

THE INFERTILITY BENEFIT: WHAT SHOULD IT COST?

Richard E. Blackwell, Ph.D., M.D.
Professor, University of Alabama
Department of Reproductive Endocrinology
Birmingham, AL

Reproductive endocrinologists define the infertility benefit in different ways; on one end of the spectrum it has been defined solely in terms of the cost of performing in vitro fertilization. On the other end, the benefit is treated as part of an overall reproductive medicine package. Individuals who would dissociate infertility from disease processes and manage it only in terms of positive outcome occupy the middle ground.



The University of Alabama at Birmingham's (UAB) philosophy has sought to maximize results by the use of algorithms, a cordial working relationship between obstetricians/gynecologists and reproductive endocrinologists, the application of evidence based medicine and outcome analysis. Further, we have attempted to set boundaries on therapy based on the literature. In an effort to understand the infertility benefit, we examined the cost of one hundred consecutive pregnancies. We found that the cost of pregnancy ranged between \$300.00 and \$11,000.00 with a mean of \$2,500.00. It should be noted that the southern United States has a lower cost of living than the West Coast or the East Coast, however, these figures might be used as a rough guideline for cost.

UAB offers three health care products: U-Care which is the classic Blue Cross/Blue Shield PPO, United HealthCare - a classic open staff HMO, and VIVA which is a closed staff HMO. Not long after VIVA was developed as an insurance product by UAB, we entered a negotiation with the plan to furnish a capitated infertility benefit for approximately 5,000 reproductive age women. We evaluated the plan's demographics with CATHI (computerized algorithm for the treatment of infertility), which was developed by Lewin VHI, and derived a figure of fifty cents per member per month for the service. As a precaution, we included 40% co-pay for surgery, 40% co-pay for IVF and GIFT, and 40% co-pay for drugs. At the completion of the first year, we attempted to analyze the data and found two trends, which were troublesome. First, we underestimated the drug cost, which appeared to be the result of underestimation of the age of women requiring ovulation-inducing agents. The second confounding factor was that we were unable to separate patients who presented for primary, specialty, and infertility services. Therefore, at the end of the first year experience we still did not know whether capitation was a good or a bad risk. Subsequently, we entered a prospective analysis of UAB 1997 fiscal year capitated data. The plan covered 15,260 individuals (100,133 member months). Five thousand, forty-six women were covered ages 15-51 (39,689-member months). This database generated a surprisingly small number at 39 new and 65 return patient visits (198 visits). Sixty-eight percent of our patient population was between age 30 and 40, 64% were Caucasian, 22% African American, 10% Asian, 3% Mexican American, 40% were professional, 13% teachers, 15% business people; 51% listed infertility as one of their chief complaints, however, 31% had mixed diagnoses; 32% of patients required one to three visits, however, 22% of the visits were generated by six patients. Fifty patients required laboratory services, 30 sonar, 57 pharmaceuticals, 21-ovulation

induction, 14 gonadotropin, 8 surgery, and 11 IVF or GIFT. IVF charges were \$33,256.00, and the infertility rider payment was \$37,891.00. Therefore, assisted reproductive technology consumed most of the benefit. Our gross collections rate for the capitated health care plan was 74% (including specialty and infertility care), Blue Cross/Blue Shield 47.4%, Champus 36.6%, and United HealthCare 30.1%.

This experience leads us to believe that entering a capitated health care plan can be a successful venture, yet it is very risky. Any adverse selection could have had a marked negative affect on our outcome. However, our data tends to confirm the experience from Massachusetts and elsewhere which indicates that less than half the people who are expected to have a problem with infertility seek care, and that perhaps 10-12% of those people will seek care in a year.

We also have experience in working with William Mercer in evaluating 1996 claims data from a 28,000-member plan that specifically excludes infertility therapy. We identified 41 CPT codes and 69 ICD-9 codes that were suggestive of the treatment of infertility. Claims were made against 34 CPT codes, and when these codes matched one or more of the designated ICD-9 codes it was felt that this represented at least partial treatment of infertility. If one considers that all of the CPT code listings represent infertility care, this would represent the maximum risk for the plan. Subsequently, these codes were evaluated by one of the authors (RB), and estimates were made as to the probability they represented infertility therapy. This represented a modified risk. From these figures, the cost of infertility therapy was estimated to range between fifty cents to \$1.50 per member per month. Our estimate suggests that insurance companies already pay between twenty-seven cents to fifty cents per member per month for "hidden infertility treatment." It is estimated that if properly managed, the cost of the management of an infertility benefit should be between forty and fifty cents per member per month.

Subsequently, William Mercer evaluated a large database that provided unmanaged infertility benefit including ART. The cost of the benefit was seventy-eight cents per member per month, and IVF accounted for 75% of the costs, confirming our experience with the UAB insurance product.

Our experience would suggest the following strategy for negotiating the managed care infertility benefit: 1) employers already pay for the treatment of infertility and their payment level is equivalent to the cost that would be furnished by a well-managed benefit. 2) The information that exists in the literature regarding utilization along with evidence-based/cost-effective driven algorithms such as CATHI, can be used to make a general estimate of the per member per month cost of furnishing the benefit. 3) Entering a contract with a large employer to furnish subspecialty health care services would generate a limited number of patients. 4) Because of the small number of patients generated for these plans, adverse selection could be extremely risky for the subspecialist. Therefore, my recommendation would be that information such as has been presented in this article is used to educate employers as to the cost of the infertility benefit. However, I see a considerable risk in small practices entering into capitated contracts to furnish the infertility benefit and I feel a better strategy would be to devise a global charge based on individual practice experience, pregnancy rate, and algorithms.

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