EDITORIAL

Be Aware of the Second Revolution: The Need to Expand the Market for Infertility Services and How to Do It

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Infertility services in the United States are more costly than in most other developed nations. This seems due principally to higher provider costs, higher facility charges, and higher medication costs. Higher facility charges, endemic to the United States (1), have been addressed by many infertility providers by moving fertility services out of overhead-burdened hospitals into freestanding facilities. Higher medication costs in the United States are difficult to defend if one considers that basically only a very small number of pharmaceutical manufacturers control the fertility market and sell the same products at greatly divergent prices inside and outside of the United States. The recent entry of more manufacturers into the U.S. market makes it likely, however, that discrepancies in medication costs between the U.S. and other markets will narrow as competition within the United States heats up.

This leaves provider costs as the last component of higher overall treatment costs for fertility services. Like hospital costs, provider costs in the United States are in all medical fields higher than in most other developed nations. They also vary greatly within the United States (2) and are thus both cause and reflection of an overall more expensive health-care system, characterized by such uniquely American cost features as high malpractice insurance costs, disproportionate administrative costs (3), and more detailed regulatory mandates, in addition to, at times, higher physician charges.

While the U.S. health-care system is in the midst of a gigantic effort of cost reduction, this effort extends principally only to services covered by third-party payors. Because infertility services in all but a few states are generally not covered by standard medical insurance products (or at most only to a limited extent), their cost structure has often not yet been exposed to cost pressures similar to those of other medical specialties.

Infertility services in many, if not most, states, therefore, represent electively covered services, principally available only to a more affluent clientele. It has been estimated that only approximately one-third of couples with infertility currently receive infertility therapy. In fact, a recent study suggested that only 24% received "specialized care" (4). One can easily assume that a vast majority of those who are not in treatment have chosen not to pursue fertility care because they simply cannot afford it. This assumption is supported by observations in Illinois and Massachusetts, two states with the most far-reaching insurance mandates, which have clearly demonstrated that the availability of insurance coverage expands the patient population seeking to enter infertility care (5).

There is a simple economic message in all of this: Infertility care currently represents a product that is unaffordable to a large majority of this product's potential market. Product manufacturers face this problem all the time and usually balance their pricing strategies accordingly. There are basically two options. (a) The manufacturer sets a high price, unaffordable to many potential customers. If this option is chosen, the product will appear "exclusive" and will have low market penetration. (b) Alternatively, the manufacturer will set a much lower price, with the anticipation that lower profit margins per unit sold will be made up by a larger

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volume. From this approach comes a much wider market penetration.

It would seem that, as physicians, we have an ethical obligation to offer medical services that are not affordable only to the rich. Our efforts should, therefore, be directed at developing means to offer fertility services that are affordable not only to the affluent but to a majority of eligible patient couples. By being successful in such an effort, we would expand the market for fertility services dramatically and, as discussed in pricing option b, be able to compensate with increasing volume for decreasing profit margins. Illinois and Massachusetts have already demonstrated the economic viability of such a concept. In these two states average costs for fertility services have greatly decreased since insurance mandates were introduced. In order to deal with decreasing reimbursement rates in an economic fashion, both of these markets have seen considerable consolidation among providers, which, in turn, has allowed for a more cost-effective provision of care. A much larger proportion of patients in these two states now receives infertility care at much lower unit costs. However, because of the market expansion, cost-effective providers are still earning a respectable upkeep.

In Illinois and Massachusetts this process was driven by third-party payors. There is, however, no reason we as providers could not duplicate the process in nonmandated states. If we want to bring our medical services to more patients, we have to make them more affordable. As baby-boomers move beyond their reproductive years, the market for fertility services will probably shrink unless we succeed in expanding the market by making our services affordable to more people (6,7).

It seems unrealistic to expect that the current political landscape will allow for more legislative insurance mandates. I also believe that our hope for increasing voluntary coverage of infertility services by third-party payors may have been too optimistic. The recently announced withdrawal of voluntary coverage by Aetna/U.S. HealthCare, one of the pioneers of such voluntary coverage, can be seen as an ominous sign and the beginning of a reversal of a very promising trend (A. N. Cohen, personal communication). Consequently, if we as providers do not take steps to enlarge the market for our product, we will find ourselves increasingly in less competitive markets and shrinking ones on top of it. Economics 101 tells us that the one place no business wants to be is in a shrinking market.

So what can we do to enlarge the market for infertility services? First, we have to define how to provide

infertility services in the most cost-effective way. And, while this by itself may appear to be an almost-impossible task, it is my belief that there are now enough data available at many of the larger fertility centers to establish the most cost-effective algorithms for at least a majority of clinical infertility situations.

The cooperation of the pharmaceutical industry in this process would also be of crucial importance. Their interests would be well served if the fertility market could be further developed. In developing a competitive cost structure for fertility services, the pharmaceutical industry should, therefore, be encouraged to narrow the cost gap for U.S. consumers, who currently still pay much higher prices than patients elsewhere.

A reasonable cost structure alone is, however, not enough to enlarge the consumer market for fertility services. It is one thing to buy a product at a predetermined and acceptable price and it is a very different thing to be asked to purchase a product at an undetermined price, with nobody even guaranteeing final delivery. It is the latter kind of purchase we expect the infertile couple to make.

Ethical guidelines for the medical profession are currently not supportive of outcome-dependent payment schedules. In fact, the marketing of "money-back guarantees" by some providers of fertility services has been severely criticized by the American Medical Association and other professional organizations (8). Outcome-dependent payment schedules have so far only been used in conjunction with assisted reproductive technologies. Their criticism, at least in large part, comes from the assumption that patient selection in such programs unfairly discriminates against many often unknowing consumers.

Much less criticism would be encountered if at least a limited outcome guarantee could be extended to the whole infertility population within a practice area. This is, in fact, possible.

One can assume a scenario in which, within a well-defined practice market, the average cost (plus reasonable profit) for 1 year of infertility care is defined. Fertility practitioners in this market offer the local patient population 1 year of unlimited infertility care in return for a written commitment by the patient to pay a preset amount for 1 year of fertility services into a central "fertility account" (FA). Patients are free to select a physician of their choice among participating providers for their fertility services. That practitioner then receives monthly payments from the FA.

Some patients will conceive quickly and the practitioner will thus receive a windfall because payments will continue for a full year. Others will not. Overall,

as is also the case with an outcome-dependent payment schedule, patients who quickly conceive subsidize the care of those who do not conceive. Actuarially, patients are asked to pay well-defined case rates for their care—not dissimilar to the format of episodic care reimbursement initially pioneered by U.S. HealthCare after a model developed by A. N. Cohen (9). In contrast to currently offered outcome-dependent payment schedules, this kind of program does not discriminate against patients and does not selectively drive patients toward assisted reproductive technologies. Instead, it encourages the responsible and cost-effective use of resources, with only one goal in mind: the establishment of pregnancy.

Another way of looking at this is that patients basically purchase their own “infertility insurance.” As with the ability to purchase selective dental or optometric coverage, this kind of “insurance” arrangement obviously adversely selects patients with very high utilization, in contrast to standard insurance products. This kind of selective enrollment could, however, easily be calculated into the relevant actuarial cost structures and could, in fact, even be expanded into a separate, true insurance product that could be offered to employers—similar, again, to dental or optometric addenda to traditional insurance products.

Patient advocates like Resolve, professional organizations like the American Society of Reproductive Medicine, and individual practitioners have made an admirable effort to expand routine insurance coverage to infertility services. This effort should continue unabated.

At the same time, it behooves us and them to recognize that a rapid expansion of insurance coverage to infertility services seems increasingly unlikely. Consequently, it is up to all of us to develop a system that expands infertility care beyond only the well-to-do

and, by doing so, expands the market for infertility services.

Only a greatly expanded market can reduce the unit cost for fertility care to a level that is affordable to a couple with an average income. We have an ethical obligation to bring the practice of fertility care to this point. Our self-interest mandates it as well, because otherwise we will find ourselves in a shrinking medical marketplace, overpopulated by fiercely competitive and unhappy practitioners.

It is a widely heard cliché that we live in the midst of a health-care revolution. A prominent health-care economist recently said that every revolution is followed by a second revolution and that it is this second revolution that usually creates the lasting facts on the ground. This second revolution is still upon us. History also tells us that this second revolution consumes the offspring of the first. We had better be ready!

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