Department of Legislative Services

Maryland General Assembly
2016 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 52 (Delegate Wivell)
Health and Government Operations

Health Insurance - In Vitro Fertilization, Pregnancy, and Childbirth Services - Surrogate Benefits

This bill prohibits insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) that provide pregnancy-related benefits from excluding benefits for outpatient expenses arising from in vitro fertilization (IVF) procedures performed on a surrogate of a policyholder or subscriber or the dependent spouse of a policyholder or subscriber. The bill also requires carriers that provide benefits for pregnancy and childbirth to provide those benefits to a surrogate of a policyholder or subscriber or the dependent spouse of a policyholder or subscriber.

The bill takes effect January 1, 2017, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.

Fiscal Summary

State Effect: State Employee and Retiree Health and Welfare Benefits Program (State plan) expenditures increase by $155,700 (59% general funds, 30% special funds, 11% federal funds) in FY 2017 due to increased medical claims. Future years reflect annualization and increases in utilization and inflation. Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2017. Review of filings can likely be handled with existing MIA resources.

(in dollars)	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
SF Revenue	-	$0	$0	$0	$0
GF Expenditure	$91,900	$198,500	$214,400	$231,500	$250,000
SF Expenditure	$46,700	$100,900	$109,000	$117,700	$127,100
FF Expenditure	$17,100	$37,000	$40,000	$43,200	$46,600
Net Effect	($155,700)	($336,400)	($363,300)	($392,400)	($423,800)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Health care expenditures for local governments that provide fully insured medical benefits may increase to the extent IVF, pregnancy, and childbirth benefits for surrogates are utilized.

Small Business Effect: Minimal. Health care expenditures for small businesses may increase to provide pregnancy and childbirth benefits to surrogates. IVF benefits are not required in the small group market.

Analysis

Bill Summary:

IVF Coverage of Surrogates: To qualify for IVF coverage of a surrogate, the policyholder or subscriber or a covered dependent of the policyholder or subscriber for whom the patient is a surrogate must have a history of involuntary infertility or infertility associated with specified medical conditions and have been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy or contract.

Pregnancy and Childbirth Benefits for Surrogates: Pregnancy and childbirth benefits must be provided to the same extent that the entity provides the benefits to the policyholder or subscriber or the covered dependent of a policyholder or subscriber.

A policy or contract issued or delivered by a carrier that is required to provide pregnancy and childbirth benefits to a surrogate and that is subject to the essential health benefits requirement under the federal Patient Protection and Affordable Care Act (ACA) must provide pregnancy and childbirth benefits to surrogates under the essential health benefit required for pregnancy, maternity, and newborn care.

Current Law:

Mandated Health Insurance Benefits: Under Maryland law, there are 49 mandated health insurance benefits that certain carriers must provide to their enrollees. The federal ACA requires nongrandfathered health plans to cover 10 essential health benefits, which include maternity and newborn care.

IVF Coverage: Health insurance carriers that provide pregnancy-related benefits are required to cover outpatient expenses arising from IVF performed on a policyholder or subscriber or the dependent spouse of the policyholder or subscriber.

To qualify for IVF benefits, the patient and the patient's spouse must have a history of involuntary infertility of at least two years' duration or infertility associated with endometriosis, diethylstilbestrol exposure, blockage or removal of one or both fallopian tubes, or abnormal male factors. The patient must have been unable to attain a successful pregnancy through a less costly infertility treatment available under the policy or contract, and IVF must be performed at specified medical facilities. In addition, for a patient whose spouse is of the opposite sex, the patient's eggs must be fertilized with the spouse's sperm.

IVF benefits may be limited to three IVF attempts per live birth, not to exceed a maximum lifetime benefit of $100,000. Carriers are not responsible for any costs incurred by a policyholder or subscriber to obtain donor sperm.

Surrogacy: No statutes govern surrogacy in Maryland and the status of surrogacy contracts is unclear. In *In re Roberto d.B.*, 399 Md. 267 (2007), the Court of Appeals held that the name of a genetically unrelated gestational host of a fetus, with whom the genetic father contracted to carry in-vitro fertilized embryos to term, was not required to be listed on the birth certificate when a child is born as a result. The court also noted that "surrogacy contracts, that is, payment of money for a child, are illegal in Maryland" under § 3-603 of the Criminal Law Article, which prohibits the sale of a minor and § 5-3B-32 of the Family Law Article, which prohibits payment of compensation in connection with an adoption.

Background:

Surrogacy: The majority of surrogacy conducted in the United States involves the use of a gestational carrier in which a woman agrees to have a couple's fertilized embryo (or a donated embryo) implanted in her uterus and carry the pregnancy for the intended parents. A gestational carrier has no genetic relationship to the child. According to the American Society for Reproductive Medicine, use of a gestational carrier is indicated for women who lack a uterus, have uterine abnormalities, or have significant medical contraindications to pregnancy. In most cases, the intended parents compensate the gestational carrier for her services and pay the expenses of the pregnancy. A gestational carrier may have her own medical insurance or the intended parents may purchase a surrogacy pregnancy policy for her. Some insurance policies exclude surrogacy (including the pregnancy and delivery expenses of the gestational carrier).

IVF and Surrogacy Coverage in Other States: Eleven states mandate some coverage of IVF. In New Jersey, coverage of IVF specifically includes IVF where the embryo is transferred to a gestational carrier or surrogate. However, payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract may be excluded from coverage. Under Illinois law, services rendered to a surrogate are not covered; however, costs for procedures to obtain eggs, sperm, or embryos from a covered individual are covered if the individual chooses

to use a surrogate and if the individual has not exhausted the maximum number of egg retrievals (six per lifetime). In Massachusetts, an insurer required to cover infertility benefits may not be required to cover surrogacy.

State Expenditures: According to the Department of Budget and Management, State plan expenditures increase by an estimated $155,743 in fiscal 2017, which reflects expenditures for the second half of fiscal 2017 only (benefits under the State plan are administered on a calendar year basis). The State plan currently covers IVF. Expenditures reflect increased utilization of IVF and medical claims associated with prenatal care and childbirth expenses for surrogates, estimated to be 0.036% of annual State plan spending. The Department of Legislative Services notes that the number of gestational surrogates used both nationally and in Maryland is unknown; therefore, actual expenditures may vary.

Future year State plan expenditures reflect annualization and projected increases in direct cost and utilization of 8% per year. State plan expenditures are split 59% general funds, 30% special funds, and 11% federal funds.

Additional Comments: MIA requested guidance from the federal Center for Consumer Information and Insurance Oversight as to whether the bill's requirements regarding pregnancy and childbirth benefits for surrogates constitute a new health insurance mandate. According to MIA, if the federal government determines that it is a new mandate, the State may need to defray the cost of the benefits. The Department of Legislative Services notes that maternity and newborn care is already an essential health benefit under ACA.

The federal Employee Retirement Income Security Act preempts states' ability to require private employers to offer insurance coverage and exempts the coverage offered by self-insured entities from state insurance regulation. Thus, insured health benefit plans (those purchased directly from a carrier) are subject to Maryland's mandated benefits law, while other (self-insured) employment-based plans are not.

In 2015, a total of 2,899,428 lives (younger than age 65) were covered through commercial health benefit plans in Maryland. However, only 36% were covered under insured health benefit plans subject to State regulation. The remaining 64% were covered through group self-insured plans or the Federal Employees Health Benefit Plan, which are not regulated by MIA and are, for the most part, not subject to Maryland law.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): American Society for Reproductive Medicine, Department of Budget and Management, Department of Health and Mental Hygiene, Health Benefit Exchange, Maryland Insurance Administration, Department of Legislative Services

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