Drive for Insurance Coverage Of Infertility Treatment Raises Questions of Equity, Cost

By Adam Sonfield

In 1998, the U.S. Supreme Court ruled that individuals suffering from a disability related to their reproductive capacity are protected from discrimination under the federal Americans with Disabilities Act (ADA). Advocates for individuals and couples suffering from infertility are seeking to use this decision as leverage in their long-standing attempts to alter how infertility is viewed and addressed in the United States—particularly in the realm of insurance coverage. Not unexpectedly, however, these efforts face opposition from those who question the economic and societal costs of infertility treatment.

Infertility and Its Treatment

Typically defined as the inability to become pregnant after one year of sexual intercourse without contraception, infertility affects over six million U.S. couples. One-third of diagnosed cases stem from male factors (such as low sperm count or malformed sperm cells) and another third from female factors (such as irregular or abnormal ovulation or blocked fallopian tubes); the remaining cases either involve both partners or are of unknown causes. The major preventable cause of infertility can be pelvic inflammatory disease, which in turn can be caused by chlamydia and other sexually transmitted infections.

Treatment for infertility is just as varied, including hormonal therapy to stimulate ovulation, artificial insemination, surgery on the fallopian tubes and invitro fertilization (IVF) and related techniques. Significantly, although current technologies can successfully treat more than half of couples experiencing infertility, most couples do not seek or receive treatment. Of those who do, most do not end up using advanced treatment; in fact, only one-third go beyond medical advice and diagnostic tests. According to the 1995 National Survey of Family Growth, 15% of the 60 million women of reproductive age have received some form of infertility services during their lifetime, including 3% using ovulation drugs and 1% using artificial insemination, IVF or other advanced procedures.

One major deterrent to infertility treatment is the cost of services. A 1998 survey by human resources consulting firm William M. Mercer found that only about one-quarter of employer-sponsored health plans cover any of the costs of infertility treatment. Moreover, the extent of coverage in these plans varies considerably, with IVF, in particular, included in only about one in 10. As the cost of one cycle of IVF is often more than $10,000—and as an individual cycle is successful only one-quarter of the time—couples with no or limited insurance coverage may be unable to afford such treatment, or may incur substantial debt in their attempts.

Infertility as Disability

In the mid-1980s, a number of state legislatures took up the question of requiring coverage—or at least the offer of coverage—for infertility services. According to the American Society for Reproductive Medicine (ASRM), which represents providers of infertility services, and RESOLVE, an advocacy group for infertility patients, mandates of one type or the other are in place in 13 states (see box). The movement seemed to stall, however, after the last of these measures were enacted in 1991. Then, in June 1998, the Supreme Court in *Bragdon* v. *Abbott* held that an HIV-positive woman must be considered disabled under the ADA because the disease interferes with reproduction. Enacted in 1990, the ADA prohibits discrimination on the basis of disability—defined as a physical or mental impairment that substantially limits a "major life activity"—in a variety of arenas, including employment.

Bragdon dealt specifically with HIV, but by identifying reproduction as a major life activity on the same level as walking, seeing or hearing, the Court may have been indicating that employers must make reasonable modifications to their policies and practices to avoid discrimination against individuals with impaired reproductive capacity. Indeed, although Bragdon did not specifically address either infertility or insurance coverage, groups such ASRM and RESOLVE assert that the decision, in fact, covers infertility and that employer-sponsored health care benefits may not discriminate against those suffering from the condition.

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These assertions found a hint of government support when the New York district office of the Equal Employment Opportunity Commission (EEOC) issued a "determination letter" in May of this year stating that a company's denial of coverage for an employee's infertility treatment may be a violation of both the ADA and the 1978 Pregnancy Discrimination Act,

STATES REQUIRING INSURERS TO COVER OR OFFER TO COVER INFERTILITY-RELATED SERVICES

Require to Cover	*Require to Offer*
Arkansas Hawaii Illinois Maryland Massachusetts Montana New York Ohio Rhode Island Virginia	California Connecticut Texas

Laws vary widely in the range of treatments covered and restrictions that apply. ***Sources:*** **ASRM and RESOLVE.**

which prohibits discrimination on the basis of pregnancy or "related medical conditions." Such a letter is a preliminary step in what can be an extended process; moreover, it involves only one specific case and does not represent an official EEOC position—or even one upon which officials will publicly comment. Nevertheless, infertility coverage advocates have applauded the letter as a logical application of *Bragdon.*

Debating Costs and Benefits

"There is quite a lack of knowledge about the typical infertility experience," contends Deborah Wachenheim of RESOLVE. As a result, she says, "infertility treatment is sometimes lumped together with cosmetic surgery as a 'life-style' type procedure," rather than considered "serious medicine." In fact, Wachenheim emphasizes, infertility is recognized as a disease by the medical community, and it is one that can be devastating to an affected couple, both financially and psychologically.

Still, many employers and insurers have expressed concern that increased coverage of infertility treatment will have a major impact on insurance costs. Echoing the traditional defense by the insurance industry against coverage mandates of all sorts, they argue that requiring employers to cover infertility treatment will force some employers to eliminate health benefits entirely and increase the already considerable number of uninsured Americans. These cost concerns have been heightened by the role played by infertility drugs and IVF—by stimulating ovulation and implanting multiple embryos to enhance the chance of a successful pregnancy—in fueling a major increase in the rate of multiple births. This, in turn, has increased costs at delivery, the need for expensive neonatal intensive care and the incidence of birth defects.

Several of the existing state coverage mandates have built-in utilization controls. The Illinois law, for example, requires coverage for IVF and two related forms of treatment only after less-costly but medically appropriate forms of covered treatment have failed; furthermore, it limits the number of IVF attempts allowed under the required coverage. Moreover, data from some recent studies indicate that the costs of infertility coverage may be overstated. One analysis, published in 1995 in *Fertility and Sterility,* calculated the total expense of all IVF treatment in the United States at that time and projected that coverage of this expense would increase premiums by $3.14 per employee per year. The major uncertainty was how much increased insurance coverage might lead to greater utilization—and thus drive up the actual costs.

Two studies of insurers in Massachusetts—which passed an infertility coverage mandate in 1987—address that question. An evaluation published in *The Journal of Reproductive Medicine* in 1997 of one health plan's experience found that despite a utilization rate substantially higher than the U.S. average, the annual cost per employee was still around $3. A broader study of insurers in the state, published in *Fertility and Sterility* in 1998, found that expenditures did not outpace overall inflation, despite an increase in coverage and utilization. The authors cited increased treatment success rates, cost-effective advances in treatment technology

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and, most importantly, discounts for services under managed care provider arrangements and capitation plans as factors contributing to these stable costs.

Moreover, Sean Tipton of ASRM contends that comprehensive coverage can act to reduce incentives to seek inappropriate, and expensive, treatment. For example, he says, patients in plans that do *not* cover IVF may opt for repeated attempts at covered tubal surgery—which can be twice as expensive as one attempt at IVF, is more invasive and is less effective for some patients. In addition, a paper presented in October 1998 at ASRM's annual meeting indicates that coverage of infertility treatment may mitigate the problem of multiple births by eliminating the financial incentive to maximize the chance of a successful pregnancy in each treatment cycle. The authors found that IVF programs in states with mandated coverage of infertility treatment transferred fewer embryos per procedure and had significantly lower rates of multiple births per transfer cycle.

Legislative Responses

How this debate over the merits of infertility coverage will play out over time remains uncertain, but even as they hope for the courts and the EEOC to validate their legal position more clearly, advocates of infertility coverage are pressing their arguments vigorously in both the private and public sectors. RESOLVE's

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Wachenheim has been working to educate employers about the extent and effects of infertility in the American workforce—and about the advantages to an employer of providing "family friendly" benefits in a competitive employment environment. And RESOLVE and other advocacy groups are working closely with lawmakers at both the state and federal levels to enact requirements that insurance plans cover infertility-related services.

Proponents of infertility coverage are clearly taking a leaf from the strategies of the contraceptive coverage movement.

This year—the first since the *Bragdon* decision, the highly publicized initial successes of the contraceptive coverage movement and the approval of the impotence drug Viagra—legislation related to infertility coverage was introduced in at least 16 states, up from 10 states in 1998 and six in 1997. Moreover, in four of these states—Indiana, New Hampshire, New York and Virginia—measures were approved by one legislative chamber; only Indiana considered legislation that seriously in the prior two years.

In Congress, meanwhile, proponents of infertility coverage are clearly taking a leaf from the strategies of the contraceptive coverage movement. In early August, two infertility-related bills were introduced. One, sponsored by Rep. Anthony Weiner (D-NY), basically parallels the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC), which was introduced in 1997 by Sens. Olympia Snowe (R-ME) and Harry Reid (D-NV) in the Senate and by Reps. Jim Greenwood (R-PA) and Nita Lowey (D-NY) in the House. As EPICC would for contraceptives, the Weiner bill would achieve comprehensive private-sector coverage for infertility treatment by amending a range of federally regulated insurance plans. As a precedent for that measure, the other bill, sponsored by Rep. Marty Meehan (D-MA), would mandate coverage by plans participating in the Federal Employees Health Benefits Program (FEHBP). Congressional proponents of contraceptive coverage successfully pressed for such a requirement for FEHBP plans as part of the annual appropriations process in 1998, and they were able to do so again this year.