Fertility Within Reach
ADVOCATING FOR FERTILITY HEALTH BENEFITS

May 5, 2021

Committee on Health Coverage, Insurance and Financial Services
% Legislative Information Office
100 State House Station
Augusta, ME 04333

Re: LD 1539, An *Act to Provide Access to Fertility Care*

Dear Senator Heather Sanborn, Representative Denise Tepler, and members of the Committee on Health Coverage, Insurance and Financial Services,

My name is Davina Fankhauser, founder of a non-profit organization, Fertility Within Reach, dedicated to providing evidence-based information to policymakers in hopes of improving access to appropriate fertility healthcare.

Since working on updating the infertility mandate in Massachusetts (MA) in 2010, I have provided educational tools, resources and data in states including Maine (2011), Connecticut, Rhode Island, and New Hampshire. Through these experiences and more, I've identified two assumptions related to fertility insurance coverage: infertility is an emotional issue and all mandates are a burden to the population.

This letter will share facts to aide your decision-making and to respectfully urge you to **vote Ought to Pass on LD 1539, An *Act to Provide Access to Fertility Care*.**

There is a misconception that infertility is solely an emotional issue that deserves sympathy. In reality, Infertility can cause life-threatening illnesses such as miscarriage, conditions that strangulate the bowel, and ectopic pregnancies from tubal disease. Denying people immediate care can delay access to treatment until the patient is 35 and older which puts them into a high-risk pregnancy category that is associated with preeclampsia, gestational diabetes, gestational hypertension, and premature labor.

The American Medical Association is one of multiple medical organizations to define infertility as a disease of the reproductive system[1]. The United States Supreme Court identified infertility as a disability (Bragdon v. Abbott, 1998)[2]. Subsequently, district courts followed by saying if there was treatment to overcome your disease, you were no longer considered disabled. Unfortunately, most patients cannot afford the out-of-pocket health care expenses. It is access to fertility treatment that will help Maine residents beat their disease and overcome their disability. This action can help employers, as well as residents.

Fortunately, only 3% of fertility cases require Assisted Reproductive Technology such as in vitro fertilization (IVF)[3]. That means more than 90% of fertility healthcare is addressed with medications and/or surgeries. Historically, the costs associated with fertility treatment are assumed to be cost prohibitive. One reason is because insurers create their own analysis which also takes into account expenses beyond the fertility treatment. Some insurers add in the use of

maternity benefits. However, unless the insurers removed the percentage of infertile population from their projections related to maternity benefits, maternity should not be counted in relation to fertility insurance coverage. To do so would be calculating this population twice.

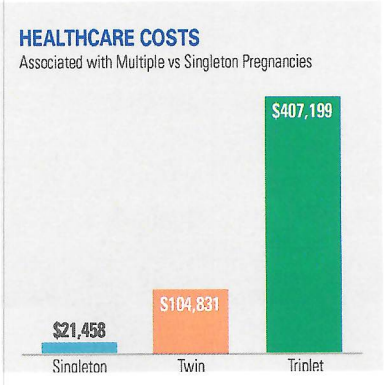
Consistently, mandate benefit reviews and actuary studies have shown insurance coverage for the diagnosis of infertility, fertility treatments, and fertility preservation, which include necessary medication, show the impact as 1% or less toward the total premium cost of healthcare. This year, for proposed legislation, Tennessee completed a Fiscal Review using facts, research and information **provided by insurance carriers** to determine costs to the state: $0.90 PMPM or $10.80 PMPY[4]. These results are in line with other states offering these benefits[5,6,7].

Fertility health benefits allow patients to make healthcare decisions based on sound medical

COMPARISON OF FIVE STATES WITH FERTILITY CARE INSURANCE LAWS

STATE	INSURANCE COVERAGE	COST IMPACT
MASSACHUSETTS *Established in 1987 Updated in 2010*	Diagnosis and treatment of infertility. Most insurers voluntarily offer fertility preservation.	<1% total premium cost (0.12%-0.95%)[30]
CONNECTICUT *Established in 1989 Updated in 2017*	Diagnosis and treatment of infertility, as well as fertility preservation.	<1% total premium cost (0.9%)[31]
RHODE ISLAND *Established in 1989 Updated in 2017*	Diagnosis and treatment of infertility, as well as fertility preservation.	<1% total premium cost (0.36%)[32]
DELAWARE *Established in 2018*	Diagnosis and treatment of infertility, as well as fertility preservation.	1% total premium cost
NEW YORK *Established in 2019*	Diagnosis and treatment of infertility, as well as fertility preservation.	1% total premium cost

advice, rather than financial concerns. Research shows patients in states without insurance coverage, who require IVF, transfer more embryos to increase their statistical chances of successfully bringing home a healthy baby[8]. Many who cannot afford treatment hope for multiples, so they only have to pay once to build their family. Additionally, research demonstrates that insurance coverage for IVF is associated with decreased odds of multiple births. Healthcare costs associated with singleton vs. multiple pregnancies are $21,458 singleton, $104,831 twin, and $407,199 triplet[9]. LD 1539 provides Mainers with the security of insurance coverage, making them open to transferring fewer embryos because they understand benefits are available to try again if their initial treatment does not work.

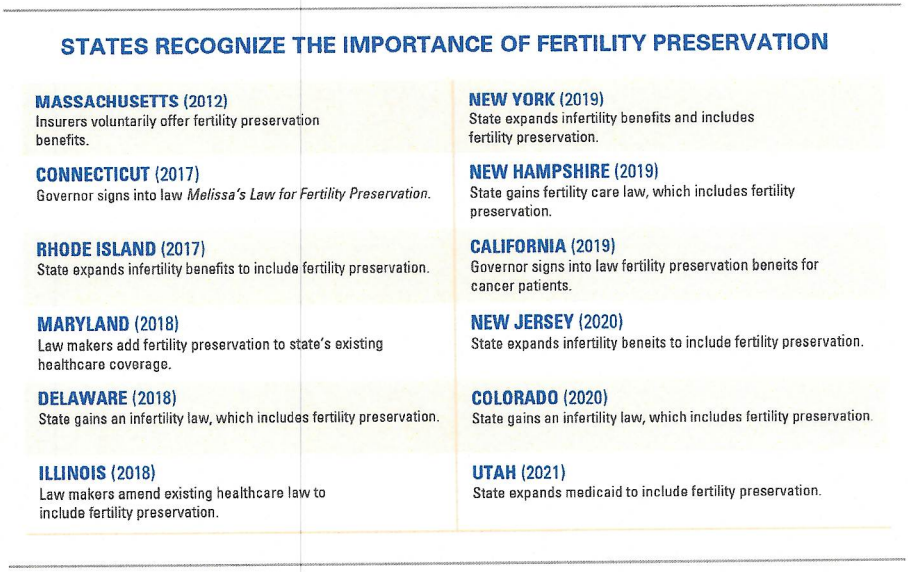


"Multiples are more likely to require long stays in the neonatal intensive care unit (NICU), which increases costs. It's important for employers and health plans to connect the dots between the cost of the infertility benefit and the significant savings on the maternity and neonatal side.[10]" - *Alex Dlugi, National Medical Director, Infertility, Optum*

In 2012, the Massachusetts Health and Human Services selected a health plan with infertility benefits to be the state's health insurance benchmark plan. Every insurer in their state voted for this plan. The insurers could have asked for a plan without state mandates or infertility benefits, but they did not. Rhode Island also selected a benchmark plan which includes infertility benefits[11]. They recognize the benefit and cost savings associated with this healthcare coverage.

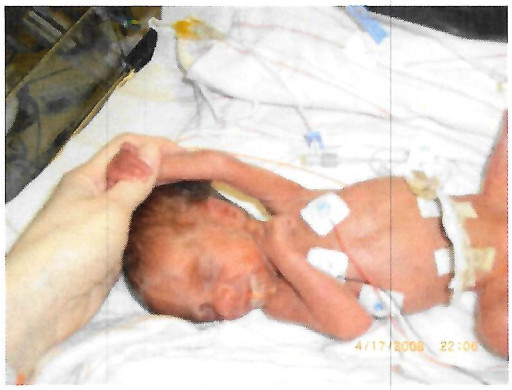
One of the most effective strategies in the realm of preventative medicine is to bank reproductive material when medically necessary. The National Institutes of Health (NIH) clarifies the definition of Fertility Preservation as, "the process of saving or protecting eggs, sperm, or reproductive tissue so that a person can use them to have biological children in the future."[12] Storage is a critical part of fertility preservation. There would be no preservation without storage. While Fertility Preservation, including storage, is a critical step for future family building, insurance plans rarely cover or support this treatment and, as a consequence, it is vastly underutilized and results in much more costly procedures later in life. For example, cancer patients may opt for a less aggressive treatment plan in hopes of maintaining their fertility, risking prolonged treatment or a reoccurrence of their cancer.

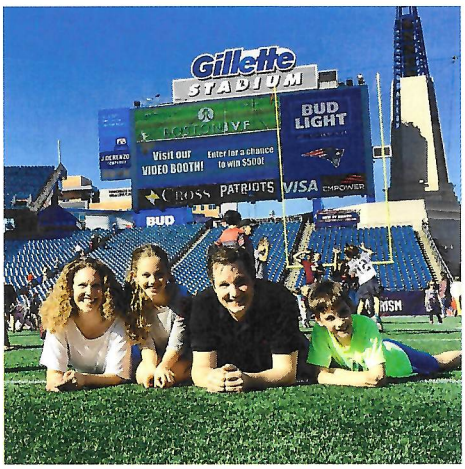
A Fertility Preservation financial analysis completed in Connecticut showed a lower range of $0.059 PMPM[6]. Their amount included medical cost, administrative fees, risk factors, and profit or surplus. Maryland found a $0.14 - $0.24 increase to premiums PMPM[13]. What each state determined was that Fertility Preservation was not only affordable to their state; it was an important healthcare option to provide.



Please allow me to share my personal experience, which brings this data to life.

We never had insurance coverage through our employers. During our last four years of treatment in Massachusetts, we were able to purchase a costly non-group plan, which had limited benefits. Due to the financial burden, we decided to increase our odds of success during our last IVF cycle, by transferring all of our embryos. I became pregnant with triplets and reverted to my husband's insurance plan. My body could not sustain a triplet pregnancy. Complications arose, and I was left with a singleton. As you could imagine, we needed to utilize our mental health benefits, as well. My pregnancy was high-risk, and our son Brennan was born three months early. He was in the NICU for 11 weeks. He was so small, he was considered disabled, and we received state insurance to cover our out-of-pocket expenses.





Now, Brennan is a happy, active, intelligent, healthy boy. However, since his birth, he has had multiple surgeries and is currently on an Individual Education Plan at school. Rather than reimbursing for an IVF cycle, his healthcare expenses have nearly reached one million dollars. It did not need to be this way.

I am committed to finding win-win options for Maine, Mainers, employers, and insurers. We can create solutions to ensure timely and appropriate healthcare to optimize safe pregnancies and healthy babies. I am asking you to take affirmative action to support your constituents because what they need most is for your voice to represent them (employers who could save from decreasing outcome costs and constituents in need of access to healthcare).

Thank you for considering these facts and support the majority committee recommendation of Ought to Pass LD 1539, An *Act to Provide Access to Fertility Care*. Your vote in favor is a legacy that will last for generations. I am available to answer any questions you may have.

Sincerely yours,

Davina Fankhauser

Davina Fankhauser
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Maine References

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TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

FISCAL MEMORANDUM

SB 425 - HB 1379

March 19, 2021

SUMMARY OF ORIGINAL BILL: Extends, from 21 days to 30 days, the time within which a health insurance entity must pay on or notify a provider regarding a claim received by electronic submission.

FISCAL IMPACT OF ORIGINAL BILL:

NOTSIGNIFICANT

IMPACT TO COMMERCE OF ORIGINAL BILL:

NOT SIGNIFICANT

SUMMARY OF AMENDMENT (003694): Deletes all language after the enacting clause. Beginning January 1, 2023, requires health carriers to provide coverage for the expenses of the diagnosis of infertility, fertility treatment, and standard fertility preservation services. Requires coverage to include: (1) three completed cycles of intrauterine insemination; (2) fertility treatment necessary to achieve two live births, or a maximum of four completed egg retrievals with unlimited fresh and frozen embryo transfers; (3) diagnosis of infertility; (4) standard fertility preservation services, including the procurement, cryopreservation, and storage of gametes, embryos, or other reproductive tissue, when the enrollee has a diagnosed medical condition, or genetic condition, that may directly or indirectly cause impairment of fertility now or in the future by affecting reproductive organs or processes; and (5) medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with an individual's religious or ethical beliefs.

Limits coverage for fertility treatment and preservation services to persons who are 44 years of age or less. Excludes the TennCare Program and TennCare's managed care organization's health plans. Prohibits health carriers from limiting benefits based on: (1) co-payments, deductibles, coinsurances, benefit maximums, waiting periods, or other limitations on coverage that are different than maternity benefits provided by the health carrier; (2) exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications by the health carrier; (3) a requirement that provides different benefits to, or imposes different requirements upon, a class protected under title 4, chapter 21, than that provided to or required of other patients; or (4) a pre-existing condition exclusion, pre-existing condition waiting periods on coverage for required benefits, or prior diagnosis of infertility, fertility treatment, or standard fertility preservation services.

Requires coverage for the diagnosis of infertility, fertility treatment, and standard fertility preservation services in accordance with the standards or guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology, when recommended by a physician as medically necessary. Establishes that making, issuing, circulating, or causing to be made, issued, or circulated, clinical guidelines that are based upon data that are not reasonably current or do not cite with specificity is an unfair and deceptive act and practice under the *Tennessee Consumer Protection Act of 1977* (the Act).

FISCAL IMPACT OF BILL WITH PROPOSED AMENDMENT:

Increase State Expenditures –
Exceeds $1,704,400/FY22-23
Exceeds $3,408,800/FY23-24 and Subsequent Years

Increase Federal Expenditures –
Exceeds $29,500/FY22-23
Exceeds $59,000/FY23-24 and Subsequent Years

Increase Local Expenditures –
Exceeds $81,800/FY22-23*
Exceeds $163,600/FY23-24 and Subsequent Years*

Assumptions for the bill as amended:

Benefits Administration:

- The proposed legislation will apply to the State Group Insurance Plan (SGIP) that takes effect January 1, 2023.
- Based on the National Assisted Reproductive Technology (ART) Surveillance by the Centers for Disease Control and Prevention, the average number of ART procedures per one million women in Tennessee in 2016 and 2017 was 1,357, or 0.14 percent (1,357 / 1,000,000).
- Of those 1,357 ART procedures, 43.8 percent or 594 (1,357 x 43.8%) resulted in pregnancy.
- Of those 594 pregnancies, 82.5 percent or 490 (594 x 82.5%) resulted in a live birth delivery.
- Of those 490 deliveries, 85 percent or 416 (490 x 85.0%) were single live birth deliveries and 15 percent or 74 (490 x 15.0%) were multiple live birth deliveries.
- Applying the same methodology to the number of women between the ages of 21 and 44 that are currently enrolled on the SGIP results as follows:
    - State Plan: 38 (26,893 eligible members x 0.14%);
    - Local Education Plan: 33 (23,310 eligible members x 0.14%); and
    - Local Government Plan: 7 (4,957 members x 0.14%).

- It is reasonably assumed that there will be a 10 percent increase in utilization of services in the first year treatment is covered. Therefore, the members who will receive services is estimated to be:
    - State Plan: 42 members (38 x 1.10);
    - Local Education Plan: 36 members (33 x 1.10); and
    - Local Government Plan: 8 members (7 x 1.10).
- The proposed language requires coverage for three completed cycles intrauterine insemination, fertility treatment and standard preservation to achieve two live births or a maximum of four completed egg retrievals.
- Due to multiple unknown variables, such as the number of egg retrievals or completed cycles on intrauterine insemination a woman might require, the increase in state expenditures is estimated to exceed $956,000 for the State Plan, and exceed $292,800 for the Local Education Plan in FY23-24 and subsequent years. For the purposes of brevity, calculations used to derive such estimates are not included in this fiscal note but are available upon request with the Fiscal Review Committee staff.
- Due to the January 1, 2023 effective date, the increase in state expenditures is estimated to exceed $478,000 ($956,000 x 50.0%) for the State Plan and exceed $146,400 ($292,800 x 50.0%) for the Local Education Plan in FY22-23.
- Some state plan member's insurance premiums are funded through federal dollars. The increase in federal expenditures in FY23-24 and subsequent years is estimated to exceed $59,000. Due to the January 1, 2023 effective date, the increase in federal expenditures is estimated to exceed $29,500 ($59,000 x 50.0%) in FY22-23.
- The state does not contribute to the Local Government Plan; any increase in costs will be entirely absorbed by the participating agencies and their members. It is estimated the Local Government Plan would be responsible for a mandatory increase in local expenditures estimated to be $163,600 in FY23-24 and subsequent years. Due to the January 1, 2023 effective date, the increase in local expenditures is estimated to be $81,800 ($163,600 x 50.0%) in FY22-23.
- The impact on local governments that do not opt into the Local Government Plan is unknown; therefore, the total increase in local expenditures is estimated to exceed $808,701.64 in FY23-24 and subsequent years. Due to the January 1, 2023 effective date, the increase in local expenditures is estimated to exceed $130,465 in FY22-23.

Department of Commerce and Insurance

- The Affordable Care Act requires states to defray the costs of state-mandated benefits in qualified health plans (QHPs) that are in excess of the essential health benefits (EHB).
- The state will be required to defray the cost of benefits required in the proposed legislation because the benefits exceed those provided under Tennessee's EHB benchmark plan.
- Based on information provided by the Department of Commerce and Insurance (DCI), it is estimated there will be a total QHP population of approximately 200,000 for calendar year 2020, consisting of approximately 190,000 individuals covered on the exchange and approximately 10,000 individuals covered off the exchange.
- The state would be responsible for the amount of premium attributed to the new benefit or the insurance carrier's actual costs. The estimate in this note assumes the state will

reimburse the health insurance carrier for the amount of premium attributed to the new benefit.

- Based on information provided by carriers who currently offer QHPs in Tennessee, the average per member per month cost is $0.90, or $10.80 per year ($0.90 x 12 months).
- The recurring increase in state expenditures in FY23-24 and subsequent years is estimated to exceed $2,160,000 (200,000 individuals x $10.80) due to the increase for which the state would be required to defray the cost. Due to the January 1, 2023 effective date, the increase in state expenditures in FY22-23 is estimated to exceed $1,080,000 ($2,160,000 x 50.0%).

Total State Impact

- The total increase in state expenditures is estimated to exceed $1,704,400 ($478,000 + $146,400 + $1,080,000) in FY22-23 and exceed $3,408,800 ($956,000 + $292,800 + $2,160,000) in FY23-24 and subsequent years.
- The total increase in federal expenditures is estimated to exceed $29,500 in FY22-23 and exceed $59,000 in FY23-24 and subsequent years.
- The total increase in local expenditures is estimated to exceed $81,800 in FY22-23 and exceed $163,600 in FY23-24 and subsequent years.

IMPACT TO COMMERCE WITH PROPOSED AMENDMENT:

Increase Business Revenue –
Exceeds $1,815,700/FY22-23
Exceeds $3,631,400/FY23-24 and Subsequent Years

Increase Business Expenditures –
Exceeds $1,815,700/FY22-23
Exceeds $3,631,400/FY23-24 and Subsequent Years

Assumptions for the bill as amended:

- Healthcare providers will experience an increase in business revenue for providing services.
- The increase in business revenue is estimated to exceed $1,815,700 ($1,704,400 + $29,500 + $81,800) in FY22-23 and exceed $3,631,400 ($3,408,800 + $59,000 + $163,600) in FY23-24 and subsequent years.
- For companies to retain solvency, any increased expenditures will be less than the amount of increased revenues collected. Therefore, the increase in business expenditures is estimated to be less than $1,815,700 in FY22-23 and less than $3,631,400 in FY23-24 and subsequent years.

*Article II, Section 24 of the Tennessee Constitution provides that: *no law of general application shall impose increased expenditure requirements on cities or counties unless the General Assembly shall provide that the state share in the cost.*

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.

Krista Lee Carsner

Krista Lee Carsner, Executive Director

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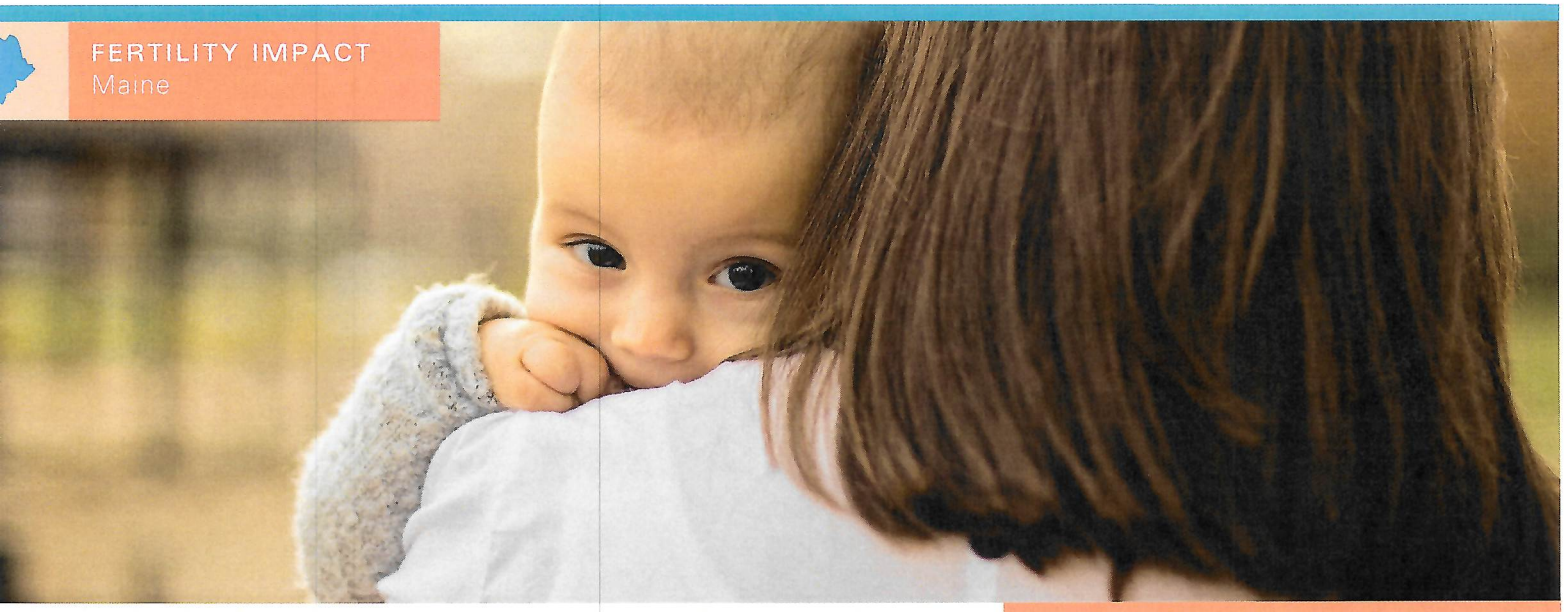
FERTILITY IMPACT
Maine



Primary Sponsor: Rep. Colleen Madigan (LR 88

An Act to Provide Access to Fertility Care

> "IT'S IMPORTANT FOR EMPLOYERS AND HEALTH PLANS TO CONNECT THE DOTS BETWEEN THE COST OF THE INFERTILITY BENEFIT AND THE SIGNIFICANT SAVINGS ON THE MATERNITY AND NEONATAL SIDE.[1]"
>
> **Alex Dlugi**
> National Medical Director, Infertility, Optum Insurance

1 in 6 couples experience infertility, a disease recognized by the *American Medical Association.*[2] However, fertility care, such as In Vitro Fertilization (IVF), is NOT offered by most insurance plans in Maine.

WHY PROVIDE FERTILITY COVERAGE IN MAINE:

- Approximately 34% of Mainers are of reproductive age[3]; 17% will face infertility and require treatment.
- In Maine, the average earnings are $38,146.[4] Those who lack IVF coverage assume out-of-pocket costs, averaging $12,400 per treatment cycle,[5] or a third of their annual earnings.
- Fertility benefits optimize safe pregnancies and healthy babies because patients are able to make medical decisions based on clinical guidance rather than financial concerns.[6]
- Early access to fertility health care reduces the extent of benefits used to overcome this disease.
- Currently only Maine and Vermont do not have fertility insurance laws among the six New England states.
- Upon signing the law in New Hampshire in 2019, Governor Chris Sununu (R) explained, "Including these (fertility care) benefits in health care plans will help retain young workers — a goal we should all be supportive of.[7]"

THIS PRO-FAMILY LEGISLATION WILL:

- Provide private insurance coverage for fertility treatment and for medically necessary fertility preservation.
- Equalize access to fertility treatment for those hoping to achieve their dream of parenthood, including LGBTQ+ people, injured military veterans, cancer survivors and more.

RNE Resolve New England | Fertility Within Reach. ADVOCATING FOR FERTILITY HEALTH BENEFITS

IMPACT OF FERTILITY COVERAGE IN MAINE

WITHOUT BENEFITS		WITH BENEFITS
Over 52% of patients, ages 25–34, incur over $10K in debt, and 26% incur over $30K in debt[8]	COST OF IVF COVERAGE	Health care reviews from multiple states show the insurance premium increase is less than 1% of the total premium cost[9, 10, 11]
Increased risk of complicated pregnancies and associated costs	OUTCOME COSTS	Timely and physician recommended healthcare optimizes safe pregnancies, healthy babies, as well as cost outcomes
Individuals saving for healthcare expenses tend to spend less on consumer goods and save less for retirement	ECONOMIC CONTRIBUTION	Financial flexibility to contribute to healthcare as well as the economy, personal savings, retirement, and more

> "As a Maine-based, family-friendly employer, we have recognized the importance of providing fertility benefits to our employees. Fertility benefits help reduce unnecessary financial and health-related concerns, allowing people to focus on their journey to fulfilling their dream of having children."
>
> **Danielle Tabor,** Chief People Officer, Emburse

If you wish to support the **An Act to Provide Access to Fertility Care** bill or have any questions, please contact **Kate Weldon LeBlanc** at Resolve New England: kwleblanc@resolvenewengland.org or 617-686-8465, **Davina Fankhauser** at Fertility Within Reach: admin@fertilitywithinreach.org or 857-636-8674 and **Alysia Melnick** at amelnick@bernsteinshur.com.

This fact sheet is a supplement of ***The Policymaker's Guide to Fertility Health Benefits*** — a guide with proprietary and evidence-based data for informed decision making produced by ***Fertility Within Reach***. Ask for your copy today at admin@fertilitywithinreach.org or 857-636-8674.

RNE Resolve New England | Fertility Within Reach. ADVOCATING FOR FERTILITY HEALTH BENEFITS

MAINE REFERENCES

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