

Chairman Lefor and Committee Members,

My name is Tara Brandner, doctorate family nurse practitioner, founder and president of Everlasting Hope, a champion constituent of HB 1147, and infertility patient. I will keep my personal story with infertility short as several individuals virtually would like to testify today.

My journey consisted of the diagnosis of endometriosis, miscarriage, 3 failed IUI treatments, IVF, high-risk pregnancy, and \$40,000 in uncovered medical bills.

More than 33,506 North Dakota Residents have trouble getting pregnant or sustaining a pregnancy, this equates to 1 in 6 individuals. I am here today speaking for myself but also for those who are suffering in silence. Since the 2019 session, I have founded the first and only nonprofit in ND and SD supporting those with infertility and raising awareness on this disease.

Over the last 9 months, I have been speaking with BCBSND and Sanford monthly to create a positive change for access to care outside of legislation. As of today, I am happy to report a strong working relationship, but no changes to access to care have been made. Ideally, insurance carriers would provide coverage for medically necessary healthcare without any kind of mandate. As it is, they do limit the insurance coverage offered to the diagnosis of infertility. That is why I am asking legislation to support HB 1147 to support access to timely and appropriate healthcare. As a co-author of this bill, I would like to clarify that it is not unlimited and has clear specifications for uses and limits for care.

Infertility is a chronic disease that often requires treatment. It is well documented the faster a person can access fertility treatment, the less invasive of care they will need and fewer 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. At this point when a health care provider diagnoses a patient with the ICD 10 code of infertility every lab draw, ultrasound, medication, and procedure is paid for out of pocket by the patient. The most basic treatment of care is taking oral medication to induce ovulation or improve sperm levels, this costs approximately \$1800 for 1 cycle of care. Yes, infertility is also a males disease: 1/3 male factor, 1/3 female factor, and 1/3 unknown or both male and female causes.

A health care disparity typically 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 very costly in a lifetime, infertility patients will utilize fertility coverage or preservation only during their reproductive years. As a nurse practitioner, I treat patients daily that have chronic diseases such as diabetes and heart disease, 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 with infertility is needed now. 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.

You will hear and read testimony from North Dakota infertility patients today on the impact of cost this disease has placed upon them, ranging from \$25,000 and more than \$190,000. Additionally, infertility patients will encounter highly inflated managed care pharmacy prices for

I will close with key facts from states and businesses that have added infertility benefits. 91% of employers offering infertility treatment have NOT experienced increases in their medical costs. Threats of large premium increases don't look at the whole picture and total costs of healthcare. States with insurance coverage have fewer rates of multiple births than states without. Multiple pregnancies cost about \$4.2 billion more than singleton pregnancies in pre-term care. Pregnancies with the delivery of twins cost approximately 5 times more than a single child and pregnancies with triplets or more cost nearly 20 times as much.

Imagine your life without your children, grandchildren, nieces, nephews, or any child whom you are close with. It's unimaginable. The time has come to support these patients diagnosed with this disease and provide insurance for infertility care and fertility preservation. If you have never experienced this journey think of it this way. Struggling with infertility is like dealing with the five stages of grief every single month waiting for that positive pregnancy test. You deny, bargain, get angry, cry, and accept. Then you pick yourself back up and do it all over again. These patients are some of the toughest, most courageous people I know. It is an honor to be standing here today on their behalf. Thank you for your time today.

Important Points for North Dakota HB 1147 Infertility Care and Fertility Preservation

1. The desire to build a family is one of the most basic human aspirations. We want people of reproductive age in North Dakota to receive care guided by relevant and state-of-the-art medical expertise, not financial limitations.
2. This includes people who need medical treatment that will likely impair their fertility, including cancer patients.
3. 1 in 6 couples have infertility, this is more than 33,506 North Dakota Residents.
4. This does NOT provide limitless services. What does HB 1147 cover? "Fertility treatment" means health care services, procedures, testing, medications, monitoring, treatments, or products. Three completed cycles of intrauterine insemination, maximum of four completed IVF retrieval cycles, OR 2 live births.
5. Infertility is not just a women's disease. 1/3 is due to female factors, 1/3 due to male factors, 1/3 of unspecified origins or both male and female.
6. The lack of insurance coverage has an economic impact on ND.
 - a. Some individuals and couples can't afford treatment at all.
 - b. Many individuals and couples pay out of pocket for care, which limits their economic security. Put off home buying, other spending.
7. 19 states have passed infertility insurance laws, 6 since 2018.
8. Threats of large premium increases don't look at the whole picture and total costs of health care. 91% of employers offering infertility treatment have NOT experienced increases in their medical costs.
9. The national average cost to individuals is \$1.39 per member per month (PMPM). States with with \$100,000 lifetime maximums have shown \$1.29 PMPM. Details of those cost analysis can be found in the attached document.
10. There are significant mental health impacts to infertility. These are hard to quantify but result in lost work time and mental health care.
 - a. Patients who are unable to afford fertility preservation before treatment are likely to have increased mental health needs (and expense)
 - b. Infertility is the 4th most traumatic life event a woman can go through, equivalent to losing her parents. 61% of women don't tell their family or friends about their disease and struggle.

IMPACT OF FERTILITY COVERAGE IN NORTH DAKOTA

WITHOUT IVF BENEFITS

Over 52% of patients, ages 25–34, incur over \$10K in debt, and 26% incur over \$30K in debt¹²

Increased risk of complicated pregnancies and associated costs

Individuals saving for healthcare expenses tend to spend less on consumer goods and save less for retirement

COST OF IVF COVERAGE

OUTCOME COSTS

ECONOMIC CONTRIBUTION

WITH IVF BENEFITS

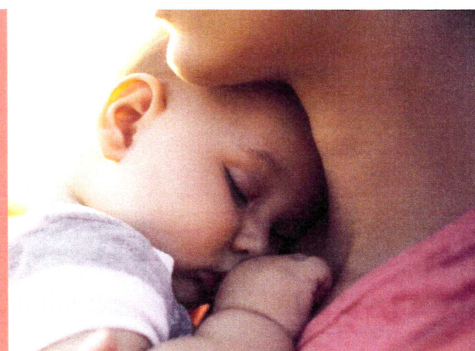
Health care reviews from multiple states show the insurance premium increase is less than 1% of the total premium cost^{13, 14, 15}

Timely and physician recommended healthcare optimizes safe pregnancies, healthy babies, as well as cost outcomes

Financial flexibility to contribute to healthcare as well as the economy, personal savings, retirement, and more

“At *TruGreen*, we strive to build benefits programming that supports the diverse needs of all of the individuals who enroll in our plan offerings. Infertility coverage is just one way we hope to support our associates as they balance their goals and dreams in both their personal and professional lives.”

Kate Pierre
Director of Compensation and Benefits, *TruGreen*



If you wish to support the **Pro-Family Fertility Care** bill or have any questions, please contact **Tara Brandner** at Everlasting Hope: tara@raisingeverlastinghope.org or 701-203-3442.

This fact sheet is a supplement of *The Policymaker's Guide to Fertility Health Benefits* — a guide with proprietary and evidence-based data for informed decision making produced by **Fertility Within Reach**. Ask for your copy today at admin@fertilitywithinreach.org or 857-636-8674.

Fertility Preservation Coverage – Key Points

Purpose

The purpose of legislation for fertility preservation coverage is to provide cancer patients access to standard medical treatments that will protect their capacity to have biological children.

Background

In the United States, approximately 160,000 individuals between ages 0-45 are diagnosed with cancer each year.¹ As cancer survivorship improves, these patients face good odds; approximately 80% will survive.² The treatments that are required to treat the cancer can directly or indirectly cause medically-induced (iatrogenic) infertility. Chemotherapy, radiation, and surgery can damage gametes (eggs and sperm), reproductive organs, and/or endocrine functioning; they may also impact the ability to carry a pregnancy. Because this damage is caused by treatments and not the disease, it can affect patients with any type of cancer. Patients with other conditions requiring similar therapies (e.g., sickle cell anemia, lupus, and thalassemia, etc.) are also at risk.³

Costs

Cost is often cited as the most significant barrier to fertility preservation.⁴ Costs can range from several hundred dollars for sperm banking, to approximately \$15,000.00 for egg banking.⁵ Without insurance coverage, these treatments are unaffordable for many patients. These costs are exacerbated by the short window of opportunity that cancer patients have before starting potentially-sterilizing cancer treatment. While the costs faced by an individual patient are high, the cost of implementing coverage across a population of insureds is very low. Independent analyses in states where coverage has been considered have shown costs ranging from one cent per member per month (PMPM) (California)⁶; to \$0.06 (Connecticut)⁷; to \$.10-\$.24 PMPM (Maryland)⁸.

Potential Cost Offsets

In some cases, increased costs of added coverage may be accompanied by decreases in costs for other health care services. This is known as a “cost offset.” Implementing coverage for fertility preservation coverage would implicate two potential cost offsets:

1. New research has shown that a sizeable percentage of patients will opt for less efficacious cancer treatment due to concerns about future infertility. One study of breast cancer patients reported that fertility concerns influenced both non-initiation and discontinuation of tamoxifen treatment. The study’s authors concluded that proper information and access to fertility preservation might positively impact adherence to treatment and survivorship.⁹ The average cost of treating early stage breast cancer over the first 24 months after diagnosis has been estimated at \$71,909; the average cost of treating stage IV breast cancer over that same

¹ Center for Disease Control and Prevention. United States Cancer Statistics: Data Visualizations. <https://gis.cdc.gov/Cancer/USCS/DataViz.html>. Published 2017. Accessed June 8, 2018.

² Barr RD, Ferrari A, Ries L, et al. Cancer in Adolescents and Young Adults: A Narrative Review of the Current Status and a View of the Future. *JAMA Pediatr*. 2016 May 1;170(5):495-501. doi: 10.1001/jamapediatrics.2015.4689

³ Katsifis GE TA. Ovarian failure in systemic lupus erythematosus patients treated with pulsed intravenous cyclophosphamide. *Lupus*. 2004;13:673-678; Rova, T., Passweg J., Heim D., Meyer-Monard, S. HW. Spermatogenesis in long term survivors after allogeneic hematopoietic stem cell transplantation is associated with age, time interval since transplantation, and apparently absence of chronic GVHD. *Blood*. 2006;108(3):1100

⁴ Quinn, G.P., Vadaparampil, S.T., Bell-Ellison, B.A., Gwede, C.K., Albrecht TL. Patient–physician communication barriers regarding fertility preservation among newly diagnosed cancer patients. *Soc Sci Med*. 2008;66(3):784-789.

⁵ FertilityIQ. The Costs of Egg Freezing. <https://www.fertilityiq.com/egg-freezing/the-costs-of-egg-freezing>. Published 2017. Accessed July 14, 2018

⁶ California Health Benefits Review Program (CHBRP) Analysis of Assembly Bill 912: Health Care Coverage: Fertility Preservation, A Report to the 2013–2014 California Legislature, April 25, 2013.

⁷ UCONN Center for Public Health and Health Policy. “Review and Evaluation of Certain Health Benefit Mandates in Connecticut 2013.”

⁸ NovaRest Annual Mandate Report: Coverage for Fertility Preservation for Iatrogenic Infertility. Prepared for the Maryland Healthcare Commission, November 16, 2017. p. 27.

⁹ Jeruss, JS. Impact of Fertility Concerns on Tamoxifen Initiation and Persistence. *J Natl Cancer Inst*. 2015 Aug 25;107(10).

By the Numbers: Providing Fertility Coverage = Better Health Outcomes, More Savings

- Across the political spectrum from New York to Arkansas, **19** other states provide benefits for fertility treatment – some for decades.
- Providing coverage for fertility treatment minimally impacts premiums. The increase in other states has been less than **1%**. *i*

Average Cost of Infertility Coverage in Three States with Comprehensive Fertility Coverage *ii*

| State | Increase |
|--------------|-------------------------------|
| Connecticut | \$1.06 per member per month |
| New York | 55 cents per member per month |
| Rhode Island | \$1.29 per member per month |

The Total Cost of Care: Other Fertility Care Options are Ineffective and Costly

- Threats of large premium increases don't look at the whole picture and **total costs of health care**.
- Because of the initial cost of IVF treatment, consumers often resort to **riskier and less effective options** which when successful often result in premature and multiple births. *iii*
- Studies show that states that do not require insurance coverage have the **highest number** of embryos transferred per cycle, **the highest rate** of pregnancy and live births from in vitro fertilization, and **the highest rate** of live births of multiple infants (especially three or more). *iv*

Providing Comprehensive Fertility Care Saves Billions

- States with IVF insurance **have fewer rates of multiple births** than states without IVF coverage. *v*
- Multiple pregnancies cost about **\$4.2 billion more** than singleton pregnancies in pre-term care. *vi*
- Pregnancies with the delivery of twins cost approximately **5 times as much** than a single child and pregnancies with triplets or more cost nearly **20 times as much**. *vii*
- Studies estimate the national savings from fewer multiple births would be over **\$6 billion a year**, making it likely that insurers could potentially save **tens, if not hundreds, of millions of dollars a year** by providing IVF coverage since patients will no longer be forced to use medical options that are more risky. *viii*
- Premature births related to multiple pregnancies **cost billions** in pre-term care and long-term care.

Business is Leading the Way

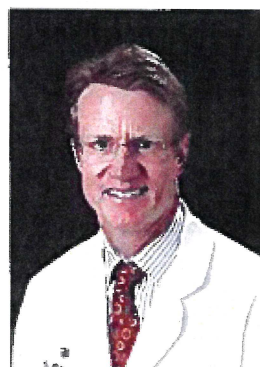
- A survey conducted by insurance broker Willis Towers Watson indicated that **55% of employers** offered fertility benefits to their employees and predicted an increase to **66% of employers** by 2019.
 - **91% of employers** offering infertility treatment have **NOT** experienced increases in their medical costs. *ix*
 - Companies investing in fertility treatments for employees include: *Ace Hardware, American Express, Apple, AT&T, Avon, Bank of America, Con Edison, Dick's Sporting Goods, Facebook, General Mills, Deloitte & Touche, ExxonMobil Ford, Gap, General Mills, Geico, IMB, JP Morgan, LinkedIn, Mass Mutual, Microsoft, Morgan Stanley, Pinterest, Proctor & Gamble, Scholastic, Starbucks, Target, Tyson Food*
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State-Mandated In Vitro Fertilization Coverage and Decrease in Multiple Gestation Rates

Helpful, But Not Enough



Violet E. Klenov, MD



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See related article on page 1205.

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Financial Disclosure

The authors did not report any potential conflicts of interest.

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ISSN: 0029-7814/16

In most states, in vitro fertilization (IVF) treatment is a costly out-of-pocket expense that averages \$12,400 per cycle.¹ In 80% of treatment cycles in the United States, multiple embryos are transferred in hopes of improving treatment efficiency, suggesting a failed cycle is considered worse than a high-risk multiple gestation pregnancy in the minds of both physicians and patients.² Despite evidence that elective single-embryo transfer in patients with a good prognosis reduces multiple birth rates without negatively affecting live-birth rates, patients are reluctant to choose this option because they remain concerned about the cost of an additional cycle.³ State-mandated insurance coverage for IVF may take some of this financial pressure off of these patients and physicians.

In this month's issue, Provost et al⁴ (see page 1205) examine the association between state-mandated IVF insurance coverage and the incidence of multiple birth. Although not a novel inquiry, this large study controls for baseline patient and cycle characteristics, providing a more accurate analysis of the data. The results are clear. Physicians in mandated states transfer fewer embryos per cycle and are twice as likely to implement elective single-embryo transfer as physicians in nonmandated states. When compared with IVF live births in nonmandated states, births in mandated states include fewer multiple gestation deliveries (29% compared with 32.8%) and fewer preterm deliveries (26.5% compared with 29.3%) without any change in the live birth rate. The decrease in multiple gestation deliveries is driven by increased application of elective single-embryo transfer among women younger than 35 years old undergoing a day 5 embryo (blastocyst) transfer. This group of women is the largest contributor to IVF-related multiple gestation deliveries and thus a critical subset of patients for whom elective single-embryo transfer should be implemented.⁵

These findings make sense. Patients and physicians are more comfortable with elective single-embryo transfer when the financial disincentive is removed. This allows reproductive endocrinologists to embrace the goal of a singleton live birth instead of a pregnancy—not just in theory but also in practice. Provost et al provide compelling evidence that it is embryo transfer practices rather than patient demographic characteristics that are responsible for increased multiple birth rates in nonmandated states, a finding supported in the literature.⁶

The number of embryos transferred per cycle fortunately has decreased over time in both mandated and nonmandated states, resulting in a marked decrease in high-order multiple pregnancies.