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By: **Delegate R. Baker**
Introduced and read first time: February 11, 2000
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

**Health Insurance - Benefits for In Vitro Fertilization**

FOR the purpose of altering the circumstances under which certain policies, contracts, and certificates that provide pregnancy-related benefits may not exclude benefits for certain expenses arising from certain in vitro fertilization procedures; prohibiting the Maryland Health Care Commission from excluding certain coverage for certain in vitro fertilization procedures from the Comprehensive Standard Health Benefit Plan under small group market health insurance; providing for the application of this Act; and generally relating to benefits for in vitro fertilization under health insurance.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-810 and 15-1207
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

**Article - Insurance**

15-810.

(a) This section applies to:

(1) each individual hospital or major medical insurance policy of an insurer that:

(i) 1. is delivered or issued for delivery in the State; or

2. covers individuals who reside and work in the State; and

(ii) is written on an expense-incurred basis;

(2) each group or blanket health insurance policy of an insurer that:

(i) 1. is issued or delivered in the State; or

2. covers individuals who reside and work in the State; and

(ii) is written on an expense-incurred basis; and

(3) each individual or group medical or major medical contract or certificate of a nonprofit health service plan that:

(i) is issued or delivered in the State; or

(ii) covers individuals who reside and work in the State.

(b) (1) A policy, contract, or certificate subject to this section that provides pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from in vitro fertilization procedures performed on the policyholder, subscriber, or certificate holder, or dependent spouse of the policyholder, subscriber, or certificate holder.

(2) The benefits under this subsection shall be provided to the same extent as the benefits provided for other pregnancy-related procedures.

(c) Subsection (b) of this section applies if:

(1) the patient is the policyholder, subscriber, or certificate holder, or a covered dependent of the policyholder, subscriber, or certificate holder;

[(2) the patient's oocytes are fertilized with the patient's spouse's sperm;]

[(3)] (2) (i) the patient [and the patient's spouse have] HAS a history of infertility of at least 5 years' duration; or

(ii) the infertility is associated with any of the following medical conditions:

1. endometriosis;

2. exposure in utero to diethylstilbestrol, commonly known as DES; or

3. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy);

[(4)] (3) the patient has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy, contract, or certificate; and

[(5)] (4) the in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

15-1207.

(a) In accordance with Title 19, Subtitle 1 of the Health - General Article, the Commission shall adopt regulations that specify:

(1) the Comprehensive Standard Health Benefit Plan to apply under this subtitle; and

(2) a modified health benefit plan for medical savings accounts that qualify under the federal Health Insurance Portability and Accountability Act of 1996, including:

(i) a waiver of deductibles as permitted under federal law;

(ii) minimum funding standards for medical savings accounts; and

(iii) authorization for offering the modified plan only by those persons who offer the Comprehensive Standard Health Benefit Plan adopted in accordance with item (1) of this subsection.

(b) The Commission shall require that the minimum benefits allowed to be offered in the Standard Plan:

(1) by a health maintenance organization, shall include at least the actuarial equivalent of the minimum benefits required to be offered by a federally qualified health maintenance organization; and

(2) by an insurer or nonprofit health service plan on an expense-incurred basis, shall be actuarially equivalent to at least the minimum benefits required to be offered under item (1) of this subsection.

(c) (1) Subject to paragraph (2) of this subsection, the Commission shall exclude or limit benefits or adjust cost-sharing arrangements in the Standard Plan if the average rate for the Standard Plan exceeds 12% of the average annual wage in the State.

(2) The Commission annually shall determine the average rate for the Standard Plan by using the average rate submitted by each carrier that offers the Standard Plan.

(d) In establishing benefits, the Commission shall judge preventive services, medical treatments, procedures, and related health services based on:

(1) their effectiveness in improving the health status of individuals;

(2) their impact on maintaining and improving health and on reducing the unnecessary consumption of health care services; and

(3) their impact on the affordability of health care coverage.

(e) (1) [The] EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, THE Commission may exclude:

[(1)] (I) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health - General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

[(2)] (II) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(2) THE COMMISSION MAY NOT EXCLUDE COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES AS REQUIRED UNDER § 15-810 OF THIS TITLE.

(f) The Standard Plan shall include uniform deductibles and cost-sharing associated with its benefits, as determined by the Commission.

(g) In establishing cost-sharing as part of the Standard Plan, the Commission shall:

(1) include cost-sharing and other incentives to help prevent consumers from seeking unnecessary services;

(2) balance the effect of cost-sharing in reducing premiums and in affecting utilization of appropriate services; and

(3) limit the total cost-sharing that may be incurred by an individual in a year.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2000. Any policy, contract, or health benefit plan in effect before October 1, 2000, shall comply with the provisions of this Act no later than October 1, 2001.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2000.