Nuts & Bolts of Insurance for Infertility

Insurance benefits for infertility-related medical services can be quite complex and confusing at best. But the good news is, if you have a basic understanding of infertility language and you’re prepared with the right questions to ask of your health plan, you can receive a detailed explanation of your healthcare benefits and understand how you can best manage the benefits to suit your situation.

Explanation of Benefits

The first step to understanding your benefits is to obtain an accurate explanation of benefits from your health plan’s Member Services department. Phrase the question specifically (“What are my infertility benefits?”) and know that the benefits are often described in more than one section of the plan document, i.e., “Infertility”, “Family Planning”, etc. If you sense that you aren’t receiving the “whole picture”, request that the analyst probe further into the plan description until you have all of your questions answered. Also, consider that some of the terminology within this benefit section isn’t common and it’s possible that the analyst isn’t familiar him/herself with all of the terms.

Benefit limits are typically described as follows:

a) Gynecology only

b) Infertility Diagnosis only

c) Infertility Diagnosis and Partial Treatment

d) Infertility Diagnosis and Treatment

Gynecology only benefits are the most restrictive and often provide little to no benefit for services performed at a Reproductive Endocrinology/Infertility (RE/I) practice. Health plans will request physician notes from the consultative visit and look for phrases such as “We are trying to get pregnant” or “I was referred for an infertility work-up” within the medical record and assuredly deny the claim.
Infertility Diagnosis only benefits will cover the initial and follow-up consultative visits with the RE/I provider. Services provided at the consultative level usually include medical history, female exam, transvaginal ultrasound, bloodwork and a follow-up visit about two weeks later to discuss test results and treatment options. Approximately 65% of the patients in our practice have **diagnostic coverage only**. However, within this coverage area it’s very important that you determine if you have unlimited diagnostic coverage or if coverage is limited to an initial diagnosis. For example, a year ago you underwent diagnostic testing but didn’t move forward with treatment. You’re now ready to start a treatment cycle but must first update some of your diagnostic tests. Do you have continued diagnostic coverage? Another example is a patient who went to Practice A for a consult but would like a second opinion from Practice B. Do you have diagnostic coverage with Practice B even though Practice A has submitted a diagnosis to your health plan? A majority of our practice’s patients who have **diagnostic coverage only** have unlimited coverage, but it certainly pays to know this information.

**Partial Treatment Coverage** refers in this article to a couple of scenarios. One scenario describes coverage for “surgical treatment of the underlying condition” that has caused the infertility. For example, coverage is available to surgically correct an anatomical cause of infertility, i.e., a blocked fallopian tube. The second scenario where we see partial treatment coverage is when a portion of, but not all of, a treatment cycle is covered. The most common example we see is coverage for ovulation induction as part of an intrauterine insemination (IUI) or in vitro fertilization (IVF) cycle but the actual IUI or IVF procedures themselves are not covered.

**Treatment Coverage** refers to insurance benefits for a portion or all of treatment cycles available in an infertility center. When there is insurance coverage for treatment, the analyst will be able to provide to you a very specific list of procedures and advanced reproductive techniques (ART) that are covered under your plan such as IUI, IVF, ICSI, Assisted Hatching, Donor Oocytes (eggs) and Embryo Cryopreservation. It’s common to
have infertility drug coverage for the treatment cycle for which you have coverage, but again, it pays to confirm the benefit. A word of caution, the higher levels of benefits often carry higher levels of restrictions and it’s critical that this information is clearly understood. An example of a restriction is the requirement of a “documented two-year history of infertility” by a healthcare provider. Another example of restriction is the delay of infertility benefit payment until a pre-existing condition period is satisfied. It is critical that the health plan analyst communicates any and all restrictions that may affect payment of your infertility benefits.

Where there are covered services...there are non-covered service. When you learn that your insurance provides coverage for infertility treatment, it’s important that you understand which services are carved out as “non-covered”. Non-covered services are often essential services, but either not considered “medically necessary” or may still be deemed “experimental” but governmental and other certifying bodies.

**Benefit Limitations**

Once you’ve determined that you have coverage for infertility services and that you’ve satisfied any restrictions that may apply, you should determine at what benefit level your health plan is obligated to pay. It is uncommon to see unlimited infertility benefits and we typically see benefits capped based on a couple of methods: a) dollar limit, or b) number of attempts. With dollar limits, you may have a maximum benefit in the range of $5,000 to $25,000. It’s important to know that only payments made by the health plan for infertility services will go toward reducing your dollar maximum. Essentially, your healthcare provider’s charges aren’t a component of this calculation, only the health plan’s payments. You can track payments made by the health plan toward your maximum through the Explanation of Benefits (EOBs). The EOB accompanies the payment to the medical provider and a copy is sent to the member (patient). The second method of capping infertility benefits based on number of attempts relates to treatment cycles such as IUI and IVF. An example of coverage limits defined in this way is coverage for a maximum of six IUI cycles and three IVF cycles. (In
some cases a health plan may stipulate that the IUI cycles are attempted before IVF coverage is available, but this is becoming a rarity as health plans realize that it is an inefficient course of treatment in certain situations such as tubal factor, male factor, etc.) An important consideration for benefits capped based on attempts: health plans typically define an IVF attempt as the transfer of embryo(s). Therefore, if you plan to undergo a frozen embryo transfer (FET), you should know that the FET will be counted as one of your attempts. Patients at our practice often choose to pay out-of-pocket for their FET (at 1/3 the price of an IVF cycle) and “save” that attempt for the higher cost IVF procedure that may need to be performed at a later date.

In conclusion, insurance benefits for infertility services range from restrictive to liberal and are most often determined by employers through group health plans. Human Resources representatives can also be a great resource for employee health benefit questions if you’re comfortable sharing this personal information. Comparing benefit information received from both your employer and the health plan is an excellent way of securing accurate benefit information and putting you in control of your benefits.