The League of Life and Health Insurers of Maryland

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January 27, 2022

The Honorable Shane Pendergrass
Chair, House Health and Government Operations Committee
Room 241
House Office Building
Annapolis, MD 21401

House Bill 142 - Health Insurance - Coverage of In Vitro Fertilization - Revisions

Dear Chairman Pendergrass,

The League of Life and Health Insurers of Maryland, Inc. respectfully **opposes** House Bill 142 – Health Insurance - Coverage of In Vitro Fertilization – Revisions and urges the committee to give the bill an unfavorable report.

House Bill 142 requires insurers, non-profit health service plans, and health maintenance organizations (collectively known as carriers) to expand the benefits for expenses related to in vitro fertilization (IVF). The bill also prohibits denial of coverage of the benefits because the policyholder or subscriber or dependent spouse is a genetic carrier.

Under the ACA, each state must pay, for every health plan purchased through the Maryland Health Benefit Exchange, the additional premium associated with any state-mandated benefit beyond the federally mandated essential health benefits. This means, should the Commissioner include the mandate in the State bench mark 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.

The League opposes any additional mandated benefits to Maryland's law. Mandated benefits add cost to health insurance policies in our state and limit the ability of insurers to design benefits to best meet the needs of enrollees, this is of particular concern in the case of IVF. Given the potential impact to health insurance costs in the State, Maryland law includes a statutory framework for review and evaluation of proposed mandated benefits by the Maryland Health Care Commission under § 15-1501 of the Insurance Article. The law requires the assessment of a proposed mandate for the social, medical and financial impact of the proposed mandate and equips the General Assembly with such information as the extent to which the service is generally utilized by a significant portion of the population; the extent to which the insurance coverage is already generally available; if coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments; if coverage is

not generally available, the extent to which the lack of coverage results in unreasonable financial hardship; and the level of public demand for the service. Before adopting this or any other mandated health benefit, we urge the Committee first request an evaluation of the proposed benefit to facilitate an informed decision.

As the committee knows, Maryland already has a mandate for IVF. Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures, and for insurers and nonprofit health service plans, benefits provided must be the same as for other pregnancy-related procedures. For HMOs, the benefits provided must be the same as provided for other infertility services. For all insurers, nonprofit health service plans and HMOs that provide infertility benefits, the coverage must be provided: (a) for a patient whose spouse is of the opposite sex, the patient's oocytes are fertilized with the patient's spouse's sperm; unless: (i) the patient's spouse is unable to produce and deliver functional sperm; and (ii) the inability to produce and deliver functional sperm does not result from: - a vasectomy; or - another method of voluntary sterilization; (b) the patient and the patient's spouse have a history of involuntary infertility, which may be demonstrated by a history of: (i) if the patient and the patient's spouse are of opposite sexes, intercourse of at least 2 years' duration failing to result in pregnancy; or (ii) if the patient and the patient's spouse are of the same sex, six attempts of artificial insemination over the course of 2 years failing to result in pregnancy; (c) the infertility is associated with any of the following medical conditions: (i) endometriosis; (ii) exposure in utero to diethylstilbestrol, commonly known as DES; (iii) blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or (iv) abnormal male factors, including oligospermia, contributing to the infertility; (d) 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 (e) the procedure must be performed at medical facilities that meet the minimum guidelines for in vitro fertilization established by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine. Carriers may limit the benefit to $100,000 per lifetime and three attempts per live birth and are not responsible for any cost incurred by the patient or the patient's spouse in obtaining donor sperm.

Besides the already expansive benefit and cost impact of the expansion of the mandated benefit, the League is concerned with the approach the bill offers to those who are at-risk for miscarriage and trying to conceive. In-vitro fertilization should not be the first choice of treatment for these individuals, especially when there are lower cost treatments such as medications addressing the underlying cause of frequent miscarriages. Steering hopeful parents to IVF will increase costs for all of the insured population, while also not being a definite way to prevent miscarriages.

For these reasons, the League urges the committee to give House Bill 142 an unfavorable report.

Very truly yours,

Matthew Celentano
Executive Director

cc: Members, House Health and Government Operations Committee