions whether to bear or beget a child.

1. Hawaii

Hawaii’s limitation on infertility treatment that requires the patient’s eggs to be fertilized with her spouse’s sperm appears to be unconstitutional as violative of the Privacy Clause of the Hawaii State Constitution. The restriction placed on infertility coverage arguably imposes an undue burden on a citizen’s right to privacy as provided in the Privacy Clause, which states that “[t]he right of the people to privacy is recognized and shall not be infringed without the showing of a compelling state interest.”

There are two approaches to establishing the right to privacy. The first approach was utilized by the court in State v. Mueller. In

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75 To clarify, in Rhode Island, as previously stated, only married women are permitted any form of infertility insurance coverage. R.I. Gen. Laws § 27-19-23 (2012). Therefore, married women with husbands with infertility problems are not excluded under Rhode Island’s infertility insurance coverage statute. Id.

76 See infra Parts III.B.1., III.B.2.


78 Id. § 6.

this case, the court held “that only personal rights that can be deemed fundamental or implicit in the concept of ordered liberty are included in this guarantee of personal privacy.”80 This decision was later reaffirmed in *Baehr v. Lewin*,81 where it was further elucidated that if a right is considered fundamental then it is “subject to interference only when a compelling state interest is demonstrated.”82

To determine which rights are fundamental, the court has “look[ed] to the ‘traditions and collective conscience of [the] people to determine whether a principle is so rooted there as to be ranked as fundamental.”83 Relying on federal case law, the court has found rights that “emphasize[] protection of intimate personal relationships such as those concerning marriage, contraception, and the family” to be fundamental, and thus protected under the right to privacy.84 The court has reinforced the notion that family decisions are afforded protection under the right to privacy in decisions such as *Doe v. Doe*,85 where the court stated:

Parents’ right to raise their children is protected under article I, section 6 of the Hawai‘i Constitution, which requires the showing of a compelling state interest prior to infringing on privacy rights. Under the constitutional right to privacy, “among the decisions that an individual may make without unjustified government interference are personal decisions relating to marriage, procreation, contraception, family relationships, and child rearing and education.”86

The second approach to establish protection under the right to privacy was applied by the Hawaii Supreme Court in *State v. Kam*.87 In this case, the court based its holding on the United States Supreme Court’s ruling in *Stanley v. Georgia*,88 which held that the right to view pornographic material in one’s home is

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80 Id. at 1355 (quoting *Roe v. Wade*, 410 U.S. 113, 152 (1973))
82 Id. at 55 (quoting *Comm. of the Whole Rep. No. 15, in 1 PROCEEDINGS OF THE CONSTITUTIONAL CONVENTION OF HAW. OF 1978*, at 1024 (1980)).
84 *Mallan*, 950 P.2d at 182.
85 *Doe v. Doe*, 172 P.3d 1067 (Haw. 2007).
86 Id. at 1078 (quoting *Mallan*, 950 P.2d at 233).
88 See generally *Stanley v. Georgia*, 394 U.S. 557 (1969) (holding that the First and Fourteenth Amendments prohibit making the possession of obscene material a criminal offense).
protected by the First Amendment. Similarly, the Kam Court decided the right to privacy encompasses the right to view pornographic material in the privacy of one’s home and the right to purchase such materials for use in one’s home. Therefore, the State cannot interfere with these rights unless a compelling state interest is shown.

There are some key differences between these approaches to achieving protection under the Privacy Clause. First, the Kam/Stanley approach looks solely to the home as the situs of privacy, whereas the Mueller/Baehr method focuses on intimate relationships. Second, the Kam/Stanley approach strongly implicates freedom of speech and the press and this is not true of the Mueller/Baehr method.

When deciding privacy cases, the court has chosen which approach to apply based on the facts and circumstances surrounding the issue. For example, in Mallan, where a convicted criminal was arrested after the police found a partially burnt marijuana cigarette in his car, the court looked to the Mueller/Baehr approach, finding that the right to possess and use marijuana is not a fundamental one. The court chose this approach as the defendant was not in his home and the issue did not involve pornographic materials.

If asked to review the infertility insurance statute under the right to privacy, the court will likely turn to the Mueller/Baehr approach as the issue of insurance coverage for infertility treatments involves intimate decision-making rights. Moreover, it will likely also view this right in comparison to the state’s strong support for procreative autonomy. In this respect, though infertility treatments differ from natural child birth, the Hawaii Supreme Court will arguably find this activity protected under the right to privacy.

If the use of infertility treatments to bear a child is deemed protected, then the marital status restrictions placed on insurance coverage will be found unconstitutional. This limitation on insurance coverage excludes certain groups such as single individuals, unmarried couples, and same-sex couples from

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89 Id. at 568.
90 Kam, 748 P.2d at 380.
91 Id.
92 Mallan, 950 P.2d at 182 (comparing Mueller/Baehr with Kam/Stanley).
93 Id.
94 Id. at 180.
95 Id. at 185–86, 192.
exercising their right to privacy. As a result, it imposes an undue burden on one’s constitutional right and should be found unconstitutional.

2. Rhode Island

The constitutional jurisprudence of Rhode Island also suggests that the state’s limitation on insurance coverage is arguably unconstitutional. In this state, a patient can only be diagnosed as infertile if she is a “presumably healthy married individual who is unable to conceive” during a two-year period. Unlike in Hawaii, there is no explicit privacy clause mentioned in the Rhode Island Constitution. A close reading of case law, however, illustrates that Rhode Island has a rich history of protecting this right, especially in relation to decisions regarding the family unit. Conversely, as there is no explicit right to privacy in the state constitution, it is also possible the state would uphold the statute if challenged.

The Rhode Island Supreme Court has adopted the principles set forth by the United States Supreme Court as a matter of its state jurisprudence regarding the right to privacy. This was illustrated in State v. Santos. In this case, though Rhode Island’s sodomy statute was found not to infringe on the defendant’s right of privacy, the court set forth the fashion in which it would analyze future privacy cases.

First, the court looked to Griswold v. Connecticut, where it was “reasoned that penumbras emanating from the specific guarantees of the Bill of Rights ... created a zone of privacy that protects the individual from governmental interference.” In Griswold, it was found that married individuals have the right to use contraceptives as protected by the right to privacy surrounding the marital relationship. In rendering its decision, the United States Supreme Court held that the right to privacy, as a concept “older than the Bill of Rights,” should be afforded protection.

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97 See generally R.I. Const. art. I, § 1 (listing the provisions of the Rhode Island Constitution and not including a Privacy Clause).
99 Santos, 413 A.2d at 61.
100 Id. at 68.
102 Santos, 413 A.2d at 66.
103 Griswold, 381 U.S. at 485.
104 Id.
Next, the court reviewed Eisenstadt v. Baird,\(^{105}\) where it was held that the right to privacy is not confined solely to the marital relationship.\(^{106}\) Here, the court held that “if the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”\(^{107}\) Thus, the United States Supreme Court expanded the right to privacy from the more limited protection of just the marital relationship to also include single individuals.

Then, the right was limited by Roe v. Wade,\(^{108}\) where the United States Supreme Court held “that only personal rights that can be deemed ‘fundamental’ or ‘implicit in the concept of ordered liberty’ are included in this guarantee of personal privacy.”\(^{109}\) Although the court, in this decision, restricted the right to those that are considered “fundamental,” it once again reaffirmed earlier opinions that “had established that the right of privacy applied to activities concerning marriage, procreation, contraception, family relationships and child rearing and education.”\(^{110}\)

As a result, federal interpretation of the right to privacy broadly applies to both single and married individuals in regards to intimate decisions affecting the family unit.\(^{111}\) Unlike the United States Supreme Court, however, the Rhode Island Supreme Court has more narrowly construed this right “find[ing] that the right of privacy is closely related to the decision whether or not to have a child.”\(^{112}\) The Rhode Island Supreme Court has reaffirmed this principle in many cases emphasizing that citizens are protected under the right of privacy when making decisions regarding marriage and parenthood and not other activities such as engaging in certain sexual acts.\(^{113}\)


\(^{106}\) Santos, 413 A.2d at 66 (citing Eisenstadt, 405 U.S. at 453).

\(^{107}\) Santos, 413 A.2d at 66 (quoting Eisenstadt, 405 U.S. at 453) (emphasis added).


\(^{109}\) Santos, 413 A.2d at 67 (quoting Roe, 410 U.S. at 152).

\(^{110}\) Santos, 413 A.2d at 67 (citing Roe, 410 U.S. at 152–53).

\(^{111}\) See generally Roe, 410 U.S. at 152 (holding that the right to privacy is limited to “fundamental” rights, but still includes those relating to the family unit); Eisenstadt, 405 U.S. at 453 (holding that the right to privacy is not confined solely to the marital relationship); Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (recognizing the right to privacy under the “penumbras” of the Bill of Rights).

\(^{112}\) Santos, 413 A.2d at 67–68.

\(^{113}\) See generally State v. Chiaradio, 660 A.2d 276, 277–78 (R.I. 1995) (holding that engaging in sexual acts with exotic dancers is not protected under the right of privacy); State v. Lopes, 660 A.2d 707 (R.I. 1995) (holding defendant’s acts of engaging in sexual assault is not protected under the right of privacy); Santos, 413 A.2d at 61 (holding that kidnapping a
An individual’s right to access infertility treatments is a decision that relates directly to one’s choice whether to have a child. Abiding by the principles set forth in *Griswold* and *Eisenstadt*, any person (single or married) has the right to privacy regarding intimate decisions affecting the family unit. Arguably then, the right to obtain infertility treatments should be afforded protection by the state’s interpretation of the right to privacy. So, limiting insurance coverage based on marital status places an undue burden on one’s ability to exercise his or her right to privacy.

However, as Rhode Island does not have an explicit privacy clause in its constitution, and no clear precedent has yet been established, it is also possible the state could find the marital status restriction on infertility insurance coverage valid. In this respect, it could be argued that there is a fundamental difference between the protection afforded to natural procreation and that afforded to one bearing a child through reproductive technology. If there is a difference between natural and assisted reproduction, then the Rhode Island Supreme Court may not find infertility insurance coverage to fall within the parameters of the right to privacy.

Rhode Island has relied heavily on federal interpretation of the right to privacy when deciding past cases. In doing so, the state has consistently reaffirmed that citizens have a guaranteed right to privacy in decisions to bear and beget a child. The use of infertility treatments arguably coincides with such decisions that have previously been afforded protection under the right to privacy. With restrictions on insurance coverage based on marital status, unmarried couples, same-sex couples, and single individuals are excluded from coverage and thus their right to privacy is unduly burdened. This undue burden would likely render the infertility insurance statutes void.

**IV. REASONS TO INCREASE COVERAGE**

Regardless of whether an individual has a right to coverage for fertility treatment under state or federal law, there are strong economic and social policy reasons for passing a legislative mandate. To elaborate, mandated insurance coverage can result in lower health care costs, as well as a decrease in the harms associated with multiple births.

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114 See *Lopes*, 660 A.2d at 710; *Chiaradio*, 660 A.2d at 277; *Santos*, 413 A.2d at 66.
115 See *Lopes*, 660 A.2d at 710; *Chiaradio*, 660 A.2d at 277; *Santos*, 413 A.2d at 67.
As for economic reasons, it has been shown that mandated infertility coverage does not increase costs significantly. A 1998 study by Martha Griffin, M.S.N., and William Panak, Ph.D., tested infertility insurance in Massachusetts, a state where such coverage had been mandated by law since 1989. Here, researchers examined infertility services costs and outcomes in Massachusetts from 1986–1993 by looking at cost data from nine large group insurance plans. It was found that the monthly cost of providing such coverage was only $0.26. Although mandated infertility coverage was associated with increased use of ART, it did not correlate with excessive increases in consumer costs for infertility insurance coverage.

One measurement of success in regards to infertility treatments (especially ART) is live singleton births. Multiple-infant births are dangerous as they have a higher chance of resulting in adverse infant health outcomes such as “prematurity, low birth weight, disability, and death.” In 2008, twenty-six percent of ART cycles resulted in multiple-infant births. Due to the exorbitant costs of infertility treatments, those who pay out-of-pocket have a financial incentive to achieve pregnancy on the first try. These individuals are willing to accept the risks associated with multiple births in order to increase their chances of pregnancy.

Recently, it was found that “[t]he proportion of in vitro fertilization (IVF) multiple births was lower in the eight states that provide insurance coverage for couples seeking IVF treatment, primarily due to fewer embryos transferred per cycle . . . .” Using data submitted by the Society for Assisted Reproductive Technology, researchers analyzed outcomes of women aged thirty-five and younger who underwent IVF in IVF-insurance-mandated states and those states with no such mandate. States that did

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117 Id. at 22.
118 Id. at 22–23.
119 Id. at 22.
121 Id. at 54.
122 Hawkins, supra note 5, at 223.
123 Id.
125 Id.
not mandate coverage, and were found to have a higher frequency of multiple births, had to endure “higher costs for couples, insurance companies, and society at large due to the higher pregnancy rate and birth complications.”

Increasing infertility insurance coverage, which would result in only nominal premium increases per month, would provide long term savings in regards to health care costs, especially those associated with multiple births. Insurance coverage would encourage individuals to more responsibly restrict the number of embryos transferred per cycle in ART, which would limit the risks of multiple births. This coverage would not create a heavy burden on insurance companies and would prove beneficial for both economic and social reasons.

V. CONCLUSION

With no clear guidance under federal law, some states have taken the initiative to mandate that insurance providers cover infertility treatments. However, in five of the fifteen states which provide such coverage, it is limited based on marital status. Though states are making a concerted effort to increase insurance coverage for infertility treatments, placing a restriction based on marital status is an undue burden on an individual’s right to privacy. Specifically, in Hawaii, where the state has a Privacy Clause and has abided by federal interpretation of this right emphasizing the sanctity of decisions regarding the family unit, it is likely this statute is unconstitutional. Similarly in Rhode Island, though there is no express privacy clause in the constitution, it will likely find the statute unconstitutional due to its rich history of protecting one’s right to procreative autonomy under the right to privacy.

Despite the limited and inconsistent coverage provided under state law, there are strong policy reasons for a federal mandate of infertility insurance coverage. An assessment of the economic and social benefits associated with insurance coverage for infertility treatments support the premise that such coverage should be enforced as it is inexpensive to cover infertility treatments and will result in lower health care costs in the future. Moreover, increased coverage has proven to be beneficial in regards to decreasing the complications linked to multiple births such as

126 Id.
127 See Griffin & Panak, supra note 116, at 28.
Infertile individuals and couples should not be penalized for their inability to conceive. A federal mandate requiring insurance companies to provide coverage for infertility treatments should be implemented to support those who want nothing more than to achieve the most fundamental human goal of parenthood.