REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

HOUSE BILL 1387 (1994): MANDATED OFFER OF COVERAGE FOR INFERTILITY TREATMENT

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 10

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH OF VIRGINIA

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SENATE

October 21, 1994

To: The Honorable George Allen
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of House Bill 1387 (1994 Session) regarding a proposed mandated offer of coverage for infertility treatment.

Respectfully submitted,

Clarence A. Holland
Chairman
Special Advisory Commission on
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INTRODUCTION

The Senate Committee on Education and Health referred House Bill 1387 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) during the 1994 Session of the General Assembly. House Bill 1387 is patroned by Delegate Jerrauld C. Jones.

The Advisory Commission held a hearing on June 13, 1994 in Richmond to receive public comment on House Bill 1387. Four speakers addressed the proposal. A reproductive endocrinologist representing the American Fertility Society (AFS) and a representative of RESOLVE of Virginia's Family Building Act Committee (FBAC) spoke in favor of the bill. Representatives of Trigon Blue Cross and Blue Shield (Trigon) and Mid-Atlantic Medical Services, Inc. (MAMSI) spoke in opposition to the measure. In addition, written comments were provided by Dr. Howard W. Jones, Jr., Professor of Obstetrics and Gynecology at the Eastern Virginia Medical School in support of the bill and by the Virginia Farm Bureau Federation, Kaiser Foundation Health Plan of the Mid Atlantic States, Inc., Blue Cross and Blue Shield of the National Capital Area, and a concerned citizen from Norfolk in opposition to House Bill 1387. A copy of the transcript of the public hearing was sent to each member that did not attend the June 13 meeting. The Advisory Commission concluded its review of House Bill 1387 on June 28, 1994.

SUMMARY OF PROPOSED LEGISLATION

The bill requires insurers, health services plans and health maintenance organizations to offer and make available coverage for medically necessary expenses of diagnosis and treatment of infertility for both individual and group policies and contracts. The terms "infertility" and "infertile" are defined as the inability to conceive after one year of unprotected sexual intercourse. Coverage is to include embryo transfer, low tubal ovum transfer, artificial insemination, in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), and zygote intrafallopian tube transfer (ZIFT). Coverage for IVF, GIFT, and ZIFT is restricted to cases where (i) other less costly covered treatment has not resulted in a successful pregnancy, (ii) the covered individual has not undergone three completed oocyte retrievals or given birth to a living baby as a result thereof, (iii) the treating facility meets certain national guidelines, and (iv) one year has passed since the covered individual was determined to be infertile. The bill allows insurers or insureds to contract for coverage which is limited to married individuals. Short-term travel, accident only, limited or specified disease, individual conversion, and Medicare supplement policies are not subject to the bill's requirements. In addition, insurers may issue a contract that does not include coverage for infertility treatment to any religious institution or organization that finds such coverage to violate its religious and moral teachings or beliefs.

PRIOR ADVISORY COMMISSION REVIEW OF THIS ISSUE

In 1990, the Advisory Commission reviewed House Bill 271 which would have mandated coverage for infertility treatment. On a vote of 6 to 5 the Advisory Commission elected to recommend passage of the bill with certain amendments.

In 1992, the Advisory Commission reviewed House Bill 990 which was similar to 1990 House Bill 271, but included amendments recommended by the Advisory Commission in 1990. The Advisory Commission voted 5 to 1 to recommend that House Bill 990 not be enacted.

As originally introduced, House Bill 1387 was substantially similar to 1992 House Bill 990. It was amended by the House of Delegates, however, and now would create a mandated offer of coverage and allow insurers and insureds to contract for coverage which is limited to married couples.

UTILIZATION AND INCIDENCE RATES

FBAC reports that based on a survey of infertility specialists in 1990, an estimated 76,000 Virginia couples (approximately 9.4 percent of married couples of childbearing age) are treated annually for infertility, but that only about 49,000 (64%) seek treatment more sophisticated than basic instruction and basal body monitoring. Of those seeking more advanced treatment, only about 500 undergo high-tech treatment such as IVF, GIFT or ZIFT. These figures do not include those married couples that choose not to seek treatment. FBAC reports that nationally, about 17 percent of married couples are estimated to be infertile.

CURRENT INSURANCE INDUSTRY PRACTICES

In December 1993, the State Corporation Commission Bureau of Insurance surveyed 50 of the top writers of accident and sickness insurance in Virginia regarding infertility treatment coverage. Five of the 38 companies that responded by May 16, 1994 indicated that they have little or no applicable health insurance business in force in Virginia and, therefore, could not provide the information requested. Of the 33 respondents that completed the survey, 8 (24%) reported that they routinely provide coverage for infertility treatment to their Virginia policyholders. All but one noted, however, that such coverage does not include IVF, GIFT, and ZIFT. Some noted other coverage limits and exclusions affecting treatments such as artificial insemination and low tubal ovum transfer. In addition to those 8 respondents, 10 companies (30%) reported that although they do not provide such coverage routinely, they make it available on an optional basis to group policyholders. In contrast, none of the respondents, other than those that cover infertility treatment routinely, make such coverage available to individual policyholders.

Trigon reports that it covers diagnostic or other medical treatment for infertility, but specifically excludes services for artificial insemination, IVF, or any other type of artificial or surgical means of conception and experimental or investigative services. It also notes that none of the self-insured groups for which Trigon provides administrative services have chosen to provide coverage for IVF, GIFT, or ZIFT. In addition, none of Trigon's insured groups have requested such additional coverage. Trigon contends that variation in coverage among insurers is a function of market and administrative matters which affect all benefits.

FBAC reports that insurers often refuse coverage for treatment of a condition such as endometriosis if it is determined that the purpose of such treatment is to achieve pregnancy. FBAC also reports that data from 1988 indicates that nationally, about 70% of infertility treatment was covered by insurers.

AFS reports that according to its own survey in 1994, less than 14 percent of Virginia patients seeking advanced reproductive technologies such as IVF, GIFT and ZIFT received partial coverage for those services.

FINANCIAL IMPACT CONSIDERATIONS

Most respondents to the State Corporation Commission Bureau of Insurance survey provided cost figures that ranged from $1.00 to $4.07 per month per group certificate holder to provide the coverage required by House Bill 1387. The two respondents that provided cost figures for individual policies estimated a one percent increase in premiums.

Trigon estimates that a group rider covering artificial insemination, IVF, GIFT, and ZIFT would average 0.3% of the current group premium per policy per month. Trigon reports that it already covers a variety of other infertility services.

AFS estimates that coverage for IVF alone would cost $0.17 per family policy per month, or $1.98 annually. AFS also cites 1993 data obtained from the Massachusetts Division of Insurance which indicates that the cost of comprehensive infertility coverage including assisted reproductive technologies such as IVF is $2.25 per family policy per month or 0.4 percent of the monthly premium.

FBAC cites 1988 Massachusetts data showing a 0.3 percent premium increase attributable to compliance with a new mandate to provide comprehensive coverage for infertility treatment including advanced procedures. In addition, FBAC estimates that a Virginia mandate would raise premiums $1.28 per family policy per month. This estimate includes the assumption that the number of

couples undergoing advanced infertility treatment in Virginia annually (500) would double to 1,000.

Dr. Howard Jones and other proponents suggest that in some cases the use of IVF is more effective and less expensive than conventional surgical treatment which is routinely covered.

FBAC reports that the average cost of treatment for about 30 percent of infertile couples is only about $500. At the other extreme, FBAC reports that the nearly 500 infertile couples that needed extensive high-tech treatment in 1989 spent an average of $13,800.

MEDICAL EFFICACY CONSIDERATIONS

The efficacy of most infertility treatment is not challenged by opponents. They do caution, however, that success rates can vary significantly by age, condition, procedure, and facility especially for high-tech procedures such as IVF, GIFT, and ZIFT.

FBAC notes that under ideal conditions a fertile couple has a 20 to 25 percent chance per menstrual cycle of achieving a successful pregnancy. FBAC reports that (i) surgical procedures such as laparoscopy and varicocelectomy have a pregnancy rate (not limited to a single cycle) of about 40 percent, (ii) hormonal therapy results in pregnancy rates from 40 to 70 percent, (iii) as a treatment for oligospermia (low sperm count), a Yale study found a rate of pregnancy of 24 percent per cycle for artificial insemination, and (iv) IVF, GIFT and ZIFT have average pregnancy rates of between 14 and 22 percent per egg retrieval although some Virginia facilities have significantly higher rates.

INFERTILITY TREATMENT COVERAGE MANDATES IN OTHER STATES

According to information published by the National Association of Insurance Commissioners (attached), 7 states currently require coverage for infertility treatment to varying degrees. For example, some statutes (i) only apply to group policies, (ii) define infertility as the inability to conceive after 2 to 5 years of unprotected sexual intercourse rather than only 1 year, and/or (iii) only require coverage for IVF. Another 3 states require only that coverage for infertility treatment be offered to policyholders. In addition to these 10 states which have statutes primarily affecting commercial insurers, 4 states include the term "infertility services" in their definition of basic health care services that must be provided by health maintenance organizations or prepaid health clinics.

The statute enacted in Illinois in 1991 is the most similar to the current proposal. The most significant differences between the two are that the Illinois law (i) is a true mandate, not a mandated offer, (ii) is limited to group policies, (iii)

exempts groups with fewer than 25 covered employees, (iv) also requires coverage for uterine embryo lavage, (v) does not include a one-year waiting period for coverage of IVF, GIFT, and ZIFT, and (vi) expands the definition of infertility to include the inability to sustain a successful pregnancy.

Proponents of House Bill 1387 do not favor a mandated offer of coverage, but rather a mandate that infertility treatment coverage be included in all policies. FBAC notes that employers are not likely to select the optional coverage because of misconceptions about infertility treatment and that as a result few people will benefit from a mandated offer of coverage.

ETHICAL CONSIDERATIONS

In written comments to the Advisory Commission, a concerned citizen from Norfolk suggests that the potential psychological impact on the child conceived by advanced reproductive techniques should be considered. This individual recommends that the current proposal not be considered until a national policy regarding the ethical use of advanced reproductive techniques is adopted.

REVIEW CRITERIA

SOCIAL IMPACT

a. *The extent to which the treatment or service is generally utilized by a significant portion of the population.*

FBAC reports that (i) an estimated 76,000 Virginia couples are treated annually for infertility, (ii) about 49,000 of those (64%) seek treatment more sophisticated than basic instruction and basal body monitoring, and (iii) about 500 undergo high-tech treatment such as IVF, GIFT, or ZIFT. FBAC also reports that it is estimated that nationally about 17 percent of married couples are infertile.

b. *The extent to which insurance coverage for the treatment or service is already available.*

A December 1993 survey by the State Corporation Commission Bureau of Insurance found that 8 of 33 respondents (24%) routinely provide coverage for infertility treatment to their Virginia policyholders. All but one noted, however, that such coverage does not include IVF, GIFT, and ZIFT. Other coverage limits and exclusions affecting artificial insemination and low tubal ovum transfer were also noted. Another 10 companies (30%) indicated that they make coverage for infertility treatment available to group policyholders on an optional basis.

c. *If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.*

Although coverage is available for some infertility treatments, coverage varies widely among insurers. FBAC reports that the 500 couples that sought high-tech treatment in Virginia in 1989 spent an average of $13,800. The high cost of such treatment creates a barrier for those that do not have insurance coverage.

d. *If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.*

Although coverage is available for some infertility treatments, coverage varies widely among insurers. FBAC reports that the 500 couples that sought high-tech treatment in Virginia in 1989 spent an average of $13,800. On the other hand, FBAC reports that about 30 percent of infertile couples only spend about $500.

e. *The level of public demand for the treatment or service.*

FBAC reports that (i) an estimated 76,000 Virginia couples are treated annually for infertility, (ii) about 49,000 of those (64%) seek treatment more sophisticated than basic instruction and basal body monitoring, and (iii) about 500 undergo high-tech treatment such as IVF, GIFT, or ZIFT. FBAC also reports that it is estimated that nationally about 17 percent of married couples are infertile.

f. *The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.*

The level of public demand for this coverage is unknown. As with many health insurance benefits, it is accepted that many policyholders are not knowledgeable about the specific terms of their coverage until they are diagnosed with a disease that requires a specific treatment. Trigon has reported that none of its group policyholders have requested additional infertility coverage.

g. *The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.*

The level of interest of collective bargaining organizations in negotiating privately for this coverage in group contracts is unknown.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

The Advisory Commission is not aware of any such findings of a state health planning agency or appropriate health system agency relating to the social impact of this proposal.

FINANCIAL IMPACT

a. The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.

Most of the respondents to the State Corporation Commission Bureau of Insurance survey provided cost figures ranging from $1.00 to $4.07 per month per group certificate holder to provide the coverage required by House Bill 1387. Trigon estimates that a group rider covering artificial insemination, IVF, GIFT, and ZIFT would average 0.3 percent of the current group premium per policy per month (Trigon has reported that it already covers certain other infertility services). AFS cites Massachusetts experience that indicates a cost of $2.25 per family policy per month or 0.4 percent of premium. FBAC estimates a premium increase of $1.28 per family policy per month.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

In generating its cost figures, FBAC estimates that the number of Virginia couples undergoing high-tech procedures each year will double from 500 to 1,000 if the coverage is mandated for all policyholders.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

Proponents of the bill suggest that in some cases the use of IVF is more cost effective than the conventional surgical treatment which is routinely covered by insurers.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

The affect such coverage would have on the number and types of providers depends how many policyholders select the optional coverage.

e. *The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.*

Insurers would be expected to incur greater administrative expenses in administering a mandated offer of coverage. Such costs would likely be spread among those policyholders selecting that coverage.

f. *The impact of coverage on the total cost of health care.*

The impact on the total cost of health care depends how many policyholders select the optional coverage.

MEDICAL EFFICACY

a. *The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.*

Opponents caution that success rates for infertility services vary significantly by age, condition, procedure, and facility especially for high-tech procedures such as IVF, GIFT, and ZIFT.

FBAC notes that under ideal conditions a fertile couple has a 20 to 25 percent chance per menstrual cycle of achieving a successful pregnancy. FBAC reports that (i) surgical procedures such as laparoscopy and varicocelectomy have a pregnancy rate (not limited to a single cycle) of about 40 percent, (ii) hormonal therapy results in pregnancy rates from 40 to 70 percent, (iii) as a treatment for oligospermia (low sperm count), a Yale study found a rate of pregnancy of 24 percent per cycle for artificial insemination, and (iv) IVF, GIFT and ZIFT have average pregnancy rates of between 14 and 22 percent per egg retrieval although some Virginia facilities have significantly higher rates.

b. *If the legislation seeks to mandate coverage of an additional class of practitioners:*

1) *The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.*

Not applicable.

2) *The methods of the appropriate professional organization that assure clinical proficiency.*

Not applicable.

EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY CONSIDERATIONS

a. *The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.*

Proponents contend that the bill meets a medical need to address infertility. Opponents point out that state mandated benefits do not affect coverage provided through Medicare and other government sponsored programs, self-funded health benefit plans, and policies issued in other states covering Virginia citizens.

b. *The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.*

The bill requires the availability of an optional benefit, the cost of which is borne by those electing such coverage.

c. *The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.*

The proposal is a mandated offer of coverage.

RECOMMENDATION

The Advisory Commission recommends that House Bill 1387 not be enacted. The Advisory Commission voted unanimously on June 28, 1994 to adopt this position.

CONCLUSION

The Advisory Commission has found that the costs associated with mandating an offer of coverage for a wide range of infertility treatments outweighs the benefits which would result from such a requirement.

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HOUSE BILL NO. 1387

House Amendments in [ ] — February 13, 1994

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 2 of Chapter 34 of Title 38.2 a section numbered 38.2-3411.3, relating to accident and sickness insurance and coverage for infertility treatment.

Patron—Jones, J.C.

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Article 2 of Chapter 34 of Title 38.2 a section numbered 38.2-3411.3 as follows:

§ 38.2-3411.3. Coverage for infertility diagnosis and treatment.

A. Notwithstanding the provisions of § 38.2-3419, every individual or group accident and sickness insurance policy, subscription contract providing coverage under a health services plan, or evidence of coverage of a health care plan (i) delivered or issued for delivery in the Commonwealth or renewed, reissued, or extended if already issued, and (ii) providing coverage to family members of the insured, subscriber, or enrollee, shall [~~provide~~ offer and make available] coverage for medically necessary expenses of diagnosis and treatment of infertility, including, but not limited to, in vitro fertilization, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer; provided that:

1. Such expenses shall only be covered for procedures for in vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer if:

a. The covered individual has been unable to attain a successful pregnancy through reasonably, less costly, medically appropriate infertility treatments for which coverage is available under the policy, plan or contract;

b. The covered individual has not undergone three completed oocyte retrievals or given birth to a living baby as a result thereof;

c. Such 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; and

d. One year shall have passed since the covered individual was determined to be infertile under this section.

2. The coverage described in this section shall not be required to be contained in any individual or group accident and sickness insurance policy, health services plan or health maintenance organization subscription contract if the subscriber to whom the policy, plan or contract is issued is either of the following:

a. A religious institution or organization that finds the coverage to violate its religious and moral teachings or beliefs; or

b. An institution or organization that is under the sponsorship of a religious institution or organization that finds the coverage to violate its religious and moral teachings or beliefs.

3. This section shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal government plans.

[4. Nothing in this section shall prohibit an insurer or an insured from contracting for this coverage only for married individuals.]