Date of Hearing: April 23, 2019

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 767 Wicks – As Amended April 9, 2019

SUBJECT: Health care coverage: infertility.

SUMMARY: Requires every health care service plan (health plan) contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2020, to provide coverage for in vitro fertilization (IVF), as a treatment of infertility, and mature oocyte cryopreservation (OC). Specifically, **this bill**:

1) Requires, on and after January 1, 2020, every health plan contract that is issued, amended, or renewed that covers hospital, medical, or surgical expenses on a group basis or every insurer issuing, renewing, or amending a policy of disability insurance that covers hospital, medical, or surgical expenses on a group basis, to provide coverage for the treatment of infertility, including IVF, and mature OC.

2) Deletes the exemption for religiously affiliated employers, health plans, and health insurance policies, from the requirements relating to coverage for the treatment of infertility, thereby imposing these requirements on these employers, plans, and policies.

3) Deletes the requirement that a health care service plan contract and health insurance policy provide infertility treatment under agreed upon terms that are communicated to all group contractholders and prospective group contractholders.

4) Defines the following:
   a) "Infertility" as the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility;
   b) "IVF" as the laboratory medical procedures involving the IVF process;
   c) "Mature OC" as the procedures consistent with established medical practices, including laboratory medical procedures, involving ovulation induction, egg retrieval, and freezing of the egg; and,
   d) "Treatment of infertility" as procedures consistent with established medical practices in the treatment of infertility by a licensed physician and surgeon, including, but not limited to, diagnosis, diagnostic tests, medication, surgery, gamete intrafallopian transfer, and IVF.

5) Makes other technical and conforming changes.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and the California Department of Insurance (CDI) to regulate health insurers.

2) Requires health plans and health insurers providing health coverage in the individual and small group markets to cover, at a minimum, essential health benefits (EHBs), including the ten EHB benefit categories in the Patient Protection and Affordable Care Act (ACA), and consistent with California's EHB benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan (Kaiser benchmark), as specified in state law.

3) Establishes, in state government, California's Health Benefit Exchange (Exchange), or Covered California, as an independent public entity not affiliated with an agency or department, and requires the Exchange to compare and make available through selective contracting, health insurance for individual and small business purchasers, as authorized under the ACA. Specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans (QHPs) through the Exchange by qualified individuals and small employers.

4) Specifies the EHBs in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care.

5) Requires health plans to provide basic health care services, including: physician services; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services; and, hospice care.

6) Requires, on and after January 1, 1990, every health care service plan contract or insurance policy that is issued, amended, or renewed that covers hospital, medical, or surgical expenses on a group basis, where the plan is not a health maintenance organization as defined, to offer coverage for the treatment of infertility, except IVF, under those terms and conditions as may be agreed upon between the group subscriber and the plan. Requires every plan to communicate the availability of that coverage to all group contractholders and to all prospective group contractholders with whom they are negotiating.

7) Defines the following:
   a) "Infertility" as either: i) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility; or, ii) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.
   b) "Treatment for infertility" as procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer.
   c) "IVF" as the laboratory medical procedures involving the actual IVF process.

8) Requires, on and after January 1, 1990, every health plan that is a health maintenance organization, as defined, and that issues, renews, or amends a health care service plan contract that provides group coverage for hospital, medical, or surgical expenses to offer infertility treatment, according to the terms and conditions that may be agreed upon between the group subscriber and the plan to group contractholders with at least 20 employees to whom the plan is offered. Requires the plan to communicate the availability of the coverage to those group contractholders and prospective group contractholders with whom the plan is negotiating.

9) Prohibits 4) to 7) above from being construed to deny or restrict in any way any existing right or benefit to coverage and treatment of infertility under an existing law, plan, or policy; to require any employer that is a religious organization to offer coverage for forms of treatment

of infertility in a manner inconsistent with the religious organization's religious and ethical principles; or, to require any plan, which is a subsidiary of an entity whose owner or corporate member is a religious organization, to offer coverage for treatment of infertility in a manner inconsistent with that religious organization's religious and ethical principles.

10) Requires coverage for the treatment of infertility to be offered and, if purchased, provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

11) Authorizes a religious employer to request a health plan contract or insurance policy without coverage for Federal Drug Administration-approved contraceptive methods that are contrary to the religious employer's religious tenets, as specified.

12) Defines religious employer as an entity for which each of the following is true:
    a) The inculcation of religious values is the purpose of the entity;
    b) The entity primarily employs persons who share the religious tenets of the entity;
    c) The entity serves primarily persons who share the religious tenets of the entity; and,
    d) The entity is a nonprofit organization as described in federal law.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, infertility is a disease that affects millions of women of child bearing age in this country. While IVF is one of many effective treatments for infertility, it is explicitly excluded from being offered by health plans in California. This prohibition of IVF health coverage in our state makes this treatment option unattainable for many couples who cannot afford it. Reproductive freedom should not be limited to those who can afford it. This bill would address this inequity in health coverage by requiring health plans and policies to provide IVF coverage so that women who seek infertility treatment can obtain IVF when needed.

2) **BACKGROUND.** According to the California Health Benefits Review Program (CHBRP), infertility is the inability to have a child and is a complex condition that can take many forms. In order for a live baby to be born without medical intervention, several conditions must be met:
    a) An egg (oocyte) must be released from an ovary;
    b) Sperm must join with (fertilize) the egg;
    c) A fertilized egg must be able to move through the fallopian tube toward the uterus;
    d) The fertilized egg must attach (implant) to the lining of the uterus to begin pregnancy; and,
    e) The fertilized egg must develop to an embryo and then fetus in the uterus and be gestated (carried) until live birth occurs.

    Infertility may result from a problem with any one of these steps, or a combination of several steps. Persons attempting to have a child may experience primary infertility (physical difficulties having a first child) or secondary infertility (having had at least one child, but experiencing difficulty having another), either of which may be related to the inability to become pregnant or successfully carry a pregnancy to term. There are important differences between male and female reproductive biology that impact infertility. Women are born with a

finite number of eggs (oocytes) that mature with the onset of menarche (median age 12 years) and decrease in number and quality until the onset of menopause, beyond which women are not able to naturally bear children; this is generally referred to as the female reproductive range. National datasets of IVF use show that less than 1% of women initiating IVF at age 44 or older will have a live birth; however, women up to the age of menopause, average age 51 in the U.S., may experience fertility treatment success using donor materials. In contrast, males become able to produce sperm during puberty (median age 12 years) and, according to the American Society for Reproductive Medicine (ASRM), retain optimal reproductive capabilities until 60 years of age.

a) CHBRP analysis. AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP states in its analysis of this bill the following:

i) Enrollees covered. According to CHBRP, benefit coverage for infertility treatments, including IVF, would increase from 4.3% premandate to 100% postmandate. Benefit coverage of planned OC would increase from 0% premandate to 100% postmandate. This bill would likely exceed EHBs.

ii) Impact on expenditures. According to CHBRP, this bill would increase total net annual expenditures by $850.5 million or 0.49% for enrollees with DMHC-regulated group plans and CDI-regulated group policies. This is due to a $537.8 million increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by decrease in enrollee expenses for covered and/or noncovered benefits. CHBRP estimates that enrollees with uncovered expenses at baseline would receive on the whole a $133.9 million reduction in their out-of-pocket spending for covered and noncovered expenses associated with this bill's coverage of infertility services. Per member per month (PMPM) premiums would increase between $2.76 among CalPERS HMOs (an increase of 0.47%) and $3.72 in the DMHC-regulated small-group market (an increase of 0.68%). Total expenditures would increase between 0.33% in the CDI-regulated large-group market and 0.64% in the DMHC-regulated small-group market. CHBRP did not find any source of data on baseline utilization for planned OC or likely changes postmandate. CHBRP estimates that if 2% of women aged 25-37 years used planned OC services, the total expenditures would increase by $319.7 million. If a higher share of women aged 25-37 used planned OC (5%), total expenditures would increase by $799.2 million. This assumes the average cost for OC is $10,078.

(1) Medi-Cal. This bill does not apply to Medi-Cal enrollees and therefore there is no measurable impact.

(2) The California Public Employees' Retirement System (CalPERS). CalPERS employer expenditures are projected to increase by $14.5 million for coverage of infertility treatments. Total premiums would increase by $2.76 PMPM (0.47%) and total expenditures would increase by $3.38 PMPM (0.53%).

(3) Number of Uninsured in California. Since the change in average premiums does not exceed 1% for any market segment for coverage of infertility treatments, CHBRP expects no measurable change in the number of uninsured persons due to the enactment of this bill. However, should 5% of female enrollees aged 25–37 use mature OC services as a form of fertility preservation, premiums would increase by more than 1% for enrollees in group and CalPERS HMO plans (premium increases for private employers for group insurance increase 1.24% and CalPERS HMO 1.31%). It is unclear how the increase in premiums translates into uninsurance since not all of the increase is transferred to the enrollee.

i) EHBs. This bill would require coverage for a new state benefit mandate that appears to exceed the definition of EHBs in California. A state that requires QHPs to offer benefits in excess of the EHBs must make payments to defray the cost of those additionally mandated benefits, either by paying the purchaser directly or by paying the QHP. CHBRP estimates that the state would potentially be required to defray the following amounts due to this bill: (1) $6.52 PMPM for each QHP enrollee in a small-group DMHC-regulated plans; and, (2) $7.14 PMPM for each QHP enrollee in a small-group CDI-regulated policy.

CHBRP estimates that this translates to a state-responsibility of $52.5 million total, which includes: (1) $51.5 million in payments to DMCH-regulated small group plans; and, (b) $1 million in payments to CDI-regulated small group policies.

iv) Medical effectiveness. CHBRP found a preponderance of evidence that IVF is an effective treatment for infertility, resulting in increased pregnancy rates and live birth rates. There is also a preponderance of evidence that planned OC is an effective treatment for infertility, resulting in pregnancies and live births. CHBRP found a preponderance of evidence that IVF is associated with certain maternal harms, including ovarian hyperstimulation syndrome and thromboembolism. There is also clear and convincing evidence that IVF can lead to multiple gestation and preterm delivery. However, it is important to note that multiple gestation is associated with higher numbers of embryos transferred per cycle, and that preterm delivery is associated with multiple gestation, these outcomes can be mitigated by single embryo transfers. CHRBP found a preponderance of evidence that IVF mandates are associated with lower numbers of embryos transferred per cycle. There is also a preponderance of evidence that IVF mandates lead to fewer births per cycle (due to the decreased number of embryos transferred per cycle), and a reduction in overall harms of IVF (i.e., lower rates of multiple gestation, preterm deliveries, and low-birthweight births).

iv) Benefit coverage. According to CHBRP, currently, 4.3% of enrollees with health insurance that would be subject to this bill in DMHC-regulated plans or CDI-regulated policies have coverage for infertility treatments, including in vitro fertilization. No enrollees currently have coverage for mature OC as defined by this bill. Benefit coverage for infertility treatments and planned OC would increase to 100% postmandate.

v) Utilization. In California, there are approximately 53,000 users of female diagnostic tests at baseline and about the same number of users of medications for infertility

(i.e., only medications and no other service). Intrauterine insemination baseline utilization is about 9,000 users annually. IVF services alone (i.e., without intracytoplasmic sperm injection (ICSI)) is estimated to have about 2,000 users and ICSI, which is done with IVF, is 2,000 users annually. For males, at baseline there are 25,000 users of diagnostic tests and 11,000 users of any male treatment. Pent-up demand is assumed to occur given the financial burden currently cited by couples hoping to use infertility services but are unable to because of cost barriers. It is assumed that utilization in the first and second year would be 10% greater. Pent-up demand for infertility services likely dissipates over time and utilization reaches a steady state after a few years postmandate.

iv) **Public health.** CHBRP estimates that the number of pregnancies resulting from infertility treatments in the first year postmandate will increase the number of pregnancies by 6,000 (from 7,000 to 13,000) and the number of live births by 5,000 (from 6,000 to 11,000).These estimates are supported by a preponderance of evidence that infertility treatments, including IVF, are medically effective and that health insurance benefit mandates are effective in increasing utilization of treatments for infertility, including IVF. Although CHBRP found evidence that engaging in infertility treatments may result in short-term psychosocial harms, evidence-based literature also indicates that the inability to have wanted children is itself associated with stress, anxiety, depression, and quality of life deficits that are likely to decrease upon the achievement of a successful pregnancy through treatment. Therefore, it stands to reason that mental health and quality of life would improve for the additional 5,000 persons and couples who would have a live birth resulting from infertility treatments postmandate. With respect to health disparities, CHBRP found that barriers in fertility treatment access related to sexual orientation are reduced with the change in language defining infertility to be more inclusive, however barriers remain as the bill does not cover donor materials (sperm or eggs) or gestational carriers (surrogates) that are required for same-sex couples. Cost-related barriers to infertility treatment would be significantly reduced for those covered by this bill, however cost sharing could still represent a significant cost barrier.

iv) **Long-term impacts**. In the short-term, the aggregate pregnancy and birth rate is expected to increase postmandate due to increased utilization of infertility services. In the longer term, it is possible that the coverage of infertility services results in encouraging couples to undergo infertility treatment earlier than they would normally and where pregnancy might be achieved naturally. For each cohort of females electing to undergo mature OC for the prevention of age-related infertility in a given year, CHBRP estimates the long-term marginal impact of this bill would yield about 685 more live births among these women over a 20-year period. Although this bill would decrease the financial burden of planned OC services in the short term, this bill would not cover future storage costs, which can range from range from $100 to $1,500 per year (average $300/year). These additional uncovered costs may have an impact on the demand for these services, but the magnitude of this effect is unknown.

b) Other states. According to CHBRP, currently, 14 states have laws that require insurance companies to cover infertility treatment and two states, California and Texas, have laws that require insurance companies to offer coverage for infertility treatment. States that require coverage of infertility treatment include: Arkansas, Connecticut, Hawaii, Illinois,

Louisiana, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, and West Virginia, and most recently Delaware, which passed legislation in 2018. In 2019, New York amended its existing mandate through a budget measure in the 2020 state budget that mandates certain large-group insurance plans cover IVF, and requires all private insurance companies to cover medically necessary egg freezing. The Connecticut, New Jersey, and Rhode Island mandates are closest to this bill, with the exception of planned OC, which is not included those states' mandates. While most states with laws requiring insurance companies to offer or provide coverage for infertility treatment include coverage for IVF, California and Louisiana have laws that specifically exclude coverage for the procedure.

Other examples of unique state laws are Louisiana and New York's previous law, which prohibit the exclusion of coverage for a medical condition otherwise covered solely because the condition results in infertility; Minnesota, which specifies that medical assistance will not provide coverage for fertility drugs when specifically used to enhance fertility; and, Utah, which requires insurers providing coverage for maternity benefits to also provide an indemnity benefit for adoption or infertility treatments. Limits on infertility coverage in other states that mandate coverage include applying dollar lifetime caps, and limiting the number of treatment cycles covered. Connecticut allows four cycles of ovulation induction, a lifetime maximum coverage of three cycles of intrauterine insemination, and a lifetime maximum coverage of two cycles of IVF, Gamete intrafallopian transfer, zygote intrafallopian transfer or low tubal ovum transfer, with not more than two embryo implantations per cycle. Hawaii requires that only one cycle of IVF be covered. Illinois mandates that each patient is covered for up to four egg retrievals. However, if a live birth occurs, two additional egg retrievals will be covered, with a lifetime maximum of six retrievals covered. New York covers up to three IVF cycles. Rhode Island limits coverage to a lifetime cap of $100,000.

3) **SUPPORT.** According to ASRM, a sponsor of this bill, the right to procreate is a fundamental right, as recognized by Supreme Court case law. With that long recognized right in observance, it is crucial that California continues its leadership role in the country and take an affirmative act by protecting access to all reproductive health care services. ASRM states that this bill will give hope to many Californians who suffer from infertility and cannot financially access treatment options.

4) **OPPOSITION.** According to the California Chamber of Commerce, this bill would impose a new benefit mandate that exceeds EHBs established for individual and small group market plans and the state would be responsible for covering the cost to subsidize that benefit for individuals purchasing subsidized coverage through Covered California. The state has not enacted a benefit mandate that clearly exceeds EHB requirements. This mandate would set precedent and would result in ongoing annual costs to subsidize the provision of infertility treatment for individuals enrolled in health care coverage through Covered California.

The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) oppose state mandates as it would increase costs of coverage, especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates. According to CAHP, ACLHIC, and AHIP, with the elimination of the federal individual mandate,

Covered California reported that new enrollment growth dropped by 24% and the average benchmark premium rose by 7.7% from 2018 to 2019. The repeal of the individual mandate has already caused increased premiums and coverage losses, and these mandates would further exacerbate the situation.

5) **RELATED LEGISLATION.** SB 600 (Portantino) clarifies that an individual or group health plan contract or health insurance policy that covers hospital, medical, or surgical expenses includes coverage for standard fertility preservation services when a medically necessary treatment may cause iatrogenic infertility to an enrollee or insured. SB 600 is currently pending in Senate Health Committee.

6) **PREVIOUS LEGISLATION.**

   a) SB 172 (Portantino) of 2017 expands the definition of basic health care services to include standard fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility. SB 172 was held in the Senate Appropriations Committee.

   b) SB 1053 (Mitchell), Chapter 576, Statutes of 2014, requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2016, to provide coverage for women for all prescribed and FDA-approved female contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related follow-up services. Prohibits a nongrandfathered plan contract or health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to this coverage, as specified.

7) **AUTHOR'S AMENDMENTS.** The author wishes to explicitly exclude the Medi-Cal program from the provisions of this bill.

8) **POLICY COMMENTS.**

   a) Cost containment. As the CHBRP analysis points out, this bill would increase total net annual expenditures by $850,696,000 for enrollees with DMHC-regulated group plans and CDI-regulated group policies. To address concerns regarding the cost of the services described in this bill, the committee recommends the following amendments:

      i) Delete small group contracts from the provisions of this bill. As noted by CHBRP, Covered California is responsible for certifying and selling QHPs in the small-group and individual markets. QHPs are required to meet a minimum standard of benefits as defined by the ACA as EHBs. In California, EHBs are related to the benefit coverage carefully selected and made available in the Kaiser Foundation Health Plan Small Group HMO 30 plan, the state's benchmark plan for federal EHBs. The benchmark plan did not include infertility coverage. While states may require QHPs to offer benefits that exceed EHBs, a state that chooses to do so must make payments to defray the cost of those additionally mandated benefits, either by paying the purchaser directly or by paying the QHP. CHBRP estimates that this translates to a state-responsibility of $51,823,000 total.

ii) To further limit the cost of these services similarly to those limitations placed by other states that mandate infertility coverage, such as applying dollar lifetime caps, or limiting the number of treatment cycles or type of treatment covered. The Committee recommends a $50,000 coverage limit for infertility treatment.

b) Religious exemption. Existing law requires health plans or insurers of group contracts or policies to offer infertility coverage and exempts any employer that is a religious organization from offering coverage for forms of treatment of infertility, as specified. This bill deletes these exemptions and appears to require such religious organizations to cover infertility services, even if such services may be inconsistent with the religious organization's religious and ethical principles. It is unclear as to whether this deletion is consistent with federal law, including the U.S. Constitution and federal rules.

REGISTERED SUPPORT / OPPOSITION:

Support

American Society for Reproductive Medicine (sponsor)
American Association of University Women – California
American Society for Reproductive Medicine
California Black Health Network
California Chronic Care Coalition
California Pan - Ethnic Health Network
California Rural Legal Assistance Foundation, Inc.
National Association of Social Workers, California Chapter

Opposition

America's Health Insurance Plans
Association of California Life & Health Insurance Companies
California Association of Health Plans
California Catholic Conference
California Chamber Of Commerce
California Right to Life Committee, Inc.

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