

Promoting fertility awareness to improve the appropriate use of infertility treatment: Considerations for the Access to Infertility Treatment and Care Act

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The Access to Infertility Treatment and Care Act (S.2960) (H.R. 2803) bill proposes an amendment to the Public Health Service Act that would require private health insurance plans that cover obstetric services to also cover infertility treatments (eg, in vitro fertilization). Although the bill would improve access to infertility services, it likely carries unintended consequences related to the overuse of infertility services. Women and couples who are unnecessarily referred for infertility services are at risk for potentially superfluous, invasive, costly, and risky interventions. The purpose of this policy and practice piece is to analyze the legal, social, and economic implications of the proposed bill as well as offer an alternative policy option that capitalizes on the expertise of women's health nurse practitioners in delivering patient-centered fertility-awareness education.

KEY WORDS: fertility, policy, infertility, insurance, health services, fertility-awareness

The proposed Access to Infertility Treatment and Care Act (S.2960) (H.R. 2803) bill before the United States Congress would amend the Public Health Service Act to require health insurance plans that cover obstetric services to also cover infertility treatments (eg, in vitro fertilization) and extend coverage to federal employees, members of the US military, and veterans. Whereas this bill would improve access to persons meeting the aforementioned criteria, it is important to consider the unin-

tended consequences of overuse if this bill passes. There is an ongoing debate regarding the potential overuse of assisted reproductive technology (ART) and its long-term risks, where less invasive treatment (for persons in heterosexual relationships) may prove as effective.¹ The use of ART has doubled over the past decade, yet only 1.7% of all infants in the US are born each year as a result of successful ART conception.² Interestingly, the utilization of in vitro fertilization (IVF) appears to be 1.5 times higher in states with mandated IVF insurance coverage (MA, NH, IL).³ If the Access to Infertility Treatment and Care Act (S.2960) (H.R. 2803) bill is passed and infertility treatment becomes more accessible to persons with health insurance plans that cover obstetric services, it is important to ensure that each referral is appropriate and high value, thus protecting patients and the system against the high-cost burden and harmful effects of unnecessary, invasive care. The purpose of this policy piece is to analyze the legal, political, social, and economic implications of the proposed bill. The specific aims are to: examine the background of the bill and its implications for state budgets, employers, and providers, and propose a viable policy option that supports the scope of nurse practitioners in promoting health and providing patient-centered fertility-awareness education.

The bill and its potential problems

Senator Cory Booker (D-NJ) introduced the Access to Infertility Treatment and Care Act (S.2960) to the Senate in 2018, and Congresswoman Rosa DeLauro (D-CT) (H.R. 2803) introduced it to the House of Representatives in 2019.^{4,5} As of this writing, the Access to Infertility Treatment and Care Act (S.2960 and H.R. 2803) is still in committee in both the Senate and the House, respectively. The required coverage encompasses treatment for infertility, including ovulation induction, egg retrieval, sperm retrieval, artificial insemination, in vitro fertilization, genetic screen, intracytoplasmic sperm injection, and any other nonexperimental treatment.^{4,5} Coverage will also be required for treatment of fertility preservation services for individuals who undergo medically necessary treatment that may cause iatrogenic infertility.^{4,5} Persons who must undergo treatments, such as chemotherapy, radiation, hormone therapy, or surgery that may harm the reproductive system, would be candidates for fertility preservation.^{4,5}

Utilization of infertility services has implications for state budgets, employers, and providers.³ Standard of practice for an infertility referral for a woman in a heterosexual relationship is based on age and duration of preg-



nancy attempt (age < 34 years and trying to conceive for 12 months, or age > 35 years and trying to conceive for 6 months). Hence, the referral usually does not include an in-depth assessment of the woman's fertility tracking behaviors.⁶ If the woman lacks knowledge related to signs of ovulation and ovulation tracking methods, she may be mistiming intercourse.⁷ In fact, studies show that women seeking pregnancy often have limited knowledge regarding the menstrual cycle, ovulation, and the fertile window.^{1,7-10} Despite limited knowledge about fertility and use of fertility-awareness methods, referrals to ART rely heavily on patient self-report of ovulation. Although the bill states that an individual will be entitled to coverage for ART if that individual has been unable to bring a pregnancy to a live birth through less costly infertility treatments, these are not defined. Women and couples who are unnecessarily referred for infertility services are at risk for potentially superfluous, invasive, costly, and risky interventions. There is no language in the proposed bill to safeguard against these consequences and, if passed, insurers would be mandated to provide infertility services without a less invasive trial of a fertility-awareness based method (FABM), which nurse practitioners are well suited to implement.

Legal factors

Under US law, it is the responsibility of the state to protect procreative rights, but not necessarily to provide for them.¹¹ In other words, government-sponsored insurance is not required to cover infertility services.¹¹ Government-sponsored insurance includes Medicaid, Medicare, TRICARE, Veteran Affairs (VA), and Indian Health Services.

Medicaid does not currently cover infertility care, except for New York, which provides three cycles worth of fertility medications. No Medicaid program, including New York's, covers ART. Medicare covers "reasonable and necessary services associated with treatment of infertility" for reproductive-age adults with permanent disabilities, but it does not specify the services nor what is reasonable and necessary.³ TRICARE, the insurance program of the US military, will only cover infertility services if pregnancy is achieved through natural conception, defined as fertilization occurs through heterosexual intercourse, thus excluding persons who only engage in same-sex intercourse.³ The VA will only cover infertility services under the conditions that the patients are legally married and the egg and sperm are from that couple, which again excludes same-sex couples.³ Indian Health Services will cover infertility diagnostics, but there is no mention in the Indian Health Services manual about treatment once infertility is diagnosed. Hence, it is unclear if infertility treatment is covered.³

For those with employer-sponsored health insurance, insurance coverage for infertility services varies by state and the size of employer. Fifteen states have a "mandate to cover" law, which requires certain health plans to cover at least some infertility costs, but these only apply to certain insurers, certain treatments, and certain patients. The proposed bill would address individuals with both types of insurance: private and government.

Economic factors

Treatment for infertility is expensive. The median price of a cycle of in vitro fertilization in the US, including med-

ications, was \$19,200 in 2015 (estimated at \$20,909.08 in FY2020).^{12,13} Most women require several rounds of treatment before achieving pregnancy, as a recent study demonstrated that only 30% of IVF patients achieve a live birth after their first cycle. Costs accrue with each cycle and frequently individuals must pay out of pocket for the portion of infertility services that are not covered.¹⁴ Patient expenses include office visits, diagnostic tests, procedures, genetic testing, storage fees for embryos, and wages lost from time off from work. Determining appropriate use is important, because if the bill is passed the cost will be transferred from the individual to the taxpayer.

Social factors

Infertility affects a broad spectrum of persons regardless of race, religion, sexuality, or economic status, but patients seeking services tend to be older than age 35 years, white, high earners, and privately insured.^{3,15} Some of this disparity may be the result of differences in coverage rates, availability for services, income, service-seeking behaviors, and societal stereotypes.³ The relative lack of Medicaid coverage for fertility services stands in contrast to Medicaid coverage of maternity care and family planning services. Nearly 50% of US births are financed by Medicaid, but there is almost no access to help low-income people achieve pregnancy. Among reproductive-age women, Medicaid covers 30% Black women, 26% Hispanic women, and 15% White women.³ The right to build a family appears to be a function of economic prowess, and this bill will address this inequality because all persons, regardless of insurance plan, will be eligible to benefit from infertility services.¹⁶

Implications for women's health nurse practitioners

It is essential that accurate information and instruction regarding identification of the fertile window be provided to women, as this may improve conception rates, subsequently reducing the harm and cost of unnecessary infertility treatment.^{17,18} The lack of fertility education to support conception is a prevalent problem in women's health. Two women interviewed about their journey to conception conveyed their provider's inclination to refer to a fertility specialist, rather than provide counselling on FABMs. One woman stated that she experienced the feeling that she was on her own because of the lack of guidance and lack of endorsement she received from her medical provider on her chosen method of fertility awareness (ovulation predictor kits). Another woman

reported she believed that the lack of guidance from her medical provider was driven by the financial incentive to refer to assisted reproductive technology rather than teaching people how to take care of their own bodies.¹⁹

Women's health nurse practitioners (WHNPs) who see reproductive-age women are the ideal providers to deliver FABM education because of their understanding of reproductive health, as well as their commitment to health promotion and patient-centered education. It is important for WHNPs to meet the needs of women in their journey to achieve pregnancy, especially surrounding knowledge about FABMs. Education regarding fertility and the use of FABM could improve conception rates and potentially decrease unwarranted and expensive referrals to ART, which could limit patient harm and burden associated with unnecessary intervention. Such education may also mitigate stress and improve emotional well-being in women during the time to successful conception. As written, however, S.2960 and H.R. 2803 bypass this high-value patient education and potentiate high risks and high cost for women seeking infertility services.

Cautions Language

The bills currently state that "coverage for treatment of infertility determined appropriate by the treating physician."^{4,5} This language is not inclusive of NPs, nurse midwives, or physician assistants. The final language of the bill should include all providers of healthcare for women seeking pregnancy, not solely physicians. In fact, the nursing model's emphasis on health promotion, disease prevention, and patient education ideally situates WHNPs to be proficient and patient-centered educators of fertility awareness. As this bill progresses through the policy process, NP professional organizations should monitor language-related changes and advocate for the inclusion of NPs in the bill as critical providers of care for this patient population.

Implementation of the bill

We support S.2960 and H.R. 2803 but recommend careful consideration in the implementation of the bill to ensure appropriate referral to, and use of, infertility services. To do this, we propose a mechanism in the implementation of the bill that insurers will uphold a protocol through which women display evidence of a trial of ovulation tracking (either through cervical mucus, basal body temperature, ovulation predictor kits, etc.) before referral. This trial could potentially reduce the number of women

who would need infertility services and subsequently lower the overall costs of the bill. However, this trial would not be necessary before referral to ART for those in need of fertility preservation. Advantages of a trial of FABMs include potential increases in spontaneous singleton conception, less risks associated with invasive treatments, and decreased healthcare costs. Furthermore, it addresses the call to decrease healthcare spending while improving healthcare outcomes through health promotion. Education on FABMs can be provided to all women who desire pregnancy regardless of their current insurance coverage.

Conclusion

As the cost of infertility treatments increase and the incidence of infertility rises, WHNPs are well positioned to be advocates of high-value, low-risk care for their pregnancy-seeking patients.

We recommend that individual WHNPs, as well as NP professional organizations, monitor the language and potential implementation issues as the Access to Infertility Treatment and Care Act (S.2960) (H.R. 2803) advances through the policy process. This is an ideal opportunity for WHNPs to maintain their voice as advocates on behalf of the best interest of their patients. ■

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