HB 908

Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 908 (Delegate Pena-Melnyk, *et al.*)
Health and Government Operations Finance

Health Insurance - Coverage of Fertility Preservation Procedures for Iatrogenic Infertility

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This bill generally requires insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) to provide coverage for "standard fertility preservation procedures" that are (1) performed on a policyholder or subscriber or on the covered dependent of a policyholder or subscriber and (2) medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause "iatrogenic infertility." However, a carrier may not be required to provide this coverage to a religious organization that requests and receives an exclusion from specified in vitro fertilization (IVF) coverage. **The bill takes effect January 1, 2019, 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: Minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) in FY 2019 from the $125 rate and form filing fee. Review of filings can likely be handled with existing MIA resources. Expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State Plan) increase by an indeterminate amount beginning in FY 2019, as discussed below.

Local Effect: Health insurance costs increase for local governments that purchase fully insured plans to the extent coverage is not already included. No effect on revenues.

Small Business Effect: Potential minimal. The bill generally does not apply to health insurance policies sold to small businesses, as discussed below.

Analysis

Bill Summary: "Standard fertility preservation procedures" means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine (ASRM), the American College of Obstetricians and Gynecologists (ACOG), or the American Society of Clinical Oncology (ASCO). "Standard fertility preservation procedures" include sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation, but they *do not* include the storage of sperm or oocytes.

"Iatrogenic infertility" means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes. "Medical treatment that may directly or indirectly cause iatrogenic infertility" means medical treatment with a likely side effect of infertility as established by ASRM, ACOG, or ASCO.

Current Law: Under Maryland law, there are 49 mandated health insurance benefits that certain carriers must provide to their enrollees, including coverage for IVF. 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 unless (1) the spouse is unable to produce and deliver functional sperm and (2) the inability does not result from a vasectomy or other method of voluntary sterilization. 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.

The federal Patient Protection and Affordable Care Act (ACA) requires nongrandfathered health plans to cover 10 essential health benefits (EHBs), which include items and services in the following categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including dental and vision care.

Under § 31-116 of the Insurance Article, EHBs must be included in the State benchmark plan and, *not withstanding any other benefits mandated by State law*, must be the benefits required in (1) all individual health benefit plans and health benefit plans offered to small employers (except for grandfathered health plans) offered outside the Maryland Health Benefit Exchange (MHBE) and (2) all qualified health plans offered in MHBE.

Background: The National Cancer Institute reports that about 70,000 adolescents and young adults (ages 15 to 39) are diagnosed with cancer annually. According to ASRM, successful cancer treatment in younger patients often leads to reduced fertility. Chemotherapy is also often used for noncancerous conditions such as autoimmune diseases and hematological diseases. If damage to reproductive organs from treatment is likely, cryopreserving eggs, sperm, or embryos may help to preserve fertility.

In 2017, both Connecticut and Rhode Island enacted legislation related to iatrogenic infertility. Connecticut expanded the state's existing mandate for coverage of infertility by altering the definition of infertility to include all cases in which such treatment is *medically necessary*. Rhode Island expanded the state's infertility mandate to include coverage for standard fertility preservation services when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person. Fertility preservation legislation has also been proposed in California and New York.

A November 2017 study prepared by NovaRest, Inc. for the Maryland Health Care Commission evaluated the potential impact of mandating coverage for fertility preservation for iatrogenic infertility. The report projected that the number of expected cases in Maryland where treatment *may* result in iatrogenic infertility for individuals ages 10 to 44 are about 1,327 females and 731 males. The report noted that fertility preservation typically costs about $500 for sperm collection, $12,500 per cycle for oocyte collection, and $13,000 per cycle for embryo collection. NovaRest estimated that the percentage impact of the mandate on health insurance premiums would range from 0.4% to 0.6% or $0.14 to $0.24 per member per month (PMPM) across the three insurance markets, depending on the number of patients who may pursue fertility preservation (scenarios of 25% or 33% were used).

CareFirst BlueCross BlueShield indicates that coverage of fertility preservation services is a contract exclusion for its fully insured products; therefore, only sparse utilization data is available. CareFirst notes that a conservative actuarial estimate of the cost of this mandate in Maryland is $0.23 PMPM.

State Expenditures: The State Plan is largely self-insured for its medical contracts and, as such, with the exception of the one fully insured integrated health model medical plan (Kaiser), is not subject to this mandate. However, the State Plan generally provides coverage for mandated health insurance benefits. The Department of Budget and

Management (DBM) advises that fertility preservation procedures *are not* covered under the State Plan, including Kaiser. Thus, the bill increases premium costs for the Kaiser plan, which are paid by both the State and participants in the Kaiser plan. DBM advises that the amount of any such premium increase is indeterminate.

Small Business Effect: Health insurance mandates generally do not apply to policies sold to small businesses. However, if the Insurance Commissioner elects to include the mandate in the State benchmark plan, the mandate would apply to policies sold to small businesses through MHBE.

Additional Comments: According to MIA, the bill applies to the large group market and grandfathered individual policies; it does not apply to nongrandfathered individual policies or to small group policies. Under the ACA, each state must pay, for every health plan purchased through MHBE, the additional premium associated with any state-mandated benefit beyond EHBs. As such, if the Insurance Commissioner elects to include the mandate in the State benchmark plan, the State would be required to defray the cost of the benefits to the extent it applies to the individual and small group market ACA plans.

Additional Information

Prior Introductions: SB 918 of 2017, a similar bill, received a hearing in the Senate Finance Committee, but no further action was taken. Its cross file, HB 876, received a hearing in the House Health and Government Operations Committee and was subsequently withdrawn.

Cross File: SB 271 (Senator Mathias, *et al.*) - Finance.

Information Source(s): American Society for Reproductive Medicine; National Cancer Institute; Department of Budget and Management; Maryland Department of Health; Maryland Insurance Administration; CareFirst Blue Cross/Blue Shield; Department of Legislative Services

Fiscal Note History: First Reader - February 5, 2018
mm/ljm Third Reader - March 27, 2018
Revised - Amendment(s) - March 27, 2018

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