

Fertility Treatment in the United States: The Case for Increased Access to Care

Paul R Brezina*

Department of Obstetrics and Gynecology, Vanderbilt University Medical Center, United States

Introduction

Approximately 10-15% of couples struggle at some point with conceiving or successfully delivering a child. Fertility treatments currently available are capable of helping the vast majority of these couples successfully conceive and deliver a healthy baby. However, the costs associated with these therapies are often costly. In many cases, couples are left to bear the brunt of these financial responsibilities without the help of their medical insurance. In this paper we define the current state of infertility, the current apparatus currently in place in the United States for financing fertility treatments, and make a case for expanded fertility coverage.

Infertility: A Common Problem

The inability to obtain or maintain a viable pregnancy is a common problem. Defining infertility as having no pregnancy following one year of unprotected intercourse, approximately 10-15% of couples is affected throughout their lifetimes. Worldwide, it is estimated that more than 70 million couples are currently struggling with infertility [1]. Thankfully, assisted reproductive technologies (ART) are now available that allow many couples to achieve pregnancy who would have otherwise remained without a biological child.

Included under the umbrella of ART are interventions such as ovulation induction, intrauterine insemination, and in vitro fertilization (IVF). The utilization of these resources has greatly increased in recent years. Since the first successful IVF procedure in 1978 [2], the use of this and related technologies has expanded to become commonplace around the globe. Over the past decade, the use of ART services has increased at a rate of 5-10% annually [3,4].

In the United States, the number of initiated IVF cycles has risen from 60,000 in 1996 to 165,172 in 2012 according to the Society for Assisted Reproductive Technology [5,6]. Currently, IVF accounts for approximately 1.5% of all live births in the United States [7]. As of 2009, 3.4 million children have been born worldwide after ART treatment, and ART utilization is currently increasing at a rate of 5-10% annually in developed countries [3].

Paying for Fertility Treatments in the United States

The costs associated with ART are significant. Many "inexpensive" intrauterine insemination cycles with ovulation induction may cost as much as \$500 to \$1,500 depending on the protocol utilized. On average, an "all in" IVF cycle in the United States inclusive of medications costs \$12,400 [7]. Fertility treatments are generally seen as an "elective" medical service in the eyes of the law [8]. In much the same way that medical insurance typically does not cover cosmetic surgery procedures; patients often do not enjoy fertility benefits even with comprehensive insurance policies [9]. In most cases within the United States, patients are left to come up with the payment for these services out of pocket.

It is common for couples requiring ART to approach friends or family members to help with this financial burden. In other cases, patients may find pharmaceutical trials that will help with some of the cost of an IVF cycle. However, as there are currently few new IVF medications currently in production, such trials are far less common

today than they were even 5 to 10 years ago. Many pharmaceutical manufacturers have programs to help economically disadvantaged couples obtain medications at discounted rates. However, even with discounted medicines, the costs that remain for the IVF cycle are still significant. Grants from foundations/charities do exist for IVF but are generally limited to couples with specific medical hardships such as cancer.

Consequently, many couples who need fertility treatments are simply unable to pursue such therapies without incurring significant debt or financial hardship. This significant access to care barrier results in decreased utilization of ART. Consequently, many couples that would be good, loving, and responsible parents do not pursue having a biologic child [10].

To increase access to care, 15 states (Arkansas, California, Connecticut, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas, and West Virginia) have passed laws requiring some sort of insurance coverage for infertility [11]. However, in many of these states such coverage is not necessarily available to all individuals and a number of "loopholes" allow many employers to avoid offering these benefits. Only several of these so called "mandated states" including Illinois and Massachusetts have legislation that functionally makes fertility coverage accessible to the majority of the population.

In 2013, U.S. Senator Kristen Gillibrand and Congressman John Lewis introduced a piece of legislation aimed to help struggling couples more easily achieve the dream of starting a family. Known as the Family Act of 2013 (S 881/HR 1851), the legislation was designed to offer a tax credit for monies spent towards fertility treatments [11]. While this legislation did not become law, it set the precedent for future legislation aimed at helping couples struggling with infertility.

The Economic Case for Expanded Fertility Coverage

There is a strong long term economic incentive for the United States and other developed countries to greatly expand the scope of fertility benefits, especially within the private insurance marketplace. The United States population is currently in a state of decline. The total fertility rate (TFR) required maintaining, not growing, the current population in the United States is 2.1. In 2009 the TFR was 2.0 and it

*Corresponding author: Paul R. Brezina, Assistant Professor, Department of Obstetrics and Gynecology, Vanderbilt University Medical Center, B-1100 Medical Center North, Nashville, Tennessee 37232, USA, Tel: 901-747-2227; Fax: 901-747-4449; E-mail: pbrezina@fertilitymemphis.com

Received January 24, 2015; Accepted January 24, 2015; Published January 31, 2015

Citation: Brezina PR (2015) Fertility Treatment in the United States: The Case for Increased Access to Care. JFIV Reprod Med Genet 3: e112. doi:10.4172/2375-4508.1000e112

Copyright: © 2015 Brezina PR. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

dropped to 1.9 in 2010 [12]. This means that the current TFR will result in a population decline.

The economic implications of this trend on a societal level are mammoth. Decreasing fertility rates ultimately augment the proportion of the population that is elderly. This elderly population as a whole is more likely to be retired and have significant health problems as compared to younger individuals [13]. A low TFR also means a relative decrease in the number of young workers ultimately brought into the economy. Consequently such a scenario can lead to an increased demand for services such as health care and social security while not increasing the tax base from active workers required for such social programs. Such imbalances are likely to be augmented in the future given medical advances that continue to advance the life expectancy. As people live longer lives, they will require more sophisticated medical therapies for more years than what has been historically observed. This means that maintaining an ever growing proportion of elderly individuals will be more costly than historical data may lead us to believe.

The reality of the economic costs associated with decreasing TFR have been well described and acknowledged as one of the key drivers for many European programs aimed at increasing access to ART, specifically IVF. In Britain, for example, projections for increased tax revenue created by new births were a central argument in the expansion of access to fertility treatments. Germany, Japan and other nations have also aggressively modified maternal leave associated with having a child to decrease barriers that discourage or delay childbearing. As a society, we have an active economic interest to increase ART access if needed to couples with a desire to responsibly raise a family.

The Moral Case for Expanded Fertility Coverage

In addition to the economic considerations, the “elective” label should be removed from medical conditions that lead to difficulty obtaining pregnancy. In extremely few circumstances have couples made decisions that resulted in infertility. In the vast majority of cases, couples simply suffer from medical problems that compromise their ability to easily conceive. Therefore, for most couples, infertility is a symptom of some other medical problem.

To allow insurance companies to “carve out” fertility treatment as arbitrarily “elective” seems to the author of this paper at best unfair and at worst unethical. When people purchase medical insurance, they do so with the understanding that they will have access to therapies that can help them when they are ill or have undesired symptoms from an unprovoked medical condition. Legislation should be in place to ensure that insurance companies cover fertility benefits in much the same way an individual suffering from coronary artery disease is offered treatments to prevent a heart attack.

Some legal and philosophical arguments also consider an individual’s “Right” to procreate. In the United States, such rights have their root in protection from being coerced or forced to have sterilization or other procedures that would limit an individual’s ability to reproduce. Some legal minds have argued that this right to reproduce should also be interpreted as a right to access to fertility treatment [14,15]. While there is not currently case law supporting the application of this assertion as a patient right, the possibility of some such action in the future cannot be entirely disregarded.

Summary

In summary, the utilization of ART is increasing in the United States. However, that utilization is far below what it would be if all couples struggling with infertility had access to such therapy. Some programs are in place to help couples afford therapy. Despite these programs, far too many couples are not able to pursue the therapies they need to have their own biologic children. We as a society have both an economic interest and a moral obligation to expand the coverage of ART services to more people in the future.

References

1. Ombelet W, Cooke I, Dyer S, Serour G, Devroey P (2008) Infertility and the provision of infertility medical services in developing countries. *Hum Reprod Update* 14: 605-621.
2. Steptoe PC, Edwards RG (1978) Birth after the reimplantation of a human embryo. *Lancet* 2: 366.
3. Chambers GM, Sullivan EA, Ishihara O, Chapman MG, Adamson GD (2009) The economic impact of assisted reproductive technology: a review of selected developed countries. *Fertil Steril* 91: 2281-2294.
4. Jones HW Jr, Cooke I, Kempers R, Brinsden P, Saunders D (2011) International Federation of Fertility Societies Surveillance 2010: preface. *Fertil Steril* 95: 491.
5. Schieve LA, Peterson HB, Meikle SF, Jeng G, Danel I, et al. (1999) Live-birth rates and multiple-birth risk using in vitro fertilization. *JAMA* 282: 1832-1838.
6. SART CORS (2014) Clinical Summary Report.
7. NPR (2014) IVF Baby Boom: Births From Fertility Procedures Hit New High.
8. Jain T, Harlow BL, Hornstein MD (2002) Insurance coverage and outcomes of in vitro fertilization. *N Engl J Med* 347: 661-666.
9. Brezina PR, Zhao Y (2012) The ethical, legal, and social issues impacted by modern assisted reproductive technologies. *Obstet Gynecol Int* 2012: 686253.
10. Chambers GM, Hoang VP, Sullivan EA, Chapman MG, Ishihara O, et al. (2014) The impact of consumer affordability on access to assisted reproductive technologies and embryo transfer practices: an international analysis. *Fertil Steril* 101:191-8.e4.
11. Resolve (2014) Insurance Coverage in Your State.
12. PRB (2012) Fact Sheet: The Decline in U.S. Fertility.
13. Bongaarts J (2015) Global fertility and population trends. *Semin Reprod Med* 33: 5-10.
14. Robertson JA (2004) Gay and lesbian access to assisted reproductive technology. *Case W Res L Rev* 55:323.
15. Floyd S, Pomerantz D (1981) Is there a natural right to have children? In: John Arthur Englewood Cliffs (Eds), *Morality and Moral Controversies*. Prentice-Hall, NJ.