

Pursuit of pregnancy by lesbian women: an opportunity to create best practice

The article Pregnancy Success Rates for Lesbian Women Undergoing Intrauterine Insemination by Johal et al. (1) is a retrospective cohort study obtained from two academic fertility practices comparing clinical pregnancy rate (CPR) and live/ongoing birth rate (LBR) between a small group of lesbian women undergoing therapeutic donor insemination (TDI) and a larger group of heterosexual women using partner or donor sperm. The overall results are encouraging in that in this study, CPR and LBR are similar for lesbian women and heterosexual women, and after a generalized estimating equation method for multivariate logistic regression, the odds of a clinical pregnancy and live birth were higher in the lesbian group. This study also highlights the fact that in this small cohort of lesbian women, CPR and LBR continued to increase for up to 10 cycles, whereas in heterosexual couples, there was no increase after 5 cycles.

As fertility specialists, we have seen marked increases in the number of lesbian couples seeking procreative management services to build their families (2). As we provide care to this growing community, it is significant to recognize if there are differences in our testing and treatment algorithms that impact outcomes and cost for these women. Compared with heterosexual couples, the optimal evaluation before pursuing pregnancy varies. Some providers evaluate lesbian women as if they were infertile before initiating inseminations. As stated in this article's discussion, there are some studies that suggest that lesbian women have an increased prevalence of risk factors for infertility such as anovulation, smoking, obesity, or sexually transmitted infections. As such, fertility testing is valuable to identify factors that may impact success and to guide treatment selection. For example, anovulatory women will require ovulation induction to achieve pregnancy, and women with tubal factor will be directed toward in vitro fertilization (IVF) as the initial course of treatment. However, deferral of the evaluation until after a woman has failed to conceive after a series of cycles, if no risk factors are apparent in her history, is acceptable practice.

The issue of sperm exposure before presenting for care varies among lesbian women. While several women have not had prior exposure to sperm, others have tried to conceive with donor insemination (with known and anonymous donor sperm) at home before presenting to a fertility clinic. Despite the fact that home cervical inseminations may be less successful per cycle, they should be considered as adequate sperm exposure attempts similar to those of heterosexual couples. Recently in Massachusetts, one insurer has begun to permit home inseminations to count toward meeting the predetermined number of required inseminations to access the fertility benefit (3).

The availability of insurance coverage is a tremendous benefit for all patients pursuing fertility treatment. In states

with no insurance coverage for fertility, standardization of practice provides for equitable treatment of all patients irrespective of sexual orientation. In these settings, all individuals should have equal opportunity to tailor the course of their treatment based on the available evidence-based success rates for both conservative treatment (TDI) and aggressive treatment (IVF), coupled with their family building goals. In states with insurance mandates, however, there is considerable variability in the prerequisites that lesbian women must meet before they can access their insurance benefit. Pretreatment evaluation, if recommended, is generally covered. The cost of donor sperm is not a covered expense under most circumstances. Significant variability exists in the number of required inseminations before couples or individuals can access their fertility benefit. This ranges from 6 to 12 inseminations in lesbian women using TDI under the age of 35 years and 3 to 6 inseminations in lesbian women aged >35 years. Ovulation induction and monitoring are typically not covered, nor is the cost of the insemination covered until the required number is met. Thus, if a woman is anovulatory and requires a monitored cycle, she will have a greater out-of-pocket expense. One insurer has recently instituted insurance coverage for both monitoring and the inseminations but maintained the number of inseminations required before more aggressive treatment such as IVF can be pursued. This has reduced the disparity in cost for lesbian women pursuing treatment compared with heterosexual couples to the cost of sperm each cycle (4). Unfortunately, this is not the case for most insurers.

The strength of this study centers on identifying typical success rates in a retrospective patient cohort and serves as a significant step in establishing evidence-based best practice for lesbian women building their families through traditional TDI. This is particularly important in guiding treatment in states with an insurance mandate where there is a requirement of sperm exposure for a period of time before accessing a fertility benefit. Efforts such as inclusion of home inseminations in the required number of inseminations before treatment coverage acknowledge the importance and frequency of this practice in lesbian family building and should be documented in the initial patient assessments. Identifying the impact of insurance coverage for monitoring and insemination while meeting this requirement is another best practice to address disparities in access to care. Ultimately, prospective studies that analyze success rates as well as typical out-of-pocket expenses incurred by lesbian patients will help to clarify the optimal number of in-office intrauterine inseminations recommended before moving on to more aggressive treatment such as IVF. The goal in establishing these best practices will be to reduce the disparities and remove some of the barriers that exist for lesbian women pursuing family building.

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