SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: AB 767
AUTHOR: Wicks
VERSION: June 6, 2019
HEARING DATE: July 10, 2019
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: in vitro fertilization

SUMMARY: Requires Covered California, in consultation with stakeholders, to develop options for the inclusion of in vitro fertilization coverage as part of, or as supplementary to, coverage currently offered through Covered California, and report the options to the Legislature on or before July 1, 2020.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Services Plan Act of 1975; the California Department of Insurance (CDI) to regulate health and other insurers; Covered California as California's health benefit exchange for individual and small business purchasers as authorized under the federal Patient Protection and Affordable Care Act (ACA); and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., GOV §100500 -100522, and WIC §14000, et seq.]

2) Establishes as California's essential health benefits (EHBs) benchmark the Kaiser Small Group Health Maintenance Organization, existing California mandates (including medically necessary basic health care services), and ten ACA mandated benefits. Requires non-grandfathered individual and small group plan contracts and insurance policies to cover these EHBs. [HSC §1367.005 and INS §10112.27]

3) Requires most health plan contracts and health insurance policies to offer group coverage for the treatment of infertility, except in vitro fertilization (IVF), as defined. This does not apply to health maintenance organizations with group contract holders with less than 20 employees to whom the plan is offered. [HSC §1374.55 and INS §10119.6]

4) Defines "infertility" as either the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or, the inability to conceive a pregnancy or to carry a pregnancy to live birth after a year or more of regular sexual relations without contraception. [HSC §1374.55 and INS §10119.6]

5) Defines "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. [HSC §1374.55 and INS §10119.6]

6) Defines "IVF" as the laboratory medical procedures involving the actual IVF process. [HSC §1374.55 and INS §10119.6]

7) Prohibits 3) above from being construed to require any employer or other specified organizations that are religious organizations to offer coverage for forms of treatment of

infertility in a manner inconsistent with the religious organization's religious and ethical principles. [HSC §1374.55 and INS §10119.6]

8) Requires coverage for infertility treatment 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. [HSC §1374.55 and INS §10119.6]

This bill:

1) Requires Covered California, in consultation with stakeholders, to develop options for the inclusion of IVF coverage as part of, or as supplementary to, coverage currently offered through Covered California. Requires Covered California to consider options that minimize impact on premiums, and state fiscal impact.

2) Requires, on or before July 1, 2020, Covered California to report to the Legislature on these options, and make the report publicly available on its internet website.

3) Sunsets this bill on January 1, 2022.

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

PRIOR VOTES:

Assembly Floor:	59 - 10
Assembly Appropriations Committee:	14 - 0
Assembly Health Committee:	11 - 2

COMMENTS:

1) *Author's statement.* 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 treatment option is unattainable for many couples who cannot afford it. Reproductive freedom should not be limited to those who can afford it. This bill will help remove the cost barrier to IVF treatment by requiring Covered California to develop options for the inclusion of the treatment as part of, or as supplementary to, coverage currently offered through Covered California. This change will provide access to IVF for those who cannot afford to pay for this medical treatment out of pocket.

2) *California Health Benefits Review Program (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, and reviewed an earlier version of this bill which would have required most group health plans and policies, excluding the individual market and Medi-Cal, to provide coverage for infertility treatments, including IVF, and mature oocyte cryopreservation. Key findings that remain relevant include:

   a) *Background on infertility*. Infertility is the inability to have a child and is a complex condition that can take many forms. There are numerous medical causes of infertility, and an individual can have more than one cause of infertility. Within a couple, one or both

partners can have a cause of infertility. In the United States, results from a prospective cohort study of almost 400 women presenting at eight infertility practices showed that 58% of infertility cases were attributable to female factors, 7% were attributable to male factors, 31% were attributable to both male and female factors, and 4% were not directly attributable to either partner. 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 US, 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.

b) *Coverage impacts and enrollees covered*. Currently, 4.3% of enrollees with health insurance in DMHC-regulated group plans or CDI-regulated group policies have coverage for infertility treatments, including IVF. Plans vary with regards to how infertility services are covered, such as imposing cost-sharing, age restrictions, restrictions on number of treatment cycles, or a cap on the dollar amount covered for services. Based on responses to the carrier survey, a portion of enrollees who currently have coverage for infertility services have cost sharing for infertility services that is the same as major medical services. For enrollees who have infertility coverage but do not have the same cost share as major medical services, CHBRP found in its carrier survey that coverage includes a 50% co-insurance for these services, including IVF, without an out of pocket maximum.

c) *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 mature oocyte cryopreservation (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).

d) *Utilization*. Data from a cohort of couples recruited from eight community and academic endocrinology clinics in California indicates that out-of-pocket costs are significant and may impact overall utilization of infertility treatments. The median out-of-pocket cost of infertility treatments is estimated to range from $912 for medications alone, up to $19,234 for one cycle of IVF, with each additional cycle of IVF costing $6,995. Further analysis found that, on average, couples undergo 3.7 cycles of IVF, which means that an average couple utilizing IVF might accrue up to $40,219 in out-of-pocket treatment costs for infertility treatment. Costs were even higher for couples utilizing donor eggs. In addition to oocyte retrieval and IVF, persons undergoing planned OC generally also need to pay out of pocket for frozen storage costs, which range from $100 to $1,500 per year

(average $300/year). Treatments for infertility are also complex and time-consuming, with one study estimating that a single cycle of IVF could account for 15.6 work-day equivalents, mostly in administrative time.

CHBRP examined claims data for estimates of utilization of infertility services among enrollees in California. There are approximately 53,000 users of female diagnostic tests and 14,000 users of medications for infertility (i.e., only medications and no other service). Intrauterine insemination (IUI) 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 about 2,000 users annually. For males, there are 25,000 users of diagnostic tests and 11,000 users of any male treatment. There are an estimated 7,000 pregnancies due to the use of infertility services and 6,000 live births from these pregnancies. In California, 41.2% of all IVF procedures result in pregnancy, 67.5% of which result in live birth, 12.4% are twin live birth, and 1.6% are multiple births.

e) *Public health*. 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 persons and couples who would have a live birth resulting from infertility treatments.

3) *Other states*. 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 are: 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 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. 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.

4) *EHB plan selection*. Under the ACA, qualified health plans (QHPs) are sold through Covered California and also provide coverage to individuals and small employers not through Covered California. QHPs are required to ensure coverage of EHBs, as defined by the federal Secretary of the Department of Health and Human Services (HHS). EHBs must include coverage of services and items in all ten statutory categories required in the ACA. In addition, states are permitted to choose a benchmark plan as the basis for a state's EHBs.

California has reviewed its EHB options twice. Once in 2012 and again in 2015. On both occasions, the consulting firm, Milliman, analyzed and compared the health services covered by the ten EHB California benchmark plan options. Both times the plans compared were comprehensive with small cost differences between them. The Legislature, with stakeholder input, chose the Kaiser Small Group HMO, which was also the default plan had California not made an affirmative choice. However, Milliman found differing coverage among the plan options for acupuncture, infertility treatment, chiropractic care, and hearing aids. In 2015, the three California small group plans were essentially the same average cost as the California EHB plan; and, the California large group and CalPERS plans were approximately 0.2-1% higher. The estimated average costs for the three federal plan options were approximately 0.8-1.2% higher than the California EHB benchmark plan. With this information, the Legislature passed SB 43 (Hernandez, Chapter 648, Statutes of 2015) which adopted the federal definition of habilitative services and maintained the Kaiser Small Group HMO Plan as California's EHB benchmark. The Kaiser Small Group HMO Plan does not cover infertility treatment.

5) *Benchmark plan.* Under a new regulation issued in 2018, a state may change its EHB-benchmark plan for plan years on or after January 1, 2020 by: a) selecting the EHB-benchmark plan that another state used for the 2017 plan year; b) replacing one or more categories of EHBs in the state's benchmark plan used for the 2017 plan year with the same category or categories of EHBs from the EHB-benchmark plan that another state used for the 2017 plan year; c) or, otherwise selecting a set of benefits that would become the state's EHB benchmark plan. The regulation requires the scope of benefits to be equal to, or greater than, the scope of benefits of a typical employer plan, to the extent any supplementation is required to provide coverage within each EHB category. The scope of benefits cannot exceed the generosity of the most generous among a set of comparison plans, including the state's EHB benchmark plan used for the 2017 plan year, and any of the state's base-benchmark plan options for the 2017 plan year. According to Covered California, the proposed federal deadline to select a new EHB benchmark plan for the 2022 plan year is May 8, 2020. The regulation also requires the state to provide reasonable public notice and an opportunity for public comment on the state's selection of an EHB-benchmark plan.

6) *Related legislation.* SB 600 (Portantino) requires a health plan contract or health insurance policy that covers hospital, medical, or surgical expenses, and Medi-Cal, to include coverage for medically necessary expenses for standard fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility to an enrollee or insured. *SB 600 is scheduled to be heard in the Assembly Health Committee on June 9, 2019.*

   AB 888 (Low) among other provisions, finds and declares nonpharmacological treatments for pain are vitally important to the state's efforts to combat the opioid crisis, and that coverage of these treatments should be considered during the next update to the state's EHB benchmark plan, as specified. *AB 888 is pending in the Senate Committee on Business Professions and Economic Development.*

AB 598 (Bloom) requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2020, to include coverage for hearing aids up to the maximum covered amount of $3,000 per individual hearing aid, for all enrollees under 18 years of age when medically necessary. *AB 598 passed the Senate Health Committee by an 8-0 vote on on June 26, 2019.*

7) *Prior legislation.* SB 172 (Portantino of 2017) would have required health plan contracts and health insurance policies to provide coverage for medically necessary expenses for standard fertility preservation services when medical treatment may directly or indirectly cause iatrogenic infertility to an enrollee or insured. *SB 172 was held on the Senate Appropriations Committee suspense file.*

AB 912 (Quirk-Silva of 2013) would have mandated that every large group health plan contract and health insurance policy to provide coverage for medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to an enrollee or insured. *AB 912 was vetoed by Governor Brown, who stated in part:*

> *Large group employers already have the ability to negotiate richer benefit packages that meet the needs of their employees. While I understand the desire to preserve fertility where possible, such coverage was not included in the essential health benefits that the Legislature passed just last year for individual and small group coverage. Coverage that goes beyond the essential health benefits is no doubt useful and desirable for many, but we should not consider mandating additional benefits until we implement the comprehensive package of reforms that are required by the [ACA].*

AB 428 (Portantino of 2011) was substantially similar to SB 172. *AB 428 was held on the Senate Appropriations Committee suspense file.*

AB 1826 (Migden of 2002) would have required health plans and disability insurers provide, instead of just offer, coverage for the treatment of infertility. Expands the coverage for the treatment of infertility by including IVF. *AB 1826 was never voted on in the Assembly Health Committee.*

8) *Support*. Proponents write that due to the lack of coverage for comprehensive infertility treatment options, the majority of patients that are able to access care are people of means that can come up with the out-of-pocket costs related to treatment. This disproportionately affects low-income individuals and partners that wish to start a family. The costs associated with infertility treatment should not bar persons from parenthood merely because they cannot afford medical treatment. It is time that California follows the lead of states such as New York by extending coverage to those who are diagnosed with infertility and provide them with options to treat their condition. The California Pan Ethnic health Network writes that infertility is a serious and chronic health condition, with health, social, and economic impacts. Rates of infertility differ by race, with black women experiencing it at nearly twice the rate of white women. Despite this, only 8% of black women have sought fertility services, compared to 15% of white women. An even lower percentage of Latinas (7.6%) have sought services. The disparity in seeking treatment has been found to be related largely to the cost of services, and puts treatment out of reach for many women.

9) *Opposition.* According to the California Chamber of Commerce, the addition of IVF coverage would exceed the EHBs, requiring the state to defray the costs of state mandated benefits. When health care issuers are required to cover new services such as infertility treatment, premiums for all enrollees and purchasers go up. This is true even though only some enrollees will utilize the mandated product or service. This bill previously mandated that all health care issuers cover infertility treatment, forcing all enrollees and purchasers to pay more in premiums whether or not they will ever use these services or find this added coverage to be a good value. The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans oppose mandate bills that lead to higher premiums, harming affordability and access for small businesses and individual market consumers. Over the past several years, employers have been losing more and more flexibility to set their own benefit designs due to costly state and federal regulations. These mandates will add to those higher health care costs.

10) *Oppose unless amended.* The California Catholic Conference asks that this bill be amended to include research of the health risks to women and overall statistics regarding IVF within California and nationwide, and hopes that the report can be clear and transparent of the IVF process in order for the legislature and all Californians to be well-informed.

11) *Policy comments.*

a) *Covered California.* If the author's intent is to ensure coverage in the large group market for IVF treatment for infertility, it is not clear why Covered California is being tasked with the responsibility to conduct this study. It may be appropriate for Covered California to conduct this study if it is the author's intent to impact EHBs which would apply to individual and small group plans only.

b) *EHB and Mandates.* California's existing coverage mandates, including EHB, provide comprehensive benefit coverage. While many policy arguments can be made to advance additional mandated benefits, Committee members may also wish to consider the cumulative effect of these bills and the tradeoffs associated with increasing health insurance premiums in the context of the already high cost of health insurance, another potential restructuring of health insurance markets nationally and in California because of actions taking place at the federal level to repeal the ACA, and in consideration of the budget action to fund state financial assistance to help Californians afford their health insurance, and a requirement that Californians have health insurance.

c) *EHB Benchmark Review.* The Legislature has reviewed California's benchmark plan twice before. Additionally, the process required under federal ACA requirements has changed from previous requirements. Since multiple bills have been introduced aimed at expanding benefits beyond California's current EHBs, it may be time for California to review its benchmark plan options again.

SUPPORT AND OPPOSITION:

Support: California Black Health Network
California Pan-Ethnic Health Network
California Rural Legal Assistance Foundation
National Association of Social Workers, CA Chapter

Oppose: America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Catholic Conference (unless amended)
California Chamber of Commerce

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