REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR INFERTILITY TREATMENT

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 66

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

COMMONWEALTH OF VIRGINIA

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SENATE

December 28, 1999

To: The Honorable James S. Gilmore, III
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 2403 regarding a proposed mandate of coverage for infertility treatment.

Respectfully submitted,

Stephen H. Martin
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

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INTRODUCTION

House Bill 2403 was referred to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) to be reviewed prior to the 2000 Session of the General Assembly. House Bill 2403 is patroned by Delegate William K. Barlow.

The Advisory Commission held a public hearing on September 21, 1999 in Richmond to receive comments on House Bill 2403. In addition to the bill's chief patron, two representatives from the Jones Institute at the Eastern Virginia Medical School, and five interested parties affected with infertility spoke in favor of the proposed bill. The two representatives from the Jones Institute were specialists in the field of infertility. One was an infertility physician who specialized in, in vitro fertilization. The other was an embryologist. The five interested parties included a physician and a registered nurse who are faced with infertility problems.

Representatives from the Virginia Association of Health Plans (VAHP) and the Health Insurance Association of America (HIAA) spoke in opposition to the proposed bill. Written comments in opposition to the proposed bill were received from the VAHP, HIAA, the Virginia Chamber of Commerce, and the Virginia Manufacturers Association. Written comments supporting the bill were received from RESOLVE, which is the National Infertility Association. Other written comments in support of the proposed bill were in the form of 48 postcards, 50 E-mails, and 66 letters from citizens. The Advisory Commission concluded its review of House Bill 2403 on October 19, 1999.

SUMMARY OF PROPOSED LEGISLATION

House Bill 2403, as introduced, would amend the accident and sickness chapter of Title 38.2 of the Code of Virginia by adding §38.2-3418.8 to require insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, corporations providing individual or group subscription contracts and health maintenance organizations (HMOs) to cover the treatment of infertility under policies, contracts, or plans delivered, issued for delivery, or renewed after July 1, 1999. The bill outlines guidelines for individuals who are eligible for infertility treatment as well as what type of treatment will be covered. It also includes a detailed definition of "infertility."

The bill defines "infertility" as "the inability to conceive after one year of unprotected sexual intercourse." Treatment for infertility as defined in House Bill 2403 includes, but is not limited to the following procedures for those less than 50 years old: in vitro fertilization, embryo transfer, artificial insemination, gamete intrafallopian tube transfer (GIFT), intracytoplasmic sperm injection, zygote

intrafallopian transfers (ZIFT), and low tubal ovum transfer. These types of infertility treatments are often referred to as assisted reproductive technologies (ART).

Treatment is required only if the covered individual has not undergone four complete oocyte retrievals, except that if a live birth follows complete oocyte retrieval, then two or more oocyte retrievals shall be covered. Treatment for infertility does not include the reversal of a vasectomy or a tubal ligation.

Prior Advisory Commission Review

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 the 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.

In 1994, the Advisory Commission reviewed House Bill 1387, which was similar to the 1992 House Bill 990. House Bill 1387 was amended by the House of Delegates to change it to a mandated offer of coverage limited to married couples. The Advisory Commission voted unanimously that House Bill 1387 not be enacted.

Infertility

Infertility is a condition of the reproductive system that impairs the biological process of reproduction or the conception of children. Infertility is determined when couples have had one year or more of unprotected sexual intercourse without resulting in pregnancy. This condition affects nearly 6.1 million women and their partners, which is about 10% of the reproductive age population. Infertility is a condition that affects males and females with equal frequency. Thirty-five percent of infertility problems are due to female factors, another thirty-five percent are caused by problems with the male partner, twenty percent of the cases involve factors with both the male and female, and the final ten percent is unexplained.

Infertility Treatments

The proposed bill provides coverage for many different types of treatment for infertility. The best known treatment is in vitro fertilization (IVF). This procedure is used when a woman's fallopian tubes are blocked. Initially medicine is administered to stimulate the woman's ovaries to produce multiple

eggs. Once the eggs are mature, they are suctioned from the ovaries and one egg is placed in a laboratory culture dish. Then the male partner's sperm is placed inside the culture dish with the mature egg. The dish is then placed in an incubator and after two days, three to five embryos are transferred to the woman's uterus. If pregnancy does not occur then the woman may try again in the next cycle.

Another common treatment method for infertility is artificial insemination. Artificial insemination may be used if the male partner has problems ejaculating normally during sexual intercourse, or if his sperm cannot bypass the vagina, or for other reasons. In this procedure the male's semen is placed into the woman's uterus or vaginal canal. The process of inserting the semen involves using a hollow, flexible tube called a catheter.

Other newer types of infertility treatment are called gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT). GIFT is similar to in vitro fertilization, but in this procedure the woman has at least one normal fallopian tube. In this process, three to five eggs are placed in the fallopian tube, along with the man's sperm for fertilization inside the woman's body. ZIFT is a variation of IVF and GIFT, but the eggs are retrieved from the woman's ovaries and are fertilized in the laboratory and replaced in the fallopian tubes, rather than the uterus.

Embryo transfer is another method that involves problems with the woman's eggs. The woman may have impaired ovaries or a genetic disease that can be transferred to the offspring. In this case eggs are donated by a healthy woman and fertilized by a male partner's sperm in the laboratory. Then the eggs are transferred to the female partner's uterus.

Intracytoplasmic sperm injection is one of the newest treatments to help those who are infertile. This procedure involves injecting a single sperm into the egg to produce an embryo that can be implanted and grown in the uterus. The procedure is used when men have very low sperm counts or non-motile sperm.

Low tubal ovum transfer is the name of the procedure of timed insemination of a fertile woman followed by a nonsurgical uterine lavage, retrieval of a flushed embryo, and subsequent transfer to the uterus of an infertile recipient. This procedure is used to help women who have experienced premature ovarian failure, surgical ovarian extirpation, or gonadal dysgenisis.

CURRENT INDUSTRY PRACTICES

Staff surveyed fifty of the top writers of accident and sickness insurance in Virginia regarding House Bill 2403. Twenty-eight companies responded to the survey by the April 9, 1999 deadline. Five of the companies indicated that they have little to no applicable health insurance business force in Virginia. Of the

twenty-three respondents that completed the survey, three indicated that they currently provide the coverage required by House Bill 2403 in their standard benefits package.

Twenty companies indicated that they did not provide coverage under their standard benefits package. However, of the twenty that currently do not provide coverage for House Bill 2403 in their standard benefit package, five companies provide group coverage on an optional basis and one company provided individual coverage on an optional basis.

SOCIAL IMPACT

Infertility is a condition that results in the abnormal functioning of the male or female reproductive system, which includes difficulty conceiving and the inability to carry a pregnancy that results in a live birth. Infertility currently affects 6.1 million men and women in the United States. These numbers are approximately ten percent (10%) of the reproductive age population. Infertility is a reproductive condition that affects each partner with equal frequency.

The majority of infertility cases are treated with conventional therapies such as counseling, drug treatment, and sometimes, surgical repair of the reproductive organs. The remaining infertile couples may be helped by treatments acknowledged in House Bill 2403. With the adoption of infertility treatments, many couples are being assisted, and these efforts have resulted in pregnancies. Since the adoption of fertility treatments, especially IVF, 45,000 babies have been born. When all assisted-reproductive technologies are included, there have been over 70,000 births in the United States since 1981.

Another social aspect of infertility is the psychological and emotional strain that is placed on those who are infertile. Infertility has been suggested as "one of the most distressing life crises that a couple has ever experienced together," as reported by the American Society for Reproductive Medicine. It has also been suggested that a long-term inability to conceive a child, combined with numerous medical decisions, along with the uncertainty associated with infertility, can evoke tremendous feelings of loss and great emotional upheaval. Many times couples and individuals may be left feeling anxious, depressed, out of control, or isolated. In these cases, psychological counseling is sought to deal with the emotional and psychological stress.

FINANCIAL IMPACT

Respondents to the Bureau of Insurance survey provided cost figures of between $3.00 and $35.60 per month per standard individual policy to provide coverage for House Bill 2403. Cost figures were between $2.22 and $11.76 per month per standard group policy to provide coverage for House Bill 2403. Insurers providing coverage on an optional basis provided cost figures from

$3.00 to $22 per month per standard individual policy. One indemnity company estimates a monthly premium of $833.33 per policyholder per optional individual coverage. One HMO company estimates a monthly premium of $625 per policyholder per optional individual coverage. Insurers providing coverage on an optional basis estimated cost figures from $3.33 to $25 per month per group certificate.

Staff also surveyed local hospitals and physicians to obtain the costs of infertility treatments as listed in House Bill 2403. Costs for in vitro fertilization ranged from $7,800 to $9,000. Artificial insemination costs ranged widely between $170 to $1,200. Embryo transfer costs were $500 to $1,600. ZIFT and GIFT had the same cost estimates of between $8,000 and $9,000. Finally, intracytoplasmic sperm injection costs were between $3,500-$3,600. The cost estimates could not be obtained for low tubal ovum transfer, because none of those surveyed offered the treatment. All cost estimates include necessary laboratory costs associated with the treatment. Also, intracytoplasmic sperm injection was noted to be necessary in performing IVF, ZIFT, and GIFT, and those cost factors are included in the cost estimates.

MEDICAL EFFICACY

Infertility is a reproductive condition that affects men and women equally. Data shows that in 1995 there were 6.1 million women from the ages 15-44 with impaired ability to have children. However, with today's medical technology, more women and men are able to get help. Since 1981, there have been a number of infertility treatments unleashed to help infertile men, women, and couples.

Among those treatments are many that are mandated in House Bill 2403 to include: IVF, artificial insemination, GIFT, ZIFT, embryo transfer, and intracytoplasmic sperm injection. By 1995, 9 million women had used infertility treatments, and in 1995, there were 9.3 million women using infertility treatments. Due to the increased availability and use of these ART treatments, 70,000 babies have been born in the United States since 1981. Also, 45,000 of the 70,000 have been born as a result of IVF treatment alone.

SIMILAR LEGISLATION IN OTHER STATES

Staff surveyed other insurance departments and received information available from the National Association of Insurance Commissioners, National Insurance Law Service, and various other sources to determine if requirements are imposed in other states that are similar to House Bill 2403. Currently, fifteen states have laws that cover infertility treatment of some kind. Seven of the fifteen states require mandated coverage of some type of infertility treatments.

These states are Hawaii, Illinois, Maryland, Massachusetts, Montana, Ohio, and Rhode Island. Of these seven, Montana and Ohio have laws that apply only to Health Maintenance Organizations (HMOs). Four states, California, Connecticut, Florida, and Texas mandate the offer of some type of infertility treatments. Arkansas requires all insurers to cover only one type of infertility treatment, in vitro fertilization. Two states, New Mexico and New York, require coverage for the diagnosis and treatment of infertility. Finally, West Virginia requires infertility to be included under basic health services.

REVIEW CRITERIA

SOCIAL IMPACT

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

Infertility currently affects 6.1 million men and women in the United States. These numbers are approximately ten percent (10%) of the reproductive age population. Infertility cannot be linked to problems with only males or females, but is a reproductive condition that affects each partner with equal frequency.

By 1995, 9 million women had used infertility treatments, and in 1995, there were 9.3 million women using infertility treatments. Due to the increased availability and use of ART treatments, 70,000 babies have been born in the United States since 1981. Also, 45,000 of the 70,000 have been born as a result of IVF treatment alone.

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

The State Corporation Commission Bureau of Insurance surveyed fifty of the top writers of accident and sickness insurance in Virginia in March 1999, regarding bills to be reviewed by the Advisory Commission this year. Twenty-eight companies responded to the survey by April 9,1999. Five of the companies indicated that they have little to no applicable health insurance business force in Virginia.

Of the twenty-three respondents that completed the survey, three indicated that they currently provide the coverage required by House Bill 2403 in their standard benefits package. Twenty companies indicated that they did not provide coverage under standard benefits package. However, of the twenty that currently do not provide coverage for House Bill 2403 in their standard benefit package, five companies provide group coverage on an optional basis and one company provided individual coverage on an optional basis.

Interested citizens affected with infertility addressed this concern. Almost all stated that they lack coverage of infertility treatments through their current insurer. Several stated that they have spent $20,000 or more from savings and retirement accounts on infertility treatments that should be covered by insurance. They also argued that insurers should cover infertility because infertility is regarded as a major life activity, which was recently supported by the U.S. Supreme Court in the case of Bragdon v. Abbott. A final proponent of House Bill 2403 stated that her insurer would not cover infertility treatments, but the same insurer covered Hodgkin's disease treatment, which caused her to become infertile.

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.*

Proponents argued that coverage by insurers was not generally available. They stated that for those who are affected with infertility, insurance coverage is the key to obtaining treatment and overcoming infertility. This is because some infertility treatments are very expensive. Staff's research from independent medical labs and hospitals provided a range of prices for the infertility treatments listed in House Bill 2403. The range of prices for least costly infertility treatment, artificial insemination, was between $170 to $1,200. Embryo transfer prices ranged between $500 to $1,600. Intracytoplasmic sperm injection costs were between $3,500-$3,600. Costs for in vitro fertilization ranged from $7,800 to $9,000. ZIFT and GIFT had primarily the same cost estimates of between $8,000 and $9,000.

Proponents at the public hearing explained why the lack of coverage results in infertile couples being unable to obtain coverage. Statements from two infertility specialists explained that not all people can overcome infertility problems by using low cost drugs and therapy. They argued that some, by no fault of their own, must use more advanced infertility treatments such as ART treatments covered by House Bill 2403. They stated that ART treatments are continually gaining more acceptances and the success rates are very high. But, without insurance coverage infertile couples cannot afford the treatments.

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.*

Several proponents of House Bill 2403 have acknowledged financial hardship because of lack of coverage for infertility treatments by insurers. Three out of the five people at the public hearing, testified of personal infertility

problems causing them to spend more than $20,000 for infertility treatments. The process of ART treatments can easily become expensive because if someone is affected with infertility, they do not always achieve pregnancy after the first treatment.

It may require two or more treatments to achieve a favorable outcome. Or it may take a combination of treatments to achieve a favorable outcome. This means that if the infertile couple can only be helped by IVF then two treatments adds up to $18,000. Or if it means trying artificial insemination and then IVF, the costs could be $10,000. More than one combination of procedures or two attempts could be required, which results in great financial burden on the infertile couple.

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

Infertility currently affects 6.1 million men and women in the United States. These numbers are approximately ten percent (10%) of the reproductive age population. According to estimates reported by RESOLVE, 9 million women had used infertility treatments by 1995, and in 1995, there were 9.3 million women using infertility treatments. Due to the increased availability and use of these ART treatments, 70,000 babies have been born in the United States since 1981. Also, 45,000 of the 70,000 have been born as a result of IVF treatment alone.

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

Infertility currently affects 6.1 million men and women in the United States. These numbers are approximately ten percent (10%) of the reproductive age population. According to estimates reported by RESOLVE, 9 million women had used infertility treatments by 1995, and in 1995, there were 9.3 million women using infertility treatments. Based on these estimates the level of public demand is high especially when a significant portion of the population (10%) is affected by infertility.

Over 200 responses were received by staff in the form of letters, E-mails, and postcards addressing House Bill 2403. The letters pledged support for the passage of House Bill 2403 by the Advisory Commission. Many letters provided personal testimony of how infertility has affected the individuals, and their family and friends. Most letters were received from concerned citizens of Virginia, but a few were from citizens outside the state.

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

No information was received from collective bargaining organizations addressing potential interest in negotiating privately for inclusion of this coverage in group contracts.

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.*

No information or relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of this mandated benefit was presented during this review.

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.*

No information was provided by either proponents or opponents that would suggest that enactment of House Bill 2403 would either increase or decrease the cost of infertility treatments.

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

The proposed coverage would increase the use of infertility treatment because infertile couples would have financial support for infertility treatments. This would cause more infertile couples who could not afford infertility treatments to use their insurance coverage to pay for infertility treatments. Infertile couples would have access to several infertility treatments if the proposed coverage were enacted. Also, couples are not limited to using just the treatments listed in House Bill 2403, but any treatments to overcome infertility.

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

Information from RESOLVE indicates that the percentage of women using ART is low compared to the percentage of women using other infertility treatments. According to research done by the National Center for Health Statistics, the number of women that had used any kind of infertility services was

15.4%. This study was conducted in 1995 and represented all women of reproductive age (15-44). Only 1% of the women using any kind of infertility treatment reported using ART like those covered in House Bill 2403. The most common services used were counseling, tests, and ovulation drugs.

The mandated coverage defines infertility treatment to include ART, but is not limited to those treatments. ART treatments would serve as an alternative for less expensive and more commonly used services such as counseling, testing, and drugs for infertility. These routinely used services generally cost between $500 and $2,000 per couple. Another method of treatment is surgery, which can cost between $4,000 and $12,000. The ART treatments can cost couples between $8,000 and $12,000.

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.*

Infertility specialists have been successfully performing ART procedures since 1981. The number of infertility specialists has grown over time, as infertility has become a well-known medical condition. Infertility specialists have grown in number also because treatments have become more accepted and routine. However, no data suggests that with the addition of insurance coverage, there would be a growth in providers of infertility treatment.

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.*

Respondents to the Bureau of Insurance survey provided cost figures of between $3.00 and $35.60 per month per standard individual policy to provide coverage for House Bill 2403. Cost figures were between $2.22 and $11.76 per month per standard group policy to provide coverage for House Bill 2403. Insurers providing coverage on an optional basis provided cost figures from $3.00 to $22 per month per standard individual policy. One indemnity company estimates a monthly premium of $833.33 per policyholder for optional individual coverage. One HMO company estimates a monthly premium of $625 per policyholder for optional individual coverage. Other insurers providing coverage on an optional basis estimated cost figures from $3.33 to $25 per month per group certificate.

Proponents argued that coverage of the treatments listed in House Bill 2403 would save insurers and families money in the long run. Dr. Suheil Muasher, an IVF specialist with the Jones Institute at the Eastern Virginia Medical School, stated that there really is no other cost-effective treatment for

those who cannot overcome infertility by counseling and drugs. He stated that insurers and patients paying for infertility often spend a significant amount of money on less effective treatment, because insurers will not cover ART treatments like those listed in House Bill 2403. Instead, they will pay for a surgery to address the infertility problems that often does not work. He concluded that if the insurers covered the treatment provided for in House Bill 2403, then the problems could be resolved and could save the insurers money.

Written comments that opposed House Bill 2403 were received from the VAHP, the Virginia Manufacturers Association (VMA), the Virginia Chamber of Commerce, and the Virginia Hospital and Healthcare Association (VHHA). Those written comments had a unifying theme that with the addition of each mandate, there would be an increase of the premiums in the insurance market. This would cause health insurance to be unaffordable for more Virginians. The people who would feel the greatest effect would be small businesses, and those who pay for their own insurance. These groups also argued that it would affect others in the group market because employers would decrease benefits and increase the employee share of cost to compensate for an increase in premiums.

Written comments argued that this mandate favors certain benefits for a small number, but works against the provision of basic benefits for all Virginians. They concluded that this mandate would cause more Virginians to be without basic health insurance coverage.

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

Opponents argue that House Bill 2403 would increase the total cost of health care in Virginia. Written comments from the VAHP argued that coverage required in House Bill 2403 covers ART treatments. ART can be very expensive with some procedures costing between $10,000 and $15,000 for one procedure, as reported by the VAHP. However, the total cost can be even more because it often takes several attempts to achieve pregnancy. The VAHP also cited a study found in the New England Journal of Medicine by Merrill Matthews reporting that the estimated cost per delivery for IVF, ranged between $66,667 in the first cycle and $114, 286 by the sixth cycle.

The VAHP went on to explain other implications of House Bill 2403 that would cause the total cost of health care to rise. They stated that some infertility treatments can "lead to high-risk pregnancies and multiple births, both of which are associated with increased prenatal morbidity and mortality and pre-term birth." These risks and implications were argued to cause an increase in health care costs, and may not achieve the original goal of overcoming infertility.

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.*

Infertility is a condition of the reproductive system that impairs the biological process of reproduction or the conception of children. Infertility is determined when couples have had one year or more of unprotected sexual intercourse without resulting in pregnancy. Infertility is a condition that affects males and females with equal frequency. Infertility treatments have been beneficial to society because there have been strides in the medical fields to overcome some of the problems with male and female reproductive systems.

The treatments, such as IVF, GIFT, ZIFT, have been beneficial to women who have problems with their fallopian tubes. Embryo transfer has been developed to overcome problems with a woman's eggs. Artificial insemination and intracytoplasmic sperm injection are techniques developed to aid male infertility problems.

Proponents at the public hearing for House Bill 2403 provided testimony about the current success rates for infertility treatment. Dr. Jacob Mayer, an embryologist with the Jones Institute at the Eastern Virginia Medical School specializes in infertility treatment. He stated that recent estimates have proven that 75% of infertile couples, who take part in infertility treatments and continue with the therapy, will achieve success. He also stated that IVF success rates used to be approximately 20%. He argued that today's IVF success rates are almost 50%. Dr. Mayer concluded that success rates and infertility treatments in general, are rapidly progressing and very different than 10 to 15 years ago.

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 argue that House Bill 2403 does address a broad medical and social need. They believe infertility is a reproductive disease that interferes with the ability of a couple to achieve pregnancy, therefore it addresses a medical need. The American College of Obstetricians and Gynecologists as well as the American Society for Reproductive Medicine concur[s] that infertility is a reproductive disease. They believe infertility treatment addresses a medical need because it helps couples reproduce.

Many proponents argued that the U.S. Supreme Court in Bragdon vs. Abbott deemed procreation a major life activity. Therefore, their belief that infertility addresses a broader social need was supported by U.S. Supreme Court's opinion that said that having children is a major life activity. Proponents also argue that infertility treatment is consistent with the role of health insurance. They argue that health insurance covers the costs of pregnancy and childbirth, but will not cover services to achieve pregnancy. They state that they pay premiums into a pool that covers the costs of maternity costs for those who are able to have children, yet no help is given to those who cannot achieve pregnancy.

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

Respondents to the Bureau of Insurance survey provided cost figures of between $3.00 and $35.60 per month per standard individual policy to provide coverage for House Bill 2403. Cost figures were between $2.22 and $11.76 per month per standard group policy to provide coverage for House Bill 2403. Insurers providing coverage on an optional basis provided cost figures from $3.00 to $22 per month per standard individual policy. One indemnity company estimates a monthly premium of $833.33 per policyholder per optional individual coverage. One HMO company estimates a monthly premium of $625 per policyholder per optional individual coverage. Insurers providing coverage on an optional basis estimated cost figures from $3.33 to $25 per month per group certificate.

Proponents of House Bill 2403 cited a study done of the state of Massachusetts where infertility treatment has been mandated. The study examined a large HMO (170,000 members) and the utilization of ART services

and the costs of providing those services. The study focused on the cost of all ART cycles between the years of 1990 to 1995 at one infertility center. There were 375 cycles performed on 148 women, resulting in 64 deliveries. The cost of the ART coverage was concluded to be $2.49 per member per year.

Opponents of House Bill 2403 argued that this mandate, because of the incremental cost increase of all mandates, would increase premiums. The increase in premiums would cause many to be without basic health because of affordability. Those affected the most would be small businesses that cannot afford to provide insurance for employees and those buying their own insurance.

They argue that procedures such as ART can be very expensive, citing treatments cost between $10,000 and $15,000 per attempt. They also noted that sometimes ART procedures could take several attempts before the infertile women achieve a pregnancy. They conclude that the cost of mandating this benefit for a specific treatment diverts resources from those who are seeking basic health insurance, therefore causing more Virginians to be uninsured.

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

In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insureds.

RECOMMENDATION

The Advisory Commission on November 22, 1999 voted against recommending that House Bill 2403 be enacted (Yes-1, No-8). The Advisory Commission also voted against recommending the enactment of House Bill 2403 as a mandated offer of coverage (Yes-3, No-6).

CONCLUSION

The Advisory Commission received information that indicates that insurers do not generally cover infertility treatment. The Advisory Commission acknowledged the need for infertility treatment and the difficulties for couples who are infertile, including financial concerns. However, the Advisory Commission was concerned about a number of issues raised by House Bill 2403 including the cost of the mandate and ambiguities in the bill language.

These issues include a correct age restriction for treatment, a woman's status of menopause, marital status, medical risk, and the number attempts for each individual insured. Advisory Commission members also discussed the possible effect that this mandate would have on basic health insurance for Virginians. The enactment of House Bill 2403 would increase premiums and the increase in premiums could affect the number of Virginians that are insured.

APPENDIX A

993795126

HOUSE BILL NO. 2403

Offered January 21, 1999

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.8, relating to accident and sickness insurance; coverage for infertility treatment.

Patrons—Barlow, Crittenden and 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 a section numbered 38.2-3418.8, as follows:

§ 38.2-3418.8. Coverage for infertility treatment.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the treatment of infertility under any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.

B. For purposes of this section, "infertility" means the inability to conceive after one year of unprotected sexual intercourse, so long as the covered individual has not undergone four complete oocyte retrievals, except that if a live birth follows a complete oocyte retrieval, then two more oocyte retrievals shall be covered. "Treatment for infertility" includes, but is not limited to, the following procedures performed on a covered individual who is less than fifty years old: in vitro fertilization, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, intracytoplasmic sperm injection, zygote intrafallopian transfers and low tubal ovum transfer. "Treatment for infertility" does not include the reversal of a vasectomy or a tubal ligation.

C. The reimbursement for treatment for infertility shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease 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 governmental plans or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.7~~ *38.2-3418.8*, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 58 (§ 38.2-5800 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives

shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

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HOUSE BILL NO. 2403
FLOOR AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by Delegate Wagner
on February 8, 1999)
(Patron Prior to Substitute-Delegate Barlow)

A BILL to amend and reenact §§ 2.1-20.1 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.8, relating to accident and sickness insurance; coverage for infertility treatment.

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-20.1 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.8, as follows:

§ 2.1-20.1. Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. a. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

b. In order to be considered a screening mammogram for which coverage shall be made available under this section:

(1) The mammogram must be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report must be sent or delivered to the health care practitioner who ordered it;

(2) The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

(3) The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits which shall be in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and

Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. Such appeals process shall include a separate expedited emergency appeals procedure which shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care.

5. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services which enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

6. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

7. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

8. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

9. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there may be no denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears.

12. Include coverage providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

13. Include coverage (i) to persons age fifty and over and (ii) to persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA

testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

14. Include coverage for the treatment of infertility. For the purpose of this subdivision, "infertility" means the inability to conceive after one year of unprotected sexual intercourse. "Treatment for infertility" includes, but is not limited to, the following procedures performed on a covered individual who is less than fifty years old: in vitro fertilization, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, intracytoplasmic sperm injection, zygote intrafallopian transfers and low tubal ovum transfer. Such treatment shall be required only if the covered individual has not undergone four complete oocyte retrievals, except that if a live birth follows a complete oocyte retrieval, then two more oocyte retrievals shall be covered. "Treatment for infertility" does not include the reversal of a vasectomy or a tubal ligation.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and beneficiaries thereof. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Personnel and Training which utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

G. The plan established by the Department shall include, in each planning district, at least two health coverage options, each sponsored by unrelated entities. In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan. This section shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan separate from the plan established by the Department.

§ 38.2-3418.8. Coverage for infertility treatment.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the treatment of infertility under

any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.

B. For purposes of this section, "infertility" means the inability to conceive after one year of unprotected sexual intercourse. "Treatment for infertility" includes, but is not limited to, the following procedures performed on a covered individual who is less than fifty years old: in vitro fertilization, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, intracytoplasmic sperm injection, zygote intrafallopian transfers and low tubal ovum transfer. Such treatment shall be required only if the covered individual has not undergone four complete oocyte retrievals, except that if a live birth follows a complete oocyte retrieval, then two more oocyte retrievals shall be covered. "Treatment for infertility" does not include the reversal of a vasectomy or a tubal ligation.

C. The reimbursement for treatment for infertility shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease 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 governmental plans or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.7~~ *38.2-3418.8*, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 58 (§ 38.2-5800 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.