SB 279-FN - AS AMENDED BY THE HOUSE

03/14/2019 0835s
5Jun2019... 2101h

2019 SESSION

19-0868
01/10

SENATE BILL ***279-FN***

AN ACT relative to access to fertility care.

SPONSORS: Sen. Hennessey, Dist 5; Sen. Sherman, Dist 24; Sen. Levesque, Dist 12; Sen. Kahn, Dist 10; Sen. Cavanaugh, Dist 16; Sen. Bradley, Dist 3; Sen. Morse, Dist 22

COMMITTEE: Commerce

AMENDED ANALYSIS

This bill requires insurers issuing or renewing group health insurance policies to cover fertility treatment.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.
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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to access to fertility care.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Findings. The general court hereby finds that infertility is a disease of the reproductive system that affects 1 in 6 couples in New Hampshire. One-third of infertility is due to male factors, one-third to female factors, and the remainder is attributed to factors in both partners or diagnostically unexplained. Some of the individuals impacted are women born without a uterus, men with azoospermia (no sperm), women with uterine abnormalities or endometriosis, women with a history of ectopic pregnancies, cancer survivors, and military veterans who received explosive shrapnel injuries. Infertility is treatable. Ninety seven percent of infertility cases are treated with conventional drug therapy or surgical procedures. Only 3 percent of cases require assisted reproductive technology, such as in vitro fertilization (IVF). IVF can be a cost-effective treatment option because, with insurance benefits, patients are known to make health care decisions based on appropriate medical advice rather than financial concerns, and thus transfer fewer embryos per cycle. This can result in a savings of $80,000 or more per pregnancy in maternity care and neonatal care costs. Individuals facing medical conditions where treatment, like chemotherapy, is known to impact future fertility, as well as hopeful parents who are carriers for serious genetic conditions, are also impacted by a lack of affordable access to fertility care. The general court finds that it is in the public interest to make medical treatment for infertility and related conditions affordable for New Hampshire residents and employers, so as to attract and retain young families, expand the state's health care resources, reduce overall health care costs, and improve health outcomes for the resulting children.

2 New Chapter; Access to Fertility Care. Amend RSA by inserting after chapter 417-F the following new chapter:

CHAPTER 417-G

ACCESS TO FERTILITY CARE

417-G:1 Definitions. In this chapter:

I. "Commissioner" means the insurance commissioner.

II. “Experimental infertility procedure” means a procedure for which the published medical evidence regarding risks, benefits, and overall safety and efficacy is not sufficient to regard the procedure as an established medical practice.

III. “Fertility treatment” means health care services or products provided with the intent to achieve a pregnancy that results in a live birth with healthy outcomes.

IV. "Health carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

V. “Infertility” means a disease, caused by an illness, injury, underlying disease, or condition, where an individual’s ability to become pregnant or to carry a pregnancy to live birth is impaired, or where an individual’s ability to cause pregnancy and live birth in the individual’s partner is impaired.

VI. "Medically necessary" means health care services or products provided to an enrollee for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

(a) Consistent with generally accepted standards of medical practice;

(b) Clinically appropriate in terms of type, frequency, extent, site, and duration;

(c) Demonstrated through scientific evidence to be effective in improving health outcomes;

(d) Representative of "best practices" in the medical profession; and

(e) Not primarily for the convenience of the enrollee or physician or other health care provider.

VII. “Standard fertility preservation services” means procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology.

417-G:2 Diagnosis of Infertility, Fertility Treatment, and Fertility Preservation.

I. Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for the diagnosis of the etiology of infertility.

II. Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for medically necessary fertility treatment. Enrollees shall be provided coverage for evaluations, laboratory assessments, medications, and treatments associated with the procurement of donor eggs, sperm, and embryos.

III. Each health carrier that issues or renews any group policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance coverage for 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. Coverage under this section shall include 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.

IV. Coverage under paragraphs I-III shall not apply to plans available through the Small Business Health Options Program (SHOP) or to Extended

Transition to Affordable Care Act-Compliant Policies.

417-G:3 Prohibited and Permissible Limitations on Coverage.

I. No health carrier shall:

(a) Impose deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for required benefits which are different from those imposed upon benefits for services not related to infertility or any limitations on coverage of fertility medications that are different from those imposed on any other prescription medications.

(b) Impose pre-existing condition exclusions or pre-existing condition waiting periods on coverage for required benefits or use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting or otherwise restricting the availability of coverage for required benefits.

(c) Impose limitations on coverage based solely on arbitrary factors including, but not limited to, number of attempts or dollar amounts or age, or provide different benefits to, or impose different requirements upon, a class protected under RSA 354-A than that provided to, or required of, other patients.

II. Limitations on coverage shall be based on clinical guidelines and the enrollee's medical history. Clinical guidelines shall be maintained in written form and shall be available to any enrollee upon request. Standards or guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology, or the Society for Assisted Reproductive Technology may serve as a basis for these clinical guidelines. Making, issuing, circulating, or causing to be made, issued or circulated, any clinical guidelines that are based upon data that are not reasonably current or that do not cite with specificity any references relied upon shall constitute an unfair and deceptive act and practice in the business of insurance under RSA 417:4.

III. This chapter shall not be construed to provide benefits for:

(a) An experimental infertility procedure.

(b) Non-medical costs related to third party reproduction.

(c) Reversal of voluntary sterilization.

IV. In instances where an enrollee is utilizing a surrogate or gestational carrier due to a medical cause of infertility unrelated to voluntary sterilization or failed reversal, the enrollee's coverage shall not extend to medical costs relating to the preparation for reception or introduction of embryos, oocytes, or donor sperm into a surrogate or gestational carrier.

417-G:4 Rulemaking. The commissioner shall adopt necessary rules, under RSA 541-A, relative to the proper administration of this chapter. Until such rules are adopted, health carriers shall fulfill their obligations under this chapter by conforming to the standards of the American Society for Reproductive Medicine.

417-G:5 Severability. If any provision of this chapter or the application thereof to any person or circumstances is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

3 Effective Date. This act shall take effect January 1, 2020.

LBAO
19-0868
Amended 4/3/19

SB 279-FN- FISCAL NOTE

AS AMENDED BY THE SENATE (AMENDMENT #2019-0835s)

AN ACT relative to access to fertility care.

FISCAL IMPACT: [X] State [X] County [X] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Appropriation	$0	$0	$0	$0
Revenue	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Expenditures	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Funding Source:	[X] General	[ ] Education	[ ] Highway	[ ] Other

COUNTY:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase

METHODOLOGY:

This bill requires insurers to cover fertility care. The Insurance Department assumes to the extent previously non-covered services must now be covered there could be an impact on claims, which may impact premiums and premium tax revenue. Any impact on premiums would be experienced by entities that pay for health insurance, including county and local governments. The federal ACA law specifies that the cost of newly enacted mandates associated with coverage through the exchange must be borne by the State (so as not to impact premiums for exchange products). According to the State's benchmark, covered services include diagnostic tests to find the cause of infertility, as well as services to treat the underlying medical conditions that cause infertility including endometriosis and hormone deficiency, but do not include artificial insemination services or assisted reproductive technologies or the diagnostic tests and drugs to support the same. The Department assumes that the costs associated with artificial insemination services and assisted reproductive technologies, as well as the cost of the diagnostics tests and drugs to support the same, for exchange products, would be borne by the State's general fund. The Department assumes the proposed language in RSA 417-G:2, IV is intended to exempt exchange based coverage from the new mandates in order to avoid the costs described above. Since the bill would not require such coverage across all platforms within a market, there may be antiselection, which may lead to changes in premiums and market enrollments.

The Department of Administrative Services indicates the bill would have zero impact on the State Health Benefit Plan for Employees and Retirees. The State Plan is a governmental self-insured plan and is not governed by managed care law.

The Department of Health and Human Services indicates the bill would have no fiscal impact on the Department. The Department is not a "health carrier" as that term is defined in the bill and the bill would not be applicable to the Department or the Medicaid program.

AGENCIES CONTACTED:

Departments of Insurance, Administrative Services and Health and Human Services