ENHANCING REPRODUCTIVE ACCESS: THE INFLUENCE OF EXPANDED EMPLOYER FERTILITY BENEFITS AT A SINGLE ACADEMIC CENTER FROM 2017-2021

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Background:
Recognized by the World Health Organization as a disease, infertility carries emotional and financial burdens. With treatments like IVF costing approximately $12,400, many Americans may allocate a significant portion of their annual income to a single ART cycle (1). In 1977, West Virginia set a precedent by instating an insurance mandate for third-party infertility coverage; by 1985, Maryland had passed the first IVF-specific mandate (2,3). Today, 21 states offer diverse fertility coverage levels (4). These mandates correlate with increased care utilization and improved obstetric outcome, including lower incidence of multiple births (5-6). Independent of state legislation, individual employers can provide fertility benefits. In 2019, one academic institution, in a non-mandated state, began providing up to $25,000 coverage for fertility treatment. Coverage expansion may ease financial stress and increase treatment access, specifically for patients who would not otherwise be able to pursue fertility treatment.

Objective: Our study examines demographic shifts and treatment utilization in patients seeking fertility treatment before and after implementation of an expanded fertility treatment insurance benefit at a single institution.

Materials and Methods: We conducted a retrospective chart review at a large, urban hospital from 2017 to 2021. Descriptive statistics provided an overview of the dataset. Chi-square tests were used to compare categorical data and t-tests for continuous variables.

Result(s): A total of 1607 new patients were seen from 2017 to 2021 including 382 prior to expanded fertility benefit coverage (2017-2018) and 1225 after implementation (2019-2021). Although the proportion of young patients (<37 years) remained similar after the implementation, there were a greater proportion of patients in the 38-40 year age group (12.7% vs. 17.9%) and less patients in the 41-42 year old (9.3% vs. 5.0%) and over 42 years (8.0% vs. 6.6%) (p=0.006). There were no differences in self-identified race/ethnicity between the two groups with patients most commonly identifying as non-Hispanic White (41.6% vs 39.5%) and closely followed by non-Hispanic Black (38.5% vs 39.4%) (p=0.81). After the introduction of benefits, there was a marked rise in healthcare professionals seeking services (38.7% vs 44.4%; p=0.0002). Notably, the most substantial percent increase among healthcare professionals was observed among social workers (133.3%) followed by physical therapists (120.0%) and advanced practice practitioners (44.44%). Additionally, a higher proportion of women without fertility issues sought care (16.4% vs 21.2%), specifically in the form of oocyte cryopreservation (12.2% vs 16.7%) and preconception counseling (2.4% vs 4.3%) (p=0.007). There was no difference between treatment types, including ovulation induction, intrauterine insemination, and in vitro fertilization (p=0.54).

Conclusion(s): The adoption of fertility benefits at a single institution significantly influenced patient demographics and fertility treatment utilization, highlighting that implementation of fertility benefits may improve healthcare access and empower reproductively aged women in family planning. Large employers, especially in non-mandated states, should consider adopting such benefits, as it may promote a more inclusive healthcare environment. The marked increase in healthcare professionals seeking services and the proactive engagement of women without fertility issues in family planning options underscores the importance of fertility benefits in fostering proactive reproductive health management.

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