

Fertility Preservation Coverage – Key Points

Purpose

The purpose of this legislation is to provide cancer patients with access to treatments that will allow them to have biological children after cancer.

Background

In the United States, approximately 160,000 people between ages 0-44 are diagnosed with cancer each year. Due to improvements in treatment, about 85% these patients will survive.

Some cancer treatments, however, can cause infertility. Chemotherapy, radiation, and surgery can damage reproductive cells (eggs and sperm), reproductive organs, and/or endocrine functioning; they can also impact the ability to carry a pregnancy.

Because this damage is primarily treatment-based, it can affect patients with any type of cancer. Patients with other conditions requiring similar therapies (e.g., sickle cell disease, lupus, and thalassemia, etc.) are also at risk.

In this age group, concerns about family building are second only to mortality, and infertility after cancer can cause depression, anxiety, and a lower quality of life.

Standard of Care

Fertility preservation is now considered part of the standard of care for age-eligible patients. Standard procedures including sperm, egg, embryo, and ovarian tissue banking are supported by all the relevant medical associations, including the American Society of Clinical Oncology (ASCO), the American Society for Reproductive Medicine (ASRM), and the American Medical Association (AMA).

Cost

Cost is the biggest barrier to fertility preservation. Nationwide, costs can range from several hundred dollars for sperm banking, to approximately \$15,000 for egg banking. Without insurance coverage, these treatments are unaffordable for many patients. The costs are exacerbated by the short window of opportunity that patients have before starting potentially sterilizing cancer treatment.

While the costs faced by an individual patient are high, the cost when spread across a population of insureds is extremely low. Independent analyses in states where coverage has been enacted have estimated costs (per member per month) ranging from a low of \$.01 (California); to a high of \$.10-\$.24 (Maryland).

Existing Fertility Preservation Coverage

Currently, 12 states have implemented some coverage for medically-necessary fertility preservation – Connecticut, Rhode Island, Maryland, Delaware, Illinois, New York, New Hampshire, California, New Jersey, Colorado, Utah (Medicaid only), and Maine.

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Rationales for Coverage

The services are *Medically Necessary*. Fertility preservation for iatrogenic infertility is not “elective” or “experimental,” but rather a needed intervention to prevent potential sterility and/or reproductive damage. Patients cannot rationally defer or forego life-saving treatments to spare their fertility. Independent clinicians uniformly find fertility preservation *medically necessary* in the context of gonadotoxic threat.

They address a side effect of cancer treatment. Remedies for other side effects, such as breast reconstruction, chemo-induced anemia, wigs, some prostheses, etc., are typically covered by insurance.

Access would prevent additional harms and associated costs.

- Studies show that significant numbers of patients make sub-optimal treatment decisions (e.g., stopping tamoxifen or choosing less gonadotoxic treatment) to minimize reproductive impact. These decisions may adversely affect both medical outcomes and treatment costs.
- Infertility causes distress, depression, anxiety; these have financial and medical consequences, and result in overall lower quality of life for survivors.

Coverage would counter current access disparities. The lack of insurance coverage disproportionately affects women and those of lower socioeconomic backgrounds.

Parenthood is a significant life activity. Loss of fertility is not merely a medical complication; it permanently affects reproduction and parenthood – basic human activities worthy of the highest levels of protection.

REFERENCES AVAILABLE ON REQUEST