Consistency in Insurance Coverage for Iatrogenic Conditions Resulting From Cancer Treatment Including Fertility Preservation

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INTRODUCTION

Insurance companies generally cover treatment for iatrogenic conditions that result from cancer treatment, including treatment for conditions that may be considered elective when "naturally" occurring (note that in this article, I am using the word "iatrogenic" to refer only to nonnegligent treatment-induced conditions). One notable exception is fertility preservation for iatrogenic infertility. In this brief article, I argue that for insurance companies to maintain consistency, they should cover fertility preservation treatment for female patients with cancer because it does not differ significantly from other treatments for iatrogenic conditions they currently cover for women, such as breast reconstruction after mastectomy and wigs for alopecia. (Although my focus in this article is on female fertility preservation, one could presumably make a similar argument that male fertility preservation should be covered by insurance.)

One reason many insurance companies refuse to cover fertility preservation treatments, and infertility treatments more generally, is that they are often viewed as elective procedures, not medically necessary ones. When it comes to iatrogenic infertility, however, the controversy over whether fertility preservation is a medically necessary treatment should be moot because other so-called elective procedures are covered when they are iatrogenic, even if they are not covered when naturally occurring. Because my focus is on iatrogenic conditions—many of which, as I will discuss in this article, are generally not considered medical conditions when they are not iatrogenic—I put aside the debate about whether infertility should be classified as a "real" disease. One example of an iatrogenic condition typically covered by insurance is breast reconstruction after lumpectomy or mastectomy. Although having only one breast is rarely, and perhaps never, a naturally occurring condition, naturally occurring breast asymmetry is quite common. Most would not classify breast asymmetry as a medical problem that insurance should cover. However, when breast asymmetry results from a lumpectomy, surgery to achieve symmetry is usually covered regardless of whether the patient had symmetric breasts beforehand. This discrepancy in coverage between iatrogenic and naturally occurring breast asymmetry can be explained, at least in part, by looking at the harm principle through the lens of responsibility: because members of the medical profession caused the harm—something they are not supposed to do—the medical profession as a whole must take responsibility for mitigating the harm. (Another factor is the static understanding of the body that dominates medicine and science. Briefly, this is the idea that the body stays the same over time and disease is aberration that must be eradicated to restore the body to its natural and "normal" state. See Eckenhower1 for a discussion of how this static understanding of the body has lead to women’s exclusion from clinical research trials.)

Certain acts and laws were passed to institutionalize the medical realm’s responsibility for iatrogenic harms. For instance, the Women’s Health and Cancer Rights Act, which was passed in 1998, mandates that if health insurance companies cover the costs of mastectomy for cancer patients, then they must also cover the costs of breast reconstruction for mastectomy patients.2 Health care providers and insurance companies sometimes assume responsibility for iatrogenic harms by the way they code for billing. For example, breast reconstruction surgery after a mastectomy is coded as cancer treatment rather than under elective treatment. By allowing treatments for iatrogenic conditions to be subsumed into the larger category of disease treatment, insurance companies are tacitly accepting financial responsibility to cover these treatments. In addition to breast reconstruction surgery, there are other treatments that may not be covered by insurance when the disease is naturally occurring (in part because treatment is not seen as medically necessary), but are covered when iatrogenic; for example, wigs after cancer treatment are usually covered, whereas wigs for thinning hair or cosmetic reasons often are not.

The same pattern of insurance coverage exists in the fertility/infertility realm. Many insurance companies do not cover infertility or fertility preservation treatments for some of the following reasons: in/fertility treatments are experimental, they do not treat an underlying disease but rather produce a desired outcome (ie, a child), and they are an elective procedure, not a medical one.3 An exception to the lack of coverage is iatrogenic infertility. Although no formal studies have been done, there is anecdotal evidence that insurance companies will sometimes take financial responsibility for iatrogenic infertility. At the Northwestern University branch of the Oncofertility Consortium (www.oncofertility.northwestern.edu), a national, interdisciplinary initiative designed to explore the reproductive options for patients diagnosed with cancer or other serious diseases, female patients with cancer have the option to chose a fertility preservation method—embryo, egg, or ovarian tissue cryopreservation—before beginning cancer treatment. These fertility preservation treatments have been billed under a primary diagnosis of cancer and a secondary diagnosis
that the American Society for Reproductive Medicine still defines egg
covers experimental procedures. Although it is true
experimental procedures and insurance companies rarely, and per-
these fertility preservation methods for patients with cancer because
not be different.4

Some may argue that insurance companies should not cover these
treatment preserves for patients with cancer because this
terms yield infertility rates of 80% or more. Indeed, some
treatment—these patients have a reserve of gametes to use to have
treatment—these patients have a reserve of gametes to use to have
that would not be covered when naturally occurring (eg, breast sur-
and dental evaluations for osteoradionecrosis. Another example that
is more analogous with fertility preservation that providers sometimes
in case of an emergency transfusion. Those who seek fertility preserva-
treatment are similarly motivated as those who store blood: in a
—patients find themselves infertile after cancer treatment—these patients have a reserve of gametes to use to have

Although treatment for most iatrogenic conditions generally oc-
covers very soon or immediately after cancer treatment, in the case of
fertility preservation, frozen embryos, eggs, and ovarian tissue may not
in treating infertility is an unfortunate inevitability. Although it
is difficult to precisely predict one’s chance of infertility, some treat-
that the biologic father could oppose transfer. As a

Second, patients with cancer do not meet the definition of infer-
tility. When insurance companies cover infertility treatment, it
generally only applies to those diagnosed as infertile, which usually
that women's gendered body and identity. Women without certain
gender markers, like breasts or head hair, often feel less feminine,
which affects their sense of self and quality of life. Moreover, others in

Fifth, fertility preservation treatment is inherently more socially
and ethically complex because it not only affects the individual patient,
but it also involves and impacts her current or future partner, as well as
her family (eg, her parents, children, and so on) and future offspring,
ways that treatment for other iatrogenic conditions does not. Al-
though fertility preservation treatment is indeed more socially and
ethically complex, I do not think this difference is pertinent to discus-
sions of insurance coverage. Insurance companies often cover socially
and ethically complex procedures outside of assisted reproductive
technology (ART), including corrective surgery for intersex infants,
fetal surgery, and genetic testing for hereditary diseases. The social and
ethical complexity of the treatment should not factor into coverage
decisions, though it may be an indicator that patients need extra
counseling before making treatment decisions.

In short, fertility preservation treatment for patients with cancer
does not differ in morally significant ways from treatments for other
iatrogenic conditions that are currently covered by insurance and thus
its exclusion from insurance coverage is unjustified. As the field of
oncology continues to develop and fertility preservation options
continue to progress, insurance companies will increasingly be con-
fronted with how to handle iatrogenic infertility for patients with
cancer. I have argued that insurance companies should, for the sake of
consistency, cover fertility preservation treatment for patients with
cancer. Given the controversy surrounding reproductive technolo-
gies, this suggestion may be met with fierce opposition. However, it is
time for insurance companies to stop relegating reproductive technolo-
gies to a separate realm outside of “real” healthcare, especially when
they cover treatment for conditions that are similar to infertility. The fact that insurance companies have begun covering fertility preservation treatment for patients with cancer gives hope that fertility and infertility treatment is finally being taken seriously by insurance companies. Yet this coverage is done secretly on a case-by-case basis rather than with a blanket policy, which implies that insurance companies are still not ready to publicly assume financial responsibility for iatrogenic infertility (M. Gerrity, personal communication, June 2009).

Perhaps a state or federal mandate, modeled after the Women’s Health and Cancer Rights Act, is necessary for insurance companies to begin openly and universally covering treatment for iatrogenic infertility. On the patient level, a mandate would open the door for more discussions between patients and providers about fertility preservation treatment. According to recent studies, more than half of female and male patients with cancer of reproductive age have no memory of discussing fertility during their initial oncology appointments. For those patients who did have such discussions, many were dissatisfied with both the quality and the amount of information provided. Educating providers about ART is key to engendering fertility discussions. However, it may not be enough. Some providers do not discuss infertility because they believe their patients will not be able to afford ART. A mandate for coverage of iatrogenic infertility would alleviate this concern, thereby propelling providers to talk about ART with patients of all socioeconomic statuses. Indeed, a mandate would provide greater ART access to patients from lower socioeconomic backgrounds, to patients without insurance, and/or to patients who do not have patient advocates to help them secure funding for this technology.

On the broader social level, a mandate would symbolize recognition of the importance of fertility for patients with cancer; it would acknowledge that fertility preservation, just like breast reconstruction after mastectomy, is a significant quality-of-life issue for patients with cancer. Moreover, such a mandate would move away from many insurance companies’ classification of ART as so-called boutique medicine rather than understanding infertility as a serious disease worthy of medical treatment. Although there is a growing consensus among health organizations (including the US Centers for Disease Control and Prevention and the WHO) and medical professionals that infertility is a disease as well as a public health matter, many insurance companies treat ART like they fall outside the scope of real medicine. Currently, 14 states have some type of ART mandate. State mandates specifically for iatrogenic infertility could serve as a stepping stone toward state mandates for infertility more generally.

**AUTHOR’S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST**
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**REFERENCES**

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