

Octomom and Multi-fetal Pregnancies: Is the Insurance Industry a Co-Conspirator?

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I. INTRODUCTION

When Nayda Suleman delivered octuplets in January of 2009, the 33 year- old single mother caused quite a stir.¹ The media dubbed her “Octomom”² and internet bloggers posted questions and comments about how this woman, who already had six children, could now nurture and care for fourteen children under the age of seven.³ Octomom delivered her babies nine-weeks early and each of them needed intensive care.⁴ The octuplets, as well as her six older children, were a result of in vitro-fertilization.⁵ Is the insurance industry a co-conspirator in the strange case of Octomom?

While the goal of in vitro fertilization is to produce a healthy baby, a negative side effect of the procedure is often multi-fetal pregnancies. The rates of twins, triplets, quadruplets and even higher order births are higher when a woman uses in vitro fertilization than when a child is conceived naturally.⁶ The impact of such multi-fetal pregnancies does not just affect the mother and her children; it affects all of society. In the case of extreme multi-fetal pregnancies like Octomom’s pregnancy, hospitals are generally not able to recoup the costs associated with the pregnancy and delivery of the resulting babies. Even in the case of twins and triplets, multi-fetal pregnancies tend to result in premature births, and as a result of being born underweight and underdeveloped, many of the babies have long term physical or mental disabilities.⁷ Treatment for such disabilities is often covered through insurance or social programs such as Medicaid. Thus, all of society bears the costs for multi-fetal pregnancies either through increased insurance premiums or tax payer funded programs.

The Octomom saga brought to the public’s attention the fact that the fertility industry is largely unregulated. Many individuals have questioned how and why so many embryos were transferred into Octomom.⁸ Critics of Octomom point to the fact that the American Society of Reproductive Medicine and the Society for Reproductive Technology have issued guidelines for fertility treatments, including guidelines as to the number of embryos that should be transferred into a woman to complete a cycle of in vitro fertilization. However, these industry guidelines are not rigid. There are no mandates for physicians to comply with the guidelines and there are no real penalties for physicians who do not comply with those guidelines.⁹ Some have suggested

¹ Ashey Surdin, *Octuplet Mother Also Gives Birth to Ethical Debate*. The Washington Post, February 4, 2009, at C01.

² Id.

³ <http://www.momversation.com/episodes/nadya-suleman-octomom> “Should We Judge Nadya Suleman, ‘Octomom’” (last visited September 15, 2009)

⁴ The Cost of Making Babies, blogs from CNN.com <http://ac360.blogs.cnn.com/2009/02/02/octuplets-the-cost-of-making-babies/> (last viewed September 15, 2009)

⁵ Id.

⁶ Id.

⁷ Id.

⁸ Dr. Kamrava transferred six embryos for implantation. Two of the embryos split and Octomom delivered eight babies. According to Octomom, he transferred the same number of embryos in each of her previous pregnancies. Such transfers produced four single pregnancies and one set of twins.

⁹ http://www.asrm.org/Media/Practice/Guidelines_on_number_of_embryos.pdf

that legal action against her physician is warranted. However, Octomom's physician was not an outlier. Recent data suggests that many physicians and fertility clinics do not follow the industry guidelines. Furthermore, there may even be an incentive for them to ignore the guidelines. The insurance industry is a co-conspirator with respect to this conduct.

Although most health insurance plans provide coverage for birth control, abortion, sterilization, and male enhancement, they do not cover in vitro fertilization or other fertility treatments.¹⁰ Since many families often take out loans or second mortgages to fund in vitro fertilization, physicians may transfer larger numbers of embryos for implantation in order to bolster the patient's chances for a successful pregnancy. Without insurance coverage, there is no incentive for either physician or patient to transfer fewer embryos. The end result is an increase in multi-fetal pregnancies.

In addition to the increase in multi fetal pregnancies, the other negative effect of a lack of insurance coverage is that all infertile individuals do not have access to in vitro fertilization. The cost of one cycle of in vitro fertilization is approximately \$12,400.¹¹ While the clinical rate of a successful pregnancy is dependent on many factors, most women require more than one cycle of in vitro in order to have a successful pregnancy.¹² It is an expensive out-of-pocket procedure. As a result of the lack of insurance coverage, middle class college educated Caucasian women utilize the procedure at a higher rate than any other group.¹³ Infertility affects all ages, ethnic backgrounds, and socioeconomic groups, and in vitro fertilization should be available to all of the groups. To deny younger women, women of color, and women who are not upper middle class the benefit of in vitro fertilization effectively denies them the ability to procreate.

In this paper I argue that there should be Federal legislation to mandate insurers to cover in vitro fertilization. Not only would such legislation help reduce the incidence of multi-fetal pregnancies, it would also make the procedure a viable option for several economically disadvantaged individuals and ethnic minority individuals who are now, for the most part, unable to utilize the procedure. After Octomom, critics suggested that there may be a need for a regulatory agency to oversee the fertility industry. A federal mandate requiring insurers to cover in vitro fertilization would eliminate the short term need for such regulatory agency because such mandate would provide strength to the industry guidelines.

Data from other countries that provide insurance coverage for in vitro fertilization shows that such countries have lower rates of embryo implantation and lower rates of multi-fetal pregnancies than the United States, where there is not mandatory insurance coverage.¹⁴ Data from states in the United States where insurance companies provide coverage for in vitro fertilization also indicates lower implantation rates and multi-fetal pregnancies, even though

¹⁰ <http://online.wsj.com/article/SB10001424052970203863204574346833989489154.html#articleTabs%3Darticle>

¹¹ www.asrm.org (This amount includes lab screenings for both parents, ultrasound and labwork, egg recovery, embryo transfer)

¹² <http://www.jonesinstitute.org/ivf-success-rates.html>

¹³ Mary Lyndon Shanley. *Involuntary Childlessness, Reproductive Technology, and Social Justice: The Medical Mask on Social Illness*. Signs: Journal of Women in Culture and Society 2009, vol. 34, no. 4

¹⁴ Doctors Perform More IVF Treatments, But Multiple Births Decline. (in vitro fertilization treatment) Women's Health Weekly August 09, 2001 http://www.accessmylibrary.com/coms2/summary_0286-776742_ITM

there are loopholes in the all of the state legislation. One of the main reasons for the lower rates of multi-fetal pregnancies is that there is no incentive for a physician to transfer more than two or three embryos per in vitro fertilization cycle if their insurance carrier will not reimburse them. Additionally, when a patient can rely on insurance rather than out of pocket funds, she is more inclined to accept the physician's decision to transfer fewer embryos because she can try again if the cycle is unsuccessful. The additional attempt is not so daunting if the individual patient does not have to finance the procedure with out-of-pocket funds. If insurance covered in vitro fertilization, neither physician nor patient would have an incentive for wayward conduct and the rate of multi-fetal pregnancies would decline. Also, insurance coverage would allow younger women, women of color, and less economically advantaged women to have the same access to the procedure.

Although insurance coverage will not fix all of the complex issues associated with in vitro fertilization, it can have a positive effect on the largest problem -- multi-fetal pregnancies. The coverage will probably not cost the insurance industry any more money. A standard maternity benefits package includes coverage for labor and delivery, regardless of the number of children. Those costs are significantly higher for multi-fetal pregnancies than they are for single birth pregnancies. Furthermore, the largest risk factor of multi-fetal pregnancies is pre-term delivery. Preterm babies often have long term health needs that are usually covered by insurance. The federal mandate will ultimately promote healthy single birth pregnancies, and open access to the procedure to groups who have traditionally not had the means to pursue it. The benefits are accomplished without complex federal legislation and regulatory bodies.

In Part II, I will discuss the use of in vitro fertilization as treatment for infertility. I will address the problems and costs associated with in vitro fertilization and offer that one solution to the problems associated with in vitro fertilization is to mandate that insurers provide coverage for the procedure. Part III addresses why a Federal mandate is necessary. I suggest that state regulation is inadequate as I analyze the statutes of the few states that address the issue. I also address the ERISA loophole that exempted self funded insurance plans from state the mandates on insurance providers. I also address why courts have been ineffective with respect to the issue. In Part III, I review the Family Building Act of 2009, legislation that has been introduced in the House of Representatives by Congressman Anthony Weiner¹⁵ and in the Senate by Senator Kirsten Gillibrand.¹⁶ The companion bills require insurers to provide coverage for in vitro fertilization. I compare legislation to the Drive Through Maternity Benefits legislation that passed in the 1990's. I conclude that that a federal mandate is simplest and most effective way to curb multi-fetal pregnancies and promote healthy single baby pregnancies.

¹⁵ H.R. 697 (Introduced January 26, 2009)

¹⁶ S. 1258 (Introduced June 15, 2009)