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DATE: February 2, 2000

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 31

RELATING TO: Infertility/Health Insurance

SPONSOR(S): Representative Wasserman-Schultz

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES
(2) INSURANCE
(3) GENERAL GOVERNMENT APPROPRIATIONS
(4)
(5)

I. SUMMARY:

HB 31 requires coverage by health insurance policies, group, franchise, blanket health insurance policies, and health maintenance contracts for the diagnosis and treatment of infertility. The bill applies the requirement to group contracts and plans of self insurance, out-of-state groups, and standard, basic, and limited health benefit plans. The bill provides an exception for religious organizations.

The bill's effective date is October 1, 2000.

This bill would have a fiscal impact on state government and could have a fiscal impact on local government. According to a study conducted on behalf of the Division of State Group Insurance, if HB 31 had been in effect for FY 1999-2000 it would have increased the total costs of the state employees' health insurance program by $11-15 million. It is estimated that in FY 2000-2001 it will increase total costs by $14-20 million.

Estimated fiscal impact on local government is not available.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Infertility Facts:

Infertility is defined as one year of unsuccessful conception. It impacts 10.2 percent of the U.S. reproductive-age females and their partners. One in 10 couples need medical intervention to conceive. Approximately 21 percent of infertile women are examined to determine the cause of their infertility. Of those who pursue treatment, 65 percent succeed in having a baby. Less than 0.2 percent of the couples in which the women are infertile receive the most advanced, high-technology treatment. There is no significant association between race and ethnicity and infertility. About 37 percent of births using advanced reproductive technologies (ART) are multiples: 31 percent twins, 6 percent triplets or more. [*Source: Resolve: The National Infertility Association.]*

In vitro fertilization (IVF) is a method of assisted reproduction in which a man's sperm and the woman's egg are combined in a laboratory dish, where fertilization occurs. The resulting embryo is then transferred to the uterus to develop naturally. Usually, two to four embryos are transferred with each cycle. Other techniques of assisted reproduction include gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), IVF with donor eggs, donor sperm, and donor embryos, and micromanipulation of eggs and embryos.

There are more than 72,000 babies born in the United States since 1980, as a result of all ART, including 45,000 as a result of IVF. According to the most recent statistics (1995), the success rate of ART procedures are as follows:

- in vitro fertilization (IVF) - 22.3% live birth per egg retrieval
- gamete intra fallopian transfer (GIFT) - 26.8% live birth per egg retrieval
- zygote intra fallopian transfer (ZIFT) - 27.7% live birth per egg retrieval

[*Source: American Infertility Association, 1999 FACT SHEET*]

An estimated $26 billion was spent on infertility treatment in the United States in 1996, according to a 1998 study by Cambridge Health Resources called “Infertility Management: Outcomes and Reducing Costs.”

Public Debate:

Infertility insurance has been the subject of heated public debate. Some consider this treatment as nonessential, cosmetic-like medical care which is very, very expensive and made available at the expense of more essential services. In addition, some religious groups oppose infertility insurance mandates on the grounds that certain infertility services lead to the intentional creation and destruction of the excess human embryos.

Division of State Group Insurance:

The State Employees' Preferred Provider Organization Plan (Plan): This plan currently covers nonexperimental diagnosis and treatment of infertility. Laboratory and other medical services related to infertility/fertility testing are covered services for subscribers or subscribers' spouses, subject to the Plan's Medical Policy Guidelines. Some infertility tests and/or treatments may be considered investigational and therefore, non-covered. The Plan does not cover assisted reproductive technology procedures such as in vitro fertilization, gamete intra fallopian transfer, zygote intra fallopian transfer, and artificial insemination. However, laboratory and other medical services rendered in relation to, or in preparation for these procedures are eligible for coverage, subject to limitations on specific procedures.

The State Contracted Health Maintenance Organizations (HMOs): State employee's HMO contracts allow HMOs to exclude or offer limited services in the diagnosis and treatment of infertility. In these HMO contracts, infertility treatment and supplies are defined as infertility testing, treatment of infertility, diagnostic procedures, and artificial insemination to determine or correct the cause or reason for infertility or inability to achieve conception. This includes IVF, ovum, or embryo placement or transfer, gamete intra fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures. HMOs may offer some of these services as "additional" services to all of its subscribers without premium increase.

Florida Insurance Mandate Requirements:

State laws frequently require private health insurance policies and health maintenance organization contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are referred to as "mandated [health] benefits."

Recognizing that "most mandated benefits contribute to the increasing cost of health insurance premiums," while acknowledging the social and health benefits of many of the mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits. At that point, the Legislature had approved 16 mandated benefits. In the thirteen years since, the Legislature has approved an additional 35 mandated benefits. With 51 mandated health benefits, Florida now has one of the nation's most extensive set of coverage requirements. The lone procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandate benefit prior to consideration--has been largely ignored. [*See, s. 624.215, F.S.*] [*Source:* House Committee on Insurance, Interim Project, "Managing Mandated Health Benefits: Policy Options for Consideration, January 28, 2000.]

According to the National Conference of State Legislatures, approximately 900 mandates have been passed among all 50 states. Currently, Congress is also considering imposing additional mandates. Many experts warn that the primary reason health care costs are rising is due to this government interference. According to these experts, the greater the number of services mandated, the greater the costs.

[*Source: Merrill Matthews Jr. (National Center for Policy Analysis), "Cadillac Care Too Rich for Some," USA Today, May 19, 1999*.]

Special Statutory Requirements for Legislation Proposing a New Mandated Health Benefit:

In 1987, the Legislature called for a "systematic review of current and proposed mandated or mandatorily-offered health coverages and established guidelines to be used to conduct the review. Since that time, proponents seeking to require a private insurer or HMO to provide a particular coverage have been required under s. 624.215, F.S., to prepare a report assessing the social and financial impacts of the proposed mandate. The law specifies twelve criteria that proponents must address in the impact analysis. These include an assessment of the extent to which:

- the treatment or service is used by a significant portion of the population;
- the insurance coverage is generally available;
- any general lack of availability of coverage causes persons to forego necessary treatment;
- any general lack of availability of coverage results in unreasonable financial hardship;
- there is a public demand for services;
- there is a public demand for insurance coverage for the services;
- the coverage is included in collective bargaining negotiations;
- cost increase or decrease result from the treatment or service;
- the coverage will increase the appropriate uses of the treatment or service;
- the coverage will be a substitute for a more expensive treatment or service;
- the coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders; and
- the coverage will impact the total cost of health care.

The proponents must submit the report to the Agency for Health Care Administration and the relevant legislative committees.

Other States:

Although no federal law requires insurance coverage for infertility treatment, 13 states have enacted some type of infertility insurance coverage. Each law is different, but most can be generally described as either a mandate to cover or a mandate to offer coverage. A mandate to cover requires health insurance companies to provide coverage of infertility treatment as a benefit included in every policy. A mandate to offer requires health insurance companies to make available for purchase a policy which offers employers to pay for infertility treatment coverage.

According to RESOLVE, an advocacy organization for infertile couples, as of 1998, 13 states have enacted some form of an infertility insurance mandate. The following states have enacted infertility coverage mandates legislation: Arkansas, Hawaii, Illinois, Maryland, Massachusetts, Montana, New York, Ohio, Rhode Island, and West Virginia. California, Connecticut, and Texas have enacted legislation mandating the offer of coverage.

Federal:

Two bills have been introduced in the House of Representatives that require insurance coverage of infertility services. These bills were introduced on August 4 and August 5,

1999. H.R. 2774, sponsored by Representative Marty Meehan (D-MA), requires federal employees' health plans to include coverage of infertility services. The bill was sent to the House Committee on Government Reform. H.R. 2706, sponsored by Representative Anthony Weiner (D-NY), requires all health plans to include coverage of infertility services. The bill was sent to the House Committee on Government Reform, the House Commerce Committee, and the House Committee on Education and the Workforce.

Americans with Disabilities Act:

The Americans with Disabilities Act (ADA), passed in 1991, provides that it is unlawful to discriminate against persons with disabilities. To be disabled under the ADA, a person must have a physiological disorder that affects a major life activity. The definition of a disability includes any physiological disorder or condition of the reproductive system. The United States Supreme Court has ruled that reproduction is a major life activity under the ADA. Thus, infertility is a disability. It is unlawful under the ADA to treat persons with disabilities differently than other employees in the terms or conditions of employment, including fringe benefits.

Although the ADA has a specific section which protects some insurance plans, the Equal Employment Opportunity Commission (EEOC) has issued guidelines in interpreting this provision that are very favorable to persons whose insurance excludes fertility coverage. The guidelines provide that in order to have the protections of the insurance provision for a disability-based distinction, the insurer must establish that it is financially impossible to include the coverage. Employers and insurance carriers cannot establish this. Studies on the cost of infertility coverage have clearly shown that the costs are minimal. Various studies have revealed the costs to be in the range of $.23 to $1.50 per month per family policy.

Currently, the insurance provision of the ADA remains unsettled in the courts. While it may be possible to bring an action directly against the insurance carrier under the ADA, there are, however, only a few court cases that interpret how the law is to be applied to insurance policies and there is no consensus among the various jurisdictions.

C. EFFECT OF PROPOSED CHANGES:

The bill requires health insurance policies, group, franchise, and blanket health insurance policies, and health maintenance contracts to provide coverage for the diagnosis and treatment of infertility, subject to specific requirements, criteria, and limitations. The bill creates an exception to the required coverage for certain religious organizations. The bill excludes payments for donor eggs or certain medical services.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates s. 627.64062, F.S., requiring coverage of diagnosis and treatment of infertility.

Subsection (1) requires that any health insurance policy that provides coverage for pregnancy-related benefits must also provide coverage for the diagnosis and treatment of infertility.

Subsection (2) specifies conditions for required coverage, subject to specified limitations and requirements.

Subsection (3), provides definitions for the following terms: pregnancy-related benefits, infertility, and nonexperimental procedure.

Subsection (4) excludes the provisions of this section from applying to certain religious organizations.

Subsection (5) provides that the provisions of this section are applicable to the state group insurance program under s. 110.123, F.S.

Subsection (6) excludes the provisions of this section from applying to payment for donor eggs or medical services rendered to a surrogate for purposes of child birth.

Section 2. Amends s. 627.651, F.S., relating to requirements for group contracts and plans of self-insurance, to specify that such contracts and plans provide for coverage of the diagnosis and treatment of infertility.

Section 3. Amends s. 627.6515, F.S., relating to out-of-state group health insurance policy requirements, to specify that such contracts provide for coverage of the diagnosis and treatment of infertility.

Section 4. Creates s. 627.65742, F.S., to require coverage of the diagnosis and treatment of infertility.

Subsection (1) requires any group, franchise, or blanket health insurance policy that provides pregnancy-related benefits to provide coverage for the diagnosis and nonexperimental treatment of infertility. Requires the inclusion of all nonexperimental assisted reproductive technology procedures and artificial insemination with partner or donor sperm.

Subsection (2) specifies conditions for coverage, subject to specified limitations and requirements.

Subsection (3) provides definitions for the following terms: pregnancy-related benefits, infertility, and nonexperimental procedure.

Subsection (4) excludes the provisions of this section from applying to certain religious organizations.

Subsection (5) excludes the provisions of this section from applying to payment for donor eggs or medical services rendered to a surrogate for purposes of child birth.

Section 5. Amends s. 627.6699(12)(b), F.S., under the Employees Health Care Access Act, providing for the application of the requirements of this act to standard, basic, and limited health benefit plans.

Section 6. Adds subsection (39) to s. 641.31, F.S., requiring any health maintenance contract that provides pregnancy-related benefits to provide coverage for the diagnosis and nonexperimental treatment of infertility.

Paragraph (a) requires the inclusion of all nonexperimental assisted reproductive technology procedures and artificial insemination with partner or donor sperm.

Paragraph (b) specifies conditions for coverage, subject to specified limitations.

Paragraph (c) provides definitions for the following terms: pregnancy-related benefits, infertility, and nonexperimental procedure.

Paragraph (d) excludes the provisions of this section from applying to certain religious organizations.

Paragraph (e) provides that this subsection applies to benefits for the state group insurance program under s. 110.123, F.S.

Paragraph (f) excludes the provisions of this section from applying to payment for donor eggs or medical services rendered to a surrogate for purposes of child birth.

Section 7. Provides that the act takes effect on October 1, 2000.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

Department of Management Services, Division of State Group Health Insurance provided the following cost estimates:

- Historical costs: Listed below are the summary charges aggregated by ICD-9-CM diagnosis code for female and male infertility, based on claims history files of the state's PPO Plan. Claims were annualized to estimate a full year's cost.

Costs of the PPO Plan for Female Infertility Related Services

DX 628 (female infertility)	Total 1998 - Annualized
Number of Claims	1,504
Charged	$310,210
Paid	$109,233
Rejected	$200,977

Costs of the PPO Plan for Male Infertility Related Services

DX 606 (male infertility)	Total 1998 - Annualized
Number of Claims	428
Charged	$110,818
Paid	$ 29,473
Rejected	$ 81,345

Note: The charges and payments are all based on adjudicated claims which had infertility-related diagnosis codes (not necessarily primary diagnosis).

Because state contracted HMOs have not been required to submit service utilization data, the Division of State Group Insurance lacks an HMO paid claims history to examine the cost history of the HMOs which elect to cover some limited diagnosis and treatment of infertility.

- Estimating the Impact of Proposed Benefit Changes: Expanding health insurance coverage to include the diagnosis and treatment of infertility can be expected to increase demand for the procedures. There is great uncertainty, however, about how utilization of these services would rise with expanded coverage.

Estimated by the U. S. Centers for Disease Control and Prevention, about 15 percent of U.S. marriages are infertile. Assuming that: (1) only those policyholders who purchase either family or spouse health insurance coverage would be the potential candidates for these proposed benefits, and; (2) the state employee's marriage and fertility status are similar to that of the nation, then by applying the CDC percentage to the current enrollment of state employee's health insurance programs, we estimate that 14,198 couples under the state employee's health insurance programs could be the potential users of services for the diagnosis and treatment of infertility.

The costs for the diagnosis and treatment of infertility for these 14,198 couples under the state employee's health insurance program would be a variable sensitive to the frequency and type of treatment procedures that would be pursued by patients and be prescribed by physicians.

Blue Cross and Blue Shield of Florida, Inc, (BCBSF), the Administrator of the state employee's self-funded group health insurance program, did some preliminary research on current costs in fees for some artificial reproductive procedures. These fees reflect the costs for one cycle and do not include prescription drugs. Patients may need three to four cycles for "an attempt" and drug costs range between $1,000 to $3,000 per cycle. As shown below, the average costs for an attempt can be in the $20,000 plus range, not including costs associated with pregnancy outcomes.

In Vitro Fertilization	$6,612 per cycle
Zygote Intrafallopian Transfer	$8,325 per cycle
Gamete Intrafallopian Transfer	$6,625 per cycle

The estimate of more than $20,000 per attempt by BCBSF coincides with the cost projection delivered by Milliman and Robertson, Inc. (M&R), an actuary consulting firm with whom the Department of Management Services has a contract. M&R projected that HB 31 would have increased the total costs of state employee's health insurance program in FY 1999-2000 by $11-15 million. M&R estimated that in FY 2000-2001 program costs would increase by $15-20 million. M&R also projected that program costs could be higher if a significant portion of the program participants have been deferring treatment because it has not been covered in the past. It was noted by M&R that there would be higher costs associated with covered care for maternity and delivery. These estimates were developed based on current program benefit design, projected service utilization, M&R's Health Cost guidelines, market price of infertility treatment, and the estimated expenditures from the November 1998 Consensus Estimating Conference.

If enactment of HB 31 would result in the fiscal impact on the state employee's group health insurance program as projected by M&R, these higher costs would probably be passed on to HMO and PPO plan participants and the state in the form of premium

increases. The actual increase in premiums, however, is difficult to assess because it depends on many unknown factors.

Additional member notification to all state group health insurance enrollees of benefit changes would be needed. The notification to all state group health insurance enrollees of benefit changes would be needed. The notification would cost the department $48,500. This non-recurring or start-up expenditures of $48,500 are estimated based on current health insurance enrollment of 16,512 and a production and bulk rate mailing costs of $0.30 per piece of mail. If new benefits are effective January 1, 2001, then notification can occur during the regular open enrollment period and no additional expenditures will be required.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

Unknown.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Department of Insurance: The department cannot estimate the additional costs to insurers of providing coverage for the various infertility treatments outlined in this bill because procedures are reported to be costly. It is likely premiums would increase as a result of these new mandated benefits.

D. FISCAL COMMENTS:

Medicaid does not cover anything specific to infertility. However, if a medical condition exists that needs to be treated, that medically necessary treatment might likely result in improving the likelihood of pregnancy. While the bill does not address Medicaid coverage for infertility, if through adoption of the bill, infertility coverage becomes a standard covered service, the Florida Medicaid Program will experience increased pressure to cover this service.

Division of State Group Insurance: In its current draft, HB 31 lacks a definition of the population to which these proposed benefits could be utilized. The bill does not provide any benefit limitation for the diagnosis and treatment of infertility. It would greatly enhance the operability of the bill if language would be amended to clearly define user population and some feasible age-related limitations of the usage of these procedures. Some employers have limited coverage to no more than five attempts, since statistically, success after five attempts is highly improbable.

The mandated benefits adversely affect small private employers who purchase fully insured health insurance products for their employees. The Employee Retirement Income Security Act (ERISA) exempts self-funded employer-sponsored health plans from state mandated benefits. Many large employers sponsor self-funded health insurance benefits. Most small-employers, however, purchase fully insured products--and they must comply with mandated benefits.

The Government Accounting Office (GAO) estimates that 40% of individuals covered by private employer-sponsored health insurance plans participate in plans exempt from mandated benefits. Also, according to the GAO, mandated benefits account for 5-22 percent of total claims costs. The additional cost of mandated benefits is more burdensome to small-employers because they are more price sensitive than larger-employers, particularly for such coverage as these relatively expensive procedures for diagnosis and treatment of infertility. Therefore, small-employers may forgo offering other benefits more attractive to their employees in order to comply with mandates to provide selected benefits. Like any other mandated coverage, requirements for disease/condition specific benefits have the potential of increasing the uninsured and underinsured population, particularly among people who rely on small employers.

HB 31 provides for an October 1, 2000, implementation date. This date would not allow notifying plan participants during the regular open enrollment period which generally occurs from mid-September to mid-October. Any benefit changes occurring other than at the beginning of the plan year (January 1) requires the department to issue special notification to plan participants. The department would undergo additional administrative process and incur costs that are not budgeted. The department recommends that any changes to the State Employee' PPO Plan and to state-contracted HMOs have a January 1, 2001, implementation date.

Department of Insurance: Policyholders who today do not have insurance policy coverage for the named infertility treatments contained in this legislation would receive these benefits if the legislation were enacted.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill could require local governments to incur expenses, i.e., to pay additional health insurance costs. Therefore, the bill may fall within the purview of Article VII, Section 18 of the Florida Constitution, which provides that cities and counties are not bound by general laws requiring them to spend funds or to take an action which requires the expenditure of funds unless certain specified exemptions or exceptions are made.

This bill does not contain a legislative finding that the bill fulfills an important state interest.

Since the bill's fiscal impact on local government is indeterminate, it is not known whether the impact would be insignificant for purposes of implementing the Florida constitutional prohibition since it may or may not exceed the threshold amount of $1.5 million.

The bill's mandate relating to infertility coverage would apply to all similar situated private, state government, and local government health plans.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill noes not reduce the percentage of a state tax shared with counties or municipalities.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the authority that counties or municipalities have to raise revenues.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

Department of Insurance: Subsection (5) of newly created s. 627.65742, F.S., and newly created paragraph (e) of s. 641.315(36), F.S., apply the new law requiring coverage for certain infertility treatments and services to the state group insurance program. These requirements should be amended directly into chapter 110, F.S., as a state employee health insurance program benefit.

Compliance with s. 624.215, F.S.: The sponsor has provided the required report for mandate proposals in accordance with s. 624.215, F.S. The report reflects the requested information on a national basis, as Florida specific information is not available. The report is on file with the House Committee on Health Care Services.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Tonya Sue Chavis, Esq.	Phil E. Williams