California Health Benefits Review Program

Executive Summary

Analysis of Assembly Bill 460: Infertility

A Report to the 2013-2014 California Legislature April 19, 2013

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Analysis of Assembly Bill 460
Infertility

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 460

The California Assembly Committee on Health requested on February 20, 2013, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 460, infertility. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.[1]

In 2014, CHBRP estimates that approximately 25.9 million Californians (67%) will have health insurance that may be subject to a health benefit mandate law passed at the state level.[2] Of the rest of the state's population, a portion will be uninsured (and so will have no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state benefit mandates. The California Department of Managed Health Care (DMHC)[3] regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers,[4] which offer benefit coverage to their enrollees through health insurance policies.

Most DMHC-regulated plans and CDI-regulated policies in the small-group and large-group markets are subject to AB 460.[5] Individual-market DMHC-regulated plans and CDI-regulated policies are not subject to AB 460. In addition, the regulator, DMHC, and the purchaser, the California Department of Health Care Services, have indicated that by referencing "group" plans AB 460 would not require compliance from plans enrolling Medi-Cal beneficiaries into Medi-Cal Managed Care.[6,7] Therefore, the mandate would affect the health insurance of approximately 14.4 million enrollees (37% of all Californians).

[1] Available at: www.chbrp.org/docs/authorizing_statute.pdf.
[2] CHBRP's estimates are available at: www.chbrp.org/other_publications/index.php.
[3] The California Department of Managed Health Care (DMHC) was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code (H&SC) Section 1340.
[4] The California Department of Insurance (CDI) licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code (IC) Section 106(b) or subdivision (a) of Section 10198.6.
[5] Small-group market DMHC-regulated plans with fewer than 20 employees are not subject to AB 460, as discussed in more depth later on in the *Executive Summary*.
[6] Personal communication, S. Lowenstein, DMHC, March 2013.
[7] Personal communication, C. Robinson, Department of Health Care Services, citing Sec. 2791 of the federal Public Health Service Act, March 2013.

Developing Estimates for 2014 and the Effects of the Affordable Care Act

The Affordable Care Act (ACA)[8] is expected to dramatically affect health insurance and its regulatory environment in California, with many changes becoming effective in 2014. It is important to note that CHBRP's analysis of proposed benefit mandate bills typically address the marginal effects of the proposed bills—specifically, how the proposed mandate would affect benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects are presented in this report. Because expanded enrollment will not occur until January 2014, CHBRP relies on projections from the California Simulation of Insurance Markets (CalSIM) model[9] to help set baseline enrollment for 2014. From this projected baseline, CHBRP estimates the marginal impact of benefit mandates proposed that could be in effect after January 2014.

Bill-Specific Analysis of AB 460

AB 460 would modify a state benefit mandate that is currently law in Health and Safety Code (H&SC) Section 1374.55 and Insurance Code (IC) Code Section 10119.6. The current state benefit mandate requires group market DMHC-regulated plans and CDI-regulated policies to *offer* coverage for the treatment of infertility.[10] Under this "mandate to *offer*," the purchaser of the plan or policy has the option to include coverage for the treatment of infertility in their employee plans or policies; "mandates to *offer*," such as this one, are often referred to as "optional riders." (See below for a further discussion of "mandates to *offer*" and "mandates to *cover*.")

The current state benefit mandate, **hereafter referred to as the "current infertility treatment mandate,"** defines infertility as either:

(1) "the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or

(2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception."[11]

Under the current infertility treatment mandate, treatment for infertility includes, but is not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfers (GIFT). **Offering coverage for in vitro fertilization (IVF) is not required.**

[8] The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L. 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

[9] CalSIM was developed jointly and is operated by the University of California, Los Angeles Center for Health Policy Research, and the University of California, Berkeley Center for Labor Research and Education. The model estimates the impact of provisions in the ACA on employer decisions to offer, and individual decisions to obtain, health insurance.

[10] H&SC Section 1374.55 and IC Section 10119.6.

[11] H&SC Section 1374.55 and IC Section 10119.6.

AB 460 would modify the current infertility treatment mandate, adding language that would require treatment for infertility be "offered and provided without discrimination." AB 460 would add the following language to the current state benefit mandate:

> *(g) Coverage for the treatment of infertility shall be offered and 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.*

Although AB 460 would add the words "offered and provided" to the H&SC and IC, both DMHC and CDI have indicated that the language AB 460 would add to the current infertility treatment mandate would not alter it from a "mandate to *offer*" to a "mandate to *cover*."[12]

AB 460 would modify a state benefit mandate that is currently law. The current state benefit AB 460 would modify is the "mandate to *offer*" coverage for the treatment of infertility. AB 460 would add language to the current infertility treatment mandate requiring that treatment for infertility be "offered and provided without discrimination," but would not alter the current infertility treatment mandate from a "mandate to *offer*" to a "mandate to *cover*."

Analytic Approach and Key Assumptions

Discrimination

The medical policies of DMHC-regulated plans and CDI-regulated insurers are not identical in how they define infertility, but, generally, infertility for heterosexual couples is defined as the inability to achieve conception after having frequent, unprotected intercourse for at least a year, or for 6 months for a woman over the age of 35. For a single woman, infertility is defined as the inability to achieve conception after having 6 to 12 cycles of artificial insemination, generally within a 1-year period.[13] Sometimes the language for the definition of infertility for a single woman includes the words "medically supervised" artificial insemination.

The bill author's office indicated that their intention is to address discrimination in coverage for the treatment of infertility specifically for single people, transgender people, and same-sex couples.[14] The bill author's office provided examples of how they believe definitions in medical policies are discriminatory, including: a single woman must pay for artificial insemination prior to being able to meet the definition of infertility, whereas a heterosexual couple does not face a similar cost to meet the definition of infertility; a single woman may be subject to medical supervision and documentation requirements to which a heterosexual couple may not be subject; and the definitions of infertility apply to a single woman, but not to a single man.[15] The bill author's office did not provide examples of how discrimination in coverage for the treatment of infertility may occur as a result of the other factors listed in the language AB 460 would add to

[12] Personal communication, S. Lowenstein, DMHC, and J. Figueroa, CDI, March 2013.
[13] These definitions align with how infertility is defined by the American Society of Reproductive Medicine (ASRM), as discussed in the subsection below, "*Definitions of infertility*."
[14] Personal communication, W. Hill, Office of Assemblymember Tom Ammiano, March 2013.
[15] Personal communication, W. Hill, Office of Assemblymember Tom Ammiano, March 2013.

the current infertility treatment mandate (e.g., age, ancestry, color, disability, national origin, race, religion).

CHBRP is not able to say whether these definitions or practices would be discriminatory or whether other definitions or practices would be considered discriminatory, nor was literature found that addressed discrimination in issuance of health insurance coverage for the treatment of infertility. Legal analysis, which CHBRP does not do, is required to understand how discrimination would be interpreted as it relates to coverage of treatment for infertility.[16] DMHC and CDI were unable to provide this level of legal analysis within CHBRP's 60-day analysis time frame, nor could they provide guidance on how discrimination would be interpreted as it relates to coverage for the treatment of infertility, indicating that the impact AB 460 may have is unknown at this time.[17]

Because the impact AB 460 may have is unknown, CHBRP is unable to estimate the marginal impact, if any, of AB 460. In this report, CHBRP presents information on infertility and infertility treatments, the impact of insurance coverage for infertility treatment on utilization, and information on current coverage for the treatment of infertility in DMHC-regulated plans and CDI-regulated policies.

What may or may not be considered discrimination as it relates to coverage for the treatment of infertility is unknown. Therefore, CHBRP is unable to estimate the marginal impact, if any, of AB 460. This report presents information on infertility and infertility treatments, the impact of insurance coverage for infertility treatment on utilization, and information on current coverage of treatments for infertility in DMHC-regulated plans and CDI-regulated policies.

Definitions of infertility

There are multiple definitions of infertility:

- The current infertility treatment mandate includes a definition of infertility;
- The medical policies for DMHC-regulated plans and CDI-regulated insurers include definitions of infertility;
- The National Survey on Family Growth (NSFG) defines infertility; and
- The American Society of Reproductive Medicine (ASRM) defines infertility.[18]

DHMC-regulated plans and CDI-regulated policies are subject to the H&SC and IC, respectively, which includes one definition of infertility, and DMHC-regulated plans and CDI-regulated insurers include other definitions of infertility in their medical policies. The definitions in the medical policies of DMHC-regulated plans and CDI-regulated insurers, discussed above, generally align with the ASRM definition, which defines infertility as the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or

[16] Personal communication, S. Lowenstein, DMHC, March 2013.
[17] Personal communication, S. Lowenstein, DMHC, and J. Figueroa, CDI, March 2013.
[18] There are likely further definitions of infertility beyond those listed here. These definitions are addressed in this report because they directly relate to AB 460 and/or the data and literature discussed in the report.

therapeutic donor insemination. However, because much of the literature on infertility treatment uses information and data from the NSFG, the definitions used by the NSFG inform much of this report. (See the *Background on Infertility* section below for NSFG definitions).

"Mandates to cover" and "mandates to offer"

State benefit mandates can be "mandates to *cover*" or "mandates to *offer*" coverage.

- Most California state benefit mandates are "mandates to *cover*," meaning they require DMHC-regulated plans and CDI-regulated policies subject to the benefit mandate to cover particular services, treatments, health conditions, or provider types.[19]
- Some California state benefit mandates are "mandates to *offer*" coverage, meaning they require DMHC-regulated plans or CDI-regulated policies subject to the benefit mandate to *offer* to cover particular services, treatments, health conditions, or provider types.[20]

"Mandates to *offer*" can be referred to as "optional riders" because the purchaser of the plan or policy decides to accept or not accept the optional coverage. If the coverage in the optional rider is accepted, it is included in addition to the benefits covered in the standard DMHC-regulated plan contract[21] or CDI-regulated policy.[22] The current infertility treatment mandate in H&SC Section 1374.55 and IC Section 10119.6 that AB 460 would modify is the "mandate to *offer"* coverage for the treatment of infertility in group market DMHC-regulated plans and CDI-regulated policies. Even with the words "offered and provided" in the language that AB 460 would add to the existing mandate, if AB 460 were enacted, the current infertility treatment mandate would remain a "mandate to *offer*" coverage for the treatment of infertility.[23]

Required coverage in DMHC-regulated plans and CDI-regulated policies

AB 460 would apply to the same DMHC-regulated plans and CDI-regulated policies that are subject to the current infertility treatment mandate. The current infertility treatment mandate requiring an *offer* of coverage for the treatment of infertility only applies to group market DMHC-regulated plans and CDI-regulated policies. Therefore, individual-market DMHC-regulated plans and CDI-regulated policies are not subject to the current mandate, nor are Medi-Cal Managed Care Plans.

For CDI-regulated policies, all group-market policies, both small group and large group, are subject to the current infertility treatment mandate requiring them to *offer* coverage for the treatment of infertility.

[19] Some state benefit mandates require DMHC-regulated plans or CDI-regulated policies subject to the benefit mandate to abide by the terms and conditions set by the benefit mandate, as opposed to requiring coverage for a specific test, treatment, or services.
[20] CHBRP's list of California state benefit mandates includes information on which mandates are "mandates to cover" and which are "mandates to offer" coverage, available at: www.chbrp.org/other_publications/index.php.
[21] DMHC regulates health care service plans, which enroll people (enrollees) through health care service plan contracts.
[22] CDI regulates health insurers, which enroll people (enrollees) through CDI-regulated polices.
[23] Personal communication, S. Lowenstein, DMHC, and J. Figueroa, CDI, March 2013.

For DMHC-regulated plans, the language in the current infertility treatment mandate differentiates between non-health maintenance organizations (HMOs) and HMOs, as defined in H&SC Section 1373.10. DMHC oversees all HMOs in California. DMHC also oversees preferred provider organizations (PPOs) issued by Blue Cross of California and Blue Shield of California.

H&SC Section 1374.55, which AB 460 would modify, requires that DMHC-regulated non-HMOs *offer* coverage to all groups in the DMHC-regulated small-group and large-group market, regardless of size, but that DMHC-regulated HMOs only *offer* coverage to groups with 20 or more employees.[24] However, DMHC has indicated that the broad definition of HMOs in H&SC Section 1373.10 would encompass all DMHC-regulated plans.[25] Therefore, CHBRP has assumed that DMHC-regulated plans are only required to *offer* coverage for the treatment of infertility to groups with 20 or more employees.[26]

Independent medical review

Both DMHC-regulated plans and CDI-regulated policies are subject to the Independent Medical Review (IMR) process for covered benefits. CHBRP examined IMR complaints from 2011 through March 2013 for both DMHC and CDI. During that period, there were three complaints, all through the DMHC IMR process, related to infertility. Of these three complaints, none involved a complaint related to discrimination.

Interaction With Other California Requirements

As stated, AB 460 would modify the current infertility treatment mandate that requires group market DMHC-regulated plans and CDI-regulated policies to *offer* coverage for the treatment of infertility.[27]

In addition, both the H&SC and the IC have language prohibiting plans or policies from refusing to enter into contracts or policies or modifying the terms of contracts or policies because of race, color, religion, sex, and sexual orientation, as well as other factors.[28] However, how these provisions in the H&SC and IC interact, if at all, with the definition of infertility and how treatment of infertility is covered would require legal analysis to answer and is unknown at this time.[29]

Requirements in Other States

There are 15 states, including California, that have an infertility state benefit mandate. Of these 15 states, 2 states—California and Texas—have "mandates to *offer*" coverage for infertility as opposed to "mandates to *cover*" infertility. Additionally, of the 15 states, 3 specifically exclude

[24] In California, a small group is defined as 2 to 50 employees, and a large group is defined as 51 or more employees. The ACA defines a large group as >100 employees. However, ACA Section 1304(b)(3) allows states to treat groups between 50 and 100 as large for plan years beginning before 2016.
[25] Personal communication, S. Lowenstein, DMHC, April 2013.
[26] Personal communication, S. Lowenstein, DMHC, April 2013.
[27] H&SC Section 1374.55 and IC Section 10119.6.
[28] H&SC Section 1365 and IC Section 10140.
[29] Personal communication, S. Lowenstein, DMHC, March 2013.

coverage for IVF: California, Louisiana, and New York. Further, some infertility benefit mandates in other states include restrictions, such as limiting coverage by age.

Background on Infertility

- The NSFG defines impaired fecundity (ability to reproduce) as a broad category encompassing difficulty conceiving or carrying a pregnancy to term for women (and their husbands or partners), whereas infertility is specific to difficulty conceiving among women who have been continuously married or cohabitating.
    - The current infertility treatment mandate defines "infertility" in a different manner. H&SC Section 1374.55 and IC Section 10119.6 define infertility as either: "(1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual activities without contraception."
    - People included in the NSFG definitions of impaired fecundity and infertility would likely meet the definition of infertility under the current infertility treatment mandate, and would therefore be eligible for the treatment of infertility. Single women (who may meet the medical policy definition of infertility) and same-sex couples are not included in the NSFG definition for either impaired fecundity or infertility. However, these enrollees—single women and same-sex couples—may meet the H&SC and IC definition of infertility. Therefore, although the NSFG is an important source of population-based information regarding reproductive health, this information must be interpreted cautiously because of differences in definitions of impaired fecundity and infertility used by the NSFG and those definitions relevant to the proposed mandate.
- There are many causes of infertility in women and men. Nearly 40% of infertility cases are due to female factors, 20% are due to male factors, 27% are due to both female and male factors, and the remaining cases are idiopathic (unexplained) and cannot be attributed to either partner.
- Of women aged 15–44 in the United States, over 7 million have impaired fecundity, over half of whom (4.2 million) are infertile, as defined by the NSFG. Of men, 7.3 million men report infertility problems. Over 7 million women have ever received any infertility treatment, with the most common being advice and infertility testing. Although infertility rates are highest among racial/ethnic minorities, the *use* of infertility treatment services is highest among non-Hispanic white women.

Medical Effectiveness

Infertility treatment generally begins with a diagnostic work-up of both the male and female reproductive organs and other bodily functions related to reproductive health. Once the cause of the infertility has been investigated, there are four types of treatment options that can be offered: surgery; medications; artificial insemination; and assisted reproductive technology.

It is not feasible for CHBRP to review the literature on effectiveness of the numerous diagnostic and treatment options for all causes of infertility to which AB 460 applies within the 60-day time

frame allotted for this analysis. In light of the wide range of conditions that cause infertility and the types of treatments to which AB 460 would apply and the fact that AB 460 addresses provision of coverage for infertility benefits, CHBRP focused the medical effectiveness review on the impact of health insurance coverage (either voluntary or mandated) for infertility treatment. Thus, the medical effectiveness review for this report summarizes the literature on the effects of insurance coverage or insurance mandates for infertility treatment on utilization, pregnancy rates, and live births of persons with infertility issues.

- Fourteen studies were identified that assessed the impact of health insurance coverage on infertility treatment utilization or outcomes.
    - None of this research looked specifically at mandates like the one currently in place in California, i.e., a "mandate to *offer*" infertility treatment coverage as an optional rider, excluding IVF treatment.
    - Therefore, the *Medical Effectiveness* review will provide a summary of the available literature on benefit mandates for infertility treatments, benefit mandates for IVF treatments, and general health insurance coverage. Although none of this literature is directly applicable to the current infertility treatment mandate that AB 460 would modify, it will provide a context for the rest of the report.

CHBRP Terminology for Grading Evidence of Medical Effectiveness

CHBRP uses the following terms to characterize the strength of the evidence it identifies regarding the medical effectiveness of a treatment for which a bill would mandate coverage:

- Clear and convincing evidence;
- Preponderance of evidence;
- Ambiguous/conflicting evidence; and
- Insufficient evidence.

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies included in the medical effectiveness review are consistent in their findings that treatment is either effective or not effective.

A grade of *ambiguous/conflicting evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

A grade of *insufficient* evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment

or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

Study Findings

- There is a **preponderance of evidence** that infertility treatment health insurance mandates are associated with an increase in utilization of infertility treatments. This association is strongest for "mandates to *cover*" infertility treatments compared to "mandates to *offer*" infertility treatments as an optional rider.
- There is a **preponderance of evidence** that IVF insurance mandates are associated with a decrease in the number of embryos transferred per IVF cycle, the number of births per IVF cycle, and the likelihood of multiple births associated with IVF.
- There is **insufficient evidence** to assess the impact of infertility treatment health insurance mandates on health outcomes outside of the impact of IVF mandates.
- There is a **preponderance of evidence** that private health insurance coverage is associated with an increase in utilization of infertility treatments.

Benefit Coverage, Utilization, and Cost Impacts

An estimated 14.4 million enrollees would be subject to AB 460 if it were enacted, the same number subject to the current infertility treatment mandate. DMHC and CDI were unable to say how discrimination would be interpreted as it relates to coverage of treatment for infertility, indicating that the impact AB 460 may have is unknown at this time.[30] **Because the impact of AB 460 is unknown, CHBRP is unable to estimate the marginal cost impact, if any, of AB 460.** This section focuses on current coverage, utilization, and cost of treatment for infertility.

Current Coverage

- CHBRP surveyed the seven largest providers of health insurance in California to estimate coverage for treatment of infertility in the privately funded DMHC-regulated and CDI-regulated small-group and large-group markets. Of the 14.4 million enrollees that would be subject to AB 460, an estimated 10.1 million (or 70%) currently have coverage for at least one type of treatment, including diagnosis, diagnostic tests, surgeries, artificial insemination, GIFT, or medication. Approximately 4.0 million of the 10.1 million enrollees are aged 19–44.

[30] Personal communication, S. Lowenstein, DMHC, and J. Figueroa, CDI, March 2013.

Current Utilization

CHBRP used the 2010 MarketScan claims data to estimate utilization of treatments for infertility by the estimated 4.0 million enrollees aged 19-44 with coverage.[31] The outpatient, inpatient, and prescription drug claims included the treatments for which coverage is required under the current infertility treatment mandate that AB 460 would modify, which include, but are not limited to, diagnosis, diagnostic tests, surgery, GIFT, and medication. IVF was excluded, because it is excluded from AB 460. Of the 4.0 million enrollees aged 19–44 estimated to have coverage for infertility, an estimated:[32]

- 1.12% of enrollees (or 45,000), including 1.83% of female and 0.41% of male enrollees, annually utilize 413,000 outpatient procedures for infertility;
- 0.007% of enrollees (or 300), including 0.015% of female and no male enrollees, annually utilize 1,100 inpatient days for infertility; and
- 0.52% of enrollees (or 21,000), including 1.02% of female and 0.02% of male enrollees, annually utilize 81,000 prescriptions for infertility.

Current Unit Costs

- CHBRP used the 2010 MarketScan claims data to estimate the average costs of treatments for infertility and applied a medical trend to inflate the costs to 2014. The average costs for an outpatient procedure is $135, for an inpatient day is $4,954, and for a prescription is $696. This results in an estimated $117 million in annual expenditures on treatment for infertility by the estimated 4.0 million enrollees aged 19-44 with coverage.

Public Health Impacts

- Medical Effectiveness found insufficient evidence to assess the impact of infertility treatment mandates on outcomes (such as pregnancy rates and live births) outside of the impact of IVF, which is excluded in the current infertility treatment mandate. Please note that the absence of evidence is not "evidence of no effect." It is possible that an impact—positive or negative—could result. However, currently available evidence does not allow CHBRP to estimate either. Although AB 460 could impact utilization of infertility treatments, CHBRP is unable to estimate any change in utilization (see the *Benefit Coverage, Utilization, and Cost Impacts* section). Therefore, the public health impact is unknown.
- Harms related to an infertility diagnosis include stress, distress, anxiety, depression, and social stigma attributed to infertility.

[31] The National Survey of Family Growth (NSFG) reports data on people aged 15–44. However, the *Benefit Coverage, Utilization, and Cost Impacts* section of this report provides estimated utilization of treatments for infertility and costs for enrollees aged 19–44 with coverage, due to the way age bands are defined in the MarketScan claims data that was used. Utilization and costs among enrollees outside the 19–44 age range were assumed to be zero.

[32] These estimates are based on numbers that are more precise than the rounded numbers reported here.

- Qualitative studies with patients and providers have documented problems with access to infertility diagnosis and treatment because of race/ethnicity, language, religion, culture, and age. **Regarding discrimination at the *health plan and health insurer level*, CHBRP found no literature that addressed 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.**
- The prevalence of infertility is higher among women than men, and CHBRP found that the percentage of women utilizing treatments for infertility is higher than that of men; however, the impact of AB 460 on utilization of treatments for infertility is unknown (see the *Benefit Coverage, Utilization, and Cost Impacts* section). Therefore, the impact of AB 460 on reducing gender disparities is unknown.
- National survey data show disparities in self-reported infertility treatment utilization by race/ethnicity. Infertility rates are highest among non-Hispanic black and African American women, yet infertility treatment use is highest among non-Hispanic white women. Although there are racial/ethnic disparities in the prevalence of infertility and infertility treatment utilization, the impact of AB 460 on utilization of treatments for infertility is unknown, thus the impact of AB 460 on reducing disparities among racial and ethnic groups is unknown.
- Infertility is not known to be a frequent cause of premature death; therefore AB 460 would not be expected to have a state-wide impact on mortality rates or years of potential life lost.
- Treatment of infertility is associated with high costs, both direct (e.g., for the treatments themselves) and indirect (e.g., lost work time). However, CHBRP was unable to identify studies quantifying these costs or assessing the impact on people related to their insurance characteristics. Because CHBRP is unable to estimate a change in utilization of treatments for infertility and because of a lack of literature quantifying economic loss as a result of treatment for infertility, the impact of AB 460 on economic loss is unknown.

Interaction With the Federal Affordable Care Act

Below is an analysis of how this proposed benefit mandate may interact with the ACA's requirement for certain health insurance to cover "essential health benefits" (EHBs).[33]

AB 460 and Essential Health Benefits

California has selected the Kaiser Foundation Health Plan Small Group HMO 30 plan as its benchmark plan for defining EHBs in 2014 and 2015.[34] The ACA allows a state to "require that a qualified health plan offered in [an exchange] offer benefits in addition to the essential health benefits."[35] If the state does so, the state must make payments to defray the cost of those

[33] Resources on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.
[34] H&SC Section 1367.005; IC Section 10112.27.
[35] ACA Section 1311(d)(3).

additionally mandated benefits, either by paying the purchaser directly or by paying the qualified health plan (QHP).

The Kaiser Small Group HMO 30 benchmark plan excludes coverage for the treatment of infertility, therefore DMHC-regulated plans and CDI-regulated policies subject to the EHB coverage requirement are not required to cover treatment for infertility.[36]

State benefits mandate that "are not part of the EHB package that are required to be offered only" are separate from the EHB coverage requirements, as these benefits are "optional from the purchaser's perspective."[37] As AB 460 would not change the current infertility treatment mandate from a "mandate to *offer*" to a "mandate to *cover*," the current infertility treatment mandate, and thus AB 460, does not interact with the EHB coverage requirement and AB 460 would not trigger the requirement that the state defray costs in 2014 and 2015 were it to be enacted.[38]

[36] Personal communication, S. Lowenstein, DMHC, March 2013.
[37] Department of Health and Human Services. Centers for Medicare and Medicaid Services. Part I Unified Rate Review Template Instructions. March 18, 2013; 27. Available at: www.serff.com/documents/plan_management_data_templates_help_partI_unified_rate_review.pdf.
[38] Personal communication, S. Lowenstein, DMHC, and J. Figueroa, CDI, March 2013.

ACKNOWLEGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Assembly Bill 460. In response to a request from the California Assembly Committee on Health on February 20, 2013, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

Sara McMenamin, PhD, of the University of California, San Diego, prepared the medical effectiveness analysis. Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine, conducted the literature search. Stephen McCurdy, MD, MPH, and Meghan Soulsby, MPH, of the University of California, Davis, prepared the public health impact analysis. Brent Fulton, PhD, of the University of California, Berkeley, prepared the cost impact analysis. Susan Pantely, FSA, MAAA, and Jose Carlo, of Milliman, provided actuarial analysis. H. Irene Su, MD, of the University of California, San Diego, provided technical assistance with the literature review and expert input on the analytic approach. Laura Grossmann, MPH, of CHBRP staff prepared the *Introduction* and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Sylvia Guendelman, PhD, LCSW, of the University of California, Berkeley, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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