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The Affordable Care Act: Early Implications for Fertility Medicine

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With the majority of the law taking effect in 2014, insurers, patients, and healthcare providers in every field of medicine anxiously await the full impact of the Patient Protection and Affordable Care Act (ACA). Patients with infertility and the field of Fertility Medicine stand much to gain, given that so few patients enjoy substantial coverage for fertility treatments. Conversely, given the ACA's basis of 'minimum ***essential***' coverage, our patients' and the field's position is precarious -- fertility treatments have historically been regarded as a luxury by insurers – and what little coverage exists may be further downscaled.

Approximately 10% of American couples experience infertility, defined as no pregnancy over 12 months of sexual activity without contraception. Of those who seek infertility evaluation, about half undergo fertility treatment, and the likelihood of proceeding with therapy is associated with healthcare coverage status. Yet the vast majority of Americans lack healthcare coverage for infertility treatments. A quarter of U.S. health insurance plans include some infertility benefit, and at present, 15 states mandate that group insurers offer some infertility benefit to employers. Two of these states, California and Texas, mandate only that group insurers *offer* infertility coverage -- employers are not obligated to provide it to their employees. A handful of these 15 apply the mandate to both group and individual insurers, the latter of which sell policies directly to the insured, rather than to their employer. The mandated procedures in some states are diagnostic rather than therapeutic. Only 7 states (Arkansas, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, and New Jersey) specifically require that employers cover any IVF. Of these, Arkansas requires only $15,000 coverage, and Hawaii requires coverage for only one IVF cycle. Among other substantial restrictions and exclusions, small employers and religiously-affiliated employers are

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generally exempt from the requirement. The end result is that even in so-called ‘mandated states,’ patients may pay for most, if not all of the treatment for their infertility, particularly when ART is needed.

That said, in states where insurers have been mandated to cover infertility treatment, utilization of fertility medical care is significantly increased. With implementation of the ACA, the market for health insurance in the United States is poised for dramatic change. Long term repercussions of the law on insurance markets may serve either to further diminish or to expand coverage for fertility care. Here we review the early indications of the ACA’s effects on fertility medicine.

THE AFFORDABLE CARE ACT

Signed into law by President Obama on March 23, 2010 after a series of contentious votes in Congress, the ACA aspires to achieve near-universal health insurance coverage while slowing the rate of increase in healthcare spending in the United States. 2012 saw the Supreme Court uphold the bulk of the law and President Obama win reelection against an opponent who had vowed repeal it on his first day in office. Taken together, these events ensured that the ACA would continue to reshape and transform the U.S. market for health insurance for years to come.

In its “findings” supporting the bill, Congress highlighted, among other points, that health insurance and healthcare services represent “17.6 percent of the Nation’s economy,” that uninsured Americans have “poorer health and a shorter lifespan,” that “the cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008,” and that “62 percent of all personal bankruptcies are caused in part by medical expenses.”[1] A principal aim of the ACA is to provide health insurance coverage to an additional 32–50 million Americans beginning in 2014. To achieve this expansion, the ACA relies heavily on two statutory mechanisms: the individual coverage provision (commonly known as the “individual mandate”) and the Medicaid expansion. Both of these have been the focus of sustained political debate and public attention.

Individual Mandate

As of 2014, the ACA requires most Americans to obtain a health insurance policy that provides “minimum essential” coverage.[1] Most Americans will satisfy this mandate through health insurance policies provided by an employer, or through their enrollment in Medicare or Medicaid. To facilitate insurance purchases by those who do not otherwise have coverage, the ACA creates “insurance exchanges” that offer qualifying insurance policies on a standardized basis (i.e., without regard to an individual’s personal medical history or preexisting conditions) and provides federal subsidies to those with incomes up to four-times the federal poverty level. Although estimates range widely and the initial enrollment numbers were disappointing after the flawed “roll out” of the website for the federal exchange, it is expected that tens of millions of Americans will ultimately purchase health insurance as a result of the mandate, the subsidies, and other changes to insurance pricing dictated by the ACA. Those subject to the mandate who fail to obtain adequate coverage must pay a “shared responsibility payment” (described in the ACA as a “penalty”) to the

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Internal Revenue Service (IRS) at the time they pay their taxes.[1] Public opinion polling indicates that the individual mandate remains deeply unpopular, and questions about the mandate's legality and propriety continue to be raised even after the Supreme Court's landmark ruling in 2012 upholding its constitutionality.

Will Fertility Healthcare be Deemed "Essential?"

What constitutes "minimum essential" coverage – and who gets to decide that question – will have important near-term and long-term consequences for access to fertility treatments in the future. The ACA expressed the standard only in broad terms, leaving the details to be worked out by the Secretary of Health and Human Services. The challenges in devising a uniform standard of coverage are considerable and politically fraught. As the *Washington Post* noted: "Draw up a package that is too bare-bones, and millions of Americans could be deprived of meaningful health coverage when they need it most - undercutting a central goal of the health-care law. Add in too many expensive benefits and premiums could spike to unaffordable levels."[2] In December 2011, the Department of Health and Human Services (HHS) proposed a policy that would provide flexibility to states in implementation of the ACA, allowing state-to-state variations in the standard of essential coverage. Under the HHS proposal, state legislatures initially have the flexibility to select a "benchmark plan" based on those offered by large public and private insurance providers in the state.

The determination to leave the definition of essential coverage in the hands of the states, rather than standardizing it nationwide, carries with it important implications for the field of fertility medicine: A significant minority of states (Arkansas, Connecticut, California, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas, and West Virginia) currently require insurance plans to cover infertility treatments. The limitations and exceptions to such mandates are often considerable. As Sean Tipton, a spokesman for the American Society for Reproductive Medicine (ASRM) explained to the *Washington Post*, "mandates often promise more than they deliver," noting exceptions for small employers and broad limitations on services covered. Nevertheless, in some of these states the coverage dramatically increases overall access to infertility treatments.

The initial launch of the exchanges in October 2013 saw few changes to the status quo – states with encompassing "mandates" such as Maryland and Massachusetts adopted "essential" healthcare coverage requirements that maintained coverage for assisted reproductive technologies, whereas no state without a mandate incorporated infertility treatments into its requirements. Still, it is predicted by some commentators that over time some covered states may reexamine their mandated coverage laws out of concern for the cost to the overall healthcare system, under the new law that seeks to curtail healthcare spending. In an example of what may come, Maryland briefly considered substitution rules that would have effectively rendered IVF outside of essential coverage, before opting to maintain its existing IVF mandate, in the face of public pressure. Furthermore, the ACA disincentivizes additional states from instituting insurance mandates for infertility treatment. Mandated benefits beyond the final HHS "essential health benefits" list, if added by state(s) after a deadline that has now passed, will result in that state paying the additional cost of

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those benefits for exchange enrollees. ACA provisions protect the federal government from picking up the tab for healthcare plans purchased on the exchanges offering state-mandated benefits beyond "essential health benefits."

At the other end of the spectrum, the ACA may prohibit charging higher prices or denying coverage based on "pre-existing conditions," which could lead more insurers to offer plans including fertility coverage. Enrolling consumers of infertility healthcare has potential to *increase* profit margins for insurers in the long-term. Much as private insurers in the Medicare Advantage program have long tried to lure and retain fitness-oriented patients onto their plans through additional "perks" such as free gym memberships, the state exchanges may lead insurers -- now barred from charging higher premiums to patients in worse health -- to offer additional services in an effort to attract healthier patients. One means to do so would be to subsidize the costs of ART. In addition to being relatively young, "individuals seeking infertility care have higher incomes and are more likely to have completed a 4-year college degree,"[3] factors that correlate with improved health. Particularly if insurance companies could find ways to control costs and retain such patients long term, offering IVF services may be an attractive option for insurance companies seeking to enroll healthy patients who happen to be infertile. Members of this largely healthy population would begin their relationship with a given insurer to get infertility coverage. Spending by insurance companies for infertility treatments is likely to be a fraction of the savings obtained via enrolment of a healthier population, particularly with the ongoing decrease in multiple pregnancy rates due to wider use of single embryo transfer. Insurance companies may even consider requiring their patients' physicians to follow ASRM/SART embryo transfer guidelines to minimize their exposure to adverse perinatal outcomes in the setting of multiple pregnancies. Although the Department of Health and Human Services has announced that it will introduce "risk-adjustment" restrictions to "help ensure that insurance plans compete on the basis of quality and service and not on attracting the healthiest individuals,"[4] the formulas involved are complex and it is hardly certain that such rule-making will ultimately succeed. Assuming HHS restrictions do not thwart insurers' efforts to attract healthy patients, subsidizing infertility services may prove to be an effective mechanism of doing so.

Medicaid Expansion

In addition to its reforms to the private insurance market, the ACA aims to expand healthcare coverage through enlargement of Medicaid, a federal program administered by states. First enacted in 1965, Medicaid assists pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care.[1] The ACA promises additional federal funding to the states in order to extend Medicaid coverage to adults with incomes up to 133 percent of the federal poverty level.[1] Federal subsidies would initially cover 100 percent of the costs of the Medicaid expansion, then fall to 90 percent by 2020. Subsequent to the law's passage, the Supreme Court gave states freedom to opt out of the Medicaid expansion without jeopardizing existing federal Medicaid funding. The Congressional Budget Office had estimated that 16–17 million people would have been added to the Medicaid program, if all states accepted federal funds toward Medicaid expansion as the law intended. However, those estimates now seem unlikely to materialize. As of December

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2013, 25 states and the District of Columbia had chosen to implement the expansion in 2014. Though they have no firm deadline to do so, 23 states have already announced that they do not have plans to expand Medicaid coverage. In states declining Medicaid expansion, Republican governors and legislatures have cited the burdens of the proposed expansion on their state's budget, notwithstanding that federal funding would cover all costs initially and 90% into the next decade. Political pressure not to accept federal funding associated with the ACA has also been speculated to play a role.

Although the expansion of Medicaid will have dramatic consequences for the provision of healthcare services generally, its effect on access to fertility treatments is likely to be limited. A 2009 study sponsored by the Kaiser Family Foundation and the George Washington University Medical Center concluded that "infertility testing and treatments . . . are rarely covered by Medicaid." The study found that "only three states cover testing and some level of treatment for infertility" and that "coverage for infertility services is very limited." A larger number of states covered other forms of preconception care such as gynecologic examinations and screening for sexually transmitted diseases. [5]

Other ACA Provisions and Patient Access to Fertility Services

Though the Supreme Court challenge and much popular debate focused on the individual mandate and Medicaid expansion, these are hardly the only important provisions in the ACA. The bill exceeded 900 pages in length and contained a broad range of legal provisions affecting healthcare services. In the words of the Supreme Court dissenting opinion, the ACA's new requirements "range from a break time and secluded place at work for nursing mothers, to displays of nutritional content at chain restaurants."

In terms of expanding access to fertility healthcare, the ACA's changes appear mixed. On the one hand, the ACA may somewhat improve the affordability of infertility treatments by prohibiting insurers from considering gender when setting premiums and precluding insurers from denying coverage on the basis of preexisting conditions, including infertility and a prior cesarean section. These changes vindicated a longstanding campaign of the ASRM and National Women's Law Center titled "Being a Woman is Not a Preexisting Condition." Congressional hearings featured accounts of women who had been denied insurance coverage because their infertility was treated as a preexisting condition.

The Affordable Care Act also eliminates lifetime caps on insurance reimbursements, which is good news for infertile patients. In particular, patients who require extensive pre-natal or neo-natal care in addition to infertility treatments may incur healthcare charges in excess of these cost thresholds.

Though under the ACA couples can't be denied health insurance on the basis of infertility, the law by no means guarantees coverage of infertility itself. Setting aside what a few individual states may choose to decide in setting the standard for essential coverage, the ACA does not include any specific guarantees of funding or support for fertility treatments. Rather, several provisions of the ACA geared toward reducing federal spending may even *increase* patients' felt cost of fertility treatments because they reduce ability to pay for them with pre-tax dollars. One example is a change in the rules governing pre-tax contributions to

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Flexible Spending Accounts (FSAs), which starting in 2013 will be capped at $2,500 (far less than the cost of many fertility treatments). In response, The Family Act, a bill currently before Congress, modeled after the long-established Adoption Tax Credit, would provide a tax credit for 50% of out of pocket costs associated with IVF or fertility preservation for cancer patients. Couples earning less than $222,520 could claim a lifetime maximum tax benefit of $13,360.

Another way the real-world cost of fertility treatments may rise for patients is via an increase in the limit after which payments for personal medical expenses become tax deductible. Under the ACA, the threshold will rise from 7.5 percent of gross income to 10 percent of gross income. In addition the ACA may create disincentives for private insurance companies to cover expensive fertility treatments because of the new 40% excise tax on so-called “Cadillac” insurance plans, high-cost plans that are more likely to cover fertility treatments than lower-cost plans. As a result of this change, some employers may no longer offer such plans to employees, and those plans that continue to be offered will effectively cost more.

Though little in the Affordable Care Act specifically regulates the funding of infertility treatment, the law dramatically overhauls the individual market for health insurance. It endeavors to expand coverage and reduce costs. In the face of these new demands, states and Insurers will be left to reevaluate to what extent fertility benefits are feasible and cost effective. For the millions of Americans who will need infertility treatment in the coming years, the outcome of these deliberations may determine the ACA’s legacy.

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