**2023 HOUSE INDUSTRY, BUSINESS AND LABOR**

**HB 1146**

# 2023 HOUSE STANDING COMMITTEE MINUTES

**Industry, Business and Labor Committee**
Room JW327C, State Capitol

HB 1146
1/10/2023

Relating to public employee fertility health benefits

Chairman Louser called the meeting to order 9:19 AM

Members Present: Chairman Louser, Vice Chairman Ostlie, Representative Boschee, Christy Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.

**Discussion Topics:**

- Fertility treatments
- Lifetime cap
- Other insurances
- Coverage costs

**In favor:**
Representative Brandenburg (no written testimony)
Tara Brandner Nurse Practitioner, #12710
Shana Beadle, Bismarck resident, #12662
LeiLanie Shannon (no written testimony)
Kaydee Pederson, Minot resident, #12537
Casie Davis, Bismarck resident, #12677
Rachel Booth, North Dakota resident, #12720
Tiffany Olsen, District 16, #12675

**Opposed:**
Andrea Fettig, Marketing Manager Greater North Dakota Association (”GNDA”) (no written testimony)
Dylan Wheeler, Government Affairs, Sandford Health Plan #12698

**Neutral:**
Scott Miller, Executive Director North Dakota Public Employees Retirement System (“NDPERS”), #12601, #20652
Rebecca Fricke, NDPERS (no written testimony)

**Additional written testimony:**
Elizabeth Carter, Doctorate family nurse practitioner, president of Everlasting Hope #12528
Robin Holt, Grafton, ND, #12542, #12541
Shauna Erickson-Abou Zahr, M.S., LMFT #12547
Lori Pierce, MD Association for Clinical Oncology, #12559
Kristin Natwick #12560
Adam Hohman, ND Nurse Practitioner Association, #12676
Patty Hulm, Mental Health Counselor, Vice President of Everlasting Hope, #12708

Jennifer Hill, District 22, #12711
Bethany Peterson, Lifetime North Dakota resident, #12714
Jamie Stewart, Board member Everlasting Hope #12716
Sarah Bulik, #28079

Chairman Louser adjourned the meeting 11:23 AM

*Diane Lillis, Committee Clerk*

# 2023 HOUSE STANDING COMMITTEE MINUTES

**Industry, Business and Labor Committee**
Room JW327C, State Capitol

HB 1146
1/24/2023

Relating to public employee fertility health benefits

Chairman Louser called the meeting to order 2:48 PM

Members Present: Chairman Louser, Vice Chairman Ostlie, Representatives Boschee, Christy Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.

**Discussion Topics:**

- Benefit cost analyst
- Number of treatments
- Expenses
- Medically necessary
- Private market insurance
- Changing procedure costs
- Program costs
- Two-year data
- New mandates
- ACA small groups
- Mandated caps and limits

Chrystal Bartuska, ND Insurance Department, to answer questions.

Representative Ruby moved Do Not Pass,
Representative Thomas seconded.

Roll call vote:

| Representatives | Vote |
|---|---|
| Chairman Scott Louser | Y |
| Vice Chairman Mitch Ostlie | N |
| Representative Josh Boschee | N |
| Representative Josh Christy | N |
| Representative Hamida Dakane | N |
| Representative Jorin Johnson | Y |
| Representative Jim Kasper | Y |
| Representative Ben Koppelman | Y |
| Representative Dan Ruby | Y |
| Representative Austen Schauer | N |
| Representative Paul J. Thomas | Y |
| Representative Bill Tveit | N |
| Representative Scott Wagner | Y |
| Representative Jonathan Warrey | N |

Motion failed 7-7-0

Chairman Louser adjourned 3:54 PM

*Diane Lillis, Committee Clerk*

# 2023 HOUSE STANDING COMMITTEE MINUTES

**Industry, Business and Labor Committee**
Room JW327C, State Capitol

HB 1146
1/25/2023

Relating to public employee fertility health benefits

Chairman Louser called the meeting to order 11:52 AM

Members Present: Chairman Louser, Representatives Boschee, Christy Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.
Member Absent: Vice Chairman Ostlie

**Discussion Topics:**

- Effectiveness
- Data
- Average policy age
- Last mandate

Representative Ruby moved Do Not Pass.
Representative Kasper seconded.

Roll call vote:

| Representatives | Vote |
|---|---|
| Chairman Scott Louser | Y |
| Vice Chairman Mitch Ostlie | AB |
| Representative Josh Boschee | N |
| Representative Josh Christy | Y |
| Representative Hamida Dakane | N |
| Representative Jorin Johnson | Y |
| Representative Jim Kasper | Y |
| Representative Ben Koppelman | Y |
| Representative Dan Ruby | Y |
| Representative Austen Schauer | N |
| Representative Paul J. Thomas | Y |
| Representative Bill Tveit | AB |
| Representative Scott Wagner | Y |
| Representative Jonathan Warrey | N |

Motion passes 8-4-2

Representative Ruby will carry the bill.

Chairman Louser adjourned 12:04 PM

*Diane Lillis, Committee Clerk*

**REPORT OF STANDING COMMITTEE**

**HB 1146: Industry, Business and Labor Committee (Rep. Louser, Chairman)** recommends **DO NOT PASS** (8 YEAS, 4 NAYS, 2 ABSENT AND NOT VOTING). HB 1146 was placed on the Eleventh order on the calendar.

**TESTIMONY**

**HB 1146**

1/6/23

Hello,

I am writing in support of HB 1146 and would like to submit my written testimony for why I believe this bill is important to the citizens of our state. I am a life-long resident of North Dakota, obtained my degrees from an in-state college, and continue to work and live in our great state. After coming here for college, my South Dakota-born husband also never left. We are hardworking and are always planning for the future. We worked multiple jobs throughout college (undergraduate and graduate school for both of us) and continued to do so after starting full-time jobs in order to fully pay back our student loans as quickly as possible. We also knew that we wanted to start a family someday, so having a solid foundation before we began that process was important. We also purchased a house, settled into our jobs, and enjoyed time as a married couple for a few years before attempting to start a family. Unfortunately, there was one thing we didn't plan for at that point: infertility.

Despite going to a number of doctor's appointments early in our marriage due to not feeling quite right, I was not diagnosed with endometriosis for several years after I had started feeling symptoms. I was diagnosed via a surgery after developing a multitude of cysts and excess tissues which caused my reproductive organs to fuse together. While the surgery helped reduce the intense abdominal pain I was experiencing, the endometriosis had caused irreversible damage during the time it had gone untreated, and since there is no cure, I still struggle with issues today that have left us with very grim prospects of having a family naturally. Therefore, due to being diagnosed with stage IV endometriosis, my husband and I are infertile and must seek fertility treatments in order to have any chance at being parents someday.

We have been blessed to have some level of insurance coverage for our infertility care through my workplace but infertility treatments are immensely expensive, so it does not get us very far. In order to save all the infertility coverage that we can, we have paid thousands of dollars out of pocket for our medications. We still have a long road ahead of us, but despite the heartache of each failed procedure so far, we have learned more about what we can do differently next time to be more likely to achieve a pregnancy. Like most illnesses, there is a bit of trial and error to figure out what procedures and protocols will work best for your body and situation. Most families do not just have one infertility intervention: they have multiple and the costs add up. We are now at the point of paying out of pocket for our medical procedures going forward. Despite both my husband and I having full-time jobs and advanced degrees, he works another part-time job, and I opened a small business in the evenings and sometimes deliver groceries in order to make money to pay for what our insurance no longer covers.

Both my husband and I eat healthy food, keep physically active, do not use drugs or overconsume alcohol, avoid reckless behaviors, or put ourselves in environments that put our health at risk. We actively make decisions to keep ourselves healthy to keep our health costs low. While we certainly empathize with other people's various health struggles, it can be hard to watch others actively make choices that knowingly harm their bodies (smoking, poor eating, dangerous behaviors, etc.) and while I know all medical issues can still cause financial strain, they have access to insurance benefits that help them treat those conditions. I did not do anything to cause my endometriosis or the associated infertility that came with it. I wish I had greater access to affordable medical care for infertility through my insurance benefits, so that my husband and I could also have the chance to have even a single child, who could be born into a stable household to two parents who fought and worked very hard to bring them

into this world. Along with being very physically taxing, infertility brings about a lot of emotional pain as well, as it is a rollercoaster of despair followed by hope over and over again. We've needed to make hard decisions that have tested our marriage, and luckily, we've come out a stronger team for our future child. Infertility will always be hard but having access to better health insurance coverage for families struggling with infertility would be a huge blessing to the families of our state.

Thank you for your time, and please let me know if there is any further information I can provide regarding your decision on this bill.

Sincerely,

Elizabeth Carter

Hello. My name is Kaydee Pederson. I am from Minot. I am speaking in support of House Bill 1143. I'd like to start by telling you all a little bit about me and why this bill is so important.

As I said, my name is Kaydee. I am 32 years old, and I have a wonderful husband of six years named Matt. For a few years now we have been ready to begin the next phase in our life: starting a family and becoming parents.

Starting a family was never going to be easy for us. I was diagnosed at birth with a genetic disorder called Turner Syndrome (TS). Turner Syndrome has resulted in my ovaries not developing and a congenital heart defect. I've known for as long as I can remember that biological children would not be in the cards for me.

When I submitted my testimony back in the 2021 session, my husband and I had not yet gone through any fertility treatment. Since then, after saving up the needed funds, my husband and I have been through two embryo transfers, so my perspective has greatly changed in the past two years.

I could spend my remaining time discussing the breakdown of our $60,000 plus out of pocket expenses for one unsuccessful embryo transfer in January 2022 and one embryo transfer in August 2022 that ended in a miscarriage, but I don't want to bore you discussing numbers and statistics.

Instead, I am going to spend my remaining time discussing the human experience of what my husband and I went through saving up to grow our family and navigating insurance when we have the limited $20,000 lifetime maximum coverage for infertility.

After working hard and sacrificing to save as much as possible, we created a GoFundMe with a relatively small goal to help us reach our savings goal after some encouragement from family and friends. Crowdfunding for infertility makes you feel extremely vulnerable. It feels like you are begging for money for a dream. You also feel like you will be judged if you eat out at McDonald's because every frivolous dollar you spend could have gone toward your savings instead.

Because our chosen clinic was non-participatory with our insurance plan, we had to pay up front before accessing that coverage, and there was no guarantee every part of our claim or every medication would be covered or reimbursed because insurance company decision makers get to choose what is covered and what is not covered, and patients requiring care are at the mercy of those decisions makers to move forward with a medical decision. After meeting my deductible for the year, the total reimbursement we received from insurance was around $7,000. When an insurance agent gets tears in their voice after hearing your frustration with trying to access coverage you have, you know even they know it's wrong, but again, the agent on the phone isn't the decision maker.

Last session, a representative said on the house floor something along the lines of it is a choice to pursue fertility treatment and that the public shouldn't have to pay higher insurance premiums because of it.

Let me tell you as someone who does not have the biological means necessary to have children naturally that pursuing the medical help needed to grow my family certainly does not feel like a choice. When a new doctor tells you two weeks after having a D&C that they do not feel it is safe for you to carry a pregnancy because of your congenital heart defect and that gestational carrier is the route they recommend for your one remaining embryo, seeking out fertility treatment certainly does not feel elective.

Many people have children naturally every day, and some of them, at a great cost to the public in tax payer dollars via programs and financial assistance. Mandating access to coverage and care for fertility treatment is a small drop in the bucket price wise to the public.

I will not apologize if I come across as bitter or angry about this matter. It has only been four months since I had a miscarriage and two months since I was forced to accept the fact I would not be allowed to carry a pregnancy for my own safety and health. And there's a lot that I am have to hold back from saying here today because we do not have the time.

I do want to end on a positive note though, because this room is full of decision makers. What the passing of this bill means is so much bigger than any one person, which is why I will continue to fight to make access to coverage a reality.

My name is Kaydee Pederson. Thank you for your time.

SANFORD HEALTH

Reproductive Medicine - Fargo
In Vitro Fertilization (IVF) Cost Estimate
–FREEZE ALL WITH PGT
_____ Prepayment

**Below is an estimate of for a cycle of in-vitro fertilization (IVF) with PGT. Please note, these are estimated fees and costs may vary. **Does not include medications****

**Calendar Visit** **starting at $486**

**Pre-cycle Testing (See page 3 for possible labs)**

| **Trial Transfer/Saline Sonogram** | | **$1,498** |
|---|---|---|
| 58974.01 Trial Transfer | $170 | |
| 76998.00 Trial Transfer Ultrasound | $485 | |
| Saline Sonogram | $843 | |

| **Cycle Monitoring** | | **$3,826** |
|---|---|---|
| 99213 Office Visits | $202*5=$1,010 | |
| 76857.TUS/76857.P Follicular Ultrasound | $242*5=$1,210 | |
| 36415 Lab Draw | $18*7=$126 | |
| 84144.001 Progesterone | $97*5=$485 | |
| 82670.005 Estradiol | $130*7=$910 | |
| 83002.003 Luteinizing Hormone | $85*1=$85 | |

| **Egg Aspiration with ICSI** (Intra-Cytoplasmic Sperm Injection) | | **$6,218** |
|---|---|---|
| 58970 Oocyte Retrieval | $1,350 | |
| 89250.001 Culture of Oocyte | $1,050 | |
| 89254.001 Oocyte Identification | $850 | |
| 89261.002 Complex Sperm Prep | $325 | |
| 89280.001 ICSI < 10 Oocytes | $1,600 (if > 10, $2,025) | |
| 76948.26/76948.TC Aspiration Ultrasound | $243 | |
| Anesthesia | $800 (estimated) | |

SANFORD HEALTH

Reproductive Medicine - Fargo
In Vitro Fertilization (IVF) Cost Estimate
–FREEZE ALL WITH PGT
_____ Prepayment

**PGT** (Sanford Biopsy Charge)

| | |
|---|---|
| 89290.001 Biopsy of Embryos | **$1,800 < 5 embryos** (ins may not cover) |
| 89291.001 Biopsy of Embryos | **$2,200 > 5 embryos** (ins may not cover) |

| | | |
|---|---|---|
| **Freezing of Embryos** (Up to 4 embryos, ONE freeze ONLY - $200 per add'l embryo) | | **$2,005** |
| 89258.04 Cryopreservation of Embryos | $1,025 (ins. may not cover) | |
| 89272.001 Extended Culture | $530 | |
| 89342.OL Annual Embryo Storage (1st year) | $450 (ins. may not cover) | |

| | | |
|---|---|---|
| **Transfer Cycle Monitoring** (2 Office Visits/2 Ultrasounds/Lab Work) | | **$1,281** |
| 99213 Office Visits | $202*2=$404 | |
| 76857.TUS & 76587.P Follicular Ultrasound | $242*2=$484 | |
| 36415 Lab Draw | $18*2=$36 | |
| 84144.001 Progesterone | $97*1=$97 | |
| 82670.005 Estradiol | $130*2=$260 | |

| | | |
|---|---|---|
| **Thaw and Transfer of Embryo(s)** | | **$3,634** |
| 89352.001 Thaw of Embryo | $900 (ins. may not cover) | |
| 89272.001 Extended Culture | $530 | |
| 76998 Embryo Transfer Ultrasound | $474 | |
| 89255.001 Embryo Transfer (LAB) | $600 | |
| 58974.01/02 Trial & Embryo Transfer (Provider) | $1,130 | |

| | | |
|---|---|---|
| **FET Cycle Lab Work** | | **$494** |
| 36415 Lab Draw | $18*3=$54 | |
| 84144.001 Progesterone | $97*2=$194 | |
| 84702.07 Beta HCG | $82*3=$246 | |

**Estimated Cost for Cycle**
**(does Not include medications)** **$21,242**

Updated 07/14/21

SANFORD HEALTH

Reproductive Medicine - Fargo
In Vitro Fertilization (IVF) Cost Estimate
–FREEZE ALL WITH PGT
_____ Prepayment

| | | |
|---|---|---|
| ***Prescription Medications (Egg Retrieval)*** | | **$3,000-$7,000** |
| ***Prescription Medications (Embryo Transfer)*** | | **$1,000-$3,000** |
| ***Additional Annual Storage Fee (ReproTech)*** | | **Billed directly to patient** |
| ***Freezing Backup Sperm (OPTIONAL)*** | | **$480-$901** |
| 89322.001 Semen Analysis | $175 | |
| 89259.001 Cryo Vials | $300 (ins may not cover) | |
| 89343 Annual Sperm Storage | $400 (ins may not cover | |
| ***Acupuncture (OPTIONAL)*** | | **$140-$206** |
| 97810 Acupuncture 1+ needles w/o elect stim | $82 | |
| 97811 Acupuncture > 1 needles w/o elect stim | $62x2 | |

SANFORD HEALTH

Reproductive Medicine - Fargo
In Vitro Fertilization (IVF) Cost Estimate
–FREEZE ALL WITH PGT
_____ Prepayment

The charges above are estimates only. **This is not an agreement or guarantee to provide these services for the amounts listed. You will be responsible for the actual costs associated with the services provided.** In addition, Sanford has not verified the amount of insurance coverage you have for this treatment. **The pre-payment amount is calculated based on your representation to Sanford of what your insurance coverage will be for this treatment. Sanford is not responsible for any variation in actual coverage provided by your insurer.**

Please feel free to contact us at (701) 234-8041 or (800) 437-4010 ext 234-8041 if you have any questions about this estimate.

**I understand and accept the above information. All of my questions have been answered. *I understand these costs are only an estimate of the charges for my treatment and actual charges may vary. I understand I may owe more money than the estimated total above, depending on the treatment I need, actual charges for services, and my insurance coverage. I understand I am responsible for payment of the total costs of my IVF treatment.***

_____ _____

Signature of Patient Date Signature of Patient Date

_____

Financial Counselor Date

SANFORD HEALTH

Reproductive Medicine - Fargo
In Vitro Fertilization (IVF) Cost Estimate
–FREEZE ALL WITH PGT
_____ Prepayment

## CooperGenomics Preimplantation Genetic Testing Cost Information

- **Preimplantation Genetic Testing – Aneuploidy (PGT-A)**
  *Screening of embryos for extra or missing chromosomes or pieces of chromosomes which can result in miscarriage*
  - Option 1: Multi-Cycle (8 before 9) - $1,850 for eight samples submitted within nine months, $250 per additional sample
  - Option 2: Single Cycle - $300 per embryo (automatically enrolled in multi-cycle pricing if 7 or more embryos)

- **Preimplantation Genetic Testing – Monogenic Disease (PGT-M)**
  *Screening of embryos for genetic disease when there is a known risk to pass on a specific genetic condition (i.e. parents are both carriers of a recessive condition or a parent is affected with a dominate condition)*
  - Cost: $4,500 for up to eight samples, $400 per additional sample
    - $1,800 per additional condition tested for

- **Combined PGT-A and PGT-M**
  *Screening for chromosome number changes and specific genetic conditions which there is a known risk of in embryos*
  - Option 1: Samples tested serially - $5,500 for up to eight samples, $525 per additional sample
  - Option 2: Samples tested simultaneously - $6,450 for up to eight samples, $525 per additional sample

- **Preimplantation Genetic Testing – Structural Rearrangement (PGT-SR)**
  *Screening for unbalanced chromosome translocations in cases where one parent is a known carrier of a balanced chromosome translocation*
  - Cost: $2,400 for up to eight samples, $250 per additional sample

- **Other Costs**
  - Logistics, Coordination, and Transportation fee: $350 (per shipment/testing cycle)

**Testing is performed by CooperGenomics, billing and payment agreements are made directly through CooperGenomics, not Sanford. CooperGenomics will contact you to set up billing and payment information.**

Updated 07/14/21

As a life-long North Dakota resident; currently living the past 12 years in Grafton, I care deeply about those struggling to build their family in our state (especially as my husband and I struggle for 9 years to grow our family), I strongly urge you to move forward on HB 1146, access to insurance benefits for infertility, so it can advance in 2023. This important legislation will help North Dakotans build their families when faced with any conditions that can cause infertility. North Dakotans need your support now.

I would like to be open and vulnerable about a challenge my husband and I are experiencing, it is a story we only share with our close family and a few friends, and a few others know about our challenge but not the details or what the experience is like. Although you can't see our struggle from the outside in our hearts we feel a missing piece. Despite our years of efforts we have yet to be able to expand our family. There has been much hurt and pain in our hearts as we align to overcome our fertility challenges. We are excited to someday share our life with our children. The fertility journey has been long, lonely, disappointing and so many other hard emotions, beyond the financial burden. In my heart I know we have children waiting to join our family, but they seem just out of reach. And yet we remain hopeful and hold a knowing in my heart I'm meant to be a mom.

I know a bill cannot magically make me pregnant or the 1 in 8 other couples struggling to get pregnant. However you can help support us and maybe that helps us get pregnant. We have worked with medical reproductive endocrinologists, gynecologists, fertility acupuncturists, chiropractor, abdominal massage therapist, mental therapists, and fertility coaches. Most of which has been self paid for. We have seen positive outcomes but no live pregnancy yet. Unfortunately a lot of IVF is trial and error figuring out what medication combination and amounts work well for each person to get quality eggs and a hospitable uterus ready for implantation. Every person is different and each cycle is different. What works for one person may not work for someone else. The doctors are trying to get it right and sometimes need a tweak from one cycle to the next. This of course causes financial burden to get the combination just right in repeated cycles, especially in the tougher cases like ours.

I need your support, along with the 1 in 8 couples in our state living with the disease of infertility. There are so many women and couples we've met on our fertility journey who are struggling as well to grow their families, some have sooner success than others. Each case is different and should be treated likewise. Many people like myself do not openly talk about it unless we are in company where we feel safe to share as it is triggering and painful. You don't know who has or is going through fertility challenges.

It is time for North Dakota to update its insurance law to include coverage for the standard of care for patients with infertility.

This pro-women and pro-family legislation is designed to ensure the best outcome for mothers and their babies. As proven in other states, insurance covering in vitro fertilization (IVF) decreases the chance of multiple births, and lowering multiple births decreases overall health care costs and results in healthier babies and healthier moms.

Please support North Dakota families by moving this bill forward. Thank you!
Robin Holt
Grafton, ND

Dear House Representative,

I write in regard to approving HB 1146. I just finished paying another month of insurmountable credit card payments related to medical payments that were not covered by my insurance company despite being related to medical diagnoses beyond my control. My name is Shauna Erickson-Abou Zahr. I am a North Dakota native who loves our state, and looks forward to raising my children here. Just under 2 years ago I was diagnosed with breast cancer at age 32. I joined the club no one wants to be a part of – cancer survivorship- a decade before screening would be required. Unfortunately, at the same time, I was also joining another club secondary to the life saving treatment I needed- infertility.

When my husband and I got engaged, we discussed goals and direction for our lives. Obviously, cancer wasn't a part of that, at least not in my early thirties, but children were. Currently, I am debuting into my third round of invitro fertilization (IVF), a procedure being utilized to see if doctors can get eggs out of my ovaries that were exposed to chemotherapy, radiation treatment, and chemical menopause (all needed to save my life). To date, my family has spent $58,892.59 on fertility treatments to fight for our future family. Zero of this treatment was covered by our insurance. This amount is more money than what I take home from the non-profit I provide child mental health therapy at each year.

How can we let this happen to North Dakotans, to our neighbors, to people that have fought and survived cancer? Shouldn't having cancer have been the worst part of this decade of my life? What did I dream of more than my future career and wedding day? Becoming a mother. This was never a "choice" in my life, but rather a destiny, hence why my husband and I have had to max out multiple credit cards in order to hopefully make parenthood a possibility for us. It isn't acceptable to have a disease, whether it's primary or secondary to another medical condition, not be covered by our health insurance and leave North Dakotans with such financial distress. Because building a family isn't a choice- it is how we are programmed here with our deep value systems.

What is most heart wrenching to me was this- it was brought to my attention that during last legislative session folks considering this issue said others shouldn't be "responsible" for helping families with fertility treatments. The amount of money my family paid in IVF bills wanes in comparison to what is covered by insurance in cancer costs. Hundreds of thousands of dollars were spent on diagnostics, chemotherapy, radiation, and surgery for me alone. The amount of money needed to support the minority of North Dakotan families facing infertility with the fertility coverage is nothing compared to what is paid for diseases that pose imminent risk to people's lives. Moreover, don't we help our neighbors with what they need in this state? Fertility coverage is one of those needs.

I ask that you vote in favor of including infertility as a covered benefit set in our state. It will be too late for my family, but no other family, cancer or not, should have to figure out how to raise limits on their credit cards in order to be able to birth beautiful children into our state. Having cancer wasn't a choice I made, having to lose all my hair to chemotherapy wasn't a choice, and having my fertility taken from me was certainly not a choice. These were/are necessities that voting in favor of HB 1146 will ensure rightful coverage for medically necessary treatments for our neighbors.

Sincerely,

Shauna Erickson-Abou Zahr, M.S., LMFT

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

January 10, 2023

The Honorable Mike Lefor, Chair
House Industry, Business, and Labor Committee
600 East Boulevard Avenue
Room JW327C
Bismarck, ND 58505

Dear Chair Lefor and Members of the House Industry Business and Labor Committee,

The Association for Clinical Oncology (ASCO) is pleased to support HB 1146, which would provide coverage of fertility preservation services to North Dakota public employees and their family members with cancer. ASCO is a national organization representing physicians who care for people with cancer. With nearly 45,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality, equitable cancer care.

ASCO believes that as part of education and informed consent before cancer treatment, health care providers should address the possibility of infertility with both male and female patients treated during their reproductive years. Providers should also be prepared to discuss fertility preservation options and/or refer all potential patients to appropriate reproductive specialists. As such ASCO advocates for coverage of embryo, oocyte and sperm cryopreservation procedures for a covered patient who is at least reproductive age and has been diagnosed with cancer but has not started cancer treatment (including chemotherapy, biotherapy or radiation therapy treatment) in accordance with guidelines developed by our affiliate organization, the American Society of Clinical Oncology.

We encourage providers to advise patients regarding potential threats to fertility as early as possible in the treatment process to allow for the widest array of options for fertility preservation. We strongly support HB 1146 and encourage the Industry, Business, and Labor Committee to pass this legislation to protect fertility preservation procedures for public employees with cancer patients. If you have questions or would like assistance on any issue involving the care of individuals with cancer, please contact Aaron Segel at ASCO at aaron.segel@asco.org.

Sincerely,

Lori J. Pierce, MD, FASTRO, FASCO
Chair of the Board
Association for Clinical Oncology

Support House Bill 1146

Dear Chairman and Committee Members,

I am writing to ask for your support of a bill that will help the many North Dakota residents who are struggling to build their families in our state.

One in 8 couples in the U.S. has trouble getting pregnant or sustaining a pregnancy. Infertility affects men and women equally and does not discriminate.

My husband and I tried to have children shortly after we were married and began doctoring soon after. We were given a medical diagnosis of unexplained infertility and tried many invasive procedures that were emotionally and financially exhausting. I was lucky to have some insurance coverage but it was a lifetime maximum amount that was quickly spent after one IVF cycle. The cost to continue treatment was astronomical but we did not want to give up on our dream of having children. We had to stop treatments for long periods of time to save up what money we could, borrow money from family, and max out our credit cards. So on top of the mental and emotional anguish, we also had to deal with the stress of how we were going to pay for continued care and the never ending medical bills. The financial stress affected every aspect of my life; my job, my relationships with family and friends, and my relationship with my husband was strained not only because of the sad reality we were living every day but also because of the financial situation we were in. It took us almost seven years and over $100,000 to finally welcome our son via gestational carrier. Infertility is a medical diagnosis I don't wish upon anyone. It's a long, lonely, and expensive process. Insurance coverage for an infertility diagnosis needs to be provided for everyone!

House Bill 1146 requires health insurance providers to provide coverage for the diagnosis and treatment of infertility. The bill complies with current medical standards of care for those affected by infertility, including coverage for fertility preservation treatments to allow women and men to preserve their fertility before undergoing cancer treatment or other medical procedures. Such coverage provides the best outcome for parents and their offspring.

I hope you will support this pro-family bill on behalf of the 1 in 8 couples in our state who are struggling to build their families and for patients whose cancer may impact their fertility.

Sincerely,

Kristin Natwick

# TESTIMONY OF SCOTT MILLER

## House Bill 1146 – Expansion of Fertility Benefits Coverage

Good Afternoon, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in a neutral position regarding House Bill 1146.

The bill would create a section in the NDCC specifying mandatory coverage provisions for treatment of infertility. The NDPERS Health Plan already has coverage for infertility treatments, with a lifetime benefit limit of $20,000. That amount is average for the industry for employers of the State's size that provide these benefits.

HB 1146 would require the NDPERS Health Plan to provide "richer" benefits by modifying several coverage provisions, increasing the number and types of services covered, and the proportion of claim payments covered by the plan. HB 1146 does not impose a lifetime benefit limit, and removes the current $20,000 limit.

This bill does satisfy the statutory requirement that its mandates first apply to the NDPERS health plan before being expanded to other plans in the state.

Deloitte, our consultant, has several observations.

- This bill would serve to increase plan payments for fertility health resulting in expanded coverage for these services. Infertility treatments can be expensive and design changes will have an actuarial impact on the program.
- Deloitte developed an actuarial model incorporating benefit costs for a significant array of infertility services and procedures. Using this model, Deloitte estimated a 2.1% cost increase in combined medical and pharmacy claim payments. That equates to about a $15 million increase in claims for the biennium, which will increase premiums.
- Scope of coverage regarding third parties, as in the case of coverage of surrogates or third-party members, should be clarified.

Related to that scope of coverage point, if we allow non-employees onto our health plan as the primary covered individual, our health plan may be in danger of losing its status as a "governmental plan". If that were to happen, we may become subject to significant ERISA regulations.

# 1146 testimony - PRO

#12662

Shana Beadle, Bismarck resident

Thank you, Chairman Louser, and the rest of the honorable IBL committee members.

My name is Shana Beadle. If I look a little familiar, that's because I am married to Thomas Beadle, your former House colleague and current state treasurer. In 2014, we were ready to start a family, so we got married. All these years later, and we are still not parents.

But, we have been trying. I have a medical condition called PCOS, which is common and affects around 10% of all women. This condition means that my hormones are off, and the most common way to regulate symptoms is a prescription of birth control. However, that doesn't really work when the goal is to have a baby! I have tried just about everything to boost my fertility. Supplements, acupuncture, naturopathic doctors, meditation, yoga, Mayan belly massage, diets, weight loss, medications, injections, and IUIs. Thanks to our most recent IUI, I had the best and worst days of my life. In August, it worked. I was pregnant for the first time ever. And then, days later, something felt wrong, and I had miscarried.

So, we continue the journey. We put our trust in medical science and our faith that something will work. But, we need the insurance and medical coverage to continue. Each medicated fertility cycle is thousands of dollars, multiple ultrasounds, multiple visits to our local provider in Bismarck, consultation with the experts in Fargo, prescriptions, injections, and then faith and waiting.

The process is hard. My body has been through so many hormones and blood draws and injections and scans. My mind has been through even more, because I am sad and ashamed and heartbroken that my body hasn't cooperated. And if you know my husband Thomas, you know he would be the best dad.

But it's not easy. This is not something someone undertakes without deep thought. As I can attest, it's also not a process that works on the first try, and those expenses add up. We are now finally in a financial position to pay for these expensive medications, but now that I'm 35 years old, it's just a harder road.

So, I am here to tell you that yes, real people need and want this legislation. This is a solution to a real problem. I am a person covered by the PERS insurance who needs and wants this benefit. You might not hear much about it, because people don't tend to speak up about their struggles with fertility, but it is real.

I know we don't love insurance mandates in this state, and I'm sure you'll hear some persuasive testimony about cost. But, we also know that the goal of insurers is to retain their money and not pay out as much as possible. That's their industry, and I respect it. However, it's also the state's prerogative to decide that some benefits are so important they require coverage. I argue that growing a family is one of the most important and beautiful goals that we could have. I'm sure that each of you with children agrees that they are a blessing, and that your life would be missing something without them. I would also add, this bill doesn't force other

companies or businesses to cover anything, it is just about what the state of North Dakota requires for their own plan that covers our state employees. From my understanding, all changes to take immediate effect are only in chapter 54, which deals with PERS.

Finally, I just want to leave you with the idea that the state of North Dakota prides itself on being family forward. Here's a chance to prove it - to support our struggling families with a little bit of insurance coverage to help grow the next generation.

Thank you for your time, and I'm happy to answer any questions you may have.

Imagine being diagnosed with cancer but denied treatment for it. It sounds inhumane and impossible.

Now imagine that the reason for this denial is that you can't afford the treatment and insurance won't cover it because treating the cancer is your choice. You don't have to do treatment, and if you want to, that's your choice, but it's unfair to make other insurance policyholders pay for cancer treatment that YOU are choosing.

It's asinine to even imagine. After all, that's the whole point of insurance. Yet for most of the 7 million Americans who have been diagnosed with the disease – yes, disease – of infertility, this is the devastating reality: limited or no insurance coverage for the treatment of our disease. Furthermore, two years ago at the last North Dakota legislative session, one reason for the denial of the bill for fertility coverage was that having a child was a personal choice, and it was therefore unfair to other policyholders to pay for this coverage.

This, from the state that prides itself on being pro-life.

Let me be clear. I did not **choose** to get diagnosed with breast cancer 16 days after my husband and I were married. I did not **choose** to be infertile as a result of the treatments that saved my life. No one who desires to have children would **choose** fertility treatments over getting pregnant on their own.

Insurance denied our claim for embryo preservation before beginning chemo, despite the fact that I had fertility benefits through my employer, claiming it was "medically unnecessary" because I did not meet their criteria of trying to conceive unsuccessfully for two years in order to be considered infertile. Any oncologist will affirm that infertility or fertility complications are a frequent result of cancer treatments. Insurance is defined as "a thing providing protection against a possible eventuality." What else is infertility as a result of cancer treatments if not a

possible eventuality of those treatments? Where is the protection provided to cancer patients for this possible eventuality?

Fortunately, my husband and I were able to do embryo preservation before I began chemotherapy, but *only* because family, friends, acquaintances, and even complete strangers rallied together on GoFundMe and in less than 24 hours raised enough money and more. Not everyone is as fortunate. Crowdfunding should not be the expected or accepted financial plan for any medical expense, infertility included. Fertility preservation must be honored in the same regard as any other part of cancer care and insurance coverage must be standard.

With two embryos preserved before my treatments, we were able to become parents to our daughter, Lola, who is now almost four years old and the center of our universe. It's impossible to imagine our life without her, but I cannot forget that she would not be here without the fertility preservation that happened just two days before I had my first chemotherapy infusion and that we couldn't afford on our own right after paying for a wedding with only days to come up with the money so I could begin chemo.

Costs for fertility preservation and fertility treatments just add a cruel and unnecessary burden to a cancer diagnosis, which is mentally, emotionally, and physically exhausting enough. We have spent over $11,000 out of pocket for fertility treatments and thousands on the medications that are required. We have maxed out the $ 20,000-lifetime maximum benefit that kicked in only **after** my cancer treatment when I was in fact infertile. This is in addition to over $22,000 for out-of-pocket medical expenses related to cancer.

While the concerns about increased healthcare costs are valid, they are also disputed. RESOLVE, The National Infertility Associated found that, "according to a 2021 employer survey conducted by consulting firm Mercer, and commissioned by RESOLVE: 97% of

respondents offering infertility treatment have **not** experienced an increase in their medical costs as a result of providing this coverage."

Fertility preservation matters. Insurance coverage of fertility preservation matters. Fertility preservation provides hope and insurance before, during, and after cancer. There is so much at stake for a cancer patient who hasn't started a family before cancer strikes. A cancer diagnosis is devastating enough. Knowing that the treatment might leave you infertile is heartbreaking. Not being able to do fertility preservation before beginning cancer treatment because it is not covered by insurance and too expensive simply should not happen to anyone. Fertility preservation must no longer be viewed as elective. It is medically necessary.

I urge you to think of, acknowledge, and support North Dakotans struggling to build families and vote yes for HB 1146.

Tiffany Olsen
District 16

North Dakota Nurse Practitioner Association
www.ndnpa.org
Legislation Tracking Team
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Written letter to
68TH NORTH DAKOTA LEGISLATIVE ASSEMBLY

HB 1146

Chairman Louser and Committee,

I am Adam Hohman Legislative Liaison for the North Dakota Nurse Practitioner Association (NDNPA). I am writing to ask you to vote **do pass** on HB 1146.

The NDNPA understands the importance of access to care for the more than 33,364 North Dakotans diagnosed with infertility or needing fertility preservation with the diagnosis of cancer and other diseases. We believe that threats of large premium increases don't look at the whole picture and total costs of health care. It has been proven that states with insurance coverage have fewer rates of multiple births than states without. Early access to fertility health care reduces the number of benefits used to overcome this disease. Fertility benefits ensure timely and provider recommended healthcare while optimizing safe pregnancies, healthy babies, as well as cost outcomes. This cost barrier should not be on patients who already have access to insurance coverage.

Thank you for your time

Adam Hohman, DNP, FNP-C
ndnpalegislative@gmail.com

My testimony is in support of HB1146. I want to start out by giving you a very brief background of my infertility journey. My husband and I began trying to get pregnant in late 2013. After being diagnosed with infertility, we tried several IUIs locally, a round of IVF (including three embryo transfers) in Fargo, and a second round of IVF in Denver. After eight and half very difficult years, I gave birth to our beautiful baby girl in April of 2022.

This is my third time testifying for the fertility benefits bill. Therefore, today I would like to take a different approach and focus on providing you some insight into what it's like for families going through infertility. I would like to start by breaking down the cost of treatment. Please keep in mind that these numbers reflect my particular needs and clinics and that the pricing varies from 2017-2021. These prices also do not include any workups or surgeries before we pursued IVF or my six IUIs. Please bear with me as I break down these numbers, as I do feel it's important for you all to get an understanding of the actual financial burden we are talking about.

First round of IVF: Paid throughout cycle

$18,236.00- included cycle monitoring, retrieval, embryo fertilization/ freezing, and one embryo transfer
$13,296.00- two additional embryo transfers
$3,742.00- pre cycle labs/procedures
$10,000.00- medications (over three transfers)(low estimate)

This round also included one miscarriage/D&C and multiple trips to Fargo, including hotel stays which I have not priced out. It also produced no viable pregnancies.

Second round of IVF: All paid upfront

$2,884.00- IVF workup
$900.00- workup labs
$1,500.00- deposit
$718.00- sperm collection
$24,239.00- retrieval, eggs fertilizations, CCS Testing, and one frozen embryo transfer
$475.00- anesthesia
$8,000.00- medication
$650.00- per year for storage of remaining embryos

This round included travel to Denver three times (not priced). It also produced our baby and two additional embryos currently frozen.

That total comes out to $84,640.00

Do all patients diagnosed with infertility who pursue treatment need IVF or incur this much cost? Thankfully, no. Therefore, I did not breakdown those numbers for you under the guise that everyone faces that challenge. It was simply to show you what this reality can look like and to give you an idea of the substantial impact infertility coverage could have.

Now, I have heard the insurance companies argue a couple of things, one of which is that adding coverage will increase premiums for all customers, including those who will never access the benefit. So, they ask, is it fair that some patients will use it for multiple treatment cycles while others will never use it? Well, let me ask you this in return: is it fair that I pay premiums that cover cancer treatment if I never get cancer? Let me emphasize something very clearly for you all today: infertility is a disease. It's not simply an unfortunate circumstance that we can "relax" our way out of. There is no magic diet or exercise regimen that will kick start our reproductive system back into working order. It is a disease diagnosed by doctors, of which patients do not have control over.

The second argument I have heard from the insurance companies is that not enough employees have requested this benefit from their employers, therefore it is not necessary to cover something that would benefit so few. However, how comfortable would you be going to your boss and revealing your personal medical information? Many people diagnosed with infertility struggle to talk to their own family or friends about it, let alone a stranger in HR. One in eight struggles with infertility. One in eight. How is that number too small for coverage to make an impact?

I would also like to draw your attention to two words those of us with infertility hear the most often: "just" and "choice." The former includes: "just relax and it will happen," "just try this vitamin, food, exercise, etc.," "just adopt," "just do IVF," "just move on with your life," or my personal favorite, "just take my kids, they're driving me insane." I would hope you can see how minimizing those statements are; how much they downplay the struggle of infertility. But why do I even bring those statements up when we are talking about infertility insurance coverage? Because they show the pervasive lack of understanding about infertility and how it works. It also shows the lack of acknowledgement that this is, once again, a disease and not a lifestyle choice.

And now moving onto the latter word: "choice." Most specifically, "you are making a choice to pursue treatment," therefore "why should it be covered by insurance" or "why are you complaining about the cost?" You can see how this goes hand in hand with the "just" statements. Which other disease can you think of where one's decision to pursue treatment is seen as a choice and not an obvious necessity? And, beyond that, where is our choice? I did not choose to have PCOS or Endometriosis. I did not choose for my body to be unable to get pregnant naturally. Let me put it another way: if someone puts a knife to your back and says you either give them your wallet or get stabbed, is that really a choice? And if you cannot afford treatment, there is no perceived "choice" at all.

I would like to end the same way I did during my last testimony: I am not supporting this bill because I will personally benefit if it passes. I say this because I want to make it very clear that, even though, I cannot benefit from this, I still believe this coverage is vitally important for other North Dakotans; many of whom cannot be here today to advocate for themselves due the heavy emotional toll of infertility and the discomfort many feel about speaking publicly about it. And if, one day, my daughter grows up with my reproductive issues, I want her to have more support than I did. In the end, I want every couple in North Dakota to have a chance to build their family, regardless of an infertility diagnosis.

Thank you.

Casie Davis

Bismarck, ND

SANFORD HEALTH PLAN

January 10, 2023

Chairman Louser and Members of the House Industry, Business and Labor Committee –

My name is Dylan Wheeler, Head of Government Affairs for Sanford Health Plan. Respectfully submitting comments in **opposition** to the House Industry, Business, and Labor committee today regarding HB 1146. To begin, I want to emphasize that Sanford and Sanford Health Plan strive to provide access to high quality health care. However, we do take the general position of opposing mandates. While true that this bill, if passed, would apply to the North Dakota Public Employees Retirement System health plan to begin, we must advocate at this time as if the mandate would apply to the commercial market in the subsequent years.

At a very high level, and as detailed below, we have concerns with the broad scope of the bill in terms of likely financial impact to premium; however, with the broad nature of the bill, it is difficult to estimate the exact impact at this time. As another resource, through the past interim, the North Dakota Insurance Department (NDID) conducted a study of potential new benefits to add to the ND state Essential Health Benefit (EHB) plan. A stark distinction needs to be noted – the interim study by the NDID scoped and evaluated a bill draft with a $50,000 coverage limit; whereas, the bill before the committee today is uncapped. Carriers submitted a range of premium impact analysis ranging from $1.98 per member per month (PMPM) to $24.85 PMPM – the consultant retained to complete the study priced the benefit at $2.38 PMPM.

In looking at HB 1146, we do have a few comments and concerns that I would like to highlight:

- **Coverage for Cryopreservation (page 4, lines 8-17):** As written, coverage for cryopreservation has no specified timeframe and could potentially continue in perpetuity or until used by the family in an attempt to conceive. With that long period of potential coverage, a person may be enrolled in different health insurance products: employer coverage, marketplace coverage, Medicaid, Medicaid Expansion, Medicare, etc. In the event that an individual who utilized cryopreservation services switches health plans and that new health plan does not offer coverage – who would continue to pay in this scenario? Finally, in light of the *Dobbs* decision, and in alignment with what has been noted by Deloitte (independent actuarial firm who assists in estimating financial impact of legislation) legal questions may arise in relation to cryopreservation services.
- **Coverage for 3rd Parties or Surrogates (page 3, lines 2-3)**: Part of the bill appears to mandate coverage for surrogates or other 3rd parties who may carry a child on behalf of a family. People who are not enrolled or not a member of a health plan should not be covered under this benefit mandate. It is important to note that maternity coverage for a surrogate or third party is likely available under that individual's own benefit plan.
- **Broadness of Language:** The legislative proposal is extremely broad, as written, and difficult to operationalize. For example, the definition of "standard fertility preservation services," as used in

the operative sections of the bill, is broad and vague in terms what actual coverage would be required.

- **Premium and Financial Impact:** as noted in the introduction, and as identified by independent consultants, the proposed legislation would have a substantial impact to the premium. In addition, and to reiterate the broadness of the bill, the true cost of implementing, operationalizing, and covering the full scope of the benefit is unclear at this time.

Thank you for your time and consideration – please do not hesitate to contact me directly with any questions.

Dylan Wheeler, JD, MPA
Head of Government Affairs
Sanford Health Plan

January 8, 2023

This letter is in regard to HB 1146. My name is Patty Hulm. I am a mental health counselor, infertility support group leader, Vice President of Everlasting Hope, and a past infertility patient. I am in support of fertility health benefits for public employees. I started the first infertility support group in the state of North Dakota in March of 2012. That group has met monthly since then, and added a virtual option during the COVID pandemic. I also have been a professional counselor in Bismarck, ND since January 2013. I have worked with couples and individuals over the years who are facing the emotional and physical struggles of infertility all across the state of North Dakota, thanks to telehealth options and virtual meeting platforms. The financial barrier that couples face to build their families puts a significant strain on their relationships. It is by no fault of their own that they are facing these medical conditions, but they are penalized by the lack of insurance coverage they receive because of their diagnosis of infertility. While emotional and physical struggles will continue for couples who face struggles with infertility, part of that burden can be lifted when they know that portions of these very expensive treatments will be covered. This is something positive that can be done at a state level to help with this burden and stress. I hope that this bill will receive the support it needs to move forward.

Sincerely,

Patty Hulm

Chairman and Committee Members,

My name is Tara Brandner, a doctorate family nurse practitioner, founder, and president of Everlasting Hope, the first and only nonprofit in ND and SD supporting those with infertility and raising awareness on this disease. This will be my third legislative session working to provide access to insurance coverage for the only disease insurance doesn't cover, infertility and fertility preservation. My infertility journey consisted of the diagnosis of endometriosis, miscarriage, three failed IUI treatments, IVF, and $40,000 in uncovered medical bills.

One in eight North Dakota Residents has trouble getting pregnant or sustaining a pregnancy, this includes those experiencing a miscarriage and those who have a diagnosis of cancer. Two written testimonies from cancer patients who couldn't be here today explain the impact of infertility on their cancer diagnosis and I encourage you to read those. I am here today speaking for myself but also for those who are suffering in silence. 61% of women do not share this diagnosis with their friends and family. The mental health impact this disease carries is significant for men and women.

Since 2019 I have been speaking with BCBSND , Sanford, and employers to create a positive change for access to care outside of legislation. Ideally, insurance carriers would provide coverage for medically necessary healthcare without any legislation involvement. As it is, they limit the insurance coverage offered or have no coverage for the diagnosis of infertility. That is why I am asking for legislation once again to support access to timely and appropriate healthcare for those diagnosed with infertility.

Infertility is a disease that often requires medical intervention. It is well documented the faster a person can access treatment, the less invasive care they will need and the less care is required to experience a live birth. Fertility treatment and preservation exist and are proven effective, but most people cannot afford the health care expenses to overcome this disease. When a healthcare provider diagnoses a patient with infertility, every lab draw, ultrasound, medication, and procedure is paid for out of pocket by the patient. Infertility impacts men and women: 1/3 male factor, 1/3 female factor, and 1/3 unknown or both male and female causes.

A healthcare disparity refers to differences between groups in health insurance coverage, access to and use of care, and quality of care, as a nurse practitioner, it is clear to me that infertility in North Dakota is a healthcare disparity. Unlike other chronic diseases that are costly in a lifetime, infertility patients will utilize fertility coverage or preservation only during their reproductive years. As a nurse practitioner, I treat patients that have chronic diseases such as diabetes, hypertension, and obesity costing inwards of $13,000 per month. In addition, individuals with infertility pay for obstetric and maternity benefits but never have an opportunity to utilize them. We all pay for benefits we don't personally find of value at the time or ever, the bottom line is ensuring timely and appropriate health care to residents of North Dakota. North Dakota families should not have to go into credit card debt, take out loans, or use their homes as equity to have access to medical care.

It's important to highlight that HB 1146 pertains to PERS, which already offers infertility benefits but carries a lifetime max that has not been changed since it was initiated over 20 years ago. Surely we are all aware of the cost changes in the medical field that have been made in that time frame. That is why we are moving to caping treatment to a particular number of rounds, not

dollar amounts, which are not even allowed per the ACA. Over the weekend, I emailed you documents backed by research and data from 20 states that have passed this legislation. Not a single one has been required to defray the cost like the opposition will tell you.

There has been a lot of mixed data produced by fiscal notes and independent companies since 2019. It is my understanding the reason legislative changes to insurance plans must run through PERS before being released to commercial insurance is to provide a report showing the effect of the fertility treatment health benefits requirement on the system's health benefits programs, information on the utilization,  costs relating to the coverage, and a recommendation regarding whether the coverage should be continued. I am simply asking today for a yes vote to proceed with this study and bill we have been working on since 2019. One in eight of your constituents is asking you to vote yes on HB 1146, and I am here making that ask on their behalf.

January 2023
ND HB 1146
Hill Testimony

As I start to write, I hear tiny feet running down our hall with the biggest smile on my two year old's face screaming "Mom" with so much excitement to see me. I thank god every day for this blessing and can't imagine this world without him. It breaks my heart not every woman is able to experience this unconditional love. Parenthood is something our society takes for granted. Children are raised into thinking this will always be a possibility but what happens when their world is shattered with news they can't? Wait…what….NO?? That has never been in our vocabulary. Being rejected can be a very painful, lonely experience with many individuals feeling ashamed and not willing to share their reality. It's time we speak out and fight for the coverage we so desperately need. I'm 1 in 8.

At the age of 17, I started on birth control after being in a serious relationship for quite some time. I had hopes and dreams for myself so felt this was a necessary step to further safeguard this. My high school sweetheart and I dated for many years and finally got married in August of 2004. I was a recent college graduate and felt completely confident in my career path. It was at that time that my husband and I decided to pursue a family. With no success and having symptoms of menopause, we decided to meet with an infertility specialist. I was diagnosed with Premature Ovarian Failure in July of 2006, just shy of my 24th birthday. My husband and I had multiple discussions with this medical team and at the time, we weren't quite ready to move forward with treatment but instead wanted answers….why?? I'm one of 4 biological siblings with no history of any fertility issues on either side. What went wrong and why me?? I still don't have any confirmed answers but do believe the longevity of my birth control played a role.

Knowing our fate, my husband and I chose to take some time for ourselves and had fun living life to our fullest throughout the next 6 years. We also spent this time slowly saving for our reality soon to come. It wasn't until August 2012 that we started down the path of infertility treatments. I, myself, knew I couldn't biologically have my own child but we had the knowledge that there were alternatives to give us the family we so desperately wanted. For various reasons, we chose egg donation. We started working with my younger sister for the next year and after thousands of dollars and a failed IVF attempt, but knowing we were so close, we switched gears fairly quickly and decided to go through an anonymous donor bank. The process was overwhelming. It's honestly like ordering a new car. Hair color, height, education level, genetics, etc. all played a role in our final decision. We only had access to baby pictures and it wasn't until we paid for the eggs that we got to see an adult photo. Of course, my husband had his responsibilities as well to make this work but we were so determined and financially invested that there was no stopping us now. So with more shifting of our financial situation, we moved forward and I believe we are the second family in the state of North Dakota to try through egg donation.

On February 16, 2015, two embryos were implanted and on February 25th we were told the breathtaking news that one stuck! My pregnancy was fairly quiet compared to all we faced prior. Cale Matthew Hill (named after my husband) was born on November 6, 2015, same day as his courageous dad that decided to fight with me which meant even more to us! We froze our last embryo and attempted again in July 2017. Lane Francis Hill (named after my grandfather) was born on March 9, 2018.

Words can't describe the pain and emotion we've experienced through this journey. It financially broke us but we have our two greatest gifts and couldn't be prouder. We fought hard to get the family we've always wanted. We were fortunate to have the best support system and financial access to funds to accomplish this great feat, not once but twice. Others may not be so lucky.

My two miracle boys are why I fight and I promise to keep fighting until every family has the same opportunity as we did. Insurance coverage matters. It's an important resource that will help struggling couples build their forever families. I strongly encourage you to consider ND HB 1146 because building North Dakota families matter.

Jennifer Hill
District 22

Infertility is not something you plan for or ever dream of happening to you especially when you come from parents of large families with no concerns in this area. Infertility as my husband and I have found out doesn't care about your family history. Six years into our journey to have a family we were blessed with our son. We were fortunate to have an insurance plan at the time that covered most of your journey that at this point did not include IVF. Due to maxing out the amount of money our insurance would cover for fertility we changed to a less expensive insurance plan after the birth of our son. When we wanted to try to grow our family again we knew we would not have any coverage under our new plan but we were thankful that we had had insurance to cover our first journey. I ask that you look at this bill that will allow couples to have insurance coverage to help grow their families just as we had prior to the change in policy. Infertility is not something a couple chooses to struggle with just as others health concerns are not a choice.
Sincerely,
Bethany Peterson
Life time North Dakota resident

To the House Industry, Business, and Labor Public Hearing Committee,

My husband and I were a young couple that experienced tragedy in the death of a young friend. This led to us realizing we didn't want to wait to start a family. I stopped taking birth control only for my cycles to become irregular and to see negative test after negative test every month. We did this for a year.

A year of hearing our family and friends ask when we would start a family. A year living in secrecy about our desire for a baby. A year embarrassed and ashamed that we were not experiencing the quick and exciting joy so many of our friends were.

After a year, we sought help from the doctor. The process was time consuming and we were overwhelmed by the costs of even just diagnostic testing to try to discover what was wrong. The medical community failed us before we even started.

Even though I was told by my health insurance at the time that, unlike other plans, I did have limited infertility coverage, it all depended on how the doctor coded procedures. The doctor was unsure of how these worked and what would be covered. Even when we did pick and choose what we could afford, we were forced to do our own research and become our own advocate. There is a tremendous lack of research and doctors often lump couples into the same treatment plans instead of listening and adapting to the challenges of the couple.

This left us, as a young couple, to spend our free time listening to podcasts, reading articles, and analyzing every little thing about our bodies. As a woman that is overweight, I had to advocate for a doctor to see me as more than my weight and treat the problems I was having. My blood work and other simple testing all came back healthy and within range proving that I was healthy and could carry a child. The only symptom I had was irregular cycles which lead to an unofficial diagnosis of Polycystic Ovarian Syndrome. The fact that I still do not have an official diagnosis is just another way the health system has failed me. There is not enough research established about PCOS or treatment for PCOS symptoms.

Ultimately, it took switching to another doctor, requesting medication, advocating for blood work at timed intervals of my cycles, finding the right supplements for us both, and researching a medical grade device to accurately track cycles when a woman has PCOS (a device many U.S. doctors still do not recognize). We finally saw 2 lines on our pregnancy test and then also on the 50 tests we took afterwards just to make sure on Mother’s day weekend 2019.

We then had a healthy pregnancy and a beautiful baby boy.

The important thing to know is that infertility affects 1 in every 8 couples in North Dakota.There is not enough medical coverage for these couples to make the best decisions for them, there is not enough research to adequately treat these couples, and there are not enough informed doctors to give these couples the individualized care they deserve. Ultimately, if something is

not done, research has proven that couples could go on to have unhealthy pregnancies because health issues are not resolved or monitored and couples with the ability to do so will leave this state or seek treatment out of state: an embarrassing travesty to our state. Creating a path of better access to infertility benefits to more people is the best foot forward.

Jamie Stewart
mclaren7739@gmail.com
682-551-2904
Everlasting Hope Board Member

My husband and I's infertility journey started 3 years ago. Of course, when we first started trying to have a baby, we didn't realize we would face such chaos. We continued with our lives, not knowing the coming battle. My husband served his four years in the military and is now working as a police officer in West Fargo. I work as a high school educator for a private school after spending years working as an EMT. For the past three years we have had no successful pregnancies, not even a miscarriage. We have been through two complete IVF cycles, both failed. And this is what brings us here today. Health insurance doesn't cover infertility treatments. Some like Blue Cross Blue Shield, allot a small sum known as artificial reproductive technology (ART) to use towards infertility treatment. We were allotted $20,000 for a lifetime. Not including medication, this barely got us through two IVF cycles. Before this we had to go through two years' worth of other infertility treatments that were less invasive first, obviously those didn't work.

When I called Blue Cross Blue Shield to ask about how I could get coverage for a disease known as infertility that I was diagnosed with, they told me getting pregnant was a choice and that's not medically necessary even though it was a disease. Blue Cross Blue Shield does cover transition surgeries for those diagnosed with gender dysphoria. My husband and I are now trying to determine how we want to go forward; do we adopt or give up on trying to have children? We explored the avenue of adoption, discovering that it is also extremely expensive whether you're adopting through the foster care system, (whose goal is to reunite the children with their biological family), or adopting an infant. To adopt an infant here in North Dakota, we are on a waiting list to get on a waiting list in order to be considered to adopt. At this point the only other option my husband and I have is to pray that God has a plan and continue to pursue infertility treatment. Since we cannot pay for it ourselves, (Cop and teacher salaries) we are asking that you consider helping us and millions of other couples faced with this disease.

I would like to point out that I am not the only person to be facing this disease. In fact, there are many men and women that battle infertility including my own husband. Being told that there is something medically wrong with you and you cannot

have children without medical intervention is extremely difficult especially when your health insurance says that they won't cover it. You have the power to change the lives of 1 in 8 people in North Dakota. Infertility impacts 1/3 of men, women, and both. The mental health impact and the damage it can do to a marriage is serious and disconcerting. Please help make an impact on North Dakotan's lives, like other states have done. As a resource, I highly recommend you use RESOLVE, the national infertility association.

Sincerely,

Rachel Booth


**January 6, 2023**

# Analysis of Draft Bill No. 147 Relating to Public Employee Fertility Health Benefits

Prepared for the North Dakota Legislative Council
Pursuant to North Dakota Century Code 54-03-28

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## I. Evaluation of Proposed Mandated Health Insurance Services

The North Dakota Legislative Council (NDLC) was asked to perform a cost benefit analysis of Draft Bill No. 147[1] (Draft Bill 147) for the standing Legislative Assembly pursuant to the North Dakota Century Code (NDCC) 54-03-28. Draft Bill 147 creates and enacts section 54-52.1-04.19, amends and reenacts 26.1-36.6-03 of the NDCC, provides for a report; provides for an application; provides an expiration date; and declares an emergency. Draft Bill 147, as proposed, states that "The board shall provide coverage for the expenses of the diagnosis of infertility, fertility treatment, and standard fertility preservation services if recommended and medically necessary." Coverage must include three completed cycles of intrauterine insemination in accordance with best practices. The bill allows the board to limit the coverage to services necessary to achieve two live births, or a maximum of four completed oocyte retrievals with unlimited fresh and frozen embryo transfers, in accordance with best practices.

NovaRest, Inc. has been contracted as the NDLC's consulting actuary, and has prepared the following evaluation of public employee fertility health benefits.

This report includes information from several sources to provide more than one perspective on the proposed mandate to provide a totally unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we considered credible, we do not offer any opinions regarding whether one source is more credible than another, leaving it to the reader to develop his/her conclusions.

NovaRest estimates the additional percentage impact above current fertility coverage on health care costs and premiums ranges from 0.7% to 0.9% on a percentage of premium basis, and $3.46 to $4.25 on a per member per month (PMPM) basis.

## II. Process

NovaRest was charged with addressing the following questions regarding this proposed mandate:

- The extent to which the coverage will increase or decrease the cost of the service;
- The extent to which the coverage will increase the appropriate use of the service;
- The extent to which the coverage will increase or decrease the administrative expenses of carriers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders; and
- The impact of this coverage on the total cost of health care.

NovaRest reviewed literature (including reports completed for other states that were either considering or have passed similar legislation) and developed an independent estimate of the proposed mandate's impact on premiums.

# *III. Mandated Coverage for Public Employee Fertility Health Benefits*

Draft Bill 147 would provide for diagnosis, preservation, storage, and infertility treatment where medically necessary, limited to services needed to achieve two live births, or a maximum of four completed oocyte retrievals with unlimited fresh and frozen embryo transfers. This bill also covers three completed cycles of intrauterine insemination, in accordance with best practices. The definition of medically necessary is (1) consistent with findings and recommendations of a licensed physician or (2) consistent with generally accepted standards of medical practice as set forth by a professional medical organization with a specialization in any aspect of reproductive health, such as the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists; or (3) clinically appropriate in terms of type, frequency, extent, site, and duration.

## Background

### *Condition*

Draft Bill 147 defines infertility as a disease or condition where:

(1) The failure to conceive a pregnancy or to carry a pregnancy to live birth after unprotected sexual intercourse;
(2) An individual's inability to cause pregnancy and live birth either as a covered individual or with the covered individual's partner; or
(3) A licensed health care provider's findings and statement based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Infertility may be caused by an issue present at birth or by a variety of issues that develop later in life. It can also be caused by treatment for a disease in what is known as iatrogenic infertility.

According to the American Cancer Institute, radiation therapy and many chemotherapy drugs used to treat patients in their reproductive years carrying a high risk of causing damage to eggs or sperm, and therefore carry a high risk of infertility.[2]

Other treatments that carry an increased risk of infertility are bone/stem cell transplants, which can be used to treat a variety of conditions, including erythematosus, lupus, severe aplastic anemia, sickle cell disease, rheumatoid arthritis, etc. Bone marrow and stem cell transplants, which usually involve high doses of chemotherapy and sometimes radiation to the whole body before the transplant, can permanently stop a woman's ovaries from releasing eggs[3] and permanently prevent a man from producing sperm.[4] Although there are several conditions where treatment may involve bone marrow and stem cell transplant, most treatments that cause iatrogenic infertility are associated with cancer treatment.[5]

## *Treatment*

Infertility is treated using a variety of methods, including medications, hormone treatments, and surgery.[6] Infertility is also treated using assisted reproductive technology (ART). ART appears to be defined differently by different sources, with some including intrauterine insemination (IUI), in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT).[7] While the CDC does not consider treatments in which only sperm are handled (IUI) or procedures with medicine only to stimulate egg production without the intention of having eggs retrieved to be part of ART.[8] For the purposes of this report we will use the CDC definition and indicate all other reproductive assistance as "non-ART."

Draft Bill 147 will require diagnosis of infertility, fertility treatment, and standard fertility preservation services, including third-party reproductive care for the benefit of the covered individual or partner. "Third-party reproductive care for the benefit of the covered individual" means the use of eggs, sperm, or embryos donated to the covered individual or partner by a donor, or the use of a gestational carrier, to achieve a live birth with healthy outcomes.

The diagnosis of infertility is defined by Draft Bill 147 as the services, procedures, testing, or medications recommended by a licensed physician, which are consistent with established, published, or approved best practices or professional standards or guidelines, such as the American Society of Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology for diagnosing and treating infertility.

"Fertility treatment" consists of a method of causing pregnancy other than sexual intercourse which is provided with the intent to create a legal parent-child relationship between the covered individual and the resulting child. It includes health care services, procedures, testing, medications, monitoring, treatments, or products, including genetic testing and assisted reproductive technologies such as oocyte retrievals, in vitro fertilization, and fresh and frozen embryo transfers, provided with the intent to achieve a pregnancy that results in a live birth with healthy outcomes. "Monitoring" includes ultrasounds, transvaginal ultrasounds, laboratory testing, and follow-up appointments.

Coverage must also include three completed cycles of intrauterine insemination, in accordance with best practices, such as the standards and guidelines of the American Society of Reproductive Medicine.

"Standard fertility preservation services" means services, procedures, testing, medications, treatments, cryopreservation of eggs, sperm, embryos, and products consistent with established best medical practices or professional guidelines such as those published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for an individual who has a medical condition or is expected to undergo

medication therapy, surgery, radiation, chemotherapy, or other medical treatment recognized by medical professionals to result in, or increase the risk of, impaired fertility.

Standard fertility preservation services, including the procurement, cryopreservation, and storage of gametes, embryos, or other reproductive tissue, and standard fertility preservation services if the covered individual has a diagnosed medical condition or genetic condition that may cause impairment of fertility affecting reproductive organs or processes. As used in this paragraph, "may cause" means the disease itself, or the necessary treatment, has a likely side effect of infertility as established by best practices, such as the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

Some disease treatment programs will result in a patient becoming infertile in a condition we will refer to as iatrogenic infertility. For those with a disease treatment that will result in iatrogenic infertility, the person may have time prior to the start of the disease treatment to undergo fertility preservation procedures. Fertility preservation services are procedures that may allow patients to safeguard their ability to have a child. According to the American Society of Clinical Oncology, the most effective preservation method for males is sperm cryopreservation while a female has multiple options for fertility preservation depending on various factors including age, type of treatment, diagnosis, whether she has a partner, the time available, and the potential that cancer has metastasized to her ovaries.[9] The most common and effective preservation methods are embryo cryopreservation and oocyte (egg) cryopreservation.[10]

After performing the fertility preservation procedure, the sample must be stored until it is ready for use. Typically, storage lasts between 5 and 10 years[11] , although more research is being released on the effectiveness of a sample which has been stored longer than 10 years. Due to effectiveness concerns, clinics will stop performing ART and non-ART methods on patients over the age of 50.[12]

For women, usage of their embryo or oocyte cryopreservation will require the use of ART.[13] Men may opt for ART or non-ART procedures for their stored sample.

## Prevalence of Coverage

### *State Employee Retiree Group Health Insurance*

The North Dakota Public Employees Retirement System (NDPERS) uniform group insurance program currently has a $20,000 lifetime maximum for infertility diagnostic and treatment services.[14] It does not appear to cover fertility preservation or storage services currently. Draft Bill 147 would remove the $20,000 maximum, expand the number and types of services covered, and extend the scope of coverage to include the covered individual's partner and third-party reproductive care for the benefit of the covered individual.

## *Consultant Comments*

Some consultant comments on the Draft Bill 147 are as follows:[15]

- Current median lifetime maximum dollar benefit for employers with more than 500 employees is $20,000, the same as currently covered under the NDPERS health plan
- Clarity regarding cryopreservation and coverage for gestational carriers would be prudent
- Estimates a 2.1% cost increase in combined medical and pharmacy claim payments, or about $15 million for the biennium

## Questions Concerning Mandated Coverage for Public Employee Fertility Health Benefits

***The extent to which the coverage will increase or decrease the cost of the service.***

Mandating a service or product increases the demand for that service or product, which typically increases the cost of the service, where allowed. Carriers can offset this upward pressure on price by contracting with providers. Potential increases in cost are not expected to have a significant impact on per member per month (PMPM) costs or percentage of premium estimates, as NDPERS has a relatively small membership compared to other markets and already covers fertility diagnosis and treatment to a $20,000 lifetime limit.

***The extent to which the coverage will increase the appropriate use of the service.***

Fertility treatment can be extremely costly, especially with multiple cycles of ART. Our understanding is that fertility preservation for iatrogenic infertility is currently not covered by NDPERS treatment for infertility, so we would not expect an uptick in fertility preservation and storage costs. However, removing the $20,000 maximum limit would cause more members to use their samples through either ART or non-ART or to pursue more cycles up to the service limits, which would increase the effectiveness of the treatments. Similarly, more members and their partners with non-iatrogenic infertility are likely to pursue more cycles of ART or non-ART, which would likewise increase effectiveness.

***The extent to which the coverage will increase or decrease the administrative expenses of carriers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders.***

Draft Bill 147 would expand the allowable treatments, the scope of the coverages, and would remove the maximum limit in favor of service limits. Expanding the allowable treatments could have administrative implications; however, we do not have sufficient information to determine this cost, which we anticipate would not be significant.

***The impact of this coverage on the total cost of health care.***

Changes to the cost of the service or utilization of the service would impact the total cost of health care. We do not anticipate any significant change in the cost, but the utilization of the service would likely increase as many (primarily female) patients do not pursue fertility preservation services due to cost. Higher utilization of services could put upward pressure on the total cost of health care. The bill may also increase the expenses associated with pregnancies and children. While the mandate might lead to lower rates of depression, lower rates of anxiety, and lower support costs for patients facing iatrogenic infertility, which could put some downward pressure on health care costs, the savings would be minor compared to the cost of infertility treatment.

## *NovaRest Estimate*

### Data

- NDPERS provided the premiums, claims, membership, and age distribution in NDPERS for 2021.
- The age and gender proportions of North Dakota's population are based on the 2021 Vintage population estimates.[16]
- Information on North Dakota households is based on 2021 American Community Survey (ACS) Data.[17]

### Assumptions

The following assumptions were used for all service estimates:

- An annual trend factor of 5.5% was applied to service costs.[18]
- An 80% carrier cost sharing was applied, consistent with the current cost sharing applied to NDPERS fertility services.[19]
- ART was modelled using in vitro fertilization (IVF), which is by far the most common form of ART[20] and therefore we assume the average cost and success rates for ART will approximate IVF.

Fertility Preservation

- We used an age range of 19-44 for male and female as the age range that would pursue fertility benefits.[21]
- While Draft Bill 147 would allow preservation in the case of genetic conditions or other diseases where treatment result in iatrogenic infertility, we could not find adequate statistics on the number of non-cancer related iatrogenic infertility. As cancer appears to be the primary cause of iatrogenic infertility, we continued to only consider cancer related cases. We believe the impact from non-cancer related cases would be small.

- New cancer cases were estimated based on data reported by the International Agency for Research on Cancer, which provided expected 2020 cases.[22]
- 10%[23] of cancers were removed for Leukemia, Lymphoma, and Myeloma, which are fast acting and require immediate treatment which would not allow time for fertility preservation.
- $12,660 was used as the cost of cryopreservation of egg/embryos.[24,25]
- $1,055 was used as the cost of sperm cryopreservation.[26]
- We assumed 50% to 80% of people facing iatrogenic infertility will take advantage of the benefit, based on a recent poll regarding adult expectations of having children.[27]

Fertility Preservation Storage

- Assume a range of 60% to 80% of people will use their stored sample.[28]
- $633 was used as the annual storage cost for egg or embryo.[29]
- The annual storage cost for sperm was set consistent with the annual storage cost assumed for egg or embryo ($633).

Fertility Diagnostic

- 2021 ACS household data was used to identify married couple and cohabitating opposite sex and same-sex households.
- A refinement to the model was made using a Pew Research study on the percentage of couples not unlikely to pursue children.[30]
- Assume 10% to 15% additional couples who may pursue diagnostic testing, based on percentage of women who gave birth in the past 12 months and do not have a spouse present or cohabitate.[31]
- Assume 13.5% of couples have trouble conceiving after 12 months.[32]
- Assume 18% of couples with a prior condition which can cause infertility, based on a CDC definition.[33,34] This includes:
    - 10% due to endometriosis[35]
    - 4% due to pelvic inflammatory disease[36]
    - 2% due to very painful periods[37]
    - 1% due to more than one miscarriage[38]
    - 1% due to suspected male condition[39]
- $185 was used as the cost of a basic semen analysis.[40]
- One round of diagnostic testing assumed.[41]
- $1,108 was used as the cost if additional advanced testing was required for males.[42]
- Assume 15% to 35% of males and females would need more advanced testing as a best estimate.[43]

- $1,000 was used as the cost of a female diagnostic panel, which includes an ovarian reserve test, hormone test, and imaging test.[44]
- $2,850 was used as the cost if additional advanced testing was required for females.[45]

Fertility Treatment

- The proposed bill includes a limited time window when expanded benefits would be available. For this reason, we believe the coverage we estimated, between 20%[46] and 30%[47] additional members, would pursue fertility treatment over the limited time window the proposed bill is in effect.
- We relied on an NIH study of people pursuing fertility treatment to determine the average cost of fertility treatment.[48] The fertility treatment options were categorized by the following:
    - No cycle treatment,[49] assume $0 cost as costs already included in diagnostic test
    - Medications only, assume $2,391 cost per cycle[50]
    - IUI-Clomiphene,[51] assume $686 cost per cycle[52]
    - IUI-Gonadotropins,[53] assume $4,943 cost per cycle[54]
    - ART, assume $12,660 for first cycle, $6,330 per additional cycle including medications[55]
    - ART – Donor Egg, assume ART costs plus $10,000 for egg donation per cycle[56]
- The number of cycles is based on the NIH study.[57]
- The probability of treatment is based on the NIH study.[58] The NIH study only provided the probability of the most invasive treatment received. We split the probability evenly among scenarios of people pursuing less invasive treatments first. For example, for IUI-Gonadotropins we split the ultimate probability into three scenarios: IUI-Gonadotropins only, medications only then IUI-Gonadotropins, and medications only then IUI-Clomiphene then IUI-Gonadotropins.
- The diagnosis was based on the NIH study.[59]
- The average cost per diagnosis was the cost of treatment times number of cycles weighted by probability of treatment.
- The average cost was the weighted average cost by diagnosis weighted by the probability of diagnosis.

Additional Births

- NIH data was used to allocate couples into those pursuing IUI and ART and those who did not.[60]

- The proposed bill will likely lead to more members pursuing fertility treatment, leading to additional pregnancy and birth related costs. A fertility provider we interviewed indicated approximately 30% of patients will not continue fertility treatment due to the cost. Because medication or non-cycle based treatments are typically less expensive than IUI or ART, we assume people pursuing these treatments are more likely to proceed even if they have to pay the full cost. Those who are more likely to pursue IUI and ART are less likely to pursue treatments if they have to pay full cost.
- We used the NIH study for the percentage of successful outcomes from fertility treatment and the % of multiple births.[61]
- $32,931 was used as the cost of a single childbirth based on a 2013 American Journal of Obstetrics and Gynecology (AJOG) article.[62]
- $181,126 was used as the cost of a multiple birth based on a 2013 AJOG article weighted by probability of two births versus three or more.[63]

**Methodology**

Fertility Preservation

- Used cancer incidence rates applied against NDPERS population to determine annual eligibility for fertility preservation.
- Apply preservation costs and cost sharing against the assumed percentage of eligible members who will pursue preservation to determine total cost.

Fertility Preservation Storage

- Beginning with the annual number who pursue preservation from the prior section, performed a durational analysis to develop the ultimate number of stored samples.
- Apply storage costs and cost sharing against the assumed percentage of eligible members who will use stored samples to determine total cost.

Fertility Diagnostic

- ACS data[64] was used to identify married couple and cohabitating opposite sex and same-sex households, applied against demographic information and Pew Research on the couples that are not unlikely to pursue having children in North Dakota.[65]
- The resulting couples and an assumption of additional couples who would pursue diagnostic treatment were applied against estimates of infertility rates over a 25-year period.
- Diagnostic costs and cost sharing were applied against couples estimated to pursue fertility diagnostic tests to determine a 25-year cost, which was applied uniformly to determine an annual cost.
- No pent-up demand was included because fertility diagnosis is currently covered and will be covered after the proposed bill expires.

Fertility Treatment

- The number of individuals or couples pursuing fertility treatment is defined as those using their cryopreserved samples plus those pursuing diagnostic treatment over a 25-year period.
- Probabilities of ultimate fertility treatment services and number of cycles was used to determine the average treatment cost, based on the ultimate fertility services.
- Average treatment cost was applied against the number of people pursuing fertility treatment to determine a 25-year cost.
- Instead of applying the 25-year cost uniformly, due to the limited time window the proposed bill would be in effect, a pent-up demand factor was applied to reflect more usage while expanded benefits are available.

Additional Births

- An annual population pursuing fertility treatment was allocated into those pursuing IUI and ART and those who did not.
- An assumption of those who will seek fertility treatment with and without insurance coverage, was applied against NIH estimated success probabilities to determine the estimated additional births and multiple births driven by coverage of fertility treatment.
- Applied pregnancy costs and cost sharing against the assumed estimate of additional successful births to determine total cost.

**Cost**

Because the first $20,000 is currently covered by NDPERS for fertility diagnosis and treatment, we estimate a net additional cost of 0.7% to 0.9% of premium or $3.46 PMPM to $4.25 PMPM to provide these benefits.

## *IV. Other State Infertility Laws*[66]

There are approximately 20 states that have passed legislation addressing the issue of insurance companies covering infertility treatments. Of those states, thirteen have laws that require insurance companies to cover infertility treatment. California and Texas have laws that require insurance companies to *offer* coverage for infertility treatment. Five states have fertility preservation laws for iatrogenic (medically-induced) infertility. The mandates are different regarding what is covered. Additionally, each State has its infertility definition, which you must meet to qualify for any benefits. Illinois and Delaware have also passed fertility preservation mandates, and New Jersey has a bill pending.

Nine (9) states passed legislation addressing infertility treatment using IVF. These states are Arkansas, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, New Jersey, Rhode Island, and Texas.[67] Each state's regulation is different and is not necessarily consistent with this North Dakota legislation being proposed. Some other states limit the number of cycles that will be covered or the total lifetime cost.

New York has a pending bill that seeks to update the state's infertility insurance mandate to include up-to-date treatments, including IVF, which is currently excluded.[68]

The estimates of the premium impact of fertility preservation and IVF varies significantly from study to study.

Milliman and Robertson conducted a study for the National Center for Policy Analysis in 1997. They estimated the cost of twelve of the most common mandates, including infertility treatment. Infertility treatment was estimated to increase costs between 3 and 5 percent, reflecting a cost increase in health insurance premiums of $105 to $175 annually (assuming a basic family policy costing $3,500 per year).

John Collins, M.D. estimated the purchasers' cost of infertility benefits. This study finds that the purchaser cost of infertility benefits is $3.14 per member per year. The study further presented the costs of the benefit for utilization increases of 300% and 500%. A utilization increase of 300% would result in a premium increase to $9.41 annually. If utilization increased by 500%, the annual premium would increase to $15.69.[69]

**Arkansas:** Ark. Stat. Ann. § 23-85-137 and § 23-86-118 (1987, 2011) require accident and health insurance companies to cover in vitro fertilization. Services and procedures must be performed at a facility licensed or certified by the Department of Health and conform to the guidelines and minimum standards of the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. (2011 SB 213)

**California:** Cal. Health & Safety Code § 1374.55 and Cal. Insurance Code § 10119.6 require specified group health care service plan contracts and health insurance policies to offer coverage for the treatment of infertility, except in vitro fertilization. The law requires every plan to communicate the availability of coverage to group contract holders. The law defines infertility, treatment for infertility, and in vitro fertilization. The law clarifies that religious employers are not required to offer coverage for forms of treatment that are inconsistent with the organization's religious and ethical principles. The law was amended by 2013 Cal. Stats., Chap. 644 (AB 460) to specify that treatment of infertility shall be offered and, if purchased, provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

Proposed SB172 would require individual or group health care service plans or policies that cover hospital, medical, or surgical expenses and that are issued, amended, or renewed on or after January 1, 2018, to include coverage for standard fertility preservation services when a necessary medical treatment may cause iatrogenic infertility. As amended (March 7, 2017), the bill would require coverage for evaluation and treatment of iatrogenic infertility, including, but not limited to, standard fertility preservation services.[70] This bill is currently in Senate Suspense File, where it will be held until consideration before moving to the Senate floor.[71]

The California Health Benefits Review Program estimates that under the amended language, utilization would increase by 30%, and annual expenditures would increase by $6,001,000 or 0.041% for enrollees with plans or policies regulated by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).[72]

**Colorado:** Colorado Revised Statutes Title 10. Insurance § 10-16-104.23 requires that all large group health benefit plans issued or renewed on or after January 1, 2023, shall provide coverage for the diagnosis of and treatment for infertility and standard fertility preservation including 3 completed retrievals with unlimited embryo transfers in accordance with the guidelines of ASRM, using single embryo transfer when recommended and medically appropriate.[73]

**Connecticut:** Conn. Gen. Stat. § 38a-509 and § 38a-536 (1989, 2005) require that health insurance organizations provide coverage for medically necessary expenses in the diagnosis and treatment of infertility, including in vitro fertilization procedures. Infertility, in this case, refers to an otherwise healthy individual who is unable to conceive or produce conception or to sustain a successful pregnancy during a one-year period. The law was amended in 2005 to provide an exemption for coverage that is contrary to the religious beliefs of an employer or individual.

Connecticut has passed H.B. 5644, which took effect January 2018 and will require health insurance to cover fertility preservation services for insureds who face likely infertility as a result of a necessary medical procedure for the treatment of cancer or other medical conditions.[74]

Connecticut estimated a 10 - 15 percent increase in the use of procedures per year and a premium increase of $0.062 PMPM for individual policies and $0.059 PMPM for fully insured group plans.[75] Using the 2016 SHCE member months and health premiums earned for the Connecticut market, this amounts to about 0.01% for individual policies and fully insured group plans.

**Delaware:** Senate Bill 139 was signed on June 30, 2018. The Act requires all individual, group, and blanket health insurance policies that provide for medical or hospital expenses shall include coverage for fertility care services, including IVF and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility.

In a letter to the members of the Delaware State Senate, Insurance Commissioner Trinidad Navarro wrote, "After consultation with an independent actuary, I am pleased to inform you that the impact of mandating coverage for IVF on health insurance premiums is estimated to be about one percent (+1%)."[76]

**Hawaii:** Hawaii Rev. Stat. § 431:10A-116.5 and § 432:1-604 (1989, 2003) require all accident and health insurance policies that provide pregnancy-related benefits to also include a one-time-only benefit for outpatient expenses arising from in vitro fertilization procedures. In order to qualify for in vitro fertilization procedures, the couple must have a history of infertility for at least five years or prove that the infertility is a result of a specified medical condition.

**Illinois:** Ill. Rev. Stat. Ch. 215, § 5/356m (1991, 1996) requires certain insurance policies that provide pregnancy-related benefits to provide coverage for the diagnosis and treatment of infertility. Coverage includes in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer. Coverage is limited to four completed oocyte retrievals, except if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals are covered. (1996 Ill. Laws, P.A. 89-669).

**Louisiana:** La. Rev. Stat. Ann. § 22:1036 prohibits the exclusion of coverage for the diagnosis and treatment of a medical condition otherwise covered by the policy, contract, or plan, solely because the condition results in infertility. The law does not require insurers to cover fertility drugs, in vitro fertilization or other assisted reproductive techniques, reversal of a tubal litigation, a vasectomy, or any other method of sterilization. (2001 La. Acts, P.A. 1045)

**Maine:** Maine Legislature Sec. 1. 24-A MRSA §4320-S, effective January 1, 2024, will require that a carrier offering a health plan in the State shall provide coverage to an enrollee for fertility diagnostic care, fertility treatment if the enrollee is a fertility patient, and fertility preservation services.[77]

**Maryland**: Md. Insurance Code Ann. § 15-810 (2000) amends the original 1985 law and prohibits certain health insurers that provide pregnancy-related benefits from excluding benefits for all outpatient expenses arising from in vitro fertilization procedures performed. The law clarifies the conditions under which services must be provided, including a history of infertility of at least a two-year period and infertility associated with one of several listed medical conditions. An insurer may limit coverage to three in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of $100,000. The law clarifies that an insurer or employer may exclude the coverage if it conflicts with the religious beliefs and practices of a religious organization, on request of the religious organization. Regulations that became effective in 1994 exempt businesses with 50 or fewer employees from having to provide the IVF coverage. (2000 Md. Laws, Chap. 283; H.B. 350) Md. Health General Code Ann. § 19-701 (2000) includes family planning or infertility services in the definition of health care services.

Maryland estimated the cost of iatrogenic fertility preservation would cost anywhere from 0.05% to 0.15%, depending upon the market.

Maryland conducts a periodic review of all mandates. The latest available was completed in 2012. Maryland is a state that mandated in vitro in the individual and large group fully insured markets. According to that study, the full cost of the in vitro mandate was 1.3% to 1.5% of the premium, depending upon the market.[78]

**Massachusetts:** Mass. Gen. Laws Ann. Ch. 175, § 47H, Ch. 176A, § 8K, Ch. 176B, § 4J, Ch. 176G, § 4 and 211 Code of Massachusetts Regulations 37.00 (1987, 2010) require general insurance policies, non-profit hospital service corporations, medical service corporations, and health maintenance organizations that provide pregnancy-related benefits to also provide coverage for the diagnosis and treatment of infertility, including in vitro fertilization. This law was amended in 2010 to change the definition of "infertility" to be a condition of an individual who is unable to conceive or produce conception during a period of one year if the female is under the age of 35 or during a period of six months if the female is over the age of 35. If a person conceives but cannot carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six-month period. (SB 2585)

A state-commissioned study of the Massachusetts mandate estimated that the law adds 0.12 percent to 0.96 percent to health insurance premiums, or 54 cents to $4.44 per person per month.[79] Research presented 20 years after the Massachusetts mandate was passed concluded that infertility treatment represents 0.89% of the premium.[80] That equates to roughly $4.16 per member per month to premiums or $200 a year for a family of four.

**Montana:** Mont. Code Ann. § 33-22-1521 (1987) revises certain requirements of Montana's Comprehensive Health Association, the state's high-risk pool, and clarifies that covered expenses do not include charges for artificial insemination or treatment for infertility. (SB 310) Mont. Code Ann. § 33-31-102 et seq. (1987) requires health maintenance organizations to provide basic health services on a prepaid basis, which include infertility services. Other insurers are exempt from having to provide the coverage.

**New Hampshire:** 2020 NH RSA CHAPTER 417-G requires coverage for the diagnosis of the cause of infertility. It also requires medically necessary fertility treatment. This includes evaluations, laboratory assessments, medications, and treatments associated with the procurement of donor eggs, sperm, and embryos. Coverage also includes fertility preservation when a person is expected to undergo surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment of fertility. This includes coverage for standard fertility preservation services, including the procurement and cryopreservation of embryos, eggs, sperm, and reproductive material determined not to be an experimental infertility procedure. Storage shall be covered from the time of cryopreservation for the duration of the policy term. Storage offered for a longer period of time, as approved by the health carrier, shall be an optional benefit.[81]

**New Jersey:** N.J. Stat. Ann. § 17:48-6x, § 17:48A-7w, § 17:48E-35.22 and § 17B:27-46.1x (2001) require health insurers to provide coverage for medically necessary expenses incurred in diagnosis and treatment of infertility, including medications, surgery, in vitro fertilization, embryo transfer, artificial insemination, gamete intrafallopian transfer, zygote intrafallopian transfer, intracytoplasmic sperm injection and four completed egg retrievals per lifetime of the covered person. The law includes some restrictions as well as a religious exemption for employers that provide health coverage to fewer than 50 employees. (SB 1076)

**New York:** N.Y. Insurance Law § 3216 (13), § 3221 (6) and § 4303(1990, 2002, 2011) prohibit individual and group health insurance policies from excluding coverage for hospital care, surgical care, and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility. The laws were amended in 2002 to require certain insurers to cover infertility treatment for women between the ages of 21 and 44 years. The laws exclude coverage for in vitro fertilization, gamete intrafallopian tube transfers, and zygote intrafallopian tube transfers. The laws were amended again in 2011 by N.Y. laws, Chap. 598 to require every policy that provides coverage for prescription fertility drugs and requires or permits prescription drugs to be purchased through a network participating mail order or other non-retail pharmacy to provide the same coverage for prescription fertility drugs that are purchased from a network participating non-mail order retail pharmacy provided the network participating non-mail order retail pharmacy agrees in advance to the same reimbursement amount and the same terms and conditions that the insurer has established for a network participating mail order or other non-retail pharmacy. The policy is prohibited from imposing additional fees, co-payments, co-insurance, deductibles, or other conditions on any insured person who elects to purchase prescription fertility drugs through a non-mail order retail pharmacy. (2011 AB 8900)

N.Y. Public Health Law § 2807-v (2002) creates a grant program to improve access to infertility services, treatments, and procedures from the tobacco control and insurance initiatives pool.

N.Y. passed a bill to update the state's infertility insurance mandate effective in 2020 to include up-to-date treatments, including IVF, which is currently excluded. The bill adds coverage for standard fertility preservation treatments for those facing iatrogenic infertility.[82]

**Ohio:** Ohio Rev. Code Ann. § 1751.01 (A)(1)(h) (1991) requires health maintenance organizations (HMOs) to provide basic health care services, which are defined to include infertility services, when medically necessary.

**Rhode Island:** R.I. Gen. Laws § 27-18-30, § 27-19-23, § 27-20-20 and § 27-41-33 (1989, 2007) require any contract, plan or policy of health insurance (individual and group), nonprofit hospital service, nonprofit medical service and health maintenance organization to provide coverage for medically necessary expenses for the diagnosis and treatment of infertility. The law clarifies that the co-payments for infertility services may not exceed 20 percent. Infertility is defined as the condition of an otherwise healthy married individual who is unable to conceive or produce conception during a period of one year. Rhode Island includes IVF coverage. The law was amended in 2007 to increase the age of coverage for infertility from forty (40) to forty-two (42) and redefines infertility to mean a woman who is unable to sustain pregnancy during a period of one year. (2007 R.I. Pub. Laws, Chap. 411, SB 453.)

Rhode Island has passed legislation requiring that, "Any health insurance contract, plan, or policy delivered or issued for delivery or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, which includes pregnancy related benefits, shall provide coverage for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years and for standard fertility preservation services when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person."[83]

Per patient advocate Christie Gross, when similar IVF bills passed in Rhode Island and Connecticut premiums in both states increased less than $2.00 PMPM.[84]

**Texas:** Tex. Insurance Code Ann. § 1366.001 et seq. (1987, 2003) requires that all health insurers offer and make available coverage for services and benefits for expenses incurred or prepaid for outpatient expenses that may arise from in vitro fertilization procedures. In order to qualify for in vitro fertilization services, the couple must have a history of infertility for at least five years or have specified medical conditions resulting in infertility. The law includes exemptions for religious employers.

**Utah:** 2014 Utah Laws, Chap. 353 (HB 347) amended § 31A-22-610.1, which requires insurers that provide coverage for maternity benefits to also provide an adoption indemnity benefit of $4,000 for a child placed for adoption with the insured within 90 days of the child's birth. The law was amended to allow an enrollee to obtain infertility treatments rather than seek reimbursement for an adoption. If the policy offers optional maternity benefits, then it must also offer coverage for these indemnity benefits under certain circumstances.

**West Virginia:** W. Va. Code § 33-25A-2 (1995) requires health insurers to cover basic health care services, which include infertility services. Applies to health maintenance organizations (HMOs) only.

## V. Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate regarding Draft Bill 147. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis may be incorrect. Appropriate staff is available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest did not have access to actual insurer claims data by service type or reimbursement rates. NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by NDPERS, changes in medical treatments and practices, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings, and inherent potential for normal random fluctuations in experience.

## VI. Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of Draft Bill 147. The reliance of parties other than the North Dakota Legislative Council (NDLC) on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by NDPERS and other public sources. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice.

We have no conflicts of interest in performing this review and providing this report.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

## *Appendix A: Definitions*

a) "Diagnosis of infertility" means the services, procedures, testing, or medications recommended by a licensed physician which are consistent with established, published, or approved best practices or professional standards or guidelines, such as the American Society of Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology for diagnosing and treating infertility.

b) "Fertility treatment" means health care services, procedures, testing, medications, monitoring, treatments, or products, including genetic testing, provided with the intent to achieve a pregnancy that results in a live birth with healthy outcomes.

c) "Infertility" means a disease or condition characterized by:

(1) The failure to conceive a pregnancy or to carry a pregnancy to live birth after unprotected sexual intercourse;

(2) An individual's inability to cause pregnancy and live birth either as a covered individual or with the covered individual's partner; or

(3) A licensed health care provider's findings and statement based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

d) "Medically necessary" means health care services or products provided in a manner:

(1) Consistent with the findings and recommendations of a licensed physician, based on a patient's medical history, sexual, and reproductive history, age, partner, physical findings, or diagnostic testing;

(2) Consistent with generally accepted standards of medical practice as set forth by a professional medical organization with a specialization in any aspect of reproductive health, such as the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists; or

(3) Clinically appropriate in terms of type, frequency, extent, site, and duration.

e) "Monitoring" includes ultrasounds, transvaginal ultrasounds, laboratory testing, and follow-up appointments.

f) "Standard fertility preservation services" means services, procedures, testing, medications, treatments, cryopreservation of eggs, sperm, embryos, and products consistent with established best medical practices or professional guidelines such as those published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for an individual who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment recognized by medical professionals to result in, or increase the risk of, impaired fertility.

g) "Third-party reproductive care for the benefit of the covered individual" means the use of eggs, sperm, or embryos donated to the covered individual or partner by a donor, or the use of a gestational carrier, to achieve a live birth with healthy outcomes.

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Date: January 9th, 2023

To: Whom It May Concern

Re: Infertility Treatments

Hello – I am writing to you today in support of the bill to mandate insurance companies to cover infertility treatment. I am a 33 year old conservative women and hopeful mother to be, who is currently going through IVF. After five failed rounds of IUI and one miscarriage, IVF is the only way my husband and I will be able to have children. Though we have unexplained infertility, we are not getting any younger and our chances of having a child naturally continues to decrease. My husband is a successful dentist and business owner in town, and I am a Mortgage Lender. Through my employer, I have $20,000 lifetime benefit for infertility treatment that will covers some of the costs, however; we are still going to have to pay about $15,000 - $20,000 out of pocket. Thankfully we are financially stable and can afford this kind of treatment, but there are many North Dakotans that cannot. Working in banking, I could not imagine having to take out a Second Mortgage or HELOC on my home in order for a chance to have a child. People around the United States are starting to talk about infertility more, and in North Dakota we can do better!

Sincerely,

Sarah Bulik