Department of Legislative Services

Maryland General Assembly
2010 Session

FISCAL AND POLICY NOTE

House Bill 41 (Delegate Kach)
Health and Government Operations

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

This bill authorizes carriers that provide in vitro fertilization (IVF) and/or surgical treatment of morbid obesity benefits to charge a copayment or coinsurance that exceeds any copayment or coinsurance required for other pregnancy-related procedures, infertility services, or other medically necessary surgical procedures. Specified limits apply in both cases.

Fiscal Summary

State Effect: Expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State plan) decrease by an estimated $219,750 in FY 2011 due to increased enrollee cost sharing for IVF and morbid obesity surgery. Future years reflect annualization and remain constant as the cost sharing is effectively capped at $1,000 per incident. Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2011. Review of filings can be handled with existing budgeted MIA resources.

(in dollars)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
SF Revenue	-	$0	$0	$0	$0
GF Expenditure	($129,700)	($172,900)	($172,900)	($172,900)	($172,900)
SF Expenditure	($65,900)	($87,900)	($87,900)	($87,900)	($87,900)
FF Expenditure	($24,200)	($32,200)	($32,200)	($32,200)	($32,200)
Net Effect	$219,800	$293,000	$293,000	$293,000	$293,000

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

Local Effect: Expenditures decrease for some local governments due to increased enrollee cost sharing.

Small Business Effect: None. The bill does not apply to the small group market.

Analysis

Bill Summary: For IVF services, the copayment authorized may not exceed the greater of $1,000 per live birth or the copayment or coinsurance required for other pregnancy-related procedures or infertility services. Copayment may be required even if (1) a copayment or coinsurance is not required for other pregnancy-related procedures or infertility services; and (2) the annual out-of-pocket limit on cost sharing under the policy or contract has been reached.

The bill's limits on the surgical treatment of morbid obesity are nearly identical, in that the copayment authorized may not exceed the greater of $1,000 or the copayment or coinsurance required for other medically necessary surgical procedures. Copayment may be required even if (1) a copayment or coinsurance is not required for other medically necessary surgical procedures; and (2) the annual out-of-pocket limit on cost sharing under the policy or contract has been reached.

Current Law: Carriers that provide pregnancy-related services may not exclude benefits for all outpatient expenses arising from IVF procedures performed on the policyholder or subscriber or the dependent spouse of the policyholder or subscriber. Benefits must be provided to the same extent as other pregnancy-related procedures for insurers and nonprofit health service plans and other infertility services for health maintenance organizations.

To qualify for IVF benefits, the patient and the patient's spouse must have a history of infertility of at least two years duration or infertility associated with endometriosis, diethylstilbestrol exposure, blockage or removal of one or more fallopian tubes, or abnormal male factors. In addition (1) the patient must be the policyholder or subscriber or the dependent spouse of the policyholder or subscriber; (2) the patient's eggs must be fertilized with the spouse's sperm; (3) the patient must have been unable to attain a successful pregnancy through a less costly infertility treatment available under the policy or contract; and (4) the IVF procedures must be performed at specified medical facilities. IVF benefits may be limited to three IVF attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.

A health insurer, nonprofit health service plan, and health maintenance organization (carrier) must cover surgical treatment for morbid obesity if the treatment is recognized by the National Institutes of Health (NIH) and consistent with NIH guidelines. Benefits must be provided to the same extent as for other medically necessary surgical procedures under the enrollee's or insured's contract.

Morbid obesity is defined as a body mass index (BMI) of greater than 40 kilograms per meter squared, or equal or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Background: The American Society for Reproductive Medicine defines infertility as the inability to achieve a successful pregnancy after 12 months for women younger than age 35. In Maryland, there were 4,062 IVF cycles reported by the federal Centers for Disease Control and Prevention in 2006. The cost per IVF cycle typically ranges from $15,000 to $20,000.

NIH guidelines on surgery for severe obesity specify that surgery may be indicated for patients whose BMI equals or exceeds 40 kg/m^2 if they strongly desire substantial weight loss, because obesity severely impairs the quality of their lives. Less severe obese patients (BMIs between 35 and 39.9 kg/m^2) also may be considered for surgery. This group primarily includes those patients with high-risk comorbid conditions (cardiovascular, sleep apnea, uncontrolled type 2 diabetes) or weight-induced physical problems interfering with performance of daily life activities. NIH indicates that weight loss surgery is an option for carefully selected patients with clinically severe obesity when less invasive methods of weight loss have failed and the patent is at high risk for obesity-associated morbidity or mortality.

Every four years, the Maryland Health Care Commission (MHCC) examines the fiscal impact of mandated health insurance benefits. In 2008, MHCC found that these benefits account for 15.4% of total premium costs for group health insurance. IVF treatment and morbid obesity treatment each account for 0.8% of total premium costs for group health insurance.

Health Insurance Mandates as They Relate to State and Local Governments and the Small Group Market

Employers have two major options when providing health insurance benefits. They can purchase a fully insured plan from an insurance company or they can self-insure by assuming risk and paying all claims for services themselves, usually through a third-party administrator. The federal Employee Retirement Income Security Act (ERISA) preempts states' ability to require private employers to offer insurance coverage and exempts the coverage offered by self-insured entities from state insurance regulation. Therefore, the health insurance requirements under Title 15, Subtitles 4, 7, and 8 of the Insurance Article apply only to fully insured health benefit plans.

Government entities that self-fund their health benefit plans are *not exempt* under ERISA from state regulation and health insurance mandates. In Maryland, these entities have

instead been exempt from these requirements based on the State definition of "insurance business." An insurance business includes the transaction of all matters pertaining to an insurance contract, either before or after it takes effect and all matters arising from an insurance contract or a claim under it. Insurance business *does not* include pooling by public entities for self-insurance of casualty, property, or health risks.

In 2008, the Maryland Association of Counties and the Maryland Association of Boards of Education conducted an informal survey of counties and county school boards about their insurance plans, to which 22 counties and 19 school boards responded. Of the 22 responding counties, 13 were self-insured, 4 were fully insured, and 5 offered both self-insured and fully insured options. Of the 19 responding county school boards, 14 were self-insured, 1 was fully insured, and 4 offered both self-insured and fully insured options. The fully insured plans offered by counties and county school boards are subject to State insurance laws.

Maryland's small group market Comprehensive Standard Health Benefit Plan (CSHBP) is not subject to mandated benefits applicable to the large group market. Rather, MHCC reviews CSHBP on an annual basis and considers making benefit or cost sharing changes at that time. While CSHBP currently covers the surgical treatment of morbid obesity, it does not cover IVF services.

The Department of Budget and Management (DBM) estimates that, in fiscal 2009, State plan costs for IVF totaled $4.69 million and costs for morbid obesity surgery totaled $2.81 million.

State Fiscal Effect: DBM estimates that expenditures for the State plan will decrease by $219,750 in fiscal 2011 due to increased enrollee cost sharing for IVF and morbid obesity surgery. This estimate is based on each enrollee paying $1,000 for each surgery related to morbid obesity and each IVF treatment that resulted in a live birth. Currently, State plan administrators generally do not charge a copay for IVF treatment or surgeries for morbid obesity if an enrollee chooses an in-network provider.

DBM advises that the State plan covered 226 surgeries for morbid obesity and 67 IVF treatments that resulted in a live birth in fiscal 2009. Under the bill, DBM estimates that enrollees will pay $1,000 per incident, decreasing State plan expenditures by an estimated $293,000 per year. This yields approximately $219,750 in savings in fiscal 2011 due to the bill's October 1, 2010 effective date. Future years reflect annualization and remain constant since cost sharing is effectively capped at $1,000 per incident.

State plan expenditures are split 59% general funds, 30% special funds, and 11% federal funds.

Local Fiscal Effect: Local government expenditures (for those that purchase fully insured plans from an insurance company) decrease for some local governments beginning in fiscal 2011 due to increased enrollee cost sharing.

Additional Comments: According to CareFirst BlueCross/BlueShield, the impact to its risk-based business (which does not include State plan costs) would be an annual decrease of $472,800 per year. This estimate is based on a premium decrease of $0.20 per contract per month, from $4.54 to $4.34.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): CareFirst Blue Cross/Blue Shield, Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, American Society for Reproductive Medicine, Department of Legislative Services

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