Mandated Benefits Review by the Pennsylvania Health Care Cost Containment Council

House Resolution 400

Infertility
Diagnosis and Treatment

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EXECUTIVE SUMMARY

The Pennsylvania Health Care Cost Containment Council's (PHC4's) role in conducting reviews of this nature is primarily to determine if sufficient evidence is available to proceed to a more formal Mandated Benefits Review Panel as outlined in Act 14 of 2003, (i.e., contracting with a panel of outside experts to review the scientific validity of the studies submitted). Act 14 places the burden of providing scientific data and information regarding the proposed mandate on interested parties. While PHC4 conducts its own research as appropriate, the reviews rely almost entirely upon outside information as detailed in the enabling legislation.

This particular review raises questions with regard to PHC4's role in reviewing Resolutions, as compared to House or Senate Bills. PHC4's enabling legislation provides that PHC4 "review current law or proposed legislation regarding mandated health benefits when requested by the executive and legislative branches of government." Since Resolutions do not carry the full effect of legislation, it is not clear what impact such a review would hold. While PHC4 went forward in examining the documentation received, a legal opinion from its counsel will be sought if there are future requests to review Resolutions.

After reviewing the documentation relevant to House Resolution 400, PHC4 does not find sufficient evidence to support this resolution in its present form or to continue with the more formal review process as outlined in Act 14 of 2003. In coming to this recommendation, PHC4 paid particular attention to the experiences of other states and inconsistencies among the submissions. We note the following points:

- Several studies made reference to individual state experiences:
  - Maryland's in vitro fertilization requirement is very expensive and has been identified as one of several benefits to be eliminated.[1]
  - In Massachusetts, where infertility benefits are mandated, the rate of assisted reproductive technology utilization is five times greater than in Pennsylvania.[2] This finding supports a 2002 *New England Journal of Medicine* article, "Insurance Coverage and Outcomes of In Vitro Fertilization," which revealed that the utilization rate for in vitro fertilization in states that require complete coverage for the procedure is 2.8 times the rate in states that do not have a mandate.[3]
  - New Jersey, which mandates infertility benefits, produces triplets, quadruplets and other multiple births at two times the national rate.[4]
  - In developing a standard benefits package for its Medicaid program, Oregon ranked assisted fertilization as 701st in importance, out of a total of 714 possible medical conditions, based on public need, medical efficacy and cost effectiveness.[5]

- One inaccuracy within the resolution itself is the statement that comprehensive infertility treatment is already available to state employees within Pennsylvania. While certain Pennsylvania state legislative staff do have such coverage, state employees covered under the Pennsylvania Employees Benefit Trust Fund (PEBTF) do not.

- With regard to cost, opponents pointed to information suggesting that infertility mandates increase cost. One study noted that infertility treatment mandates can add between $105 and $175 annually to the cost of a standard family policy.[6] This same study noted that while the cost of 12 of the most common mandates can increase the cost of health insurance by 30%, infertility treatment mandates alone can add 3% to 5% to the estimated annual cost of family coverage. Another study found that New York's infertility

mandate increased annual premiums by $27.54 for an individual and $66.06 for a family.[7] As a result of New Jersey's infertility mandate, AmeriHealth New Jersey increased its rates by 3% for both its medical and pharmaceutical programs.[8] Highmark actuaries estimated that an assisted reproductive services mandate in Pennsylvania would add $34.5 million to its claims expenses. PHC4's analysis, based on information provided by opponents and proponents, suggests additional statewide costs of between $250 million and $2 billion, depending on utilization. (Part of PHC4's cost analysis was based on RESOLVE's comment that Pennsylvania could expect up to a 20 percent increase in utilization of assisted reproductive technology services. However, it is important to point out that these estimates do not take current utilization into account and are over and above those who currently have health coverage for infertility diagnosis and treatment.)

Proponents insist, however, that states with infertility mandates can actually reduce overall health care costs through heightened disease management and eliminating unnecessary, outdated procedures. One referenced study found that a comprehensive infertility mandate could actually reduce premiums by $1 per member per month if accompanied by heightened disease management.[9]

- Inconsistent information regarding how multiple births are affected by infertility mandates was provided. Proponents argued that coverage enables infertile couples to make purely medical decisions and avoid risk taking that can lead to higher order multiple births. One referenced study found that states with full coverage for infertility treatment have lower multiple birth rates than states without mandated coverage. New Jersey's experience, however, seems to contradict this finding as it produces multiples at twice the national rate

- Inconsistent information was also provided regarding the success rates of infertility treatment. For example, one submission noted that although the success rates for different procedures vary, they generally do not exceed 20% to 30%. Another submission cited overall success rates as high as 80%.

- Finally, PHC4 also considered HR 400 in light of the serious concerns about the cumulative financial effect of enacting all types of mandates in Pennsylvania. Citations that highlight this collective impact include:
  - In New York, mandated benefits increased premiums by 12.2%, an increase of $444.57 per year for single coverage and $1,066.37 per year for family coverage.[10]
  - Mandated benefits increased the costs of basic coverage from slightly less than 20% to more than 50%, depending on the state (over 1,800 mandates analyzed).[11]
  - For every 1% increase in insurance premiums, an average of 120,000 working people are added to the rolls of the uninsured.[12]
  - Of the $67 billion increase in national health care costs between 2001 and 2002, 15% or $10 billion was attributable to health benefit mandates and regulations.[13]

[1] Mercer Human Resource Consulting. (2004). "Study of Mandated Health Insurance Services: A Comparative Evaluation." Prepared for the Maryland Health Care Commission.
[2] Panak, W.F., Griffin, M., Smith, M.S., Dennler, B., & Erickson, J. (1998). "Report to the Pennsylvania Health Care Cost Containment Council on Senate Bill 1183: A Bill to Mandate Infertility Benefits within Health Insurance Policies." Cedar Falls, Iowa.
[3] Jain, T., Harlow, B.L., & Hornstein, M.D. (2002). "Insurance Coverage and Outcomes of In Vitro Fertilization." *New England Journal of Medicine*, 347(9).
[4] Nussbaum, D. (2005, October 23). "Triplet Nation." *The New York Times*.
[5] Highmark, Inc. (1998). "Mandated Benefits Submission to the Pennsylvania Health Care Cost Containment Council on Senate Bill 1183."

[6,9] National Center for Policy Analysis. (1997). "The Cost of Health Insurance Mandates."
[7] Novak, D. (2003). "New York State Mandated Health Insurance Benefits." NovaRest Consulting.
[8] Independence Blue Cross. (2005). "Mandated Benefits Submission to the Pennsylvania Health Care Cost Containment Council on House Resolution 400."
[10] Blackwell, R., et al. (2000). "The Hidden Costs of Infertility Treatment in Employee Health Benefits." *American Journal of Obstetrics and Gynecology*, 182(4).
[11] Bunce, V.C., & Wieske, J.P. (2005). "Health Insurance Mandates in the States." Council for Affordable Health Insurance.
[12] Barents Group, LLC. (1998). "Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003." Prepared for the American Association of Health Plans.
[13] PricewaterhouseCoopers. (2002). "The Factors Fueling Rising Healthcare Costs." Prepared for the American Association of Health Plans.

REVIEW OF HOUSE RESOLUTION 400

Overview of Resolution

House Resolution 400 directs the Pennsylvania Health Care Cost Containment Council (PHC4) to conduct a study* regarding the requirement of comprehensive insurance coverage for the diagnosis and treatment of infertility. In the resolution, infertility is defined as the inability to conceive after one year of unprotected intercourse for women under 35 years of age or after six months for women 35 years of age or older. The mandate would cover men and women (though women have to be 21 to 45 years of age) who are either the policyholder or the spouse with co-payments and deductibles for assisted reproductive technology procedures, which do not exceed those for all other pregnancy-related benefits, up to a maximum of 20% of the cost of the procedure. While coverage would not be limited to these specific treatments, in vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer are among the treatments mentioned in the resolution. The resolution also cites the exclusion of specific services – including, but not limited to, elective sterilization reversal; use of assisted reproductive technology when infertility is the result of elective sterilization; services provided in connection with the use of a surrogate mother; and experimental procedures.

Mandated Benefits Review Process

PHC4's enabling legislation, Act 89 of 1986 (as re-authorized by Act 34 of 1993 and Act 14 of 2003), provides that PHC4 review current law or proposed legislation regarding mandated health benefits when requested by the executive and legislative branches of government.

Representative Nicholas A. Micozzie, Chairman of the House Insurance Committee, requested that PHC4 review the provisions of House Resolution 400 (PN 2469 – Representative Bunt). House Resolution 400 directs PHC4 to study the requirement of comprehensive insurance coverage for the diagnosis and treatment of infertility.

Notification was published in the *Pennsylvania Bulletin* on September 17, 2005, requesting that interested parties submit documentation and information pertaining to the resolution to PHC4. Letters were also sent to potentially interested individuals and organizations informing them of the pending review and inviting them to submit information pursuant to the notice. Following the initial comment period, an opportunity was provided for interested individuals and organizations to examine the responses received and submit a second round of documentation. Final submissions were due to PHC4 on January 17, 2006. The Pennsylvania Department of Health and the Insurance Department were notified of the review and received a copy of the submissions.

A list of the submissions received and a copy of the bill are attached.

Act 14 provides for a preliminary PHC4 review to determine if the documentation submitted is sufficient to proceed with the formal Mandated Benefits Review process outlined in the Act. This formal process involves another step beyond PHC4 review by contracting with five additional experts to review the documentation submitted by proponents and opponents.

This report presents the results of PHC4's preliminary review and conclusions regarding whether the material is sufficient to proceed with the formal review process.

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* PHC4 was asked to study a similar infertility mandate in 1997 in the form of Senate Bill 1183. PHC4 issued its report on the bill in September 1998.

Analysis of Documentation Submitted by Opponents and Proponents in Response to the Eight Categories Required by Act 14, Section 9

I. The extent to which the proposed benefit and the services it would provide are needed by, available to and utilized by the population of the Commonwealth.

Affected population. RESOLVE, the national infertility association, reported that there are approximately 268,883 infertile people in Pennsylvania. Other submissions included differing figures regarding the number of infertile *couples*. Blue Cross of Northeastern Pennsylvania and Highmark cited American Society of Reproductive Medicine (ASRM) figures, indicating that infertility is experienced by about 6.1 million couples in the United States – or 10% of the reproductive age population. In addition, Highmark cited studies confirming that roughly 8% of couples – or 2.5 million couples – are infertile under the definition of 12 months or more of unprotected sex without pregnancy. Blue Cross of Northeastern Pennsylvania also presented figures from the InterNational Council on Infertility Information Dissemination, which reports that there are five million infertile couples in the United States.

Medical necessity. Several submissions expressed that while there are emotionally compelling arguments for infertility mandates, infertility services do not rise to the level of medical necessity. An article submitted by Highmark noted that most health plans exclude coverage for in vitro fertilization based on the argument that it is not a medically necessary procedure. The Insurance Federation of Pennsylvania maintains that the *desire* for the proposed benefit is not the same as the *need* for it and argues that "it remains the unfortunate fact that the weight of health care costs is endangering the extent of coverage and the provision of essential services to the population." According to the Federation, in terms of medical necessity, the urgency of curing infertility is rather low compared to other medical priorities.

In contrast, RESOLVE argued that "[i]nfertility is a medically recognized disease of the reproductive system that affects millions of women and men in this country. It is not a minor medical inconvenience, but instead a medical condition that impacts individuals both physically and mentally." RESOLVE also noted that infertility can be life-threatening as individuals can die due to multiple miscarriages.

Availability. In their submissions, Highmark and RESOLVE included a Centers for Disease Control and Prevention (CDC) report, which indicated that there were 20 assisted reproductive technology clinics operating in Pennsylvania in 2002. RESOLVE also noted that there are 49 reproductive endocrinologists in Pennsylvania and that while an "infrastructure is available to provide the appropriate care to those struggling with infertility," lack of insurance hinders utilization.

Additional information about availability as it relates to insurance coverage is included in section (II) below.

Utilization. Utilization figures were discussed in several submissions. According to RESOLVE, only 50% of all infertile people seek treatment, and people who do not seek treatment do so because it is cost prohibitive. RESOLVE also reported that the CDC found that, from 1998 to 2002, Pennsylvania infertility clinics saw a 10% increase in in vitro fertilization cycles using fresh embryos. Citing PHC4's 1998 analysis of Senate Bill 1183, Blue Cross of Northeastern Pennsylvania pointed to Massachusetts' experience with mandated infertility benefits, where the rate of assisted reproductive technology utilization is

five times greater than in Pennsylvania. However, RESOLVE pointed to another study that said it was impossible to tell whether higher utilization rates in Massachusetts existed prior to the mandate. Highmark referenced a 2002 *New England Journal of Medicine* article, "Insurance Coverage and Outcomes of In Vitro Fertilization," which revealed that the utilization rate for in vitro fertilization in states that require complete coverage for the procedure is 2.8 times the rate in states that do not have a mandate.

II. The extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the Commonwealth.

Existing coverage. Several submissions cited studies related to current levels of insurance coverage for infertility services. A 2005 Society for Human Resource Management study found that "41% of 355 U.S. large group employers offered insurance coverage for at least some infertility treatment" even though most plans excluded in vitro fertilization. Another national study found that in vitro fertilization is routinely covered by 17% of POS networks and HMOs, 16% of PPOs, and 14% of large group health plans.

According to RESOLVE, infertility treatment is not covered by most health insurance plans in Pennsylvania; however, there are a few employers within the state who provide voluntary coverage.

Currently, Blue Cross of Northeastern Pennsylvania covers artificial insemination for three attempts in a lifetime. Yet, beyond artificial insemination, infertility coverage is not a core benefit, but can be included at a purchaser's discretion.

Regarding its coverage, Highmark noted the following:

> Highmark's traditional fee-for-service and managed care plans (PPOs, HMOs, POS) generally cover medical, surgical and diagnostic services performed to diagnose and treat infertility (i.e., pelvic sonograms and ultrasounds, sperm count evaluation and analysis), unless the member's contract specifically excludes the diagnosis and treatment.

Generally excluded services from standard Highmark contracts include assisted fertilization treatment services, such as artificial insemination, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and blastocyst transfer. While Highmark does make additional optional benefits available to groups, only a limited number of its customers have elected to include coverage for assisted fertilization treatments. In addition, Highmark noted that its jointly owned Gateway Health Plan – a Medicaid managed care plan – does not provide infertility treatment coverage, and its members are referred to Adagio (formerly the Family Health Council) for assistance.

Highmark also reported that, according to the Fertility LifeLines Web site (www.fertilitylifelines.com), there are other payment options available for couples seeking assisted reproductive technologies. Some infertility centers offer payment plans called "shared risk." While these plans differ, the patient generally pays a fee for in vitro fertilization. If the treatment is successful and the patient achieves pregnancy or delivery, the specialist keeps the fee. However, if the treatment is not successful, either all or a large part of the fee is refunded. Some infertility centers have more traditional financing plans and others have relationships with banks and other financial institutions.

Inadequate care. RESOLVE stated that lack of coverage for infertility treatment does result in inadequate health care. It said that coverage leads to safer pregnancies and health outcomes for both mothers and their babies. As evidence of this fact, RESOLVE cited the 2002 *New England Journal of Medicine* article, "Insurance Coverage and Outcomes of In Vitro Fertilization," which reported that states with full coverage for infertility treatment have lower multiple birth rates than states without mandated coverage. As RESOLVE sees it, this study indicates that:

> Those couples with insurance coverage are free to make purely medical decisions while pursuing some infertility treatments, as opposed to couples who must also weigh financial considerations that often result in medical risk taking, multiple births and a high rate of complications during and post-pregnancy.

However, Independence Blue Cross submitted articles – including the 2005 *New York Times* story "Triplet Nation" – that contradict the above claim. According to "Triplet Nation," New Jersey – which has the highest number of fertility clinics per capita in the country and mandates infertility benefits – produces triplets, quadruplets and other multiple births at two times the national rate.

In its submission, the Insurance Federation of Pennsylvania addressed the extent to which lack of coverage for infertility treatment results in inadequate care. According to the Federation, the fact that the benefit is a *desired* one is not evidence that a lack of coverage means that individuals are receiving substandard care.

Financial hardship. RESOLVE noted the following financial hardships:

> Those who pay for treatment out-of-pocket are often forced to borrow money, spend down their 401(k) plans or other savings, take out second mortgages on homes, or delay the purchase of a home. Out-of-pocket payments for infertility treatment often result in an insecure financial future for many couples.

RESOLVE also indicated that mandated coverage would enable couples to have the financial resources available to pursue adoption if infertility treatments fail, and it would alleviate some of the financial hardships related to persons seeking costly mental health counseling as a result of this disease.

Like the question broached about lack of coverage resulting in inadequate care, the Insurance Federation of Pennsylvania stated that whether lack of coverage results in financial hardship is also a question of perspective. While individuals sometimes make the personal choice to seek treatment beyond what their insurance covers, the Federation contends that this is self-imposed financial hardship.

III. The demand for the proposed benefit from the public and the source and extent of the opposition to mandating the benefit.

Support for House Resolution 400. In support of the resolution, PHC4 received a submission from RESOLVE, the national infertility association; a letter from Representative Raymond Bunt, Jr. (the resolution's sponsor); and 67 individual constituent letters.

As previously noted in section (I), RESOLVE stated that infertility is a disease that impacts people both mentally and physically and, in some cases, is life-threatening when multiple miscarriages occur; therefore, access to treatment should be the same as with other diseases. Contrary to opponents who point to low success rates, RESOLVE noted that infertility is highly treatable, with more than 80% of couples achieving successful outcomes. It cited the American Society of Reproductive Medicine, which reports that "85% to 90% of infertility cases can be treated with conventional medications" while in vitro fertilization comprises less than 3% of infertility services.

RESOLVE also indicated that the perceived costs of treating infertility are overstated, as most individuals find success with less costly treatments, such as prescription medications and minimally invasive procedures. One referenced study found that states with infertility mandates have – through effective cost containment measures, such as heightened disease management and eliminating unnecessary procedures – *reduced* overall health care costs. Thus, Pennsylvania can update its infertility coverage by making cost-neutral or cost-saving revisions to current insurance policies. It is important to note that RESOLVE supports the restrictions placed on the diagnosis and treatment of infertility included in the resolution. RESOLVE said they are reasonable from both a disease management and cost containment perspective.

As mentioned in section (II), another reason for the mandate is that coverage would enable couples to have the financial resources available to pursue adoption if infertility treatments fail. Supporters also contend that since Pennsylvania lags behind other East Coast states in terms of modernizing infertility coverage, young, upwardly mobile couples could move to other states with more family friendly coverage. Some advocates have made the case that not providing infertility benefits is a form of discrimination and violates the Americans with Disabilities Act.

Below are a few studies cited by proponents making the case for the adoption of an infertility mandate:

Effects of Infertility Insurance Mandates on Fertility (Schmidt, August 2005)
- While state infertility mandates increase first birth rates by 32% for women over 35, they have had no significant effect on overall birth rates.

The Hidden Costs of Infertility Treatment in Employee Health Benefits (Blackwell, R., et al., April 2000)
- A comprehensive infertility mandate could actually reduce premiums by $1 per member per month if accompanied by heightened disease management.

Insurance Coverage and Outcomes of In Vitro Fertilization (Jain, Harlow & Hornstein, August 2002)
- Multiple birth rates are lower in states with full coverage for infertility treatments than in states without such mandates.

Opposition to House Resolution 400. PHC4 received submissions from seven organizations that oppose mandating infertility treatment benefits. Arguments against the mandate were grounded in the following observations: 1) mandated infertility benefits are especially costly, 2) mandates, in general, increase health care costs, 3) inclusion of infertility benefits should remain a purchaser's decision, 4) the language of the resolution is open-ended, 5) other methods exist for financing assisted reproductive technologies, 6) the lack of

medical necessity and low success rates for assisted reproductive technologies, and 7) the mandate violates moral and religious teachings.

- *Mandated infertility benefits increase health care costs*

  A number of opponents are concerned that mandated coverage for infertility would drastically spike infertility treatment utilization, thereby increasing costs. Previously noted in section (I), Blue Cross of Northeastern Pennsylvania pointed to Massachusetts' experience with mandated infertility benefits, where the rate of assisted reproductive technology utilization is five times greater than in Pennsylvania. According to Independence Blue Cross, AmeriHealth New Jersey – one of its subsidiaries – had to increase its rates by 3% for both its medical and pharmaceutical programs as a result of New Jersey's infertility mandate. Highmark actuaries estimated that an assisted reproductive services mandate in Pennsylvania would add $34.5 million to its claims expenses. Opponents are also concerned about the enormous costs associated with higher order multiple births that typically accompany certain treatments.

  Below are a few studies that opponents cited regarding the impact of infertility mandates on health care costs:

  Study of Mandated Health Insurance Services: A Comparative Evaluation (Maryland Health Care Commission/Mercer Human Resource Consulting, January 2004)
  - Maryland's in vitro fertilization requirement is very expensive, and the benefit is identified as one of several benefits to be eliminated.
  - The elimination of this mandate would result in a savings of 0.8% of premium based on the full cost of the mandate.

  The Cost of Health Insurance Mandates (National Center for Policy Analysis, August 1997)
  - While the cost of 12 of the most common mandates can increase the cost of health insurance by 30%, infertility treatment mandates alone can add 3% to 5% to the estimated annual cost of family coverage.
  - Infertility treatment adds between $105 and $175 annually to the cost of a standard family policy.

  Insurance Coverage and Outcomes of In Vitro Fertilization (Jain, Harlow & Hornstein, August 2002)
  - The utilization rate for in vitro fertilization in states that require complete coverage for the procedure is 2.8 times the rate in states that do not have a mandate.

  New York State Mandated Health Insurance Benefits (Novak, May 2003)
  - New York's infertility mandate contributed 0.7% to the direct and net costs of premiums. In terms of net dollar increase, the infertility mandate added $27.54 annually for an individual and $66.06 for a family.

- *Mandates, in general, increase total health care costs*

  Rather than ensure better health care, opponents stated that mandates increase premium costs, reduce health coverage for some individuals, and force others to become uninsured. The opponents suggest the following scenario as one of the mechanisms that increase the total cost of health care:

- Large employers become self-insured to avoid mandates.
- This increases the burden on medium-size and small businesses that are already struggling to provide their employees with health care coverage.
- These smaller employers are forced to pass on the costs to their employees.
- Employees' real wages are affected through higher contributions toward health care coverage and/or lowered hourly rates or salaries.
- Some employees may not be able to afford the increases and join the ranks of the working uninsured.
- Others may be laid off and join the ranks of the unemployed uninsured.
- Either way, health care costs are increased.

Opponents cited many studies regarding the impact of all types of mandates on total health costs. Several of these citations are noted below:

New York State Mandated Health Insurance Benefits (Novak, May 2003)

- In New York, mandated benefits increased premiums by 12.2%, an increase of $444.57 per year for single coverage and $1,066.37 per year for family coverage.

Health Insurance Mandates in the States (Council for Affordable Health Insurance, January 2005)

- Mandated benefits increased the costs of basic coverage from slightly less than 20% to more than 50%, depending on the state (over 1,800 mandates analyzed).

Impacts of Four Legislative Provisions on Managed Care Consumers 1999-2003 (Barents Group, LLC)

- For every 1% increase in insurance premiums, an average of 120,000 working people are added to the rolls of the uninsured.
- Between 2000 and 2003, the number of employers offering health insurance decreased from 70% to 66.5%.

The Factors Fueling Rising Healthcare Costs (PricewaterhouseCoopers, April 2002)

- Of the $67 billion increase in national health care costs between 2001 and 2002, 15% or $10 billion was attributable to health benefit mandates and regulations.

- *Offering infertility benefits should be a purchaser's decision*

Although Blue Cross of Northeastern Pennsylvania currently provides limited coverage for artificial insemination as previously noted in section (II), it believes that infertility coverage as a core benefit should remain at the discretion of the purchaser. Employer groups who want to include such coverage can work with their insurer to accommodate their needs. Furthermore, the current health insurance benefit structures do not seem to impede employers who want to add elective infertility coverage.

- *Language of the resolution is open-ended*

Most of the opponents were concerned about the resolution's open-ended language. It was pointed out that, among the states that mandate some level of infertility coverage, most of them impose major restrictions, such as lifetime or annual financial caps, which seek to mitigate overall cost impacts. While the resolution does limit the number of fertilization and transfer cycles, Blue Cross of Northeastern Pennsylvania is concerned

that the proposed benefit is not limited to a smaller sector of the population and that there are no explicit financial limitations. It also questions whether the mandate would include coverage for fertility drugs and what would be covered as new technologies develop. (Note: House Resolution 400 does not specifically call for mandating coverage for fertility drugs, but it does not exclude prescription drug regimens either.) Despite the limits placed on fertilization and transfer cycles, the Insurance Federation of Pennsylvania states that the proposed number of cycles and covered procedures are still very broad, compared to existing mandates in other states. Referencing PHC4's earlier report on Senate Bill 1183, the Federation noted that two states with infertility mandates do not apply the mandate to small businesses, three exclude in vitro fertilization, and several others limit coverage to correctable medical conditions.

- *Other financing opportunities for assisted reproductive technologies*

  As previously mentioned in section (II), Highmark reported that, according to the Fertility LifeLines Web site (www.fertilitylifelines.com), there are other payment options available for couples seeking assisted reproductive technologies. Some infertility centers offer payment plans called "shared risk." While these plans differ, the patient generally pays a fee for in vitro fertilization. If the treatment is successful and the patient achieves pregnancy or delivery, the specialist keeps the fee. However, if the treatment is not successful, either all or a large part of the fee is refunded. Some infertility centers have more traditional financing plans and others have relationships with banks and other financial institutions.

- *The lack of medical necessity/low success rates for infertility treatments*

  Also discussed in section (II), most opponents contend that, while there are emotionally compelling arguments for infertility mandates, infertility services do not rise to the level of medical necessity and lack of coverage for such services does not mean individuals are receiving substandard care. The Insurance Federation of Pennsylvania maintains that the *desire* for the proposed benefit is not the same as the *need* for it, and in terms of medical necessity, the urgency of curing infertility is rather low compared to other medical priorities.

  Additionally, given the high costs of infertility procedures, the relatively low success rates are troubling to opponents. Highmark noted that recent studies indicate that most infertility clinics have success rates averaging about 35%, or one in three assisted productive procedures result in a baby. Blue Cross of Northeastern Pennsylvania indicated that although the success rates for different procedures vary, they generally do not exceed 20% to 30%. More information about the success rates of various infertility treatments is outlined in section (VII).

- *The mandate violates moral and religious teachings*

The Pennsylvania Catholic Health Association opposes the resolution as it covers in vitro fertilization and other procedures deemed immoral by the Catholic Church. According to the Association, the mandate would require Catholic-sponsored health care plans and managed care organizations to cover and pay for procedures that violate the Church's teachings and beliefs. Moreover, Catholic employers would be forced to purchase policies that cover infertility treatments – a practice prohibited by the Vatican's *Donum Vitae*. The Association notes that, under Maryland's mandate, there is an exclusion for coverage that is inconsistent with the beliefs and practices of a religious organization. In addition to these concerns, Highmark contends that other ethical and moral issues would arise if the mandate was adopted, particularly ones surrounding the storage of eggs and sperm, unused eggs and sperm donations, and coverage for individuals in same-sex partnerships.

IV. All relevant findings bearing on the social impact of the lack of the proposed benefit.

RESOLVE indicated that infertility affects one's general health, marriage, job performance, financial status and social relationships. It noted the high levels of depression experienced by people dealing with infertility, as well as the stigma that accompanies not being able to build a family. Citing an article written by the author of several infertility books, RESOLVE indicated that "women with infertility have the same levels of anxiety and depression as do women with cancer, heart disease and HIV+ status."

RESOLVE also said that, contrary to what opponents contend, mandating infertility coverage will help to alleviate the harmful emotional effects of infertility. It wrote, "Relieving the financial burden and allowing infertility patients to pursue treatment that they otherwise could not afford to pursue, or would have to delay, will have a tremendous impact on the emotional aspects associated with this disease."

While Highmark recognized that infertility can cause psychological, emotional, social and economic stress, it said that quantifying the human toll is nearly impossible – beyond looking at the costs associated with diagnosis and treatment. Highmark wrote:

> There is no doubt that infertility has a definite social impact affecting the self-image and self-worth of individuals and couples, and the broader implications for their families, and the medical community. It is unrealistic, however, to assume that the crisis of infertility can be effectively minimized by mandating coverage of expensive procedures, successful only if culminating in a live birth in less than 15% of all cases.

As previously mentioned in section (III), Highmark also noted that the impact of alternative lifestyles and same-sex partnerships is another societal issue that mandated infertility benefits bring forth. Highmark commented, "The adoption of assisted reproductive technology in Pennsylvania may lead to utilization not envisioned or intended by current legislation, raising significant ethical and moral questions…including what happens to eggs and sperm donations that may not be used."

Referring to PHC4's earlier review of Senate Bill 1183, the Insurance Federation of Pennsylvania wrote that while infertility clearly has an impact on individuals affected, it is not clear that a lack of a mandate does have an impact.

> The reason is that the mandate does not necessarily spread the availability of treatment to a very large portion of the population which needs it, and, just as importantly, the

treatments are unsuccessful in the vast majority of cases even as to those who may become covered.

V. Where the proposed benefit would mandate coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapies and no therapy.

House Resolution does not call for the coverage of one particular therapy, but for a range of possible infertility treatments. Additional research regarding the medical outcomes of various infertility treatments is presented in section (VII).

VI. Where the proposed benefit would mandate coverage of an additional class of practitioners, the result of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits.

This point is not applicable to House Resolution 400.

VII. The results of any other relevant research.

A number of submissions provided research related to the cost and efficacy of in vitro fertilization and other assisted reproductive technologies.

As previously noted in section (III), Blue Cross of Northeastern Pennsylvania indicated that although the success rates for different infertility treatments vary, they generally do not exceed 20% to 30%. Blue Cross of Northeastern Pennsylvania also provided detailed cost and success rate information specific to different types of treatments:

Infertility Treatment	Approximate Success Rates	Approximate Costs Per Procedure
Artificial insemination	5%-25%	$300 to $700
In vitro fertilization	28%-35%	$8,000 to $15,000
In vitro fertilization (using donor eggs)	43%	$10,000 to $20,000
Gamete intrafallopian transfer	25%-30%	$8,000 to $15,000
Zygote intrafallopian transfer	25%-30%	$8,000 to $15,000
Intracytoplasmic sperm injection	35%	$10,000 to $17,000

Highmark noted that company research and experience indicates that one cycle of in vitro fertilization, gamete intrafallopian transfer or zygote intrafallopian transfer costs approximately $10,000 to $15,0000, putting a typical procedure expense (based on the eight-cycle limit in the resolution) at about $80,000 to $120,000. This estimate did not include complications, multiple births, and neonatal intensive care cases.

Highmark also referenced a 2004 *New York Times* article, which provided the following cost estimates for certain infertility treatments in the Northeast:

Infertility Treatment	Approximate Costs Per Procedure
Fertility pills and artificial insemination	$1,000 to $2,000
Injectable fertility drugs and artificial insemination	$1,500 to $5,000

In vitro fertilization	$12,000 to $25,000
In vitro fertilization (using donor eggs)	$20,000 to $35,000

With respect to assisted reproductive technology success rates, Highmark added that recent studies have found that most infertility clinics have average success rates of about 35%.

Raising their concerns about the enormous costs associated with higher order multiple births that accompany certain treatments, several opponents cited research regarding this issue. Independence Blue Cross referenced a 2005 *Wall Street Journal* article, which noted that multiple pregnancies are associated with higher risks of low birth weight, premature birth and complications, such as cerebral palsy. Mothers of multiples are at higher risk for post-partum depression and high blood pressure. The same article indicated that studies have found that 30% to 40% of higher order multiple births are the result of in vitro fertilization. Furthermore, many fertility doctors sidestep the *voluntary* guidelines about how many embryos should be implanted in their patients. As mentioned in section (II), a recent *New York Times* article submitted by Independence Blue Cross discussed how New Jersey – with the highest number of fertility clinics per capita in the country and mandated infertility benefits – produces triplets, quadruplets and other multiple births at two times the national rate.

PHC4's hospital discharge data indicates that there were approximately 5,000 neonates born as part of a multiple birth in Pennsylvania hospitals in 2004. The average length of stay for these neonates was 10.8 days, and the average hospital charge was $50,313. The average length of stay for neonates in general was 2.2 days, with an average hospital charge of $2,673.

In its submission, RESOLVE indicated that the William M. Mercer report, "Infertility as a Covered Benefit," found that most infertile patients can be treated with less costly, more conventional techniques, such as fertility drugs and artificial insemination. According to the report:

> Comprehensive coverage of infertility enables health plans to monitor infertility treatments and manage the true cost by eliminating unnecessary, repetitive, costly and ultimately unsuccessful treatments by replacing them with well-managed, cost-effective treatments that are more likely to result in positive outcomes.

The same report revealed that employers could save money by adding a managed fertility component to a standard health plan because the use of high-priced, invasive procedures could be reduced.

> In many plans in which tubal surgery is a covered benefit and [assisted reproductive technology] is excluded, patients (and plans) may be subjected to one or more courses of tubal surgery simply because it is covered. In many cases, costs and outcomes could be improved by offering [in vitro fertilization] IVF coverage for appropriate patients. The decline in the use of high-cost procedures like tubal surgery would likely offset the cost to include IVF as a benefit and provide improved health outcomes.

RESOLVE also noted that better management of the overuse of ovulation induction medications and more quickly moving patients to assisted reproductive technologies could reduce current insurance costs. It said research demonstrates that women are more likely to have multiple births the longer they remain on ovulation stimulation medications.

VIII. Evidence of the financial impact of the proposed legislation.

A. The extent to which the proposed benefit would increase or decrease cost for treatment or service.

While a number of submissions addressed the current costs associated with various procedures as identified in section (VII), RESOLVE included the only reference to how the proposed benefit would affect costs for infertility treatments. It noted that the cost of infertility treatment is 30% to 40% lower in plans where insurance companies extend coverage under negotiated discounts.

RESOLVE also added:

> A critical point to understand about the existing cost equation—absent this resolution—is that in all but the most restricted individual insurance policies, insurance covers the cost of the pregnancy, and all its attendant costs, as well as the cost of some or all of those high-order multiple birth children. The cost of a high-risk pregnancy plus the related costs of birthing multiple children is what makes high-order multiples so expensive to insurers now. In mandated states such as Massachusetts, managed care oversight of the care of such patients has been proven to lower treatment cost and the subsequent cost impact of multiple births substantially.

B. The extent to which similar mandated benefits in other states affected charges, costs and payments for services.

In its submission, RESOLVE reinforced the findings of previously referenced studies, which found that "states that require ovulation induction, intrauterine insemination and in vitro fertilization to be covered have demonstrably fewer multiple births." RESOLVE contends that a mandate would promote greater adherence to the voluntary guidelines on embryo transfers and, therefore, avoid costly high-order multiple births.

Twelve states (Arkansas, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, and West Virginia) currently have some level of mandated coverage for infertility treatment. Additionally, California and Texas require insurers *to offer* infertility treatment coverage. In most of these states, the mandate was approved between 1977 and 1991. Approving its mandate in 2001, New Jersey has been the only state to implement an infertility mandate after 1991.

As noted in section (I), the rate of assisted reproductive technology utilization in Massachusetts where infertility benefits are mandated is five times greater than in Pennsylvania. This experience suggests that a mandate could raise costs substantially in the Commonwealth.

As noted in section (III), AmeriHealth New Jersey had to increase its rates by 3% for both its medical and pharmaceutical programs as a result of New Jersey's infertility mandate.

On a different note, but related to experience in other states, Highmark repeated an item it included in its review of Senate Bill 1183. It referenced Oregon's prioritization of health care services in developing a standard benefits package for that state's Medicaid program. Out of a total of 714 possible medical conditions, Oregon ranked assisted fertilization as 701st in importance based on public need, medical efficacy and cost effectiveness.

C. The extent to which the proposed benefit would increase the appropriate use of treatment or service.

As mentioned in section (I), RESOLVE noted that only 50% of all infertile people seek treatment because of cost barriers and lack of insurance coverage. It reported:

> Based on the experience of those states now requiring coverage of infertility treatment, Pennsylvania can expect up to a 20% increase in utilization of these services. However, the cost of providing insurance coverage for these services would be offset by a reduction in the misuse of other currently covered services, such as varicocele vein removal for men and surgery to remove scarring on a woman's fallopian tubes…Moreover, where infertility coverage has been mandated, utilization of the most costly of advanced approaches, [in vitro fertilization], has not exceeded 7% of all those receiving infertility care.

Highmark noted that its experience "has found that whenever a service becomes eligible for insurance coverage, utilization of that service or benefit immediately increases." Regarding appropriate use, it also mentioned that the mandate would bring up serious issues about the storage and tracking of eggs previously mentioned in section (III). Highmark also indicated that:

> Concern with the mandate is further linked to the prospect of multiple births often associated with assisted fertility procedures, and frequently resulting in premature births. As a consequence, and not withstanding the human suffering factor, babies born seriously underweight and with immature respiratory systems require significant neonatal intensive care, often for several months until the infant achieves a viable prospect of survival.

While reiterating the impact on utilization of services in Massachusetts and New Jersey as noted in the previous section, Blue Cross of Northeastern Pennsylvania said it would be hard "to determine if such utilization represents a medically appropriate administration of this benefit if insureds are seeking the service 'because they can' due to the mandate."

D. The impact of the benefit on administrative expenses of health care insurers.

Although it did not provide an estimated dollar amount, Blue Cross of Northeastern Pennsylvania indicated that the mandate would bring new administrative costs, such as those associated with contractual arrangements with new classes/types of providers; the credentialing of new types of providers; internal systems changes to accommodate new billing procedures; and communication of changes in benefits.

Highmark actuaries estimated that $3.5 million will be required annually to administer its claims and related costs resulting from an assisted reproductive services mandate in Pennsylvania. Highmark went on to mention that this figure does not take into account those administrative costs that would result from medical management of complications related to multiple pregnancies and neonatal intensive care services.

RESOLVE, however, said that it expects administrative expenses for insurers to decrease. In addition to receiving fewer appeals, insurers would be able to avoid administrative expenses associated with recapturing patients/employers who dropped coverage because it was

inadequate and administrative expenses associated with customer service representatives explaining coverage limitations to beneficiaries.

E. The impact of the proposed benefits on benefits costs of purchasers.

RESOLVE indicated that the resolution's provisions would be cost-neutral or result in savings, as long as "purchasers require insurers to adequately adjust their current premiums to reflect a reduction in the use of outdated, less effective treatments, in favor of more effective, equally or less costly treatments." RESOLVE further noted that this mandate would enable employees to receive the most appropriate – and often less invasive – infertility treatments, enabling them to return to work faster. The mandate could also save purchasers by reducing costly mental health counseling services.

As previously referenced in section (III), a 1997 National Center for Policy Analysis report, "The Cost of Health Insurance Mandates," revealed that while the cost of 12 of the most common mandates can increase the cost of health insurance by 30%, infertility treatment mandates alone can add 3% to 5% to the estimated annual cost of family coverage. It also found that infertility treatment adds between $105 and $175 annually to the cost of a standard family policy.

Also noted in section (III), Highmark actuaries estimated that an assisted reproductive services mandate in Pennsylvania would add $34.5 million to its claims expenses, and Independence Blue Cross indicated that AmeriHealth New Jersey – one of its subsidiaries – had to increase its rates by 3% for both its medical and pharmaceutical programs as a result of New Jersey's infertility mandate. Highmark also included a statement from Anthem Blue Cross and Blue Shield on a proposed infertility mandate in Connecticut, which revealed that Anthem's fully-insured customers would see a $34 million increase in premiums if the mandate was adopted.

F. The impact of the proposed benefits on the total health care within the Commonwealth.

PHC4's estimate for the impact of House Resolution 400 is based on several points previously raised:

- As mentioned in section (I), RESOLVE estimates that there are 268,883 infertile people in Pennsylvania. Based on Pennsylvania Department of Insurance projections, a mandated infertility benefit would only affect one-third – or 88,731 – of these individuals (i.e., persons enrolled in fully insured, private health insurance plans).
- Earlier in this section, it was noted that Pennsylvania can expect up to a 20% increase in the utilization of assisted reproductive technologies based on the experience of other states with mandates. This rate of increase means that about an additional 17,746 people (20% x 88,731) would use such technologies.
- It was also noted that utilization of the most costly treatment – in vitro fertilization – has not exceeded 7% of all patients receiving care in states where infertility coverage is mandated.
- Finally, based on cost information submitted by Blue Cross of Northeastern Pennsylvania and Highmark, an average cost per cycle was estimated for in vitro fertilization ($18,000 per cycle), gamete intrafallopian transfer ($12,000 per cycle), and zygote intrafallopian transfer ($12,000 per cycle).

Based on these figures and the limitations in the resolution, PHC4 calculated that a 20% increase in utilization could cost $250 million for one cycle, $1 billion for four cycles and $2 billion for eight cycles.

Assuming 20% increase in utilization				
Procedure	**Total Individuals**	**Cost per Cycle**	**Total Cost for 1 Cycle**	**Total Cost for 8 Cycles**
Gamete intrafallopian transfer and Zygote intrafallopian transfer	11,535 (13%)	$12,000	$138,420,000	$1,107,360,000
In vitro fertilization	6,211 (7%)	$18,000	$111,798,000	$894,384,000

Submissions for House Resolution 400

1. Blue Cross of Northeastern Pennsylvania

    - Statement addressing Section 9 requirements.
    - Attachments addressing health insurance coverage, health insurance mandates, and factors driving the rising cost of health care.

2. Highmark

    - Statement addressing Section 9 requirements.
    - Attachments addressing the diagnosis and treatment of infertility.

3. Independence Blue Cross

    - News articles on insurance coverage of infertility treatment

4. The Insurance Federation of Pennsylvania

    - Statement addressing Section 9 requirements and opposing House Resolution 400.
    - Attachments addressing the health care coverage, health insurance mandates, and factors driving the rising cost of health care.

5. Pennsylvania Catholic Health Association

    - Letter and comments in opposition to House Resolution 400.

6. Pennsylvania Chamber of Business and Industry

    - Letter and comments in opposition to mandated benefits.

7. Representative Raymond Bunt, Jr., Member, Pennsylvania House of Representatives

    - Letter in support of House Resolution 400.

8. RESOLVE

    - Letter indication support of House Resolution 400.
    - Documentation addressing Section 9 requirements.
    - Attachments addressing the diagnosis and treatment of infertility.

9. Wolf Block Government Relations

    - Statement by AFLAC noting the importance of excluding certain policies from those affected by House Resolution 400.

10. 67 constituent letters in support of House Resolution 400.