HB 838

Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

House Bill 838 (Delegate Hill, *et al.*)
Health and Government Operations

Health Insurance - Mandated Benefits - In Vitro Fertilization and Artificial Insemination Procedures

This bill establishes a new mandated health insurance benefit for artificial insemination procedures and alters the existing mandated benefit for in vitro fertilization (IVF).

The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2015.

Fiscal Summary

State Effect: State Employee and Retiree Health and Welfare Benefits Program (State plan) expenditures increase by $240,000 in FY 2016 from increased utilization of the mandated benefits during the first half of calendar 2016. Future years reflect annualization and increases in utilization and inflation. Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2016. Review of filings can be handled with existing budgeted MIA resources.

(in dollars)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
SF Revenue	-	$0	$0	$0	$0
GF/SF/FF Exp.	$240,000	$499,200	$539,100	$582,300	$628,800
Net Effect	($240,000)	($499,200)	($539,100)	($582,300)	($628,800)

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

Local Effect: To the extent utilization of the mandated benefits increases, health care expenditures for local governments may increase.

Small Business Effect: None.

Analysis

Bill Summary:

Artificial Insemination: Health insurers, health maintenance organizations, and nonprofit health service plans (collectively known as carriers) that provide pregnancy-related benefits may not exclude benefits for outpatient expenses related to artificial insemination procedures for married couples.

In Vitro Fertilization: The bill specifies that coverage applies if, *for a patient whose spouse is capable of producing sperm,* the patient's oocytes are fertilized with the patient's spouse's sperm. The bill modifies conditions on coverage that require certain infertility, by requiring coverage if the patient and the patient's spouse are of the same sex.

Both Benefits: The bill requires that all covered procedures be performed at medical facilities that conform to *applicable guidelines or minimum standards issued by* the American College of Obstetricians and Gynecologists *or the American Society for Reproductive Medicine*.

Current Law: Carriers that provide pregnancy-related services are required to cover outpatient expenses related to IVF. 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 both fallopian tubes, or abnormal male factors. In addition, the patient must be the policyholder or subscriber or the dependent spouse 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.

State Expenditures: State plan expenditures increase by an estimated $240,000 in fiscal 2016, which reflects expenditures for the second half of fiscal 2016 only (benefits under the State plan are administered on a calendar year basis). The State plan currently covers both artificial insemination and IVF. Thus, expenditures reflect increased utilization of these benefits by same sex married couples. This estimate assumes that the cost of any sperm donor charges would not be covered.

Future year State plan expenditures reflect annualization and projected increases in direct cost and utilization of 8% per year. State plan expenditures are split 59% general funds, 30% special funds, and 11% federal funds.

Additional Comments: The federal Employee Retirement Income Security Act preempts states' ability to require private employers to offer insurance coverage and exempts the coverage offered by self-insured entities from state insurance regulation. Thus, insured health benefit plans (those purchased directly from a carrier) are subject to Maryland's mandated benefits law, while other (self-insured) employment-based plans are not. According to MIA, of the total number of covered lives enrolled in commercial health insurance in the State in 2013, only 37.1% were in plans subject to State regulation, while 62.9% were in plans not subject to such regulation.

CareFirst BlueCross BlueShield advises that the bill could increase premium rates by $1.2 million – to as much as $9.5 million – annually due to the increased utilization of artificial insemination and IVF procedures.

Additional Information

Prior Introductions: None.

Cross File: SB 416 (Senator Kagan, *et al.*) - Finance.

Information Source(s): CareFirst BlueCross BlueShield, Maryland Insurance Administration, Department of Budget and Management, Department of Health and Mental Hygiene, Department of Legislative Services

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