



Fertility Preservation for Cancer Patients: “We Need to Foot the Bill”

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Editorial

A 27-year-young G0 P0 female presented to the office for a consultation on fertility preservation after a referral from her oncologist with her friend as her sole medical supporter. She was distraught by a recent medical diagnosis of cancer, but leaned in as we broached the subject of possibly losing her fertility. We sat for about an hour discussing the likelihood of damage to her reproductive functioning and the options available to attempted to preserve her fertility. She anxiously reiterated “My oncologist says I need to start cancer therapy within the next three weeks.”

“Should I bank my eggs? Should I use donor sperm?”

“Should I freeze a portion of my eggs and freeze a portion as embryos (using donor sperm) to increase chances of a successful pregnancy?”

“Oh I could use my boyfriend, who I am not even sure I’ll be within a year.”

Excitedly she said she would use donor sperm and have a girl’s night out party with her friends to select the “winning donor”. However, when the conversation turned to the cost of these options, she began to lean back just a little, reentering her world of despair and worry.

At that point I could see her eyes shining like a deer in headlights. After reviewing payment options and discounted costs, she was fully slumped back in her chair, completely overwhelmed with how she would afford the cost of a treatment she so desperately desired. You could read her fears,

“While I need emotional support, who will financially support me along my journey?”

In the United States, between 2007 and 2011, approximately 6% of women diagnosed with cancer were less than 45 years old [1]. Fortunately, with earlier diagnosis and better treatments, there has been a significant increase in cancer survival rates during the past decade [2]. From 2002 to 2012, 83% of female patients less than 45 years old diagnosed with cancer survived greater than 5 years [1]. The incidence of cancers in reproductive age women would suggest a need for fertility preservation options, and is widening with the current trend of delaying childbearing and increased cancer survival.

Infertility treatment with the use of assisted reproductive technology (ART) has emerged as an effective but costly form of health care. Currently, there is no federal legislation in place to ensure

infertility treatment coverage by health care plans, and regulations vary greatly by state [3]. Overall, the availability of insurance for infertility treatment for any patient is limited in the United States. Currently, only fifteen states have laws mandating insurance companies provide infertility treatment, although some exclude IVF coverage, and some are not binding on self-insured or employers with few employees. In 2011, California State Assembly Bill 428 was introduced to mandate insurance companies provide health care coverage for fertility preservation [3]. However, overall, the majority of health insurance plans do not offer coverage of infertility treatment and reimbursement is often not included in managed-care plans due to the perception that fertility is a social, and not medical condition [4,5]. ART therapies for patients whose infertility is due to iatrogenic causes (non-negligent treatment induced conditions), or cancer patients where the cancer therapy is toxic to reproductive functioning present unique issues. Where ART is necessary because of prescribed treatment, the ethical responsibility of health care providers and the health care system demands a new viewpoint. We struggle as we use the guiding principles of beneficence (the welfare of the patient) balanced with non-maleficence (in the course of caring for oncofertility patients, the treatment of cancer and the toxic harm of chemo-radiation with resulting infertility seems inevitable, yet we are morally bound to choose the lesser of the two evils) [6]. Shouldn’t the medical profession, including insurance companies and state health benefit plans, be responsible for alleviating the harm of infertility caused by lifesaving treatment as we our do our best to return ill patients to their natural, healthy state?

The irony is that insurance typically covers treatment for other conditions related to cancer treatments, such as breast reconstructive surgery following mastectomy. The Women’s Health and Cancer Rights Act of 1998 mandated that private health insurance companies cover the cost of these reconstructive surgeries as part of cancer treatment and not as an elective treatment [7]. Oddly, treatment for breast asymmetry is covered by insurance when the cause is iatrogenic, but rarely when the cause is natural. Following the same rationale, should it not be reasonable for insurance companies to provide coverage for ART as fertility preservation along with cancer treatment?

Sadly, the estimated cost of a live birth baby in the oncofertility setting is significantly higher (\$41,132) than the average price for a cycle of IVF (\$12,513), due to the cost of extended storage and likelihood of multiple cycles [8]. Even as a physician with a good salary, I would have to think twice about affording this therapy, and it is estimated that the cost of a standard cycle of IVF constitutes an average of 50% of an individual’s disposable annual income [8]. So how can we expect these patients to pay for this treatment given that insurance companies will not cover the costs? External resources exist, such as Fertile Hope, which is a non-profit agency that provides free medications for fertility preservation to cancer patients if they financially qualify. While this is a wonderful resource, the patient still incurs thousands of dollars in fees including storage costs, which are unavoidable. In a climate of massive health care reform, what kind of support can we expect from our government?

The Affordable Care Act (ACA) provides for ten essential health benefits (EHB’s) that must be covered by certain plans as of January 2014. Infertility or reproductive medicine, however, is not specifically named on the list of EHB’s, although it could potentially fall under the umbrella of several categories, such as maternity and newborn care. Each state is required to define the EHB benefit package based on a

state-specific benchmark plan. Coverage of infertility treatments is required only for plans sold in a state with a mandate enacted on or before December 31, 2011 and has infertility coverage included in its benchmark plan. For currently non-mandated states, the ACA stipulates that states may require benefits in excess of the EHB, but that states must defray the cost of these additional benefits (infertility mandates), and that additional cost is a major deterrent. In non-mandated states where employers voluntarily offer infertility coverage, many employer sponsored health plans are dropping infertility coverage with the implementation of the ACA due to increased costs of the benefit. In order to implement infertility coverage in all states' EHB, we need to raise awareness to state regulators and policymakers in order to pass a new law or petition for its inclusion in a new benchmark for policy years beginning in 2016.

Although not formally documented, there is anecdotal evidence that some insurance companies are assuming financial responsibility for iatrogenic infertility in some cases where fertility preservation treatments have been billed under a primary diagnosis of cancer and a secondary diagnosis of procreative management. This billing method is often coupled with a Letter of Medical Necessity from the physician [9]. With respect to the ACA, this method ensures the patient's right to appeal insurer's denial of coverage, but the patient must independently navigate this process. Through appeals and negotiations, insurance companies have accepted this billing and covered costs for treatment at some institutions [6]. This provides hope that insurance companies may acknowledge iatrogenic infertility as a serious condition that affects quality of life and deserves medical treatment; however, this select coverage only occurs on a case-by-case basis and does not apply universally. Moreover, patients must decide whether to proceed with treatment within days without knowing if it will be covered and could be burdened with unexpected and significant costs if not covered.

What is needed is a state or federal mandate that requires insurance companies and employers to cover the costs of treatment for iatrogenic or onco-infertility that would enable universal, comprehensive care of the cancer patient. Many providers fail to discuss the options for fertility preservation with their patients for reasons including unfortunately a lack of knowledge, but also understandably a belief that many young patients simply cannot afford treatment [10]. A mandate would eliminate that concern and facilitate conversation regarding fertility to patients across all socioeconomic backgrounds. This would also bolster the legitimacy of infertility as a disease and fertility preservation as a medical treatment. Through this approach, providers may become better advocates for their patients, and improve health on a broader and deeper scale.

Looking at my patient slumped in my office, I wish I could offer her financial support in order to alleviate one aspect of the devastating weight of a cancer diagnosis. As advocates in health care reform, it should be our collective desire to keep her and all of these hopeful survivors leaning in, engaged in our discussion, and focused on the goal of surviving cancer and achieving their dream of a family.

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