A Report to the Committee on Health Coverage, Insurance, and Financial Services 131st Maine Legislature

Concerning LD 1539:

An Act To Provide Access to Fertility Care

Prepared by the Maine Bureau of Insurance

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Procedural History

L.D. 1539, "An Act To Provide Access to Fertility Care," was enacted as PL 2021, c. 692.[1] The law requires carriers offering health plans in this State to provide coverage for fertility diagnostic care, for fertility treatment if the enrollee is a fertility patient, and for fertility preservation services. The requirements apply to individual and group health plans issued or renewed on or after January 1, 2024.

The law permits a health plan that provides coverage for the required fertility services to include reasonable limitations subject to certain conditions and in accordance with adopted regulations of the Superintendent of Insurance. The law authorizes the Superintendent of Insurance to adopt routine technical rules to implement the provisions of the law including, without limitation, cost-sharing, benefit design, and clinical guidelines. In adopting rules, the Superintendent must consider the clinical guidelines developed by the American Society for Reproductive Medicine.

The law also requires the Superintendent of Insurance to consult with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), to evaluate whether fertility benefits may be part of the essential health benefit package that is required under all health insurance plans in the State or whether CMS would determine that the transfer of costs defrayed by the state to CMS pursuant to 42 U.S.C. § 18031(d)(3)(B) would be required. The Bureau of Insurance (Bureau) is to report the outcome of that consultation to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters.

The Addition of Fertility Coverage Will Require Defrayal

The federal Affordable Care Act (ACA) requires certain health plans in the individual and small group markets to cover essential health benefits (EHBs).[2] States may require plans to offer health insurance benefits that are not essential health benefits. These are considered additional required benefits or non-EHB benefits.[3] If a state enacts benefit mandates after December 31, 2011, the ACA requires the state to defray the cost of those benefits for individual plans sold on the exchange. Although federal guidance is unclear on this point, it is our analysis that the defrayal requirement does not apply to Maine's small group and large group plans. The requirement also does not apply to expanded coverage under an existing benefit mandate. Each qualified health plan (QHP) issuer must quantify the cost attributable to each additional required benefit based on an actuarial analysis. Using this information, the

[1] 24-A M.R.S. § 4320-U (PL 2021, c. 692 is attached as Exhibit A).
[2] EHBs must come from ten categories, including ambulatory patient services, emergency services, hospitalization, maternity/newborn care, mental health/substance use disorder/behavioral health, prescriptions, rehabilitative and habilitative services, preventive/wellness/chronic disease, and pediatric (including oral/vision) care.
[3] 42 U.S.C. § 1311(d)(3) and 45 C.F.R. § 155.170.

state must make the payment either directly to the enrollee who has received the benefit or to the carrier that has paid the benefit.

Recent guidance from CMS is consistent regarding the requirement that defrayal payments are made to either individual enrollees or to issuers. In its draft 2024 *Notice of Benefit and Payment Parameters*, published December 14, 2022, CMS commented that Section 1311(d)(3)(B) of the ACA permits a state, at its option, to require QHPs to cover benefits in addition to EHBs. This section also requires a state to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional State-required benefits.

The Health Plan Improvement Act defines Maine's EHBs at 24-A M.R.S. § 4320-D(2). The benefits include, among others, chronic disease management. Although infertility is considered a chronic condition, it does not come within the scope of Maine's essential health benefits. The word "fertility" did not appear anywhere in Title 24-A, the Maine Insurance Code, until 24-A M.R.S. § 4320-U became law in 2022. And Bureau Bulletin 206, *Definitions Related to Diagnosis and Treatment of Infertility*, states that Maine law does not require coverage for the diagnosis and treatment of infertility. Although this bulletin was issued in 1992, this interpretation was in effect when Maine's benchmark plan was established.

Bureau staff discussed the fertility mandate and defrayal during the summer of 2022 with CMS staff. CMS said that the mandate as enacted likely would require a defrayal because it is a new mandate and does not expand any current requirement to provide the benefit. It is the state's responsibility to identify which benefits require defrayal and to make those determinations using the framework finalized at 45 C.F.R. § 155.170, cited in footnote 3 above. This provision specifies that benefit mandates enacted on or before December 31, 2011, may be considered EHBs, whereas benefit mandates enacted since then, other than to comply with federal requirements, are in addition to EHBs and must be defrayed by the state even if the text of a state law requiring the new benefit mandate says otherwise.

Although the fertility mandate does not take effect until January 1, 2024, Maine's health carriers will need to start preparing their plan year 2024 rate filings early in 2023, and file them with the Bureau in May or June 2023. The Bureau will review them for adjustments and file the final rates with CMS in August 2023. The cost of adding fertility treatment coverage will be noted as a non-EHB benefit and not covered by premium tax credit subsidies or pass-through funds. Insured individuals will pay the extra premium, not the carrier, if the cost is not defrayed as required.

In accordance with 45 CFR §155.170, the Commonwealth of Massachusetts is paying to offset the cost of certain mandated benefits not included in the EHB benchmark plan through its marketplace, the Massachusetts Insurance Connector. After collecting and validating member information, the Connector funnels to the insurers funding that it receives from the state budget. Reimbursement for state mandated benefits is available for QHPs sold in the

Massachusetts merged non-group and small group market irrespective of whether those products are sold "on Exchange" (i.e., through the Health Connector) or "off Exchange" (i.e., sold directly by the carrier or through an alternative distribution channel).

Utah also makes defrayal payments for their mandated autism spectrum disorder benefits for exchange plans. Utah determined that health benefit plans offering the state-required benefit exclusively off-exchange are not eligible for a defrayal payment. The total defrayal payments are based on an aggregate of the data received from their carriers. Carriers must exclude the expected defrayal payment from the premium rates submitted.

The Process for Selecting a New Benchmark Plan

Regulations adopted under the Patient Protection and Affordable Care Act allow states to select modified EHB plans for plan years beginning on and after January 1, 2020 if certain conditions are met. This process would require repealing the fertility mandate in 24-A M.R.S. § 4320-S and then amending 24-A M.R.S. § 4320-D, Comprehensive Health Coverage, to include fertility treatment. Revisions of the state benchmark selections must pass two tests. First, Federal statute requires that the scope of benefits be equal to those in a "typical" employer plan. Second, the benchmark plan cannot "exceed the generosity" of either the benchmark plan for plan year 2017 or any of the 10 benchmark plan options the state had available for 2017. Considerations include:

- Plan generosity: To avoid defrayal, the new set of benefits must be no more generous than the current essential health benefits. This means that some benefits in the other nine categories would have to be reduced.
- Timing: The deadline for seeking CMS approval of new essential health benefits for plan year 2024 was May 2022. The deadline for plan year 2025 is May 2023.

The U.S. Department of Health & Human Services (HHS) approved new essential health benefit (EHB) benchmark plans for Michigan, New Mexico, Oregon, Colorado and Vermont bringing to seven (with Illinois and South Dakota) the number of states that have revised their benchmarks in recent years. These states added benefits without triggering the ACA provision requiring states to defray any additional premium costs associated with new mandated benefits.

Illinois, Michigan, New Mexico, and Oregon used the new process for updating the EHB benchmark plan to enhance coverage of treatments for substance use disorders (SUDs) and/or to encourage the use of non-opioid pain treatments. South Dakota expanded coverage of treatments for Autism Spectrum Disorder (ASD), while New Mexico's analysis led the state to end coverage limits on prosthetics, expand coverage of testing for heart disease, and increase eligibility for weight loss treatment.

Maine's current benchmark plan is the Anthem Health Plans of Maine (Anthem BCBS) – Blue Choice, $2,500 Deductible plan. CMS posts information about benefits covered by states' benchmark plans and can be found at Essential Health Benefits Benchmark Plans.

To achieve federal approval of their new state benchmark plan, each state was required to provide an actuarial analysis demonstrating that its new benchmark plan is at least equal in scope to the typical employer plan and does not exceed the generosity of the most generous plan among the comparison set of 10 benchmark plan options for 2017. Actuaries may determine that the changes to the benchmark plan would not have a "material" impact on the premium for approval. It is likely that Maine's fertility benefit would have a material impact given the expected premium impact of the additional coverage.

Conclusion

The Bureau's analysis is that the fertility mandate is a new benefit requiring defrayal. The Bureau would not recommend taking the risk that defrayal will never be required, as CMS could choose to enforce this in the future or carriers could request reimbursement from the State to keep premiums lower. If the Legislature does decide to proceed with this added benefit without adjusting other benefits to avoid defrayal, the Bureau would recommend that the Legislature budget for the appropriate defrayal. If the Legislature does not want to budget for the defrayal, it could repeal this mandate entirely, or repeal it for small group and individual plans, leaving it in place for large group plans.

If the Legislature considers redesigning the state EHB benchmark plan, the Legislature will need to identify benefits currently in the EHB benchmark plan to trim or eliminate in order to meet the generosity provision. Those potential benefit reductions would be evaluated for their cost savings compared to adding fertility coverage. A contracted actuarial firm could assist in making the cost comparison analysis once the appropriate benefits have been identified. It may be difficult to find benefits to replace with enough premium impact to add fertility coverage without a defrayal.

Links

L.D. 1539 An Act to Provide Access to Fertility Care

Updating the Essential Health Benefit Benchmark Plan: An Unexpected Path to Fill Coverage Gaps? September 11, 2020, Sabrina Corlette, Georgetown Center on Health Insurance Reforms and Joel Ario, Manatt Health

Review and Evaluation of L.D. 1539, An Act to Provide Access to Fertility Care LD 922, An Act to Help Cancer Patients with Fertility Preservation, January 2022, Maine Bureau of Insurance

Bureau of Insurance, Bulletin 206, *Definitions related to diagnosis and treatment of infertility* (December 21, 1992)