Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE

House Bill 44 (Delegate Waldstreicher)
Health and Government Operations

Health Insurance - Coverage of In Vitro Fertilization Services

This bill requires an insurer, nonprofit health service plan, or health maintenance organization (carrier) that provides pregnancy-related benefits to cover in vitro fertilization (IVF) services if the patient and the patient's spouse have a history of infertility of at least *one* years' duration rather than at least two years' duration.

The bill applies to all policies and contracts issued, delivered, or renewed in the State on or after October 1, 2012.

Fiscal Summary

State Effect: Potential significant increase in expenditures (all funds) for the State Employee and Retiree Health and Welfare Benefits Program (State plan) beginning in FY 2014. Minimal special fund revenue increase for the Maryland Insurance Administration from the $125 rate and form filing fee in FY 2013. Review of filings can be handled with existing MIA budgeted resources.

Local Effect: To the extent that IVF coverage mandated under the bill exceeds that currently provided by local governments, expenditures may increase for some local governments beginning in FY 2013.

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

Analysis

Current Law: Carriers that provide pregnancy-related services may not exclude benefits for outpatient expenses arising from IVF. 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. IVF is not a covered benefit under the small group market's Comprehensive Standard Health Benefit Plan.

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, the patient must be the policyholder or subscriber or a covered dependent of the policyholder or subscriber; the patient's eggs must be fertilized with the spouse's sperm; the patient must have been unable to attain a successful pregnancy through a less costly infertility treatment available under the policy or contract; and the IVF 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.

Background: According to the American Society for Reproductive Medicine (ASRM), infertility is a disease defined by failure to achieve a successful pregnancy after *12 months* or more for women younger than age 35. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35.

At least some carriers in Maryland calculate infertility by the amount of time a couple has failed to *successfully conceive*. In practical terms, this means that if a woman miscarries, the two-year "infertility clock" starts from the time of her miscarriage and is not calculated by the total length of time that a couple has been trying to conceive. This is a key difference from ASRM's definition, which *does not* restart the 12-month clock if a woman miscarries.

About 7.3 million women and their partners nationally (12% of the reproductive age population) experience infertility. While IVF accounts for less than 5% of all infertility treatments in the United States, it is often the most successful method of achieving pregnancy for infertility related to blocked or absent fallopian tubes or low sperm counts.

In Maryland, there were 4,777 IVF cycles reported by the federal Centers for Disease Control and Prevention in 2009.

Every four years, the Maryland Health Care Commission (MHCC) examines the fiscal impact of mandated health insurance benefits. MHCC's January 2012 report found that the full cost of all 45 mandated benefits accounts for total premium costs of 18.8% for group health insurance, 19.6% for individual policies, and 17.9% for the State plan. IVF treatment accounts for total premium costs of 1.4% for group health insurance, 1.5% for individual policies, and 1.3% for the State plan. The report notes that significantly less

than half of surveyed employers with self-funded health insurance plans (those exempt from the mandate) provide IVF services that comply with the mandate. Many self-funded plans do not view IVF as medically necessary; therefore, the marginal cost of the mandate (the full cost minus the value of the benefit that would be covered in the *absence* of a mandate) is 1.2% to 1.3% of premium – nearly as high as the full cost of the mandate.

Under federal health care reform, beginning January 1, 2014, all health plans offered through the new health benefit exchange marketplaces must include certain "essential health benefits." Under the federal Affordable Care Act, each state must pay, for every health plan purchased through the exchange, the additional premium associated with any state-mandated benefit beyond the essential health benefits. States can choose one of four benchmark plans to meet the requirement for essential health benefits: (1) one of the three largest small group plans in the state by enrollment; (2) one of the three largest state employee health benefit plans by enrollment; (3) one of the three largest federal employee health benefit plans by enrollment; or (4) the largest insured commercial non-Medicaid health maintenance organization operating in the state. Any Maryland mandates that apply to the selected benchmark plan will apply to the essential health benefits package in 2014 and 2015. The U.S. Department of Health and Human Services advised in December 2011 that any new mandate enacted during the 2012 legislative session or beyond, or any benefits that do not apply to the benchmark plan, *will not* apply to the essential health benefits package, and thus the State will be liable for the cost of the additional premiums associated with those benefits. Legislative Services notes that this advice could be subject to change.

State Fiscal Effect: Although not required to follow health insurance mandates, the State plan generally does. Thus, this estimate is based on the assumption that the State plan will follow the bill's requirement.

A December 2009 report prepared by Mercer for MHCC examined the financial impact of altering the State IVF mandate as proposed under this bill. The report acknowledged the difficulty of determining exactly how many additional IVF cycles would result since information is not available regarding the reasons for, and the duration of, infertility for those who receive IVF. Likewise, there are no counts of the additional women who would be eligible for IVF treatments under the revised criteria.

The report compared costs in Maryland, with its two-year waiting period, and Massachusetts, which has a one-year waiting period. The report indicated that IVF utilization is 40% higher in Massachusetts than in Maryland. However, the Massachusetts mandate applies to all insurance markets, whereas the small group market in Maryland is excluded from the mandate. The report also acknowledges that other differences between the two states might account for the large difference in utilization.

The report used a model assuming that utilization would increase by between 10% and 40%. Legislative Services uses this range to illustrate possible increases in State plan expenditures.

These estimates are *for illustrative purposes only.* The Department of Budget and Management (DBM) reports that, in fiscal 2011, 477 women received IVF services under the State plan at a cost of $5.7 million. **Exhibit 1** illustrates the utilization and cost increases that could result under a 10% increase and 40% increase in utilization of IVF services.

Exhibit 1
Annualized Impact of Enhancing IVF Mandate

	Current Mandate	**10% Increase**	**40% Increase**
Number of Women Receiving Services	477	524	667
Total Annual Cost	$5.7 million	$6.27 million	$7.98 million
Increased Cost		**$0.57 million**	**$2.28 million**

Source: Department of Legislative Services

In this example, a 10% increase results in an estimated 47 additional women qualifying for IVF services under the new mandate, at an annualized cost of approximately $0.57 million. If utilization increases by 40%, an estimated 190 additional women qualify under the new mandate, at an annualized cost of $2.28 million. Due to the bill's October 1, 2012 effective date, any potential fiscal impact on the State plan would not occur until the fiscal 2014 plan year.

Legislative Services notes that the estimate does not take into account any additional costs associated with an increase in complicated pregnancies, live births, and multiple births that can result from increased utilization of IVF. Again, estimating an actual utilization increase is extremely difficult and depends on a number of factors that cannot be quantified.

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) may increase for some local governments beginning in fiscal 2013 due to modification of the IVF mandate.

Additional Comments: According to CareFirst BlueCross/BlueShield, if the limit of three IVF attempts per live birth and the $100,000 lifetime maximum benefit for IVF services are maintained, reducing the standard from two years' to one year's duration would have no significant fiscal impact on CareFirst's business.

Additional Information

Prior Introductions: This bill is nearly identical to HB 30 of 2010, which received an unfavorable report from the House Health and Government Operations Committee.

Cross File: None.

Information Source(s): *2009 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports*, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2011; *Annual Mandated Health Insurance Services Evaluation*, Prepared for the Maryland Health Care Commission, December 17, 2009; *Study of Mandated Health Insurance Services: A Comparative Evaluation*, Maryland Health Care Commission, January 1, 2012; American Society of Reproductive Medicine; CareFirst Blue Cross/Blue Shield; Department of Budget and Management; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - January 16, 2012
ncs/mwc

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510