2021

Mandated Benefit Review: Infertility Treatment

December 2021

Washington State Department of Health

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Para solicitar este documento en otro formato, llame al 1-800-525-0127. Clientes sordos o con problemas de audición, favor de llamar al 711 (servicio de relé de Washington) o enviar un correo electrónico a civil.rights@doh.wa.gov.

Publication Number

120-055

For more information or additional copies of this report:

Health Systems Quality Assurance

P.O. Box 47850

Olympia, WA 98504-7850

Phone: 360-236-4612

Email: sunrise@doh.wa.gov

Report Authors

Ashley A. Noble, JD, MPIA

Umair A. Shah, MD, MPH
Secretary of Health

Contents

Sunrise Review Process

In 1997, the legislature passed House Bill 1191. This bill amended the statute on mandated health insurance benefits. The statute now requires proponents of a new mandate to provide a proposal to the legislature. At the request of the legislature, the Department of Health makes recommendations on the proposal using statutory criteria. This review is done only at the request of the chairs of legislative committees, usually the House Health Care and Wellness Committee or Senate Health and Long-Term Care Committee.

The criteria for these "sunrise reviews" are contained in RCW 48.47.030 (see Appendix A). The legislature's intent is that all mandated benefits show a favorable cost-benefit ratio and do not unreasonably affect the cost and availability of health insurance. RCW 48.47.005 states, "…the cost ramifications of expanding health coverage is of continuing concern and that the merits of a particular mandated benefit must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage."

Executive Summary

The legislature requested the Department of Health review draft bill H-1640.1/21, *Concerning fertility services*, under the State's mandated benefit review law, RCW 48.47.030. The proposed mandated benefit would require insurance plans regulated under Chapter 41.05 RCW: *State Health Care Authority* and 48.43 RCW: *Insurance Reform* beginning January 1, 2024, to provide "coverage for the diagnosis of infertility, treatment for infertility, and standard fertility preservation services," as well as "four completed oocyte retrievals with unlimited embryo transfers…using single embryo transfer when recommended and medically appropriate."

Insurance plans examined by the Department of Health on the State's Health Benefits Exchange generally did not include coverage for fertility treatments. Out-of-pocket costs for the diagnosis and treatment of infertility and fertility preservation services are generally expensive, easily reaching tens of thousands of dollars. The mandated benefit proposed would likely result in increased costs to the state, insurance carriers, and plan holders in the form of higher premiums. However, mandated coverage for infertility treatments may also decrease out-of-pocket costs for patients and allow for better quality care and more informed decision-making.

Additionally, inequities regarding access to infertility treatments are likely to persist in the presence of a mandated benefit for infertility treatments. That's because people with low incomes may not be able to afford the types of health insurance coverage contemplated in the draft legislation under review.

The Department does not have sufficient information on the financial impacts of including infertility treatment as a mandated insurance benefit. However the Department offers the following suggestions that may clarify some of the terminology used in the bill text, as well as address some potential issues that may arise, including:

- Language specifying that infertility coverage in this bill is meant to apply to people regardless of sex or gender.
- Defining what services are included under the terms "pregnancy-related benefits" and "standard fertility benefits."
- Whether the coverage mandated in this draft legislation would include treatments for single or unpartnered people who are otherwise fertile but wish to become single parents.[VM(1)]
- Whether benefits for infertility treatments would include coverage for donated eggs or donated sperm, and, if so, under what circumstances donated gametes would be included in coverage.
- Language regarding state funding to pay for services not included as essential health benefits under the federal Affordable Care Act.

Introduction

The legislature requested the Department of Health review draft bill H-1640.1/21, *Concerning fertility services*, under the State's mandated benefit review law, RCW 48.47.030.

The proposed mandated benefit would apply to insurance plans offered under Chapter 41.05 RCW: *State Health Care Authority* and 48.43 RCW: *Insurance Reform* beginning January 1, 2024. The draft legislation would require plans renewed or issued under these statutes to provide "coverage for the diagnosis of infertility, treatment for infertility, and standard fertility preservation services," as well as "four completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer when recommended and medically appropriate." The legislation defines infertility as "the failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse; a person's inability to reproduce either as a single individual or with the person's partner without medical intervention; a licensed physician's or osteopathic physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing; or disability as an impairment of function." See Appendix C for the full text of the draft legislation.

The applicant organization for this mandated benefit proposal is the Building Families Coalition.

Background

The draft legislation subject to this review defines infertility as:

> [A] disease, condition, or status characterized by:
>
> > (i) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse;
> >
> > (ii) A person's inability to reproduce either as a single individual or with the person's partner without medical intervention;
> >
> > (iii) A licensed physician's or osteopathic physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing; or
> >
> > (iv) Disability as an impairment of function.

"Regular sexual intercourse" is defined in the draft legislation as "no more than 12 months of unprotected sexual intercourse for a woman under the age of 35 or no more than six months of unprotected sexual intercourse for a woman 35 years of age or older."

These definitions align with the definitions of infertility available on the Centers for Disease Control and Prevention (CDC) website.

Infertility can affect people of all genders and ethnicities and can be caused by many factors.[1] Nationally, 13.1 percent of all women between ages 15 and 49 years old have impaired fecundity.[2] Impaired fecundity is naturally occurring difficulty or impossibility of becoming pregnant or carrying a pregnancy to a live birth.[3]

Infertility treatments include a range of interventions including obtaining medical advice, fertility testing, medication, surgery, intrauterine insemination (IUI), in vitro fertilization (IVF), and using a gestational carrier or surrogate. Surrogacy is not included in the legislation under this review.

Social Impact

To what extent is the benefit generally utilized by a significant portion of the population?

According to the CDC, "Approximately 1.9 percent of all infants born in the United States every year are conceived using Assisted Reproductive Therapy (ART)."[4] Nationally, 12.7 percent of women ages 15—49, regardless of marital status, report using infertility treatment services.[5]

To what extent is the benefit already generally available?

Department of Health staff surveyed health insurance plans available on the Washington Health Benefit Exchange. Staff browsed plans in Clark County, Seattle, Spokane County, and Yakima County by entering demographic information for a nonsmoking patient assigned female at birth and born on August 5, 1986, in four zip codes into the relevant data fields. Data fields for annual household income and additional family members were left blank. Results were sorted by metal tier level and monthly premium. The lowest-cost premium plan in each metal tier was chosen to review in each zip code. When the same insurance carrier offered the lowest premium plan in more than one metal tier in a zip code, the plan with the next least expensive premium cost was chosen.

Clark County: 98607

Molina Healthcare Core Care Bronze 1 is the health insurance plan with the lowest estimated monthly premium ($290.87) in zip code 98607. The plan covers diagnostic services for

[1] Coverage and Use of Fertility Services in the U.S. | KFF
[2] NSFG - Listing I - Key Statistics from the National Survey of Family Growth (cdc.gov)
[3] NSFG - Listing I - Key Statistics from the National Survey of Family Growth (cdc.gov)
[4] ART Success Rates | CDC
[5] NSFG - Listing I - Key Statistics from the National Survey of Family Growth (cdc.gov)

infertility; however, the plan does not provide coverage for infertility services except to treat underlying causes of infertility.

Molina Healthcare also offers the lowest premium silver tier health insurance plan in 98607. The next lowest estimated premium silver tier plan is Kaiser Permanente's KP WA Silver 2500/40 ($452.97 per month). The plan provides coverage for infertility diagnoses. Infertility treatments, prescription medications to treat infertility, and ART are not covered under this plan. Policy holders who enter into surrogacy arrangements and receive coverage for treatments related to that arrangement must enter into a formal agreement with Kaiser Permanente to reimburse the company for expenses.

Molina Healthcare and Kaiser Permanente offer the lowest premium cost gold tier insurance plans in 98607. The next lowest estimated premium gold tier plan not offered by either company is PacificSource Health Plans Navigator Gold 2000 ($473.02 per month). Infertility treatment is not covered.

Table 1: Clark County 98607

Metal Tier	Insurance Carrier	Plan Name	Estimated Premium	Diagnosis	ART	Underlying Cause(s)	Other Treatments
Bronze	Molina Healthcare	Core Care Bronze 1	$290.87	Yes	No	Yes	No
Silver	Kaiser Permanente	KP WA Silver 2500/40	$452.97	Yes	No	No	No
Gold	PacificSource Health Plans	Navigator Gold 2000	$473.02	n/a	No	n/a	No

Seattle/King County: 98101

Molina Healthcare Core Care Bronze 1 is the health insurance plan with the lowest estimated monthly premium in zip code 98101 ($262.04). Coverage is identical to the Core Care Bronze 1 plan offered in Clark County.

Kaiser Permanente offers the lowest estimated premium cost silver tier plan in 98101 ($342.62 per month). The Virtual Plus Silver – 21 plan offers "[g]eneral counseling and services to

diagnose infertility conditions in accordance with KFHPWA clinical criteria," however, it does not include coverage for treatment of infertility or sterility, assisted reproductive technology, surrogacy, or testing for "congenital or heritable disorders."

Molina Healthcare and Kaiser Permanente offer the lowest premium price gold tier plans in 98101.The next lowest premium cost plan ($457.07 per month) is offered by Ambetter Coordinated Care. The Ambetter Secure Care 1 (2021) with 3 Free PCP Visits provides coverage for diagnosis of infertility, however, the plan does not provide coverage for treatment of infertility, artificial insemination, sterilization reversal, prescription infertility treatment drugs, unless such drugs are included on the plan's formulary elsewhere, or surrogacy. Fetal reduction surgery is covered only if medically necessary.

Table 2: Seattle/King County 98101

Metal Tier	Insurance Carrier	Plan Name	Estimated Premium	Diagnosis	ART	Underlying Cause(s)	Other Treatments
Bronze	Molina Healthcare	Core Care Bronze 1	$262.04	Yes	No	Yes	No
Silver	Kaiser Permanente	Virtual Plus Silver – 21	$342.62	Yes	No	No	No
Gold	Ambetter Coordinated Care	Ambetter Secure Care 1 (2021) with 3 Free PCP Visits	$457.07	Yes	No	n/a	No

Spokane County: 99201

Ambetter Coordinated Care offers the lowest estimated premium bronze tier plan in the 99201-zip code ($240.61 per month). The Ambetter Essential Care 1 (2021) plan includes coverage for infertility diagnosis. Infertility coverage is identical to the Ambetter Secure Care 1 with 3 PCP Visits plan discussed above.

Ambetter Coordinated Care offers the lowest estimated premium silver tier plans in the 99201-zip code. Molina Healthcare offers the next lowest estimated premium cost silver tier plan. The Molina Cascade Silver plan ($346.12 per month) does not include coverage for infertility treatments, supplies, or drugs. Surrogacy agreements are also not included in coverage.

Ambetter Coordinated Care and Molina Healthcare offer the lowest estimated premium plans in the gold tier level. Community Health Network of Washington's Cascade Select Gold plan is the plan with the next lowest estimated premium in that metal level for 99201 ($401.35 per month). Infertility diagnoses are included benefits. Coverage is not provided for sterilization reversal surgeries, drugs to enhance fertility, fertility treatments, or assisted reproductive technologies. Treatments for gestational surrogates are not included unless the gestational carrier is covered "under the plan at the time the services were rendered."

Table 3: Spokane County 99201

Metal Tier	Insurance Carrier	Plan Name	Estimated Premium	Diagnosis	ART	Underlying Cause(s)	Other Treatments
Bronze	Ambetter Coordinated Care	Ambetter Essential Care 1 (2021)	$240.61	Yes	No	n/a	No
Silver	Molina Healthcare	Molina Cascade Silver	$346.12	n/a	No	Yes	No
Gold	Community Health Network of Washington	Cascade Select Gold	$401.35	Yes	No	n/a	No

Yakima County: 98901

Ambetter Coordinated Care offers the lowest estimated premium bronze tier plan in the 98901-zip code. The Ambetter Essential Care 1 (2021) plan ($255.08 per month) is identical to the coverage offered in the Ambetter Secure Care 1 with 3 PCP visits.

Ambetter Coordinated Care offers the lowest estimated premium silver tier plans in the 98901-zip code. The next least expensive premium plan in this tier is offered by the Community Health Network of Washington. The Cascade Select Silver plan ($382.54 per month) provides coverage

for “the initial evaluation and diagnosis of infertility.” Infertility treatments, sterilization reversal, and prescription drugs to treat infertility are not covered benefits under this plan.

Ambetter and Community Health Network of Washington offer the lowest estimated premium cost gold tier health plans in this zip code. The gold tier plan with the next least expensive premium is offered by LifeWise Health Plan of Washington. The plan covers surgeries for correction of underlying causes of infertility. The LifeWise Essential Gold plan ($431.61 per month) does not provide coverage for ART or surgeries to reverse sterilizations.

This survey suggests that private insurance coverage on the individual market for infertility treatments is generally not available or is available on a limited basis.

Table 4: Yakima County 98901

Metal Tier	Insurance Carrier	Plan Name	Estimated Premium	Diagnosis	ART	Underlying Cause(s)	Other Treatments
Bronze	Ambetter Coordinated Care	Ambetter Essential Care 1 (2021)	$255.08	Yes	No	n/a	No
Silver	Community Health Network of Washington	Cascade Select Silver	$382.54	Yes	No	n/a	No
Gold	LifeWise Health Plan of Washington	LifeWise Essential Gold	$431.61	Yes	No	Yes	No

Availability in other states

California and New York have been cited as examples of states with mandated insurance for infertility treatments. California has required “every health care service plan contract 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 in Section 1373.10, [to] offer coverage for the treatment of infertility, except in vitro fertilization, under those terms and conditions as may be agreed upon between the group subscriber and the plan” since

1990.[6] This requirement includes Health Maintenance Organizations (HMO) offered to group contract holders with at least 20 employees.[7] Life and disability insurers are also required to offer this coverage.[8]

Coverage for fertility preservation services for treatment of iatrogenic infertility is required for health care services plans.[9] Iatrogenic infertility means that it was caused by medical examination or treatment.

The California State Health and Safety Code defines infertility as "either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) 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," and infertility treatment 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.[10] "In vitro fertilization" means the laboratory medical procedures involving the actual in vitro fertilization process."[11]

Table 5: California Coverage Requirements

	Insurers Impacted	Diagnosis	Treatment	Fertility Preservation	Exceptions
Cal. Health and Safety Code Art. 5 §1374.55	HMO	Yes	Yes	Yes	IVF
Cal. Ins. Code Art. 1 §10119.6	Life and Disability	Yes	Yes	Yes	IVF
Cal. Health and Safety Code Art. 5 §1374.55	Health Care Services Plans	Yes	Yes	Yes	IVF

Section 3216 of New York's Insurance Law statutes for individual accident and health insurance policy provisions require- accident and health insurance policies that provide coverage for

[6] Cal. Health and Safety Code Art. 5 §1374.55
[7] Cal. Health and Safety Code Art. 5 §1374.55
[8] Cal. Ins. Code Art. 1 §10119.6
[9] Cal. Health and Safety Code Art. 5 §1374.551
[10] Cal. Health and Safety Code Art. 5 §1374.55
[11] Cal. Health and Safety Code Art. 5 §1374.55

hospital care to also "provide coverage for standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility," and every plan that provides coverage for prescription drugs from in-network pharmacies to provide coverage for prescription drugs to treat infertility.[12] [13]

Group and blanket accident and health insurance plans, as well as hospital service and health service corporations that provide coverage for hospital, surgical, and medical care in New York are required to cover in-hospital treatments that would result in correcting the cause of a patient's infertility, in addition to the original condition being treated.[14] Diagnostic tests for infertility or that find a cause of infertility in the process of diagnosing another disease or condition must also be covered.[15] Plans must also cover prescription drugs to treat infertility if prescription drugs are otherwise covered under a plan's terms.[16] However, coverage for diagnosis and treatment of infertility is not required if the diagnosis and treatment is conducted in connection with IVF, experimental procedures, or elective sterilization reversal procedures.[17] Plans must also provide coverage for fertility preservation services when medical treatments will result in iatrogenic infertility.[18]

Large group plans that provide comprehensive coverage in New York must cover three cycles of IVF treatment regardless of a patient's "expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity."[19]

Table 6: New York Coverage Requirements

	Insurers Impacted	Diagnosis	Treatment	Fertility Preservation	Exceptions
Consolidated Laws of New York Chapter 28, Article 32 §3216(i)(13)(C)	Individual accident and health	n/a	Yes (fertility drugs)	Yes	
Consolidated Laws of New York Chapter	Group and blanket	Yes	Yes	Yes	Experimental procedures

[12] Consolidated Laws of New York Chapter 28, Article 32 §3216(i)(13)(C), (i)(13-a)
[13] Consolidated Laws of New York Chapter 28, Article 43 §4303
[14] Consolidated Laws of New York Chapter 28, Article 32 §3221(k)(6)
[15] Consolidated Laws of New York Chapter 28, Article 32 §3221(k)(6)
[16] Consolidated Laws of New York Chapter 28, Article 32 §3221(k)(6)
[17] Consolidated Laws of New York Chapter 28, Article 32 §3221(k)(6)
[18] Consolidated Laws of New York Chapter 28, Article 32 §3221(k)(6)
[19] Consolidated Laws of New York Chapter 28, Article 32 § 3221 (16)(e)(6)(C)(vii)

28, Article 32 § 3221	accident and health			
Consolidated Laws of New York Chapter 28, Article 43 §4303	Hospital service and health service corporations	Yes	Yes	Yes
Consolidated Laws of New York Chapter 28, Article 32 § 3221	Large group plans that provide comprehensive coverage	n/a	Yes (IVF)	n/a

If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services?

An opinion published in the July 2021 issue of *Fertility and Sterility* states that utilization of infertility services tripled in states that require some level of insurance coverage.[20] The same opinion cited a 2009 study that estimated 24 percent of the demand for assisted reproductive technology (ART) is being met.[21] These statistics suggest that there is a significant unmet demand for insurance coverage for fertility services.

If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship?

Iatrogenic Infertility and Fertility Preservation

Certain medical treatments carry the risk of negatively impacting a patient's ability to have biological children in the future. Adolescent and adult male patients who require medical treatments that place their future fertility at risk may choose to undergo cryogenic preservation of semen.[22] This service ranges in cost from $500—$1,000, with additional annual storage fees ranging from $150—$400.[23] Postpubescent male patients may also choose to preserve sperm

[20] Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion (asrm.org)
[21] Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion (asrm.org)
[22] Fertility Preservation for Pediatric and Adolescent Patients With Cancer: Medical and Ethical Considerations | American Academy of Pediatrics (aappublications.org)
[23] Paying For Treatments | Cancer Fertility Preservation (allianceforfertilitypreservation.org)

obtained via testicular sperm extraction or electroejaculation. The costs for testicular sperm extraction range from $7,500—$10,000, with additional annual storage fees ranging from $300–$500.[24] Electroejaculation costs range from $10,000—$12,000, with additional annual storage fees ranging from $300—$500.[25] The preserved genetic material can later be used in ART. Prepubescent males may also be able to preserve fertility using testicular tissue cryopreservation, however this is an experimental procedure.[26]

Female patients who require medical treatments that place their future fertility at risk may choose to have their oocytes (eggs) cryogenically frozen for later use in ART. According to a study published in the journal *Pediatrics*, "A typical oocyte cryopreservation cycle can cost between $7,000 and $14,000," while "[m]edications per egg retrieval cycle can cost between $2,000 and $7,000…"[27] Cryogenic preservation of ovarian tissue in prepubescent girls is an experimental procedure, however the Alliance for Fertility Preservation states that costs for the procedure range from $10,000—$12,000, with storage costs ranging from $300—$500 per year.[28] [29]

Other Infertility Diagnoses and Treatments

Costs for infertility diagnosis and treatment are variable, depending upon the type of service sought. According to Planned Parenthood, the out-of-pocket cost for intrauterine insemination (IUI) ranges from $300—$1,000.[30] The Fertility Blog at the University of Pennsylvania School of Medicine published an article in 2018 estimated the average cost of one cycle of in vitro fertilization (IVF) ranges between $10,000 and $15,000.[31] Gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures in IVF can range from $15,000 to $20,000, according to Healthwise, Inc.[32]

[24] Paying For Treatments | Cancer Fertility Preservation (allianceforfertilitypreservation.org)
[25] Paying For Treatments | Cancer Fertility Preservation (allianceforfertilitypreservation.org)
[26] Testicular Tissue Cryopreservation | The Oncofertility Consortium (msu.edu)
[27] Fertility Preservation for Pediatric and Adolescent Patients With Cancer: Medical and Ethical Considerations | American Academy of Pediatrics (aappublications.org)
[28] Fertility Preservation for Pediatric and Adolescent Patients With Cancer: Medical and Ethical Considerations | American Academy of Pediatrics (aappublications.org)
[29] Paying For Treatments | Cancer Fertility Preservation (allianceforfertilitypreservation.org)
[30] What Is Intrauterine Insemination (IUI)? (plannedparenthood.org)
[31] IVF by the Numbers - Penn Medicine
[32] Gamete and Zygote Intrafallopian Transfer (GIFT and ZIFT) for Infertility | Michigan Medicine (uofmhealth.org)

What is the level of public demand for the benefit?

Globally, between eight and 12 percent of couples experience issues with fertility.[33] An opinion published in the July 2021 issue of *Fertility and Sterility* cited a 2009 study that approximately 24 percent of the demand for ART is being met.[34]

Nationally, 197,706 ART procedures were performed in 2016, or 3,075.2 ART procedures per 1 million women ages 15-44 years. Of those, 4,129 were performed in Washington state, or 2,872.4 per 1 million women ages 15-44 years.[35] Of 90,505 live births reported in Washington state in 2016, 1,511 (1.7 percent) were conceived via ART. Singleton infants conceived via ART in 2016 accounted for 1.3 percent of total singleton infants born in Washington state.[36]

What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?

Unknown. The applicant report (Appendix D) states that "there has been interest by collective bargaining agents in other states and locally with respect to inclusion of infertility coverage in health plans," however no data is cited.

Financial Impact

To what extent will the benefit increase or decrease the cost of treatment or service?

While the exact effect of mandated insurance benefit coverage for infertility treatments is unknown, the costs of health care in the United States have consistently risen over the decades. It is reasonable to assume this trend will continue.[37] California analyzed the potential outcomes of a mandated infertility treatment bill in April 2020. Their analysis cited research finding that per unit infertility treatment costs were higher in states with mandated benefits for these services than in states without such mandates.[38] However, they also qualified that statement

[33] Assisted reproductive technology: Definition, types, and ethics (medicalnewstoday.com)
[34] Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion (asrm.org)
[35] Assisted Reproductive Technology Surveillance — United States, 2016 | MMWR (cdc.gov)
[36] Assisted Reproductive Technology Surveillance — United States, 2016 | MMWR (cdc.gov)
[37] *See* Coverage and Use of Fertility Services in the U.S. | KFF
[38] California Health Benefits Review Program Analysis of California Assembly Bill 2781 Treatment of Infertility A Report to the 2019–2020 California State Legislature April 3, 2020, pg.48.

with an observation that such costs may have increased regardless. Out-of-pocket costs for patients may decrease as a result of such benefits.[39] [40]

To what extent will the coverage increase the appropriate use of the benefit?

It is likely that Washington would see an increase in the number of patients who undergo infertility treatments if mandated insurance coverage were available. A 2020 issue brief published by the Kaiser Family Foundation states that use of ART grew 1.5 percent over the national rate in Illinois, Massachusetts, and New Hampshire following the requirement of "comprehensive" infertility treatment coverage, and states that required IVF coverage experienced higher rates of IVF use.[41]

To what extent will the benefit be a substitute for a more expensive benefit?

Pregnancies of twin or multiple fetuses often carry higher risks during the pregnancy and are more likely to result in premature births than singleton pregnancies.[42] It is possible that some patients may choose to transfer fewer blastocysts if this benefit mandate is implemented. Some people who undergo IVF may choose to have two or more blastocysts transferred into the uterus to increase the odds of successful implantation.[43] [44] Motivations for transferring two or more blastocysts vary, however cost per IVF cycle and advancing maternal age are potential considerations for patients.[45] [46]

To what extent will the benefit increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders?

Department of Health staff were unable to find data regarding the overall trends of administration costs in health insurance. Job and wage growth in health care administration has

---

[39] California Health Benefits Review Program Analysis of California Assembly Bill 2781 Treatment of Infertility A Report to the 2019–2020 California State Legislature April 3, 2020, pg. 50.
[40] *Virtual Mentor*, January 2014—Vol 16, pg. 64
[41] Coverage and Use of Fertility Services in the U.S. | KFF
[42] Guidance on the limits to the number of embryos to transfer: a committee opinion - Fertility and Sterility (fertstert.org)
[43] California Health Benefits Review Program Analysis of California Assembly Bill 2781 Treatment of Infertility A Report to the 2019–2020 California State Legislature April 3, 2020, pg. 59.
[44] *Virtual Mentor*, January 2014—Vol 16, pg. 64
[45] *See* California Health Benefits Review Program Analysis of California Assembly Bill 2781 Treatment of Infertility A Report to the 2019–2020 California State Legislature April 3, 2020, pg. 59.
[46] MILITARY MEDICINE, 185, 9/10:e1700, 2020

risen, however rises in these areas are not out of the norm when compared to health care employment overall.[47]

What will be the impact of this benefit on the total cost of health care services and on premiums for health coverage?

It is likely that health insurance premiums would increase as a result of this new mandate. When considering similar legislation, California estimated that premiums for the state's Medicaid plan would rise 0.35 percent and would rise 0.79 percent in the individual market.[48] New York commissioned an analysis on the feasibility of mandating infertility treatment coverage for commercial plans offered in the state and estimated that premiums would rise by "0.5 percent to 1.1 percent" for IVF and 0.2 percent for medically necessary fertility preservation.[49]

What will be the impact of this benefit on costs for state-purchased health care?

The draft legislation under review would apply to Washingtonians covered under Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) plans. It is reasonable to assume that premiums for PEBB and SEBB plans would increase as a result of this new mandate. Apple Health, the State's Medicaid program, would not be impacted by this mandate as outlined in the draft legislation.

The State would also need to consider the financial impact of requiring a mandated benefit not identified as an essential health benefit (EHB) under the federal Patient Protection and Affordable Care Act (ACA). States that require benefits for individual and small market plans not included in the original~~as~~ EHB plan under the ACA are required to offset certain costs.[50]

What will be the impact of this benefit on affordability and access to coverage?

It is likely that adoption of a mandate for insurance coverage of infertility treatments would improve patient access and affordability generally, since out-of-pocket costs will likely be lower for patients.[51] [52] However, inequities regarding access to infertility treatments are likely to

---

[47] How Administrative Spending Contributes To Excess US Health Spending | Health Affairs
[48] Key Findings: Analysis of California Assembly Bill 2781 Treatment of Infertility Summary to the 2019–2020 California State Legislature, April 3, 2020, pg. 3
[49] DFS: Report on In-Vitro Fertilization and Fertilization Preservation Coverage (ny.gov)
[50] *See* Coverage and Use of Fertility Services in the U.S. | KFF
[51] *See Virtual Mentor*, January 2014—Vol 16, pg. 65
[52] Molly Quinn, M.D. and Victor Fujimoto, M.D., Racial and ethnic disparities in assisted reproductive technology access and outcomes. VOL. 105 NO. 5 / MAY 2016

persist in the presence of a mandated benefit for infertility treatments. That's because people with low incomes may not be able to afford the types of health insurance coverage contemplated in the draft legislation under review.[53]

Evidence of health care service efficacy

To what extent have professionally accepted controlled trials been conducted to examine the health consequences of that service compared to no service or an alternative service?

In the absence of infertility testing and diagnostic tests, some people may never be aware of potentially treatable medical conditions that may make pregnancy or successfully carrying a pregnancy to term difficult or impossible. Others may never be able to have biological children in the absence of ART or undergo procedures to preserve their fertility prior to receiving lifesaving medical treatments that will negatively impact their fertility. However, the receipt of infertility treatment or fertility preservation services is not a guarantee of pregnancy or birth. Fertility tends to decline with the age of the biological parents, particularly in women.[54] The likelihood of giving birth to a child with a chromosomal abnormality increases with the age of the person giving birth.[55]

The chances of becoming pregnant after undergoing IVF also decrease with age. The Office of Women's Health at the U.S. Department of Health and Human Services cites a 2014 CDC report finding that, on average, 39 percent of pregnancies achieved via ART to women under 35 years of age resulted in live births.[56] The percentage of ART pregnancies resulting in live births declined to 30 percent among women ages 35-37 years, 21 percent in women ages 37-40 years, and 11 percent in women ages 41-42 years.[57]

Penn Medicine states that patients under 35 years of age who undergo IVF using fresh, non-donor eggs have a 21.3 percent chance of delivering a live, healthy infant from a singleton pregnancy.[58] Penn Medicine estimates that the chances of delivering a healthy, live infant from a singleton pregnancy conceived using fresh, non-donor eggs decreases to 17 percent for patients between 35 and 37 years of age, 11.1 percent for patients ages 38—40 years, 5.7

[53] Molly Quinn, M.D. and Victor Fujimoto, M.D., Racial and ethnic disparities in assisted reproductive technology access and outcomes. VOL. 105 NO. 5 / MAY 2016
[54] Evaluating Infertility | ACOG
[55] Genetic risk maternal age - Embryology (unsw.edu.au)
[56] Infertility | Office on Women's Health
[57] Infertility | Office on Women's Health
[58] IVF by the Numbers - Penn Medicine

percent for patients ages 41 to 42 years, 2.3 percent for patients ages 43 to 44 years, and 0.6 percent for patients older than 45 years.[59]

If a person is unable to have biological children, they may be able to foster or adopt a child. Fostering and adoption can require significant investments of time and other resources before a successful placement can be made. The Washington Department of Children Youth and Families (DCYF) estimates that private adoptions conducted outside of the agency range in cost from $4,000—$40,000, and with a similar range of $8,000—$40,000 for independent adoptions conducted outside the agency.[60] DCYF does not include a cost estimate for adoptions conducted within the agency, however, the Department states that such costs "are typically kept to a bare minimum."[61] Parents who choose to adopt a child with special needs through DCYF may be eligible for up to $1,500 in adoption expense reimbursements.[62] Families who adopt a special needs child through the public child welfare system may also qualify for $14,300 in tax credits through the federal government.[63] It is possible for fostering and adoption plans to fail; there is no guarantee that a given child will be placed with a given family.

One of the people who submitted comments and testimony for this review recounted her family's experiences with becoming parents as carriers of a rare genetic condition. The use of IVF would have allowed for blastocysts to be screened for the condition prior to transfer, however the cost of the treatment was prohibitively expensive. Treatment for children born with genetic conditions can be expensive and last the course of a lifetime.

To what extent will the mandated benefit enhance the general health status of the state residents?

Creating a new mandated benefit for infertility treatments may result in improved health outcomes among Washingtonians. Testimony offered at public hearing referenced a health care provider's experiences in treating patients who had been diagnosed with cancer, and how some of her patients have chosen to undergo less effective cancer treatments out of concern for fertility loss. Requiring coverage for fertility preservation services may prevent some patients from choosing to undergo less effective cancer treatments in an attempt to preserve the potential for future biological children.

California's 2020 analysis of the potential effects of mandating insurance coverage for infertility treatments cited studies conducted in 2009 and 2018 suggesting patients who lack insurance

[59] IVF by the Numbers - Penn Medicine
[60] Cost | Washington State Department of Children, Youth, and Families
[61] Cost | Washington State Department of Children, Youth, and Families
[62] Cost | Washington State Department of Children, Youth, and Families
[63] Cost | Washington State Department of Children, Youth, and Families

coverage for infertility services "are not offered clinically appropriate treatments and receive substandard care." [64]

Like most medical treatments, infertility treatment involve risk to the patient's health. According to an article published in *EMBO Reports,* the long-term consequences associated with pregnancies and births achieved through ART are yet unknown.[65] Shorter-term health risks include the development of ovarian hyperstimulation syndrome, which causes painful swelling of the ovaries.[66] [67] Some cases of this syndrome resolve without treatment, however, others may require hospitalization.[68] Hospitalization for OHSS would likely result in additional healthcare costs. In cases in which a patient chooses to transfer more than one embryo as part of ART treatment, the odds of more than one embryo implanting in the uterus increases. Pregnancies with multiple fetuses carry higher risks to both the patient and the fetuses. According to the CDC, "Multiple-birth infants are at increased risk for low birth weight, preterm delivery, infant death, and disability among survivors."[69] The CDC also notes that "ART-conceived singletons also face increased risks for low birth weight, very low birth weight, preterm delivery, and fetal growth restriction."[70] These health conditions may also lead to higher health care costs.[71]

Recommendations

The mandated benefit proposed would likely result in increased costs to the state, insurance carriers, and plan holders in the form of higher premiums. However, mandated coverage for infertility treatments may also decrease out-of-pocket costs for patients and allow for better quality care and more informed decision-making.

The Department believes further financial information is necessary to determine appropriate action on the draft legislation under review.

---

[64] California Health Benefits Review Program Analysis of California Assembly Bill 2781 Treatment of Infertility A Report to the 2019–2020 California State Legislature April 3, 2020, pg. 19.
[65] The long-term health risks of ART: Epidemiological data and research on animals indicate that in vitro fertilization might create health problems later in life: EMBO reports: Vol 18, No 7 (embopress.org)
[66] A Public Health Focus on Infertility Prevention, Detection, and Management | Public Health | Infertility | Reproductive Health | CDC
[67] Ovarian hyperstimulation syndrome - Symptoms and causes - Mayo Clinic
[68] Ovarian hyperstimulation syndrome - Symptoms and causes - Mayo Clinic
[69] A Public Health Focus on Infertility Prevention, Detection, and Management | Public Health | Infertility | Reproductive Health | CDC
[70] A Public Health Focus on Infertility Prevention, Detection, and Management | Public Health | Infertility | Reproductive Health | CDC
[71] A Public Health Focus on Infertility Prevention, Detection, and Management | Public Health | Infertility | Reproductive Health | CDC

The draft legislation submitted for this review would benefit from clarifying some of the terminology used in the bill text, as well as addressing some potential issues that may arise. These recommendations are discussed in brief below.

The current draft bill language regarding regular, unprotected sexual intercourse could be reasonably interpreted to include same-sex couples, however, it may be beneficial to include language specifying that infertility coverage in this bill is meant to apply to people regardless of sex or gender. Such explicit language regarding the scope and intent of the legislation could be beneficial should future questions arise regarding the applicability of the coverage mandate.

Insurance carriers may encounter difficulty in determining the extent to which benefits should be offered. The current draft bill forbids the imposition of limits or exclusions on infertility care that are different than those imposed upon benefits for services not related to infertility. Insurers may have difficulty implementing this due to the large number of benefits and combinations of benefits offered. Similarly, the legislation may benefit from defining what services are included under the terms "pregnancy-related benefits" and "standard fertility benefits." If the term "standard fertility treatments" is interpreted to include those treatments generally recognized as the standard of care among practitioners and does not include experimental treatments, regulators, providers, and carriers will benefit from guidance or standards to use to establish when a treatment falls under the term.

~~It is unclear~~There is ambiguity regarding whether the coverage mandated in this draft legislation would include treatments for single or unpartnered people who are otherwise fertile but wish to become single parents. [VM(2)][NAA(3]For example, would these extend to surrogacy in the case of an otherwise fertile, unpartnered man who wished to become a single father? The proposed legislation requires "a person's inability to reproduce either as a single individual or with the person's partner without medical intervention," but it does not specify whether the inability to reproduce includes non-infertility circumstances that prevent a person from becoming a biological parent. It is also unclear whether benefits for infertility treatments would include coverage for donated eggs or donated sperm, and, if so, under what circumstances donated gametes would be included in coverage. Clarifying this ambiguity would ensure future administrative rules and legal interpretations align with legislative intent.

Lastly, the legislation may benefit from including language regarding state funding to pay for services not included as essential health benefits under the federal Affordable Care Act.

Conclusion

The draft legislation under this review would require insurance carriers to provide coverage for infertility treatments. Infertility treatments are expensive and require a significant investment in resources for patients who choose to pursue them to have biologically related children. It is likely that insurance premiums would rise as a result of requiring coverage for these

treatments. However, there is also a large unmet demand for infertility treatments which could be addressed by requiring insurance coverage. The Department finds insufficient information on the financial impact of this legislation to make a recommendation. This legislation may benefit from clarification of certain and terms and provisions to ensure effectiveness.

Appendix A

Chapter 48.47 RCW: Mandated Health Benefits

RCW 48.47.005: Legislative findings—Purpose.

The legislature finds that there is a continued interest in mandating certain health coverages or offering of health coverages by health carriers; and that improved access to these health care services to segments of the population which desire them can provide beneficial social and health consequences which may be in the public interest.

The legislature finds further, however, that the cost ramifications of expanding health coverages is of continuing concern; and that the merits of a particular mandated benefit must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage. The legislature hereby finds and declares that a systematic review of proposed mandated benefits, which explores all the ramifications of such proposed legislation, will assist the legislature in determining whether mandating a particular coverage or offering is in the public interest. The purpose of this chapter is to establish a procedure for the proposal, review, and determination of mandated benefit necessity.

[1997 c 412 § 1; 1984 c 56 § 1. Formerly RCW 48.42.060.]

RCW 48.47.010: Definitions.

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Appropriate committees of the legislature" or "committees" means nonfiscal standing committees of the Washington state senate and house of representatives that have jurisdiction over statutes that regulate health carriers, health care facilities, health care providers, or health care services.

(2) "Department" means the Washington state department of health.

(3) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under *chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if

owned and operated by a political subdivision or instrumentality of the state, and such other facilities as required by federal law and implementing regulations.

(4) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(5) "Health care service" or "service" means a service, drug, or medical equipment offered or provided by a health care facility and a health care provider relating to the prevention, cure, or treatment of illness, injury, or disease.

(6) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, plans operating under the state health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated in chapter 48.43 RCW.

(7) "Mandated health benefit," "mandated benefit," or "benefit" means coverage or offering required by law to be provided by a health carrier to: (a) Cover a specific health care service or services; (b) cover treatment of a specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services; however, it does not mean benefits established pursuant to chapter 74.09, 41.05, or 70.47 RCW, or scope of practice modifications pursuant to chapter 18.120 RCW.

[1997 c 412 § 2.]

NOTES:

***Reviser's note:** Chapter 70.96A RCW was repealed and/or recodified in its entirety pursuant to 2016 sp.s. c 29 §§ 301, 601, and 701.

RCW 48.47.020: Submission of mandated health benefit proposal—Review—Benefit must be authorized by law.

Mandated health benefits shall be established as follows:

(1) Every person who, or organization that, seeks to establish a mandated benefit shall, at least ninety days prior to a regular legislative session, submit a mandated benefit proposal to the appropriate committees of the legislature, assessing the social impact, financial impact, and

evidence of health care service efficacy of the benefit in strict adherence to the criteria enumerated in RCW 48.47.030.

(2) The chair of a committee may request that the department examine the proposal using the criteria set forth in RCW 48.47.030, however, such request must be made no later than nine months prior to a subsequent regular legislative session.

(3) To the extent that funds are appropriated for this purpose, the department shall report to the appropriate committees of the legislature on the appropriateness of adoption no later than thirty days prior to the legislative session during which the proposal is to be considered.

(4) Mandated benefits must be authorized by law.

[1997 c 412 § 3; 1989 1st ex.s. c 9 § 221; 1987 c 150 § 79; 1984 c 56 § 2. Formerly RCW 48.42.070.]

NOTES:

Effective date—Severability—1989 1st ex.s. c 9: See RCW 43.70.910 and 43.70.920.

Severability—1987 c 150: See RCW 18.122.901.

RCW 48.47.030: Mandated health benefit proposal—Guidelines for assessing impact—Inclusion of ad hoc review panels—Health care authority.

(1) Based on the availability of relevant information, the following criteria shall be used to assess the impact of proposed mandated benefits:

> (a) The social impact: (i) To what extent is the benefit generally utilized by a significant portion of the population? (ii) To what extent is the benefit already generally available? (iii) If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services? (iv) If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship? (v) What is the level of public demand for the benefit? (vi) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?
>
> (b) The financial impact: (i) To what extent will the benefit increase or decrease the cost of treatment or service? (ii) To what extent will the coverage increase the appropriate use of the benefit? (iii) To what extent will the benefit be a substitute for a more expensive benefit? (iv) To what extent will the benefit increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders? (v) What will be the impact of this benefit on the total cost of health care services and on premiums for health coverage? (vi) What will be the

impact of this benefit on costs for state purchased health care? (vii) What will be the impact of this benefit on affordability and access to coverage?

(c) Evidence of health care service efficacy:

(i) If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences of that service compared to no service or an alternative service?

(ii) If a mandated benefit of a category of health care provider is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of health care provider?

(iii) To what extent will the mandated benefit enhance the general health status of the state residents?

(2) The department shall consider the availability of relevant information in assessing the completeness of the proposal.

(3) The department may supplement these criteria to reflect new relevant information or additional significant issues.

(4) The department shall establish, where appropriate, ad hoc panels composed of related experts, and representatives of carriers, consumers, providers, and purchasers to assist in the proposal review process. Ad hoc panel members shall serve without compensation.

(5) The health care authority shall evaluate the reasonableness and accuracy of cost estimates associated with the proposed mandated benefit that are provided to the department by the proposer or other interested parties, and shall provide comment to the department. Interested parties may, in addition, submit data directly to the department.

[**1997 c 412 § 4**; **1984 c 56 § 3**. Formerly RCW **48.42.080**.]

Appendix B—Sunrise request letter

State of Washington
House of Representatives

The Honorable Eileen Cody 303
John L. O'Brien Building
Olympia, WA 98504

May 26, 2021

The Honorable Umair Shah
Secretary of Health
Washington State Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Shah,

I am requesting that the Department of Health consider a Sunrise Review application for a proposal that would require all small, large, and individual health insurance plans to include coverage for the diagnosis of and treatment for infertility, as well as standard fertility preservation services for cancer patients and others at risk for medically induced infertility.

A copy of the proposal is attached (H-1640.1). The House Health Care & Wellness Committee would be interested in an assessment of whether the proposal meets the Sunrise Review criteria for expansion of mandated insurance benefits in Washington.

I appreciate your consideration of this application and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

Eileen Cody

Representative Eileen Cody, RN
Chair, House Health Care & Wellness Committee

34th Legislative District

Cc: Kelly Cooper, Washington State Department of Health Ryan
Black, Washington State Department of Health Christie
Spice, Washington State Department of Health Abby Moore,
Washington State Building Families Coalition
Jim Morishima, Washington State House of Representatives Office of Program Research
Chris Blake, Washington State House of Representatives Office of Program Research

Appendix C: Draft of Proposed Legislation

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: H-1640.1/21

ATTY/TYPIST: RB:akl

BRIEF DESCRIPTION: Concerning fertility services.

AN ACT Relating to fertility services; adding a new section to chapter 48.43 RCW; adding a new section to chapter 41.05 RCW; and creating new sections.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1**. (1) The legislature finds that:

(a) According to the federal centers for disease control and prevention, over 12 percent of women of reproductive age in the United States have difficulty becoming pregnant or staying pregnant;

(b) Infertility is evenly divided between men and women and approximately one-third of cases involve both partners being diagnosed or are unexplained;

(c) Increasing accessibility for infertility treatment will expand the state's health services and improve the short and long term health outcomes for the resulting children and mothers, which may also reduce health care costs by reducing adverse outcomes; and

(d) Insurance coverage reduces disparities in access to care for racial and ethnic minorities as well as for LGBTQ persons.

(2) The legislature, therefore, intends to provide coverage for the diagnosis of and treatment for infertility, as well as for standard fertility preservation services.

NEW SECTION. **Sec. 2**. A new section is added to chapter 48.43 RCW to read as follows:

(1) Health plans issued or renewed on or after January 1, 2024, must include coverage for the diagnosis of infertility, treatment for infertility, and standard fertility preservation services. The benefits must be provided to enrollees, including covered spouses and covered nonspouse dependents, to the same extent as other pregnancy related benefits. Coverage must provide for four completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American society for reproductive medicine, using single embryo transfer when recommended and medically appropriate.

(2) Health plans issued or renewed on or after January 1, 2024, may not include:

(a) Any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications;

(b) Any exclusions, limitations, or other restrictions on coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party; or

(c) Any deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for the diagnosis of infertility, treatment of infertility, and standard fertility preservation services, except as provided in this section, that are different from those imposed upon benefits for services not related to infertility.

(3) For the purposes of this section:

(a) "Diagnosis of and treatment for infertility" means the recommended procedures and medications from the direction of a licensed physician or osteopathic physician that are consistent with established, published, or approved medical practices or professional guidelines from the American college of obstetricians and gynecologists or the American society for reproductive medicine.

(b) "Infertility" means a disease, condition, or status characterized by:

(i) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse;

(ii) A person's inability to reproduce either as a single individual or with the person's partner without medical intervention;

(iii) A licensed physician's or osteopathic physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing; or

(iv) Disability as an impairment of function.

(c) "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a woman under the age of 35 or no more than six months of unprotected sexual intercourse for a woman 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or six-month time period to qualify as having infertility.

(d) "Standard fertility preservation services" means procedures that are consistent with the established medical practices or professional guidelines published by the American society of reproductive medicine or the American society of clinical oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

NEW SECTION. **Sec. 3**. A new section is added to chapter 41.05 RCW to read as follows:

(1) Health plans offered to employees and their covered dependents under this chapter issued or renewed on or after January 1, 2024, must include coverage for the diagnosis of infertility, treatment for infertility, and standard fertility preservation services. The benefits must be provided to enrollees, including covered spouses and covered nonspouse dependents, to the same extent as other pregnancy-related benefits. Coverage must provide for four completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American society for reproductive medicine, using single embryo transfer when recommended and medically appropriate.

(2) Health plans offered to employees and their covered dependents under this chapter issued or renewed on or after January 1, 2024, may not include:

(a) Any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications;

(b) Any exclusions, limitations, or other restrictions on coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party; or

(c) Any deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for the diagnosis of infertility, treatment of infertility, and standard fertility preservation services, except as provided in this section, that are different from those imposed upon benefits for services not related to infertility.

(3) For the purposes of this section:

(a) "Diagnosis of and treatment for infertility" means the recommended procedures and medications from the direction of a licensed physician or osteopathic physician that are consistent with established, published, or approved medical practices or professional guidelines from the American college of obstetricians and gynecologists or the American society for reproductive medicine.

(b) "Infertility" means a disease, condition, or status characterized by:

(i) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse;

(ii) A person's inability to reproduce either as a single individual or with the person's partner without medical intervention;

(iii) A licensed physician's or osteopathic physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing; or

(iv) Disability as an impairment of function.

(c) "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a woman under the age of 35 or no more than six months of

unprotected sexual intercourse for a woman 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or six-month time period to qualify as having infertility.

(d) "Standard fertility preservation services" means procedures that are consistent with the established medical practices or professional guidelines published by the American society of reproductive medicine or the American society of clinical oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

NEW SECTION. **Sec. 4**. This act may be known and cited as the Washington state building families act.

--- END ---

Appendix D—Applicant Report

Sunrise Review criteria (from RCW 48.47.030)

Based on the availability of relevant information, the following criteria shall be used to assess the impact of proposed mandated benefits:

1. The social impact:

(i) To what extent is the benefit generally utilized by a significant portion of the population?

Approximately 12% of U.S. women 15–44 years of age have difficulty getting or staying pregnant[1]. This means about one in eight face medical challenges in having children. Infertility equally affects men and women. Overall, one-third of infertility cases are caused by male reproductive issues, one-third by female reproductive issues, and another one-third by both male and female reproductive issues or is unexplained. It is estimated that over 200,000 Washington State residents are impacted by the disease of infertility[2].

In addition to heterosexual couples, other populations may require medical assistance to have children, and without insurance coverage for fertility treatment, these populations face significant barriers to family building. For these populations, disparities in access to care are even greater. Persons of color particularly face considerable disparities in access to care and lack of health equity; studies show that insurance or employer mandates can improve utilization.[3]

Cancer Patients. In the United States, approximately 160,000 individuals between ages 0-45 are diagnosed with cancer each year[4]. As cancer treatment improves, these patients face good odds; approximately 85% of this age group will survive their disease[5]. Chemotherapy, radiation, and surgery can cause medically induced (iatrogenic) infertility through damaging gametes (eggs and sperm), reproductive organs, and/or endocrine functioning; they may also impact the ability to carry a pregnancy. Patients with certain non-cancerous medical conditions (e.g., sickle cell disease, lupus, and thalassemia, etc.) may require similar therapies as cancer patients, and are, therefore, also at risk[6,7]. Sickle cell disease, for example, affects approximately 100,000 patients per year in the U.S[8]. Sickle cell patients are increasingly being recommended for stem cell transplants, which, while curative, are sterilizing due to their toxic effects on the ovaries and sperm-producing germ cells.

In Washington, approximately 3,800 persons of reproductive age are diagnosed annually with cancer[9]. Many of these patients would face at least some risk for infertility due to their cancer treatments and could, therefore, benefit from having the opportunity to preserve their fertility prior to treatment. Fertility preservation treatments need to be undertaken quickly, before the start of cancer treatments, which makes it very difficult for patients to afford the out-of-pocket costs. The direct costs of fertility preservation represent an additional burden to the already considerable direct and indirect costs from

the cancer itself, including lost wages during cancer treatment. Studies confirm that preservation of fertility is of high importance to patients with a new diagnosis[10,11]. The majority (51.7%) of young women undergoing cancer treatment prioritized having children was "most important" in their life[12].

Again, cost is often cited as the most significant barrier to fertility preservation[13]. Costs can range from several hundred dollars for sperm banking, to approximately $15,000 for egg banking, underscoring the additional costs faced by females over males[14]. These costs are also exacerbated by the short window of time that cancer patients have before starting potentially sterilizing treatment.

Racial and ethnic minorities. Racial disparities in both infertility incidence and utilization of infertility treatment have been well documented[15]. Non-Hispanic Black women are 80% more likely to report infertility than Caucasian women yet they access infertility services at a substantially lower rate[3]. Data show that of those using assisted reproductive technology (ART) procedures, approximately 85% are non-Hispanic Whites, with Hispanic and Blacks representing only 4.5 – 6.5% of ART patients. While the roots of these disparities are multi-faceted, race is often linked to lower socioeconomic status, which, in turn, is linked to diminished access to healthcare services. Some studies have also suggested sociocultural factors may influence Black women's reluctance to seek infertility services[16]. Asian women also experience declining fertility earlier than White women and also have higher rates of endometriosis and other conditions that cause infertility[17,18].

LGBTQ and single parents. Unmarried individuals and many in the LGBTQ community require medical assistance and encounter additional barriers to building their families. Some experience discrimination based on their sexual orientation, and some cannot meet narrow, heteronormative definitions of infertility that link coverage to attempts at pregnancy within a partnered, heterosexual relationship.

In addition, transgender individuals may need to preserve their gametes before undergoing gender-affirming treatments. Such services could be viewed as akin to those for iatrogenic infertility for other conditions and diseases (like cancer), but discrimination and cost may still present obstacles to care. Health insurers are required to cover preventative services and cannot limit sex-specific recommended preventive services based on one's sex assigned at birth, gender identity, or recorded gender. The health care law prohibits discrimination on basis of sex.

Military. More than 95% of active-duty servicewomen are in their child-bearing years, yet their access to infertility care is severely limited. In addition, both those serving as well as female veterans report higher rates of infertility than women in the general population[19]. IVF and egg and sperm freezing are critical options for many military members prior to deployment. Active deployment in dangerous areas can lead to injuries and trauma that can impact service members' reproductive functions. Access to reproductive care is vital to both readiness and retention of a skilled military force. However, due to a Congressional ban, the VA specifically excludes coverage for in vitro

fertilization (IVF), one of the leading ART procedures; similarly, TRICARE, which provides health benefits to active duty members, does not cover IVF. Congressional and DoD authorizations now allow for certain exceptions, but IVF is only available when the infertility is causally linked to service, and is further restricted to those who are legally married and use the gametes of their spouse, necessarily limiting coverage to only partnered heterosexuals[20].

While the proposed legislation cannot affect government-managed fertility benefits for Washington's sizable military population, it can create access for this deserving population by making benefits available to the partner or spouse of a service member.

Carriers of Pediatric Genetic Diseases. Health care for children and adults with genetically transmitted diseases like cystic fibrosis and sickle cell disease is a significant cost to the health care system[21], but can be preventable with genetic carrier screening [currently referred to as preimplantation genetic testing for monogenic/single gene defects (PGT-M) or past as preimplantation genetic diagnosis (PGD)]. If couples have a child with a genetic disease or know they are at high risk of having one, their options moving forward are to have no more children, to terminate a pregnancy if it is affected, to hope that luck is on their side and they don't have a child with a serious illness, or to do IVF with special preimplantation genetic testing to select for embryos that do not carry the disease. In general, only individuals who have insurance that already covers infertility have partial or complete coverage can effectively access IVF-PGT M can prevent these serious and costly genetic diseases. A mandate to cover fertility care could prevent the often devastating emotional, financial and social burden of these diseases to affected families as well as on the health care system.

(ii) To what extent is the benefit already generally available?

In the United States, only one in four people can access the care they need to become pregnant[22], disparities highlighted in the White Paper released by the American Society for Reproductive Medicine in 2015[23]. The single largest barrier in access to care is due to the out-of-pocket cost[15]. The high cost of IVF in the United States principally reflects the overall costliness of the U.S healthcare system rather than uniquely high service costs intrinsic to IVF as a medical intervention [24]. For patients without insurance coverage, financial constraints add to the considerable, and often overwhelming, stress and anxiety experienced with infertility. For a vast number of Washington state residents without insurance coverage, the financial barriers make accessing infertility treatment prohibitive.

The current landscape for insurance coverage for infertility in the United States is changing. As of 2021, nineteen states have infertility insurance mandates. Five (Colorado, Delaware, New Hampshire, New York, Utah) have passed in the last three years[25]. Eleven states have added fertility preservation coverage since 2017[26].

(iii) If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services?

Although Washington is presently a non-mandated state, select narrow demographics in Washington state do have excellent insurance benefits for fertility needs, including comprehensive IVF and fertility preservation benefits. These demographics are primarily represented by employees in technology, such Amazon, Google, Microsoft. Most individuals (which includes school teachers, nurses, vocational workers) do not have insurance coverage for fertility care.

At the heart of the problem -- which is what this bill seeks to address -- is a lack of equitable access to fertility care in Washington state. Lower-income persons, people of color, and LGBTQ persons encounter profound disparities in access to care and lack of health equity[15]. These disparities have been widely established in studies and brought to the forefront by ASRM, most recently in the ASRM Diversity, Equity, and Inclusion Taskforce Report[27]. Although barriers remain, studies confirm that insurance coverage improves utilization of treatments in these groups[153]. In a study at University of Michigan, employer-sponsored IVF coverage increased utilization among all women, including a larger proportional increase among low-salary groups, Black and Asian women[28]. Insurance mandates are necessary to achieving greater equity to address the needs of lower income persons, people of color and LGBTQ persons[15], which the proposed legislation seeks to address.

(iv) If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship?

One fresh IVF cycle accounts for 52% of an individual's average disposable income in states without ART insurance mandates, compared with 13% for states with mandates[29]. The average cost of an IVF cycle in the United States is $15,000[30]. A recent survey found that women (25-34 years old) accrued $30,000 of debt on average after undergoing fertility treatment[31]. In addition to the substantial direct costs, there are significant indirect costs to patients. Patients with IVF insurance coverage are 2.5 times less likely to miss time from work due to infertility[32]. The LGBTQ community also faces additional financial obstacles, including when insurers define infertility based on heterosexual sexual intercourse, which would be updated in the pending legislation[15].

(v) What is the level of public demand for the benefit?

One in eight struggle with infertility, yet only one in four receive the treatment needed to overcome infertility[22,23]. The above statistics do not take fully into account the needs of the LGBTQ community and other unpartnered individuals who cannot reproduce without medical intervention. According to a 2003 Harris Interactive Poll, 80% of the general population believes infertility treatment should be covered by insurance and a subsequent poll in 2019 found that most Americans (84%) think treatments should be affordable for anyone who needs it[33,34]. The majority of IVF physicians support insurance coverage for infertility[35].

According to the 2021 Mercer Survey on Fertility Benefits, a survey of over 450 employers, more employers are responding to the requests of their employees and

adding fertility benefits as part of a comprehensive program that seeks to support all aspects of employee health and well-being[36]. At the top of the list of achievements resulting from providing coverage was "ensuring access to quality, cost-effective care" – 71% report that their infertility benefits have achieved this outcome to a significant or moderate extent. Second was "satisfying employee requests," cited by 64% of respondents. Additional reasons cited by employers for covering infertility treatment were to "stay competitive to recruit and retain top talent" (51%) and to "be recognized as a "family friendly employer" (50%). Additionally, respondents that have added coverage within the last two years are more likely to have done so in support of Diversity, Equity, and Inclusion: 61% of respondents cited it as a primary objective.

(vi) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?

There has been interest by collective bargaining agents in other states and locally with respect to inclusion of infertility coverage in health plans.

2. The financial impact:

(i) To what extent will the benefit increase or decrease the cost of treatment of service?

A Milliman actuarial report was provided to the Arizona legislature in 2018 for a bill (SB 1149) requiring coverage for infertility health benefits for insurance plans. According to the report, "We have no reason to believe that covering infertility benefits in an insurance plan will change the fees charged for infertility services"[37]. In Massachusetts, which has had a mandate since 1987, mandated infertility coverage was associated with increased use of IVF in the population[38]. This increased utilization, however, was not associated with excessive increases in consumer cost for infertility insurance coverage. Health care expenditures for IVF increased only at a rate comparable or slower than inflation[38].

An IVF cycle is a complex service, requiring multiple injectable medications, blood draws, ultrasounds, a surgery that requires anesthesia sedation and, arguably, the most complex laboratory and sophisticated procedures in all medical care. In most fertility centers, the charges to a patient for an IVF cycle are very close to the real costs of providing the care to keep prices low to make services as accessible as possible to cash-paying patients. It is possible that higher volumes of IVF resulting from expanded insurance coverage could introduce some efficiencies that could lower cost to an extent. We expect cost to remain relatively stable except for CPI adjustments.

(ii) To what extent will the coverage increase the appropriate use of the benefit?

According to the Arizona Milliman Report, "Including infertility treatment in health insurance coverage removes a large portion of the financial burden for paying for these services, and thus can provide freedom to the insured individual and her doctor to choose the most clinically appropriate course of treatment"[37]. A national study found that

IVF availability and utilization were significantly higher in states with mandated IVF coverage[39]. A study in Massachusetts, which provides unlimited IVF coverage, found IVF utilization increased after implementation of their IVF mandate, but overutilization by patients with a low chance of pregnancy success was not observed[38].

(iii) To what extent will the benefit be a substitute for a more expensive benefit?

According to the Milliman Report, "The mandated treatment or service will not be a substitute for a more expensive treatment or service"[37]. State-mandated insurance coverage of IVF has been associated with lowering multiple births, which will make pregnancy care not only safer for patients but less expensive for insurance companies and for the government[40]. Studies have demonstrated patients are more likely to transfer a single embryo with IVF when insurance covers their treatment. In addition, they are less likely to pursue less expensive treatments like gonadotropin therapy coupled to intrauterine insemination that can be associated with higher-order twin and triplet pregnancies[41]. Any reduction in multiple births significantly reduces health care costs and saves insurance companies money. Pregnancies with the delivery of twins cost approximately five times as much on average when compared with singleton pregnancies, and pregnancies with the delivery of triplets or more increase cost nearly twenty-fold[42]. These numbers do not include the long-term health care and societal costs of prematurity associated with multiple births, which can include medical care for chronic lung disease, special education for development and learning delays, and financial and emotional impact on families.

(iv) To what extent will the benefit increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders?

We expect that the coverage will have a minimal effect on the administrative expenses of insurers[37] and that insurers could save significant money in the long run[43]. A 2011 study showed that patients in states with IVF insurance mandates report lower multiple gestation rates due to transferring significantly fewer embryos per cycle than states without insurance coverage for IVF[44]. The health care costs of twin and triplet pregnancies, deliveries and neonatal care are considerable[43]. Patients with insurance coverage are free to make more appropriate decisions with their physicians based on medical necessity rather than financial considerations that often result in multiple births, which are more costly in the long run, as detailed in above section.

Inclusion of coverage for fertility treatment minimally impacts premiums[38,45]. A 2016 study of the Massachusetts mandate, which is one of the most comprehensive state laws in the country in respect to extent of covered infertility benefits, estimated that the law increases premiums by as little as 0.12 percent to 0.96 percent[46]. Colorado, which passed a comprehensive infertility insurance law in 2020, estimated $4,951 in costs to the Division of Insurance in FY 2020-21 and $8,906 in FY 2021-22 and future years for plan review in the Department of Regulatory Agencies[47].

(v) What will be the impact of this benefit on the total cost of healthcare services and on premiums for health coverage?

A New England Journal of Medicine study found that states with IVF insurance have lower rates of multiple births than states without IVF coverage[48]. National savings from fewer multiple births have been estimated to be over $6 billion a year, making it likely that insurers could potentially save tens, if not hundreds, of millions of dollars a year by providing IVF coverage since patients will no longer be forced to use medical options that are more risky[43]. Clinical practices in states without IVF insurance coverage have the highest number of embryos transferred per cycle and the highest rate of live births of multiple infants, especially three or more[44,48]. Multiple pregnancies cost about $4.2 billion more than singleton pregnancies in pre-term care[49]. As noted earlier, pregnancies with the delivery of twins cost approximately five times as much than a single child and pregnancies with triplets or more cost nearly twenty times as much[42]. These costs do not include the considerable long-term care costs that can sometimes result from multiple pregnancies and premature births.

The proposed legislation requires coverage in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when medically appropriate to avoid multiple pregnancies. It is also well documented that requiring infertility insurance minimally impacts insurance premiums. Comprehensive reviews from Connecticut, Maryland, Massachusetts, and Rhode Island, which have mandated infertility benefits since the 1980s, show that the cost of infertility coverage is less than 1% of the total premium cost[46,50,51]. In many states, this translates to about a dollar or less per member per month. In 2019, New York updated its insurance laws to cover IVF and fertility preservation, effective January 1, 2020. The New York State Department of Financial Services estimated that premiums would increase 0.5% to 1.1% due to mandating IVF coverage, and 0.02% for mandating fertility preservation for iatrogenic (medically-induced) infertility[52].

The goal of the proposed legislation is to reduce the financial strain on families while only minimally impacting insurance premiums, if at all, while at the same time generating significant savings (and healthier outcomes) from a reduction in multiple births. As noted earlier, a 2014 study estimated that the national savings from fewer multiple births would be over $6 billion a year, making it likely that insurers could potentially save tens, if not hundreds, of millions of dollars a year by providing IVF coverage since patients will no longer be forced to use medical options that are more risky[43].

It is also noteworthy that a 2021 Mercer survey of over 450 employers nationwide found that 97% of employers offering infertility treatment, even those that include IVF, have not experienced increases in their medical costs[36].

(vi) What will be the impact of this benefit on costs for state-purchased healthcare? State employment?

Several states provide infertility insurance coverage for state employees. Maryland, which was the first state to pass an infertility insurance mandate in 1985, provides the same coverage to state employees. New York covered IVF for its state employees before extending it to more New Yorkers in 2020. New Jersey added coverage for state and school employees in 2017.

At the county level, in Washington state, King County has provided its employees infertility insurance coverage, including for IVF, for over two decades and has maintained coverage over that interval.

(vii) What will be the impact of this benefit on affordability and access to coverage?

The average cost of an IVF cycle in the United States is approximately $15,000[30]. A recent survey found that women (25-34 years old) accrued $30,000 of debt on average after undergoing fertility treatment[31]. As a result, only Washington state residents who have the financial means to pay out of pocket or who work for employers like Google, Microsoft, Nordstrom, and Starbucks that provide coverage are able to afford the medically necessary treatment to build their families.

One fresh IVF cycle accounts for 52% of an individual's average disposable income in states without ART insurance mandates, compared with 13% for states with mandates[29]. Insurance coverage improves utilization of treatments among previously underserved communities and does not lead to overutilization; a study in Massachusetts, which provides unlimited IVF coverage, found IVF utilization increased after implementation of their IVF mandate, but as cited earlier, overutilization by patients with a low chance of pregnancy success was not found. Insurance coverage also encourages safer, more medically effective treatment protocols. When patients do not have coverage for IVF and must pay out of pocket, they are more likely to transfer multiple embryos. Studies show patients in mandated states are more likely to have elective single embryo transfer.

By requiring insurance coverage for infertility and defining infertility in an inclusive manner, the proposed legislation will help Washingtonians in the individual, small and large group markets gain access to the treatments they need to build their families.

3. Evidence of healthcare service efficacy:

(i) If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the

health consequences of that service compared to no service or an alternative service?

IVF has been long established to be the most effective treatment for infertility; its versatility extends past infertility and includes fertility preservation for cancer patients, preimplantation genetic testing of embryos in parents who are carriers for life-altering genetic diseases, and partner IVF for lesbian couples. In 2018, the most recent year for

which IVF outcomes are currently available, of the 50,651 IVF cycles performed in the United States in patients under the age of 35, the live birth rate was 52.0%[53]. This rate is substantially higher than the live birth rate associated with alternative fertility treatments, specifically gonadotropin IUI (15-20% per cycle) and clomiphene or letrozole IUI (8-12% per cycle). In addition, alternative treatment or no treatment for patients with bilateral tubal obstruction or with severe male factor may correspond to a 0% success rate, meaning there are patients for whom no alternative fertility treatment to make possible biological parenting.

The consequences of no fertility care can be profound. Potential fertility loss due to cancer treatment is associated with emotional distress, fear, anxiety, and moderate or severe depression[54,55]. Some patients with cancer even select less effective cancer treatment options due to the risk of infertility[56,57]. Less effective cancer treatment is associated with unnecessary increased morbidity and mortality which carries additional preventable costs.

An actuarial report prepared by Wakely Consulting, Inc., for the Department of Financial Services in New York cited studies showing that the prevalence of major depression in infertile couples can range anywhere from 15% up to 54%, and the prevalence of clinically significant anxiety can range anywhere from 8% to 28%[52]. A study in Journal of Clinical Psychiatry estimates that the economic burden of depression is approximately $210.5 billion per year, with about half of that cost being associated with loss of productivity in the workplace, and the other half being the true medical costs[58]. When applying that to the population of couples struggling with both infertility and depression, Wakely estimated that the cost of depression related to infertility ranges from $3 billion to $10 billion a year in the U.S. Offering fertility benefits that cover effective therapeutic treatments for infertile couples may reduce associated mental health costs, and, at the very least, reduce the additional financial stress that exacerbates the psychosocial burden of infertility. Lower dropout rates and shorter return to treatment have been observed in patients having insurance coverage for IVF[59].

(ii) If a mandated benefit of a category of healthcare provider is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of healthcare provider?

In the United States, fertility treatments via assisted reproductive technologies are provided by board-certified/board-eligible subspecialists in Reproductive Endocrinology & Infertility. According to the Fertility Clinic Success Rate and Certification Act of 1992,

all cycles performed in the United States fertility clinics are reported to the Centers for Disease Control and Prevention (CDC). In addition, there is additional voluntary oversight of all reported cycles by the Society for Assisted Reproductive Technology (SART) for which most IVF clinics maintain membership.

(iii) To what extent will the mandated benefit enhance the general health status of the state residents? The department may supplement these criteria to reflect new relevant information or additional significant issues.

Studies show states that cover IVF – now considered the standard of care for many infertility cases – have better outcomes for both mother and child and achieve long-term health care savings through the reduction of multiple births[48,49]. Similarly, fertility preservation is widely accepted as the standard of care for patients diagnosed with cancer during their reproductive years[60,61]. Patients unable to afford fertility preservation sometimes choose less effective medical treatments, which can lead to worse, and more costly, results if their cancer is not cured or treated properly[62].

For a vast number of patients without insurance coverage, the financial barriers make accessing their treatment limiting or, in too many cases, simply prohibitive. At best, financial constraints add to the considerable, and often overwhelming, stress and anxiety experienced with infertility. At worst, patients give up their hopes of becoming parents or choose more aggressive treatments that lead to multiple births with costlier and worse outcomes for mothers and babies. Lack of insurance coverage implies that infertility is a condition undeserving of financial assistance and minimizes both its impact and importance to patients[63].

Importantly, mandating infertility insurance coverage will also improve access to care and outcomes for currently underserved communities, including racial and ethnic minorities and lower-income populations. The more inclusive definition of infertility proposed in the legislation (and passed elsewhere) will also remove the financial obstacles to care for the LGBTQ community and unpartnered individuals.

Carriers of pediatric genetic diseases, such as cystic fibrosis and sickle cell disease, will be able to access IVF to prevent the passing on of these diseases to their offspring, not only enhancing the health status of their children but relieving the health care system of considerable costs.

The World Health Organization (WHO), American Medical Association (AMA) and the American Congress of Obstetricians and Gynecologists (ACOG) all recognize infertility as a disease. As such, infertility should be covered by health insurance like other diseases to improve the health of the more than 200,000 Washingtonians living with this disease and other residents who face barriers building their families in the Evergreen State.

Washington should join the growing number of states with an infertility insurance law (19 to date), particularly since Oregon and California have already introduced legislation to address this lack of health equity.

REFERENCES

1. Centers for Disease Control and Prevention. Reproductive Health: Infertility FAQs. Reproductive Health: Infertility FAQs. Published April 16, 2015. Accessed November 9, 2020. http://www.cdc.gov/reproductivehealth/infertility

2. RESOLVE. RESOLVE Fertility Scorecard. Accessed May 1, 2021. http://familybuilding.resolve.org/fertility-scorecard/index.html

3. Dieke AC, Zhang Y, Kissin DM, Barfield WD, Boulet SL. Disparities in Assisted Reproductive Technology Utilization by Race and Ethnicity, United States, 2014: A Commentary. *J Womens Health 2002*. 2017;26(6):605-608. doi:10.1089/jwh.2017.6467

4. Centers for Disease Control and Prevention. United States Cancer Statistics: Data Visualizations. Published online 2017. Accessed June 8, 2018. https://gis.cdc.gov/Cancer/USCS/DataViz.html

5. Barr RD, Ferrari A, Ries L, Whelan J, Bleyer WA. Cancer in Adolescents and Young Adults: A Narrative Review of the Current Status and a View of the Future. *JAMA Pediatr*. 2016;170(5):495-501. doi:10.1001/jamapediatrics.2015.4689

6. Katsifis GE, Tzioufas AG. Ovarian failure in systemic lupus erythematosus patients treated with pulsed intravenous cyclophosphamide. *Lupus*. 2004;13(9):673-678. doi:10.1191/0961203304lu2012oa

7. Rovó A, Tichelli A, Passweg JR, et al. Spermatogenesis in long-term survivors after allogeneic hematopoietic stem cell transplantation is associated with age, time interval since transplantation, and apparently absence of chronic GvHD. *Blood*. 2006;108(3):1100-1105. doi:10.1182/blood-2006-01-0176

8. CDC. Data & Statistics on Sickle Cell Disease | CDC. Centers for Disease Control and Prevention. Published December 16, 2020. Accessed May 23, 2021. https://www.cdc.gov/ncbddd/sicklecell/data.html

9. 2017 Cancer in Washington Annual Report of the Washington State Cancer Registry. Published online December 2020. https://fortress.wa.gov/doh/wscr/PDF/17Report/ReportText17.pdf

10. Peddie VL, Porter MA, Barbour R, et al. Factors affecting decision making about fertility preservation after cancer diagnosis: a qualitative study. *BJOG Int J Obstet Gynaecol*. 2012;119(9):1049-1057. doi:10.1111/j.1471-0528.2012.03368.x

11. Schover LR. Patient attitudes toward fertility preservation. *Pediatr Blood Cancer*. 2009;53(2):281-284. doi:10.1002/pbc.22001

12. Reh AE, Lu L, Weinerman R, Grifo J, Krey L, Noyes N. Treatment outcomes and quality-of-life assessment in a university-based fertility preservation program: results of a registry of female cancer patients at 2 years. *J Assist Reprod Genet*. 2011;28(7):635-641. doi:10.1007/s10815-011-9559-z

13. Quinn GP, Vadaparampil ST, Bell-Ellison BA, Gwede CK, Albrecht TL. Patient-physician communication barriers regarding fertility preservation among newly diagnosed cancer patients. *Soc Sci Med 1982*. 2008;66(3):784-789. doi:10.1016/j.socscimed.2007.09.013

14. The Costs of Egg Freezing - FertilityIQ. Accessed May 23, 2021. https://www.fertilityiq.com/egg-freezing/the-costs-of-egg-freezing

15. Weigel G, Ranji U, Long M, 2020. Coverage and Use of Fertility Services in the U.S. KFF. Published September 15, 2020. Accessed May 23, 2021. https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/

16. Chin HB, Howards PP, Kramer MR, Mertens AC, Spencer JB. Racial Disparities in Seeking Care for Help Getting Pregnant. *Paediatr Perinat Epidemiol*. 2015;29(5):416-425. doi:10.1111/ppe.12210

17. Yamamoto A, Johnstone EB, Bloom MS, Huddleston HG, Fujimoto VY. A higher prevalence of endometriosis among Asian women does not contribute to poorer IVF outcomes. *J Assist Reprod Genet*. 2017;34(6):765-774. doi:10.1007/s10815-017-0919-1

18. Purcell K, Schembri M, Frazier LM, et al. Asian ethnicity is associated with reduced pregnancy outcomes after assisted reproductive technology. *Fertil Steril*. 2007;87(2):297-302. doi:10.1016/j.fertnstert.2006.06.031

19. Service Women's Action Network,. Access to Reproductive Health Care: The Experiences of Military Women. Published online 2018. Accessed May 1, 2021. /wp-content/uploads/2018/12/2018ReproReport_SWAN-2.pdf

20. Access to IVF for Servicemembers and Veterans | Center for Reproductive Rights. Accessed May 23, 2021. https://reproductiverights.org/access-to-ivf-for-servicemembers-and-veterans/

21. Orenstein DM, Abood RN. Cost(s) of caring for patients with cystic fibrosis. *Curr Opin Pediatr*. 2018;30(3):393-398. doi:10.1097/MOP.0000000000000625

22. Davis OK, Sokol RZ. Introduction: Access to fertility care. *Fertil Steril*. 2016;105(5):1111-1112. doi:10.1016/j.fertnstert.2016.03.034

23. American Society for Reproductive Medicine. White Paper: Access to Care Summit September 10-11, 2015. Published online 2015. Accessed May 1, 2021. https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/news-and-research/press-releases-and-bulletins/pdf/atcwhitepaper.pdf

24. Chambers GM, Sullivan EA, Ishihara O, Chapman MG, Adamson GD. The economic impact of assisted reproductive technology: a review of selected developed countries. *Fertil Steril*. 2009;91(6):2281-2294. doi:10.1016/j.fertnstert.2009.04.029

25. Kawwass JF, Penzias AS, Adashi EY. Fertility-a human right worthy of mandated insurance coverage: the evolution, limitations, and future of access to care. *Fertil Steril*. 2021;115(1):29-42. doi:10.1016/j.fertnstert.2020.09.155

26. RESOLVE. Infertililty Coverage by State. Published online April 2021. https://resolve.org/what-are-my-options/insurance-coverage/infertility-coverage-state/

27. American Society for Reproductive Medicine. ASRM Task Force on Diversity, Equity, and Inclusion Report. Published online November 30, 2020. Accessed May 1, 2021.

https://www.asrm.org/globalassets/asrm/asrm-content/about-us/pdfs/asrm-dei-task-force-report-11-30-2020.pdf

28. Dupree JM, Levinson Z, Kelley AS, et al. Provision of Insurance Coverage for IVF by a Large Employer and Changes in IVF Rates Among Health Plan Enrollees. *JAMA*. 2019;322(19):1920-1921. doi:10.1001/jama.2019.16055

29. Chambers GM, Hoang VP, Sullivan EA, et al. The impact of consumer affordability on access to assisted reproductive technologies and embryo transfer practices: an international analysis. *Fertil Steril*. 2014;101(1):191-198.e4. doi:10.1016/j.fertnstert.2013.09.005

30. Cost - FertilityIQ. Accessed May 23, 2021. https://www.fertilityiq.com/topics/cost

31. Fertility Treatments in the United States: Sentiment, Costs and Financial Impact. Prosper Blog. Published May 20, 2015. Accessed May 28, 2021. https://www.prosper.com/blog/fertility-treatments-in-the-united-states-sentiment-costs-and-financial-impact/

32. RESOLVE. Impact of Infertility Insurance Benefits on Employee/Employer Relationship. Published online August 2016. http://familybuilding.resolve.org/site/DocServer/Infertility-Insurance-Infographic-Oct17.pdf?docID=10585

33. Harris Interactive. A public opinion survey of embryo donation research. Study no. 17532. Published online 2003.

34. LifeSpring Insurance Services. *One in Three American Parents Worry Their Children May Suffer from Infertility in the Future*.; 2019. https://www.prnewswire.com/news-releases/one-in-three-american-parents-worry-their-children-may-suffer-from-infertility-in-the-future-300967782.html

35. Seifer DB, Wantman E, Sparks AE, et al. National survey of the Society for Assisted Reproductive Technology membership regarding insurance coverage for assisted reproductive technologies. *Fertil Steril*. 2018;110(6):1081-1088.e1. doi:10.1016/j.fertnstert.2018.07.016

36. Mercer. 2021 Survey on Fertility Benefits. Published online 2021. https://resolve.org/wp-content/uploads/2021/05/2021-Fertility-Survey-Report-Final.pdf

37. Bennett, SJ; Snook TD. Milliman Report: Infertility Coverage Actuarial Study. Published online October 2018.

38. Griffin M, Panak WF. The economic cost of infertility-related services: an examination of the Massachusetts infertility insurance mandate. *Fertil Steril*. 1998;70(1):22-29. doi:10.1016/s0015-0282(98)00107-1

39. Hammoud AO, Gibson M, Stanford J, White G, Carrell DT, Peterson M. In vitro fertilization availability and utilization in the United States: a study of demographic, social, and economic factors. *Fertil Steril*. 2009;91(5):1630-1635. doi:10.1016/j.fertnstert.2007.10.038

40. Provost MP, Thomas SM, Yeh JS, Hurd WW, Eaton JL. State Insurance Mandates and Multiple Birth Rates After In Vitro Fertilization. *Obstet Gynecol*. 2016;128(6):1205-1214. doi:10.1097/AOG.0000000000001733

41. Reindollar RH, Regan MM, Neumann PJ, et al. A randomized clinical trial to evaluate optimal treatment for unexplained infertility: the fast track and standard treatment (FASTT) trial. *Fertil Steril*. 2010;94(3):888-899. doi:10.1016/j.fertnstert.2009.04.022

42. Lemos EV, Zhang D, Voorhis BJV, Hu XH. Healthcare expenses associated with multiple vs singleton pregnancies in the United States. *Am J Obstet Gynecol*. 2013;209(6):586.e1-586.e11. doi:10.1016/j.ajog.2013.10.005

43. Allen BD, Adashi EY, Jones HW. On the cost and prevention of iatrogenic multiple pregnancies. *Reprod Biomed Online*. 2014;29(3):281-285. doi:10.1016/j.rbmo.2014.04.012

44. Martin JR, Bromer JG, Sakkas D, Patrizio P. Insurance coverage and in vitro fertilization outcomes: a U.S. perspective. *Fertil Steril*. 2011;95(3):964-969. doi:10.1016/j.fertnstert.2010.06.030

45. Omurtag KR, Styer AK, Session D, Toth TL. Economic implications of insurance coverage for in vitro fertilization in the United States. A review. *J Reprod Med*. 2009;54(11-12):661-668.

46. Compass Health Analytics. State-Mandated Health Insurance Benefits and Health Insurance Costs in Massachusetts. Published online 2016.

47. Legislative Council Staff Colorado Legislature. Final Fiscal Note: Insurance Cover Infertility Diagnosis Treatment Preserve HB 20-1158. Published online October 6, 2020. https://leg.colorado.gov/sites/default/files/documents/2020A/bills/fn/2020a_hb1158_f1.pdf

48. Jain T, Harlow BL, Hornstein MD. Insurance coverage and outcomes of in vitro fertilization. *N Engl J Med*. 2002;347(9):661-666. doi:10.1056/NEJMsa013491

49. Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes. *Preterm Birth: Causes, Consequences, and Prevention*. (Behrman RE, Butler AS, eds.). National Academies Press (US); 2007. Accessed May 28, 2021. http://www.ncbi.nlm.nih.gov/books/NBK11362/

50. Horan, E et al. Review of Connecticut Mandated Health Insurance Benefits: 2014. Published online January 2015.

51. Highland, J et al. State-Mandated Health Insurance Benefits and Health Insurance Costs in Massachusetts. Published online January 2013.

52. Linda A. Lacewell. *New York State Department of Financial Services Report on In-Vitro Fertilization and Fertilization Preservation Coverage*.; 2019.

53. 2018 Assisted Reproductive Technology Fertility Clinic Success Rates Report. Published online December 2020.

54. Rosen A, Rodriguez-Wallberg KA, Rosenzweig L. Psychosocial distress in young cancer survivors. *Semin Oncol Nurs*. 2009;25(4):268-277. doi:10.1016/j.soncn.2009.08.004

55. Benedict C, Thom B, Kelvin JF. Fertility preservation and cancer: challenges for adolescent and young adult patients. *Curr Opin Support Palliat Care*. 2016;10(1):87-94. doi:10.1097/SPC.0000000000000185

56. Partridge AH, Gelber S, Peppercorn J, et al. Web-based survey of fertility issues in young women with breast cancer. *J Clin Oncol Off J Am Soc Clin Oncol*. 2004;22(20):4174-4183. doi:10.1200/JCO.2004.01.159

57. Ruddy KJ, Gelber SI, Tamimi RM, et al. Prospective study of fertility concerns and preservation strategies in young women with breast cancer. *J Clin Oncol Off J Am Soc Clin Oncol*. 2014;32(11):1151-1156. doi:10.1200/JCO.2013.52.8877

58. Greenberg PE, Fournier A-A, Sisitsky T, Pike CT, Kessler RC. The economic burden of adults with major depressive disorder in the United States (2005 and 2010). *J Clin Psychiatry*. 2015;76(2):155-162. doi:10.4088/JCP.14m09298

59. Bedrick BS, Anderson K, Broughton DE, Hamilton B, Jungheim ES. Factors associated with early in vitro fertilization treatment discontinuation. *Fertil Steril*. 2019;112(1):105-111. doi:10.1016/j.fertnstert.2019.03.007

60. Oktay K, Harvey BE, Partridge AH, et al. Fertility Preservation in Patients with Cancer: ASCO Clinical Practice Guideline Update. *J Clin Oncol Off J Am Soc Clin Oncol*. 2018;36(19):1994-2001. doi:10.1200/JCO.2018.78.1914

61. Ethics Committee of the American Society for Reproductive Medicine. Electronic address: ASRM@asrm.org. Fertility preservation and reproduction in patients facing gonadotoxic therapies: an Ethics Committee opinion. *Fertil Steril*. 2018;110(3):380-386. doi:10.1016/j.fertnstert.2018.05.034

62. Llarena NC, Estevez SL, Tucker SL, Jeruss JS. Impact of Fertility Concerns on Tamoxifen Initiation and Persistence. *J Natl Cancer Inst*. 2015;107(10). doi:10.1093/jnci/djv202

63. Insogna IG, Ginsburg ES. Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy. *AMA J Ethics*. 2018;20(12):E1152-1159. doi:10.1001/amajethics.2018.1152

Appendix E—Written Testimony

The Department received written testimony in lieu of or in addition to spoken testimony from six interested parties. The contents of the written testimony follow below.

Kelly Henry WA Sunrise Hearing Testimonial

I was diagnosed with stage 3B invasive ductal carcinoma in December 2018 at the age of 32. I had no family history and no reason to believe this was ever in my future. Being diagnosed at a young age (before recommendations for mammograms) usually means you are at a late stage in the cancer and therefore need to react quickly in order to ensure the best possible outcome. I found my lump Thursday December 6th and was able to get in with my gynecologist Friday December 7th. I was able to be seen for an ultrasound and biopsy that same day over at SCCA once my gynecologist determined it was in fact a mass. Monday December 10th the gynecologist called me to say how sorry she was about my cancer diagnosis. The next few days were a series of tests, a mammogram, another biopsy, and bloodwork. Somewhere in there there were some discussions about steps moving forward. My husband and I had to rapidly think about what we wanted from life in this completely hectic situation. On Saturday December 15th I was able to get an appointment to determine my follicle count and the feasibility of harvesting eggs. That appointment indicated I had a great number of follicles and harvesting eggs for use later was definitely an option. But it was indicated that this would not be covered by my insurance, and would cause a slight delay in treatment options. My husband and I had a 21 month old daughter at this point and had previously thought we would be trying for our second child spring/summer 2019. Now we had to figure out what this was going to look like for us.

In investigating costs for harvesting eggs and implantation when we finally could use them, it was looking like somewhere between $6,000 to $10,000. At this point we were also facing a litany of tests and treatment for cancer and were unsure how much *that* would cost as well as wondering if I would be able to continue working or have paid time off (I had used most of my PTO during my maternity leave and didn't have much accrued). Facing this situation; uncertain employment, unknown medical bills, and an uncertainty as to whether we would even be able to use the harvested eggs due to not knowing if I would be on tamoxifen post treatment or not, with all of these unknowns (financial and otherwise) we determined the cost was too much to risk proceeding with egg harvesting. However, if the cost of egg retrieval had been covered this would have been something we looked into more closely. Instead, we chose to have Lupron shots monthly during chemotherapy with a hope that my ovaries would be protected and we could potentially try for a second child on our own after treatment. For me personally this became another fraught journey as my period did not return after chemotherapy for almost 2 years. And even as it has returned it is not regular and it has been indicated I am in a perimenopausal state. The recommendation of tamoxifen post treatment has also help make

our decision to not have any more children due to the teratogen effects of tamoxifen. This is not the plan I had had for my family when I was younger.

Cancer patients at the beginning of treatment are faced with so many unknowns and uncertainties. And the choice as to whether or not they will have children in the future should not be something that we have to debate due to financial reasons. There are so many other factors in this life altering event that a financial blockade should not be part of it. Our lives have already changed in more ways than we could have ever imagined, and taking away the potential of future children due to the prohibitive cost of fertility treatment should not be one more thing that changes our life course. Please consider passing a law that allows for fertility treatments to be covered for cancer patients. We've already lost so much.

Testimony of Joyce Reinecke

Executive Director, Alliance for Fertility Preservation

Good Afternoon.

Thank you honorable Committee Members for allowing me to speak to you today on behalf of young cancer patients in Washington who will be able to have a family if fertility preservation coverage as described in proposal H-1640.1/21 is enacted.

I am here before you as the Executive Director of the Alliance for Fertility Preservation, a national non-profit organization dedicated to helping cancer patients understand and navigate the reproductive consequences of their treatment, but I also come to this hearing as a cancer survivor.

In my twenties, while living in Seattle, I was diagnosed with a rare cancer - leiomyosarcoma. The diagnosis was sudden and terrifying . . . and it came just as I was starting my professional life as an attorney in Seattle, as well as my married life. The diagnosis delivered two blows: the first, that cancer threatened my life; the second, that my life-saving treatments would probably destroy my ability to one day become a mom. But I was very fortunate. I got great medical care, and my oncology team told me about the threats to my fertility and recommended that I preserve embryos – the only option at that time. Because these treatments weren't covered by insurance, my husband and I had to raid our savings to come up with nearly $10,000 to cover the costs. Today, I am more than 20-years out from my cancer diagnosis, and I have healthy twin daughters in college. Daughters that I have because of fertility preservation.

***

This experience dramatically affected my personal life – but it also redirected my professional life. For the past 15 years, I have worked to raise awareness about the reproductive side effects of cancer treatment for young adults. Chemotherapy, radiation, bone marrow transplant, and certain surgeries can all cause infertility. Through my work, I am in constant contact with young

cancer patients, survivors, and their family members. I hear their fears about cancer, and their distress over infertility.

When I first started working in this space many years ago, all we could do was listen. The options for patients were very limited, especially for women, so there was really no discussion at all about insurance coverage. But as you have heard today, the technology for protecting sperm and eggs has advanced tremendously over the past decade. These procedures are now recognized as the standard of care by all of the leading cancer and reproductive societies.

The remaining barrier to parenthood for these patients is insurance coverage that denies fertility preservation and post-treatment family building options. Insurers have long labeled infertility treatments as "elective" as a means to avoid coverage. In failing to cover these procedures, they have forced many patients to be sterilized as the cost by their life-saving cancer treatments. This cost is both unnecessary and cruel.

As you have heard today, over the past few years several other states and regulatory agencies across the country have recognized infertility as a disease and have acknowledged that these procedures are **medically necessary** for many patients and are, therefore, worthy of coverage. For this reason, I would respectfully ask that you address this unjust coverage gap. This will give Washington's young cancer survivors the ability to protect their fertility and their future parenthood.

Thank you for your consideration.

Hello, my name is Brittany Tonning. I am 29 years old from Marysville, WA. I have been married for 3 years. My husband is a firefighter, and I am a referral and insurance coordinator for a local hospital.

Even though we have good jobs and medical insurance, we were shocked to find out that infertility treatments were NOT covered. Our insurance only covers "some diagnostic testing".

Over the last 3 years of trying to conceive we've been scrambling to find the money for our infertility treatments. Infertility is a disease that affects hundreds of thousands if not millions of people across the United States. Treatment for infertility IS medically necessary, and it is NOT an elective treatment. Infertility has a HUGE financial cost, a HUGE physical cost to your body, and an INTENSE mental cost to those yearning for a baby.

Over the last 3 years my husband and I have spent over $15,000 out of pocket on many supplements, medications, ovulation and pregnancy tests, ultrasounds and x rays, surgeries, and 7 Intrauterine Inseminations with no success.

Invitro Fertilization is our only option now. Which will cost us at least $20,000 if not more for each CHANCE at a successful pregnancy. However, we cannot afford IVF and we will have to take out a loan and go into debt with every IVF treatment and embryo transfer that is needed to have a baby.

I cannot understand how most insurance companies can cover abortion, birth control, tubal ligation, vasectomies, and erectile dysfunction treatments but DO NOT cover important fertility treatments needed for family building.

1 in 8 American couples suffer from infertility and thousands of people go into tens of thousands of dollars worth of debt each year due to insurance not covering their treatments. Infertility is a medical condition! We are all are aching for a baby. We are all struggling mentally and financially. We are all fighting every day to build our families.

Please pass a law in Washington state, so that insurance companies must cover infertility treatments across the board! This would be life changing for hundreds of thousands of people in Washington state who are yearning to become parents.

Thank you for your time.

Dear Sunrise Review Committee,

I am a Reproductive Endocrinology and Infertility physician at the University of Washington in Seattle. My position is Assistant Professor and Medical Director in the Division of Reproductive Endocrinology and Infertility.

I write in strong support of the proposed legislative mandate currently under Sunrise Review for health insurance plans in Washington state to include coverage for the diagnosis of and treatment for infertility, as well as standard fertility preservation services for cancer patients and others at risk for medically induced infertility.

Infertility is a disease recognized by the World Health Organization, the American Medical Association, and the American College of Obstetricians and Gynecologists. As a physician who trained in both states with and without an insurance mandate for infertility coverage, I can attest to the difference that an insurance mandate can make for a patient struggling with the devastating impact of infertility. It is, in a word, transformative. It can mean the difference between despair and hope, between shattered dreams and the life-altering experiences and joys of parenting, between a state that affirms the right of all to family building and a state of glaring inequities. The presence or absence of a mandate determines to a large extent who can become a parent.

The lack of insurance coverage and the resulting out-of-pocket costs for infertility treatments make it difficult, if not impossible, for far too many in our state to access this medically necessary care. Imagine, for a moment, if Washingtonians had to pay out-of-pocket for arthroscopic knee surgery, which costs roughly the same as an IVF cycle, because insurers were not required to cover it. What would that look like? Of those struggling to walk in that system due to untreated disease - what would likely be their income level or the color of their skin? Knee surgery and IVF may seem a misaligned comparison, but the World Health Organization has ranked infertility as the fifth leading generator of disability among the population under 60

worldwide. Studies on the psychosocial impact of infertility have placed it on par with a diagnosis of cancer.

A mandate for insurance coverage is a critically needed intervention within our current health care realities to ensure even a basic level of access. In its absence, the right to build a family in the face of infertility becomes a function of economic prowess, with access to medical care reserved only for those who can afford it, predominately those who are older, wealthier, White, or work for the "right" employer.

This mandate is, at its heart, a call for equity in Washington state.

The real-world impact of the absence of an insurance mandate for infertility is heartbreaking. It is sobering to consider how many thousands in our state have struggled with infertility but unable to receive effective standard of care treatments or who prematurely discontinued their treatments because their savings ran out. How many irreversibly lost their fertility because they could not put together the means to afford fertility preservation in the short time window between a new cancer diagnosis and starting chemotherapy? For these patients, it was not the limits of medical science that was the short-coming, it was because infertility, and its impact, was weighed as undeserving of financial assistance through the absence of a mandate.

This reality needs to change and is changing. Over the past three years, four states (Delaware, New Hampshire, New York and Colorado) have passed comprehensive legislation mandating coverage for infertility. Studies show better health outcomes for women and children in mandated states due to safer medical practices and patient choices. Inclusive legislation supports the right of LGBTQ and others who may need medical assistance for building families.

There is robust data and long-term precedents with other states that comprehensive coverage only nominally increases premiums and administrative costs. Of note, Colorado, the most recent state to mandate insurance coverage for infertility, passed their bill in the COVID-19 pandemic. In signing the bill for his state, Governor Polis cited the impact of the COVID-19 pandemic as adding to the many reasons why infertility should be covered by insurance.

In closing, I ask that this proposed bill be considered for what it is, a mandate that is essential to mitigate the profound health disparities and lack of equity that has long existed in Washington state. Although no one can change or correct the past, this legislative mandate will be transformative in the lives of those in the Evergreen State who struggle with infertility or face the prospect of infertility for years to come.

Thank you for your consideration and support of our patients.

Sincerely,

Christopher Herndon, M.D.

Reproductive Endocrinology and Infertility Seattle, Washington

My name is Betsy Campbell and I am Chief Engagement Officer for RESOLVE: The National Infertility Association. RESOLVE represents the millions of women and men in the U.S. with the disease of infertility and the more than 200,000 Washington residents who struggle to build a family. The proposal before you would update existing law to improve access to the standard of care for patients with infertility and those diagnosed with cancer or other conditions that may cause infertility. We sincerely thank you for your time and consideration.

For many families, an infertility diagnosis is not the largest barrier to becoming a parent. Sadly, the largest barrier is cost. An average in vitro fertilization (IVF) cycle in the United States is $15,000. A recent survey found that women of reproductive age accrued

$30,000 of debt on average after undergoing treatment. As such, only 1 in 4 people get the treatment needed to overcome infertility.

At RESOLVE, we work with countless men and women who have been forced to sell their homes, go into credit card debt, or perhaps most tragic of all, abandon their hopes of becoming parents due to the cost of fertility treatments. And we know this disproportionately and unfairly impacts Blacks and other minorities.

By passing insurance coverage for fertility, Washington would help correct this inequity and join 19 other states that help hardworking families get access to medically necessary treatments. In the past 3 years alone, 5 states have passed new infertility laws, and since 2017, 11 states have passed fertility preservation laws to help cancer patients and others at risk of medically induced infertility. The American Medical Association, the American Congress of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the World Health Organization all recognize infertility as a disease. As such, infertility should be covered by health insurance like other diseases. Likewise, the American Society of Clinical Oncology and other leading cancer societies recognize fertility preservation as the standard of care for cancer patients diagnosed during their reproductive years. Again, the standard of care for cancer patients and infertility patients should be covered by health insurance just like other diseases.

This legislation does that, reducing the financial strain on families while only minimally impacting insurance premiums if at all. Comprehensive reviews from Connecticut, Maryland, Massachusetts, and Rhode Island, which have mandated infertility benefits since the 1980s, show that the cost of infertility coverage is less than 1% of the total premium cost. This translates to about a dollar or less per member per month. A 2016 study of the Massachusetts mandate, which is one of the most comprehensive laws in the country, estimated that the law increases premiums by as little as 0.12 percent to 0.96 percent. In 2019, New York updated its insurance law to cover IVF and fertility preservation, and the New York State Department of Financial Services estimated that premiums would increase 0.5% to 1.1% for IVF coverage, and 0.02% for fertility preservation.

Long-term health care costs are estimated to decrease because coverage equates to healthier outcomes. States with insurance coverage have lower rates of multiple births than states without coverage, and this drives down costs.

Pregnancies with multiples cost about $4.2 billion more than single child pregnancies in pre-term care. Pregnancies with the delivery of twins cost approximately 5 times as much than a single child and pregnancies with triplets or more cost nearly 20 times as much. And these costs do not include the long-term care costs often associated with multiple pregnancies and premature births.

A 2014 study estimated that the national savings from fewer multiple births would be over $6 billion a year, making it likely that insurers could potentially save tens, if not hundreds, of millions of dollars a year by providing IVF coverage since patients paying out of pocket will no longer be forced to use medical options that are far riskier.

Self-insured employers, who are not covered by state law, are leading the way in providing this coverage. In Washington State, employers like Microsoft, Nordstrom, and

Starbucks are providing comprehensive fertility benefits for their employees. They are not just doing this out of the goodness of their hearts, they are doing this because it's good for business. In fact, a 2021 national survey by Mercer found virtually all employers covering infertility treatment, including IVF, have NOT experienced increases in their medical costs.

I respectfully request that you consider this real-world data instead of the scary projections that the insurers are likely to provide. The only reason treatment for infertility is considered "expensive" is because patients are paying out of pocket for it; for insurers and self-insured employers, the expense is practically negligible. As the VP of Benefits at Black & Decker said, "… in perspective of how much we spend on MRIs and CT scans, for example, the cost of the fertility benefit isn't even a rounding error." Washingtonians are paying monthly premiums for insurance coverage, yet they are unable to access the standard of care for infertility and cancer during their reproductive years. And insurers are already paying the price for multiple pregnancies and births resulting from patients paying out of pocket for more aggressive or riskier treatments. Similarly, patients paying out of pocket often spend too long on less costly treatments before moving on to the most medically effective treatment, wasting money and valuable time that may hurt their chances of a successful outcome given that infertility treatments are often time-sensitive.

In other states, we have heard insurers argue that an infertility benefit would exceed the Essential Health Benefits covered under the Affordable Care Act and that the state would potentially have to defray the cost of the required benefit.

Determination of when a new coverage mandate would trigger a defrayal requirement is entirely up to each state. Maternity care and rehabilitative and habilitative services are already considered Essential Health Benefits, and infertility treatment falls within these categories.

Eight states have passed new or expanded infertility insurance laws since 2015, and 11 states have passed new fertility preservation laws since 2017. Not one has been required to defray the cost.

The proposed legislation will reduce the financial strain on Washington families and mitigate existing health disparities while only minimally impacting insurance premiums, if at all, while at the same time generating significant savings from a reduction in multiple births that also results in healthier outcomes for babies and moms.

This proposal is an important step forward for the patients testifying today and for so many hopeful future parents throughout the state. As the Governor of Colorado said in his signing statement for similar legislation in April 2021, “The bill will help families have children in the wake of COVID-19 and is important for our state's future economic success.”

Thank you.

Respectfully submitted, Betsy Campbell

Betsy Campbell

Chief Engagement Officer

RESOLVE: The National Infertility Association

My name is Kelsey Ross and I am from Camano Island, Washington. I am in support of proposed bill H-1640.1. I am representing the genetic carrier community of Washington state.

My husband and myself are genetic carriers of a rare disease called 3C Syndrome, a condition that causes brain and heart malformations. Most individuals with this condition experience severe medical problems, as well as intellectual and physical deficits. There is a 30 percent infant mortality rate associated with this disorder. We have a 5 year old daughter diagnosed with this condition who is severely affected with life limiting disabilities. When she was diagnosed at 2 years old we learned we were recessive carriers and were essentially genetically incompatible. This meant we had a 25 percent chance of passing on the condition with each subsequent pregnancy. We were given a few options with building our family; try to conceive naturally and go through prenatal genetic testing or use assisted reproductive technology like donor gametes (eggs or sperm) or IVF with PGT-M (prenatal diagnosis of embryos) to prevent passing on this disorder. Our first choice was to use IVF treatment, but we could not afford this route. The estimated cost for PGT-M was $30k-40k. I am a stay at home mom who is a caretaker to our disabled daughter and my husband is a professional firefighter with insurance that offered no coverage. We moved forward trying naturally knowing the risk we faced. We had 3 more pregnancies affected with 3C syndrome. 3 daughters girls who are no longer living.

If our insurance would’ve covered IVF we would not have undergone these heartbreaking losses and we would’ve prevented passing on this disease to our children. Instead insurance

paid out over $60k for 3 pregnancies that did not make it to term. Insurance is currently paying out massive amounts for my living daughter's medical bills, therapies and equipment. If my 3 other daughters would have been born insurance would have likely paid an astronomical amount to support them medically. The state through Medicaid, SSI and the DDA would be paying out massive amounts of money like they will for my living daughter. It is advantageous to the state of Washington and medical insurance companies to provide mandated infertility coverage.

My family is not alone in this struggle as genetic carriers. There are many other families facing passing on inheritable diseases to their offspring in our state. All individuals are carriers of 2-7 disease causing genetic mutations, so everyone is at risk of going through what my family has. Genetic disease does not discrimate. This topic of genetics is an important one when reviewing the pros and cons of passing a bill to mandate infertility coverage.

Please consider passing this legislation for the thousands of people it will benefit in our state. There will be financial benefit to insurance companies and the state of Washington by providing progressive aid to those in need of assisted reproductive technology.

Thank you for reading my testimony and considering my family's story and the story of the genetic carrier. I am willing to be contacted for question.

Kelsey Ross

Appendix F—Rebuttals to Draft Report

Good afternoon,

Please find attached Coordinated Care Corporation's redline edits, which more accurately capture what infertility benefits are covered/not covered on our plans in PY 2021. For ease, the following is the full edit we'd like to see represented on page 10 of the attached:

> "The Ambetter Secure Care 1 (2021) with 3 Free PCP Visits provides coverage for the diagnosis of infertility and correction for any underlying medical condition (medical surgical procedure). However, the plan does not provide coverage for treatment of infertility, such as Zygot Intrafallopian Transfer, Gamete Intrafallopian Transfer, Artificial Insemination, In Vitro Fertilization (unless required by federal or state law), sterilization/vasectomy reversal, prescription infertility treatment drugs unless such drugs are included on the plan's formulary, or surrogacy. Fetal reduction surgery is covered only if medically necessary."

We appreciate the opportunity to provide feedback on the draft Mandated Benefits for Infertility Treatments Sunrise Review report.

Thank you,

Isabel Lee

Senior Manager, Marketplace (Ambetter) Product Operations

Dear Sunrise Review Panel,

On behalf of the Building Families Coalition, I want to express our great appreciation for your Panel's consideration in the Mandated Benefits for Infertility Treatments Sunrise Review. We are very pleased with the Panel's strong recommendation in the Report that a bill for mandated infertility coverage be considered in an upcoming legislative session. We appreciate your citing the findings related to the lack of private insurance coverage for infertility throughout the state and the resulting lack of access to medically necessary treatments. We also affirm the positive impact insurance coverage can have on patients, including lower out-of-pocket costs, greater access, better quality care, and more informed decision making.

Thank you for sharing the draft for consideration and review. We highlight a few areas we would like to clarify within the report, as you have requested of stakeholders. They are arranged in the order in which they appear in the report, although we want to call special attention to pages 17-18 and to make clear that the draft legislation does by intent feature LGBTQ+ and single or unpartnered inclusive language, which has been used in other states and

vetted by LGBTQ+ advocacy organizations among others. We hope that you will find these comments additive, and we welcome any questions you may have.

Page 6: In addressing the extent that persons are not receiving needed services and that only 24 percent of the demand for assisted reproductive technology is being met, we think it is important to cite that, in the backdrop of this significant unmet demand, the disparities are even further magnified in certain groups, including those with lower income and persons of color.

Page 9: While surrogacy is not expressly mentioned in the legislation, the legislation does reference third party reproduction, which includes surrogacy. Specifically, Section 4.(c) states that an insurance policy may not "impose any exclusions, limitations, or other restrictions on coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party..." This language means only the medical costs associated with surrogacy would be covered, such as embryo transfer to a surrogate. This legislation does not intend to cover any compensation or other non-medical costs associated with surrogacy.

Page 12: The report states that "Cryogenic preservation of ovarian tissue in prepubescent girls is an experimental procedure." We are pleased to share that the American Society for Reproductive Medicine lifted the experimental label in 2019: https://www.allianceforfertilitypreservation.org/_assets/pdf/fertility_preservation_in_patients_undergoing_gonadotoxic_therapy_or_gonadectomy.pdf.

Page 14: The statement, "It is possible that some patients may choose to transfer fewer blastocysts if this benefit mandate is implemented," does not recognize the multiple studies demonstrating that patients are more likely to transfer a single embryo with IVF when insurance covers their treatment, including one where patients in mandated states were more than twice as likely to have elective single embryo transfer (Provost, Meredith P., et al. "State Insurance Mandates and Multiple Birth Rates After In Vitro Fertilization." Obstetrics & Gynecology, December 2016). Several other studies found that states with IVF insurance mandates have lower rates of multiple births (Jain, et al., "Insurance Coverage and Outcomes of In Vitro Fertilization." New England Journal of Medicine, August 2002; Omurtag and Toth, "The Cost Effectiveness of and Health Outcomes of In-Vitro Fertilization as a Mandated Benefit," research presented at ASRM Conference, October, 2007; Stillman RJ, Richter KS, Banks NK, Graham JR. "Elective single embryo transfer: a 6-year progressive implementation of 784 blastocyst transfers and the influence of payment method on patient choice." Fertility and Sterility. 2009; 92(6):1895-1906). We believe these studies indicate a stronger likelihood than is suggested by the wording in the report.

Page 15: When stating that "It is likely that health insurance premiums would increase as a result of this new mandate," we believe that it would be helpful in that statement to provide

some perspective of the extent to readers by qualifying the increase as modest or slight, given the estimates cited for similar legislation in California and New York.

Page 15: In addressing the impact of this benefit on affordability and access to coverage, we think a stronger statement is needed. "It is likely" understates the well-established multifold impact realized in other states with insurance mandates, especially when compared to the more definitive language used that premiums will increase as a result of an insurance mandate.

Page 16: Statistics from Penn Medicine are cited, but we respectfully suggest that statistics from the CDC for IVF are the gold standard reference: Percentage of new patients having live births after 1 intended retrieval of IVF: 56.2% (< age 35 years of age) 42.4% (35 – 37 years of age) 26.3% (38 – 40 years) 12.4% (41 – 42 years of age) 3.8% (>= 43 years of age). These can accessed found here: https://www.cdc.gov/art/pdf/2018-report/ART-2018-Clinic-Report-Full.pdf

Page 17: The report points out that "mandated coverage for infertility treatments may also decrease out of pocket costs for patients and allow for better quality care and more informed decision making." We respectfully request inclusion of a statement about the potential long-term savings associated with better health outcomes linked to fewer multiple and premature births, which can be considerable. Also, we think it can be accurately stated that mandated coverage for infertility treatments *would likely decrease* out of pocket costs, which is also the language used on page 15, rather than *may also decrease* out of pocket costs used in the current version of this sentence.

Pages 17-18: The report recommends that "it may be beneficial to include language specifying that infertility coverage in this bill is meant to apply to people regardless of sex or gender." Importantly, the draft bill was written with the specific intent of inclusion for all people regardless of sex and gender and is based on model legislation developed in collaboration with LGBTQ+ organizations. The definition of infertility utilized in the draft legislation was vetted by the National Center for Lesbian Rights and Men Having Babies to ensure that the language was inclusive of the LGBTQ+ community, men as well as women, and unpartnered individuals. Specifically, the second bullet defines infertility as a "status characterized by: (ii) A person's inability to reproduce either as a single individual or with the person's partner without medical intervention." This same language was included in a bill signed into law in Illinois in July 2021 that expanded the current infertility insurance mandate to cover same-sex couples and unpartnered individuals (https://ilga.gov/legislation/publicacts/fulltext.asp?name=102-0170&GA=102&SessionId=110&DocTypeId=HB&DocNum=3709&GAID=16&SpecSess=&Session=). Similar inclusive language was used in a new infertility law that passed in Colorado in April 2020 (https://leg.colorado.gov/sites/default/files/2020a_1158_signed.pdf). We respectfully request that any questions about whether the legislation is inclusive be removed from the final report, as we believe it undercuts the original intent of the legislation to be inclusive and non-discriminatory. We will work with the code reviser on additional language to make clear that

discrimination based on sex and gender and any other protected characteristics are not allowed.

Page 18: The report also questions whether single or unpartnered people are covered, which is addressed above. We respectfully request that any questions about whether the legislation is inclusive be removed from the final report.

Page 18: The report states, “It is also unclear whether benefits for infertility treatments would include coverage for donated eggs or donated sperm, and, if so, under what circumstances donated gametes would be included in coverage.” The third party language in Section 4.(c) of the legislation also applies to donated eggs, donated sperm and donated embryos, meaning that the costs to procure the donated (third party) gametes/embryos would be covered and that the procedures, such as IVF, using the donated gametes/embryos would be covered as well.

We appreciate the opportunity to provide feedback and, above all, for the positive recommendation to introduce this legislation in the upcoming legislative session. We are happy to provide further clarification or answer any questions and look forward to the final report.

Sincerely,

Christopher Herndon, M.D.

Reproductive Endocrinology and Infertility, Seattle, Washington

On behalf of the Building Families Coalition

Thank you for sending out this bill. After reading it, I would request that the language in Section 2 about the diagnosis of infertility and what services should be covered be amended to include other licensed healthcare providers, in addition to only licensed physicians or osteopathic physicians. There are a lot of ARNPs who diagnose and treat patients for infertility in Washington State (myself included), and it would be a really huge oversight if our care was not covered due to restrictive language in this bill.

Thank you very much for your consideration,

Julia Kase DNP, ARNP, FNP-BC

I would appreciate if it could be addressed that another possible future direction is to ban insurance companies from excluding medical coverage of surrogate pregnancies, or having medical insurance liens.

Nevada has done so:

https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/MIP/Images/AB472-Surrogacy.pdf

https://abovethelaw.com/2019/06/a-world-first-for-insurance-laws-nevada-prohibits-surrogacy-discrimination/

https://fertilitycenterlv.com/the-fertility-center-of-las-vegas/new-nevada-surrogacy-law-prevents-insurance-discrimination/

And Oregon is in the process of considering it:

https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB242/A-Engrossed

Aba Nduom