Need for expanding insurance coverage for in vitro fertilization in the United States

In this issue, Bedrick and colleagues (1) examine factors associated with discontinuation of in vitro fertilization (IVF) treatment and time to return for a second IVF cycle (1). The authors found that the three groups most likely to discontinue IVF treatment and have a longer time of return to treatment were patients without insurance coverage for IVF, African American women, and older women with a poor prognosis. Women without insurance coverage for IVF had a three-hold higher odds of treatment discontinuation in comparison to patients with access to insurance coverage.

A recent study in an insurance-mandated state identified the heavy psychological burden of care associated with IVF as a major cause for premature treatment discontinuation (2). For patients without insurance coverage, financial constraints add to the considerable, and often overwhelming, stress and anxiety experienced with infertility. For a vast number of Americans, the financial barriers to accessing IVF are either limiting or simply prohibitive. Importantly, the study by Bedrick et al. (1) looks beyond the role of insurance coverage in initial entry to care to examines its impact on treatment continuation. The cost of a single IVF cycle is the minimum financial barrier that non-insured patients must overcome, either by out-of-pocket means or through financing, to access care through assisted reproductive technologies. As patients commonly require more than one cycle of IVF to obtain a successful outcome, the financial barriers can be proportionately higher. A prospective study of infertility patients presenting to Bay Area fertility centers in California, for example, reported a median per-person cost for IVF at $24,373 with a cost of successful live-birth outcome from IVF at $61,377 in 2006 dollars (3).

The setting for the study by Bedrick et al. (1) is a high-volume academic IVF center in a metropolitan area in the Midwestern U.S. from 2001 to 2014. As the authors comment, this city straddles the border between a state with mandated comprehensive coverage for IVF and a state without coverage. The current landscape for insurance coverage for IVF in the U.S. is evolving and becoming more complex and heterogeneous. In non-mandated states, select demographics may have excellent insurance benefits for fertility needs, such as those with employers in technology or other sectors. Yet, in these states, the vast majority of the population, which includes schoolteachers, farmers, and small business owners, have no coverage. While some states have mandated infertility insurance coverage, significant heterogeneity exists state to state with respect to the extent of services covered and the eligibility criteria required to qualify for benefits. Few states can truly claim to have comprehensive mandated coverage for IVF. Even in these states with comprehensive coverage, significant disparities persist among minority groups, immigrant and uninsured populations.

The drivers of disparities in access to care that exist today in our communities are complex, multifactorial and not restricted to financial barriers. In their study, Bedrick et al. (1) note that African Americans comprise 18% of the population of the metropolis surrounding the study center, yet only 7% of the women in patient cohort were African American. Although African-American women were the most likely among racial groups to have IVF insurance coverage in this study, they were also the group less likely to return and with more delay than non-Hispanic white women irrespective of IVF insurance coverage, income or distance to clinic. These findings point to the vital role of mandated insurance coverage in supporting access to care for minority groups. Additionally, the findings also highlight the need for further understanding of the barriers contributing to disparities in utilization and outcomes in these groups.

In 2015, the American Society for Reproductive Medicine launched the Access to Care Initiative to recognize the wide disparities that exist in access to care with the overarching goal of achieving universal access to reproductive care in the U.S. and globally. Improving access to care in the U.S. poses particular challenges in comparison to other countries. U.S. has the most expensive health care system in the world, with high costs of health service delivery in a largely for-profit, complex multilayer payer system (4). Chambers et al. (4) argues that the high cost of IVF in the U.S. should be viewed less in the lens of uniquely high service costs intrinsic to IVF and more as a reflection of the overall costliness of the U.S. healthcare system. Among countries surveyed, the cost of an IVF cycle and its percentage of the gross national income per capita was the highest in the U.S. In comparison, the cost of an IVF cycle in Japan was approximately one-third the cost of an IVF cycle in the U.S.

Expanding insurance coverage for fertility care is not an all-encompassing solution that will address the full disparities that exist today in our communities but a necessary step in the context of the high cost of healthcare in the U.S. In our present health care realities, mandated insurance coverage for IVF is arguably the single most effective and efficient intervention for improving access to care. The benefits of insurance coverage extend beyond increasing access and include lower rates of multiple gestation outcomes. Recently, the majority of Society for Assisted Reproductive Technology members surveyed support expanding insurance to the population who are presently uninsured and to specific segments of vulnerable populations with special needs (5).

Once the elephant in the room in discussions of IVF practice in the U.S., access to care has now taken center stage. How do we reach this goal of universal access? In part through tireless outreach, education and advocacy led by health care providers, patient advocates, grassroots initiatives and organizations at state and national levels in partnership with stakeholders and legislators. Recently,

major strides have been made and momentum achieved in increasing insurance coverage for IVF at the state level. In 2018, Delaware signed into law a bill (SB 139) mandating insurance coverage for IVF, becoming the first state to do so in over twelve years. In April 2019, New York state legislature passed a budget measure requiring health plans operating in a large group market (employers with 100 or more full-time staff) to provide coverage for three cycles of IVF. These milestones are real victories for patients in these states and point the direction toward which we can work to attain the goal of universal access.

Christopher N. Herndon, M.D.
Division of Reproductive Endocrinology and Infertility, Department of Obstetrics and Gynecology, University of Washington, Seattle, Washington

https://doi.org/10.1016/j.fertnstert.2019.04.040

You can discuss this article with its authors and other readers at https://www.fertstertdialog.com/users/16110-fertility-and-sterility/posts/48383-28194

REFERENCES

1. Bedrick BS, Anderson K, Broughton DE, Hamilton B, Jungheim ES. Factors associated with early in vitro fertilization treatment discontinuation. Fertil Steril 2019;112:105–11.
2. Domar AD, Rooney K, Hacker MR, Sakkas D, Dodge LE. Burden of care is the primary reason why insured women terminate in vitro fertilization treatment. Fertil Steril 2018;109:1121–6.
3. Katz P, Showstack J, Smith JF, Nachtigall RD, Millstein SG, Wing H, et al. Costs of infertility treatment: results from an 18-month prospective cohort study. Fertil Steril 2011;95:915–21.
4. Chambers GM, Sullivan EA, Ishihara O, Chapman MG, Adamson GD. The economic impact of assisted reproductive technology: a review of selected developed countries. Fertil Steril 2009;91:2281–94.
5. Seifer D, Wantman E, Sparks AE, Luke B, Doody K, Toner JP, et al. National survey of the Society for Assisted Reproductive Technology membership regarding insurance coverage for assisted reproductive technologies. Fertil Steril 2018;110:1081–8.e1.