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Comprehensive State-Mandated Insurance Coverage of Infertility Treatments in Minimum Benefits Packages of Employee Health Insurance

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Minimum benefits packages for employee health insurance plans usually only include the basic coverage necessary to survive in an attempt to control costs, similar to the new categorization of essential health benefits (EHBs) outlined in the Patient Protection and Affordable Care Act (ACA). However, in some cases, the advantages that accompany the inclusion of higher-level, more expensive services in a minimum benefits package actually lead to decreased costs over time. Coverage of infertility treatments, such as *in vitro* fertilization, is an example of a higher-level service that actually leads to lower health care costs in the long run. The decrease in cost through coverage, in turn, leads to healthier outcomes for infants born through these services and their mothers, as well as greater utilization of infertility treatment services. Universal insurance mandates covering *in vitro* fertilization should be implemented at the state level for minimum benefits packages of employee health insurance, since comprehensive coverage results in lower out-of-pocket costs, which therefore leads to lower rates of multiple births and increased utilization of infertility treatment services. As a recommendation, each state's legislation should implement insurance mandates, but these mandates should also set limits on the number of cycles of IVF performed, in order to effectively control costs, promote healthier outcomes, and encourage utilization.

The paper proceeds as follows. Section I presents the basic facts of infertility. Section II outlines the main issue of infertility treatment and its negative consequences. After describing what has been done so far to solve the problems surrounding infertility treatment in section III, I provide an explanation of the support and backlash that has been expressed regarding these solutions thus far in section IV. Section V details my own proposal for attempting to fix the problems concerning infertility treatment. Finally,

Section VI concludes the argument, and presents a potentially threatening hindrance to implementation.

I. The Facts of Infertility and Its Treatment

First and foremost, infertility is a disease, but has only recently been recognized as an affliction worthy of medical treatment (King & Harrington Meyer, 1997, p. 10). It is most commonly defined as the inability to conceive after one year of unprotected sex. The malady plagues about 7.9 million women and 3.3-4.7 million men in the United States alone (Bitler & Schmidt, 2011, p. 126; "Infertility FAQs," 2013). In addition, a woman's fertility declines as she ages, particularly past the age of 35. Infertility has unfortunately worsened in the last few decades because in today's society, women are waiting longer to have children since they are focusing more time and energy on their educations and careers. In fact, statistics show that between the years 2000 and 2008, the rates of pregnancy per 1000 women in the United States has decreased among younger women, but increased among older women. For example, the rate for ages 20-24 decreased substantially from 180.7 to 163.0. Also, for ages 30-34, the rate increased from 131.1 to 141.2, for ages 35-39, it increased from 67.5 to 78.5, and for ages 40-44, there was an increase from 15.4 to 18.8 (National Center for Health Statistics, 2012). Consequently, if a woman has issues with her fertility but does not attempt to conceive until later in life, her issues will not be discovered or diagnosed until much later. Therefore, unfortunately, the older women are when they are diagnosed, the smaller their window of opportunity is to seek treatment that will ultimately be successful.

Multiple different treatment options are available, for both male and female infertility. Moreover, there are three different levels in the hierarchy of treatments through

which couples usually progress in a set order, based on if the preceding level is unsuccessful in producing a pregnancy. In addition, as the levels increase in rank, so does the cost. Level I involves diagnostic testing, level II involves intrauterine insemination (IUI), and assisted reproductive technologies (ART), like *in vitro* fertilization (IVF), constitute level III (Bitler & Schmidt, 2011, p. 129). First, diagnostics are performed to determine what is causing the infertility. Next, in the standard sequence is IUI, the simple insertion of sperm into the woman's uterus by a clinician, without the retrieval of an oocyte (unfertilized egg). Last, ART describes any procedure in which there is a handling of egg and sperm outside of the woman's body by a clinician. ART is one of the last possible efforts that couples can make in an attempt to overcome their infertility.

In vitro fertilization is the main type of assisted reproductive technology, accounting for 96% of all ART procedures (Jain & Hornstein, 2005, p. 221). IVF is the combination of egg and sperm outside the body in a Petri dish, with the subsequent transfer of the embryo into the female's uterus. Today, clinicians wait five days after fertilization to transfer the embryo into the uterus, as opposed to only three days in the past. The justification behind this waiting period is that the identification of chromosomal abnormalities or malformation of cells is much more accurate after five days; and since clinicians have discovered that identifying and transferring only the healthiest embryos tremendously increases chances of a successful pregnancy, they now wait five days (Tarkan, 2008). In addition, IVF commonly involves the transfer of multiple embryos per cycle, and is most often performed for multiple cycles until a successful pregnancy is achieved. "163,039 ART cycles were performed at 451 reporting clinics in the United States during 2011, resulting in 47,818 live births and 61,610 live born infants," with 1% of infants born each year in the United

States conceived through ART ("Assisted Reproductive Technology," 2013). In addition, interestingly, out of all infertile couples, only 15% attempt *in vitro* fertilization or similar treatments (King & Harrington Meyer, 1997, p. 9). Although the reasoning behind this low percentage is unknown and is most likely multifactorial, there are multiple issues surrounding *in vitro* fertilization that could potentially deter or even prohibit couples from utilizing this technology.

II. The Issue of High Cost

The chief point of contention surrounding *in vitro* fertilization is its extremely high cost. More specifically, in the United States, the average cost of a single IVF cycle is $12,400, with factors like hormone drugs, oocyte retrieval procedures, and preimplantation genetic diagnosis contributing to this shockingly high price (Bitler & Schmidt, 2011, p. 129). Moreover, around 1.3 million fertility drug prescriptions are filled each year, totaling over $230 million annually (Elster, 2000, p. 617). Therefore, not surprisingly, according to Lunenfeld and Van Steirteghem (2004), the typical American couple would have to spend 25% of annual income to undergo a single IVF cycle. Furthermore, since numerous cycles are ordinarily executed in order to achieve a successful pregnancy and delivery, the average cost per successful delivery ranges from $44,000 to $211,940 (Bitler & Schmidt, 2011, p. 129). This calculation was done in 1992, so with inflation, it would be much higher in today's terms. Yet, most insurance companies do not any cover infertility treatments, especially not IVF, which is the most expensive treatment; so these costs are generally all out-of-pocket for couples trying to conceive.

Undesirable Consequences of the High Cost of IVF

The high cost of infertility treatments has two major unfavorable consequences: increased rates of multiple births and the underutilization of services.

Increased rates of multiple births. First, for IVF treatments, there is a 23.9-32% incidence of twins and a 2.4-4.7% incidence of triplets or other higher order births (Lunenfeld & Van Steirteghem, 2004, p. 323). Additionally, the twin birth rate in the United States increased by 76% between 1980 and 2009, with one in every 30 babies born a twin in 2009, compared to one in every 53 babies in 1980, mainly due to the increased use of ART (Sunderam et al., 2012, p. 9). The explanation for the increased rate of multiples among ART infants is that couples undergoing a cycle of IVF desperately want to increase their chances of becoming pregnant on the first try, without having to pay for subsequent cycles. Therefore, in order to control their costs, patients opt for the transfer of multiple embryos per cycle to heighten their chances of a successful pregnancy (Sunderam et al., 2012, p. 9). Logically, the more embryos transferred, the greater the probability of multiple births (Tarkan, 2008). This evidence suggests that fewer patients are willing to opt for elective single-embryo transfer (eSET), or single-embryo transfer (SET), in which only one embryo, which is selected as the healthiest prospect from a large number of available embryos, is transferred into the uterus. There is currently no written law outlining the precise number of embryos that should be transferred, but physicians generally discourage the transfer of a large number of embryos. The American Society for Reproductive Medicine (ASRM) does provide guidelines, however, stating that the number of embryos to be implanted is two for women under the age of 35, except in extraordinary circumstances, in which case the physician may use his or her discretion (Sivinski, 2010, p. 897). However,

the most direct way to limit the risk of multiples from ART is SET (Sunderam et al., 2012, p. 9).

There are countless reasons why the high incidence of multiple births is considered a negative consequence of infertility treatments. First, multiple births contribute to high rates of preterm and low birthweight infants. For instance, in 2005, only 9% of ART singletons, but 57% of ART twins and 95% of ART higher order multiples, were low birthweight (Sivinski, 2010, p. 900). Low birthweight leads to a variety of dangerous complications at delivery and has been linked to developmental delays later in life. In addition, in the same year, upwards of 66% of ART twins and 97% of ART higher order multiples were preterm (Sivinski, 2010, p. 900). Preterm births contribute overwhelmingly to infant mortality and morbidity, and these infants have substantially more health and developmental problems than full-term infants (Sunderam et al., 2012, p. 9). Similarly, triplets and other higher order multiples are 13 times as likely as singleton infants to die during the first year of life (Sivinski, 2010, p. 900). Further supporting this notion, IVF twins carry a higher risk of admittance to the neonatal intensive care unit (NICU) than control twins, and spend a greater number of days in the NICU than control twins (Pinborg et al., 2004, p. 438).

Next, multiple births are considered objectionable because they pose risks to the child's psycho-emotional state and cognitive functioning. In this respect, children born as multiples are at a disadvantage compared to those born as singletons, because on average, they are held less, talked to less, and touched less; and decreased contact of this type delays cognitive and language development (Lunenfeld & Van Steirteghem, 2004, p. 323). Moreover, in a study conducted in New Zealand, researchers found that by the age of eight,

very-low-birthweight infants' chances of being enrolled in special education was nine times greater that of normal birthweight infants (Elster, 2000, p. 621). This illustrates how being a multiple has detrimental impacts on psycho-emotional states and cognitive functioning of children.

An additional reason why multiple births are undesirable is because, ironically, they generate higher costs than singleton births. The cost of solely delivering multiples is estimated to be ten times the cost of delivering a singleton baby (Sivinski, 2010, p. 912). One factor that contributes to the exorbitant cost of the delivery of multiples is the high rate of Cesarean sections in IVF infants when compared to naturally conceived children, due to the increased chance of C-section when delivering multiples (Pinborg et al., 2004, p. 438). More specifically, in 2008, a vaginal delivery without complications cost an average total of $2,900 per stay, whereas a C-section without complications cost an average total of $4,700 per stay, a sizable difference (Agency for Healthcare Research and Quality, 2012). In addition, the lifetime cost of multiples to the health care system and community could amount to upwards of 100-200 times that of the costs of a singleton (Leese & Denton, 2010, p. 31) and in 2005, the estimated cost associated with preterm births in the United States was $26 billion, or $51,600 per infant born preterm (Sunderam et al., 2012, p. 9). For the most part, the cost of delivery and care of preterm and/or low birthweight multiples ends up being greater than IVF costs. As a result, couples attempting to control their costs by transferring multiple embryos per cycle actually end up having to pay substantially more for the care of multiples than they would have had to pay for the care of a singleton, defeating the purpose of transferring multiple embryos in the first place.

Finally, a compelling reason why multiple births are disagreeable is because they have serious implications on the mother's well being. In general, multiple births present the maternal risk of pregnancy-induced-hypertension, gestational diabetes, vaginal-uterine hemorrhage, and hospitalization and/or bed rest, resulting in weight loss and muscle atrophy, among many other risks (Elster, 2000, p. 619). In terms of the mother's psycho-emotional state, according to Lunenfeld and Van Steirteghem (2004), mothers of multiple children, either twins or higher order multiple births, are more than twice as likely to suffer fatigue and depression. This could potentially lead to marital problems or divorce, among other detriments. Additionally, as previously stated, multiples are at higher risk for infant mortality, which can lead to maternal bereavement, and perpetuate maternal fatigue and depression (Lunenfeld & Van Steirteghem, 2004, p. 323). Overall, it is not difficult to understand how some individuals might believe that multiple births, especially higher-order multiples, are failures rather than successes of the entire IVF enterprise (Elster, 2000, 618).

Underutilization of services. Another consequence of the high cost of treatments, in addition to the high rate of multiple births, is the underutilization of IVF, especially by minorities and low-income populations. Since treatments cost so much, the individuals who access them are primarily wealthy, highly educated Caucasian women (Jain & Hornstein, 2005, p. 222). This makes perfect sense because, as previously stated, women who focus on their educations and careers, and therefore wait longer to conceive, are more likely to employ infertility treatments. In addition, since treatments are so expensive and are paid for out-of-pocket in most cases, the wealthy constitute the segment of the population that is able to actually employ these services. Interestingly though, Black,

Hispanic, and other non-Caucasian women experience higher rates of infertility than Caucasian women do (Jain & Hornstein, 2005, p. 222-223). If these categories of women are most likely to be infertile, but are not most likely to utilize treatment services, a feasible reason is because they cannot afford treatments. This could also be the rationale behind why the percentage of infertile couples that attempt IVF is so low (King & Harrington Meyer, 1997, p. 9). Under the Americans with Disabilities Act, reproduction is considered a major life activity. The fact that some women are unable to reproduce just because they do not have adequate funds and/or insurance coverage for treatment is basically denying them a fundamental human right, which is why high levels of utilization of these services is so important (Sivinski, 2010, p. 904).

III. What Has Been Done So Far?

Unfortunately, the insurance coverage of infertility treatments in today's system is seemingly unsystematic. There is currently no federal law mandating insurance providers to cover infertility treatments, and the advent of the Affordable Care Act did little to mitigate this dilemma. Under the act, each state chooses a benchmark plan that must cover what are described as essential health benefits: basic services necessary to survive. The selected benchmark plan then acts as the model for all of the plans sold in the state insurance marketplaces. Fertility drugs and ART are not considered EHBs in most plans; but states can decide whether or not they want to include infertility treatment as a part of their state's EHBs (Cahill, 2013; Mehmud & Neiman, 2013, p. 37). Since covering these services would cost more, few insurance plans would be willing to participate, unless of course they were properly educated on the benefits of covering infertility treatments. Essentially, Obamacare hasn't done anything in terms of insurance coverage for infertility

treatments, except for the fact that it no longer allows infertility to be considered a preexisting condition and used as a basis for denying insurance (Salahi, 2013).

The ACA, nonetheless, preserves the state's autonomy in insurance regulation. Therefore, in the absence of federal compulsion, 15 states have taken notice of the high cost and inadequate coverage issues surrounding IVF. These 15 states implemented mandates on private employee health insurance to either offer or provide coverage of infertility treatments as part of a minimum benefits package (Bitler & Schmidt, 2011, p. 129-130; Reynolds, Schieve, Jeng, & Peterson, 2003, p. 16). That being said, the logistics behind which states decide to propose and pass legislation mandating coverage is essentially random. According to Lahey (2011), "states do not appear to pass infertility mandates in a manner correlated with prior fertility trends, nor does it appear that more wealthy states are likely to pass mandates first." Since the reason why certain states have these mandates and why others do not is unknown, it is particularly difficult to lobby for legislation. Furthermore, unfortunately, not all of the aforementioned state's mandates include *in vitro* fertilization, the most expensive and effective service, as part of their minimum benefits package because they believe it is too expensive. This is ironic since most of the patients that resort to *in vitro* fertilization need the most help financially. This is due to the fact that they have already spent their money on other, unsuccessful treatment options because they were unable to pay for IVF to begin with. If insurance mandates just included coverage for IVF (the most successful service) in the first place, then they would actually be saving money so patients could bypass other middleman treatments. In addition, as of July 2013, no state without an infertility mandate has chosen to now add infertility as an essential health benefit, meaning states that previously excluded coverage for infertility

treatments will continue to do so under the ACA (Cahill, 2013). Unfortunately, this data does not paint a positive picture for the future of coverage of infertility treatments by individual states with the application of the ACA.

One example of a state that has implemented universal insurance mandates to cover infertility treatments, including *in vitro* fertilization, is Massachusetts. This state is important to examine because although it only accounts for 2.3% of the United States population, approximately 10% of IVF procedures each year are performed there (Griffin & Panak, 1998, p. 27). Furthermore, according to Sunderam et al. (2012), because of comprehensive coverage, Massachusetts has one of the highest percentages of elective single-embryo transfers in ART procedures. 58.8% of ART infants born in the state were singletons, meaning that the percentage of multiples in ART infants in Massachusetts was significantly lower when compared to the rest of the United States. Attributable to low rates of multiples, only 26.0% of low birthweight infants were ART infants and only 3.9% of very low birthweight infants were ART infants, which are low percentages compared to other states. Also, only 27.6% of preterm births in Massachusetts can be attributed to ART infants, which was one of the lowest percentages of all 50 states (Sunderam et al., 2012). This data makes sense because if patients' infertility treatments are covered under mandated, universal, comprehensive insurance, then they are more likely to adopt eSET; and therefore, they are less likely to have multiples, leading to healthier outcomes, like a decreased number of preterm and low birthweight infants. Massachusetts provides clear evidence as to how increased coverage of infertility treatments leads to healthier outcomes and increased utilization.

IV. Support and Opposition of Proposed Solutions

As with any proposed legislation, there has been support, as well as backlash, surrounding the mandated coverage of ART in some states. First, in support of insurance coverage of ART, is RESOLVE: The National Infertility Association, "a national grassroots organization of 25,000 women and men, most of whom suffer from infertility problems" (King & Harrington Meyer, 1997, p. 18). This organization lobbies for state legislation for coverage infertility treatments, and has been successful, acting as a main player in getting this Illinois' legislation passed. Additionally, it seems as if people who have not experienced infertility personally would not be likely to support a mandate that could potentially raise their premiums even in the slightest. On the contrary, it has been proven that the public wouldn't mind risk pooling in the case of infertility treatments. According to research conducted by Neumann (1997), individuals were willing to pay $32 per year on average (which would be much higher in today's standards due to inflation) for a hypothetical program that would provide 1,200 couples per year in Massachusetts a 10% chance at IVF. This is a large amount to contribute per year for something that would not necessarily benefit the respondents personally, indicating that they demonstrate altruistic and supportive attitudes regarding infertility treatments. This is a hopeful notion for future legislation that would mandate the insurance coverage of infertility treatments.

On the other hand, there has been a good deal of opposition to the coverage of ART, most prominently by the Catholic Church and anti-abortion activists. These individuals are against the coverage of ART because, as a whole, it goes against the Catholic Church's advocacy of natural family planning and can, in some cases, result in the destruction of embryos that have not been used in treatment (King & Harrington Meyer, 1997, p. 19).

Similar to how there is a debate currently going on pertaining to the coverage of contraceptives under Catholic institutions' insurance plans, if all states were to implement coverage of ART, controversy would undoubtedly emerge. Also, opposition comes from adversaries who argue that it is unfair for mandates to force insurers to offer benefits for services that some of the insurees neither want nor need, and may not be able to afford (Bitler & Schmidt, 2011, p. 126). This parallels the current dialogue regarding the individual mandate of the ACA, which forces individuals to either purchase insurance or pay a penalty. These antagonists raise decent points, but in my view, the support of infertility coverage trumps the criticism.

V. My Proposal

In light of the aforementioned support and because the high cost of infertility treatments carries along with it such unfavorable consequences, I believe a solution to these problems needs to be executed, and done so expediently. My proposal to resolve the exorbitant out-of-pocket costs for couples trying to conceive would be state-mandated comprehensive insurance coverage of infertility treatments, including IVF, in minimum benefits packages for employee health insurance plans, similar to what is in place in Massachusetts. Coverage would solve the problems of high costs, and as a result, would decrease the high rates of multiple births and underutilization of services. First, if insured patients are not burdened with large out-of-pocket expenses, they have less financial pressure to conceive in fewer cycles, and therefore less incentive to transfer multiple embryos per cycle (Sivinski, 2010, p. 907). This results in an increased rate of eSET, therefore a decreased rate of multiples, which leads to healthier outcomes in ART infants and mothers, as well as a decreased cost of delivery and care after birth for ART infants.

More specifically, since the cost of lifetime care for multiples typically outweighs the cost of IVF procedures, then increased coverage for infertility treatments, resulting in less multiple births, would actually decrease health care costs to the insurance providers overall and over time (Sivinski, 2010, p. 913). In addition, through reducing cost, insurance coverage of these types of services would increase access for, and therefore utilization by, minorities and low-income individuals in particular, who suffer most frequently from infertility. For instance, it has been shown that for low-income individuals, having insurance significantly decreases the likelihood that they will forgo treatment (Staniec & Webb, 2007, p. 984). Moreover, even just a 10% decrease in cost would increase utilization by 30% in total (Lunenfeld & Van Steirteghem, 2004, p. 323).

One pitfall of my proposal would be a necessary limitation on the number of treatment cycles that infertile couples would be permitted to utilize under insurance coverage. Without putting a cap on the number of cycles, patients could technically utilize an unlimited amount, known as moral hazard, which would obviously have a significant negative impact on cost. A solution to this issue would be to put the covered number of cycles on a sliding scale depending on the woman's age and severity of infertility. Hamilton and McManus (2012) describe how, in the current insurance system, the number of embryos transferred is most commonly placed on a sliding scale, depending on level of infertility, with couples experiencing the lowest natural fertility transferring a greater number of embryos. Since my proposal discourages transferring multiple embryos, I would include a sliding scale, but pertaining to number of cycles (not number of embryos transferred) and base it on a combination of severity of infertility and maternal age (not just level of infertility). Although the general idea for my proposal is based off of the

Massachusetts plan, this particular dimension is opposite of what is outlined in its mandate. In Massachusetts, there is no limit on the number of treatment cycles that patients may undergo, and patients do not have a dollar lifetime cap on infertility expenditures ("Insurance Coverage in Your State," 2013). This standardized sliding scale that would be used by clinicians in my proposal would rule out the issue of patients attempting to transfer an increasing amount of embryos as their number of cycles runs out.

Just as there has been an expression of disapproval of infertility mandates that are in practice so far, there would most likely be opposition to my proposal as well; but I believe that these dissenters' arguments are weak. In response to opposition, King and Harrington Meyer (1997) propose two compelling arguments. First, in reply to the argument that cost being distributed to all individuals, some of whom cannot afford it, is unreasonable, they describe how after the state mandate was established in Massachusetts, the cost per family per month was only $1.70, $1.00 in Maryland, and just $.060 in Delaware, which are negligible amounts. Neumann (1997) supports this argument, noting that even with large utilization increases, premiums would not increase that much because of the very small percentage of the population that actually makes use of IVF services. Basically, this means that even though utilization would be expected to increase with the advent of insurance coverage, the percentage of the general population that would be employing these services would remain minor. Second, in terms of individuals not needing the infertility treatment services and therefore not wanting to pay for them, King and Harrington Meyer (1997) posit that the costs of pregnancies and deliveries under insurance coverage have been spread across both fertile and infertile families alike, so it only makes sense that the costs of infertility be spread as well. This notion is further

supported by the previously described study that explains how people have particularly altruistic and supportive views regarding risk pooling in the case of infertility services. Most individuals, therefore, do not actually have the attitude of not wanting to pay for infertility treatment services if they do not need or utilize them; in fact, they wouldn't mind contributing a small amount to pay for these services for others, just as they currently don't mind having to pay for the costs of others' pregnancies and deliveries. Also, if the Affordable Care Act forces individuals to purchase insurance or pay a penalty and was still passed into law, then insurance companies can surely oblige individuals to pay a few extra dollars for the coverage of infertility treatments. Overall, the opposition to insurance mandates covering *in vitro* fertilization provides weak evidence that can be easily challenged; whereas the strong support for and significant benefits of ART exemplify that these state mandates should most definitely be implemented.

VI. Conclusion

Essentially, multiple births and underutilization of infertility treatment services have emerged as particularly unfavorable effects of the high costs of these treatments, specifically IVF. Multiple births are considered to be negative consequences because of their detrimental results, including low birthweight and preterm infants, impaired psycho-emotional states and cognitive functioning of infants, maternal health risks, and increased short-term and long-term general costs of care. Underutilization of services is also considered to be undesirable because reproduction is a major life activity and basic human right; and those who have the highest risk of infertility most often have the least financial ability to utilize these services on their own, and consequently have the least access to care, basically denying them a core human right.

With the mandated insurance coverage of infertility treatments in my proposal, though, the issues of multiple births and underutilization can be resolved. The high rates of multiple births as a result of ART would decrease because more individuals would be willing to participate in eSET, therefore leading to healthier outcomes and decreasing costs even further. Utilization would increase if insurance companies ameliorated the financial burden on minority and low-income infertile couples, without significantly increasing premiums. I propose the implementation of these state mandates, with the limit on the number of covered cycles to avoid moral hazard and careless spending. The strong support and weak opposition of coverage of IVF indicates that this proposal could potentially be successful.

In spite of the aforementioned support, there is one major roadblock to a proposal like this one being implemented in states that do not already cover infertility treatments, and it is a ramification of Obamacare. As expressed by the ACA, any insurance plans with state-mandated insurance benefits added after December 31, 2011 will not be grandfathered into the new system, and therefore will not be subsidized by the federal government as a part of the essential health benefits starting in 2014 (Cahill, 2013). This means that if a state that does not currently have an insurance mandate attempts to legislate one, it will not do anything to help anyone. No insurance provider wants to have its federal subsidies taken away by changing their plans after 2011, which would inevitably lead to much controversy and hostility. Unfortunately, despite the demonstrated benefits and support of state-mandated universal coverage of infertility treatments, specifically *in vitro* fertilization, in minimum benefits packages of employee health insurance, it does not

seem likely that this advancement will be made in the near future, especially not if Obamacare is fully and successfully implemented.

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