Americans for IVF Cover Memorandum re Commissioned Economic Analyses on Proposed HOPE with Fertility Services Act

Infertility is the body's reproductive system's failure to function as is naturally intended and it is highly prevalent. The most recent CDC survey of on this subject, released in 2021, found that 13.4% (9.7 million) U.S. women 15-49 years of age (of all marital statuses) have impaired fecundity. A staggering 1 in 4 (26%) married women in this age group with no prior births have difficulty getting pregnant or carrying a pregnancy to term. Across America, 12.2% of women have received infertility services. Additionally, recent studies have found that among men, who account for about half of infertile couples' challenges, male factor infertility has substantially increased 76.9% across the globe since 1990.

Despite the widespread prevalence and significance of infertility, and while incredible scientific breakthroughs have been made in the field of assistive reproductive technology (ART), the dream of having children is out of reach for too many families due to the cost of those treatments. Most insurance plans are designed to provide comprehensive coverage and yet do not cover diagnosis, testing, or treatments for infertility, unjustifiably classifying them as "elective" services. Families that are just starting out, often already with student loans or other debt, are forced to pay out of pocket for care that can cost tens of thousands of dollars and can often add up to much more throughout a couple's infertility journey. There is nothing elective about trying to reproduce and being unnaturally inhibited from doing so due to disease. It is therefore critical that we address the needs of the millions of American men and women who need help starting or growing their families.

This is why the Helping to Optimize Patients' Experience with Fertility Services Act (HOPE Act) is so desperately needed. This bill would amend the Employee Retirement Income Security Act (ERISA), to require all self-insured and fully-insured group health plans cover testing and treatment for infertility, declaring infertility a disease that must be treated like any other. Under the HOPE Act, the millions of Americans who have plans governed by ERISA would no longer be exposed to astronomical out of pocket costs for these vital treatments.

To assess what these new requirements for coverage will mean for taxpayers and plan members, Americans for IVF retained Avalere, an expert healthcare consultancy with expertise estimating Federal revenue impacts and projected premium increases, to estimate the effects of this bill, in a style similar to the Congressional Budget Office. Americans for IVF also retained Fertility Dynamics, a data analytics leader in the fertility services space, to provide a supplemental report that incorporates additional analysis and dynamic scoring considerations.

Avalere found that the HOPE Act would minimally raise insurance premiums by only between $0.58 and $0.79 per member per month, across all ERISA plans. For less than a

dollar a month in premiums, millions of Americans struggling with infertility will be able to realize the dream of having a child.

Since healthcare premiums are generally paid out of pretax income, an increase in premiums means a decrease in tax revenue only with respect to the premium increase. **Avalere estimated that the reduction in tax revenue would average only around $155.5 million per year, for a total of $1.4 billion over the first ten years after enactment of the bill**. It is important to note that there is no direct cost to taxpayers from this bill, as this bill only affects private insurance, with the government not spending any additional funds. All of these costs come solely from the reduction in tax revenue because the slight premium increase is tax deductible.

When factoring in dynamic scoring considerations undertaken by the Fertility Dynamics report, the proposed legislation *increases* federal revenue by at least $212 million dollars over the first 10 years, and $119B over a 70-year timeline, with ongoing annual revenue increases of $1.1B in current dollars. This increase in federal tax revenues is due to increased taxable business revenue for fertility services, increased spending to raise the incremental babies born, and increased individual income taxes paid in future years. Additionally, there is academic research supporting the Parent Investment theory,[1] which contends that parents will work harder to earn more money because they want to provide a more comfortable life for their children.

There will be positive changes to the marketplace for fertility treatments, by shifting the cost from consumers to insurers, including:

1) As insurance companies are mandated to cover fertility treatments, the marginal costs per treatment overall should significantly decrease, as their adoption spreads, due to the volume and competitive practices of insurance companies to drive down prices.
2) A decrease in the number of multiple births, and the costs associated with them, due to reduced implantation of multiple embryos, since the financial incentive to implant multiple embryos at a time will be removed.
3) With the insurance coverage of fertility services, more doctors will specialize in fertility, increasing the options for families, reducing costs, and encouraging research.

Conclusion:

The data presented in these reports show that the projected increase in plan member premiums, as low as 58 cents per month, is small, while the federal budgetary impact is at worst relatively slight, and at best a net positive for federal revenue. When considering the significant impact this will have on millions of Americans wishing to have children and start families of their own, this is a small cost to bear for such a deeply needed and worthwhile endeavor.

[1] https://genus.springeropen.com/articles/10.1186/s41118-020-00111-5

To: Avalere

From: Americans for IVF

Date: May 6, 2024

Re: Estimated Federal Impact of a Proposed Legislation Aiming to Expand Health Plan Coverage of IVF Services

Overview

Americans for IVF (AIVF) commissioned Avalere to estimate the 10-year budget impact of proposed legislative text titled, Helping to Optimize Patients' Experience with Fertility Services Act, or the "HOPE with Fertility Services Act." The proposed legislation, as provided to Avalere by AIVF on May 2, 2024, would require health insurance plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) to cover infertility and iatrogenic infertility treatments. (See Appendix for draft legislation.) Specifically, the draft legislation includes coverage of treatments that involve the handling of human eggs, sperm, and embryos outside of the body, as well as within the body. Covered treatments would include, but would not be limited to, in vitro fertilization (IVF), cryopreservation, egg and embryo donation, intracytoplasmic sperm injection, ovulation induction, genetic screening and diagnosis, and intrauterine insemination
(IUI). Under the proposed legislation, benefits provided by plans may be subject to coverage limits, including utilization management, as well as cost-sharing requirements, such as coinsurance and deductibles.

Avalere estimates that the proposed legislative text would lead to a total federal budget impact of $1.4 billion over the 2025-2034 period (Table 1).

Table 1. Estimated Budgetary Effects Due to the Implementation of a Policy Requiring Health

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-2034
Total Federal Budget Impact	-	0.16	0.19	0.17	0.16	0.15	0.14	0.14	0.14	0.15	1.40

Note: Sums may not total due to rounding.
Source: Avalere analysis of proposed legislative text provided by AIVF on May 2, 2024.

Background

Infertility, as defined by the CDC, is the inability to achieve pregnancy after one year of regular, unprotected heterosexual intercourse. The condition affects approximately one in ten men and women in the United States.[1] Infertility can be due to issues with the reproductive tracts of both men and women, including damage from radiation, chemotherapy, or surgery. Infertility can also be attributed to problems with ovulation, other hormonal diseases, or unknown causes.[2]

Treatment for infertility typically begins with medical consultation and testing and then can range from medications to help with ovulation or sperm motility to IVF, which requires creating an embryo outside of the body. The costs associated with these treatments and to achieve a successful outcome can be anywhere from several hundred dollars to over $100,000.[3] Many people end up foregoing or delaying treatment due to the high costs and the lack of insurance coverage. From a study conducted by Prosper Marketplace, a financial services firm, 44% of those undergoing fertility treatments incurred more than $10,000 in debt due to the treatments.[4]

ERISA regulates most employer health plans to provide protection for their enrollees. The law provides exemptions from the required standards for plans provided by government institutions as well as religious institutions. In its current form, ERISA does not require regulated health plans to include coverage of infertility treatments.

In recent years, many employers have begun to voluntarily offer coverage for treatments to their employees and some states have opted to go above the ERISA minimum requirements and mandate coverage for these treatments. These mandates are typically applied to certain plan types and not others. Fully insured plans, even those subject to ERISA, must comply with state benefit mandates, while self-funded plans subject to ERISA are exempt from state benefit mandates.[5] As of 2023, 21 states require commercial insurers to include some form of coverage for treating infertility, though the types of treatments included vary from state to state.[6] Of those 21 states, 14 require coverage for IVF, which is the most expensive form of treatment explicitly included in the proposed legislation and Avalere's analysis. In states that require IVF coverage and have published premium impact analyses, premiums appear to have increased less than 1% due to the mandate.[7]

[1] National Health Statistics Report (2013). "Infertility and Impaired Fecundity in the United States, 1982–2010: Data From the National Survey of Family Growth." Available here.
[2] NIH (2017). "What are some causes of infertility?" Available here
[3] NIH (2010). "Costs of infertility treatment: Results from an 18-month prospective cohort study." Available here.
[4] Prosper (2015). "U.S. Fertility Treatments: Sentiment, Costs and Financial Impact." Available here.
[5] NCSL (2024). "Commercial Health Insurance Mandates: State and Federal Roles." Available here.
[6] Resolve (2023). "Insurance Coverage by State." Available here.
[7] KFF (2020). "Coverage and Use of Fertility Services in the U.S." Available here.

Description of Key Provisions

Under the HOPE with Fertility Services Act, ERISA will be amended to require that most group health plans provide coverage for infertility or iatrogenic infertility treatments. As defined in the legislation, infertility generally means being unable to achieve pregnancy or incapable of reproducing to live birth, and iatrogenic infertility covers those who are experiencing infertility due to damage of the reproductive organs from a medical procedure or diagnosed condition. The treatment options that are assumed to be covered under this legislation include ovulation induction, genetic screening and diagnosis, IVF, cryopreservation, egg and embryo donation, and IUI. Beneficiaries receiving any of the included services under the legislation would be subject to their plan's cost-sharing rules, which may be no more restrictive than cost-sharing requirements applied to other benefits. Plans may enforce utilization management tools for the defined services.

Assumptions and Methodology

For this analysis, Avalere leveraged internal expertise to develop an approach and key assumptions like those used by CBO. However, there is a significant range of assumptions that CBO could use in its estimate. Avalere's estimate is subject to uncertainty driven by patient, health plan, employer, and provider behaviors, as well as the availability of infertility treatment services. The assumptions used to construct this estimate regarding premium impact, the effect of increased utilization, distribution of premium impact across stakeholders, estimated tax liability, and implementation timeline are outlined below.

Additional Premium Cost Related to Legislative Proposal

Under the legislative proposal, Avalere analyzed the utilization and cost associated with the coverage of infertility treatments enumerated in the legislation to identify the increased liability incurred by health plans. The increased liability would presumably result in an increase in premiums for employers and employees, which must be considered when forecasting tax implications for the federal government.

Identifying the Relevant Population

Avalere limited the scope of the analysis to patients enrolled in employer-sponsored insurance governed by ERISA. The proportion of male and female beneficiaries in eligible plans was estimated using data from the Census Bureau's American Community Survey on insurance coverage by sex. The population was further narrowed by excluding people in fully insured plans that reside in states that already require infertility coverage for fully insured employer groups. As of 2023, 21 states required commercial insurers to include some form of coverage for treating infertility.[8] Only 14 of those states, however, required coverage for IVF, which is the most expensive form of treatment explicitly included in the proposed legislation and Avalere's analysis. Avalere assumed insurance coverage for all costs associated with infertility treatments

[8] Resolve (2023). "Insurance Coverage by State." Available here.

in the 14 states that required coverage for IVF and estimated that roughly half (i.e., 52%) of costs incurred for infertility-related treatments would be covered by insurance in the remaining 7 states that do not mandate coverage for IVF.

In addition to the effect of state coverage mandates, Avalere also estimated the amount of coverage that currently is and will be voluntarily provided by fully insured and self-funded plans for infertility treatments. Utilizing employer data from Mercer, Avalere found that 43% of employees who would be eligible for coverage under this proposed legislation already have an existing level of coverage.[9] To project the voluntary uptake by employers in future years, Avalere looked to other benefits that employers have chosen to expand as a proxy for growing infertility coverage. Employer coverage of mental health services has followed a similar trajectory as infertility coverage in recent years. Avalere referenced the growth in coverage of this benefit to estimate infertility coverage growth. Utilizing data on the increasing coverage of mental health treatments, Avalere estimates that even without the proposed legislation, 59% of eligible employees would have some form of coverage for infertility treatments by 2034.[10, 11]

Lastly, Avalere accounted for the "church plan" and governmental plan exemptions within ERISA by excluding approximately 14.8% of the overall workforce to account for those individuals who are employed by religious entities that may seek the exemption.[12] Avalere considered behavioral responses by individuals not covered by an ERISA plan, including church and governmental plans, and concluded while there may be some enrollment shift into ERISA-governed plans, the net federal budget implications are likely negligible.

Utilization of Infertility Treatments

Based on a previously published Avalere analysis of the rate of IVF procedures among commercially insured women in 2021, Avalere used a baseline utilization rate of 0.23%.[13] This aligns with the number of new IVF patients (i.e., patients undergoing their first intended retrieval) in 2021 as reported in the CDC's ART Fertility Clinic and National Summary Report.[14] Avalere then leveraged a study conducted by the National Center for Health Statistics to identify baseline utilization of ever having used infertility treatments by men and women in the United States.[15] Based on the study, approximately 8.9% of women have experienced issues related to infertility and sought out medical treatment, 6% have received testing, 4% have received ovulation drugs, 0.7% have undergone surgery, 1.7% have undergone IUI, and 0.5% have utilized IVF. The annual rate of IVF, as described in the above referenced Avalere analysis, is approximately half the rate of those who reported utilizing IVF. Accordingly, Avalere scaled the utilization rates of other infertility services by the same proportion to approximate an annualized rate for baseline utilization. For male factor treatments (i.e., fertility drugs, surgery, sperm retrieval, sperm cryopreservation), Avalere assumed that utilization rates were proportionally

[9] Mercer (2021). "2021 survey on fertility benefits." Available here.
[10] Mercer (2023). "Survey: Employers support growing demand for mental health services." Available here.
[11] McKinsey (2020). "Mental health in the workplace: The coming revolution." Available here.
[12] US Bureau of Labor Statistics (2023). "May 2022 National Industry-Specific Occupational Employment and Wage Estimates." Available here.
[13] Avalere Health (2022). "After Roe, Growing Fertility Industry Faces Risks at State Level." Available here.
[14] CDC (2023). "2021 National ART Summary." Available here.
[15] National Center for Health Statistics (2022). "Key Statistics from the National Survey of Family Growth – I Listing" Available here.

lower than similar female factor treatments based on the marginally lower prevalence of infertility among men relative to women.[16] Avalere estimated intracytoplasmic sperm injection (ICSI) utilization based on national reported rates.[17, 18]

Avalere also assumed that there is an unrealized demand for infertility treatment due to lack of insurance coverage nationwide. Studies from multiple states that passed mandates for coverage of infertility benefits showed an increase in utilization in comparison to pre-mandate and the national average. Employing a study comparing IVF utilization pre- and post-mandate in New Jersey and Connecticut to other non-mandate states in the region, Avalere identified a net 26% increase in the number of patients that was observed in the short-term after mandates were implemented.[19] Avalere used a three-year ramp for pent-up demand to the full 26% increase in service utilization with a subsequent three-year ramp down. In addition, Avalere included long-term growth in utilization based on the increase over time in embryo transfers for IVF as published by the CDC, while also subtracting out the impact of state-level coverage mandates and their associated impact on utilization.[20]

Cost of Infertility Treatments and Impact to Premiums

Costs of specific treatments were based on published studies, adjusted for medical inflation, as well as publicly advertised rates by fertility treatment providers. These costs were compared against the analysis of California Assembly Bill 2029 by the California Health Benefits Program.[21] Compared to California's baseline expenditures of 54% for IVF, 40% for non-IVF female factor treatments, and 6% for male factor treatments; Avalere estimated national baseline expenditures to be 48% for IVF, 42% for non-IVF female factor treatments, and 10% for male factor treatments. The difference in baseline expenditures is attributable to California utilizing IVF at a higher rate than the national average, driving up the proportion of IVF expenditures in the state estimates.[22] Avalere forecasted medical inflation (CPI-M) by analyzing Bureau of Labor Statistics data showing the average difference in CPI-U and CPI-M from 2014-2023 and applying that difference to CBO forecasts of CPI-U.

Avalere adjusted the cost of infertility treatments to account for the effects of commercial coverage. Avalere assumed that commercial negotiated rates would be a proportion of current treatment costs, which are largely reported for self-pay patients. Avalere assumed an average negotiated rate of 91%.[23] Some stakeholders point out that commercial negotiations could result in steeper discounts relative to cash pay depending on the relative bargaining power of insurers, which could decrease the financial impact of infertility coverage. However, there appears to be limited public data beyond what Avalere has cited in its analysis.

[16] NIH (2018). "How common is infertility?" Available here.
[17] JAMA (2015). "Trends in Use of and Reproductive Outcomes Associated With Intracytoplasmic Sperm Injection." Available here.
[18] CDC (2023). "2021 National ART Summary." Available here.
[19] ASRM (2016). "Assisted reproductive technology use, embryo transfer practices, and birth outcomes after infertility insurance mandates: New Jersey and Connecticut." Available here.
[20] CDC (2023). "2021 National ART Summary." Available here.
[21] CHBRP (2022). "Analysis of California Assembly Bill 2029: Health Care Coverage: Treatment for Infertility. Available here.
[22] CDC (2021). "State-Specific Assisted Reproductive Technology Surveillance, United States: 2021 Data Brief." Available here.
[23] Health Affairs (2023). "The relationships among cash prices, negotiated rates, and chargemaster prices for shoppable hospital services." Available here.

To calculate total additional health plan outlays related to the legislative proposal, Avalere multiplied the number of previously ineligible beneficiaries utilizing treatments by the estimated negotiated reimbursement costs of treatments. Avalere then excluded cost sharing, as allowed for by the proposed legislation, that would be incurred directly by patients receiving infertility treatments. Based on a Prosper Marketplace survey of women seeking infertility treatments, Avalere assumed an average coinsurance rate of 30%.[24]

Avalere also considered the potential of fewer multiple embryo IVF treatments under the proposed legislation. Due to the financial pressure put on individuals without infertility treatment coverage, some people pursue multiple embryo IVF, which can lead to an increased risk of preterm births and higher medical costs.[25] CDC data estimates that currently 6.7% of all IVF live-births deliveries are non-singleton births.[26] Avalere assumed marginally more patients would pursue singleton IVF as a result of the proposed legislation, which could yield potential cost avoidance through fewer preterm births.

Distribution of Premium Impact Across Market and Stakeholders

Avalere distributed the adjusted premium cost across fully funded and self-funded ERISA plans based on market share. Market share was based on CBO's enrollment projections for employer-sponsored coverage as well as the share of covered lives for fully funded and self-funded plans from the KFF Employer Health Benefit Survey report.[27]

Avalere then calculated the approximate liability for each stakeholder under each plan type. For fully funded and self-funded plans, Avalere applied different marginal elasticities for health plans, employers, and employees to determine their respective share of the premium liability. Avalere expects health plans will assume a share of the additional premium cost and pass on the balance to employers and employees. Based on an analysis by the Society of Human Resources Management (SHRM), Avalere estimated health plans will mitigate 20% of the increased costs by modifying overall plan structure, including deductibles, copayments, coinsurance rates, and maximum out-of-pocket amounts for all services, not just those newly added.[28] Avalere then assumed that employers would initially absorb the vast majority of the remaining cost at an elasticity that reflects the high current demand for labor. Avalere then forecast that the supply and demand dynamics for labor would moderate during the budget window, thereby decreasing the portion assumed by employers to approximately 66%, which trends in the allocation of total insurance costs between employers and employees.[29] Finally, Avalere accounted for employer behavior whereby increases in the cost of insurance are factored into total compensation and cost of business, which places downward pressure on wage growth.[30]

[24] Prosper (2015). "U.S. Fertility Treatments: Sentiment, Costs and Financial Impact." Available here.
[25] Scientific Reports (2022). "Risk factors associated with preterm birth after IVF/ICSI." Available here.
[26] CDC (2021). "Assisted Reproductive Technology (ART) Data. Available here.
[27] KFF (2023). "2023 Employer Health Benefits Survey." Available here.
[28] SHRM. Miller, S (2022). "Medical Plan Costs Expected to See Bigger Rise in 2023." Available here.
[29] KFF (2019). "Tracking the rise in premium contributions and cost-sharing for families with large employer coverage." Available here.
[30] Health Economics (2016). "Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey." Available here.

For plans which had not previously offered infertility coverage, Avalere calculated that the premium impact would be $1.54 per member per month (PMPM) in 2026. This was calculated by dividing the total increase in premiums due to the proposed legislation by the number of individuals enrolled in impacted health plans that do not currently offer infertility benefit coverage. This premium amount increases to a peak of $1.85 PMPM in 2028 and decreases to $1.68 by the end of the budget window. When looking at the premium impact on all non-exempt ERISA plans, which includes those that already offer the benefit voluntarily, the premium impact would be $0.70 in 2026, $0.79 in 2028, and $0.58 in 2034.

Federal Tax Liability

After distributing the costs across stakeholders, Avalere estimated the impact to federal tax liability for each stakeholder considering health insurance premiums are tax deductible and increased premiums would reduce federal tax revenue. First, Avalere determined that increased premiums would be associated with increased payroll deductions, affecting the tax amount under the Federal Insurance Contribution Act (FICA). Avalere calculated FICA liability by applying the FICA tax rates for Social Security (6.20%) and Medicare (1.45%) to the premium cost for both employers and employees under fully funded and self-insured plans. The application of the FICA tax rate accounted for the average 6% of individuals who earn more than the Social Security wage base each year.[31] FICA liability was deducted from each stakeholder's respective premium cost.

Avalere then used the adjusted premium cost to determine the extent to which increased premiums would reduce federal income tax liability. To calculate the federal income tax liability for employers and employees under fully funded and self-funded plans, Avalere applied corporate and personal income tax rates to the adjusted share of premium cost for employers and employees, respectively. The corporate income tax rate was set at 21% as stipulated by the Tax Cuts and Jobs Act of 2017.[32] The individual income tax rate applied ranged from 19.1% to 22.0% over the budget window, based on the blended rate for all tax filers published by CBO.[33]

Avalere also considered the counter effects of existing tax policies, such as the deduction for medical and dental expenses that exceed 7.5% of adjusted gross income (AGI).[34] Theoretically, the deduction would be used less if more people had coverage for infertility treatments. To evaluate the impact of the proposed legislation, Avalere analyzed the cost of infertility treatment, the income distribution of patients seeking those treatments, and the filing patterns (e.g., use of standard vs. itemized deductions) of taxpayers. The effects of the existing deduction on the federal budget impact of the proposed legislation are expected to be marginal. That's because the deduction only applies to amounts exceeding 7.5% of AGI, and the incomes of individuals seeking infertility treatments skews higher than average tax filers. Further, for those individuals with lower incomes who utilize infertility treatments, they must also weigh the relative benefit of

[31] SSA (2021). "Taxable Maximum Earners." Available here.
[32] Public Law 115-07. Available here.
[33] Congressional Budget Office (2023). Supplement to "The Budget and Economic Outlook: 2023 to 2033." Available here.
[34] IRS (2023). "Publication 502 (2023), Medical and Dental Expenses." Available here.

itemizing as opposed to taking the standard deduction, which was $29,200 for those married filing jointly in 2024.[35]

Implementation Timeline

Avalere assumed the legislation has an effective date of January 1, 2026, as stipulated in the draft legislation. For the purposes of this analysis, Avalere assumed the coverage requirement would apply to health plan years beginning on or after this date.

Additional Considerations

As discussed in detail, Avalere employed an approach and key assumptions like those used by CBO to develop a conventional score, as opposed to a dynamic analysis. According to long-standing practice, CBO conducts conventional scoring for proposed legislation unless the expected economic impact is greater than 0.25% of total Gross Domestic Product (GDP). When the impact exceeds 0.25% of GDP, CBO may use dynamic analysis to estimate the total federal budget impact. Avalere determined, as CBO would most likely also determine, that the impact of the proposed legislation would be less than 0.25% of GDP and would be assessed using conventional scoring methods.

The proposed legislation may have macroeconomic impacts beyond the direct effects accounted for within this conventional score. The coverage of infertility treatment services, as suggested by the marginal increase in utilization among those with coverage, may lead to additional births and add to the total size of the US population. Further, there would be economic activity associated with those additional births and subsequent child rearing, contributing directly and indirectly to the economy. Moreover, additional births would eventually lead to additional workers, which could have a variety of benefits. However, those additional potential benefits would likely not be included in a CBO conventional score due to limitations on using dynamic analysis and a focus on 10-year budget windows.

Data Sources

Avalere used the following data sources to develop our estimate:

- Congressional Budget Office (CBO)
    - An Update to the Budget Outlook: 2023 to 2033
    - The Budget and Economic Outlook: 2023 to 2033
- Centers for Medicare & Medicaid Services
    - Medicare Trustees Report, 2023
    - National Health Expenditure Data

[35] IRS (2023). “IRS provides tax inflation adjustments for tax year 2024.” Available here.

- 2023 Marketplace Open Enrollment Period Public Use Files

- National Institutes of Health
  - Infertility and Fertility
  - Cost of Infertility Treatment
  - Utilization of Infertility Treatments: The Effects of Insurance Mandates
- Internal Revenue Service (IRS)
  - Social Security and Medicare Withholding Rates
  - Blended Tax Rates for Corporations
- Health Affairs
  - The Relationships Among Cash Prices, Negotiated Rates, and Chargemaster Prices for Shoppable Hospital Services
- Kaiser Family Foundation (KFF)
  - KFF Employer Health Benefits Survey, 2023
  - Coverage and Use of Fertility Services in the U.S.
  - Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage
- Centers for Disease Control and Prevention
  - National Health Statistics Report
  - National Survey of Family Growth
  - 2021 National ART Summary
- Health Economics
  - Health Insurance Costs and Employee Compensation
- Mercer
  - Survey on Fertility Benefits, 2021
  - Survey on Employer Mental Health Services, 2023
- McKinsey
  - Mental Health in the Workplace

- Avalere
    - After Roe, Growing Fertility Industry Faces Risks at State Level
- Prosper Marketplace
    - U.S. Fertility Treatments: Sentiment, Costs and Financial Impact
- American Society for Reproductive Medicine
    - Reproductive Healthcare: A National Priority That Cannot Wait
    - Assisted reproductive technology use, embryo transfer practices, and birth outcomes after infertility insurance mandates: New Jersey and Connecticut
- Resolve
    - Insurance Coverage by State
- National Conference of State Legislatures
    - Commercial Health Insurance Mandates

Appendix – Proposed Legislative Text

Title: To ensure coverage for the treatment of infertility for certain conditions.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Helping to Optimize Patients' Experience with Fertility Services Act" or the "HOPE with Fertility Services Act".

SEC. 2. ENSURING BENEFITS FOR TREATMENT OF INFERTILITY AND IATROGENIC INFERTILITY.

(a) In General.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by inserting after section 714 the following:

"SEC. 714A. STANDARDS RELATING TO BENEFITS FOR TREATMENT OF INFERTILITY AND IATROGENIC INFERTILITY.

"(a) In General.—A group health plan or a health insurance issuer offering group health insurance coverage shall ensure that such plan or coverage provides coverage for infertility or iatrogenic infertility treatments, including—

"(1) the treatment of infertility, if such plan or coverage provides coverage for obstetrical services; and

"(2) standard fertility preservation services when a medically necessary treatment described in subparagraph (A), (B), (C), or (D) of subsection (b)(1) causes, or is expected to cause, iatrogenic infertility.

"(b) Definitions.—In this section:

"(1) IATROGENIC INFERTILITY.—The term 'iatrogenic infertility' means an impairment of fertility due to damage of reproductive organs and processes resulting from—

"(A) a surgical or other invasive medical procedure as a result of an injury or life-threatening illness, or involving a reproductive organ or process in a manner likely to cause damage to such organ or process;

"(B) radiation therapy;

"(C) chemotherapy; or

"(D) myeloablative conditioning.

"(2) INFERTILITY.— The term 'infertility' means a disease or condition characterized by—

"(A) the inability to achieve spontaneous pregnancy without medical treatment after a period of at least 12 consecutive months of unprotected sexual intercourse;

"(B) the inability to achieve pregnancy after receiving standard clinical treatment protocols under the supervision of a treating physician who is a board-certified reproductive endocrinologist or obstetrician-gynecologist;

"(C) being incapable of reproduction to live birth based on medical and reproductive history, age, physical findings or diagnostic testing of the individual, as determined by a treating physician; or

"(D) the inability to achieve spontaneous pregnancy on account of a diagnosed condition that is a disorder of ovulation, or a testicular or hormonal disease or disorder.

"(3) INFERTILITY OR IATROGENIC INFERTILITY TREATMENT.—The term 'infertility or iatrogenic infertility treatment' means treatments or procedures with the intent of facilitating a pregnancy, including—

"(A) such treatments or procedures that involve the handling of human egg, sperm, and embryo outside of the body, including in vitro fertilization and maturation, egg and embryo cryopreservation, egg and embryo donation, and intracytoplasmic sperm injection; or

"(B) such treatments or procedures that do not involve the handling of human egg, sperm, and embryo outside of the body, including ovulation induction, genetic screening and diagnosis, sperm cryopreservation, and intrauterine insemination.

"(c) Required Coverage.—A group health plan and a health insurance issuer offering group health insurance coverage that includes coverage for obstetrical services shall provide comprehensive coverage for infertility or iatrogenic infertility treatments, as determined by the Secretary in consultation with relevant stakeholders, provided to a participant or beneficiary if—

"(1) the participant or beneficiary has infertility, including iatrogenic infertility; and

"(2) the treatment or service is performed at a medical facility that is in compliance with standards set by appropriate Federal and State agencies.

"(d) Financial Requirements and Treatment Requirements.—Any coverage provided by a group health plan or health insurance issuer in accordance with this section may be subject to coverage limits (such as medical necessity, pre-authorization, or pre-certification) and cost-sharing requirements (such as coinsurance, copayments, and deductibles), as required under the group health plan or health insurance coverage, that are no more restrictive than the predominant coverage limits and cost-sharing requirements applied to substantially all medical and surgical benefits covered under the plan or coverage.

"(e) Prohibitions.—A group health plan and a health insurance issuer offering group health

insurance coverage may not—

"(1) provide incentives (monetary or otherwise) to a participant or beneficiary to encourage such participant or beneficiary not to be provided infertility or iatrogenic infertility treatments to which such participant or beneficiary is entitled under this section, or to providers to induce such providers not to provide such treatments to qualified participants and beneficiaries;

"(2) prohibit a provider from discussing with a participant or beneficiary infertility or iatrogenic infertility treatments or medical treatment options required to be covered under this section; or

"(3) penalize or otherwise reduce or limit the reimbursement of a provider because such provider provided infertility or iatrogenic infertility treatment services to a participant or beneficiary in accordance with this section.

"(f) Rule of Construction.—Nothing in this section shall be construed to—

"(1) require a participant or beneficiary in a group health plan or group health insurance coverage to undergo infertility or iatrogenic infertility treatments;

"(2) impact the use by a group health plan or a health insurance issuer offering group health insurance coverage of utilization management tools; or

"(3) prevent a group health plan or a health insurance issuer offering group health insurance coverage from contracting with providers as to the level and type of reimbursement with a provider for care provided in accordance with this section.

"(g) Utilization Management Tools Requirements.—

"(1) IN GENERAL.—In the case of a group health plan or a health insurance issuer offering group health insurance coverage that imposes utilization management tools on infertility and iatrogenic infertility treatment benefits, for the first 5 plan years that begin after the date of enactment of the Helping to Optimize Patients' Experience with Fertility Services Act, such plan or issuer shall perform and document analyses of the design and application of the utilization management tool such analysis and the following information:

"(A) The specific plan or coverage terms or other relevant terms regarding the utilization management tools and a description of all infertility or iatrogenic infertility treatment benefits, to which each such term applies in each respective benefits classification.

"(B) The factors used to determine that the utilization management tool will apply to infertility or iatrogenic infertility treatment benefits.

"(C) The evidentiary standards used for the factors identified under subparagraph (B), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the utilization management tool to infertility and iatrogenic infertility treatment benefits.

"(D) An analysis demonstrating that the processes, strategies, evidentiary standards,

and other factors used to apply the utilization management tools to infertility and iatrogenic infertility treatment benefits as written and in operation, are consistent with, and are applied no more stringently than with clinical guidelines for infertility or iatrogenic infertility treatments.

"(E) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this paragraph that indicate that the plan or coverage is or is not in compliance with this section.

"(2) SUBMISSION PROCESS.—

"(A) ANNUAL SUBMISSION.—A group health plan or health insurance issuer offering group health insurance coverage shall submit to the Secretary the analyses described in paragraph (1) annually for first 5 plan years that begin after the date of enactment of the Helping to Optimize Patients' Experience with Fertility Services Act. For subsequent plan years, the Secretary may request that a group health plan or a health insurance issuer offering group health insurance coverage submit the analysis described in paragraph (1) in the case of potential violations of this section or complaints regarding noncompliance with this section that concern utilization management tools and any other instances in which the Secretary determines appropriate.

"(B) ADDITIONAL INFORMATION.—If the Secretary concludes that a group health plan or health insurance issuer has not submitted sufficient information for the Secretary to review the analysis described in paragraph (1), the Secretary shall specify to the plan or issuer the information the plan or issuer is required to submit pursuant to subparagraph (A). Nothing in this subparagraph shall require the Secretary to conclude that a group health plan or health insurance issuer is in compliance with this section solely based upon the inspection of the analyses described in paragraph (1), as requested under subparagraph (A).

"(3) REQUIRED ACTION.—

"(A) IN GENERAL.—If, after review of the analyses described in paragraph (1), the Secretary notifies the group health plan or health insurance issuer that such plan or issuer is not in compliance with this section, the plan or issuer—

"(i) shall specify to the Secretary the actions the plan or issuer will take to be in compliance with this section and provide to the Secretary additional analyses described in paragraph (1) that demonstrate compliance with this section not later than 45 days after the initial notification by the Secretary that the plan or issuer is not in compliance; and

"(ii) following the 45-day corrective action period under clause (i), if the Secretary makes a final determination that the plan or issuer still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the applicable plan or health insurance coverage

that such plan or coverage has been determined to be not in compliance with this section.

"(B) EXEMPTION FROM DISCLOSURE.—Documents or communications produced in connection with the Secretary's recommendations to a group health plan or health insurance issuer shall not be subject to disclosure pursuant to section 552 of title 5, United States Code.

"(4) REPORT.—For plan years beginning on or after January 1, 2026, the Secretary shall submit to Congress, and make publicly available, a report that contains—

"(A) a summary of the analysis submitted under paragraph (1), including the identity of each group health plan or health insurance issuer offering health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in paragraph (3)(A)(ii);

"(B) the Secretary's conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the analysis under paragraph (2);

"(C) for each group health plan or health insurance issuer that did submit sufficient information under paragraph (2), the Secretary's conclusions as to whether and why the plan or issuer is in compliance with the requirements under this section;

"(D) the Secretary's specifications described in paragraph (3) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the analyses described in paragraph (1) for compliance with this section; and

"(E) the actions the Secretary specifies under paragraph (3)(A)(i) that each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section is required take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.

"(h) Notice.—Beginning with the second plan year beginning after the date of enactment of the Helping to Optimize Patients' Experience with Fertility Services Act, a group health plan and a health insurance issuer offering group health insurance coverage shall provide notice to participants and beneficiaries in such plan or coverage regarding the coverage required by this section in accordance with regulations promulgated by the Secretary.

"(i) Effective Date.—This section, and the amendments made by this section, shall apply with respect to plan years beginning on or after January 1, 2026.".

(b) Enforcement.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking "or (9)" and inserting "(9), or (13)";

(2) in subsection (b)(3), by striking "subsection (c)(9)" and inserting "paragraphs (9) and

(13) of subsection (c)"; and

(3) in subsection (c), by adding at the end the following:

"(13)(A) The Secretary may assess a civil penalty against a health insurance issuer for failing to provide coverage for infertility or iatrogenic infertility treatments as required under section 714A, in an amount up to $100 per day, beginning on the date on which the issuer first denies such coverage and ending on the date on which the issuer approves coverage, with respect to each participant or beneficiary denied such coverage in violation of such section.

"(B) The Secretary may assess a civil penalty against a health insurance issuer for failing to submit an analysis as required under section 714A(g)(2), in an amount up to $100 for each day, beginning 45 days after the date on which the Secretary notifies such issuer that the issuer is not in compliance with the requirement under section 714A(g)(2), and ending on the date on which the issue submits the analysis as required.".

(c) Conforming Amendment.—Section 731(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191(c)) is amended by striking "section 711" and inserting "sections 711 and 714A".

FERTILITY DYNAMICS

Impact of Americans for IVF's Proposed Legislation to Expand Health Plan Coverage of IVF Services
May 16, 2024

The fiscal impact of the proposed legislation is four-fold, excluding less easily quantified impacts such as a stronger economy and nation. It adds at least $212 million in federal revenue over 10-years 2025-2034 and $119B over 70-years 2026-2095 with ongoing annual revenue increase of $1.1B in current dollars.

1. **Reduction in federal revenue due to increased health insurance deductions and reduced taxable income.** According to an analysis by Avalere, the proposed legislation will increase the use of fertility treatments among those with ERISA health plans and shift much of the cost of treatment from those without fertility coverage to insured members generally. Their analysis indicates that annual deductions, related to health insurance and medical expenses, will increase by $1.6B in current dollars, equal to just over $10 for each of ERISA's 150 million plan members.

   The modest nature of this per member shift stems from the following: not everyone is covered under the proposed legislation, many already have fertility coverage and not all who need IVF elect to get it.

   Avalere's analysis indicates that the legislation (1) will increase ERISA health insurance premiums by about $.63 per month and (2) reduce federal revenue by about $155.5 million annually.

2. **Increase in federal revenue due to increased fertility business revenue and increased taxable income.** Based on Avalere's analysis, and their assumption about the downward impact that expanded insurance coverage would have on price, the data suggests that the legislation will cause taxable income to rise by $290.8 million annually in current dollars. Assuming owners pay federal tax at the 35% rate, this will increase federal revenue by $101.8 million annually in current dollars.

   Note, revenue derived from increased owner taxable income may be more "dynamic" than the cost assessment in item 1 above but is just as real. Increased spending on a tax deductible expense has the duel effect of reducing tax payments from those who pay it and increasing tax payments from those who receive it.

3. **Increase in federal revenue due to increased spending to raise the incremental babies born.** Based on Avalere's estimate of the proposed legislation's impact on fertility treatment along with current treatment efficacy per SART, the legislation will result in approximately 6,000 additional, wanted American babies born per year.

   According to the USDA, consumer spending per child is $310,605 (adjusted for inflation) and according to data from the Brookings Institution and US Bureau of Labor Statistics, federal tax revenue is approximately 11.8% of consumer spending (17.4% of GDP per Brookings x 68%

personal spending proportion of GDP per BLS). This indicates that federal revenue increases by $36,750 for every baby born ($310,605 x 11.8%).

6,000 additional babies born x $36,750 incremental federal tax revenue per child (derived from increased spending on children) will increase federal revenue by $220.5 million annually in current dollars, starting at $13.0 million in year 1 and building to $220.5 million in year 17 as the first set of babies reach the age of 18.

Note, revenue derived from increased spending on children may also be more "dynamic" than the cost assessment in item 1 above but is just as real. Having additional children is an immediate and growing boost to the U.S. economy and, in turn, to federal revenue.

4. **Increase in federal revenue due to increased individual income tax paid in future years.** As stated above, based on Avalere's estimate of the proposed legislation's impact on fertility treatment along with current treatment efficacy per SART, the legislation will result in approximately 6,000 additional, wanted American babies born per year. As these children enter the workforce they will pay increasingly larger amounts in individual income taxes.

   According to a 2011 study by Georgetown's Center for Education in the Workforce, the average American will earn $1.7 million over their lifetime or $2.5 million in current dollars, and according to the Bureau of Labor Statistics will pay 10%[1] in federal income tax, or $250,000. Adjusted for the delay until additional children reach the ages of 18-24 and begin to work, the current value of their future tax payments will be $150,000 per child born.

   6,000 additional babies born x $150,000 incremental federal tax revenue per child (derived from their future income) will increase federal revenue by the equivalent of $900.0 million annually in current dollars, starting at $20.0 million in year 21 and building to $900.0 million in year 65 as the first set of babies reach the retirement age of 65.

   Note, revenue derived from children's future income may also be more "dynamic" than the cost assessment in item 1 above but is just as real. Additional children turn into additional, productive citizens who contribute to the U.S. economy and increase the amount of taxes paid.

   [1]$2.2T individual federal tax paid on $21.8T personal income in 2022.

Fiscal Impact by Source and Year in Future Dollars (Millions) - Assuming CBO 2.3% CPI

	From Medical Deductions	From Business Income	From Spend on Children	Future Taxes Paid	Net Impact
2026	(160)	107			(53)
2027	(190)	109	14		(67)
2028	(170)	112	28		(30)
2029	(160)	114	44		(2)
2030	(150)	117	60		27
2031	(140)	120	76		56

	From Medical Deductions	From Business Income	From Spend on Children	Future Taxes Paid	Net Fiscal Impact
2032	(140)	122	94		76
2033	(140)	125	112		97
2034	(150)	128	131		109
2035	(153)	131	150		128
2036	(157)	134	171		148
2037	(161)	137	192		169
2038	(164)	140	214		190
2039	(168)	143	238		213
2040	(172)	147	262		237
2041	(176)	150	287		261
2042	(180)	154	313		287
2043	(184)	157	340		313
2044	(188)	161	348		321
2045	(193)	164	356		328
2046	(197)	168	364		336
2047	(202)	172	373		343
2048	(206)	176	381	35	386
2049	(211)	180	390	71	430
2050	(216)	184	399	109	476
2051	(221)	188	408	148	524
2052	(226)	193	418	189	574
2053	(231)	197	427	232	626
2054	(236)	202	437	277	680
2055	(242)	206	447	324	736
2056	(247)	211	457	373	795
2057	(253)	216	468	424	855
2058	(259)	221	479	478	918
2059	(265)	226	490	533	984
2060	(271)	231	501	591	1052
2061	(277)	237	513	651	1123
2062	(284)	242	524	713	1196
2063	(290)	248	536	778	1272
2064	(297)	253	549	846	1351
2065	(304)	259	561	916	1433
2066	(311)	265	574	989	1518
2067	(318)	271	587	1066	1606
2068	(325)	277	601	1145	1698
2069	(332)	284	615	1227	1793

	From Medical Deductions	From Business Income	From Spend on Children	Future Taxes Paid	Net Fiscal Impact
2070	(340)	290	629	1312	1891
2071	(348)	297	643	1400	1993
2072	(356)	304	658	1492	2098
2073	(364)	311	673	1588	2208
2074	(372)	318	689	1687	2321
2075	(381)	325	705	1789	2438
2076	(390)	333	721	1896	2560
2077	(399)	340	737	2006	2685
2078	(408)	348	754	2121	2816
2079	(417)	356	772	2240	2950
2080	(427)	364	790	2363	3090
2081	(437)	373	808	2490	3234
2082	(447)	381	826	2623	3383
2083	(457)	390	845	2760	3538
2084	(468)	399	865	2901	3698
2085	(478)	408	885	3048	3863
2086	(489)	418	905	3201	4034
2087	(501)	427	926	3358	4211
2088	(512)	437	947	3521	4393
2089	(524)	447	969	3690	4582
2090	(536)	457	991	3865	4778
2091	(548)	468	1014	4046	4979
2092	(561)	479	1037	4233	5188
2093	(574)	490	1061	4330	5307
2094	(587)	501	1086	4430	5429
2095	(600)	513	1110	4532	5554
70 Year Total					**$119B**
70 Year Average					**$1.7B**