HOUSE BILL 41

C3 0lr0640

(PRE–FILED)

By: **Delegate Kach**
Requested: September 24, 2009
Introduced and read first time: January 13, 2010
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Copayments for In Vitro Fertilization Procedures and Surgical Treatment of Morbid Obesity

FOR the purpose of authorizing certain insurers, nonprofit health service plans, and health maintenance organizations to require, notwithstanding certain provisions of law, a copayment not to exceed a certain amount for certain in vitro fertilization procedures and certain surgical treatment of morbid obesity under certain circumstances; and generally relating to health insurance copayments for in vitro fertilization procedures and surgical treatment of morbid obesity.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–810 and 15–839
Annotated Code of Maryland
(2006 Replacement Volume and 2009 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) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies that are issued or delivered in the State; and

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) (1) An entity 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 or subscriber or dependent spouse of the policyholder or subscriber.

(2) The benefits under this subsection shall be provided:

(i) for insurers and nonprofit health service plans, to the same extent as the benefits provided for other pregnancy–related procedures; and

(ii) for health maintenance organizations, to the same extent as the benefits provided for other infertility services.

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

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

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

(3) (i) the patient and the patient's spouse have a history of infertility of at least 2 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;

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

4. abnormal male factors, including oligospermia, contributing to the infertility;

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

(5) 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.

(d) An entity subject to this section may limit coverage of the benefits required under this section to three in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.

(e) Notwithstanding any other provision of this section, if the coverage required under this section conflicts with the bona fide religious beliefs and practices of a religious organization, on request of the religious organization, an entity subject to this section shall exclude the coverage otherwise required under this section in a policy or contract with the religious organization.

(F) (1) NOTWITHSTANDING SUBSECTION (B)(2) OF THIS SECTION, AN ENTITY SUBJECT TO THIS SECTION MAY REQUIRE A COPAYMENT FOR IN VITRO FERTILIZATION PROCEDURES THAT EXCEEDS ANY COPAYMENT OR COINSURANCE REQUIRED FOR OTHER PREGNANCY–RELATED PROCEDURES OR INFERTILITY SERVICES.

(2) THE COPAYMENT AUTHORIZED UNDER PARAGRAPH (1) OF THIS SUBSECTION:

(I) MAY NOT EXCEED THE GREATER OF:

1. $1,000 PER LIVE BIRTH; OR

2. THE COPAYMENT OR COINSURANCE REQUIRED FOR OTHER PREGNANCY–RELATED PROCEDURES OR INFERTILITY SERVICES;

(II) MAY BE REQUIRED EVEN IF A COPAYMENT OR COINSURANCE IS NOT REQUIRED FOR OTHER PREGNANCY–RELATED PROCEDURES OR INFERTILITY SERVICES; AND

(III) MAY BE REQUIRED EVEN IF THE ANNUAL OUT–OF–POCKET LIMIT ON COST–SHARING UNDER THE POLICY OR CONTRACT HAS BEEN REACHED.

15–839.

(a) (1) In this section the following words have the meanings indicated.

(2) "Body mass index" means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

(3) "Morbid obesity" means a body mass index that is:

(i) greater than 40 kilograms per meter squared; or

(ii) equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State;

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; and

(3) managed care organizations, as defined in § 15–101 of the Health – General Article.

(c) An entity subject to this section shall provide coverage for the surgical treatment of morbid obesity that is:

(1) recognized by the National Institutes of Health as effective for the long–term reversal of morbid obesity; and

(2) consistent with guidelines approved by the National Institutes of Health.

(d) An entity subject to this section shall provide the benefits required under this section to the same extent as for other medically necessary surgical procedures under the enrollee's or insured's contract or policy with the entity.

(E) (1) NOTWITHSTANDING SUBSECTION (D) OF THIS SECTION, AN ENTITY SUBJECT TO THIS SECTION MAY REQUIRE A COPAYMENT FOR THE SURGICAL TREATMENT OF MORBID OBESITY THAT EXCEEDS ANY COPAYMENT OR COINSURANCE REQUIRED FOR OTHER MEDICALLY NECESSARY SURGICAL PROCEDURES UNDER THE ENROLLEE'S OR INSURED'S CONTRACT OR POLICY WITH THE ENTITY.

(2) THE COPAYMENT AUTHORIZED UNDER PARAGRAPH (1) OF THIS SUBSECTION:

(I) MAY NOT EXCEED THE GREATER OF:

1. $1,000; OR

2. THE COPAYMENT OR COINSURANCE REQUIRED FOR OTHER MEDICALLY NECESSARY SURGICAL PROCEDURES UNDER THE ENROLLEE'S OR INSURED'S CONTRACT OR POLICY WITH THE ENTITY;

(II) MAY BE REQUIRED EVEN IF A COPAYMENT OR COINSURANCE IS NOT REQUIRED FOR OTHER MEDICALLY NECESSARY SURGICAL PROCEDURES UNDER THE ENROLLEE'S OR INSURED'S CONTRACT OR POLICY WITH THE ENTITY; AND

(III) MAY BE REQUIRED EVEN IF THE ANNUAL OUT–OF–POCKET LIMIT ON COST–SHARING UNDER THE POLICY OR CONTRACT HAS BEEN REACHED.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2010.