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INFERTILITY COVERAGE WITHIN HEALTH CARE PLANS

SUMMARY

Current federal and state laws do not require health insurance coverage for infertility treatment. Of the 60 million women of reproductive age in the United States, 15 percent have received infertility services at some point in their lives. This report investigates the current status of health plan coverage for infertility, the social and financial impacts of mandating such coverage, as specified in s. 624.215, F.S. Section 624.215, F.S. requires that a report be prepared for legislative review of any legislative proposal that would mandate health coverage or the offering of such coverage. This report also presents different plans of action the Legislature could take in mandating infertility coverage.

A comprehensive infertility mandate will affect around 50 percent of all insureds in Florida due to preemption by the federal Employee Retirement Income Security Act. Comprehensive infertility coverage will increase the availability and affordability of treatment. However, consideration of the monetary costs of an infertility mandate is necessary given the rising cost of health care in Florida and the impact on private and public plans. A comprehensive mandate is also the most expensive option facing the Legislature, increasing the cost of health insurance policies and burdening small business with few employees. Other options include limiting the mandate to larger employers or putting limits on types and costs of treatment. A limited mandate to cover will reduce the effects of a mandate on premium costs, but be less effective at increasing access to all types of treatment. A mandate to offer treatment is another possibility and likely the most inexpensive option outside of not providing a mandate, but a mandate to offer may do little to improve the availability of infertility treatment. In addition, couples may not know that they will need treatment at the time that coverage is purchased and could also be considered a pre-existing condition making coverage hard to get. An infertility mandate

may also have moral and religious implications similar to the concerns raised about providing coverage for impotence and contraception.

BACKGROUND

Infertility is defined as the inability to conceive a child. Generally, a person is considered to be infertile after one year of unsuccessful conception.¹ The Centers for Disease Control states that of the 60 million women of reproductive age in the United States, 15 percent had received infertility services² at some time in their lives, with 2 percent (1.2 million) receiving treatment in the past year.³

Whether infertility is a "disease" is debated between insurance companies and advocates for infertility treatment. The debate is important because insurance coverage is generally not provided when a condition is considered not to be a disease, illness, or injury. Advocates for infertility coverage define infertility as a disease of the reproductive system, noting that the condition hampers a major physical function, procreation, as well as the psychological trauma to couples who cannot conceive. Recent federal court cases have defined infertility as a disease,⁴ but stop short of requiring that treatment be mandated under Title VII or other federal laws.⁵ Opponents of an infertility mandate argue that infertility is not a disease and does not have the physical symptoms or physical

¹ The one year period is the majority definition used by most states with infertility mandates, but some states do require longer infertile periods to receive coverage.

² Infertility services include medical tests to diagnose infertility, medical advice, treatment to help induce pregnancy, and non-routine prenatal care to prevent miscarriage.

³ Information taken from the 1995 National Survey of Family Growth.

⁴ See *Bragdon v. Abbott*, 524 U.S. 624 (1998).

⁵ See *Saks v. Franklin Cover Co.*, 316 F. 3d 337 (U.S. 2nd. Cir. 2003).

pain normally associated with an injury or illness. Additionally, opponents claim that infertility is often caused by lifestyle choices such as waiting until later in life to have a child.

Infertility has many different causes known and unknown, and both women and men can carry factors that are the cause of infertility. Approximately 40 percent of infertility is due to a female factor and 40 percent is due to a male factor, with the remaining 20 percent of cases resulting from both the man and woman or unexplained sources.⁶ Female causes of infertility include structural abnormalities or obstruction in the fallopian tubes or elsewhere in the reproductive organs, endometriosis,⁷ ovulatory disorders, polycystic ovarian syndrome,⁸ luteal phase defect, uterine factor, poor egg production, and lifestyle factors.⁹ Causes of male factor infertility include structural abnormalities,¹⁰ sperm production disorders, ejaculatory disturbances, immunologic disorders, and lifestyle factors.

The first step in providing care to an infertile couple is making a careful diagnosis of the cause of the infertility. Many diagnostic tests are necessary to make the proper diagnoses and determine which types of treatment are appropriate. Certain diagnostic tests, such as the dye test, may also be considered treatment since the dye has the benefit of flushing out the fallopian tubes.

With millions of Americans dealing with infertility problems, it is not surprising that the treatment of infertility has become a prominent public policy issue in both the national and various state legislatures. Fourteen states have passed some form of legislation that addresses the issue of infertility coverage. A variety of solutions have been crafted by various state legislatures, with differences in the requirement of the

⁶ Information provided by Resolve: The National Infertility Association.

⁷ Endometriosis is a disorder of the female reproductive system in which endometrial tissue (the normal lining of the uterus) is found outside the uterine cavity, resulting in blockage that prevent the egg and sperm from moving normally.

⁸ PCOS is a common hormone disorder in women and a leading cause of infertility.

⁹ Lifestyle factors that have a bearing on fertility include age, weight, smoking, alcohol, and sexually transmitted diseases.

¹⁰ Structural abnormalities of the reproductive tract in men usually contribute to infertility by blocking the flow of sperm or seminal fluid.

mandate on coverage, the procedures covered, and the pre-requisites for patient coverage.

Types of Infertility Treatment

Once a proper diagnosis has been made, doctors have a variety of treatments available to recommend. Infertility treatment is administered in three different ways. Drug therapy, surgical procedures, and medical procedures, such as intrauterine insemination (IUI) and assisted reproductive technology (ART), may be used to treat infertility in both men and women. In most instances, doctors begin with the least invasive and therefore, the least expensive treatments.

Drug therapy is often the first treatment given to women for the treatment of infertility, since it is easily administered and the least expensive treatment.¹¹ A wide variety of drug and hormone treatments are available to women, with a wide range of prices for various treatments. For example, the fertility drug Clomid costs \$50 per dosage while an injection of Pergonal costs roughly \$1,500 to \$2,000 per injection.¹² Often the treatments serve to increase ovulation, stimulate egg production and improve the conditions of the uterus for maintaining a viable pregnancy. Many women are able to conceive following drug therapy and may not need any further infertility treatment.

Surgical procedures are also used to treat certain types of infertility, often by correcting structural abnormalities in men and women that lead to infertility. Surgical treatment is often necessary to treat male infertility since male factor problems are often due to structural abnormalities.¹³ Surgery is also an option for women with infertility and can be used to treat multiple structural abnormalities.¹⁴

Intrauterine insemination (IUI)¹⁵ or assistive reproductive technologies (ART) are the other options in treating infertility. IUI involves taking the sperm of a husband or donor, treating it, and placing it into the

¹¹ Men are far less likely to benefit from drug therapies and hormone treatments.

¹² Michelle Marchetti, *How Much Would You Pay for This Baby?*, SMART MONEY, Sept. 2003, at 101.

¹³ Male structural abnormalities usually involve problems that hinder the flow of sperm. Such problems can be congenital, illness related, or caused by prior surgery.

¹⁴ Asherman's Syndrome, DES, Endometriosis, Fibroids, Sdenomyosis, and Tubal Factor.

¹⁵ Intrauterine insemination is another term for artificial insemination.

woman during ovulation. IUI is often used in conjunction with medication that increases ovulation, which increases the success rates, but also makes a multiple child pregnancy more likely.

Assistive reproductive technology includes all fertility treatments in which both the egg and sperm are handled.¹⁶ There are three basic types of ART: in vitro fertilization (IVF),¹⁷ gamete intrafallopian transfer (GIFT),¹⁸ and zygote intrafallopian transfer (ZIFT).¹⁹ ARTs can utilize fresh or frozen embryos. ARTs are the most expensive form of infertility treatment, costing approximately \$12,400 per cycle.²⁰ Drug therapy is often used in conjunction with ART as well. ARTs are the most controversial forms of infertility treatment since they cause fertilization rather than eliminating natural barriers to conception.

Insurance Coverage Mandates

A mandatory health insurance benefit requires that certain policy benefits either be provided or offered. Florida has over 30 mandated benefits.²¹ A health insurance mandate may be placed on individual health policies, group health policies, and HMO contracts. However, states cannot place coverage mandates on businesses' self-funded insurance plans because federal ERISA²² law pre-empts employer-sponsored health coverage from direct state regulation.²³ It is estimated

¹⁶ CENTERS FOR DISEASE CONTROL, *CDC's Reproductive Health Information Source: Commonly Asked Questions About the U.S. ART Clinic Reporting System* (2000), found at www.cdc.gov/nccdphp/drh/ART00/faq.htm

¹⁷ See note 16. IVF is a procedure whereby the woman's eggs are extracted and fertilized in a laboratory, with the resulting embryo transferred into the woman's uterus through the cervix. For some IVF procedures, intracytoplasmic sperm injection is used, which involves injecting a single sperm into the egg in the laboratory.

¹⁸ See note 16. GIFT uses a fiber optic instrument (laparoscope) to place unfertilized eggs and sperm into the woman's fallopian tubes.

¹⁹ See note 16. ZIFT uses a laparoscope to place fertilized eggs into the woman's fallopian tubes.

²⁰ See AMERICAN SOCIETY OF REPRODUCTIVE MEDICINE *Fact Sheet: In Vitro Fertilization (IVF)*, <<http://www.asrm.org/Patients/FactSheets/invitro.html>>.

²¹ All of Florida's coverage mandates applying to individual health policies and group health policies are located in ch. 627, F.S., while mandates on HMO contracts are found in both chs. 627 and 641, F.S.

²² 29 U.S.C. 1001 et seq. (1974).

²³ GOVERNMENT ACCOUNTING OFFICE, *PRIVATE HEALTH INSURANCE: FEDERAL AND STATE REQUIREMENTS AFFECTING COVERAGE OFFERED BY SMALL BUSINESSES*,

that around 52.8 percent of all workers in Florida are under self-funded plans to which state coverage mandates do not apply.²⁴

METHODOLOGY

This project seeks to determine the costs and benefits of a mandate for infertility coverage in the State of Florida. Section 624.215, F.S., requires that the Legislature review any legislative proposal that mandates health coverage. The Legislature is directed to study twelve factors that include the availability and cost for the treatment to be mandated, the effects that a mandate will have on the cost and usage of treatment, the mandate's effect on insurance premiums, and the overall impact the mandate will have on health care in Florida. A review of the infertility policies of states that have infertility mandates is also included in this analysis, as is a review of some of the ethical and moral arguments surrounding infertility treatment. A thorough review of legal, scientific and economic data and reports will help the Florida Senate to undertake the expert review that s. 624.215, F.S., requires.

FINDINGS

Fourteen states have laws related to insurance coverage for infertility therapy. Each state that has legislation on the subject has formulated a distinctive approach to insurance mandates for infertility. Arkansas, Hawaii, Maryland, Massachusetts, and Rhode Island have laws requiring that health insurers that provide pregnancy benefits also include infertility coverage as a provided benefit. Each of these states has approached the mandate differently, and provides options for the Florida Legislature to consider regarding mandated infertility coverage. The following is a review of the various infertility mandates enacted by different states.

States Mandating Coverage

Five states mandate that infertility treatment be automatically provided by health insurers that provide pregnancy benefits. The mandate of coverage is the strongest type of mandate. This is in contrast to a mandate to offer coverage, whereby the insurer is merely required to offer infertility coverage to

GAO-03-1133, pg. 6-7 (September 2003).

²⁴ Christina Park, *Prevalence of Employer Self-Insured health Benefits: National and State Variation*, Medical Care Research and Review, Vol. 57 No. 3 (September 2000) pg. 351.

customers, who may then decide whether they want to purchase the additional benefits.

Massachusetts features the most sweeping infertility coverage mandate in the country. Health insurers and HMOs that cover pregnancy benefits are required to cover infertility treatment.²⁵ Treatment is available for those who are infertile, which is defined as being unable to conceive during a one-year period. A wide array of benefits are offered in the mandate, including artificial insemination and IVF.²⁶

Arkansas' mandate requires health insurers covering maternity benefits to cover the cost of IVF procedures, though the patient must meet certain conditions in order to receive coverage.²⁷ Arkansas allows insurers to place a \$15,000 lifetime cap on benefits for IVF. HMOs are exempt from the coverage mandate.²⁸

Hawaii also has an infertility mandate, but strictly limits coverage for in vitro fertilization.²⁹ Hawaii's mandate is limited to a one-time only benefit for outpatient expenses related to IVF. Hawaii requires that in order to qualify for the IVF benefit, the patient or her spouse must have a five year history of infertility.³⁰

Maryland places an infertility mandate on health and hospital insurance companies providing pregnancy

benefits that includes IVF procedures.³¹ Businesses with 50 or fewer employees are exempt from having to provide IVF coverage, and the law does not apply to HMOs. Maryland requires a five year history of infertility, or infertility associated with certain medical conditions for IVF to be covered by insurance.³² Rhode Island places a mandate on insurers covering pregnancy services to cover medically necessary infertility expenses.³³ A patient is considered infertile after a year of being unable to conceive. A distinctive element of the state's law is that a 20 percent limit is placed on the patient's co-payment obligation.

Mandate to Offer Coverage

Another infertility coverage option is to require insurers to offer infertility coverage, but not include it as a mandated benefit in all policies. Under this model, insurers are not required to provide coverage to a policyholder unless the infertility coverage is specifically purchased. California, Connecticut, and Texas are the states that currently require insurance companies to offer infertility coverage, but do not mandate that benefits be provided in all policies offering pregnancy benefits. The mandate to offer coverage will do less to raise the costs of all insurance policies, but may result in greater increases among policyholders who elect to receive coverage because there will be a smaller group of customers to spread the cost of coverage over. A mandate to offer is also likely to be less effective in expanding the availability of coverage, but does allow employers and policyholders who do not want infertility coverage to avoid having to help pay for it.

California requires group health insurers that cover medical expenses to offer infertility coverage to employers.³⁴ Employers are not required to include infertility benefits in employee insurance packages. Therefore, infertility treatment may not be a covered benefit for many people. California also has an

²⁵ MASS. GEN. LAWS ANN., Chapter 175-47H, 176A-8K, 176B-4J, 176G-4.

²⁶ Other covered treatments include GIFT, ICSI, ZIFT, and the retrieval of inseminated eggs, sperm or eggs if not such costs are not covered by the donor's insurer.

²⁷ Arkansas places the following conditions on patients wanting coverage for IVF procedures: 1) The patient's eggs must be fertilized with her spouse's sperm; 2) Patient and spouse must have unexplained infertility for over 2 years; or the infertility must be associated with Endometriosis, DES (fetal exposure to diethylstilbestrol), blocked or surgically removed fallopian tubes that were not voluntarily sterilized, or abnormal male factors leading to infertility.

²⁸ ARK. STAT. ANN., Sections 23-85-137, 23-86-118.

²⁹ HAW. REV. STAT., Sections 431-IOA-116.5 and 432.1-604.

³⁰ Other conditions that must be met for coverage include: 1) the patient's eggs must be fertilized with sperm from her spouse; 2) the patient has been unable to stay pregnant through other infertility treatments covered by insurance or is the result of a specified medical condition and; 3) the IVF is performed at a medical facility that conforms to the standards of the American Society for Reproductive Medicine (ASRM) or the American College of Obstetricians and Gynecologists (ACOG).

³¹ The Maryland mandate specifically applies the mandate to all persons who live and work in the state, regardless of the policy's origin. See MARY. ANN. CODE, Article 48A, Sections 354DD, 470W, and 477EE

³² Other conditions in Maryland include that the patient's eggs must be fertilized with sperm from the patient's spouse, that the patient is unable to stay pregnant through less expensive treatments that are covered, and that the IVF is performed at facilities conforming to standards set by the ASRM or ACOG.

³³ R. I. GEN. LAWS, Sections 27-18-30, 27-19-23, 27-20-20, 27-41-33.

³⁴ CAL. HEALTH AND SAFETY CODE, Section 1374.55

exemption that insurers do not have to provide coverage for in vitro fertilization, though other procedures are included as part of infertility treatment under the law.³⁵ Religious organizations are exempt from offering treatment if it would conflict with their doctrine and purposes.

Connecticut law is similar to that of California and requires health insurers to offer coverage for infertility diagnosis and treatment, but does not require insurers to provide the coverage, or employers to include it in their insurance plans.³⁶ The main difference between California and Connecticut is that Connecticut includes IVF as a covered means of treatment for infertility policies.

Texas requires all insurers and nonprofit hospital and medical service plan corporations that offer pregnancy coverage to offer coverage for in vitro fertilization and other types of infertility treatment.³⁷ An insurer must offer infertility coverage to insureds, subject to certain conditions.³⁸ Rejections of the offer of infertility treatment must be made in writing. An exemption from offering IVF exists for an insurer, HMO, or self-insuring employer directly affiliated with a religious organization for whom IVF is contrary to their beliefs.

Limited Mandates

Some states have enacted limited mandates that require infertility coverage to be provided in certain policies.³⁹ One form of limited mandate is to apply the mandate

³⁵ In California, infertility insurance coverage must include treatment for diagnostic tests, medication, surgery, and GIFT procedures.

³⁶ CONN. GEN. STAT. ANN., Section 38a-536.

³⁷ TEX. INS. CODE, 3.51-6, Section 3A.

³⁸ The following conditions must be met for infertility coverage to be available to a policyholder: 1) the IVF patient is covered under the policy, 2) the fertilization attempt is made only with the patient's spouse's sperm; 3) the patient and her spouse have a 5 year history of infertility associated with endometriosis, DES, blockage/removal of a fallopian tube, or oligospermia; 4) the patient is unable to maintain pregnancy through less costly infertility treatment; and 5) the IVF is performed at a facility conforming to ACOG or American Fertility Society minimal standards for IVF.

³⁹ Louisiana has not mandated coverage of infertility, but passed legislation in 2002 that prohibits insurers from excluding coverage for diagnosis and treatment of a correctable medical condition otherwise covered by the policy, contract, or plan solely because the condition results in infertility. LOU. REV. STAT., 22: 215.23

only to group policies that cover a certain amount of members. Many ART procedures are expensive, and can be burdensome to small employer policies that have few members to spread the cost of coverage across.

Illinois requires infertility treatment coverage in policies that cover more than 25 people.⁴⁰ Illinois' plan covers IVF and IUI but places a lifetime limit of four completed egg retrievals per patient.

New Jersey requires HMOs, group health policies, and hospital/medical service corporations with over 50 members to provide infertility benefits if the plan covers pregnancy benefits.⁴¹ The New Jersey mandate includes ART procedures and has a limit of four completed egg retrievals per lifetime. New Jersey exempts religious organizations from its mandate.

Two states have placed infertility mandates solely on HMOs. Montana requires HMOs to provide infertility services, but specifically exempts all other health insurers from providing health coverage.⁴² Ohio requires HMOs to cover infertility, but places a \$2,000 cap on coverage unless another condition or medically related problem is a cause of the patient's infertility.⁴³

New York requires group policies to provide coverage for correctable medical conditions that result in infertility. The coverage must include surgical procedures that correct physical conditions that result in infertility. Such insurers must provide infertility treatment for women who are 21 to 44 years old, but specifically excludes ART procedures from coverage.

Financial Costs of Mandated Infertility Coverage

A cost-benefit analysis of an infertility mandate is crucial in deciding whether the state's resources should be spent in providing coverage. A new mandate will likely increase costs for insurers and the insured.⁴⁴ An

⁴⁰ ILL. COMP. STAT., Chapter 215, Sections 5/536m and 125/5-3

⁴¹ N. J. PERM. STAT., Sections 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B27-46.1x, and 26:2J-4.23.

⁴² MONT. CODE ANN., Sections 33-22-1521 and 33-31-102.

⁴³ OHIO REV. CODE ANN., Chapter 1742.

⁴⁴ A 2002 study on the factors contributing to rising healthcare costs found that government mandates and regulation accounted for 15 percent of the national increase in health insurance premiums from 2001-2002. See PRICE WATERHOUSE COOPERS, AMERICAN

infertility mandate also will increase the availability of treatment, thus likely making its usage more widespread.⁴⁵ Utilization of expensive ART treatments increases markedly when mandated coverage is available, thus raising insurance costs.⁴⁶ However, financial costs cannot solely be measured with regard to insurers. A coverage mandate would make infertility treatment more affordable and accessible for those seeking treatment, as the price for these procedures could be spread across all insureds.

One key factor in determining whether Florida should enact an infertility mandate is determining how much it will cost. Different studies on infertility mandate costs have yielded different results.⁴⁷ A 1997 study by the National Center for Policy Analysis reported that an infertility mandate is likely to raise the cost of a family insurance policy between \$105 and \$175 per year.⁴⁸ Lower cost estimates have also been made. The National Conference of State Legislatures estimates the cost of an infertility mandate at \$1 to \$3 per policy

member, per month.⁴⁹ A study examining Massachusetts' comprehensive infertility mandate estimated its costs at \$1.71 per month.⁵⁰ Another study states that in a large group policy, the cost of an infertility mandate will only raise premiums \$.60 to \$2.00 a month.

ART procedures will likely drive costs upward if an unlimited infertility mandate is enacted in Florida. There were 4,168 ART procedures performed in Florida during the 2000 calendar year. The average cost of an ART procedure is \$12,400⁵¹ and statistics show that 47.2 percent of Florida's workforce is covered by insurance plans that the mandate would effect. For ART procedures alone, a comprehensive infertility mandate would add approximately \$24 million in costs if utilization levels remain at current levels and no limits are imposed. These costs could be higher if utilization levels increase with a mandate,⁵² but must be reduced by the cost insurers who currently offer infertility coverage already pay for such procedures.⁵³

Unlimited coverage of infertility drugs such as Clomid, Pergonal and Lupron also will drive costs and are more commonly utilized than ART procedures.⁵⁴ However, the costs of all types of treatments may be reduced by

ASSOCIATION OF HEALTH PLANS, *THE FACTORS FUELING RISING HEALTHCARE COSTS*, pg. 3 (April 2002).

⁴⁵ An analysis of the states with the greatest number of ART procedures performed in the year 2000 shows that larger states with a comprehensive coverage mandate have higher utilization rates than states without an infertility mandate, while states with no mandate or a partial mandate have similar utilization rates to their population size. For example, California (1st in pop., 1st in ART usage), Texas (2nd in pop., 6th in ART usage), New York (3rd in pop., 2nd in ART usage) and Florida (4th in pop., 7th in ART usage) all have ART utilization rates in line with or below their level of population. Compare this with Massachusetts and Maryland, two larger states that have mandates to cover ART. Massachusetts has the most comprehensive mandate of any state. Though Massachusetts ranks 14th in population (with 10 million less residents than Florida) it ranks 3rd in ART usage (with 8,041 ART procedures in 2000, almost twice the amount carried out in Florida). Maryland shows a similar trend, ranking 17th in population but 10th in ART usage.

⁴⁶ J. Collins, et. al, "An Estimate of the Cost of In Vitro Fertilization Services in the United States in 1995", *Fertility and Sterility*, Vol. 5, No. 3 at pg. 543 (September 1995). The authors of this report call the potential for a sizable increase in the utilization of ART procedures "a matter for serious concern."

⁴⁷ A U.S. General Accounting Office study into the costs of state-mandated health benefits reached the same conclusion. *See* fn. 23 at page 38.

⁴⁸ NATIONAL CENTER FOR POLICY ANALYSIS, *THE COST OF HEALTH INSURANCE MANDATES*, Brief Analysis No. 237, (August 13, 1997), <<http://www.npc.org/ba/ba237.html>>.

⁴⁹ NATIONAL CONF. OF STATE LEGISLATURES, *INSURANCE COVERAGE FOR INFERTILITY THERAPY*, (2003), <<http://www.ncsl.org/programs/health/infert.htm>>.

⁵⁰ Shorge Sato, *A Little Bit Disabled: Infertility and the Americans With Disabilities Act*, 5 N.Y.U.J. Legis & Pub. Policy 189, 198-199 (2001); Wendy Kaminer, *Reproductive Entitlement*, AMERICAN PROSPECT, March 27, 2000, at 14, 15.

⁵¹ According to the ASRM, *see* fn. 22. However, representatives of Blue Cross/Blue Shield of Florida state that for the year 2000, their cost calculation for ART procedures such as IVF, GIFT, and ZIFT is \$20,000 per procedure. If ART procedures cost \$20,000, then the estimated cost rises to approximately \$39 million.

⁵² PENN. HEALTH CARE COST CONTAINMENT COUNCIL, *MANDATED BENEFITS REVIEW - SENATE BILL 1183 INFERTILITY DIAGNOSIS AND TREATMENT: COUNCIL COST ESTIMATES*, pg. 2, <http://www.phc4.org/reports/mandates/1183/review_of_senate_bill_1183.htm>.

⁵³ For insurance policies already providing infertility coverage, a mandate will not add to costs. Depending on how many ART procedures are currently covered by large insurers, the overall monetary effect on costs of the mandate could be greatly reduced.

⁵⁴ Blue Cross Blue Shield of Florida representatives estimate the costs of Clomid at \$60, Lupron at \$360, and a Pergonal injection at \$2,200.

insurers and HMO plans using their bargaining power with providers to reduce infertility treatment costs.

Insurance costs for the state employee's group health insurance program were projected to rise in a study conducted by Milliman and Robertson, Inc (M&R) that investigated the costs of an infertility mandate as proposed in HB 31 during the 2000 legislative session.⁵⁵ M&R projected that the proposed infertility mandate would increase program costs in fiscal year 1999-2000 by \$11-15 million and that in fiscal year 2000-2001 costs would increase by \$15-20 million. The study also indicated that program costs could be higher if patients had deferred treatment because it had not been covered in the past, and expected higher costs associated with maternity care.⁵⁶

Availability of Coverage in Florida

Florida ranks second among states in the number of medical centers (28) performing ART procedures.⁵⁷ During the year 2000, 4,168 ART procedures were performed in Florida, the seventh most in the nation.⁵⁸ Infertility treatment is widely available in Florida, but barriers exist that prevent many people from having access to treatment. The first barrier is cost. Many advanced infertility treatments are expensive, costing thousands of dollars. As a result, most couples seeking infertility treatment cannot afford those procedures without the aid of insurance. The second barrier to treatment is the lack of available insurance.

Many of the larger insurance carriers in Florida do not include infertility benefits in their policies. Blue Cross Blue Shield of Florida (BCBSF) excludes infertility services from their standard insurance and HMO policies. For large group policies that specifically

request infertility coverage BCBSF offers an endorsement rider to. Representatives from the Office of Insurance Regulation (OIR) verified that infertility coverage is not common among insurers in Florida. The experience of the OIR is that infertility coverage is only seen in a large group policy, usually at the behest of the employer who has requested the coverage. Given the limited availability of infertility insurance coverage and the high costs of treatment, many people have limited or no real access to infertility treatment.

An infertility coverage mandate will increase the availability of infertility treatment in Florida. However, opponents of treatment mandates argue that they increase the cost of insurance and thus increase uninsured rates.⁵⁹ Research by the National Conference of State Legislatures shows that there is no direct correlation between the number of mandated benefits and the number of uninsured, though large states such as Texas, California, and Florida both rank in the top ten in uninsured rates and mandated benefits. However, New York, Pennsylvania and Virginia rank in the top ten in mandates but have moderate rates of uninsured. While it stands to reason that the rising cost of insurance also increases the number of uninsured, the number of mandates by itself does not appear to be a factor that automatically results in higher uninsured rates.

Health Risks of Infertility Treatment

Both mother and child face increased health risks from all multiple-child pregnancies, including multiples occurring spontaneously and those occurring as a result of infertility treatment. There is a greater risk of post partum hemorrhage, anemia, gestational diabetes, pregnancy related hypertension and caesarian section associated with multiple pregnancies. Sixty children that are born as a result of a multiple pregnancy face higher risks of serious health problems as well. These include malformations, long term handicaps, cerebral palsy, mental retardation, chronic lung disease, premature birth, low-birth weight, and death.⁶⁰ Very premature births (birth before the 33rd week of pregnancy) occur in 2 percent of singleton pregnancies, 14 percent of twin pregnancies, and 41 percent of

⁵⁵ The study was performed at the behest of the Department of Management Services to estimate the costs of the infertility mandate proposed in HB 31 during the 2000 legislative session.

⁵⁶ The study was unable to determine the exact amount of any premium increases because such a determination rests on unknown factors.

⁵⁷ Florida trails only Cal., which has 56 ART centers, and is tied with N. Y. See CENTERS FOR DISEASE CONTROL, SURVEILLANCE SUMMARY: ASSISTED REPRODUCTIVE TECHNOLOGY SURVEILLANCE—UNITED STATES, 2000, vol. 52, No. SS-9 at page 4. (Aug. 29, 2000) at page 9.

⁵⁸ See note 58 at pg. 9. The leading state, California had over 13,000 procedures performed. Massachusetts, with a comprehensive mandate and population of approximately 6,400,000 (compared with around 16,700,000 in Florida) had 8,041 procedures performed.

⁵⁹ HEALTH POLICY TRACKING SERVICE, ISSUE BRIEF MANDATED BENEFITS: INFERTILITY TREATMENT COVERAGE REQUIREMENTS, (Oct. 10, 2003).

⁶⁰ See C. Strong, *Too Many Twins, Triplets, Quadruplets, And So On: A Call For New Priorities*, 31 *Journal of Law, Medicine and Ethics* 272, 273-274 (2003); See fn. 59 at pg. 20.

triplet pregnancies.⁶¹ The mortality rate for single pregnancies is 8.8 per 1,000 births, while for twins it is 46.8 per 1,000 births, and triplets die at a rate of 82 per 1,000.⁶²

Infertility treatment greatly increases the odds of multiple-child pregnancies. Of the 23,042 reported pregnancies resulting from ART cycles in 2000, 28 percent were twin pregnancies, 8 percent were triplet or greater, and 6 percent (3,782) ended in miscarriage, stillbirth, or induced abortion.⁶³ Of all infants resulting from an ART, 53.1 percent were born in multiple-birth deliveries.⁶⁴ Since 1980, triplet or greater pregnancies have increased five-fold.⁶⁵ The main factors causing increased multiple child pregnancies are older maternal age, superovulation, and ARTs.⁶⁶

Reducing the incidence of multiple-child pregnancies has become a goal of infertility providers, state and national governments. The American Society of Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART) have jointly issued voluntary guidelines that recommend limits on the number of embryos that should be transferred in an ART procedure.⁶⁷ Many of the states that have infertility mandates require that ART procedures be performed in clinics that conform to ASRM and SART guidelines. Eight nations, including Great Britain, have also passed laws limiting pre-embryo transfers to between two and four embryos.⁶⁸

⁶¹ See G.R. Alexander et. al., *What Are the Fetal Growth Patterns of Singletons, Twins, and Triplets in the United States?*, 41 *Clinical Obstetrics and Gynecology* 115-125 (1998).

⁶² See B. Lieberman, *An Embryo Too Many?*, 13 *Human Reproduction* 2664-2666.

⁶³ See note 59, at pg. 20.

⁶⁴ See also, CENTERS FOR DISEASE CONTROL, MORBIDITY AND MORTALITY WEEKLY REPORT: ASSISTED REPRODUCTIVE TECHNOLOGY SURVEILLANCE—UNITED STATES, 2000, Volume 52 No. SS-9, page 12 (Aug. 29, 2000). This calculation was formed using data from the cited CDC report.

⁶⁵ See fn. 60 at pg. 272.

⁶⁶ See id; See CENTERS FOR DISEASE CONTROL AND PREVENTION, CONTRIBUTION OF ASSISTED REPRODUCTIVE TECHNOLOGY AND OVULATION-INDUCING DRUGS TO TRIPLET AND HIGHER-ORDER MULTIPLE BIRTHS—UNITED STATES, 1980-1997, *Morbidity and Mortality Weekly Report*, 49, no. 24, pgs. 535-538 (June 23, 2000).

⁶⁷ See AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, GUIDELINES ON NUMBER OF EMBRYOS TO TRANSFER—PRACTICE COMMITTEE REPORT, (1999).

⁶⁸ H.W. Jones, Jr. and J. Cohen, “IFFS Surveillance 01”, 76 *Fertility and Sterility* S1-S36 (2000); See note 60 at pg.

Moral and Religious Objections

An infertility mandate may also have moral and religious implications similar to the concerns raised about providing coverage for impotence and contraception. Infertility prevents couples who wish to start a family with children from having a child of their own, and prevents many men and women from experiencing all the joys and travails of parenthood. Infertility treatments enable infertile couples and women to procreate. Proponents of infertility treatment argue that parents willing to take the time and expense of having a child through such treatment are likely work hard at raising that child.

Many religious adherents and organizations conclude that a fertilized egg is a human life, and are opposed to certain types of fertility treatments, such as ART procedures, on the grounds that it is destructive of human life.⁶⁹ The possibility that some embryos may be damaged or destroyed in the ART process is a matter of concern for some in the religious community. The possibility that future scientific developments in gene manipulation may give parents control over their children’s genetic makeup also is an area of debate.⁷⁰

Infertility treatment also has raised the question of what is to be done with the extra embryos that result from certain ART procedures, and has ramifications with regard to the stem cell research debate. Extra embryos from ART procedures are a major potential source of embryonic stem cells.⁷¹ The problem of what to do with extra embryos is debated with some parties arguing for their use in stem cell and other research, some arguing

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⁶⁹ CONGREGATION FOR THE DOCTRINE OF THE FAITH, INSTRUCTION ON RESPECT FOR HUMAN LIFE IN ITS ORIGIN AND ON THE DIGNITY OF PROCREATION REPLIES TO CERTAIN QUESTIONS OF THE DAY, (Feb. 27, 1987). <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html>

⁷⁰ A potentially positive aspect of such technology is the elimination of genetic disorders in children. Opponents worry that trait selection may result from the technology, with children genetically forced to conform to current social mores and tastes in society. See Carl Coleman, *Conference on Religious Values and Legal Dilemmas in Bioethics: Assisted Reproductive Technologies and the Constitution*, 30 *Fordham Urb. L. J.* 57-58 (2002).

⁷¹ See Janet Doglin, *Embryonic Discourse: Abortion, Stem Cells, and Cloning*, 31 *Fla. St. U. L. Rev.* 101, 112 (2003).

that it is morally permissible to destroy embryos, and others proposing that embryo adoption should be an option.⁷² For these reasons and perhaps others, many of the states that have passed some form of an infertility mandate include exemptions for religious organizations that oppose infertility treatment.

RECOMMENDATIONS

A determination of whether infertility coverage should be mandated involves the consideration of many questions regarding the nature and morality of infertility treatment: Is infertility a disease or condition, such that it should be covered by insurance? Are all types of infertility treatment morally permissible? Does infertility treatment provide a benefit to society? If the answers to these questions are “yes,” then a cost benefit analysis must be made to determine if a mandate of infertility coverage is a wise investment of public and private funds in comparison to other potential uses of the money necessary to enact a mandate. A consideration of the monetary costs of an infertility mandate is a necessity given the rising cost of health care in Florida which imposes ever-rising costs both on private employers as well as state government via the state employees health plan.

A comprehensive infertility mandate will effect around 50 percent of all policyholders in Florida due to ERISA preemption. A comprehensive mandate will greatly increase the availability and affordability of infertility treatment. However, a comprehensive mandate is also the most expensive option facing the Legislature, possibly increasing the cost of health insurance policies and burdening small business with few employees. Other mandate options include limiting the mandate to larger employers or putting limits on types and amounts of treatment. A limited mandate to cover will reduce the effects on premium costs of a mandate, but at the cost of reducing the availability of certain types of treatment. A mandate to offer treatment is another possibility and likely the most inexpensive option outside of not offering a mandate, but a mandate to offer may do little to improve the availability of infertility treatment.

⁷² See Olga Batsedis, *Embryo Adoption a Science Fiction or an Alternative to Traditional Adoption?*, 41 Fam. Ct. Rev. 565 (2003).