AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-24)

Introduced by: Medical Student Section

Subject: Infertility Coverage

Referred to: Reference Committee A

Whereas, fertility assistance and preservation are commonly used by patients diagnosed with or at risk for infertility (including iatrogenic infertility due to medical interventions, such as cancer treatment or hormone replacement therapy), LGBTQ+ patients, military and veteran patients, and patients who desire future pregnancy at advanced reproductive age[1-2]; and

Whereas, cost for services such as in vitro fertilization or oocyte cryopreservation ranges from $10,000 to $13,000, not including medications, further tests, multiple cycles, and cryostorage fees[3-5]; and

Whereas, the average cost for semen analysis by emission is around $750, with additional costs for cryostorage[6]; and

Whereas, cost due to lack of insurance coverage and need for supplemental insurance is the most common barrier for patients with infertility, often leading them to end treatment[7-8]; and

Whereas, in states where employer plans cover assisted reproductive technology, the cost of in vitro fertilization (IVF) is 13% of average annual disposable income compared to 52% in other states, indicating that coverage regulations drastically affect affordability[9]; and

Whereas, Medicaid covers fertility drugs in only one state, covers infertility diagnostics in only a few states, and does not cover other fertility assistance or preservation services[10]; and

Whereas, TRICARE only covers infertility care that enables “natural conception,” and the VA only covers care for infertility due to service-related injuries and only if donor eggs and sperm are from a couple, excluding LGBTQ+ and unmarried individuals[10]; and

Whereas, 25 states and DC have various regulations at least partially restricting coverage of some fertility diagnostics or services in at least a portion of employer plans offered, although sex and gender-based restrictions, cost-sharing, age cutoffs, marital requirements, exemptions for small and large employers, and other stipulations vary widely[10-14]; and

Whereas, states with private coverage for fertility services do not experience significant premium increases, with estimates ranging from 0.5-1% ($1-5), while demonstrating 150-300% greater use of fertility services compared to states without[10,15-17]; and

Whereas, Black women may have higher infertility rates but are less likely to use fertility services, and Black, Hispanic, and Asian women all experience poorly understood lower success rates for fertility services, alongside many financial and logistic barriers[18-20]; and

Whereas, women of color also report hearing comments disregarding their fertility concerns or perpetuating stereotypes (that they can become pregnant easily or that they should not become pregnant at all)[20]; and

Whereas, LGBTQ+ individuals and unmarried individuals are often excluded from conditions and requirements for fertility services[10,11,21,22]; and

Whereas, unlike the IHS, other federal health programs such as the Veterans Health Administration and Federal Employees Health Benefit Program, provide a spectrum of coverage for infertility diagnostics and treatment[23]; and

Whereas, the prevalence of infertility and impaired fecundity (reproductive fitness) among American Indian and Alaska Native (AI/AN) persons is 7.0% and 13.2%, respectively, which is greater than that of the U.S. population (6.4% and 11.0%)[24]; and

Whereas, positive pregnancy (PP) and ongoing pregnancy/delivery (OP/D) rates are estimated to be 15% and 10% per IUI cycle in the general population, respectively, but AI/AN patients have marked PP/OP/D disparities (5.10% PP and 3.3% OP/D)[25]; and

Whereas, the IHS defines Level 5 (Excluded Services) as services and procedures considered purely cosmetic in nature, experimental or investigational, or with no proven medical benefit and includes IVF and related services in this category, preventing IHS, Tribal, and Urban Indian Health Programs from paying for this care[26-28]; therefore be it

RESOLVED, that our American Medical Association amend Policy H-185.990, "Infertility and Fertility Preservation Insurance Coverage" by addition and deletion to read as follows;

1. Our AMA ~~encourages third party payer health insurance carriers to make available insurance benefits~~ supports federal protections that ensure insurance coverage by all payers for the diagnosis and treatment of recognized ~~male and female~~ infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
3. Our AMA will work with interested organizations to encourage the Indian Health Service to cover infertility diagnostics and treatment for patients seen by or referred through an Indian Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA study the feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility (Directive to Take Action); and be it further

RESOLVED, that our AMA support the review of services defined to be experimental or excluded for payment by the Indian Health Service and for the appropriate bodies to make evidence-based recommendations for updated health services coverage. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/5/2024

REFERENCES

1. Benaloun E, Sermondade N, Moreau E, et al. Place de la préservation de la fertilité dans le parcours de transition des femmes transgenres [Fertility preservation for transwomen]. Gynecol Obstet Fertil Senol. 2021;49(6):547-552. doi:10.1016/j.gofs.2021.01.007
2. Colmorn LB, Kristensen SG, Dueholm M, Macklon KT. Ugeskr Laeger. 2021;183(48):V05210409.
3. Paying For Treatments. Cancer Fertility Preservation. Allianceforfertilitypreservation.org. https://www.allianceforfertilitypreservation.org/costs/paying-for-treaments. Published 2021. Accessed September 12, 2021.
4. Hirshfeld-Cytron J, Grobman WA, Milad MP. Fertility preservation for social indications: a cost-based decision analysis. Fertility and Sterility. 2012;97(3):665-670. doi:10.1016/j.fertnstert.2011.12.029
5. Jeong Perry, A., Nguyen, A. How to decide if freezing your eggs is right for you — and where to get started. www.npr.org https://www.npr.org/2021/11/18/1056834875/egg-freezing-process-how-much-does-it-cost. Published December 2, 2021. Accessed March 20, 2022.
6. Insogna IG, Ginsburg ES. Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy. AMA J Ethics. 2018;20(12):E1152-E1159. Published 2018 Dec 1. doi:10.1001/amajethics.2018.1152
7. Gilbert K, Nangia AK, Dupree JM, Smith JF, Mehta A. Fertility preservation for men with testicular cancer: Is sperm cryopreservation cost effective in the era of assisted reproductive technology?. Urol Oncol. 2018;36(3):92.e1-92.e9. doi:10.1016/j.urolonc.2017.11.002
8. Berger R, Paul MS, Henshaw LA. Women's experience of infertility: A multi-systemic perspective. Journal of International Women's Studies. 2013;14(1):54-68. https://vc.bridgew.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1651&context=jiws
9. Mosalanejad L, Parandavar N, Abdollahifard S. Barriers to infertility treatment: an integrated study. Glob J Health Sci. 2013;6(1):181-191. Published 2013 Nov 25. doi:10.5539/gjhs.v6n1p181
10. Weigel, G. Coverage and Use of Fertility Services in the U.S. | KFF. https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s. Published September 15, 2020. Accessed March 19, 2022.
11. State Laws Related to Insurance Coverage for Infertility Treatment. www.ncsl.org. https://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx. Published March 12, 2021. Accessed March 20, 2022.
12. Insurance Coverage by State | RESOLVE: The National Infertility Association. https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/. Published August 27, 2021. Accessed March 20, 2022.
13. The Birth Rate is Rising Among Older Women. Got IVF Coverage? Our Thinking. www.mercer.us. https://www.mercer.us/our-thinking/healthcare/the-birth-rate-is-rising-among-older-women-got-ivf-coverage.html. Published May 28, 2018. Access March 20, 2022.
14. Benoit M, Chiles K, Hsieh M. The Landscape of Coverage for Fertility Preservation in Male Pediatric Patients. Urology Practice. 2018;5(3):198-204. doi:10.1016/j.urpr.2017.03.007
15. Jain T, Hornstein MD. Disparities in access to infertility services in a state with mandated insurance coverage. Fertil Steril. 2005;84(1):221-223.
16. Jain T. Socioeconomic and racial disparities among infertility patients seeking care. Fertil Steril. 2006;85(4):876-881.
17. Insogna I. Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy. AMA J Ethics. 2018;20(12):E1152-1159. doi: 10.1001/amajethics.2018.1152.
18. Craig LB, Peck JD, Janitz AE. The prevalence of infertility in American Indian/Alaska Natives and other racial/ethnic groups: National Survey of Family Growth. Paediatr Perinat Epidemiol. 2019;33(2):119-125. doi:10.1111/ppe.12538
19. Chin HB, Howards PP, Kramer MR, Mertens AC, Spencer JB. Racial Disparities in Seeking Care for Help Getting Pregnant. Paediatr Perinat Epidemiol. 2015;29(5):416-425. doi:10.1111/ppe.12210
20. Ethics Committee of the American Society for Reproductive Medicine. Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion. Fertil Steril. 2015;104(5):1104-1110. doi:10.1016/j.fertnstert.2015.07.1139
21. Kaufman, D. The Fight for Fertility Equality. The New York Times. Published July 22, 2020.
22. Ethics Committee of the American Society for Reproductive Medicine. Access to fertility treatment irrespective of marital status, sexual orientation, or gender identity: an Ethics Committee opinion. Fertil Steril. 2021;116(2):326-330. doi:10.1016/j.fertnstert.2021.03.034
23. U.S. Department of Veterans Affairs. In Vitro Fertilization Treatment. December 21, 2022. Accessed August 22, 2023. https://www.va.gov/COMMUNITYCARE/programs/veterans/ivf.asp
24. Craig LB, Peck JD, Janitz AE. The prevalence of infertility in American Indian/Alaska Natives and other racial/ethnic groups: National Survey of Family Growth. Paediatr Perinat Epidemiol. 2019;33(2):119-125. doi:10.1111/ppe.12538
25. Craig LB, Weedin EA, Walker WD, Janitz AE, Hansen KR, Peck JD. Racial and Ethnic Differences in Pregnancy Rates Following Intrauterine Insemination with a Focus on American Indians. J Racial Ethn Health Disparities. 2018;5(5):1077-1083. doi:10.1007/s40615-017-0456-8
26. Indian Health Service. Requirements: Priorities of Care. Accessed August 22, 2023. https://www.ihs.gov/prc/eligibility/requirements-priorities-of-care
27. Indian Health Service. Indian Health Service Medical Priority Levels. Accessed August 22, 2023. https://www.ihs.gov/sites/ihm/themes/responsive2017/display_objects/documents/pc/58619-1_Manual_Exhibit_2-3-B_IHS_MedicalPrioritiesRolesAndResponsibilities.pdf
28. Weisner M. White House to require more fertility treatment options for workforce. Federal Times. March 10, 2023. https://www.federaltimes.com/fedlife/benefits/2023/03/10/white-house-to-require-more-fertility-treatment-options-for-workforce

RELEVANT AMA POLICY

H-185.990 Infertility and Fertility Preservation Insurance Coverage
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician. [Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended Res. 114, A-13; Modified: Res. 809, I-14]

H-65.956 Right for Gamete Preservation Therapies
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. [Res. 005, A-19]

H-185.922 Right for Gamete Preservation Therapies
3. Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility. [Res. 005, A-19]

H-510.984 Infertility Benefits for Veterans
1. Our AMA supports: (A) lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; and (B) efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries; and (C) additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
2. Our AMA encourages: (A) interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries, and (B) the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process. [CMS Rep. 01, I-16; Appended: Res. 513, A-19]