

HB

440

file 2

Curt Menard

351 W. Swanson Ave.
Wasilla, Alaska 99687

Or

P.O. Box V
Juneau, Alaska 99811

376-5315 Work

745-8122 Work

376-5855 Home

465-2679 Juneau



M E M O R A D U M

TO: Representative Koponen, Co-Chair
Health, Education, and Social Services Committee

FROM: Representative Menard *CM*

DATE: April 6, 1988

RE: Proposed CSHB440

Changes in HB440:

1. Only mandate coverage for the State of Alaska and all political subdivisions of the state.
2. Require that insurance providers offer infertility coverage.
3. Limit the definition of the diagnosis and treatment of infertility to that accepted by the American College of Obstetrics and Gynecology and The American Fertility Society (Incorporate their guidelines for experimental and non-experimental procedures).
4. Mandate the coverage for (up to) three in vitro fertilization cycles--additional cycles will be at the discretion of the insurance provider.

5-1772B ✓

Ford
4/1/88

Original sponsor: Menard

Menard

1 IN THE HOUSE

2 CS FOR HOUSE BILL NO. 440 ()

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to insurance coverage for treatment
7 of infertility."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 21.42 is amended by adding a new section to read:

10 Sec. 21.42.365. COVERAGE FOR TREATMENT OF INFERTILITY. (a) An
11 insurer authorized under AS 21.09 to offer, issue for delivery, de-
12 liver, or renew a disability insurance policy for medical coverage on
13 an expense incurred basis in the state, or a hospital or medical ser-
14 vice corporation authorized under AS 21.87 to offer or renew a sub-
15 scriber's contract for ^{group} medical coverage in the state, that provides
16 coverage for pregnancy-related expenses, ^{complications of preg. ← mandatory offer} shall to the same extent that
17 benefits are provided for pregnancy-related expenses, provide benefits
18 for all nonexperimental infertility procedures, including artificial
19 insemination and in vitro fertilization and embryo placement, ^{if the}
20 policy is provided to the state, a municipality, or a political subdi-
21 vision of the state. If the policy is not provided to the state, a
22 municipality, or a political subdivision of the state, the benefits
23 specified in this subsection shall be offered to the insured.

24 (b) The insurer, hospital, or medical service corporation
25 providing benefits to a covered person under this section may not

26 (1) limit coverage for infertility-related drugs unless the
27 limitation is imposed on other prescription drugs;

28 (2) exclude from coverage costs associated with sperm, egg,
29 or inseminated egg procurement, processing, and banking, if the donor

1 is the covered spouse;

2 (3) impose a preexisting condition exclusion or preexisting
3 condition waiting period;

4 (4) use a prior diagnosis of, or prior treatment for infer-
5 tility to exclude, limit, or restrict coverage;

6 (5) impose a deductible, copayment, coinsurance, benefit
7 maximum, or waiting period that is different than that imposed on
8 benefits provided for coverage of (pregnancy-related expenses.) ?

9 (c) The insurer, hospital, or medical service corporation may

10 (1) deny coverage for

11 (A) an experimental infertility procedure, including
12 but not limited to, gamete intra-fallopian transfer;

13 (B) surrogacy;

14 (C) reversal of voluntary sterilization;

15 (D) the fourth or greater in vitro fertilization

16 cycle;

17 ? (2) establish eligibility requirements related to the
18 covered person's medical history;

19 (3) establish standards relating to provider contracts.

20 (d) In this section

21 (1) "covered person" means the insured or subscriber or the
22 insured or subscriber's covered spouse or dependent child;

23 (2) "experimental infertility procedure" means a procedure
24 not yet recognized as generally accepted or nonexperimental by the
25 American Fertility Society or the American College of Obstetrics and
26 Gynecology;

27 (3) "infertility" means the condition of a presumably
28 healthy individual who is unable to conceive or produce conception for
29 a period of at least one year ^{of unprotected intercourse} before diagnosis and treatment for

1 infertility;

2 (4) "nonexperimental infertility procedure" means a proce-
3 dure recognized as generally accepted or nonexperimental by the Ameri-
4 can Fertility Society or the American Society of Obstetrics and
5 Gynecology.

6 * Sec. 2. AS 21.87.340 is amended to read:

7 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
8 provisions contained or referred to previously in this chapter, the
9 following chapters and provisions of this title also apply with re-
10 spect to service corporations to the extent applicable and not in
11 conflict with the express provisions of this chapter and the reason-
12 able implications of the express provisions, and for the purposes of
13 the application the corporations shall be considered to be mutual
14 "insurers":

- 15 (1) AS 21.03
16 (2) AS 21.06
17 (3) AS 21.09, except AS 21.09.090
18 (4) AS 21.18.010
19 (5) AS 21.18.030
20 (6) AS 21.18.040
21 (7) AS 21.18.120
22 (8) AS 21.21.321
23 (9) AS 21.36
24 (10) AS 21.69.400
25 (11) AS 21.69.520
26 (12) AS 21.69.600, 21.69.620, and 21.69.630
27 (13) AS 21.78
28 (14) AS 21.90
29 (15) AS 21.42.345 - 21.42.365 [AS 21.42.345 AND 21.42.355]

1 (16) AS 21.89.040

2 (17) AS 21.89.060.

3 * Sec. 3. AS 21.42.365, enacted by sec. 1 of this Act, applies to
4 disability insurance policies and to hospital or medical service subscriber
5 contracts entered into or renewed on or after the effective date of this
6 Act.

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211 CMR 37.00

INFERTILITY BENEFITS

Section:

37.01: Authority

37.02: Purpose

37.03: Definitions

37.04: Scope of Coverage

37.05: Required Infertility Benefits

37.06: Prescription Drugs

37.07: Optional Infertility Benefits

37.08: Prohibited Limitations on Coverage

37.09: Permissible Limitations on Coverage

37.10: Effective Date

37.11: Severability

37.01: AUTHORITY

This regulation is issued under the authority of M.G.L. c. 175; M.G.L. c. 176A; M.G.L. c. 176B; M.G.L. c. 176D; and M.G.L. 176G.

37.02: PURPOSE

The purpose of this regulation is to implement Chapter 394 of the Acts of 1987, an Act Providing a Medical Definition of Infertility.

37.03: DEFINITIONS

The following words as used in this regulation shall be defined as follows:

Commissioner: The Commissioner of Insurance or his or her designee.

Experimental infertility procedure: A procedure not yet recognized as generally accepted or non-experimental by the American Fertility Society (AFS) or the American College of Obstetrics and Gynecology (ACOG) or another infertility expert recognized as such by the Commissioner.

Infertility: The condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year.

Insured: A subscriber, member, policy holder, certificate holder or his or her covered spouse or other covered dependent.

Insurer: Any company as defined in M.G.L. c. 175, §1 and authorized to write accident and health insurance; any hospital service corporation as defined in M.G.L. c. 176A, §1; any medical service corporation as defined in M.G.L. c. 176B, §1; or any health maintenance organization as defined in M.G.L. c. 176G, §1.

Non-experimental infertility procedure: A procedure recognized as generally accepted or non-experimental by the American Fertility Society or the American College of Obstetrics and Gynecology or another fertility expert recognized as such by the Commissioner.

37.04: SCOPE OF COVERAGE

Insurers shall provide benefits for required infertility procedures, as described in 37.05, which are furnished to an insured, covered spouse and/or other covered dependent.

Insurers shall not be required to provide benefits for services furnished to a spouse or dependent if the spouse or dependent is not otherwise covered by the insurer.

37.05: REQUIRED INFERTILITY BENEFITS

(1) Subject to any reasonable limitations as described in subsection 37.08 below, insurers shall provide benefits for all non-experimental infertility procedures including, but not limited to:

(A) Artificial Insemination (AI);

(B) In Vitro Fertilization and Embryo Placement (IVF-EP).

(2) The required benefits provided by 37.05(1) shall include any costs associated with the attendant sperm, egg and/or inseminated egg procurement, processing and banking only if the donor is the covered spouse.

37.06: PRESCRIPTION DRUGS

Insurers shall not impose exclusions, limitations or other restrictions on coverage for infertility-related drugs that are different from those imposed on any other prescription drugs.

37.07: OPTIONAL INFERTILITY BENEFITS

No insurer shall be required to provide benefits for:

- (1) Any experimental infertility procedure, including but not limited to, Gamete Intra-Fallopian Transfer (GIFT), until the procedure becomes recognized as non-experimental and is so designated by the Commissioner;
- (2) Procurement, processing and/or banking of donor egg(s) and/or sperm, except as provided for by 37.05(2);
- (3) Surrogacy;
- (4) Reversal of Voluntary Sterilization.

37.08: PROHIBITED LIMITATIONS ON COVERAGE

- (1) No insurer shall impose deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for required infertility benefits which are different from those imposed upon benefits for services not related to infertility.

- (2) No insurer shall impose pre-existing condition exclusions or pre-existing condition waiting periods on coverage for required infertility benefits. No insurer shall use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting or otherwise restricting the availability of coverage for required infertility benefits.

37.09: PERMISSIBLE LIMITATIONS ON COVERAGE

Insurers may establish reasonable eligibility requirements, based upon the insured's medical history, and reasonable provider contracting standards. These requirements and standards shall be maintained in written form and shall be available to any insured and/or the Commissioner upon request. Standards or guidelines developed by the American Fertility Society or the American College of Obstetrics and Gynecology may serve as a basis for these eligibility and contracting requirements.

37.10: EFFECTIVE DATE

This regulation shall apply to any contract, policy or plan offering hospital, surgical or medical expense coverage as

described in M.G.L. c. 175, §§108 and 110, M.G.L. c. 176A, M.G.L. 176B, and M.G.L. c. 176G, and which is issued or renewed, within or without the Commonwealth, on or after January 6, 1988. The immediate promulgation of this regulation is necessary to preserve the public health, safety and general welfare and to afford full coverage to those with an immediate need for infertility benefits, thereby implementing the public policy of the Commonwealth as evidenced by Chapter 394 of the Acts of 1987.

37.11: SEVERABILITY

If any section or portion of a section of this regulation or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of this regulation or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

BLUE CROSS & BLUE SHIELD OF MASSACHUSETTS
ESTIMATED PURE PREMIUM ASSOCIATED WITH
ENACTMENT OF C.394
(INFERTILITY)

ITEM	DATA	SOURCE
1. a. Married Couples in Massachusetts, 1985 (married females aged 18 - 44)	709,234	1980 Census Data, Massachusetts - Table 205 Massachusetts Data Center, 1985
b. Percent of Married Couples who are Infertile	17.2%	National Center for Health Statistics
c. Percent of Infertile Couples who might seek treatment for infertility in a year	14.3%	Research Estimate
d. Number of Infertile Couples who might seek treatment for infertility in a year	17,444	Item 1a x Item 1b x Item 1c
2. a. Percent of Infertile Couples using the In Vitro Fertilization Technique	4.0%	Machelle Seibel, MD Beth Israel Hospital
b. Number of Infertile Couples using the In Vitro Fertilization Technique	698	Item 1d x Item 2a
c. Cost per Case for In Vitro Fertilization	\$14,605	Research Estimate
d. Total Additional Liability Associated with Mandating Benefits for In Vitro Fertilization	\$10,194,290	Item 2b x Item 2c
3. a. Percent of Infertile Couples using Hormone Therapy	25.0%	Machelle Seibel, MD Beth Israel Hospital
b. Number of Infertile Couples using Hormone Therapy	4,361	Item 1d x Item 3a
c. Cost per Case for Hormone Therapy	\$1,375	Research Estimate
d. Total Additional Liability Associated with Mandating Benefits for Hormone Therapy	\$5,996,375	Item 3b x Item 3c
4. a. Percent of Infertile Couples using Artificial Insemination	30.0%	Machelle Seibel, MD Beth Israel Hospital
b. Number of Infertile Couples using Artificial Insemination	5,233	Item 1d x Item 4a
c. Cost per Case for Artificial Insemination	\$150	Research Estimate (1 - 3 attempts @ \$75)
d. Total Additional Liability Associated with Mandating Benefits for Artificial Insemination	\$784,950	Item 4b x Item 4c
5. a. Total Additional Annual Liability Associated with Enactment of C.394	\$16,975,615	Item 2d + Item 3d + Item 4d
b. Total Massachusetts Population, Ages 19 - 64	3,575,615	Massachusetts Data Center, 1985
c. Additional Annual Liability per Adult	\$4.748	Item 5a / Item 5b
d. Additional Monthly Liability per Adult	\$0.396	Item 5c / 12
6. a. Individual Contract Rate	\$0.40	Item 5d
b. Family Contract Rate	\$0.80	Item 5d x 2
	Individual Family	
7. a. Blue Cross Costs for Infertility	\$0.32	\$0.64
b. Blue Shield Costs for Infertility	\$0.08	\$0.16

At least
in 1985
3/8/85

Original sponsor: Menard

1 IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR HOUSE BILL NO. 440 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to insurance coverage for pregnancy
7 and infertility."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 21.42 is amended by adding a new section to read:

10 Sec. 21.42.365. COVERAGE FOR PREGNANCY AND INFERTILITY. An
11 insurer authorized under AS 21.09 to offer, issue for delivery, de-
12 liver, or renew a disability insurance policy for medical coverage on
13 an expense incurred basis in the state, or a hospital or medical ser-
14 vice corporation authorized under AS 21.87 to offer or renew a sub-
15 scriber's contract for medical coverage in the state, that provides
16 coverage for hospital and surgical expenses, shall also provide to the
17 same extent that benefits are provided for medical conditions not
18 related to pregnancy or infertility, coverage for medically necessary
19 expenses of prenatal care, childbirth, postpartum care, and diagnosis
20 and treatment of infertility. In this section, "infertility" means
21 the condition of a presumably healthy individual who is unable to
22 conceive or produce conception for a period of at least one year
23 before diagnosis and treatment for infertility.

24 * Sec. 2. AS 21.87.340 is amended to read:

25 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
26 provisions contained or referred to previously in this chapter, the
27 following chapters and provisions of this title also apply with re-
28 spect to service corporations to the extent applicable and not in
29 conflict with the express provisions of this chapter and the

1 reasonable implications of the express provisions, and for the pur-
2 poses of the application the corporations shall be considered to be
3 mutual "insurers":

- 4 (1) AS 21.03
- 5 (2) AS 21.06
- 6 (3) AS 21.09, except AS 21.09.090
- 7 (4) AS 21.18.010
- 8 (5) AS 21.18.030
- 9 (6) AS 21.18.040
- 10 (7) AS 21.18.120
- 11 (8) AS 21.21.321
- 12 (9) AS 21.36
- 13 (10) AS 21.69.400
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- 15 (12) AS 21.69.600, 21.69.620, and 21.69.630
- 16 (13) AS 21.78
- 17 (14) AS 21.90
- 18 (15) AS 21.42.345 - 21.42.365 [AS 21.42.345 AND 21.42.355]
- 19 (16) AS 21.89.040
- 20 (17) AS 21.89.060.

21 * Sec. 3. AS 21.42.365, enacted by sec. 1 of this Act, applies to
22 disability insurance policies and to hospital or medical service subscriber
23 contracts entered into or renewed on or after the effective date of this
24 Act.

5-1772B ✓

Ford
4/1/88

Original sponsor: Menard

1 IN THE HOUSE

2 CS FOR HOUSE BILL NO. 440 ()

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to insurance coverage for treatment
7 of infertility."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 21.42 is amended by adding a new section to read:

10 Sec. 21.42.365. COVERAGE FOR TREATMENT OF INFERTILITY. (a) An
11 insurer authorized under AS 21.09 to offer, issue for delivery, de-
12 liver, or renew a disability insurance policy for medical coverage on
13 an expense incurred basis in the state, or a hospital or medical ser-
14 vice corporation authorized under AS 21.87 to offer or renew a sub-
15 scriber's contract for medical coverage in the state, that provides
16 coverage for pregnancy-related expenses, shall to the same extent that
17 benefits are provided for pregnancy-related expenses, provide benefits
18 for all nonexperimental infertility procedures, including artificial
19 insemination and in vitro fertilization and embryo placement, if the
20 policy is provided to the state, a municipality, or a political subdi-
21 vision of the state. If the policy is not provided to the state, a
22 municipality, or a political subdivision of the state, the benefits
23 specified in this subsection shall be offered to the insured.

24 (b) The insurer, hospital, or medical service corporation
25 providing benefits to a covered person under this section may not

26 (1) limit coverage for infertility-related drugs unless the
27 limitation is imposed on other prescription drugs;

28 (2) exclude from coverage costs associated with sperm, egg,
29 or inseminated egg procurement, processing, and banking, if the donor

1 is the covered spouse;

2 (3) impose a preexisting condition exclusion or preexisting
3 condition waiting period;

4 (4) use a prior diagnosis of, or prior treatment for infer-
5 tility to exclude, limit, or restrict coverage;

6 (5) impose a deductible, copayment, coinsurance, benefit
7 maximum, or waiting period that is different than that imposed on
8 benefits provided for coverage of pregnancy-related expenses.

9 (c) The insurer, hospital, or medical service corporation may

10 (1) deny coverage for

11 (A) an experimental infertility procedure, including
12 but not limited to, gamete intra-fallopian transfer;

13 (B) surrogacy;

14 (C) reversal of voluntary sterilization;

15 (D) the fourth or greater in vitro fertilization
16 cycle;

17 (2) establish eligibility requirements related to the
18 covered person's medical history;

19 (3) establish standards relating to provider contracts.

20 (d) In this section

21 (1) "covered person" means the insured or subscriber or the
22 insured or subscriber's covered spouse or dependent child;

23 (2) "experimental infertility procedure" means a procedure
24 not yet recognized as generally accepted or nonexperimental by the
25 American Fertility Society or the American College of Obstetrics and
26 Gynecology;

27 (3) "infertility" means the condition of a presumably
28 healthy individual who is unable to conceive or produce conception for
29 a period of at least one year before diagnosis and treatment for

1 infertility;

2 (4) "nonexperimental infertility procedure" means a proce-
3 dure recognized as generally accepted or nonexperimental by the Ameri-
4 can Fertility Society or the American Society of Obstetrics and
5 Gynecology.

6 * Sec. 2. AS 21.87.340 is amended to read:

7 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
8 provisions contained or referred to previously in this chapter, the
9 following chapters and provisions of this title also apply with re-
10 spect to service corporations to the extent applicable and not in
11 conflict with the express provisions of this chapter and the reason-
12 able implications of the express provisions, and for the purposes of
13 the application the corporations shall be considered to be mutual
14 "insurers":

- 15 (1) AS 21.03
16 (2) AS 21.06
17 (3) AS 21.09, except AS 21.09.090
18 (4) AS 21.18.010
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20 (6) AS 21.18.040
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29 (15) AS 21.42.345 - 21.42.365 [AS 21.42.345 AND 21.42.355]

1 (16) AS 21.89.040

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3 " Sec. 3. AS 21.42.365, enacted by sec. 1 of this Act, applies to
4 disability insurance policies and to hospital or medical service subscriber
5 contracts entered into or renewed on or after the effective date of this
6 Act.

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Insurance - mandated benefits

617-722-2130

Mass. House Health Care Committee

Mass. Div. of Insurance

Jennifer Keley

617-727-1895

Nancy Turnbull

STATE MANDATED HEALTH
CARE COVERAGE LAWS
(ENACTED THROUGH JUNE, 1987)

PREPARED BY THE OFFICE OF
GOVERNMENT RELATIONS,
STATE SERVICES DEPARTMENT,
BLUE CROSS AND BLUE SHIELD
ASSOCIATION

CONTACT PERSONS:
GREG SCANDLEN
BRENDA LARSEN
AUGUST, 1987

THIS INFORMATION IS PROVIDED BY THE



National
Conference
of State
Legislatures

1050 17th Street
Suite 2100
Denver, Colorado 80265
303-623-7800

MANDATED COVERAGES

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA
ALL LICENSED HEALTH PROFESSIONALS				75						
NURSES						8				
NURSE MIDWIVES		83	85				84		83	
NURSE PRACTITIONERS			85				84			
NURSE ANESTHETISTS			85				84			
PHYSICAL THERAPISTS		87					75			
OCCUPATIONAL THERAPISTS		87			78		82			
SPEECH/HEARING THERAPISTS				85	78					
PROFESSIONAL COUNSELORS					80/81					
PSYCHOLOGISTS	82		83/87	75	80	79	75			80
PSYCHIATRIC NURSES					82		84			
SOCIAL WORKER					76		79			
DENTISTS	75	83	77		76		75			
ORAL SURGEONS										
OPTOMETRISTS	67	83			80		75	X*	74	
PODIATRISTS	76			75	76			X*	74	
CHIROPRACTORS	75	83	83/87		76		71	X*	76/86	80
OSTEOPATHS		83								
NATUROPATHS		87					75			
ALCOHOLISM	79		79	87	78	76	74/77		79	
DRUG ABUSE			79				76		79	
MENTAL HEALTH			79	83	73	76	75/82		76/83	81/84
BREAST RECONSTRUCTION			81	78	78					
MATERNITY				76	76	75	76			78
PRESCRIPTION DRUGS							75			
ORTHOTIC AND/OR PROSTHETIC DEVICES					85					
CLEFT PALATE						87				
DIABETIC EDUCATION					81					
DIABETIC OUTPATIENT										
SECOND OPINION										
HOME HEALTH			82		78	84	75/76			
HOSPICE						84	76			
LONG TERM CARE										
INVITRO FERTILIZATION				87						
AMBULATORY SURGERY			71						77	
ANTI-ABORTION						85	82			
PUBLIC INSTITUTIONS										
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS					74				86	
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							82			79
ADOPTED CHILDREN			85						85	
NEWBORNS	75	75	74	75/83	71	75	74	74	80/84	74
MENTALLY/PHYSICALLY HANDICAPPED			77	69	71		71		70	72
NON-CUSTODIAL CHILDREN							84			
CONVERSION PRIVILEGE			85	79/85	83		75			
CONTINUATION FOR DEPENDENTS			85	85	76		75/76			80/81
CONTINUATION FOR EMPLOYEES				85	77/84	86			75	86
CATASTROPHIC COVERAGE										
MANDATE EVALUATION			85							87

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

06/87

MANDATED COVERAGES

	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD
ALL LICENSED HEALTH PROFESSIONALS			82							83
NURSES										
NURSE MIDWIVES								84		78
NURSE PRACTITIONERS										79
NURSE ANESTHETISTS										84
PHYSICAL THERAPISTS										
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS										
PROFESSIONAL COUNSELORS										
PSYCHOLOGISTS	84			85		74		75	75	73
PSYCHIATRIC NURSES									83	83
SOCIAL WORKER						82			83	77
DENTISTS	74			74		73		74	75	
ORAL SURGEONS										
OPTOMETRISTS			80	74	83	73			82	73
PODIATRISTS			81	74		73				73
CHIROPRACTORS				74	86	73	80/86	75	86	73
OSTEOPATHS										73
NATUROPATHS										
ALCOHOLISM				76		86	78	80	74	82 80
DRUG ABUSE						78/86		80	83	78
MENTAL HEALTH			74/77			78/86	86	75	79/83	73/86
BREAST RECONSTRUCTION			80							
MATERNITY	74								75	75
PRESCRIPTION DRUGS									83	
ORTHOTIC AND/OR PROSTHETIC DEVICES										78
CLEFT PALATE		85		85						82
DIABETIC EDUCATION					84					
DIABETIC OUTPATIENT										
SECOND OPINION										85
HOME HEALTH							82		77	79
HOSPICE										82
LONG TERM CARE							86			
INVITRO FERTILIZATION	87									85
AMBULATORY SURGERY	74						78			
ANTI-ABORTION							78			
PUBLIC INSTITUTIONS										67
AMBULANCE/TRANSPORT FOR NEWBORNS								80		
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS				85					79	76
DEPENDENT STUDENTS								78		79
ADOPTED CHILDREN			81							79
NEWBORNS	74	74	75	76	74	74	76	73	76	77
MENTALLY/PHYSICALLY HANDICAPPED	68	72	67	69/86				72		X
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE			83		86	78/80	74		82	79
CONTINUATION FOR DEPENDENTS			76/85		86	78/84	85			77
CONTINUATION FOR EMPLOYEES	74	75	84		86	84	80	83	83/86	79
CATASTROPHIC COVERAGE										78
MANDATE EVALUATION	87									

X = Year unknown

* = Commercial only

Bold Print = Mandated offerings

08/87

MANDATED COVERAGES

	MA	MI	MN	MS	MO	MT	NE	NY	NH	NJ
ALL LICENSED HEALTH PROFESSIONALS										
NURSES								85		84
NURSE MIDWIVES			83	80		87	84			82
NURSE PRACTITIONERS				80		87			85	
NURSE ANESTHETISTS			83	80						
PHYSICAL THERAPISTS										75
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS					84					
PROFESSIONAL COUNSELORS						85/87			83	
PSYCHOLOGISTS	75	68*	75	74	83	81	74	80	75	73
PSYCHIATRIC NURSES	86									
SOCIAL WORKER	82					85			83	
DENTISTS	75		73	74	78	83	75	75		79
ORAL SURGEONS		85							75	
OPTOMETRISTS			73	66	78		69	75		67
PODIATRISTS			73		78		69	75		
CHIROPRACTORS		79	73	80	78		67	82		80
OSTEOPATHS							67	75		
NATUROPATHS										
ALCOHOLISM	73	74/82	73/82	74	77/85	79	80	83		77
DRUG ABUSE		74/82	73/82		80	81		83		
MENTAL HEALTH	73/82		75		80	81			75/83	
BREAST RECONSTRUCTION		85	80					83		83
MATERNITY		<i>in effect 86</i>	73		73			77		
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES		85								
CLEFT PALATE										
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION										80
HOME HEALTH	86					81		75		
HOSPICE		84						83		
LONG TERM CARE										
INVITRO FERTILIZATION			<i>in effect 89</i>							
AMBULATORY SURGERY		84/85	76		75/81					
ANTI-ABORTION					83					
PUBLIC INSTITUTIONS			73			73	84			
AMBULANCE/TRANSPORT FOR NEWBORNS				79						
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							76			
ADOPTED CHILDREN	75		83							
NEWBORNS	74		73	74	74	73	75	76	75	75
MENTALLY/PHYSICALLY HANDICAPPED	56	66	69	72		71		76	69	66
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	76		77		81	81	78	80		
CONTINUATION FOR DEPENDENTS			73/77		69		80	80	81	76/80
CONTINUATION FOR EMPLOYEES			73		85	81	79			82
CATASTROPHIC COVERAGE			76							
MANDATE EVALUATION							86			

* according to Dir. of Ins. in Mass.

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

MANDATED COVERAGES

	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC
ALL LICENSED HEALTH PROFESSIONALS										
NURSES		84						86		
NURSE MIDWIVES	85	82			84	71		82		
NURSE PRACTITIONERS				84			80	86		
NURSE ANESTHETISTS								86		
PHYSICAL THERAPISTS		73								
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS										
PROFESSIONAL COUNSELORS										
PSYCHOLOGISTS	77	71	77	87	74	71	76	78		
PSYCHIATRIC NURSES										
SOCIAL WORKER		85								
DENTISTS	77	75			73	71	71			
ORAL SURGEONS										
OPTOMETRISTS	77	X			80	71	76	78		85
PODIATRISTS	77	X			80	71				72
CHIROPRACTORS	84	X	73	79	80	71		81	87	80
OSTEOPATHS	77				80					
NATUROPATHS										
ALCOHOLISM	83	82/83	84	75/87	78		75/81	86	80	
DRUG ABUSE			84	75/87					87	
MENTAL HEALTH		77		75/87	83		73			
BREAST RECONSTRUCTION		75								
MATERNITY		76			79		73			
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE			82							
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION		76							83*	
HOME HEALTH	77	72/75							84*	
HOSPICE		85								
LONG TERM CARE										
INVITRO FERTILIZATION										
AMBULATORY SURGERY		X				76				
ANTI-ABORTION				79				82		
PUBLIC INSTITUTIONS			75		76					
AMBULANCE/TRANSPORT FOR NEWBORNS	75									
PREVENTIVE CARE FOR CHILDREN/INFANTS		82								
OTHER HEALTH CENTERS		X								
DEPENDENT STUDENTS										
ADOPTED CHILDREN										
NEWBORNS	75	77	73	79	74	84	75	76		74
MENTALLY/PHYSICALLY HANDICAPPED	69	65	69/73	82	71			68		70
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	83	71/81	82	83	75/84		77		78	78
CONTINUATION FOR DEPENDENTS	83	81	83	87					83	78
CONTINUATION FOR EMPLOYEES				80						
CATASTROPHIC COVERAGE									74	
MANDATE EVALUATION							85	86		

X = Year unknown

* = Commercial only

Bold Print = Mandated offerings

08/87

MANDATED COVERAGES

	SD	TN	TX	UT	VT	VA	WA	WV	MI	WY
ALL LICENSED HEALTH PROFESSIONALS	80									71
NURSES							81			
NURSE MIDWIVES	80			79			81	83		
NURSE PRACTITIONERS	80						81			
NURSE ANESTHETISTS										
PHYSICAL THERAPISTS						87				
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS			83							
PROFESSIONAL COUNSELORS						87				
PSYCHOLOGISTS	86	74	77	75		77				85
PSYCHIATRIC NURSES			<i>offering</i>					77		
SOCIAL WORKER		85	87	75		79/87				
DENTISTS		74	83						75	
ORAL SURGEONS										
OPTOMETRISTS		65	79	75		77			75	
PODIATRISTS		65	77	75		79	83		75	
CHIROPRACTORS		81	79	75		79*	83		76/87	
OSTEOPATHS			98			77				71
NATUROPATHS										
ALCOHOLISM	79	79	81	81	82/85	77/80	74/87	82	74/85	
DRUG ABUSE			81			77/80			74/85	
MENTAL HEALTH		79/80	81		76	76/77	83	77*	74/86	
BREAST RECONSTRUCTION							83/85			
MATERNITY		84	77			78			82	
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE										
DIABETIC EDUCATION									84	
DIABETIC OUTPATIENT				84					82	
SECOND OPINION										
HOME HEALTH			87		76		83		78	
HOSPICE							83			
LONG TERM CARE								86		
INVITRO FERTILIZATION			87							
AMBULATORY SURGERY				76						
ANTI-ABORTION										
PUBLIC INSTITUTIONS									80	75
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS			83						75	
DEPENDENT STUDENTS										
ADOPTED CHILDREN	83			85						
NEWBORNS	76	74	73	77	76	76	74/84	75	76	75
MENTALLY/PHYSICALLY HANDICAPPED		69	81	75		74	69		75	71
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	79	80	77	79		82	84		80	83
CONTINUATION FOR DEPENDENTS	80	86	79		84		80	83	80	
CONTINUATION FOR EMPLOYEES							73	82	73/80	
CATASTROPHIC COVERAGE										
MANDATE EVALUATION							84			

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

MANDATED COVERAGES

Miscellaneous

- AZ - Maternity benefits for natural mother of an adopted child on adopted parents policy (86)
- CA - Sterilization (70); Prenatal Care (76,79); Acupuncture (84); Psychiatric Health Facility (84)
- CT - Notice of Termination (82); most passed under comprehensive health care act of 1975; HMO Rehabilitation Facilities (82); Emergency Ambulance Services (83); Home Health Aides; (84) Home Health Aides under Medicare supplement policies (86)
- CO - Anti abortion mandate for state group only (85)
- HI - Prepaid Health Care Plans (74)
- ID - Complications of Pregnancy (76)
- IL - Rape or Sexual Assault (75,82); Psychologists Mandated Through Regulation (76); Liver Transplants (84);
- KY - Newborn Nursery Care (80); Nursing Home (86)
- LA - Non-group to age 65 (74)
- MA - Cardiac rehabilitation (86) *Mammography & Dep Screen (87)*
- MD - Partial Psychiatric Hospitalization (76); Blood Products (75); Orthopedic Braces (78); OP benefits resulting from UR programs (85)
- MI - Non-group Medicare Complimentary Coverage (85); Mental Hospitals (83)
- MS - Pre-existing Conditions (82)
- ND - Pharmacists (78)
- NT - Denturists (85)
- NY - Chinese Medicine (75)
- NJ - Diagnostic X-rays by Chiropractors (76)
- NY - Pre-admission Testing (76); Ambulance Cancer Treatment (82); Nursing Home Option (X)
- ND - Continued Coverage after HMO Selections (83)
- NM - Practitioner Mandates of 1977 do not apply to Plan; Lay Midwives (85)
- OH - OP Dialysis (72)

OR - Denturists (80)

TN - School Psychologists (82)

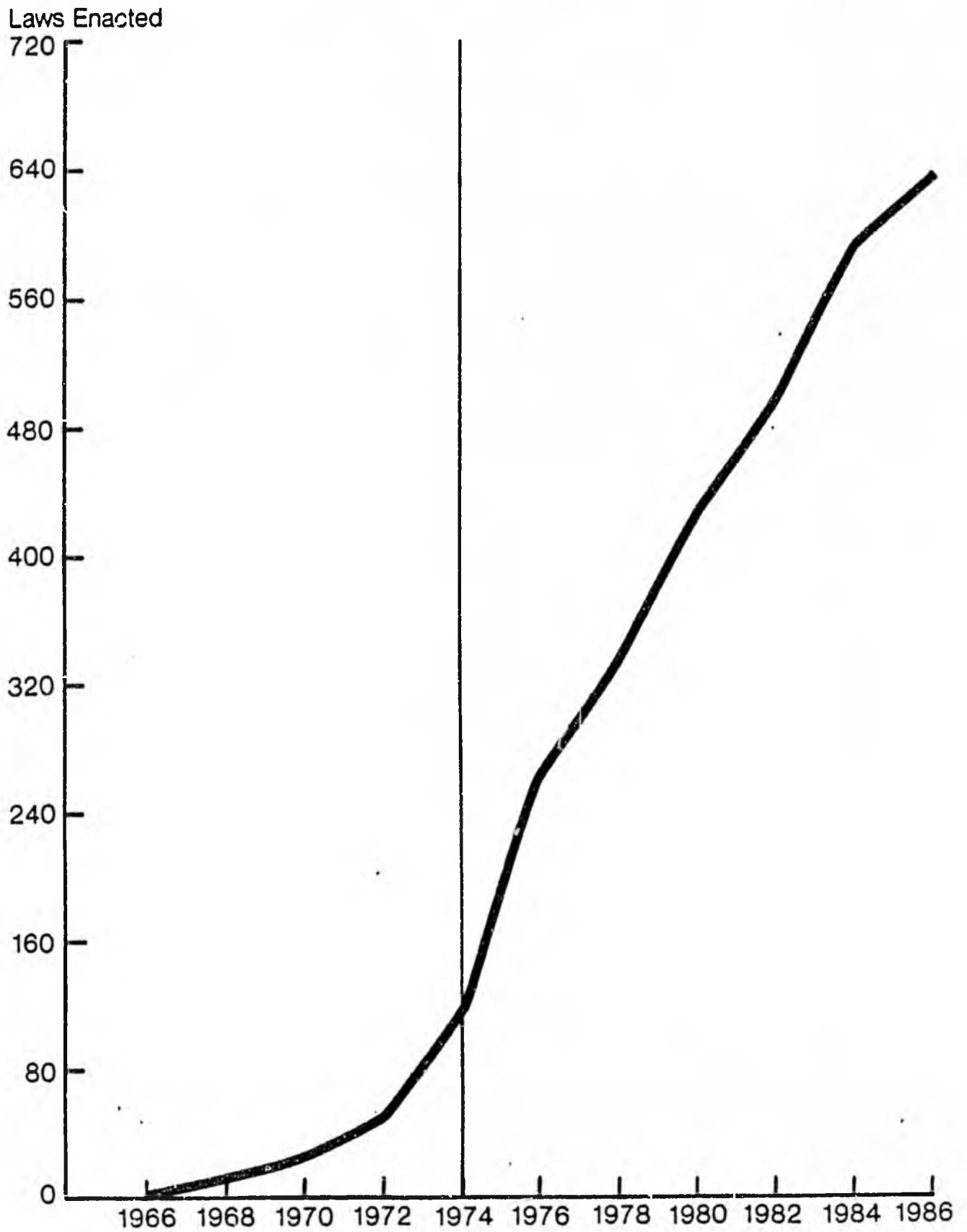
TX - OP Psychiatric Centers (83); Dietician (87)

VA - Opticians (77); Termination Notice (82); Mandated Benefit Option (82)

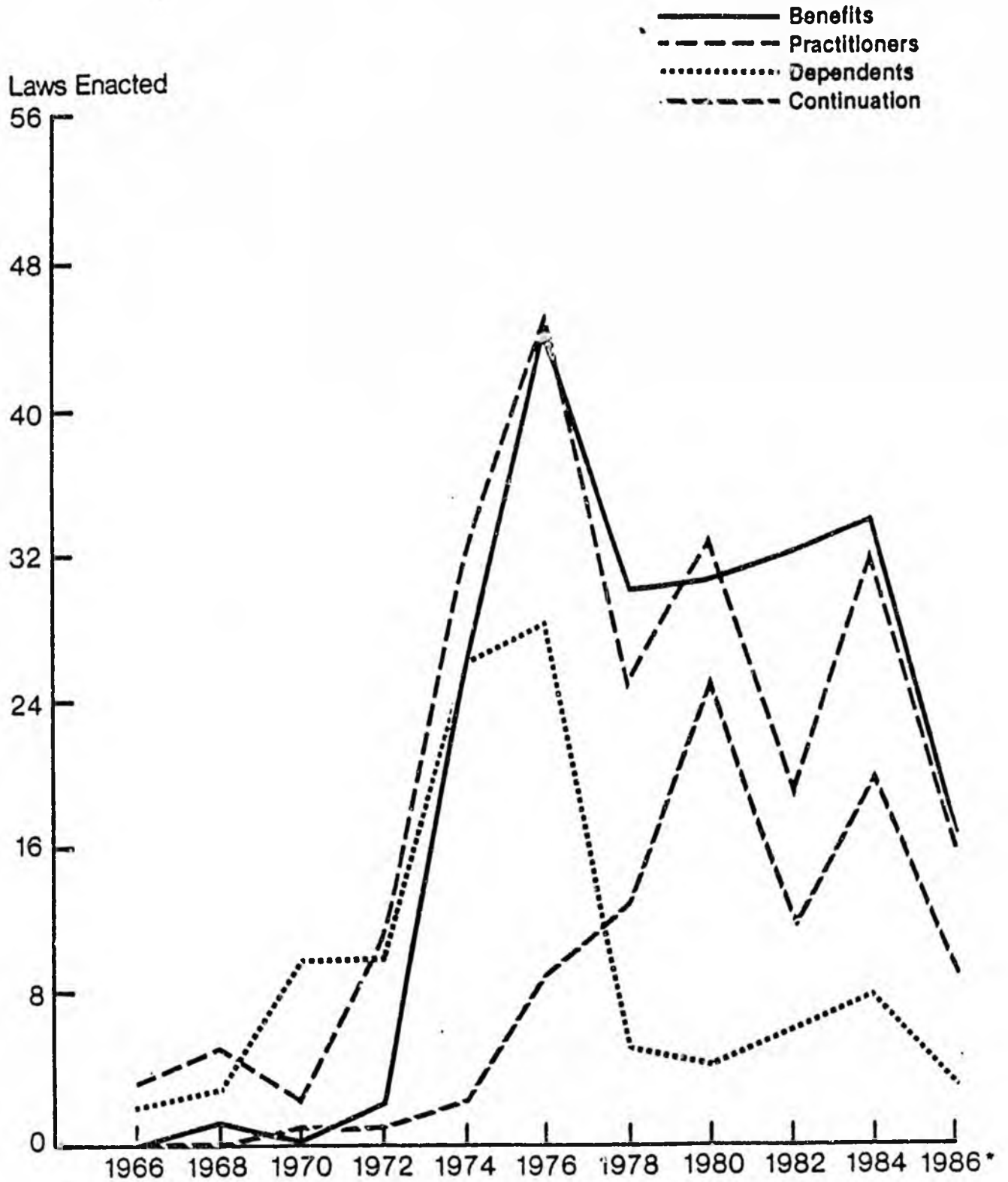
WA - Removal of a rider (87)

WI - Tuberculosis; Skilled Nursing Homes (75); Kidney Disease (74) Insulin
Infusion Pumps (81)

MANDATED COVERAGES ALL TYPES 1965-1986 (APRIL)

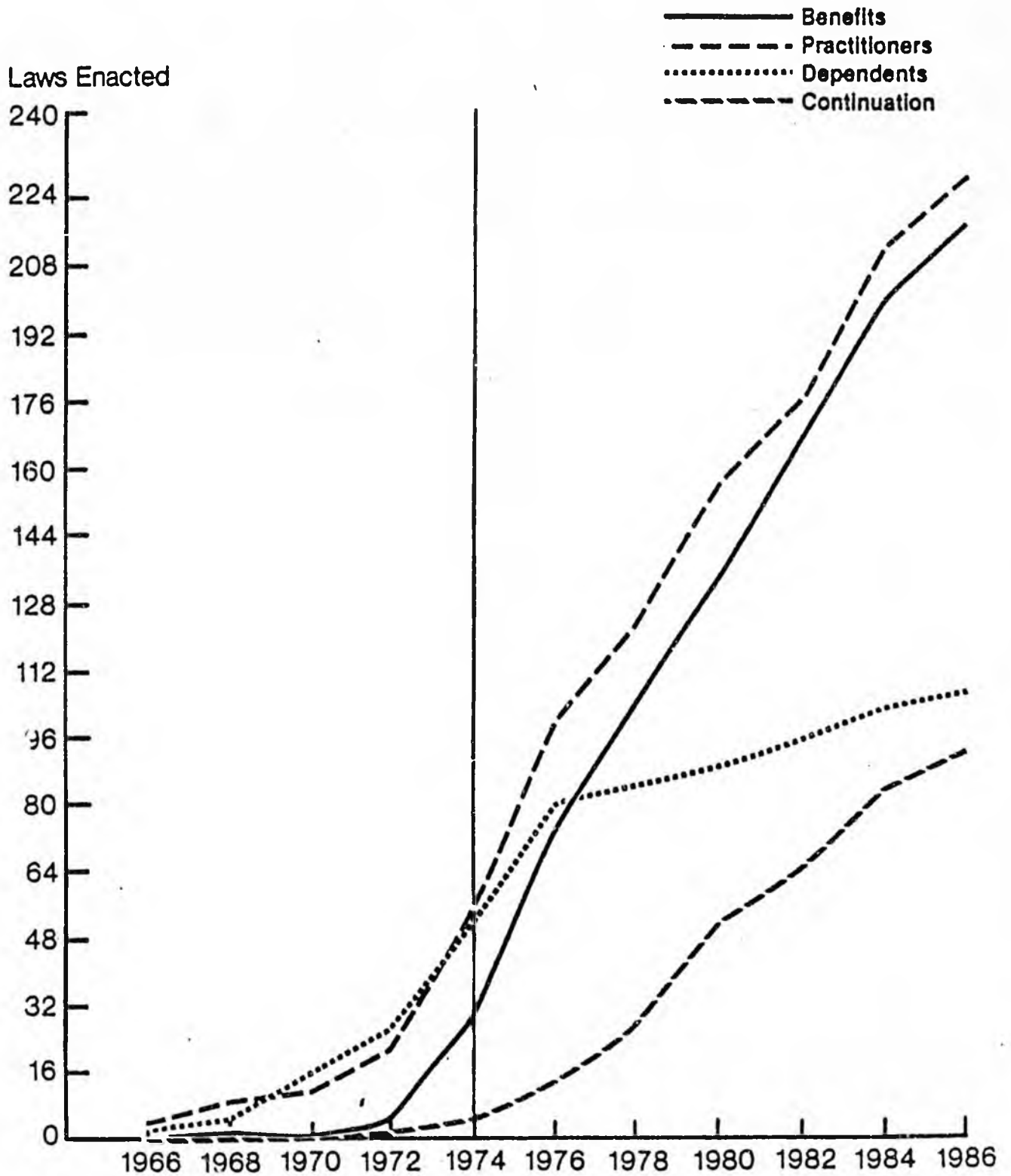


MANDATED COVERAGES PASSED PER BIENNIUM 1965-1986



* Through April of 1988

MANDATED COVERAGES AGGREGATE OF EACH TYPE 1965-1986 (APRIL)



HOUSE COMMITTEE REPORT

(7)

Date referred: 2/8/88

FURTHER REFERRALS: HESS
Judiciary

DATE: 2/25/88

The Labor & Commerce Committee has considered HB 440

"An Act relating to insurance coverage for treatment of infertility."

RECOMMENDS:

- replace with _____ the same title
- attached amendment(s) a new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(S):

- fiscal impact same as previous fiscal note published _____
- zero fiscal note same as previous zero fiscal note published _____
- zero with analysis

SIGNING DO PASS:

[Signature]

SIGNING OTHER RECOMMENDATIONS:

[Signature] - NO REC

[Signature] - NO REC

[Signature] (NO REC)

[Signature]

[Signature] No Rec

[Signature] no rec

[Signature]
Chairman's signature

ALASKA STATE LEGISLATURE

Curt Menard

351 W. Swanson Ave.
Wasilla, Alaska 99687
Or
P.O. Box V
Juneau, Alaska 99811
373-CURT
376-5315 Work
376-5855 Home
465-2679 Juneau



MEMORANDUM

February 23, 1988

TO: Members
House Labor and Commerce
Committee

FROM: Curt Menard
Representative

RE: HB440

HB440 is an Act relating to insurance coverage for treatment of infertility.

This bill would require that an insurer that provides coverage for pregnancy-related expenses shall also provide, to the same extent that benefits are provided for pregnancy-related expenses, coverage for medically necessary expenses of diagnosis and treatment of infertility.

"Infertility" means: the condition of a presumably healthy individual who is unable to conceive or produce conception for a period of at least one year before diagnosis and treatment for infertility.

This Act applies to disability insurance policies and to hospital or medical service subscriber contracts entered into or renewed on or after the effective date of this Act.

I have received more than 22 letters in favor of HB440.

I have contacted seven physicians who report that as many as 15% of America's reproductive age group have infertility problems.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: HB 440
PUBLISH DATE: 02/08/88

FISCAL NOTE

REQUEST:

Revision Date: 02/25/88
Title: Relating to insurance coverage for treatment of infertility
Sponsor: Menard
Requester: _____

Agency Affected: Commerce & Economic Dev. Insurance
BRU: _____
Components: Public Protection

EXPENDITURES / REVENUES : (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Prepared by: John L. George, Director *John L. George* Phone: 465-2515
Division: Division of Insurance Date: February 25, 1988
Approved by Commissioner: J. Anthony Smith *J. Anthony Smith* Date: February, 1988
Agency: Department of Commerce and Economic Development

Distribution (by preparer):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

FISCAL NOTE

REQUEST:

Revision Date: _____ Agency Affected: Administration
 Title: An Act relating to insurance BRU: Retirement and Benefits
coverage for treatment of infertility
 Sponsor: Menard Components: Retirement and Benefits
 Requestor: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

There is no anticipated cost to the division other than the estimated increase to the health insurance component of our budget. The attached letter addresses costs to each State agency for the increased health insurance costs.

Prepared By: Robert F. Stalnaker Phone: 465-4460
 Division: Retirement and Benefits Date: February 18, 1988

Approved by Commissioner: John M. Andrews Date: 3/9/88
 Agency: Department of Administration

Distribution (by preparer):
 Legislative Finance
 Legislative Sponsor
 Requestor
 Office of Management and Budget
 Impacted Agency(ies)

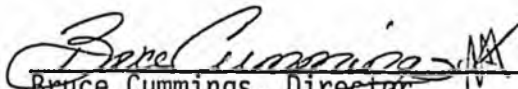
POSITION PAPER
HB 440

If enacted, this bill would require mandatory insurance coverage for medically necessary expenses of diagnosis and treatment of infertility to the same extent as that provided for pregnancy related expenses. The State's health plans currently exclude coverage for sexual dysfunctions such as infertility while pregnancy is covered as any other medical condition.

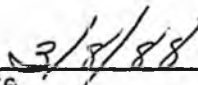
The level of coverage outlined in the bill is estimated to result in a \$4.30 per month increase in health insurance costs for the estimated 12,000 State employees effective July 1, 1988.

The fiscal effect of this bill is directly contrary to the State's efforts to reduce employer-paid premium costs for State employees via collective bargaining. In addition to increasing premium costs, this statutorily mandated benefit level would reduce the flexibility of the parties in negotiations to alter coverage/benefit levels in order to contain costs. Since the legislation would take effect for the next contract year, the agreements reached in health insurance negotiations would have to be rapidly revised to provide the new coverage required.


The Department of Administration opposes this bill.



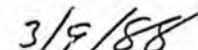
Bruce Cummings, Director
Division of Labor Relations



Date



Commissioner John M. Andrews
Department of Administration



Date

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

P.O. BOX CR
JUNEAU, ALASKA 99811-0203
PHONE: (907)465-4460

2600 DENALI ST. SUITE 401
ANCHORAGE, ALASKA 99503-2740
PHONE: (907) 277-7504

Public Employees Retirement System
Teachers' Retirement System
Judicial Retirement System
Elected Public Officers Retirement System
National Guard Retirement System
Territorial Retirement System
Retirees' Voluntary Dental-Vision-Audio Plan
Supplemental Benefits System
Group Health/Life Insurance Benefits
Deferred Compensation Plan
Public Employers Social Security Contributions

STEVE COWPER, GOVERNOR

February 19, 1988

The Honorable Dave Donley
Chairman, Labor & Commerce Committee
P.O. Box V
Juneau, AK 99811

Dear Representative Donley:

Re: HB 440

The purpose of this letter is to provide you with our analysis of the fiscal impact on all agencies of the state resulting from HB 440. Other than the estimated increase to the health insurance component of our division's budget, we anticipate no fiscal impact to the ongoing operation of the division, as the attached fiscal note indicates.

This bill would require mandatory coverage for medically necessary expenses of diagnosis and treatment of infertility to the same extent as that provided for pregnancy related expenses. The state's health plans currently exclude coverage for sexual dysfunctions such as infertility while pregnancy is covered as any other medical condition. It is assumed that this mandatory coverage would relate only to infertility treatment such as in vitro fertilization and would not be extended to include such services as prosthetic implants.

The level of coverage outlined in the bill is estimated to result in a \$4.30 per month increase in health insurance costs for the estimated 12,000 state employees effective July 1, 1988. The cost is assumed to remain level each year thereafter because the state does not yet have any experience analysis to indicate that costs will increase annually for this additional benefit. This cost increase is based on a maximum of 20 in vitro fertilization procedures plus additional services such as counseling. This exposure leads to the \$4.30 per month increase assuming a \$307 per month premium per employee. This coverage would also become mandatory for the retiree health plan but we would estimate no increase in premiums for this group.

The FY 89 estimated cost for active state employees is calculated as follows:

The Honorable Dave Donely

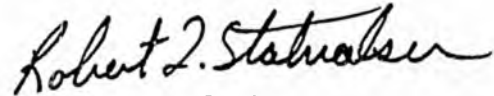
-2-

February 19, 1988

The increase of \$4.30 per month health cost times the number of
state employees (12,000) x 12 months \$619,200.

Please contact me should you have questions or require any further
information on this analysis.

Sincerely,



Robert F. Stalnaker
Acting Director

RFS/bb/7



committee statement

STATE-OF-THE-ART OPINION
IN OBSTETRICS AND GYNECOLOGY

COMMITTEE ON: Gynecologic Practice

Human In Vitro Fertilization and Embryo Placement

The technique for extracorporeal fertilization commonly known as in vitro fertilization and embryo placement (IVF-EP) was originally evaluated in the early 1970s. The first studies were carried out chiefly in England by a group of investigators headed by Dr. Robert Edwards and Dr. Patrick Steptoe (1). In 1978, the first live human offspring resulting from IVF-EP was born in England. During 1978-80 programs began in Australia in two different universities, both of which reported successful live births in 1980 and 1981 (2-4). In 1980, the first in vitro fertilization program in the United States was established at Eastern Virginia Medical School, which delivered its first live healthy offspring in December 1981 (5). The second program established in the United States, at the University of Southern California, resulted in a live birth in June 1982 (6,7). In the past year, there has been a marked increase in the number of programs being established in the United States, both in the private sector and at the major university centers.

Originally, IVF-EP was designed for patients with severe tubal disease, although the technique has expanded to include treatment of severe male factor infertility (oligozoospermic male) as well as of couples who have not had an explanation for their infertile state (the so-called idiopathic infertility group). Success rates with these groups have not been established.

Because the number of infertile couples in the United States is increasing, the need for IVF-EP programs is apparent. The main concern right now is determining what qualifications and types of facilities are necessary to provide optimal chances for successful outcome. Ideally, IVF-EP should be per-

formed and managed in a hospital setting. Whether the procedure is carried out in a university research center or in private community hospitals, rigid standards and quality control must be maintained.

TECHNIQUE

The human IVF-EP process involves several steps. Currently, ovarian hyperstimulation is induced with several different types of medications. Protocols most commonly used are clomiphene citrate in doses ranging from 50-150 mg/day or variable doses of human menopausal gonadotropins (Pergonal) either combined with clomiphene or as a single agent (7,8). This hyperstimulation encourages the development of multiple oocytes, which are recovered by laparoscopy for fertilization in vitro. The use of gonadotropin-releasing hormone may be a future development that could provide a more physiologic ovarian stimulation for multiple follicle development (9).

The response to stimulation is monitored primarily by serum or urinary estradiol measurement. Luteinizing hormone measurements and daily real-time ultrasound are utilized to determine follicular growth parameters, the number of follicles developing, and the time of ovulation initiation. The results of these determinations are correlated to judge the response to stimulation and the time of follicle maturation.

Laparoscopy for oocyte retrieval is performed under general anesthesia with a specifically designed oocyte collection system. Follicular fluid analysis is performed very rapidly for identification



THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
600 MARYLAND AVENUE SW • SUITE 300 EAST • WASHINGTON, D C 20024 • (202) 638-5577
COMMITTEE STATEMENTS ARE SUBJECT TO CHANGE AND
ARE NOT TO BE CONSIDERED POLICY OF THE ACOG

operating theater setup. The availability must be rigidly controlled so that patients can be moved in and out of the operating room on a regular schedule 7 days a week, within a maximum of 24 hours notice.

- *Anesthesia.* Must be available 7 days a week.
- *Laboratory.* The quality of the embryo culture laboratory is very important. The purity of the water and quality of the culture media and their supplement are critical to obtaining viable pregnancies in an IVF-EP program. Rapid hormonal assay systems capable of measuring estradiol and luteinizing hormone must be available 7 days a week. The facility for oocyte-sperm culturing should be close to the operating room, with two-way communication. Necessary equipment varies from laboratory to laboratory, but must include a controlled incubation system, magnification system for identifying oocytes and embryos, and a system to maintain quality control of media preparations from week to week. Most commonly, mouse embryo growth and development rates are used to determine the safe media for use in the human egg system.

SUMMARY

Today in the United States, human IVF-EP is a clinically applicable procedure.* It is no longer considered purely experimental.

*Classifications:

- *Experimental:* Techniques that have been largely confined to laboratory and/or animal research.
- *Investigative:* Techniques that have progressed to limited human application but lack wide recognition as proven and effective procedures in clinical medicine.
- *Clinically applicable:* Techniques that have been accepted as clinically effective procedures for general or limited use† based on risk/benefit and cost implications.

†Limited use to be explained.

IVF-EP requires maintenance of certain standards which have been outlined here and thoughtful consideration given to ethical issues involved. If done by competent individuals in well-organized centers, this process can benefit a large segment of the infertile population that was heretofore unable to be treated satisfactorily. If the aforementioned guidelines are followed, a program for IVF-EP can be established in a private setting as well as in university-based hospital systems. However, it should be cautioned that the procedure itself is very complex, highly technical, and requires a large backup system of laboratory support and specialized personnel available 7 days a week.

REFERENCES

1. Edwards RG: Test-tube babies, 1981. *Nature* 293(5830):253-256, 1981
2. Trounson AO: Current perspectives of in vitro fertilization and embryo transfer. *Clin Reprod Fertil* 1:55-56, 1982
3. Lopata A, Johnston IWH, Hoult IJ, et al: Pregnancy following intrauterine implantation of an embryo obtained by in vitro fertilization of a pre-ovulatory egg. *Fertil Steril* 33(2):117-120, 1980
4. Trounson AO, Leeton JF, Wood C, et al: Pregnancies in humans by fertilization in vitro and embryo transfer in the controlled ovulatory cycle. *Science* 212(4495):681-682, 1981
5. Jones HW Jr, Jones GS, Andrews MC, et al: The program for in vitro fertilization in Norfolk *Fertil Steril* 38(1):14-21, 1982
6. Marrs RP, Vargyas JM, Saito H, et al: Clinical applications of techniques used in human in vitro fertilization research. *Am J Obstet Gynecol* 146(5):477-481, 1983
7. Marrs RP, Vargyas JM, Gibbons WE: A modified technique of human in vitro fertilization and embryo transfer. *Am J Obstet Gynecol* 147(3):318-322, 1983
8. Quigley MM, Maklad NF, Wolf DP: Comparison of two clomiphene citrate dosage regimens for follicular recruitment in an in vitro fertilization program. *Fertil Steril* 40(2):178-182, 1983
9. Liu JH, Durfee R, Muse K, et al: Induction of multiple ovulation by pulsatile administration of gonadotropin-releasing hormone. *Fertil Steril* 40(1):18-22, 1983
10. Personal Communication, Howard W. Jones, MD, 1983
11. Unpublished data, Richard P. Marrs, MD, 1983

April 1984



committee statement

STATE-OF-THE-ART OPINION
IN OBSTETRICS AND GYNECOLOGY

COMMITTEE ON: Ethics

Ethical Issues in Human In Vitro Fertilization and Embryo Placement

CLINICAL IN VITRO FERTILIZATION AND EMBRYO PLACEMENT

Current Practices

The most frequent users of in vitro fertilization (IVF) and embryo placement (EP) are married couples who are seeking a remedy for their infertility. In the simplest case gametes are provided by the husband and wife, and no early embryos are frozen. The pregnancy, if one is successfully initiated, is carried by the wife. The use of IVF and EP in this simplest case is supported by a broad social consensus in the United States and can be justified by strong and convincing ethical arguments.

The short-term safety of IVF and EP for children produced by this method had once been thought to raise serious clinical and ethical questions. However, in the first 2200 reported births initiated with the aid of these techniques, the incidence of chromosomal abnormalities and genetic defects following IVF does not appear to differ from the incidence following conventional reproduction. Therefore, the early experience with simple IVF and EP offers little support for the view that the techniques are likely to be harmful to offspring. The long-term effects of IVF and EP on children conceived by means of these techniques should be assessed through careful follow-up study of the children.

Several immediate questions remain, however, in the current clinical use of IVF and EP. The first question concerns the optimum number of eggs to be fertilized and the optimum number of embryos to be placed during one cycle. Here a balance should

be struck between two kinds of risks—the risk of not achieving a pregnancy (thereby requiring additional cycles of treatment and possibly additional egg recoveries) and the complications, for both the pregnant woman and fetuses, of a multiple pregnancy. This issue should be discussed with each couple at the time of entry into the IVF program.

A second ethical question relates to surplus embryos: How does one deal with embryos that are not placed in the uterus? In the future the surplus embryo problem may be alleviated by the increasing availability of freezing and storage techniques. The freezing option and the alternatives of donation to another couple, donation for research, or discard should be discussed with the gamete providers and the issues resolved well in advance of the IVF procedure. Research on the early embryo and discard may raise ethical and legal questions that go beyond the consent of the genetic parents. (For further discussion of these issues, see the later sections of this document.)

A third ethical issue concerns the coverage of IVF by private and public health insurance plans, as well as by other payment mechanisms. In the years immediately following 1978, IVF and EP were regarded as experimental procedures and were seldom covered by insurance plans. By the mid-1980s, however, these techniques have become an important part of mainstream medical care for infertility. As such, IVF and EP should be covered in the same way and to the same extent as more traditional methods of infertility treatment (eg, tubal reconstruction) have been covered.

A further question is whether IVF and EP (or the more traditional technique of artificial insemina-



THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
600 MARYLAND AVENUE SW • SUITE 300 EAST • WASHINGTON, D.C. 20024 • (202) 638-5577
COMMITTEE STATEMENTS ARE SUBJECT TO CHANGE AND
ARE NOT TO BE CONSIDERED POLICY OF THE ACOG

should be organized into a two-tiered system that protects the privacy of donors yet allows access to relevant medical information on a need-to-know basis. The professional societies that seek to assist infertile couples should develop clear screening and record-keeping standards and should urge their members to adhere to such standards.

The question of the sale of gametes poses a serious choice for our society—whether we wish to have assisted reproduction follow the pattern of organ donation or of the sale of plasma. Commercial sperm banks exist in the United States; if the cryopreservation of eggs becomes technically feasible, such banks will probably also want to provide human eggs for a fee. A different approach to the collection and distribution of human gametes has been adopted by the government of France and is being considered by the British government. In both countries there is interest in voluntary, nonprofit systems for recruiting semen donors. A nonprofit system for gamete collection and distribution in the United States would be ethically preferable to the current system, both because it would reduce the incentive for gamete providers to withhold information in giving their medical histories and because it would reduce the likelihood that commercial banks will make extravagant claims for their products. A nonprofit system might also facilitate the setting of limits on the number of donations per individual.

The successful cryopreservation and storage of human embryos has already made embryo banks a technical possibility. As in the case of gamete collection and distribution, a voluntary, nonprofit approach to the collection and distribution of embryos is preferable. The maintenance of high standards of care in this important matter should take precedence over the profit motive.

EARLY GENDER SELECTION. Noninvasive techniques for determining the gender of early human embryos *in vitro* will almost surely be developed. To the extent that these techniques would be used to help couples avoid sex-linked genetic disorders, preimplantation gender selection is ethically justifiable. Other applications of gender selection are more difficult to justify.

EARLY DIAGNOSIS OF GENETIC OR CHROMOSOMAL ABNORMALITIES. Techniques for removing one cell or several cells from an early human embryo, freezing the remaining cells, and performing various diagnostic procedures on the removed cell or cells appear to be technically feasible. Presumably, embryos found to be affected by a chromosomal or genetic abnormality would not be placed but would, rather, be discarded. If the safety and accuracy of this diagnostic technique can be demonstrated, it would be a preferable alternative to prenatal diagnosis and selective abortion during the first or second trimester of pregnancy because it involves less physical and psychological trauma to the woman. However, the safety of such "embryonic biopsies" to potential children will need to be established in careful studies.

RESEARCH INVOLVING IVF

Clinical Research

Few ethical objections can be raised to studies directed toward monitoring the safety and efficacy of IVF and EP. Indeed, such studies would seem to be an essential component of clinical programs offering IVF and EP. Prospective studies comparing alternative clinical procedures are also ethically appropriate.

Laboratory Research

There are three primary viewpoints on the ethical acceptability of research with early human embryos. The first viewpoint asserts that human embryos are entitled to protection as human subjects from the time of fertilization. On this view, any research that damages an embryo or interferes with its prospect for placement and further development is ethically unacceptable. This perspective on embryonic status is based on two kinds of factual evidence: first, the embryonic genotype is established at the time of fertilization; second, given the appropriate environment, many early embryos have the potential to become full-term fetuses, children, and adults.

A second viewpoint is diametrically opposed to the first. This viewpoint denies that we have any moral obligations to early human embryos. Factual evidence cited by proponents of this view includes the high rate of natural loss at the early embryonic stages in humans and the primitive state of embryonic development during the first two or three post-fertilization weeks.

A third and intermediate viewpoint on the moral status of the early human embryo is that it deserves greater respect than other human cells or tissues because of its potential to become a person and that our moral obligations become stronger as the early embryo develops into a later embryo, a fetus, and a newborn infant. On this view, even if we have certain moral obligations to early human embryos, these obligations may be outweighed by the duty to develop new and better methods for providing care to pregnant women, infertile couples, early embryos, and future children.

The third viewpoint is the most rationally defensible position on the moral status of the early embryo (1, 2). In light of this conclusion, it is recommended that laboratory research with early human embryos proceed, guided by ethical standards and subject to prior review. The standards should require that:

1. The importance of the research problem be sufficient to justify the use of human embryos
2. The research be designed in a way that allows valid scientific conclusions to be drawn
3. The knowledge sought cannot be gained from studies with nonhuman embryos

THE AMERICAN FERTILITY SOCIETY

RECEIVED MAR 14 1988

Rapid and continuous advances in medical science challenge physicians and researchers to stay abreast of the latest findings and medical techniques. The primary objective of The American Fertility Society is to provide the most up-to-date information on all aspects of infertility, reproductive endocrinology, conception control and reproductive biology.

The Society is the fastest growing subspecialty group in the medical field. From its modest beginnings of 100 members in 1944, its membership has grown to over 10,000 physicians and scientists from every state in the union and more than 75 foreign countries.

THE NEED

For many couples today there is no longer easy access to adoptive children. Therefore, the Society finds it increasingly important to explore and pursue every possible resource to help patients conceive their own children.

At the same time, the Society addresses the concerns of unwanted pregnancies by keeping its members apprised of the newest technologies for conception control.

In recent years reproductive medicine has expanded its horizons by studying the problems of the aging population. Osteoporosis, cardiovascular disorders and other conditions affecting the older population are being researched.

THE SERVICES

Booklets and pamphlets prepared by specialists; suggested readings in the area of reproductive health; resource lists; a monthly medical journal, Fertility and Sterility; regional postgraduate courses for continuing medical education and an annual scientific meeting.

In addition, the Society has prepared a set of ethical guidelines governing the new reproductive technologies; a position paper on insurance coverage for infertility services; revised procedures for semen donor insemination; established three affiliates in the areas of Reproductive Endocrinology, Reproductive Surgery and Alternative Reproductive Technology.

Additional information may be obtained from the Society's Administrative Office. Contact: Joyce Zeitz

Public Relations Coordinator
The American Fertility Society
2140-11th Avenue South, #200
Birmingham, Alabama 35205-2800



THE AMERICAN FERTILITY SOCIETY

(205) 251-9764

NEWS

2131 Magnolia Avenue
Suite 201
Birmingham, Alabama 35256

The growing problem of infertility affects one in seven American couples of childbearing age. However, with proven medical technologies now available, physicians can help a large percentage of these couples achieve parenthood. Unfortunately, access is restricted in many cases due to inequities in health insurance coverage.

Provision of fair and consistent access to medically accepted procedures for the evaluation and treatment of infertility has been established as a priority of The American Fertility Society.

To this end, the following position statement was adopted in September, 1986:

The American Fertility Society, representing over 10,000 physicians and scientists involved in the care of infertile couples as well as basic and clinical research in reproductive science, considers the right to procreate to be a fundamental human right. Further, we believe that society has a moral obligation to provide, either directly or indirectly, access to health services for the treatment of infertility.

It is therefore our recommendation that private health insurance plans be required to cover the expenses of infertility care, including those of in vitro fertilization, which is no longer considered to be an experimental procedure.

For additional information, contact:

Joyce Zeitz
Public Relations Coordinator
The American Fertility Society
2131 Magnolia Avenue, Suite 201
Birmingham, Alabama 35256
(205) 251-9764



THE AMERICAN FERTILITY SOCIETY

2140 ELEVENTH AVENUE SOUTH, SUITE 200, BIRMINGHAM, ALABAMA 35205 • 205/933-8494

STATE MANDATED INSURANCE COVERAGE FOR INFERTILITY SERVICES

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TEXAS

2/24/88

Minimal standards for programs of in vitro fertilization

American Fertility Society**†

I. *General Considerations*

Every group initiating a program of in vitro fertilization should have all aspects of the program approved by a properly constituted Institutional Review Committee. The Institutional Review Committee or its equivalent should ensure that a record is kept of all attempts made at securing pregnancies by these techniques. The records should include all medical aspects of the treatment cycles and a record of success or failure with respect to oocyte recovery, fertilization, cleavage, conceptus transfer, biophysical monitoring of fetal growth, pregnancy outcome, and complications. These institutional records, which should be separate from the regular records of the medical institution, should be confidential. Summaries for statistical purposes, including details of any congenital abnormalities among offspring, should be available for correlation.

It is recommended that special attention be given to the emotional needs and the emotional support of these patients.

It is recommended that the director of the program have clinical experience and competence.

In view of the many research opportunities offered by programs of in vitro fertilization, it is urged that all programs be

designed to take advantage of these opportunities.

II. *Personnel*

Personnel with the following four types of skills are required as a minimum. A single individual may possess one or more of the required skills.

(1) An individual with the experience and training required for board certification in reproductive endocrinology. While individuals with equivalent training and experience are certainly acceptable, board certification clearly indicates that the required skills in reproductive endocrinology have been obtained.

(2) A pelvic reparative surgeon with laparoscopic experience with evidence of specialized training in follicular aspiration.

(3) An individual experienced in male reproduction (andrology) with special competence in semenology.

(4) An individual with knowledge of and practical experience in tissue culture, gamete maturation, fertilization, and early zygote cleavage in human and animal systems.

III. *Special Services and Facilities*

These services and facilities must be on call on a daily basis with 24-hour availability.

(1) Ultrasonography.

(2) Hormonal assays.

(3) Facilities for follicular aspiration and conceptus transfer.

(4) Anesthesia.

(5) A laboratory for gamete fertilization and conceptus development near the operating room with two-way communication between the laboratory and operating room.

*Report of an ad hoc committee of The American Fertility Society: Howard W. Jones, Jr., M.D., Chairman, Anne Colston Wentz, M.D., Martin M. Quigley, M.D., Richard P. Marrs, M.D., and C. Alvin Paulsen, M.D. Approved by the Board of Directors of The American Fertility Society.

†Reprint requests: The American Fertility Society, 1608 13th Avenue South, Suite 101, Birmingham, Alabama 35256.

Two as Family continued

More than a Difference in Words ...

When I was involved with infertility testing, there were times when the word "infertility" seemed synonymous with the word "marathon." It was an ordeal that tried the mettle of my very essence. I was pushed physically, emotionally and psychologically to the edge of my being and emerged, despite it all, intact, feeling strained, older, and infinitely wiser.

Even though my spouse and I weathered the storm together, it was a different experience for each of us. We both have our own precious dreams, bitter tears, and final resolutions. These special memories are mine; no one can take them from me.

Today there are people who question if parenthood is the right lifestyle for them. These people are capable of physically bearing their own children but for various reasons have made a decision not to do so. The appropriate description of these people is "childfree." There are those, however, who are not capable of physically bearing their own children. They made no "free" decision, and are therefore correctly termed "childless."

The "childfree" are as much outsiders to the rigors of infertility as any other member of the general population. The "childless" don't have more or less in common with the "childfree" than

with any other non-infertile person. One lifestyle is the fulfillment of life's plans; the other is the opposite. The categorization of these infertile as "childfree" diminishes the importance of and denies acknowledgment of the experience of infertility. It also inaccurately suggests that freedom of choice was involved.

Even in those cases where couples who cannot conceive do not actively pursue alternatives such as adoption, surrogate parenting, or artificial insemination, these people are still "childless." The alternatives to childlessness were not choices, but second-best alternatives for them. Their choice was to bear a child and they were unable to achieve that choice.

I would like to see the counseling community discontinue use of the term "childfree" when referring to the infertile. I have faced my childlessness and survived, and I do not wish to have my accomplishment diminished or its acknowledgment denied. It is much more than a technical difference in words. It is what I am. I am childless!

(adapted from the RESOLVE of the Twin Cities July/Aug. and Sept./Oct. '86 newsletters)

Ann Scheuring Hill
1059 Burke Avenue W.
St. Paul, MN 55113

**Suggested Readings:
Childfree Living**

- Bombardieri, M. *The Baby Decision*. New York: Rawson Associates, 1981.
- Bombardieri, M. "Childfree Living — The Road Not Taken: An Interview with Lynne Wood." RESOLVE Newsletter, September, 1982.
- Burgwyn, D. *Marriage Without Children*. New York: Harper and Row, 1982.
- Fabe, M and Wikler, N. *Up Against the Clock: Women Speak on the Choice to Have Children*. New York: Random House, 1979.
- Faux, M. *Childless by Choice: Choosing Childlessness in the Eighties*. New York: Anchor Press/Doubleday, 1984.
- Whelan, E. A *Baby? Maybe*. New York: Bobbs-Merrill, 1975.

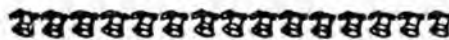
The RESOLVE fact sheet on "Childfree Decision-making" also offers guidance on this issue.

**A Tribute to
A Special Person**

RESOLVE now offers you the opportunity to honor someone special in an important way. A donation of \$50 or more in the name of a dedicated physician, caring friend, loving relative, new baby, or special occasion will be used to maintain RESOLVE's quality services. A Tribute Card will be sent indicating your kind gift. RESOLVE in recognition of the special person.

We are pleased to report that RESOLVE has received nearly \$2,000 in Tribute Card contributions. RESOLVE appreciates your using Tribute Cards as a tangible way to recognize someone special while helping the organization.

Send donations to: Tribute Card, RESOLVE, 5 Water Street, Arlington, MA 02174. Include your name and address, and the complete name and address of the special person and their relationship to you. Please allow 2 weeks for delivery.



**Board Establishes New
Policy on Surrogating**

At its annual meeting, September 19-20, in Boston, the national Board of Directors reviewed results of an opinion referendum with RESOLVE chapters concerning the use of surrogate mothers by infertile couples. As a result of this discussion, and two years of review of this issue, the Board has established the following statement on this option:

RESOLVE, Inc. supports the right of infertile couples to make their own decisions in family building. RESOLVE, Inc., recognizing surrogating as one option among many for family building, believes that this option should remain available to those infertile couples who find it acceptable. We urge those who consider surrogating to educate themselves thoroughly about all issues involved so that they can make informed decisions.

We urge infertile couples choosing this option to use their special perspective to enter into arrangements which are humane, and respectful of the rights and feelings of all the parties: the child, the surrogate, and themselves.

We recognize that legal regulation is appropriate and necessary. We urge infertile couples to stay informed about the status of law and regulation in their own states and to follow their own consciences in evaluating and taking individual political action on specific legislative proposals. Overall, RESOLVE, Inc. opposes legislation which would prohibit surrogating as an option.

RESOLVE's fact sheet on this option will continue to provide those interested with information about current programs, and the legal issues surrounding surrogating.

**Insurance Victory in
Massachusetts**

After two years of intensive effort, RESOLVE of the Bay State has been instrumental in the passage of the Infertility Benefits Bill. On October 8, 1987, Governor Michael Dukakis signed into law this bill requiring coverage of all infertility treatment, including IVF. This law goes into effect January 6, 1988 and affects everyone insured by Blue Cross/Blue Shield, all commercial insurers and HMOs. It requires coverage of infertility treatment expenses to the same extent that maternity benefits are offered by your insurance policy. Congratulations to the chapter's Steering Committee, led by Karen and Skip Sweet, and the many RESOLVE members and friends who wrote and spoke to legislators on behalf of the bill.



Gov. Dukakis signs Infertility Bill, with Bay State RESOLVE advocates present.

Welcome New Chapters

We would like to welcome two new chapters: RESOLVE of Los Angeles County and RESOLVE of the Triangle, NC (Raleigh, Durham, Chapel Hill). The contact persons and addresses are, L.A. County: Vince Budrovich, President, (213) 833-5416, and Elaine Winer Smith, (213) 699-2587, P.O. Box 5244, Torrance, CA 90510; and for Triangle: Debbie Dixon, President, (919) 829-4331, 208 Trapper's Run Drive, Cary NC 27511. RESOLVE now has 48 chapters!

Upcoming Conferences

Parents of Tomorrow, an information gathering organization whose goal is to assist those looking for alternatives in family building, will sponsor a conference, March 10-13, at the Concord Resort Hotel in Kiamesha Lake, NY. Registration fee is \$120 per couple plus lodging. Call (212) 644-2659 for more information.

RESOLVE of Chicago will present a symposium on infertility and adoption issues, Feb. 27 in Rosemont. Call (312) 743-1623 for more information.

RESOLVE enters the computer age—For more than two years, the national office has been involved in establishing its own computer system for handling memberships and other types of information. With this *National Newsletter* issue, we will be handling "in-house" the production of labels for the newsletter, all our renewal notices, and other mailings. We hope that you will receive even better service as a result of this new system, but if for some reason you don't receive your newsletter, or if information about your membership appears incorrect, please call or write us. It could be a result of an error during this implementation phase. Thank you!



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

January 20, 1988

MEMORANDUM

TO: Representative Curt Menard

FROM: Karla Hart *KH*
Legislative Analyst

RE: Massachusetts Legislation Regarding Insurance Coverage of Infertility

You asked this agency to obtain a copy of Massachusetts legislation regarding insurance coverage for the treatment of infertility. A copy of Massachusetts Chapter 394, 1987 Regular Session Laws is attached. Section 1 defines infertility as the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year. The Massachusetts law provides that insurance which includes pregnancy-related benefits must provide, to the extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility.

I spoke with Ms. Cottle regarding the Massachusetts law. She is interested in having similar legislation enacted in Alaska. Using STAIRS, I found that the only reference to infertility which currently exists in Alaska statutes relates to veterinary practices.

I hope this information is helpful. If you have additional questions, please call.

Attachment

**MASSACHUSETTS
LEGISLATIVE SERVICE**

1987

Acts of the General Court

**Chapters 346 to 394
1987 Regular Session
Convened January 7, 1987**

**ST. PAUL, MINN.
WEST PUBLISHING CO.**

**INFERTILITY—INSURANCE COVERAGE—DIAGNOSIS
AND TREATMENT**

CHAPTER 394

ACT providing a medical definition of infertility.

As it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1.

Chapter 176 of the General Laws is hereby amended by inserting after section 47G, created by section 1 of chapter 363 of the acts of 1987, the following section:—

Section 47H.

Any blanket or general policy of insurance, except a blanket or general policy of insurance which provides supplemental coverage to medicare or other governmental programs, described in subdivisions (A), (C) or (D) of section one hundred and ten which provides hospital expense or surgical expense insurance which includes pregnancy-related benefits and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, while this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense or surgical expense insurance which includes pregnancy-related benefits and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in the commonwealth while this provision is effective, or any employees' health and welfare plan which provides hospital expense and surgical expense benefits which includes pregnancy-related benefits and which is promulgated or renewed to any person or group of persons in the commonwealth while this provision is effective shall provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility. For purposes of this section, "infertility" shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

SECTION 2.

Chapter 176A of the General Laws is hereby amended by inserting after section 8J, created by section 8 of said chapter 363, the following section:—

Section 8K.

Any contract, except contracts providing supplemental coverage to medicare or other governmental programs, between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued for delivery or renewed in the commonwealth while this provision is effective and which provides pregnancy-related benefits shall provide as a benefit for all individual subscribers or members within the commonwealth and all group members having a principal place of employment within the commonwealth, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility. Said infertility benefits shall meet all other terms and conditions of the subscriber certificate. For purposes of this section, "infertility" shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

SECTION 3.

Chapter 176B of the General Laws is hereby amended by striking out section 4G, created by section 4 of said chapter 363, and inserting in place thereof the following two

parts:—

Section 4I.

Any subscription certificate under an individual or group medical service agreement, except certificates which provide supplemental coverage to Medicare or other governmental programs, which shall be delivered or issued or renewed in the commonwealth shall provide as benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth for expense of cytologic screening and mammographic examination. Said benefits shall be at least equal to the following minimum requirement: (a) in the case of benefits for cytologic screening, said benefits shall provide for an annual cytologic screening for women eighteen years of age and older; and (b), in the case of benefits for mammographic examination said benefits shall provide for a baseline mammogram for women between the ages of thirty-five and forty and for mammogram on an annual basis for women forty years of age and older.

Section 4J.

Any subscription certificate under an individual or group medical service agreement, except certificates which provide supplemental coverage to medicare or other governmental programs, which is delivered, issued for delivery or renewed in the commonwealth while this section is effective shall provide as a benefit for all individual subscribers or members within the commonwealth and all group members having a principal place of employment within the commonwealth, to the same extent that benefits are provided for other pregnancy-related procedures and subject to the other terms and conditions of the subscription certificate, coverage for medically necessary expenses of diagnosis and treatment of infertility. Said infertility benefits shall meet all other terms and conditions of the subscription certificate. For purposes of this section, "infertility" shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

SECTION 4.

Section 4 of chapter 176G of the General Laws, as amended by section 5 of said chapter 363, is hereby further amended by adding the following sentence:— Such health maintenance contract shall also provide coverage for diagnosis and treatment of infertility as set forth in section forty-seven H of chapter one hundred and seventy-five.

Approved October 8, 1987.



100 Summer Street
Boston, MA 02110

January 29, 1988

The Hon. Roger Singer
Commissioner of Insurance
Division of Insurance
Commonwealth of Massachusetts
100 Cambridge Street
Boston, MA 02202

Dear Commissioner Singer:

Reference is made to our letters of:

September 30, 1986 filing Master Medical Certificate MM 1 7-1-86;
January 15, 1973 filing the Blue Cross Method of Experience Rating
effective February 1, 1973.

The recommended Blue Cross Group monthly rates effective January 1, 1988
are indicated in the attached exhibit.

The monthly rates are designed to remain in effect for one year for each
policy anniversary date from January 1, 1988 through March 31, 1988.

This is submitted in accordance with the requirements of section 10 of
Mass. G.L. c. 176-A, as amended.

Sincerely,

A handwritten signature in cursive script that reads "Timothy M. Harrington".

Timothy M. Harrington, M.A.A.A.
Assistant Actuary

TMH/cf

Enclosure

BY MESSENGER

BLUE CROSS & BLUE SHIELD OF MASSACHUSETTS
ESTIMATED PURE PREMIUM ASSOCIATED WITH
ENACTMENT OF C.394
(INFERTILITY)

ITEM	DATA	SOURCE
1. a. Married Couples in Massachusetts, 1985 (married females aged 18 - 44)	709,234	1980 Census Data, Massachusetts - Table 205 Massachusetts Data Center, 1985
b. Percent of Married Couples who are Infertile	17.2%	National Center for Health Statistics
c. Percent of Infertile Couples who might seek treatment for Infertility in a year	14.3%	Research Estimate
d. Number of Infertile Couples who might seek treatment for Infertility in a year	17,444	Item 1a x Item 1b x Item 1c
2. a. Percent of Infertile Couples using the In Vitro Fertilization Technique	4.0%	Machelle Seibel, MD Beth Israel Hospital
b. Number of Infertile Couples using the In Vitro Fertilization Technique	698	Item 1d x Item 2a
c. Cost per Case for In Vitro Fertilization	\$14,605	Research Estimate
d. Total Additional Liability Associated with Mandating Benefits for In Vitro Fertilization	\$10,194,290	Item 2b x Item 2c
3. a. Percent of Infertile Couples using Hormone Therapy	25.0%	Machelle Seibel, MD Beth Israel Hospital
b. Number of Infertile Couples using Hormone Therapy	4,361	Item 1d x Item 3a
c. Cost per Case for Hormone Therapy	\$1,375	Research Estimate
d. Total Additional Liability Associated with Mandating Benefits for Hormone Therapy	\$5,996,375	Item 3b x Item 3c
4. a. Percent of Infertile Couples using Artificial Insemination	30.0%	Machelle Seibel, MD Beth Israel Hospital
b. Number of Infertile Couples using Artificial Insemination	5,233	Item 1d x Item 4a
c. Cost per Case for Artificial Insemination	\$150	Research Estimate (1 - 3 attempts @ \$75)
d. Total Additional Liability Associated with Mandating Benefits for Artificial Insemination	\$784,950	Item 4b x Item 4c
5. a. Total Additional Annual Liability Associated with Enactment of C.394	\$16,975,615	Item 2d + Item 3d + Item 4d
b. Total Massachusetts Population, Ages 19 - 64	3,575,615	Massachusetts Data Center, 1985
c. Additional Annual Liability per Adult	\$4.748	Item 5a / Item 5b
d. Additional Monthly Liability per Adult	\$0.396	Item 5c / 12
6. a. Individual Contract Rate	\$0.40	Item 5d
b. Family Contract Rate	\$0.80	Item 5d x 2
	<u>Individual</u>	<u>Family</u>
7. a. Blue Cross Costs for Infertility	\$0.32	\$0.64
b. Blue Shield Costs for Infertility	\$0.08	\$0.16

At least
3 in vitro
cycles.

211 CMR 37.00

INFERTILITY BENEFITS

Section:

- 37.01: Authority
- 37.02: Purpose
- 37.03: Definitions
- 37.04: Scope of Coverage
- 37.05: Required Infertility Benefits
- 37.06: Prescription Drugs
- 37.07: Optional Infertility Benefits
- 37.08: Prohibited Limitations on Coverage
- 37.09: Permissible Limitations on Coverage
- 37.10: Effective Date
- 37.11: Severability

37.01: AUTHORITY

This regulation is issued under the authority of M.G.L. c. 175; M.G.L. c. 176A; M.G.L. c. 176B; M.G.L. c. 176D; and M.G.L. 176G.

37.02: PURPOSE

The purpose of this regulation is to implement Chapter 394 of the Acts of 1987, an Act Providing a Medical Definition of Infertility.

37.03: DEFINITIONS

The following words as used in this regulation shall be defined as follows:

Commissioner: The Commissioner of Insurance or his or her designee.

Experimental infertility procedure: A procedure not yet recognized as generally accepted or non-experimental by the American Fertility Society (AFS) or the American College of Obstetrics and Gynecology (ACOG) or another infertility expert recognized as such by the Commissioner.

Infertility: The condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year.

Insured: A subscriber, member, policy holder, certificate holder or his or her covered spouse or other covered dependent.

Insurer: Any company as defined in M.G.L. c. 175, §1 and authorized to write accident and health insurance; any hospital service corporation as defined in M.G.L. c. 176A, §1; any medical service corporation as defined in M.G.L. c. 176B, §1; or any health maintenance organization as defined in M.G.L. c. 176G, §1.

Non-experimental infertility procedure: A procedure recognized as generally accepted or non-experimental by the American Fertility Society or the American College of Obstetrics and Gynecology or another fertility expert recognized as such by the Commissioner.

37.04: SCOPE OF COVERAGE

Insurers shall provide benefits for required infertility procedures, as described in 37.05, which are furnished to an insured, covered spouse and/or other covered dependent.

Insurers shall not be required to provide benefits for services furnished to a spouse or dependent if the spouse or dependent is not otherwise covered by the insurer.

37.05: REQUIRED INFERTILITY BENEFITS

(1) Subject to any reasonable limitations as described in subsection 37.08 below, insurers shall provide benefits for all non-experimental infertility procedures including, but not limited to:

(A) Artificial Insemination (AI);

(B) In Vitro Fertilization and Embryo Placement (IVF-EP).

(2) The required benefits provided by 37.05(1) shall include any costs associated with the attendant sperm, egg and/or inseminated egg procurement, processing and banking only if the donor is the covered spouse.

37.06: PRESCRIPTION DRUGS

Insurers shall not impose exclusions, limitations or other restrictions on coverage for infertility-related drugs that are different from those imposed on any other prescription drugs.

37.07: OPTIONAL INFERTILITY BENEFITS

No insurer shall be required to provide benefits for:

- (1) Any experimental infertility procedure, including but not limited to, Gamete Intra-Fallopian Transfer (GIFT), until the procedure becomes recognized as non-experimental and is so designated by the Commissioner;
- (2) Procurement, processing and/or banking of donor egg(s) and/or sperm, except as provided for by 37.05(2);
- (3) Surrogacy;
- (4) Reversal of Voluntary Sterilization.

37.08: PROHIBITED LIMITATIONS ON COVERAGE

- (1) No insurer shall impose deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for required infertility benefits which are different from those imposed upon benefits for services not related to infertility.

- (2) No insurer shall impose pre-existing condition exclusions or pre-existing condition waiting periods on coverage for required infertility benefits. No insurer shall use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting or otherwise restricting the availability of coverage for required infertility benefits.

37.09: PERMISSIBLE LIMITATIONS ON COVERAGE

Insurers may establish reasonable eligibility requirements, based upon the insured's medical history, and reasonable provider contracting standards. These requirements and standards shall be maintained in written form and shall be available to any insured and/or the Commissioner upon request. Standards or guidelines developed by the American Fertility Society or the American College of Obstetrics and Gynecology may serve as a basis for these eligibility and contracting requirements.

37.10: EFFECTIVE DATE

This regulation shall apply to any contract, policy or plan offering hospital, surgical or medical expense coverage as

described in M.G.L. c. 175, §§108 and 110, M.G.L. c. 176A, M.G.L. 176B, and M.G.L. c. 176G, and which is issued or renewed, within or without the Commonwealth, on or after January 6, 1988. The immediate promulgation of this regulation is necessary to preserve the public health, safety and general welfare and to afford full coverage to those with an immediate need for infertility benefits, thereby implementing the public policy of the Commonwealth as evidenced by Chapter 394 of the Acts of 1987.

57.11: SEVERABILITY

If any section or portion of a section of this regulation or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of this regulation or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

Anchorage Obstetrics & Gynecology

Richard T. Nist, M.D.
 Diplomate of the American Board
 of Obstetrics & Gynecology
 Fellow American College
 of Obstetrics and Gynecology

Robert G. Thompson, M.D.
 Diplomate of the American Board
 of Obstetrics & Gynecology

ESTIMATED IVF CYCLE CHARGES

Charges up to and including Day 8, air fares, room and board

Anchorage OB/GYN screening appt.	\$ 250.00	
Stimulation cycle nursing consult	65.00	
Seven ¹⁴ amp. Pergonal	238.00 476.00	
Ten (10) tabs Clomid (pharmacy charges)	40.00	
Estradiol x2	173.60 185.80	
Ultrasound x1	<u>50.00</u> 60.00	
TOTAL	\$ 816.60 1076.80	\$ 816.60

Air Fare	\$ 460.00	
(Reservations should be made 30 days in advance - \$230 round trip per person)		
		<i>whatever savings is</i>
Housing	280.00	
(Day 9 through 16 (7 days) estimated \$35/\$40 per day)		
Meals	<u>280.00</u>	
(Estimate \$20 per day/per person \$140 x2)		
TOTAL:	\$1,020.00	<u>\$1,020.00</u>
TOTAL		<u>\$1,836.60</u>

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UNIVERSITY OF WASHINGTON IN VITRO FERTILIZATION PROGRAM

IVF AVERAGE ACTIVE CYCLE CHARGES January 1986 Protocol

I. Hospital Costs		
A. Pharmacy		
	HCG 5,000/u	15.00
	2 tabs Valium	3.50
	Progesterone Inj.	20.99
	8 Tylenol #3	3.60
	10 Doxycycline	<u>6.35</u>
		49.44
B. Central Supply		
	(syringes)	3.50
		3.50
C. Radiology		
	(U/S x4)	99.00
		99.00
D. Women's Care Center		
	Clinic Visits	129.00
	Embyro transfer	87.00
	Therapeutic Inj.	<u>56.00</u>
		272.00
E. Emergency Room		
	(3 injections)	61.50
		61.50
F. Operating room		
	OR 1½ hr.	359.00 (1 3/4 - \$460)
	Anesthesia 1-1½ hrs.	106.50 (1½-2 - \$110)
	Recovery 4½ hrs.	304.25
	Resp. Therapy	17.00
	Disposable Supp.	<u>16.50</u>
		803.25
G. Laboratory Medicine		
	Estradiol x8	300.00
	LH x3	69.00
	Progesterone x7	203.00
	Serum Pregnancy x3	70.50
	Hct.	7.25
	Blood prep x13	<u>74.25</u>
		724.00
TOTAL HOSPITAL COSTS:		<u>\$2,012.60</u>

(Assumptions: 60" lap, monitoring on Day 8, Lap on Day 12)

Anchorage Obstetrics & Gynecology

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 U.S. Army Medical College
 Obstetrics and Gynecology

Robert G. Thompson, M.D.
 Diplomate of the American Board,
 Obstetrics and Gynecology

IVF AVERAGE ACTIVE CYCLE CHARGES
 Page 2

II. Associate University Physicians' Charges
 A. Obstetrics/Gynecology

IVF Physician		
Clinic Visits	\$110.00	
Laparoscopy	553.00	
Embryo Transfer	144.00	
IVF Lab (Tissue Cult.)	<u>996.00</u>	\$1,803.00
B. Anesthesiology	325.00	325.00
C. Radiology (U/S x4)	60.00	<u>60.00</u>
TOTAL AUP CHARGES		\$2,188.00
TOTAL CYCLE CHARGES		<u>\$4,200.60</u>
PAYMENT TO UNIVERSITY		\$3,700.00
SAVINGS		\$1,200.69
TOTAL CYCLE CHARGES (Day 1 through 8)		\$1,836.60
(Day 9 through 16)		<u>3,700.00</u>
		\$5,536.60

Reserve

Expenses - Infertility

\$185⁰⁰ ↑ First Visit - not including blood work up.

\$25⁰⁰ ↑ Semen Analysis

\$1,700.00⁽¹⁹⁷⁹⁾ Vericoceal

\$55⁰⁰ day Artificial Insemination

\$50⁰⁰ Sperm Washing

\$110.00 Follicular Study (per day)

\$50.00 (After first time)

\$175.90 Progesterone Level (once per cycle)

\$3000-3500 Laparoscope

\$250⁰⁰ Blood Workup Testosterone DHEA
Prolactine

\$70⁰⁰ Sperm Antibody Test

\$1000 Source (per cycle)

\$30⁰⁰-60⁰⁰ Ovulation Predictor Test

\$400⁰⁰-500⁰⁰ Lupron Injections (per month)

\$25.⁰⁰ Clomid - 50 mil @ 5 pills per month

\$476.⁰⁰ Pergonal

\$300.⁰⁰ Hysterosalpingogram

\$165.⁰⁰ ↑ Pap Smear

6
+ft

Anchorage Obstetrics & Gynecology

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Robert G. Thompson, M.D.
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of Obstetrics & Gynecology

March 16, 1988

The Honorable Dave Donnely
P.O. Box V
Juneau AK 99811

RECEIVED
MAR 22 1988

RE: House Bill No. 440

Dear Representative Donnely:

I am sending this letter as a physician's statement in support of House Bill No. 440 entitled "An Act Relating to Insurance Company Coverage for the Treatment of Infertility", which is currently before the Alaska State Legislature.

WHEREAS one out of every six couples of childbearing age in the State of Alaska, consistent with elsewhere in the United States, is currently unable to conceive for one year of regular sexual relations, defined as infertility or having an infertility problem, and

WHEREAS 15% of couples of usual childbearing age from 22-40 are currently unable to conceive after one year of effort, and

WHEREAS over 90% of single mothers today are retaining their babies instead of considering adoption, making less babies available for adoption as an option for the fertility or completion of families in these particular couples, and

WHEREAS most of these couples are currently employed and paying for insurance with pregnancy-related coverage which they may never be able to utilize, and

WHEREAS the diagnosis and treatment of infertility is no longer considered experimental in any way, shape, or form in modern medical practice with overall success rates of 70-80% in treatment of some medical problems related to fertility including a 50% success rate after three attempts of in-vitro fertilization, indicating a significant resolution of a large number of fertility cases, and

WHEREAS involuntary childlessness creates a tremendous social impact on society, pervading every waking moment, making the couples' decisions for the future nearly impossible, and creating stressful events that significantly threaten their well-being and psychosocial health, and

WHEREAS most problems related to infertility or inability to conceive are related to specific medical treatments that may otherwise be covered in most circumstances or specific medical instances, e.g. endometriosis; however, in the case of the patient trying to conceive where her chart reveals that the treatment of this condition is related to fertility, insurance companies may

The Honorable Dave Donnelly

March 16, 1988

Page 2

have the right or the option to deny payment or reimbursement for such treatment, and

WHEREAS the insurance companies' current ability to discriminate against the patients with a diagnosis of infertility in selective payment of their medical costs represents an outright injustice in their fair treatment of medical problems which may normally be covered and may have come to light only with the onset of evaluation for fertility reasons in many cases, in addition to the fact mentioned above that these patients are paying for coverage which they are not able to utilize, i.e. pregnancy-related coverage.

BE IT RESOLVED THEREFORE, that it is my opinion that the legislators of the State of Alaska should strongly consider support of House Bill No. 440, which is receiving the same overwhelming support in other states as it originally received in the State of Massachusetts where a similar bill was passed in 1987. This bill states that infertility is defined, and correctly so, that basically the individual who is unable to conceive and has been attempting to do so for at least one year and is now under medical treatment, which may in some cases be required to achieve a successful conception, must be covered by her insurance company to the same extent that she would be covered for the cost of medical care that she would be receiving if she were pregnant and under a physician's care.

LET IT BE FURTHER RESOLVED that these patients, as stated above, are currently paying for pregnancy-related coverage which they may not be able to utilize in many cases. Medical insurance companies' ability to discriminate against these people in regards to receiving medical care for the diagnosis and treatment of their fertility-related condition is an outright injustice and implies discrimination, specifically against these couples.

LET IT BE FURTHER RESOLVED that it is quite clear that any choice but to support this legislation would be considered supporting the discrimination of selective reimbursement by insurance companies against one-sixth of couples in the State of Alaska whose mere problem is that they want to have a baby.

FINALLY, LET IT BE RESOLVED that the diagnosis and treatment of infertility or fertility problems does not imply specifically that there is a serious or life threatening problem for this particular couple but merely a problem with which medical therapy or specific treatment, and in some cases surgery, may help them to successfully enjoy the blessings of completing their Alaskan family. I encourage you to consider this bill carefully and hope that you will arrive at the same conclusion that I have outlined above, that this bill needs to be supported and passed.

Sincerely,


Robert G. Thompson, M.D.

DIST: Editor, Anchorage Times
Editor, Daily News

RGT:smc

Attachment A

"In Vitro Fertilization Enters Stormy
Adolescence as Experts Debate the Odds,"
Journal of the American Medical Association

In Vitro Fertilization Enters Stormy Adolescence As Experts Debate the Odds

A CASINO may have been just the right choice to discuss in vitro fertilization. Like gambling, "test-tube baby" technology is a chancy and expensive proposition, suggested many practitioners interviewed during the 43rd Annual Meeting of the American Fertility Society in Reno, Nev.

Ten years after Louise Brown's birth was ballyhooed in banner headlines, nearly 3000 babies owe their births to in vitro fertilization. This has given the procedure a cachet in the public's mind that even some of its advocates think is unwarranted.

Others think the technique is or will soon become the infertility treatment of choice.

Buffeted by the pressures of commercial interests and near-desperate patients searching for a technological miracle, the technique has become a major player in an increasingly lucrative infertility market. As such, it is at the center of a swirl of controversy. Questions about whether and how the performance of in vitro fertilization clinics should be monitored stir professional passions. Some even question whether the "pay-off" is worth the price tag.

The In Vitro Fertilization Market

In vitro fertilization has the potential to be a profit-making proposition, because the pool of possible candidates is large. According to the National Center for Health Statistics, in 1982 (the latest year for which figures are available) 2.4 million couples experienced either primary or secondary infertility.

While the overall rate of infertility has actually declined from 1965 to 1982, the rate in women 20 to 24 years of age tripled in that period, to 10.6% in 1982. One out of three births is to women in that age group. The increased rate of infertility in these women has been attributed to a tripling in the rates of gonorrhea and, perhaps, the introduction of the intrauterine device.

By one estimate, in vitro fertilization procedures alone (excluding the value of equipment and the cost of fertility evaluation) are a \$30- to \$40-million market. This figure is based on the number and cost of stimulation cycles performed in the United States each year.



Geoffrey Sher, MD (center, holding knife), director of the Pacific Fertility Center in San Francisco, and several colleagues blow out the candles on a cake celebrating the grand opening of the center in autumn 1987. Several babies born via in vitro fertilization look on.

According to Paul Manberg, MD, director of clinical research at Serono Laboratories, Inc. Randolph, Mass, 6000 cycles were performed during 1986. Serono is the sole US source of the menotropins Pergonal that is used for ovarian hyperstimulation in in vitro fertilization.

Each attempted cycle of stimulation, oocyte retrieval, fertilization, and embryo transfer costs about \$5000. A woman often undergoes several cycles (as many as four to six) before either becoming pregnant or giving up.

Perhaps one indication of in vitro fertilization's financial allure is the rapidly growing number of centers opening their doors. Ten new clinics have gone into business in the last nine months, bringing the current count in the United States to 160, according to the American Fertility Society. About one fourth are privately run.

The advent of commercial interests is a point of contention. Geoffrey Sher, MD, director of the Pacific Fertility Center in San Francisco and one of the field's more outspoken critics, says the Northern Nevada Fertility Center in Reno, Nev, of which he also is codirector, showed a profit last year, performing about 200 procedures. "There's no sin in being profitable, provided you can deliver" what you promise, he says. "Once we get large enough numbers, we'll be able to reduce the cost" by

spreading out the high initial fixed costs over many patients, he says.

But in the opinion of Richard P. Marrs, MD, who oversees one of the most highly regarded in vitro fertilization clinics at Cedars-Sinai Medical Center, Los Angeles, an emphasis on profit making tends to hinder basic research efforts. He believes that many for-profit private firms pay little attention to research. But, says Marrs, "we turn 20% of income back into basic research."

Because "in vitro fertilization has been sensationalized from the very beginning and PhDs were exposed to the bright lights and cameras . . . they want to work on things that attract [attention]" rather than more mundane but necessary research, says Marrs.

Sher agrees. "We've been complacent and haven't improved outcome in the last 2 1/2 years, because we've forgotten the lab. There's no research being done on the implantation process, and we still haven't come close to mimicking the female reproductive tract."

Howard Jones, MD, whose Eastern Virginia Medical School-affiliated Jones Institute for Reproductive Medicine can claim the first in vitro fertilization baby born in the United States, says that clinics such as his are not likely to reap a profit. "It's not a profit maker the way we do it. Those who are making a profit are cutting corners somewhere."

One of the things that bothers Jones about the increasing number of private for-profit clinics is that "in vitro fertilization is pushed as being the infertility treatment of choice."

Victor Gomel, MD, a noted Canadian microsurgeon and in vitro fertilization practitioner, cites studies that he thinks raise questions about this trend. One such study, reported in Reno, looked at 274 women undergoing in vitro fertilization at the Ohio State University Hospitals, Columbus. It found that, after excluding women referred because of bilateral tube blockage, 11.3% of women achieved pregnancies independent of treatment, 13.9% following embryo transfer. Of the former, 44% occurred within three menstrual cycles following a failed in vitro fertilization and transfer attempt. The investigators think that

prior follicular stimulation or adnexal manipulation may in some way benefit women with at least one patent tube.

"I think maybe we're using in vitro fertilization too quickly without looking at . . . other possibilities" says Gomel, a professor in the Department of Obstetrics and Gynecology, University of British Columbia, Vancouver, Canada.

Not everyone agrees. Sher argues that comparing in vitro fertilization with conventional tubal surgery is "comparing apples and oranges." With the exception of reanastomosis of the fallopian tubes, "in most cases, you're looking at about a 20% chance in about two thirds of tubal surgeries performed in this country . . . for a woman to get pregnant sometime in the future, after a major procedure. That could take two to three years, and in most cases she won't get pregnant, and have to end up with in vitro fertilization anyhow."

On the other hand, with one single cycle of in vitro fertilization, "a woman gets a yes or no answer immediately . . . and in the proper hands, in vitro fertilization can get above the 20% pregnancy rate."

So far, only a few insurance companies reimburse for all or part of in vitro fertilization treatment. In October 1987, Massachusetts legislators passed a law mandating coverage for in vitro fertilization and other fertility treatments for all those with private health insurance. If other states follow suit, this is likely to further increase the demand.

Conflicting Success Rates

What has become a business proposition for some is still a clinical experiment to others. Some familiar with the field estimate that nearly a third of in vitro fertilization centers in the United States have yet to register a live birth. Jones disputes this. "I've heard that figure a lot but I've never seen the evidence to back it up," he said. Sher says that based on his own discussions and a survey of in vitro fertilization clinics conducted by *Medical World News* in 1985, he's calculated that more than half of all in vitro fertilization births in the United States occurred in just three clinics: his, the Cedars-Sinai center, and the Jones clinic in Norfolk.

The issue of success rates and public perception of them is a thorny one. On one side are those who insist that the only statistic of any use to patients is what's called the "take-home baby rate," ie, the percentage of women giving birth per stimulation cycle. (In

the procedure, follicles are stimulated to produce several oocytes for retrieval.)

Using this figure, the consensus seems to be that at the best centers women can expect a success rate somewhere in the vicinity of 12% to 18%. However, the national rate is much lower: if one takes the number of in vitro fertilization births for a given year (393 in 1985), subtracts about 20% for multiple births, and divides it by the number of attempted stimulation cycles, the national success rate is about 4% to 5%.

For differing reasons, others think it inappropriate to use this latter figure as a yardstick. "The time has passed when overall pregnancy rates are adequate, because there is a lot of variation depending on the diagnosis for which the patient is being treated and their [individual] response to stimulation," Jones argues. Thus, the Virginia clinic emphasizes the success rate per embryo transfer, citing rates as high as 35% for some subpopulations of women.

But, says Seattle's Paul W. Zarutskie, MD, this figure is misleading. For every 100 women who come in for screening, fewer than half remain after negotiating the intervening steps of ovarian stimulation, egg recovery, and fertilization before an attempted transfer. To cite rates per transfer is "giving the best possible figure," he says.

Sher takes a middle position. He thinks it unfair to calculate births per stimulation attempt, because of the great individual variability in response to stimulation drugs. Many women give up after failing one stimulation attempt, even though they might eventually have responded.

"It's only when the woman comes in for oocyte retrieval that the financial, emotional, and physical roller coaster ride begins," he says. For the same reason, he thinks it is misleading to cite rates per embryo transfer. "If a woman goes through laparoscopy, she's invested. Statistics should be from the beginning of the roller coaster ride," he says.

Sher has developed a figure he calls the probable birth rate, which is the number of pregnancies carried beyond three months per the number of retrievals performed. (Anywhere from 20% to 35% of in vitro fertilization conceptions result in a miscarriage in the first trimester.) Using this figure, the Reno clinic claims a 20% success rate. According to Sher, the national rate is about 10%.

In an analysis presented at the Reno

IN INTERVIEWS, in vitro fertilization specialists suggested physicians advise couples seeking treatment to ask the following questions:

- What is that center's pregnancy rate and how is pregnancy defined? The rate should include only pregnancies verified by ultrasound, not so-called chemical pregnancies.

- What is the pregnancy rate for other women with similar diagnoses?

- How many babies are produced per procedure? Per oocyte retrieval?

- Does the clinic offer other fertility therapies?

- How many cycles are attempted per patient, with what likelihood of success over that period?

- Is the program community-based or a referral center? In vitro fertilization programs may come to be organized on a regional basis. Such is the case with the program at the University of Washington School of Medicine in Seattle. It is the hub of a referral system intended to reduce the cost of in vitro fertilization therapy by training private physicians to conduct the preliminary screening, blood tests, and semen analysis and, on the clinic's approval, initiate ovulation induction. Satellite laboratories also are available for local physicians to use ultrasound and conduct early estrogen monitoring. To date, 18 physicians have participated and 40 couples have saved \$250 000 in housing and travel costs to and from Seattle for a stimulation attempt, Paul Zarutskie, MD, reports. Viable pregnancy rates are similar to those in women undergoing all the procedures on-site.—C.A.R.

meeting, Robert Stillman, MD, associate professor and director of the reproductive endocrinology and fertility program at George Washington University Medical Center, Washington, DC, reviewed the published data comparing various fertility treatment alternatives. He points out that since selection criteria vary from center to center, statistics are not easily transferable. Each set of criteria "are a clinical experiment," he says.

Marrs says that "everyone is looking for a recipe and there isn't a recipe yet." Both he and Jones point to the complex interrelations in the reproductive system. "If there is a problem . . . it is that the designers of new programs take

(Continued on p 469.)

(Continued from p 465.)

something from one program and something from another and they don't fit together. They try to design something better without ever having proven that they can do [what another program did]," says Jones. Marrs adds that "you don't know when you manipulate one variable and have an effect whether that was the only variable [affected]."

The track record of an individual clinic is a touchy issue. Couples, of course, would like to know which clinics are doing the best. The fertility society established a national registry this year, to which clinics voluntarily report their data (the first survey will appear in February's issue of *Fertility and Sterility*); however, it will not divulge statistics for individual centers.

The registry was established for several reasons, according to Marrs: to track success rates and developments in techniques; to follow the long-term health of infants and mothers; to provide an avenue for doing large, controlled, multicenter studies of the effects of differing selection criteria and techniques; and to look for evidence of obstetric complications in in vitro fertilization pregnancies.

The Australians have observed an increased incidence of prematurity, low birth weight, and intrauterine growth retardation in babies born through in vitro fertilization. A study presented in Reno by investigators from Beth Israel Hospital in Boston found that, compared with matched controls, in vitro fertilization pregnancies were more

likely to result in premature delivery, cesarean sections, premature rupture of the membranes, and transfers to neonatal intensive care units.

Marrs believes that one of the benefits of the registry will be to demonstrate that in vitro fertilization's "efficacy is not as high as people may have been led to believe."

Sher, however, has serious qualms about the registry's merits. "These are volunteered results, without peer review, entered into a register that's closed from the patient and the referring doctor," he says. In 1987, Sher hired the firm of Arthur Young to conduct an independent audit of the data at the Reno clinic he codirects. The audit determined that their probable birth rate is around 20%. Sher thinks that all in vitro fertilization clinics should undergo such outside scrutiny, and he and Marrs have been strong proponents of a voluntary accreditation system—an idea that has met with resistance from others in the field. Sher would like to see a review board made up of representatives from medicine, religion, the public, and the insurance industry who would accredit programs that meet acceptable standards.

Sher favors this system for two reasons: to avoid governmental regulation and to give the public access to information they have a right to. "We are dealing with a double-edged sword. As we are pushing for more and more states to mandate insurance companies to fund in vitro fertilization, the [greater is] the probability that those same legislators



Egg retrieval.

... may become the ones who rescind the legislation when they find out the world of in vitro fertilization is not in order," Sher says. Furthermore, he says, "when you have a million people in this country and a procedure that's only available to 10 000, it tells you . . . in vitro fertilization is a procedure for the haves, not for the have nots."

Zarutskie acknowledges that given the success rate per recovery attempt at the center based at the University of Washington School of Medicine in Seattle (50% confirmed pregnancies after three cycles), "a couple could spend \$10 000 to \$15 000 for a 50-50 chance at a baby."

While medical and organizational developments may ultimately vastly lower the cost and improve the odds in the "baby roulette," until then—and perhaps even afterward—patients might well be advised to take the attitude encouraged by counselors at Baylor's in vitro fertilization clinic. All incoming couples are evaluated to determine their psychological and emotional concerns and needs.

In a study of 174 couples presented at Reno, Patty Mahlstedt, EdD, found that a fourth of them had no plans of how they might handle failure to have a baby following the procedure. "I suggest [to them] that there are actually four goals: become closer as a couple, feel that they are doing everything they can to achieve pregnancy, learn more about their reproductive systems, and conceive a child," Mahlstedt said.

"If the couple and the staff are working well together, three out of four of these goals can definitely be achieved; only the fourth is out of their control."

—by Chris Anne Raymond, PhD

"Test-tube babies" attend a reunion at the opening of the Pacific Fertility Center, San Francisco.



Bob Larson

Attachment B

Hawaii Act 332, 1987

Became Act 332, 1987.

THE SENATE
FOURTEENTH LEGISLATURE, 1987
STATE OF HAWAII

S.B. NO. 1112

A BILL FOR AN ACT

RELATING TO INSURANCE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. Chapter 431, Hawaii Revised Statutes, is amended
2 by adding a new section to be appropriately designated and to
3 read as follows:

4 "§431- In vitro fertilization procedure coverage. All
5 individual and group health insurance policies which provide
6 pregnancy-related benefits shall include in addition to any other
7 benefits for treating infertility, a one-time only benefit for
8 all outpatient expenses arising from in vitro fertilization
9 procedures performed on the insured or the insured's dependent
10 spouse; provided that:

11 (1) Benefits under this section shall be provided to the
12 same extent as the benefits provided for other
13 pregnancy-related benefits;

14 (2) The patient is the insured or covered dependent of the
15 insured;

1 (3) The patient's oocytes are fertilized with the patient's
17
18

S.B. NO. 1112

1 spouse's sperm;

2 (4) The:

3 (A) Patient and the patient's spouse have a history of
4 infertility of at least five years' duration; or

5 (B) Infertility is associated with one or more of the
6 following medical conditions:

7 (i) Endometriosis;

8 (ii) Exposure in utero to diethylstilbestrol,
9 commonly known as des;

10 (iii) Blockage of, or surgical removal of, one or
11 both fallopian tubes (lateral or bilateral
12 salpingectomy); or

13 (iv) Abnormal male factors contributing to the
14 infertility.

15 (5) The patient has been unable to attain a successful
16 pregnancy through other applicable infertility
17 treatments for which coverage is available under the
18 insurance contract; and

19 (6) The in vitro fertilization procedures are performed at
20 medical facilities that conform to the American College
21 of Obstetric and Gynecology guidelines for in vitro
22 fertilization clinics or to the American Fertility
23
24

S.B. NO. 1112

Society minimal standards for programs of in vitro fertilization.

(7) The term "spouse" means a person who is lawfully married to the patient under the laws of the State.

The requirements of this section shall apply to all new policies delivered or issued for delivery in this State after the effective date of this section."

SECTION 2. Chapter 433, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§433- In vitro fertilization procedure coverage. All individual and group hospital or medical service plan contracts which provide pregnancy-related benefits shall include in addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures performed on the subscriber or member or the subscriber's or member's dependent spouse; provided that:

(1) Benefits under this section shall be provided to the same extent as the benefits provided for other pregnancy-related benefits;

(2) The patient is a subscriber or member or covered

S.B. NO. 1112

1 dependent of the subscriber or member;

2 (3) The patient's oocytes are fertilized with the patient's
3 spouse's sperm;

4 (4) The:

5 (A) Patient and the patient's spouse have a history of
6 'infertility of at least five years' duration; or

7 (B) Infertility is associated with one or more of the
8 following medical conditions:

9 (i) Endometriosis;

10 (ii) Exposure in utero to diethylstilbestrol,
11 commonly known as des;

12 (iii) Blockage of, or surgical removal of, one or
13 both fallopian tubes (lateral or bilateral
14 salpingectomy); or

15 (iv) Abnormal male factors contributing to the
16 infertility.

17 (5) The patient has been unable to attain a successful
18 pregnancy through other applicable infertility
19 treatments for which coverage is available under the
20 contract; and

21 (6) The in vitro fertilization procedures are performed at
22 medical facilities that conform to the American College
23

S.B. NO. 1112

of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

(7) The term "spouse" means a person who is lawfully married to the patient under the laws of the State.

The requirements of this section shall apply to all hospital or medical service plan contracts delivered or issued for delivery in this State after the effective date of this section."

SECTION 3. New statutory material is underscored.

SECTION 4. This Act shall take effect upon its approval.

INTRODUCED BY:
FEB 11 1987

Richard M. Matsumura
Barry K. ...
...
Peter K. Young
Joe Kuwada
Dennis M. Nakasato

STAND. COM. REP. NO. 1309

Honolulu, Hawaii
April 22, 1987

RE: S.B. No. 1112

Honorable Daniel J. Kihano
Speaker, House of Representatives
Fourteenth State Legislature
Regular Session of 1987
State of Hawaii

Sir:

Your Committee on Consumer Protection and Commerce, to which was referred S.B. No. 1112 entitled: "A BILL FOR AN ACT RELATING TO INSURANCE", begs leave to report as follows:

The purpose of this bill, as received by your Committee, is to require individual and group health insurance policies and individual and group hospital or medical service contracts, which provide pregnancy-related benefits to allow a one-time only benefit for all one-patient expenses arising from in vitro fertilization procedures performed on the insured or the insured's dependent spouse.

Your Committee has received testimony from the Department of Commerce and Consumer Affairs, the Department of Health, the Legislative Information Services of Hawaii, the Pacific In Vitro Fertilization Institute, the John A. Burns School of Medicine, the University of Hawaii, the Hawaii Medical Association, and the Hawaii Medical Service Association.

Your Committee finds that infertility is a significant problem for many people in Hawaii, and that this bill will encourage appropriate medical care. Additionally, this bill limits insurance coverage to a one-time only benefit, thereby limiting costs to the insurers. This bill will be a significant benefit to those married couples who have in vitro fertilization as their only hope for allowing pregnancy.

Your Committee on Consumer Protection and Commerce is in accord with the intent and purpose of S.B. No. 1112 and recommends that it pass Second Reading and be placed on the calendar for Third Reading.

Respectfully submitted,

Mazie Hirano
MAZIE HIRANO, Chairman

Kenneth Hiraki
KENNETH HIRAKI, Vice Chairman

Mark J. Andrews
MARK J. ANDREWS, Member

Reb Belling
REB BELLINGER, Member

Romy M. Cachola
ROMY M. CACHOLA, Member

David Hagino
DAVID HAGINO, Member

Joan Hayes
JOAN HAYES, Member

Wayne Metcalf
WAYNE METCALF, Member

Henry H. Peters
HENRY H. PETERS, Member

Mitsuo Shito
MITSUO SHITO, Member

Dwight Y. Takamine
DWIGHT Y. TAKAMINE, Member

Dwight L. Yoshimura
DWIGHT L. YOSHIMURA, Member

Fred Hemmings WR
FRED HEMMINGS, Member

excused
HAL JONES, Member

John Medeiros
JOHN MEDEIROS, Member

Attachment C

Massachusetts Statute

**INFERTILITY—INSURANCE COVERAGE—DIAGNOSIS
AND TREATMENT**

CHAPTER 394

AN ACT providing a medical definition of infertility.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1.

Chapter 175 of the General Laws is hereby amended by inserting after section 47G, inserted by section 1 of chapter 363 of the acts of 1987, the following section:—

Section 47H.

Any blanket or general policy of insurance, except a blanket or general policy of insurance which provides supplemental coverage to medicare or other governmental programs, described in subdivisions (A), (C) or (D) of section one hundred and ten which provides hospital expense or surgical expense insurance which includes pregnancy-related benefits and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, while this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense or surgical expense insurance which includes pregnancy-related benefits and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in the commonwealth while this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits which includes pregnancy-related benefits and which is promulgated or renewed to any person or group of persons in the commonwealth while this provision is effective shall provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility. For purposes of this section, "infertility" shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

SECTION 2.

Chapter 176A of the General Laws is hereby amended by inserting after section 8J, inserted by section 3 of said chapter 363, the following section:—

Section 8K.

Any contract, except contracts providing supplemental coverage to medicare or other governmental programs, between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued for delivery or renewed in the commonwealth while this provision is effective and which provides pregnancy-related benefits shall provide as a benefit for all individual subscribers or members within the commonwealth and all group members having a principal place of employment within the commonwealth, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility. Said infertility benefits shall meet all other terms and conditions of the subscriber certificate. For purposes of this section, "infertility" shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

SECTION 3.

Chapter 176B of the General Laws is hereby amended by striking out section 4G, inserted by section 4 of said chapter 363, and inserting in place thereof the following two sections:—

Section 4I.

Any subscription certificate under an individual or group medical service agreement, except certificates which provide supplemental coverage to Medicare or other governmental programs, which shall be delivered or issued or renewed in the commonwealth shall provide as benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth for expense of cytologic screening and mammographic examination. Said benefits shall be at least equal to the following minimum requirement: (a) in the case of benefits for cytologic screening, said benefits shall provide for an annual cytologic screening for women eighteen years of age and older; and (b), in the case of benefits for mammographic examination said benefits shall provide for a baseline mammogram for women between the ages of thirty-five and forty and for mammogram on an annual basis for women forty years of age and older.

Section 4J.

Any subscription certificate under an individual or group medical service agreement, except certificates which provide supplemental coverage to medicare or other governmental programs, which is delivered, issued for delivery or renewed in the commonwealth while this section is effective shall provide as a benefit for all individual subscribers or members within the commonwealth and all group members having a principal place of employment within the commonwealth, to the same extent that benefits are provided for other pregnancy-related procedures and subject to the other terms and conditions of the subscription certificate, coverage for medically necessary expenses of diagnosis and treatment of infertility. Said infertility benefits shall meet all other terms and conditions of the subscription certificate. For purposes of this section, "infertility" shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

SECTION 4.

Section 4 of chapter 176G of the General Laws, as amended by section 5 of said chapter 363, is hereby further amended by adding the following sentence:— Such health maintenance contract shall also provide coverage for diagnosis and treatment of infertility as set forth in section forty-seven H of chapter one hundred and seventy-five.

Approved October 8, 1987.

Attachment D

Maryland Statute

§ 477EE. Group or blanket health insurance policies excluding benefits for outpatient expenses arising from in vitro fertilization.

Each group or blanket health insurance policy issued or delivered within the State on an expense-incurred basis and which provides pregnancy-related

benefits, may not exclude benefits for all outpatient expenses arising from in vitro fertilization procedures performed on the certificate holder or the certificate holder's dependent spouse, provided that:

(1) Benefits under this section shall be provided to the same extent as the benefits provided for other pregnancy-related procedures;

(2) The patient is a certificate holder or covered dependent of the certificate holder;

(3) The patient's oocytes are fertilized with the patient's spouse's sperm;

(4) (i) The patient and the patient's spouse have a history of infertility of at least 5 years' duration; or

(ii) The infertility is associated with 1 or more of the following medical conditions:

1. Endometriosis;

2. Exposure in utero to diethylstilbestrol, commonly known as DES; or

3. Blockage of, or surgical removal of, 1 or both fallopian tubes (lateral or bilateral salpingectomy);

(5) The patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy; and

(6) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization. (1985, ch. 237; 1986, ch. 5, § 1.)

Effect of amendment. — The 1986 amendment, effective July 1, 1986, substituted "Obstetricians and Gynecologists" for "Obstetric and Gynecology" in paragraph (6).

Editor's note. — Chapter 237, Acts 1985, designated this section as § 477CC, but since a

§ 477CC had been added by ch. 110, Acts 1985, and since a § 477DD had been added by ch. 111, Acts 1985, the section added by ch. 237 has been designated as § 477EE herein.

Section 2 of ch. 237 provides that the act shall take effect July 1, 1985.

Attachment E

"State Mandated Health Care Coverage Laws
(Enacted Through June, 1987)"

IN DEEP WATER

And out again

Page 3



THE FIGHT FOR NICARAGUA

An embattled country, an embittered people

First in a series of four articles
Opinion Page



THEY'RE OFF

To Nome

Race Coverage

Page 6



IDITAROD '88

MIDWEEK

Volume 40, Number 49 March 9, 1988 12 Pages



Frontiersman

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This snow roller was found at the Palmer Cemetery. A pen was inserted for size.

Another man who refused to suit, she said. The corporation "The people at the sale felt we (Please see Foxes Back Page)

Couples seek help from Legislature to get pregnant

By CONNIE BRANDEL

Frontiersman staff

WASILLA—They wistfully collect maternity tops and baby blankets. Month after month, for years they've gone from hope to bitter disappointment. Medical bills drained thousands of dollars from their pockets.

Now two Wasilla couples are hoping the state can help them receive the gift of life.

Kirk and Toni Hartley, and Henry and Claudia Cottle aren't asking for more jobs or a handout from state coffers: both couples are undergoing treatment for infertility, and they want the state to require insurance companies to

pick up some of the bills.

Pointing out that dental and vision insurance is becoming commonplace, and some insurance plans cover abortions, pre-natal care and vasectomies, they say the insurance companies are discriminating against one condition: infertility.

"If they cover things like preventing future pregnancies, couldn't we have a little assistance creating a future pregnancy?" Claudia asked. "Most people are surprised it isn't covered already."

Through their doctor in Anchorage the couples learned of a Massachusetts law that requires insur-

ance companies to cover infertility treatments. They immediately contacted Rep. Curt Menard, who recently introduced similar legislation in the Alaska House. Currently Massachusetts is the only state to put such a law on the books.

Far from benefiting only a very few, they cite statistics that about 15 percent of young couples experience fertility problems. Not only couples trying for their first child would be affected, but those having difficulty conceiving a second or third child.

"The cost is so small, while the reward is so great," Claudia added. "Sure the costs have to come

out somewhere, but look what it would give us—a chance to become parents. How do you measure what a child is worth?"

Toni began trying to get pregnant two months after she was married. Ten years later they've spent more than \$20,000 on medical bills and she is little closer to carrying a child.

She and her husband have shelved plans to buy a house. They put every spare dollar toward future treatments, primarily artificial insemination.

Claudia has been trying to conceive for two years. Both women have been diagnosed as having endometriosis, a condition in

which uterine tissue enters the pelvic area, often causing scarring that results in infertility. Because her condition was initially diagnosed as endometriosis, not infertility, Claudia's insurance has so far picked up the tab.

Both women are hoping treatments for the endometriosis, including microsurgery, may allow them to get pregnant. However, they say the condition creates one of the most stubborn infertility problems.

Although Claudia is awaiting the results of microsurgery and hormone treatments, Toni has gone through several such surgeries and at least a half dozen arti-

ficial insemination procedures.

The microsurgery costs at least \$3,000. Each blood or semen test runs from \$25 to more than \$100. Hormone injections can cost \$500 per month. Artificial insemination costs \$500 per try. In vitro (test tube) fertilization, including travel to an Outside hospital, costs at least \$5,000 per try.

The price tag is the only thing keeping Toni from trying in vitro fertilization.

"If they passed that bill I'd be on a plane for my next cycle," she says eagerly. "But we don't have the \$5,000."

Menard said some legislators (Please see Baby Back Page)

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inued from Front Page)
 on, she said.
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 is from Hudson's Bay, an
 onal marketer of furs, and
 s from Chocktaw.

es of cruelty to animals
 being investigated by the
 State Troopers Fish and
 ; Protection office, said
 :hard Graham. Charges, if
 ould be filed in about 10
 ; said.
 ight of the foxes and the

OW

inued from Front Page)
 re Burkhart, another Butte
 t, also saw acres of the
 : snowhalls that ranged in
 :m golf balls to basketballs.
 were rolled up like jelly-
 he said.

phenomenon seems to have
 ed during a freak snow-
 A windy blizzard of wet
 descended on the area for
 an an hour and then faded
 shine as quickly as it came.
 flash storm apparently set
 perfect conditions to devel-
 :now rollers," said Mark
 ;elista, a meteorologist with
 ational Weather Service. A
 roller recipe requires a very
 wind in the upper air, that
 break apart snowflake
 s, along with stronger wind
 20 feet above the ground.

farm was first reported late last
 month when workers on the farm
 called the state to say they were
 leaving the farm because they
 were not getting paid.

State investigators and workers,
 and borough animal control offic-
 ers found the farm Friday with
 carcasses of skinned foxes strewn
 about the property and cages un-
 cleaned for months. The animals
 had been poorly looked after and
 some died either from thirst, star-
 vation or disease.

Add warm snow falling onto a
 layer of cold ground snow, so that
 the warmer snow won't stick right
 away.

Toss the sticky snow down from
 the clouds. As soon as the snow
 hits, the stronger lower wind will
 pick up an edge and roll the
 warmer snow up in the few sec-
 onds before it cools down.

"They're a lot more common in
 the Minnesota and Michigan ar-
 eas," Evangelista said, because
 the lack of mountains in those ar-
 eas allows sweeping masses of
 warm air, but added they are not
 real common.

"They're probably rare in Min-
 nesota and very rare in Alaska,"
 he said, adding that this is the first
 occurrence he has heard of in
 Alaska since he came here five
 years ago.

Baby

(Continued from Front Page)
 support the bill and others are
 "ho-hum" about it. The only real
 opposition has come from insur-
 ance companies, who don't like
 the "mandatory coverage" word-
 ing and the extra costs they will
 have to pass on.

The cost to the state for the
 change would be minimal, Me-
 nard said. A rough guess of the
 cost to insurance companies is
 \$36 per year per individual cov-
 ered. The legislation is aimed at
 group insurance plans which al-
 ready offer pregnancy coverage.

Menard could give the bill no
 better than a "fair" prognosis this
 term. Supporters might have to
 settle for a compromise suggest-
 ing, rather than requiring, compa-
 nies provide the coverage.

"If nothing else, we've surfaced
 the issue this year and we can re-
 group and supporters can build
 grassroots support for another
 try," Menard said.

"This isn't some pie-in-the-sky
 request," he added. "It's time it
 became an issue."

The bill would pay only for
 medical, not travel expenses, and
 would be limited to three in vitro
 fertilization tries to hold down
 costs, Kirk said.

Such infertility treatments are
 no longer experimental and have
 a proven record of success, he
 added. Although they're not
 cheap, compared to cancer treat-
 ments and transplant operation-
 s—many of which are of a more
 experimental nature—the costs

are relatively low.

Sharing with each other, as well
 as an Anchorage-based support
 group for infertile couples, has
 helped the Hartleys and the Cot-
 tles. Although they live in a
 monthly cycle of expectation and
 disappointment, they are sure of
 three things: their lives center on
 striving for pregnancy, the biolog-
 ical clock is ticking.

"Everything else revolves
 around it," Toni said of their in-
 fertility. "It affects your life every
 day. But the worst time is Christ-
 mas and family reunions. That's
 when everyone else announces
 their pregnancies. You're happy
 for them, but at the same time it's
 depressing when you're trying so
 hard and can't."

The women realize that as the
 years go by, time is counteracting
 their efforts. Claudia, 29, would
 like two children, although her
 husband is holding out for three.
 Toni, a year older, wants four
 children. Their eyes light up at the
 possibility.

But both know they have a lim-
 ited number of years to conceive
 even one child.

In the meantime, they agree
 adoption isn't an acceptable alter-
 native.

"I'm not against adoption, but I
 want to try everything I can first
 to have a baby before we adopt,"
 Claudia said. "We've checked in-
 to it already. There's an \$8,000 to
 \$10,000 adoption fee and a three
 year wait for a Caucasian baby."

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women's health: a medical update

ners used con-

on. Women can receiving blood therefore, women users and who rs could become naining on the

o be contracted is, though the singly unlikely, been screening antibodies since tests positive is 1 who does not o falls into a high to donate blood. e is a minuscule ood could enter nple, an infected ng the "window six months or so first contracted be detected by a

Women can be rough artificial semen contains d, however, by ame way blood who are thinking ocedure should eceive has been

AIDS

e hopeful that a covered, others is not possible ould also mean ells in the body. Looking for new ine to at least f the virus. Re- he first tests on icacy of an AIDS orks: A healthy roteins from the rus, which the the actual virus; ping protective owever, is not e general public

ing the survival s to be treating combination of p transform the e to a chronic ay that chemo-

therapies have altered the course of illnesses such as diabetes, rheumatoid arthritis and some forms of cancer. The goal is to improve the quality of life and length of survival of AIDS patients. Among the drugs currently being used are:

- **AZT:** To date, the only drug approved to specifically treat the AIDS virus, AZT works by interrupting HIV replication, preventing the virus from proliferating. It can improve the condition and lengthen the lives of many AIDS patients, especially when administered early in the course of the disease.

- **Immunostimulants,** currently under investigation, are drugs that help improve the functioning of AIDS patients' immune systems. They include interleukin-2, gamma interferon and amipligen.

- **Detran sulfate** is a drug that Japanese researchers have shown interferes with the replication of the virus in laboratory experiments and has produced some clinical improvement in selected AIDS patients; when

combined with AZT, the action of both drugs was enhanced.

- **Peptide T,** a new substance that shows promise for treating AIDS patients, was synthesized last year in U. S. laboratories at the National Institute of Mental Health. Controlled clinical trials of the effect of Peptide T on AIDS patients will begin soon.

Major improvements have also been seen in the treatment of infections and tumors that commonly strike AIDS patients as a result of their weakened immune systems. Until six years ago, pneumocystis carinii, a type of bacterium that invades the lungs and causes pneumonia, killed most AIDS patients when it was contracted. Now, the use of drugs, including pentamidine, has been shown to be effective in treating this type of pneumonia. Although pneumocystis carinii pneumonia still kills over one quarter of those it infects, with drugs such as pentamidine, AIDS victims can increase their chances of survival.

—Susan J. Blumenthal, M.D.

infertility: new treatment technologies

These procedures may not appeal to everyone; the price tags are high and the emotional stress great

Until quite recently, in vitro fertilization, or IVF, was considered an experimental procedure. But today it is an accepted medical practice and is seen as a major breakthrough in the treatment of infertility. In addition, IVF has opened the door for a whole new field of high-tech solutions to infertility. One in five couples seeks help for infertility, so these new options promise to bring "miracle babies" to thousands of infertile couples around the world.

While fertility specialists have greeted these new methods with enthusiasm, the procedures may not appeal to everyone; both price tags and emotional stress run high. In addition, this kind of fertilization is far from a

sure thing: There is at best a 50-percent chance of delivering a baby through one of these methods. To help put all the options in perspective, here's the latest information on IVF and related technologies.

in vitro fertilization

IVF is a procedure in which a follicle—an egg and its surrounding cells—is extracted from one of a woman's ovaries and fertilized outside her body with the husband's sperm

(see "In Vitro Fertilization: How It Works," page 91, for details). The resulting embryo is then implanted in the woman's uterus and develops as a normal pregnancy. ("In vitro"—Latin for "in glass"—refers to the test tube or dish in which the egg is fertilized.) IVF, the oldest and most established of the new fertility technologies, first succeeded with the birth of Louise Brown in the U.K. in 1978.

IVF was originally intended for women who could not conceive because of blocked or damaged Fallopian tubes, but it can also help in cases of unexplained infertility and instances of male infertility. The prospects are encouraging: In carefully screened and selected couples, the chances for delivering a healthy baby after one IVF treatment are about one in five or six. If a couple aren't successful on their first try, it can be repeated, but the odds of conceiving decrease after three or four attempts.

In order to be considered for IVF, each member of a couple must be in good general health and undergo extensive screening and counseling to see if the procedure is appropriate for them. Age is one factor that can make a couple poor candidates for IVF; success rates for women over 40 are much lower than those for younger women.

Basic infertility tests—semenalysis (a microscopic examination of the semen in which the quantity and quality of the sperm are evaluated), hysterosalpingogram (X ray of the uterus and the Fallopian tubes) and tests to check for regularity of ovulation—should always precede IVF, as should standard infertility treatments. For example, a patient with damaged Fallopian tubes (often due to pelvic infections) or endometriosis may benefit from microsurgery, which results in conception rates of up to 60 percent. When the cause of the problem is male infertility, due to such factors as a low sperm count or poor sperm motility, artificial insemination is an option that should be considered before in vitro fertilization.

IVF is associated with a higher miscarriage rate than is noted among normal pregnancies, but the chance of birth defects is not increased. Cesarean-section rates may approach 50 percent among women with IVF pregnancies, partly due to a 15-to-20-percent occurrence of multiple births. This happens because of the use of fertility drugs and the implantation of multiple embryos.

the GIFT procedure

This procedure with the catchy acronym,

shopping for an IVF program

IVF programs vary in the expertise of the medical staff involved, as well as in their success rates.

The number of IVF procedures performed at a clinic each year often is linked to its success. The Jones Institute for Reproductive Medicine, in Norfolk, Virginia—currently the nation's largest program—boasts delivery of about 100 IVF babies a year. While most programs remain hospital-affiliated so they have access to appropriate medical specialists and sophisticated laboratory equipment, a small, well-run IVF center can match the success rates of the larger programs. For example, Humana Women's Hospital in Tampa, Florida, a 200-bed private facility that started using IVF in 1986, reports a 20-percent live-birth rate—about the national average—for couples entering their program.

Pregnancy rates, however, don't tell the whole story since they are not presented in standardized terms. Furthermore, success rates not only vary from program to program but also within a program. The type of infertility problems that need to be overcome, for instance, can affect the overall success rates of a particular program.

which stands for Gamete Intra-Fallopian Transfer, was first made public in 1984 and now represents the most promising alternative to IVF. Like IVF, GIFT begins with the surgical removal of eggs from a woman's ovary. Then the most mature eggs are selected, mixed with the husband's sperm and immediately placed in one of the woman's Fallopian tubes, where natural fertilization usually occurs.

To be eligible for GIFT, a woman must have at least one healthy Fallopian tube. GIFT minimizes the time the egg and the sperm are exposed to laboratory conditions; this could account for the excellent success rates that have been obtained—up to 42 percent in couples with unexplained infertility. GIFT is also becoming popular because extensive lab facilities are not necessary, and it can usually be completed in less than one hour.

A woman considering IVF should, therefore, check both the pregnancy and birth rates of a particular program. The American Fertility Society may serve as a resource for finding a qualified fertility specialist. They've compiled a list of recognized IVF programs, meaning the staff is board-certified and the center has documented that it has delivered three babies from three different mothers each year. For referrals, contact The American Fertility Society, 2131 Magnolia Avenue, Suite 201, Birmingham, Alabama 35256; phone, 205-251-9764.

Going through an IVF program may be a great financial burden for infertile couples. The cost is about \$5,000 for each cycle of IVF; GIFT may cost up to 20 percent less. Some insurance programs don't cover the costs of procedures designed to overcome infertility because it is not considered an illness, or they may specifically exclude artificial insemination or in vitro fertilization. Also, GIFT is now excluded from some insurance programs because it is considered experimental. But for couples who can afford them, these new infertility technologies could make their dreams come true.

IVF: The odds of conceiving decrease after three or four attempts

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intrauterine insemination (IUI)

IUI, because of its simplicity and low cost, should be considered by infertile couples before turning to more sophisticated technologies like IVF or GIFT. IUI involves hormonal stimulation of the ovaries, combined with artificial insemination inside the uterus.

A small catheter is used to place the sperm in the uterus, thus bypassing the cervix where a variety of factors—from infections to sperm-killing antibodies—can be the cause of infertility. IUI can be done in a doctor's office, requires no anesthesia and may help couples with some forms of male infertility or with unexplained infertility.

donor sperm or eggs

Donor sperm refers to sperm that are collected and stored in what is commonly known as a sperm bank. It can be used in connection with artificial insemination and with the new technologies—IVF, GIFT or IUI. Donor sperm are used when male infertility is severe enough that even the small numbers of sperm necessary to fertilize an egg in the laboratory are unavailable from the husband. Although sperm donation is simpler than egg retrieval—extracting an egg from the ovaries of a woman—donor eggs may be used if a woman's ovaries lack eggs (in the case of premature menopause, for example), or if her ovaries have been surgically removed. Egg donation may also help women with certain genetic disorders such as Huntington's chorea. Through egg donation, a woman can carry to term donor eggs, fertilized by her husband's sperm in the lab and then transferred to her uterus.

Most donor eggs come from other infertility patients undergoing IVF or GIFT, but with improved cryopreservation methods (see below) some women are storing their own eggs to use in the future. Another possible future source of eggs will be patients who are having unrelated surgery (such as tubal ligation) or who just wish to donate eggs to an infertile relative or friend. In such instances, egg "harvesting" is done; to encourage egg production, the donor takes hormones for a few days before egg retrieval is performed.

While the procedure may sound like the answer to many infertile couples' problems, its success rate is not yet up to clinical expectations. In a recent study of 17 women who underwent egg donation, only seven became pregnant. And egg donation has raised a number of ethical issues as well, such as how donors will be selected; how much will be paid for eggs; and how confidentiality will be ensured.

cryopreservation

This technique, which is still being tested, was first performed in Australia in 1984. It involves freezing and preserving eggs and early-stage embryos, or fertilized eggs, for later use. The frozen egg or embryo can be

in vitro fertilization: how it works

IVF involves four basic steps. Each is coordinated by a team of physicians, nurses, skilled technicians and, usually, a reproductive endocrinologist.

1. Hormone treatment. Fertility drugs, like clomiphene and HMG (Pergonal), are administered daily for about one week in order to stimulate the ovaries to develop several large follicles (each follicle is a tiny fluid-filled structure containing an egg). The fertility drugs make egg retrieval easier and more efficient, but sometimes it works too well; multiple births average 15 to 20 percent among women who've undergone this fertility treatment, compared to one to 2 percent in fertile women. Blood tests and ultrasound (a process using sound waves to produce an image of the enlarging follicles) are used to determine when follicles are "ripe" for retrieval.

2. Egg retrieval. The eggs are retrieved either through a surgical procedure that requires general anesthesia (laparoscopy), or through an uncomplicated method using ultrasound. In laparoscopy, the gynecologist makes a small incision just below the navel, through which a thin, flexible, telescopelike device is inserted. Then, through another tiny incision, a hollow needle is inserted for withdrawing an egg from each mature follicle.

The newer ultrasound method is simpler and less costly than laparoscopy and is therefore gaining in popularity. The doctor uses ultrasound to direct the egg-collecting

needle through the abdomen, vagina or urethra and into the follicle. The sound waves are produced by a scanner or transducer held over the stomach. A recent refinement of ultrasound egg retrieval utilizes a vaginal transducer. This device provides a clear view of the pelvic area and also contains a suctioning needle that can be directed into the follicle through the vagina when the patient is under local anesthesia.

3. Fertilization. The eggs are placed in a special culture medium and fertilized with about 100,000 sperm. This is a much lower number of sperm than needed when fertilization occurs naturally since, under controlled lab conditions, the sperm do not need to travel to the egg, facilitating fertilization. In instances of male infertility, additional steps are sometimes taken to find the most active healthy sperm for fertilization. In either case, the resulting embryo incubates for approximately 48 hours before being transferred into the woman's uterus.

4. Embryo transfer. Embryo transfer occurs with the assistance of a small tube that helps position the embryos in the uterus. While there is about an 80-percent chance of retrieving and fertilizing at least one egg, only one of three embryos successfully implants in the uterine wall. The rest of the pregnancy occurs normally, although hormone supplements are often given to enhance chances of carrying to term.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

April 19, 1988

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Patricia Brawley *pb*
Legislative Analyst

RE: Infertility Treatments--Costs and Success Rates
Research Request 88.222 (Revised)

You asked this agency to provide information on the success rates of various infertility treatments, the success rates of individual clinics offering such treatments, and the costs involved. You also requested a comparison of costs and coverage for states which mandate infertility insurance coverage. Finally, you wished to know which states mandate pregnancy/maternity insurance.

Infertility Treatments--Success Rates of Procedures and Clinics

Several procedures for the treatment of infertility are currently being tested, many of them involving donors or surrogates. The most common nonexperimental procedures which do not necessarily involve donors of sperm or eggs are hormonal treatments, in vitro fertilization (IVF) and artificial insemination by husband (AIH). Neither IVF nor AIH will be successful, of course, if the fertility problem is with the male. According to current data, "when the causes of a couple's infertility are investigated, a male problem is found primarily responsible forty percent of the time, a female problem forty percent of the time, and a combination twenty percent of the time."¹

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Representative Koponen

April 19, 1988

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The American Fertility Society recently established a national registry of IVF, embryo transfer (ET), and related practices. The main purpose of the IVF/ET Registry is to document pregnancy and birth outcomes (not, however, by individual clinic). Accurate, meaningful statistics would enable providers to identify optimal treatments for different patient groups, and to detect and measure possible adverse health effects on patients and their offspring. "In Vitro Fertilization/Embryo Transfer in the United States: 1985 and 1986 Results from the National IVF/ET Registry," published in the February 1988 issue of Fertility and Sterility, summarizes the first data collected and analyzed through a survey of clinics which perform these procedures in the U.S. (Attachment A). Forty-one clinics supplied the voluntary data and therefore serve as the basis for the result summary. Participation is voluntary, criteria may vary, and there is no form of peer review involved at any level. According to the author, Richard P. Marrs, M.D., the "statistics . . . should be interpreted with caution, due mainly to the restrictive nature of the data collection forms used."

Because there are no federal standards for IVF programs and no reporting requirements, establishing meaningful success rates for either individual treatments or for individual clinics is not currently possible. Criteria for judging success rates may differ with each clinic.

The figures a clinic quotes can be misleading in a number of ways. Some cite success rates achieved by the best IVF programs instead of their own. Others may state the number of 'chemical' pregnancies, determined by a very early blood test; many of these never go on to become 'clinical' pregnancies, which involve the presence of a fetal heartbeat. Even when success rates are described in terms of live births, it is crucial to know the denominator for that figure: is it the total number of women who have been accepted by the program? [And what are the acceptance criteria?] Is it only the group from whom eggs have been retrieved? Those in whom an embryo has been implanted? The same clinic's success rate can vary tremendously--from perhaps five percent to almost thirty percent--depending on which criteria are used... 'IVF has become a terribly competitive field,' says Dr. Alan DeCherney, director of reproductive endocrinology at Yale University Hospital's IVF clinic, 'and the means by which the clinics compete is by statistics.'²

²"The Grueling Baby Chase," Newsweek, November 30, 1987, pp. 79-81. For an excellent discussion of the issue of success rates, see Chris Anne Raymond's "In Vitro Fertilization Enters Stormy Adolescence as Experts Debate the Odds," Journal of the American Medical Association, January 22 - 29, 1988, p. 464 (3)--Attachment B.

Joyce Zeitz, Public Relations Coordinator of the American Fertility Society, indicates that there are approximately 260 clinics worldwide which are actively engaged in providing IVF treatments; 170 of them are in the U.S. (Attachment C). Of these, the American Fertility Society recognizes 64 as "accepted"--or meeting their minimal standards criteria. (See Attachment D for list and minimal standards.) Criteria include that at least one staff member has the "experience and training required for board certification in reproductive endocrinology." The American Board of Obstetrics and Gynecology lists 262 individuals as having reproductive endocrinology subspecialty certification (Attachment E).

The insurance industry predicts that the number of clinics will continue to grow as the infertility rate continues to increase and insurance coverage becomes available. Without some form of standard accreditation and review, however, a ready availability may not truly serve consumers.

Cost of Infertility Treatments

Treatment expenses vary sharply. "A typical charge for one artificial insemination is \$75. Usually, two or three are performed during each monthly cycle, and four of every five couples achieve a pregnancy within six months. Women who take Pergonal, a fertility drug, are on a \$1,000-a-month regimen."³ Each IVF procedure costs between \$4,000 and \$6,000, and several tries are often necessary. Also, IVF treatments frequently require that couples find lodging close to the clinic for the ten days required for each cycle.

Mandatory Insurance Coverage for Infertility by States--Costs and Coverage

In spite of the success rate dilemma, three clinics are generally considered to be responsible for the majority of all IVF live births in this country: the Jones Institute for Reproductive Medicine in Norfolk, Virginia; the Cedars-Sinai Medical Center in Los Angeles; and the Northern Nevada Fertility Center in Reno, Nevada. Monash University's Queen Victoria Medical Centre in Melbourne, Australia, is frequently cited as the world's most successful IVF center. According to a December, 1985 interview with Alan Trounson, lead researcher at the clinic, research

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techniques--including embryo freezing--used in Australia were at that time far in advance of those being used in the United States, and success rates were also far higher. At that time, the Queen Victoria clinic reportedly had produced more live IVF births than all of the IVF clinics in the U.S.⁴ I was unable to locate statistics on the current Australian success rates, but as with the U.S. clinics, criteria used are determined by the clinic, and comparisons may not be useful.

Arkansas, Hawaii, Maryland, Massachusetts, and Texas all currently mandate insurance coverage for infertility. (California is once again considering the possibility.) In 1985 Maryland became the first state to mandate coverage for infertility; the other states enacted such legislation in 1987, and are currently in the process of incorporating the coverage. Because statistics on costs and utilization of coverage are not available for states other than Maryland, I will provide the available Maryland figures and a brief comparative analysis of the coverage provided by the different states.⁵

The laws in each of these four states say that insurers will provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for infertility. Beyond that, they vary in several ways. Texas law covers group, but not individual, policies; and coverage is not actually mandated, it is a mandated option. Insurers must offer the coverage; however, employers need not accept it. Coverage is for IVF only. To qualify, a couple must have a continuous five-year history of infertility, unless the infertility is associated with endometriosis, exposure in utero to diethylstilbestrol (DES), blockage or one or both fallopian tubes, or oligospermia (a scarcity of sperm in the semen). They must have tried less costly procedures. Treatments must be performed in medical facilities which conform to the American College of Obstetricians and Gynecologists' guidelines for such clinics, or to the American Fertility Society's minimal standards for such programs. (See Attachment F for full text.)

The law in Hawaii provides for both individual and group coverage. The condition of oligospermia is broadened to "abnormal male factors contributing to the infertility"; however, there is a restriction in IVF that the sperm must be supplied by the husband of the patient. Because "abnormal male factors" are the cause of 40 percent of couple infertility, this restriction may become a problem. The most distinctive feature of Hawaii's statute is its limiting of IVF coverage to one procedure. (See Attachment G for full text.)

⁴Robert Weil, "Alan Trounson: Interview," Omni, December 1985, p. 82 (8) .

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Unlike the laws in Texas and Hawaii, "infertility" in Massachusetts is defined as "the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year." Thus, diagnosis and treatments are available to both sexes without the five year wait. Problems may arise due to the lack of limits to the number of IVF procedures allowed. Also of concern to insurers is the Division of Insurance regulation that procedures currently defined as experimental will automatically be covered at such time as their definitions are changed to nonexperimental. Procedures are defined as experimental or nonexperimental by the American College of Obstetricians and Gynecologists. Insurers believe that the connection between receiving payment for services and the classification of treatment is a conflict of interest situation, and they would prefer that treatments receive their classification from a more neutral party such as the Department of Public Health. (See Attachment H for full text.)

More narrow in its coverage than Massachusetts, Maryland law provides for IVF treatments and artificial insemination by husband (AIH) only. Criteria for eligibility are very strict and focus primarily on female infertility. Criteria include that the woman be married; that the sperm used be her husband's; and that she and her husband, as a couple, have a history of infertility of at least five years' duration unless the infertility is associated with endometriosis, exposure in utero to DES, and/or blockage or surgical removal of one or both fallopian tubes. Under this law, couples are denied treatment unless the fertility problem rests with the woman. In addition to discriminating against infertile men, this law appears to give preferential treatment to women who have undergone voluntary sterilization.⁶ (See Attachment I for full text.)

Maryland's infertility benefits began in 1986. Since then, approximately 925 couples have submitted preauthorization forms (500 for IVF, 425 for AIH) through their physicians. These numbers, however, do not necessarily reflect the numbers of couples who have subsequently undergone treatment. Also, no statistics which reflect the number of procedures each couple received were available. Robert Sirian, Director of Actuarial Projects, Blue Cross-Blue Shield of Maryland--cautioning that his figures are both preliminary and tentative--indicated that in 1986 the total incurred cost had been about \$312,000, resulting in a seven cent increase per covered party per month.⁷ This is far below even the most conservative overall

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Representative Koponen
April 19, 1988
Page 6

cost predictions made by the insurance industry. Mr. Sirian indicated, however, that the number of treatment facilities is expected to increase steadily, and utilization of coverage and cost are expected to rise proportionately to a level of between \$9 and \$13 million annually, resulting in an increase for covered parties of \$2 to \$3 per month. (I will forward a copy of their just-released "Mandated Benefits Summary" to you upon its arrival.)

While Maryland's inclusion of coverage for infertility treatments appears not to have had the financial impact sometimes predicted, the potential for significant impact is still present--as it is for any state which does not set some limit to the number of IVF procedures allowed, or to the number of other costly procedures which may at some future date gain nonexperimental classification and coverage. Insurance representatives in both Maryland and Massachusetts expressed concern over the lack of such limits. In addition, the lack of a standard accreditation and review process for clinics is of wide concern. Carefully worded laws, carefully designed systems for monitoring and evaluating procedure and clinic success rates, and carefully designed systems for tracking utilization and costs of both specific treatments and related procedures might mitigate problems experienced in other states which offer infertility insurance coverage.

I have provided a listing of which states mandate pregnancy/maternity insurance coverage, entitled, "State Mandated Health Care Coverage Laws (Enacted Through June, 1987)." (See Attachment J) I have also included a report by the Alan Guttmacher Institute, entitled "Infertility Services in the United States: Need, Accessibility and Utilization," (Attachment K); a Research Note from Family Planning Perspectives, entitled "The Need and Unmet Need for Infertility Services in the United States," (Attachment L); and "Desperately Seeking Baby," from U.S. News and World Report, (Attachment M).

* * *

I hope this information is useful to you. If you have any questions, please contact this agency.

Attachments



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

April 7, 1988

MEMORANDUM

TO: Representative Niilo Koponen
ATTN: Lisa McLaren
FROM: Patricia Brawley *pb*
Legislative Analyst
RE: Infertility Treatments--Costs and Success Rates
Research Request 88.222

You asked this agency to provide information on the success rates of various infertility treatments, the success rates of individual clinics offering such treatments, and the costs involved. You also requested a comparison of costs and coverage for states which mandate infertility insurance coverage. Finally, you wished to know which states mandate pregnancy/maternity insurance.

Infertility Treatments--Success Rates of Procedures and Clinics

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Representative Koponen

April 7, 1988

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Representative Koponen

April 7, 1988

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* * *

I hope this information is useful to you. If you have any questions, please contact this agency.

Attachments

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

P.O. BOX CR
JUNEAU, ALASKA 99811-0203
PHONE: (907)465-4460

701 East Tudor Road, Suite 240
Anchorage, AK 99503
Phone: (907) 563-5885

Public Employees' Retirement System
Teachers' Retirement System
Judicial Retirement System
Elected Public Officers Retirement System
National Guard Retirement System
Territorial Retirement System
Retirees' Voluntary Dental Vision Audio Plan
Supplemental Benefits System
Group Health/Life Insurance Benefits
Deferred Compensation Plan
Public Employers Social Security Contributions

STEVE COWPER, GOVERNOR

April 6, 1988

Ms. Portia Babcock
Legislative Assistant
Office of Representative Curt Menard
P.O. Box V
Juneau, AK 99811

Dear Ms. Babcock:

Re: Draft CS for HB 440 (dated 4/1/88)

The purpose of this letter is to provide you with our analysis of the fiscal impact on all agencies of the state resulting from the attached draft committee substitute to HB 440 that you have provided to me. The total cost to all agencies is estimated to be \$289,440. Other than the estimated increase to the health insurance component in our division's budget, as outlined in this letter, we anticipate no additional fiscal impact on this division for the administration of this proposed legislation.

The committee substitute limits the number of in vitro fertilization cycles to three. It also makes a number of technical changes that serve to clarify the intent and the scope of coverage under this bill. It is still assumed that this mandatory coverage would not extend to such services as prosthetic implants.

The level of coverage outlined in the bill is estimated to result in a \$2.01 per month increase assuming a \$307 per month premium per employee.

The FY 89 estimated cost for active state employees is calculated as follows:

The increase of \$2.01 per month health cost times the number of state employees (12,000) x 12 months = \$289,440.

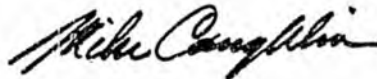
Ms. Portia Babcock

-2-

April 6, 1988

Please contact me should you have questions or require any further information on this analysis.

Sincerely,

A handwritten signature in cursive script, appearing to read "Mike Coughlin".

Michael B. Coughlin
Deputy Director

MBC/bb/6
Attachment

A M E N D M E N T

Offered in the HOUSE

TO: HCS CSSB 339(HESS)

Page 1, following line 7:

Insert a new bill section to read:

"* Section 1. PURPOSE. AS 11.76.105, added by sec. 3 of this Act, makes the purchase of cigarettes by persons under age 19 a violation. The sole penalty for a violation is a fine. The amendment of AS 47.10.010(b), made by sec. 4 of this Act, implements legislative intent. Because children's proceedings do not provide for the imposition of fines, the amendment of AS 47.10.010(b) excludes these offenses from the juvenile jurisdiction of the superior court, allowing the citation of minors and the imposition of fines by the district court."

Page 1, line 8:

Delete "* Section 1."

Insert "* Sec. 2."

Renumber subsequent section accordingly.

Page 2, following line 10:

Insert a new bill section to read:

"* Sec. 4. AS 47.10.010(b) is amended to read:

(b) When a minor is accused of violating a traffic statute or

regulation, a traffic ordinance or regulation of an incorporated municipality, AS 11.76.105 relating to the purchase of tobacco by a minor, a fish and game statute or regulation under AS 16, or a parks and recreational facilities statute or regulation under AS 41.21, excepting a statute the violation of which is a felony, the procedure prescribed in AS 47.10.020 - 47.10.090 may not be followed, except that a parent, guardian, or legal custodian shall be present at all proceedings. The minor accused of an [A TRAFFIC] offense specified in this subsection [, A FISH AND GAME STATUTE OR REGULATION VIOLATION UNDER AS 16 OR PARKS AND RECREATIONAL FACILITIES VIOLATION UNDER AS 41.21] shall be charged, prosecuted, and sentenced in the district court in the same manner as an adult."

ALASKA STATE LEGISLATURE

Curt Menard

351 W. Swanson Ave.
Wasilla, Alaska 99687

Or

P.O. Box V
Juneau, Alaska 99811

373-CURT
376-5315 Work
376-5855 Home
465-2679 Juneau



M E M O R A N D U M

February 23, 1988

TO: Members
House Labor and Commerce
Committee

FROM: Curt Menard
Representative

RE: HB440

HB440 is an Act relating to insurance coverage for treatment of infertility.

This bill would require that an insurer that provides coverage for pregnancy-related expenses shall also provide, to the same extent that benefits are provided for pregnancy-related expenses, coverage for medically necessary expenses of diagnosis and treatment of infertility.

"Infertility" means: the condition of a presumably healthy individual who is unable to conceive or produce conception for a period of at least one year before diagnosis and treatment for infertility.

This Act applies to disability insurance policies and to hospital or medical service subscriber contracts entered into or renewed on or after the effective date of this Act.

I have received more than 22 letters in favor of HB440.

I have contacted seven physicians who report that as many as 15% of America's reproductive age group have infertility problems.

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

P.O. BOX CR
JUNEAU, ALASKA 99811-0203
PHONE: (907)465-4460

2600 DENALI ST. SUITE 401
ANCHORAGE, ALASKA 99503-2740
PHONE: (907) 277-7504

Public Employees Retirement System
Teachers Retirement System
Judicial Retirement System
Elected Public Officers Retirement System
National Guard Retirement System
Territorial Retirement System
Retirees Voluntary Dental-Vision-Audio Plan
Supplemental Benefits System
Group Health/Life Insurance Benefits
Deferred Compensation Plan
Public Employers Social Security Contributions

STEVE COWPER, GOVERNOR

February 19, 1988

The Honorable Dave Donley
Chairman, Labor & Commerce Committee
P.O. Box V
Juneau, AK 99811

Dear Representative Donley:

Re: HB 440

The purpose of this letter is to provide you with our analysis of the fiscal impact on all agencies of the state resulting from HB 440. Other than the estimated increase to the health insurance component of our division's budget, we anticipate no fiscal impact to the ongoing operation of the division, as the attached fiscal note indicates.

This bill would require mandatory coverage for medically necessary expenses of diagnosis and treatment of infertility to the same extent as that provided for pregnancy related expenses. The state's health plans currently exclude coverage for sexual dysfunctions such as infertility while pregnancy is covered as any other medical condition. It is assumed that this mandatory coverage would relate only to infertility treatment such as in vitro fertilization and would not be extended to include such services as prosthetic implants.

The level of coverage outlined in the bill is estimated to result in a \$4.30 per month increase in health insurance costs for the estimated 12,000 state employees effective July 1, 1988. The cost is assumed to remain level each year thereafter because the state does not yet have any experience analysis to indicate that costs will increase annually for this additional benefit. This cost increase is based on a maximum of 20 in vitro fertilization procedures plus additional services such as counseling. This exposure leads to the \$4.30 per month increase assuming a \$307 per month premium per employee. This coverage would also become mandatory for the retiree health plan but we would estimate no increase in premiums for this group.

The FY 89 estimated cost for active state employees is calculated as follows:

The Honorable Dave Donely

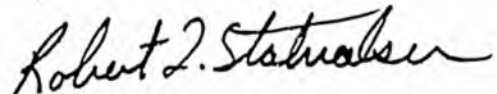
-2-

February 19, 1988

The increase of \$4.30 per month health cost times the number of
state employees (12,000) x 12 months \$619,200.

Please contact me should you have questions or require any further
information on this analysis.

Sincerely,



Robert F. Stalnaker
Acting Director

RFS/bb/7



RECEIVED MAR 11 1988

Burritt W. Newton M.D.
Diplomate American Board Obstetrics & Gynecology

March 3, 1988

Representative Curt Menard
Pouch V
Juneau, Alaska 99801

Dear Representative Menard:

Congratulations on your introduction of House Bill #440. As a physician caring for many infertility patients, I feel that your bill is timely and necessary. I support it wholeheartedly.

Best of luck in getting it passed.

Sincerely,

Burritt W. Newton, M.D.

BWN:ces

Humana Medical Plaza

1200 Airport Heights Drive, Suite 300 • Anchorage, Alaska 99508-2995 • Phone: (907) 276-3711

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

NAME: JODEE FORCE
TITLE:
ADDRESS: POB 873112
CITY: WASILLA ZIP: 99687
PHONE: 373-1472
BILL NO: HB 440
SUBJECT: INSURANCE COVERAGE FOR INFERTILITY CARE
MESSAGE: I HEARTILY SUPPORT INSURANCE COVERAGE FOR TREATMENT OF INFERTILITY
IT IS IMPERATIVE WE APPROVE HB 440 TO PROVIDE PARENTS WITH LIMITED
FINANCIAL RESOURCES NON DISCRIMINATORY INSURANCE COVERAGE. STARTING A
FAMILY SHOULD NOT BE THWARTED BY AN INSURANCE POLICY'S LIMITED BENEFITS.

POMID: 14092242
DATE: 03/09/88
TIME: 09:22:42
LIONAME: MAT-SU LIO

COPIES: REPRESENTATIVES

PUBLIC OPINION MESSAGE

DONLEY
ELLIS
GRUENBERG
HANLEY
HUDSON
KOPONEN
PHILLIPS
BARNES
COTTEN
NAVARRE
SUND
TAYLOR
ULMER

DEAR: REPRESENTATIVE MENARD

NAME: CAROL WATERS
TITLE:
ADDRESS: 10300 HILLSIDE DR.
CITY: ANCHORAGE
PHONE: 346-3148
BILL NO: HB 440

RECEIVED MAR 11 1988

ZIP: 99516

SUBJECT: INSURANCE COVERAGE FOR INFERTILITY CARE
MESSAGE: I URGE YOU TO SUPPORT HB 440 REQUIRING INSURANCE COMPANIES TO COVER
DIAGNOSTIC INFERTILITY WORKUPS. INSURANCE COMPANIES MUST COVER PREGNANCY, BUT
FIND A LOOP HOLE WHEN COUPLES SEEK TO DISCOVER WHY THEY CANNOT HAVE CHILDREN.
PLEASE HELP BY SUPPORTING THE BILL. PLEASE CALL ME FOR MORE INFORMATION.

POMID: 03154049
DATE: 03/10/88
TIME: 15:40:49
LIONAME: ANCHORAGE LIO

COPY

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DONLEY	ELLIS
FRANK	FURNACE
GOLL	GRUENBERG
GRUSSENDORF	HANLEY
HERRMANN	HOFFMAN
HUDSON	KOPONEN
LARSON	MARTIN
MILLER	NAVARRE
PEARCE	PETTYJOHN
PHILLIPS	POURCHOT
RIEGER	SHULTZ
SPRINGER	SUND
SWACKHAMMER	TAYLOR
ULMER	WALLIS
ZAWACKI	

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

RECEIVED 3/10/88

NAME: REGINA ROBBINS
TITLE:
ADDRESS: 8420 METRA COURT
CITY: ANCHORAGE ZIP: 99518
PHONE: 344-4281
BILL NO: HB 440
SUBJECT: INSURANCE COVERAGE FOR INFERTILITY CARE
MESSAGE: I THINK THAT INFERTILITY DIAGNOSTICS SHOULD BE COVERED BY INSURANCE.

POMID: 03150247
DATE: 03/10/88
TIME: 15:02:47
LIONAME: ANCHORAGE LIO

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C 10 10

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

RECEIVED 3/10/88

NAME: CATHY GREENSTREET
TITLE:
ADDRESS: PO BOX 3396
CITY: PALMER ZIP: 99645
PHONE: 745-6778
BILL NO:
SUBJECT: INFERTILITY BILL
MESSAGE: I WOULD LIKE FOR YOU TO SUPPORT HB 440 AND URGE YOU TO HOLD A HEARING ON IT.

POMID: 14123918
DATE: 02/29/88
TIME: 12:39:18
LIONAME: MAT-SU LIO

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DONLEY
ELLIS
GRUENBERG
HANLEY
HUDSON
KOPONEN
PHILLIPS

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

RECEIVED MAR 14 1988

NAME: JENALEE HEIKES
TITLE:
ADDRESS: P O BOX 520529
CITY: BIG LAKE
PHONE: 892-6425
BILL NO: HB 440
SUBJECT: INSURANCE COVERAGE FOR INFERTILITY CARE
MESSAGE: MASSACHUSETT HAD THE RIGHT IDEA. LEGAL ABORTIONS PAID FOR BY INSURANCE COMPANIES CAUSE FEWER ADOPTABLE INFANTS. COUPLES WITH FERTILITY PROBLEMS SHOULD NOT HAVE TO REMAIN CHILDLESS BECAUSE THEIR INSURANCE CARRIER DOES NOT ASSIST THEM. I URGE PASSAGE OF HB440. THAT'S FROM A GRANDMOTHER WHO WANTS TO BE A GRANDMOTHER AGAIN.

ZIP: 99652

POMID: 14092735
DATE: 03/10/88
TIME: 09:27:35
LIONAME: MAT-SU LIO

COM

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

RECEIVED MAR 14 1988

NAME: MICHAEL O'BRIEN
TITLE:
ADDRESS: PO BOX 995
CITY: PALMER
PHONE: 745-6354
BILL NO: HB 440
SUBJECT: INSURANCE COVERAGE FOR INFERTILITY CARE
MESSAGE: I AM IN STRONG SUPPORT ON THIS BILL TO EXPAND INSURANCE COVERAGE FOR PEOPLE SUFFERING FROM INFERTILITY.

ZIP: 99645

POMID: 03123535
DATE: 03/10/88
TIME: 12:35:35
LIONAME: ANCHORAGE LIO

COM

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

NAME: JAN FLANDERS
TITLE:
ADDRESS: BOX 112057
CITY: ANCHORAGE
PHONE: 653-7533
BILL NO: HB 440
SUBJECT: INSURANCE COVERAGE FOR INFERTILITY CARE
MESSAGE: I URGE YOU TO SUPPORT INSURANCE COVERAGE OF INFERTILITY DIAGNOSTICS FOR WOMEN AND MEN.

RECEIVED 03/11/88

ZIP: 99511

POMID: 03153749
DATE: 03/10/88
TIME: 15:37:49
LIONAME: ANCHORAGE LIO


C S h

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	FRANK	FURNACE	FAIKS
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	HERRMANN	HOFFMAN	HALFORD
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	MILLER	NAVARRE	JOSEPHSON
	PEARCE	PETTYJOHN	KELLY
	PHILLIPS	POURCHOT	KERTTULA
	RIEGER	SHULTZ	RODEY
	SPRINGER	SUND	STURGULEWSKI
	SWACKHAMMER	TAYLOR	SZYHANSKI
	ULMER	WALLIS	UEHLING
	ZAWACKI		ZHAROFF

of the two, as it will provide delivery services as well as prenatal and postpartum care for pregnant women with incomes up to 185 percent of poverty. New York's Prenatal Care and Nutrition Program (PCNP), which provides prenatal care to poor women ineligible for Medicaid, was made a permanent program and received additional funding in 1987, a portion of which will support an increase in provider fees.

Universal Health Insurance - Other state legislative initiatives designed to improve access to and availability of maternity care services for poor women target employers by attempting to improve coverage for maternity care under employer-based insurance plans. Although a 1978 federal law, the Pregnancy Discrimination Act, was designed to do just that, its impact has been somewhat limited. The Act does not cover policies that are not employer-based, nor does it apply to small employers (those with 15 or fewer employees). Moreover, the Act does not extend to non-spouse dependents, specifically teenage daughters. Added to these inherent shortcomings, is the bias of private insurance policies generally which, since their inception, have emphasized treatment for episodic illnesses or injuries rather than preventive, predictable or long-term health care needs. The Alan Guttmacher Institute (AGI) reports that ten years after enactment of the Pregnancy Discrimination Act, many women age 15-44 have private health insurance coverage that does not cover maternity care. AGI also reports that some existing insurance plans that do cover maternity care, nevertheless do not pay the full cost of services nor do they pay for newborn hospitalization.

Massachusetts' Governor proposed a universal health insurance initiative last fall which would ensure health care for all Massachusetts residents by requiring employers in the state to provide health benefits for their workers. At the same time, the unemployed would continue to be covered under an existing free-care program funded by a surcharge on hospital bills. The state's senior senator in the Congress, Senator Kennedy, has introduced a similar measure. Both proposals are expected to trigger lively debate in the coming months.

 Mandated Benefits Laws (Maternity and Newborn Services, IVF, Mammography and Cytologic Screening) - Mandated benefits laws are another strategy states are exploring to address the health care needs of poor pregnant women. Rhode Island lawmakers last year enacted broad legislation providing insurance coverage for maternity care and pediatric preventive care. Under the new law, which was introduced at the request of the Lieutenant Governor, all health insurance plans and HMOs must provide pediatric preventive care and maternity care without deductible or co-pay requirements. Maternity care is defined under the law to encompass all services recommended by a physician. Rhode Island is the only state of which we are aware that enacted a mandated benefit law in 1987 specifically related to maternity care.

Other mandated benefits laws of interest to obstetrician-gynecologists were enacted last year in Arkansas, California, Florida, Hawaii, Illinois, Massachusetts and Texas. The legislatures in Arkansas, Hawaii, and Texas voted to require insurance coverage for in vitro fertilization procedures. The Arkansas law applies to disability insurers in that state. Hawaii's law applies to all individual and group health insurance policies providing pregnancy-related benefits and is limited to a one-time only benefit for out-patient expenses. In Texas, all insurance companies and HMOs providing pregnancy benefits must also provide benefits for outpatient in vitro fertilization procedures. It should be noted here that Maryland was the first state to mandate insurance coverage for in vitro fertilization. The mandate was approved in 1985.

Legislation approved in Massachusetts last year requires all insurers providing pregnancy-related benefits to also provide benefits for medically necessary expenses of diagnosis and treatment of infertility. Infertility is defined under the law as the "condition of the presumably healthy individual who is unable to conceive or produce conception during a period of one year."



Alaska State Legislature
 House of Representatives
 COMMITTEE ON HEALTH, EDUCATION
 AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
 JUNEAU, AK 99801
 465-3759

March 28, 1988

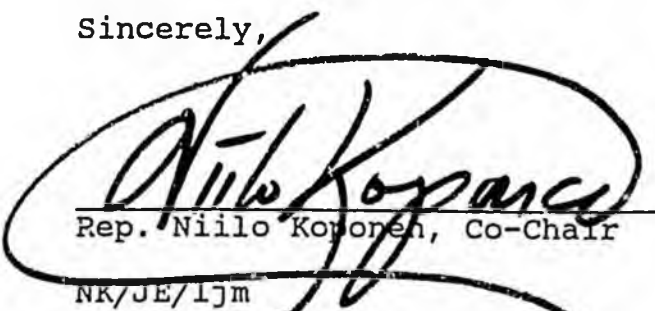
Dr. Robert G. Thompson
 Anchorage Obstetrics & Gynecology 1200 Phillips Heights Dr. Suite 150
 Anchorage, Alaska 99508

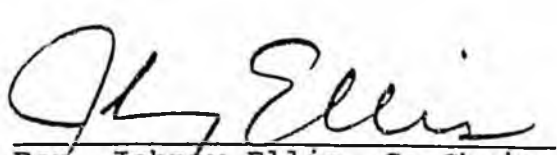
Dear Dr. Thompson:

Thank you for your letter in support of HB 440, which would mandate coverage for treatment of infertility. We understand the importance and desire for treatment of the condition of infertility. The House HESS Committee, which we co-chair, is planning to hold a hearing on this bill on Thursday, April 7, and may continue hearing it on Friday. We expect that hearing to be teleconferenced and your testimony would be welcomed. HB 440 would mandate coverage for infertility treatment be included if pregnancy benefits are provided. At this time Alaska does not mandate maternity coverage. Testimony in a previous committee of referral indicated that passage of HB 440 might reduce the number of employers who cover maternity services. Six states have some form of mandated coverage for treatment of infertility, but they all have previously mandated maternity coverage.

We appreciate you taking the time to contact us and we will keep your concerns in mind. Please continue to stay in touch.

Sincerely,


 Rep. Niilo Koponen, Co-Chair
 NK/JE/IJM


 Rep. Johnny Ellis, Co-Chair



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

December 24, 1987

MEMORANDUM

TO: Representative Curt Menard

FROM: Sandi Depue *Sandi*
Administrative Officer

RE: Proposed Massachusetts Health Coverage Law

You requested copies of the proposed health coverage law currently before the Massachusetts legislature. You also wanted pertinent back-up information.

Attached is a letter from Mr. Erik Canada, Research Intern, Massachusetts Legislative Service Bureau, forwarding the requested information.

If this agency can be of further service, please let me know.

Attachments



General Court Massachusetts

LEGISLATIVE SERVICE BUREAU
STATE HOUSE, BOSTON 02133

December 4, 1987

DP. AM...

Sandy Depue
House Research Agency
Capitol, P.O. Box Y
Alaska 99811-3100

Dear Ms. Depue:

In response to your recent request concerning legislation relative to Universal Health in Massachusetts, please find enclosed the following:

(1) House Bill Number 6000: A Message from His Excellency, the Governor, Recommending Legislation Relative to Making Health Care Available to Citizens of the Commonwealth of Massachusetts, and to Make Certain Other Improvements in the Health Care Delivery System of the Commonwealth.

(2) House Bill Number 6068: A Bill to Make Health Care Available to Citizens of the Commonwealth and Make Certain Improvements in the Health Care Delivery System in the Commonwealth.

(3) A Bill Relative to Interim Hospital Charge.

Status of H6000, H6068, and H6096.

on Universal Health Care in Massachusetts
Boston Globe.

I hope that you find this information to be helpful. If I can be of any further assistance, please do not hesitate to contact me again at (617)-722-2

Sincerely,

Erik M. Canada
Erik M. Canada

Research Intern

Supervisor: John M. Horgan

Senior Research Analyst

HOUSE No. 6096

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, October 13, 1987.

The committee on Ways and Means to whom was recommitted the Bill to make health care available to citizens of the Commonwealth, and make certain other improvements in the health care delivery system of the Commonwealth (House, No. 6068, amended), reports (in part) recommending that the accompanying bill (House, No. 6096) ought to pass.

For the committee,

RICHARD A. VOKE.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Seven.

AN ACT RELATIVE TO INTERIM HOSPITAL RATES OF PAYMENT AND CHARGES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Notwithstanding the provisions of any other
2 special or general law to the contrary, all rates and charges
3 established for acute care hospitals pursuant to Chapter 6A of the
4 Massachusetts General Laws and in effect on August 1, 1987 shall
5 remain in effect during the period between October 1, 1987 and
6 March 31, 1988, except as modified pursuant to paragraph 2 of
7 this act.

1 SECTION 2. Notwithstanding the provisions of any other
2 special or general law to the contrary, during the period between
3 October 1, 1987 and March 31, 1988, the rate setting commission
4 shall possess all powers, rights, obligations, and responsibilities
5 possessed by said commission on August 1, 1987 along with the
6 authority to issue and enforce regulations required to preserve the
7 system for providing acute care hospital reimbursement in
8 Massachusetts in a form identical to that existing on August 1,
9 1987.

1 SECTION 3. Notwithstanding the provisions of any other
2 special or general law to the contrary, each and every entity
3 charged with a responsibility under law on August 1, 1987 for
4 providing or financing otherwise uncompensated care as
5 described in the Massachusetts General Laws Chapter 6A, Section
6 75 shall bear that same responsibility during the period between
7 October 1, 1987 and March 31, 1988.

1 SECTION 4. Notwithstanding the provisions of any other
2 special or general law to the contrary, all parties bound on August
3 1, 1987 by the provisions of Hospital Agreement 30, the successor

4 agreement to Hospital Agri
5 Section 31, shall remain
6 agreement until March 31,

1 SECTION 5. The provi:
2 October 1, 1987.

1 SECTION 6. The prov
2 operative on March 31, 198

[October

1987]

budgets

4 agreement to Hospital Agreement 29 as defined in Chapter 6A,
5 Section 31, shall remain bound by the provisions of that
6 agreement until March 31, 1988.

Eighty-Seven.

1 SECTION 5. The provisions of this act shall be effective as of
2 October 1, 1987.

TERMS OF PAYMENT AND

1 SECTION 6. The provisions of this act shall cease to be
2 operative on March 31, 1988.

representatives in General
Assembly, as follows:

provisions of any other
rates and charges
to Chapter 6A of the
August 1, 1987 shall
October 1, 1987 and
it to paragraph 2 of

provisions of any other
the period between
setting commission
and responsibilities
1987 along with the
required to preserve the
reimbursement in
existing on August 1,

provisions of any other
and every entity
August 1, 1987 for
compensated care as
Chapter 6A, Section
the period between

provisions of any other
is bound on August
the successor

Governor's Summary

SECTION-BY-SECTION SUMMARY

- SECTION 1: Establishes new chapter that will require employers to enroll all employees and dependents in health benefit plans after an ERISA exemption is obtained. Mandatory benefits are defined in Section 5. Permissible exceptions to covering employees' dependents are defined in Section 6.
- SECTION 2: If by January 1, 1989, the Commonwealth has not obtained an ERISA exemption from the federal government, employers who do not offer a health plan equivalent to the Kennedy bill plus mandated Massachusetts benefits will be required to contribute to the Massachusetts Health Partnership Trust fund to finance the state's purchase of health coverage for their employees.
- SECTION 3: Amends Section 46 of Chapter 151A by adding words "Massachusetts Health Partnership."
- SECTION 4: Mandates a study by the rate review board to evaluate comparative merits of administration of health insurance contributions by the Department of Employment and Security and the Department of Revenue, to be submitted to the Governor by October 31, 1988.
- SECTION 5: Mandates a study by the commissioner of administration to establish guidelines for purposes of reimbursing cities and towns for reasonable costs incurred because of this Act.
- SECTION 6: Establishes effective dates of SECTION 2 through SECTION 5.
- SECTION 7: Amends Section 16 of Chapter 6A by adding "and the Massachusetts Health Partnership."
- SECTION 8: Establishes new chapter defining the provisions of the department entitled "Massachusetts Health Partnership", which shall make health benefit programs available to residents of the Commonwealth. The Partnership has the authority to purchase all state-managed health care (Medicaid, state employees, uninsured, etc.), manage the acute hospital free care/bad debt pool, manage Medicaid and Group Health Insurance contracting and assume health responsibilities

from the Rate Setting Commission. This chapter also authorizes the Partnership to: include certain mandated services in health benefit plans; establish a program of medical care and assistance for certain disabled individuals; and establish and administer a re-employment training incentive program to provide training in health care professions for those employees who are or might be affected by hospital layoff, closure or reduction in hours.

- SECTION 9: Establishes effective date of October 1, 1987 for start of the Massachusetts Health Partnership.
- SECTION 10A: Authorizes Health Partnership assumption of all unexpended funds appropriated in FY88 for state agencies that will become part of the Health Partnership.
- SECTION 10B: Amends Section 2(b) of Chapter 18 by adding words "financial assistance for health services and medical care."
- SECTION 10C: Substitutes "Massachusetts Health Partnership" for the "Department of Public Welfare" in Section 2(b) of Chapter 118E.
- SECTION 11A: Defines method of reimbursing acute hospitals for the four-year period beginning on October 1, 1987. In the first year, increased charges would be limited to inflation plus a 2% adjustment applied to the non-Medicare base. \$60 million in allowances for extraordinary labor cost increases are also included in the proposed legislation. As of October 1, 1988, a negotiated rate between the purchaser and provider of hospital services is the preferred method of setting hospital rates. The Commissioner of the Health Partnership will have the authority to promulgate regulations to govern hospital rates from October 1, 1988 to September 30, 1991.
- SECTION 11B: Grants authority to the Health Partnership to assume health insurance responsibility for Medex and nongroup populations if and when Blue Cross/Blue Shield ceases to serve those groups.
- SECTION 11C: Repeals Sections 37 through 47 of Chapter 6A, which, among other things, authorize the Rate Setting Commission to regulate rates charged by non-acute hospitals.

- SECTION 12: Eliminates Determination of Need (DoN) for acute care hospital projects under \$10 million as well as for conversions of acute care services to skilled nursing, acute psychiatric, rehabilitation, and substance abuse services costing less than \$600,000. New technology, innovative services, ambulatory surgery, and long-term care still require a DoN.
- SECTION 13: Amends DoN law to account for possible successor agencies to health system agencies.
- SECTION 14: Removes clinical laboratories from DoN.
- SECTION 15: Establishes a review board composed of the secretaries of Human Services, Administration and Finance and the Commissioner of the Massachusetts Health Partnership to permit review of Public Health Council DoN decisions that may have a significant impact on health care costs. The review board decision overrides the Public Health Council decision in instances where differences occur.
- SECTION 16
through
SECTION 20: Requires all publicly and privately owned and operated facilities and programs to notify the Department of Public Health of any acquisition of new medical technology or a health care facility. Failure to provide such a notice shall result in a fine.
- SECTION 21: Authorizes the establishment of rates of payment for Title XIX (Medicaid) services provided by acute and non-acute hospitals consistent where applicable with the principles of reimbursement under Title XVIII and Title XIX of the Social Security Act.
- SECTION 22: Delineates the conditions for provider participation in the Medicaid program.
- SECTION 23: Authorizes the Department of Public Health to permit the return of certain prescription drugs to a pharmacy for resale.
- SECTION 24
through
SECTION 27: Empowers the Department of Public Welfare to impose administrative fines against providers, to recover interest from providers for overpayments and to extend amnesty for such fines and interest to encourage voluntary payment.

- SECTION 28: Amends statutory language regarding standards to be applied on provider rate appeals.
- SECTION 29: Requires a nonprofit hospital service corporation to make available supplemental group coverage to Medicare to a group of Medicaid recipients designated by the Department of Public Welfare.
- SECTION 30: Requires insurers who offer policies of accident and sickness insurance to make available supplemental group coverage to Medicare to a group of Medicaid recipients designated by the Department of Public Welfare.
- SECTION 31: Requires health insurers and Health Maintenance Organizations (HMOs) to match their subscriber and beneficiary files with Medicaid eligibility files, in an effort to ensure that Medicaid is the payer of last resort.
- SECTION 32
and
SECTION 33: Requires attorneys to notify the Department of Public Welfare whenever filing a lawsuit or insurance claim on behalf of a recipient to recover monies due as a result of an accident, illness, or other loss, and simplifies procedures for perfecting the Welfare Department's liens in such cases.
- SECTION 34: Allows the Department of Public Welfare to require a nominal copayment or deductible for medical services.
- SECTION 35
through
SECTION 39: Tightens rules for transfer of assets in determining Medicaid eligibility.
- SECTION 40
and
SECTION 41: These sections make the Department of Public Welfare a party in interest in guardianship proceedings involving individuals entitled to benefits from the Department, and require guardians and conservators to notify the Department of their appointment or any proceedings affecting the estate of the ward.
- SECTION 42
and
SECTION 43: Decreases the rate of interest payable in civil actions.

- SECTION 61: Allows an employee or Division of Labor and Industries to complain and seek damages when an employer fails to notify the employee of the availability of extended group health and medical benefits.
- SECTION 62:
and
SECTION 63: Expands the definition of entities subject to the unfair and deceptive insurance practices statute to include HMOs and PPOs.
- SECTION 64: Subjects HMOs to the insurance laws applicable to mergers and acquisitions.
- SECTION 65: Subjects health care facility mergers and acquisitions to Department of Public Health approval. Such approval will require analysis of the proposed transaction on access to health care, quality, cost and competition.
- SECTION 66: Allows the Insurance Commissioner to consider local and regional competitive impact of proposed mergers and acquisitions.
- SECTION 67,
68, 70, 71: Permits Blue Shield to create a PPO comparable to commercial insurers and subject to Chapter 176I.
- SECTION 69: Gives Commissioner of Insurance power to disapprove Blue Shield rules and regulations.
- SECTION 72: Codifies provider rights to receive from Blue Shield full and fair explanation of payment decisions and establishes appeal mechanism. Also increases information on Blue Shield payment system available to providers.
- SECTION 73: Allows providers to file class action suits against Blue Shield for unresolved disputes that do not involve compensation.
- SECTION 74: Permits Blue Cross to create a PPO comparable to commercial insurers and subject to Chapter 176I.
- SECTION 75: Establishes a process for determining whether and on which terms and conditions Blue Cross/Blue Shield should be reorganized into a commercial insurer. This process includes: (1) a detailed study of Blue Cross/Blue Shield and the relevant market; (2) a public hearing on reorganization issues; (3) a final decision to be made and terms and conditions imposed by a 5-member governmental panel. A major factor in the reorganization decision will be the continued availability of affordable nongroup and Medicare supplemental insurance.

- SECTION 76
through
SECTION 78: Directs the Commissioner of Insurance to promulgate regulations governing the scheduling of rate filings and the standards governing the rates of nongroup insurance except Medex, and to promulgate cost containment regulations.
- SECTION 79: Creates a Bureau of Hospital and Medical Service Corporation Analysis within the Division of Insurance to advise the commissioner regarding requests for rates for nongroup contracts. Allows an assessment to be levied on Blue Cross/Blue Shield to pay for the Bureau, which is capped at \$350,000.
- SECTION 80
through
SECTION 82: Allows Blue Cross/Blue Shield to seek increases in Medex rates based on changes in Medicare deductibles and coverages. Allows persons enrolled in HMO Medicare plans to switch to Medex if the HMO cancels the plan.
- SECTION 83: Standardizes the open enrollment period for HMOs, and prohibits HMOs from imposing "preexisting condition" clauses on nongroup contracts.
- SECTION 84: Changes the hospital and clinic licensing law to allow the Department of Public Health to place prescribed quality and access conditions on licenses as well as conduct a public hearing on licensure applications upon request by fifty or more interested persons. The applicant must publish notice of the application.
- SECTION 85: Establishes a grievance procedure for a licensee who has had a license conditioned, denied or revoked.
- SECTION 86: Provides for a Department of Public Health unit to develop quality indicators and further provides for 90-day written notices of discontinued hospital services and operations and 30-day written notices of reduction in workforces or scheduled hours.
- SECTION 87: Strengthens the Department of Public Health's license by service authority.

SECTION 88

through

SECTION 90:

Extends authority of advocacy office to investigate complaints based on discrimination from all federal and state payment sources and extends to it general investigatory powers held by survey branch of the Department of Public Health.

SECTION 91

and

SECTION 92:

Mandates hospitals to post the patients' rights statute and preserves those rights in law for the patients.

SECTION 93:

Gives the Department of Public Health authority to issue orders to correct deficiencies, impose civil administrative fines for failure to correct deficiencies and to issue cease and desist orders to hospitals or clinics.

SECTION 94:

Extends the Department of Public Health's authority to enforce the patients' rights statute into Health Maintenance Organizations.

SECTION 95:

Authorizes a study on the nurses' shortage in acute care hospitals.

SECTION 96:

Requires colleges and universities to offer health insurance to full time students.

SECTION 97

through

SECTION 108:

Improves protection of children and custodial parents' access to health insurance by tightening notice and reimbursement practices in a divorce situation.

SECTION 109

and

SECTION 110 :

Establishes standard clauses of severability and limitations on expenditures based on appropriated funds.

Section 111:

Outlines budget request for the Massachusetts Health Partnership.

HIGHLIGHTS OF HOUSE WAYS AND MEANS HEALTH CARE BILL

I. HEALTH BENEFITS

Endorses and expands upon the Governor's proposal by:

- A. Mandating insurers to provide Preventive Health Care to children from birth to age 6
- B. Prohibits deductibles and co-insurance for low-income pregnant women
- C. Allows low-income elders opportunity to purchase coverage from the state
- D. Establishes a program of medical assistance (\$5.0m) for disabled children not eligible for Medicaid
- E. Makes new health agency the insurer of last resort for those with pre-existing conditions
- F. Proposes expansion of Medicaid benefits to elderly, disabled, pregnant women, and severely disabled children
- G. Makes Healthy Start part of the General Laws
- H. Mandates Pilot Program for severely disabled children

II. ESTABLISHES NEW DEPARTMENT OF MEDICAL SERVICES

- A. New Agency will administer Medicaid, GIC, and plan for uninsured
- B. Makes any transfer of employees consistent with existing Civil Service and Collective Bargaining laws and subject to budget cycle
- C. Rate Setting Commission will remain an Independent Agency thereby protecting against purchaser and provider conflicts
- D. HW&M's eliminates all administrative funding for New Agency. Agency can only use existing Medicaid and GIC administrative funds. Any additional funds will have to be directly requested by the Administration through budgetary process
- E. HW&M's allows DMS to contract through negotiation with providers
- F. HW&M's Deletes excessive powers of Commissioner

III. HOSPITAL PAYMENT

- A. Proposes inflation + 3% to be targeted to labor (\$22.5m over Governor)
- B. Removes CAP on BAD DEBT - ie. hospitals will continue to be reimbursed in full for BD-(\$40m over Governor)
- C. Removes Medicaid CAPS on outpatient and all AWD days -(\$30m over Governor)
- D. Continues \$60m for labor for underfinanced hospitals
- E. Allows unlimited discounts through negotiated agreements
- F. Allows exemption from cap for out-of-country patients

*Thus HW&M's proposes an additional \$90m to hospitals over Governor's package now worth at least \$300m of new money to hospitals.

IV. DETERMINATION OF NEED

- A. HW&M's allows full pass-through of costs for any project that receives a D.O.N.
- B. HW&M's requires no DON review for any hospital bed conversions in an underbedded area as certified by DPH
- C. HW&M's maintains \$10m threshold and raises non-acute threshold to \$800,000 for equipment and raises threshold for change in service to \$350,000
- D. HW&M's allows Public Health Council rather than A&F to make final determinations of projects
- E. Allows Nursing Home builders in Urban-underbedded areas to be exempt from DON and RSC reimbursement CAPS
- F. HW&M's mandates study to study criteria for the delicensure, conversion, and consolidation of excess beds

V. MEDICAID

- A. HW&M's removes H.6000 proposals for deductibles and co-insurance; prohibitions against asset transfers, restrictions on chronic hospitals payments, and all provisions previously requested in REAP

VI. BLUE CROSS/BLUE SHIELD

- A. HW&M's mandates state auditor to undertake audit of BC/BS
- B. Mandates Secretary of Consumer Affairs and independent panel to study mutualization of BC/BS and to submit findings to legislature by 10/1/89 - Medex and BC/BS maintained as is until legislative changes

- C. HW&M's allows Blue Shield to establish PPO's but only if consistent with New C. 176I
- D. HW&M's continues protections against balance billing

VIII. DPH LICENSURE, QUALITY, AND LABOR

- A. HW&M's endorses Governor's Licensure, Quality, Suitability Reviews, and consumer protections
- B. HW&M's endorses labor protections and expands existing re-employment assistance program to hospital workers

VII. HMO'S AND PPO'S

- A. HW&M's endorses 2.28% tax on HMO's and PPO's, but does not allow this revenue to go to DMS, but rather to general fund
- B. HW&M's endorses the remainder of Governor's PPO provisions which will allow regulation of this new program
- C. HW&M's sunset HMO Tax in 1991 if no tax on Blue Cross/ Blue Shield

VIII. BUDGET PROVISIONS

- A. HW&M's removes all budget provisions except \$1.0m for disabled adults and \$5.0m for disabled children
- B. Any additional administrative funds (other than those currently in Medicaid and GIC) will have to be requested in a Supplemental Budget or in FY'89 budget

H.6000

SECTION 1

Mandatory health coverage following ERISA exemption

SECTION 2

Unemployment Health Insurance contribution

SECTION 3

MHP added to Section 46 of Chapter 151A

SECTION 4

Study of health insurance contributions by employers

SECTION 5

Reimbursing cities and towns for mandated costs

SECTION 6

Effective dates

SECTION 7

EOHS amended to include MHP

SECTION 8

Creation of Massachusetts Health Partnership

HOUSE WAYS & MEANS CHANGES

SECTION 1

- prohibited copayments and deductibles for prenatal, delivery, and well baby care for low income women
- defined small employer and expanded definition of "coverage period" to 120 days relative to small employer
- changed coverage period to begin 60 days after hire for other than small employer
- changed civil penalty for failure to comply from 10% of payroll to 2%
- added preventive care for children up to age 6 to be included in all coverage
- changed definition of employee to require 25 hours per week

SECTION 2

- changed time frame for assessing a penalty if an employer fails to file appropriate reports or forms (H.6000 section 14I) from 15 to 21 days

SECTION 3

- named new agency Department of Medical Services

SECTION 4

- added the Legislature as a recipient of the report

SECTION 5

- no significant changes

SECTION 6

- no significant changes

SECTION 7

- EOHS amended to add Dept. of Medical Services

SECTION 8

- creation of Dept. of Medical Services
- changed composition of advisory boards to be established
- excluded transfer of Rate Setting Commission employees and duties
- included civil service protections and deleted management rights provisions consistent with other state agencies
- deleted excessive powers of the agency

- included a program for medical assistance for disabled children not otherwise eligible for Medicaid
- specified the establishment of a sliding fee program for the low-income elderly
- added provision regarding pre-existing conditions so that DMS will be insurer of last resort
- added provision that HMO's must accept Medicaid clients as a condition of contracting with the DMS
- raised free care and bad debt to 100% reimbursement but exempted certain populations. Raised cap to \$375M
- eliminated new funds, the administrative fund and provision enabling 9% of total revenue to be spent for administration, all administrative funding made subject to appropriation
- eliminated H.6000 Section 11 regarding access to financial records
- specified that copayments and deductibles be established only by the Legislature

SECTION 9

- Date new agency assumes powers

SECTION 10

Interagency agreements with relevant agencies

SECTION 11

FY'88 control of Medicaid, RSC, and GIC funds

SECTION 11A & 11B

[no comparable sections]

SECTION 9

- established date for DMS to assume authorities and powers (July 1, 1989)

SECTION 10

- eliminated the Dept. of Public Health and the Rate Setting Commission from specified list of interagency agreements

SECTION 11

- eliminated reference to the Rate Setting Commission

SECTION 12 & 13

- no substantial change

SECTIONS 14 - 19

- established Healthy Start in General Laws
- established Medicaid eligibility for severely disabled children; presumptive Medicaid eligibility for pregnant women; expanded Medicaid eligibility for children, elderly, and disabled

SECTION 11C
Hospital Financing

[no comparable sections]

SECTIONS 12-20
Determination of Need

SECTION 20

- allowed unlimited discounts through negotiated agreements
- proposed inflation + 3% to be targeted to labor
- continued \$60M for underfinanced hospitals
- allowed full pass-through of costs for any hospital that receives a DoN
- allowed exemption from cap for out-of-country patients

SECTION 21

- exempted comprehensive cancer centers from hospital reimbursement system

SECTION 22

- Removed nursing homes in underbedded areas from reimbursement caps

SECTION 23

- required Rate Setting Commission to report to the Legislature on increased rates

SECTION 24

- established uncompensated care pool for community health centers

SECTION 25

- removed RSC oversight of Blue Cross contract if DMS takes over Medex and non-group

SECTIONS 26 - 36

- clarified the definitions of "new technology" and "innovative services"
- raised threshold for non-acute health care facilities from \$600,000 to \$800,000 for capital expenditures
- exempted DoN for hospital bed conversions in underbedded areas
- eliminated reconversion provision regarding non-acute facilities, raised bed capacity change in service from 4 beds to 12 and raised operating expenditure threshold (change in service or increase in staff) from \$250,000 to \$350,000
- eliminated A & F DoN oversight board of review, Public Health Council continues existing powers
- added provision for optional DoN for projects not at threshold

SECTIONS 21-43

Medicaid provisions for coinsurance, deductibles, restrictions against asset transfers, restrictions on chronic hospital payments, and miscellaneous REAP provisions

- deleted all Medicaid provisions

SECTION 44

2.28% HMO tax on premiums

SECTION 37

- clarified continuation of Chapter 6A

SECTION 38

- eliminated dedication to MHP Fund II
- revenues received from the tax will be deposited into the general fund

SECTIONS 45-49

Tax on commercial insurers dedicated to new agency

- deleted entire sections, therefore commercial tax assessments will continue to go to the general fund

SECTIONS 50 & 51

BC/BS subject to HMO and PPO tax

SECTIONS 39 & 40

- no substantial changes

SECTION 52

effective dates of taxes on premiums

SECTION 41

- corrected to reflect renumbered sections

[no comparable sections]

SECTIONS 42 - 44

- mandated preventive health care coverage for children through age 6

SECTION 53

New PPO statute (C.176I)

SECTION 45

- clarified that benefit levels to nonpreferred providers must be at least 80% of the benefit level for preferred providers and can not be less than 60%
- in Section 11, eliminated dedication of taxes to MHP Fund II and clarified that assessment be based on premiums not gross revenues
- changed PPO tax to be deposited into the general fund (not dedicated to new agency)

SECTION 54

rehabilitation and liquidation of HMO's

SECTION 46

- no change

SECTION 55

Risk management program as
a condition of licensure

SECTION 56 - 60

requires insurers or
policy holders to give
written notices if coverage
is about to lapse

SECTION 61

employee notification of
eligibility for extended
benefits

SECTIONS 62-63

HMO's and PPO's in unfair
practices act

SECTION 64

Subjects HMO's to
insurance laws

SECTIONS 65 & 66

Mergers and acquisitions

SECTIONS 67 & 68

Blue Shield PPO

SECTION 69

disapproval of Blue Shield
rules and regulations

SECTION 70

Blue Shield PPO

SECTION 71

Blue Shield PPO

SECTION 72

Blue Shield PPO

SECTION 73

Blue Shield provider
rights

SECTION 47

- added DPH approval of risk management
programs

SECTION 48 - 51

- continued notification requirements,
but mandated employers or policy
holders to notify insured

SECTION 52

- no significant changes

SECTIONS 53 & 54

- no substantial change

SECTION 55

- no change

SECTIONS 56 & 57

- clarified that long term care
facilities are not included in the
definition of health care facility
- corrected (c) to read public hearing

SECTIONS 58 & 59

- changed reference of nonpreferred to
nonparticipating

SECTION 60

- changed filing date to read "30 days
before their effective dates"

SECTION 61

- deleted second paragraph to be
consistent with C.176I

SECTION 62

- no substantial change

SECTION 63

- included provision for termination
of an agreement
- clarified that Blue Shield PPO
physicians are subject to balanced
billing laws

SECTION 64

- no changes

SECTION 74
Blue Cross PPO

SECTION 75
BC/BS audit and study of
mutualization

SECTION 76
Rate filings

SECTION 77
Blue Cross standards for
findings

SECTION 78
Blue Shield standards for
findings

SECTION 79
New bureau at the division
of insurance

SECTION 80
Medex rate adjustment

SECTIONS 81-83
Open enrollments

SECTION 84
Hospital Licensure

SECTION 85
Hearing for conditions on
licenses

SECTION 86
Quality indicators and
Hospital Closure

SECTIONS 87-89
Licensure by service,
expansion of Advocacy Office

SECTION 90
Access to records

SECTION 65
- eliminated mandate for separating
revenue sources

SECTIONS 66 & 67
- gave responsibilities for audit of
BC/BS to the state auditor;
mutualization report remains
responsibility of Exec. Office of
Consumer Affairs

- deleted entire section

SECTION 68
- no change

SECTION 69
- deleted specifications of regulations

- deleted entire section

- deleted entire section

SECTIONS 70 - 72
- changed open enrollment period to
January 1 through the last day in
February

SECTION 73
- no substantial change

SECTION 74
- changed from public hearing to
adjudicatory hearing

SECTION 75
- no substantial change

SECTIONS 76 - 78
- no changes

SECTION 79
- added "with the consent of the
patient or the patient's legal
guardian"

SECTIONS 91-92

DPH Advocacy Office

SECTION 93

finances against hospitals

SECTION 94

Patients' Rights

[no comparable section]

SECTION 95

Study of nursing shortage

[no comparable sections]

SECTION 96

Students' benefits

SECTIONS 97 - 108

Access to health insurance
in divorce settlements

SECTION 109

limits expenditures to
appropriated funds

SECTION 110

Severability

SECTION 111

Budget request

SECTIONS 80 & 81

- no substantial changes

SECTION 82

- deleted (e) and (f)

SECTION 83

- no change

SECTIONS 84 & 85

- established pilot program for
handicapped children

SECTION 86

- no change

SECTION 87

- provided for identification of
medically underserved areas

SECTION 88

- added study on delicensure of excess
beds

SECTION 89

- no significant changes

SECTIONS 90 - 101

- no changes

SECTION 102

- no change

SECTION 103

- no change

SECTION 104

- eliminated administrative funding

By Robert Lenzner
and Peter G. Gosselin
Globe Staff

Boston's Fidelity Investments, one of the country's largest mutual fund operators, sold off \$850 million of stock during the stock crash Oct. 19, starting in London even before US markets opened and greeting the New York Stock Exchange with about a half a billion dollars of sell orders.

Sources said Fidelity was one of the most successful of major firms whose selling helped drive the market into its current charge Fidelity declines.

The same Fidelity sell order of \$500 million is sure on the way as the pressing price

December 15, 1992

Agreement reported on health bill outline

By Richard A. Knox
Globe Staff

Major interest groups reached agreement yesterday evening on the outlines of a new Massachusetts hospital financing mechanism and a phased-in approach to insuring workers who now lack health coverage, according to the Senate Ways and Means Committee chairman, Patricia McGovern (D-Lawrence).

"I'm cautiously optimistic," she said in a telephone interview. "I believe we've reached agreement on a general approach. It's still very volatile. ... But once you've reached general agreement on overall concepts - and we indeed have - you can begin to move forward."

McGovern has labored for weeks to salvage a bill out of the wreckage of Gov. Dukakis' original "health care for all" proposal, which was nearly killed on the House floor Oct. 5.

"Whatever emerges [from the committee] will be brand new and quite different from anything put on the table before," she promised.

McGovern declined to divulge specifics, but the tentative agreement among various interest groups reportedly would provide Massachusetts hospitals with new 1988 revenues just shy of \$400 million and phase in a mechanism to provide affordable health

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HEALTH, Page 40

Condom debate: (

needed his help.

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is no question that Cur-
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donation from a person
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es a lot to the imagina-
as said that nobody ever
m hand-to-hand, but the

. Page 2



Pope John Paul II receives flowers from Mandy Lynn Wolff, 10, on his arrival in San Antonio yesterday.

UPI photo

"Come back to this source of...
the pontiff told them, in a message aimed at a nation
where use of the sacrament has fallen drastically since
the Second Vatican Council ended in 1965.

"Christ himself is waiting for you," he said. "He will
heal you and you will be at peace with God."

About 20 persons were taken to hospitals for heat-
related illness by the end of the Mass, and dozens more
were reported stricken in the long walk from the Mass
site to parking areas.

Choice of the Mass site was controversial, and the
medical director chosen for the event resigned in July to
protest the lack of public health precautions.

POPE, Page 5

Inside

Today: Sci-Tech

olph wins at PV
Randolph captured
ank of Boston
ic at Pleasant Valley
rday. Page 49.

er protest reported



Dan Rather re-
portedly stormed
off the set last
week, causing
CBS to go six min-
utes without
transmitting a
e. Page 22.

ker, lighter, faster

heelchair designs are bor-
g from spacecraft, bicycle
rplane technology. Sci-
Page 33.

Guide to features

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Dukakis health proposal to meet political reality

Quick action by Legislature, industry sought

By Richard A. Knox
Globe Staff

Gov. Dukakis' gamble that this is
the time and Massachusetts is the
place to show the nation how to re-
structure its jumbled health care sys-
tem now will be put to the test.

The governor's move is embodied in
legislation rushed into final form this
weekend. Its preamble simply states: It
shall be the policy of the common-
wealth to implement programs that
will make affordable health care avail-
able to every citizen of the common-
wealth.

Within the next few days, it should
be possible to get a reading on whether
the governor and his advisers are in
touch with reality in trying to enact
such an ambitious proposal by the end
of this month. That is the adminis-
tration's deadline, dictated by the ex-
piration of the state's current hospital fi-
nancing law - and, with it, the state's
current \$315 million-a-year pool for
covering hospital costs of the unin-
sured.

The governor's proposal, which car-
ries a price tag of up to \$600 million a
year, would be funded mostly by busi-
nesses, with additional amounts from
state tax funds and consumers.

"The most shocking prospect is that
this might actually be passed by Oct.
1," one leading Massachusetts health
care analyst said yesterday after perus-
ing the 159-page proposal. "And I guess
that it's not that unlikely. The attitude
in this Democratically-controlled state
may well be, 'We've got to do it for the
governor and we'll fix it later.'"

Dukakis is proposing a major red-
esign of both the financing and the in-
frastructure of Massachusetts health
care - a \$12.7 billion-a-year enterprise
- in order to insure the nearly 600,000
citizens who now lack health insur-
ance. Much of the task would be put in
the hands of a health care czar at the
top of a new agency called the Mass-
achusetts Health Partnership.

Within the administration and the
health care community, state Welfare
HEALTH INSURANCE, Page 16

TWILIGHT PASSAGE



UPI/Reuters photo

The US Navy warship Flatley steams through
the Persian Gulf as the sun goes down. The Flat-
ley was helping clear the way for two Kuwaiti
tankers. Page 6.

Divers organ Bork'

By Gregory Witt
Globe Staff

WASHINGTON
confirmation in
Supreme Court
broad national
his confirmation
the "soul of the

These opposi-
women's, civil
have opposi-
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marches in a
against Bork.

Former cu-
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BORK, Page

Dukakis health insurance proposal to meet political reality

■ **HEALTH INSURANCE**
Continued from Page 1

Commissioner Charles A. Atkins is already widely rumored

to be in line for the job, though one of Dukakis' top aides denied last weekend that any decision has been made.

The partnership would have very broadly defined powers to control hospital costs and purchase \$2.5 billion in health care benefits on behalf of the poor, state employees, the unemployed, workers whose companies do not buy coverage, people who now buy individual health insurance policies from Blue Cross and, possibly, the elderly.

The proposal would also require:

- A major reorientation of the state's dominant health insurer, the nonprofit, financially troubled Massachusetts Blue Cross-Blue Shield, that would ultimately make it resemble any commercial insurance company.

- Incentives to nurture a host of new organizations to market, broker and manage health care, in the hope of sharpening competition among both insurers and care providers. New and existing "managed care" entities, such as health maintenance organizations, would be able to bargain for discounts from hospitals and doc-

tors - but the state would limit such discounts to 10 percent.

- Dismantling much of the state's regulatory authority over health care and putting up new and entirely untested mechanisms designed to protect citizens from the new incentives on providers to cut costs - and perhaps corners - in their effort to survive.

- Closure or conversion of nearly 40 percent of the commonwealth's hospital capacity, a step discussed for nearly two decades but - because of its extreme political sensitivity - never actually attempted.

Groups must act this week

Given the intense pressure to act, major interest groups must take a position and swing into action this week. This is no easy task, those in the health care world said yesterday, because the legislation is so complex, sweeping and open-ended.

Major insurers and the state's largest businesses are convening this morning to determine its im-

pact for them and decide whether they can support the governor's plan. At first reading of the bill yesterday, one source said it was not obvious whether businesses that now insure their employers - and subsidize firms that do not - would actually save much money.

Representatives of the poor and the elderly are nervous about some of the plan's features but are generally supportive.

Small businesspeople feel beleaguered and outgunned by the big-business support the governor appears to have in his attempt to make them buy insurance for the 480,000 Massachusetts workers who now cannot get coverage through their place of employment.

The governor would do this one of two ways: By securing congressional permission to require employers to purchase health insurance for their workers; or, if this fails by Jan. 1, 1989, by making all businesses pay a surcharge on the unemployment insurance they must buy. If they offered a basic health insurance plan and paid 80 percent of the premium, the surcharge would be essentially forgiven.

But perhaps the key question at this point is whether the state's \$5 billion-a-year hospital industry will play the pivotal role in the fate of the governor's proposal that it has in previous years when major health care legislation has been enacted.

Closely related to this is the extent to which hospital workers and their unions will support hos-

pitals, noting that a proportion of Massachusetts hospital budgets devoted to pay has declined in recent years.

The Massachusetts Nurses Association, while urging that state officials recognize the need for significant increases in hospital wages, does not want to be blamed for helping to scuttle the Dukakis proposal, an association lobbyist said yesterday.

Steven Hegarty, president of the Massachusetts Hospital Association, said last week he was confident that hospitals - the dominant employers in many communities - can get their message across to legislators. "I real decisionmakers have to list to their local constituency, and our people are speaking very clearly to every legislator in the commonwealth right now," Hegarty said.

Dukakis and his administration, who have the public support of legislative leaders of both houses, are painting the hospitals as unreasonable in their immediate financial demands.

Hospitals, for instance, are pressing for Massachusetts insurers, government and consumers make up for the fact that the federal Medicare funds will not go in 1988. Medicare provides about 40 percent of hospitals' revenue.


Dr. J. Robert Buchanan, general director of the Massachusetts General Hospital, said in an interview Friday his institution would suffer a \$15 million deficit in the coming year unless its revenue climb by 0.1 percent. Because

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AIDS

IS SPREADING THROUGHOUT

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nor's bill does not provide enough money in the coming year to fund a pent-up demand for wage increases. This demand, fueled further by a severe shortage of nurses and other skilled hospital workers, is beginning to result in double-digit wage settlements.

The Massachusetts Hospital Association is orchestrating a major campaign to persuade legislators that the governor's bill is too stingy to permit needed wage increases. On Wednesday the trade group plans to bus several thousand hospital workers to the State House for a rally, followed by visits to local legislators.

However it appears that hospitals and unions are not speaking with one voice when it comes to how much additional hospital revenue is needed. Local 285 of Service Employees International Union, which represents about 6,000 hospital workers, will issue a report today that sharply challenges hospitals' record in using revenue surpluses to increase wages.

"While hospital costs continue to grow well beyond inflation, fewer of these dollars are going to health care workers' salaries,"

Medicare won't pay more, this would require nearly 18 percent more from Massachusetts payers.

"I have very serious questions whether several hundred million dollars more for insuring the uninsured is tolerable at a time when the system requires some serious readjustment after five years of tight control," Buchanan said.

Hegarty argued last week with Dukakis that hospitals need 17.7 percent more from Massachusetts payers next year — an additional \$544 million.

Dukakis officials have flatly said no to that kind of increase, offering only about \$200 million more. Privately they express exasperation with hospitals for making the demand. After meeting with Hegarty, Dukakis increased a special fund in his proposal earmarked for hospital wage increases from about \$45 million to \$60 million.

Under the governor's proposal, one administration official said yesterday, Massachusetts businesses and consumers would pay about 10 percent more to hospitals in the coming fiscal year. This would produce about 5 percent more in net hospital revenues, the official said.

Hurdles remain in bid for global ozone treaty

By Dianne Dumanoski
Globe Staff

MONTREAL — Several key

their consumption of chlorofluorocarbons, or CFCs — which are widely used in air conditioners, refrigerators, aerosol spray cans

contacted no one else, including Mayor Flynn, the owner of the quarry and the town of Weston. Bulger said he hoped his suggestions would be considered on the merits, but he was not optimistic. "I'm hopeful that the mayor will look at it and say, 'I welcome a new idea,'" Bulger said in an interview in his office. "But once I make the suggestion I want to be away from it so the critics will no

INCINERATOR, Page 68

Constitution Day, as it is being called here, is the culmination of years of planning and millions of dollars in government, corporate and individual spending that have drawn applause and criticism.

It is also the beginning of a yearlong series of special events celebrating the progress of the Constitution, through the ratification process by a confederation of

al principles.

The celebration here is being viewed by Philadelphians as an opportunity to boost the image of the city as well as a historical obligation to commemorate the drafting and signing of the 200-year-old document.

"The hope I have is that the confidence of the city to do things, to get things done, will be en-

CONSTITUTION, Page 23



Pope John Paul II reaches reception School in Los Angeles

Pope calls to work again

By James L. Franklin
Globe Staff

LOS ANGELES - In the important address so far second American visit, Pope Paul II yesterday urged the nation's Roman Catholic bishops to hold the line on dissent, to mount a new campaign to win hearts and minds of a well-ed and questioning church membership.

In a four-hour meeting at the National Conference of Catholic Bishops, the pontiff acknowledged that some church members believe that dissent from the church's teaching "is totally incompatible with being a 'good Catholic' and poses no obstacle to the reception of the sacraments."

Inside

Today: Calendar, Money

House backs import limits

The House yesterday approved tighter limits on imports of textiles, apparel and shoes. Page 41.

O'Neill on '62 Senate fight



In the fifth of six excerpts from his memoirs, former House Speaker Thomas P. O'Neill Jr. discusses the maneuvering behind the 1962 Edward Kennedy-Edward McCormack Senate primary fight. Page 2.

ate primary fight. Page 2.

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Health plan cost seen as eroding support

By Richard A. Knox
Globe Staff

While Massachusetts hospitals were telling legislators yesterday that Gov. Dukakis' proposed health plan would underfund them to a dangerous degree, big-business and insurer representatives have concluded that the bill is too rich for a hospital system they consider already bloated.

New estimates of the sweeping plan's cost impact appear to be eroding support for the proposal among business and insurance interests. The governor is counting heavily on that support to push his plan through the Legislature in the next few weeks.

Groups representing the poor, elderly and parents of disabled children are also complaining about how the proposal addresses their concerns - or fails to.

Hale Champion, the governor's chief secretary, said last night that the balance of interests the administration tried to achieve is

Thousands of hospital workers gathered at Boston Common yesterday to protest the governor's universal health care proposal. Page 56.

not yet toppling under the mounting criticism. None of the objections he has heard, Champion said, "are frozen or fixed or seriously jeopardize the bill."

However, business and insurance leaders are taking a hard-line stance on further increases in revenues sought from the Legislature by the hospital industry, which says it needs \$544 million in additional funds next year.

The business community analysis, completed late yesterday, concludes that the Dukakis plan would increase payments to Massachusetts hospitals in the coming year by \$248 million. This figure is widely at odds with the hospital industry's estimate of \$115 million.

HEALTH INSURANCE, Page 14

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champagne

clusion runs counter to argu-
ments by some scientists that
acid-rain damage is widening in
the United States and poses an in-
creasing threat to the nation's
lakes and forests. The report sup-
ports the Reagan administration's
position that acid rain does not
warrant new pollution controls.
(Washington Post)

Vrdolyak aligns with Republicans

CHICAGO - Edward Vrdolyak, who once headed one of the nation's most powerful Democratic machines but lost his bid to unseat Chicago's black mayor, has become a Republican, pledging to make the GOP the city's dominant party. "There is no future in the

Agency urges rules for fishermen, boats

WASHINGTON - The National Transportation Safety Board broke sharply with Reagan administration policy yesterday in saying sweeping regulations should be imposed on fishermen and fishing vessels to cut down on accidents and deaths at sea. Joseph T. Nall, a member of the independent federal agency, told a Senate subcommittee that the Coast Guard should mandate training for captains and crews, require licenses for captains, establish vessel stability standards, order added lifesaving equipment, require periodic vessel certification and bar on-board alcohol and drug use. Nall said the recommen-

ding from treatment and medica-
tion to preventing bedsores and
injuries. No state-by-state records
were made available. (AP)

N.Y. woman killed in escalator mishap

NEW YORK - A woman was killed yesterday when an escalator opened up at a New York Telephone Co. building and she was pulled in, police said. Emma Niskala, 35, of Lynbrook, was riding the down escalator to the mezzanine of the building in Brooklyn when the accident occurred at 7:45 a.m., police said. Officials said she was on her way to her job as an accounting clerk when the escalator mechanism failed and the bottom step opened. (AP)

Health plan cost seen eroding support

HEALTH INSURANCE

Continued from Page 1

tion in additional 1988 revenue, and nearly \$60 million more than the governor's figure.

Under the Dukakis plan, health insurance premiums would go up about 17 percent for the hospital component alone, according to the analysis, which administration officials say is in line with their revised figures.

When nonhospital components of health insurance premiums are added in, the typical policy could jump more than 20 percent in cost, said Massachusetts Blue Cross-Blue Shield president John Larkin Thompson.

Thompson said he considers the proposal as it is written to be "generous" to hospitals. "The new numbers by themselves don't lead us to withdraw from continuing to work on the bill," he said. "It's got to be seen somewhat in the sense of where the hospital industry is coming from, which was a number substantially higher than that. But if a higher number comes out of the process, we'd have a very difficult time living with it."

"I can't see how anybody could think it is too generous for hospitals," responded J. Antony Lloyd of Beth Israel Hospital, who said major teaching hospitals are working on a rebuttal to the big-business and insurer critique.

Spokesmen for big business groups, who had been generally supportive of the governor's plan or at least open-minded about it, said last night they are balking at its short-term costs. They also are raising fundamental objections about other features, such as the

requirement that all employers would eventually have to pay 80 percent of their workers' health insurance premiums.

"Based upon our present reading, the bill fails to contain costs in a significant way, and the move to mandate universal health insurance is too much too fast," said John Crosier of the Massachusetts Business Roundtable. "Yes, you can accuse us of being a little late with our criticism. We have tried to stay in discussion [with the administration] and understand how the numbers work. We come down concluding that it doesn't contain costs the way it was supposed to."

Richard Mastrangelo of Associated Industries of Massachusetts said his organization has decided that Dukakis should abandon his attempt to enact a broad health care reform bill - with the centerpiece of insuring the 600,000 residents now without coverage. He said the Legislature should merely "roll forward" the current hospital reimbursement law with some sort of cap on reimbursement for hospital free care and bad debt.

Not on board

"We're not getting on board because it's a different ship than we thought it would be, and it's not taking us to the same place we planned to go," said Mastrangelo.

The revised computation was done by a group that calls itself the purchasers of health care. It includes the Roundtable, Associated Industries, Blue Cross-Blue Shield and the Life Insurance Association of Massachusetts, representing commercial health insurance companies.

The analysis suggests that hospitals could count on at least 6 percent in total additional revenues next year. Those who pay premiums to Blue Cross and commercial insurers, the analysis concludes, would pay nearly 12 percent more in hospital costs to make up for shortfalls in Medicare and Medicaid payments.

The Massachusetts Hospital Association insists, on the other hand, that hospitals can count on only 2.3 percent more.

The hospitals' assumptions about their 1988 Medicaid and Medicare revenues also are strongly disputed. An industry fact sheet projects a \$40 million drop in Medicaid in the fiscal year beginning Oct. 1, and no increases in their Medicare payments, which account for about 40 percent of the total.

Dukakis administration officials, say, however, that Medicaid efforts to reduce hospital reimbursement for outpatient care and for patients awaiting nursing home placement will save, at most, \$20 million in 1988. They added that other increases in Medicaid payments to hospitals may offset those reductions.

The Medicare picture is less clear, since Congress has not yet acted on fiscal 1988 payment levels. However, Stuart Altman of Brandeis University, chairman of a national Medicare task force on hospital payments, said in an interview that Medicare payments to Massachusetts hospitals are likely to increase in the coming year.

"I don't understand why they're saying they'll get a zero increase," Altman said.

the contenders in the Democratic presidential campaign looked like characters out of Walt Disney's "Snow White and the Seven Dwarfs."

Now they look as if they're trapped in a reissue of the classic Agatha Christie novel "And Then There Were None" - with the press playing the role of killer.

With the withdrawal of Gary Hart amid reports of his relationship with Donna Rice and the controversy over Sen. Joseph Biden's unattributed use of the political speeches of others and his plagia-

happened 22 years ago, when Biden was in law school, rather than on "important issues," such as relations with the Soviet Union, jobs and literacy?

The answer, according to a number of political observers, reporters and press critics, is no.

What is happening instead, several suggest, is that the role of the press in a presidential campaign is changing.

"In the old politics, before 1968, the candidates were picked
PRESS, Page 4

Inside

Today: Sci-Tech

Red Sox take two

Roger Clemens picked up his 17th victory as the Red Sox beat the Orioles twice yesterday, 5-1 and 6-3. Page 45.

'Promise' wins 5 Emmys



"Promise," a drama about mental illness, won five Emmys last night, while "L.A. Law" won four awards for dominant NBC. Page 11.

The throwaway society

Combustion of waste, a method almost abandoned in the 1970s after federal Clean Air Act standards forced many older incinerators to shut down, has come back in demand in recent years. Sci-Tech, Page 33.

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Compromises reached on health plan

By Richard A. Knox
Globe Staff

The Dukakis administration agreed yesterday to make significant changes in the governor's proposed health plan in an effort to placate elderly, disabled and low-income constituents as well as organized labor.

However, one leading administration figure said last night that Dukakis will hold firm against hospitals' demands to increase their revenues next year, despite heavy industry pressure on legislators.

The compromises reached this weekend may signal that the administration has virtually abandoned its strategy of trying to hold together a diverse coalition of interest groups. One state official said the politics of the governor's plan "appear to be lining up in the traditional way" - consumers and labor unions in favor and business and hospitals against.

The proposal will have its first legislative hearing today before the House Ways and Means Committee.

HEALTH PLAN, Page 22

tal - \$3,149 - than in Massachusetts General Hospital - \$2,821, while Winthrop Hospital's price matched MGH.

The inconsistent hospital pricing is exhaustively documented in the first Massachusetts hospital price guide, published today by the Massachusetts Business Roundtable and the Massachusetts Health Data Consortium.

The document, nearly two inches thick, provides an unprecedented glimpse of what individual hospitals charge for 19 common surgical procedures as well as charges for vaginal childbirth. These charges often vary by thousands of dollars from one institution to another. They have heretofore been an industry secret so carefully kept that even hospitals did not know their competitors' prices - and sometimes their own - for a particular procedure.

The price guide "opens up the black box of hospital prices," said Debra Lerner, research director of the Data Consortium, which intends to update the survey annually.

One of the most "intriguing" findings, Lerner said on Friday, is that "the smallest of the community hospitals are frequently the most expensive."

For example, 183-bed Southwood Community Hospital in Norfolk charged \$2,895 for an uncomplicated hernia repair, while the median charge for the same procedure was only \$1,260 in 221-bed Emerson Hospital in Concord.

A dozen Massachusetts hospitals with fewer than 200 beds charged more than the statewide median of \$3,930 for uncomplicated abdominal hysterectomy, compared with higher prices in nine hospitals with more than 200 beds.

The guide is based on analysis of nearly 90,000 cases of hospitalization in the state's 109 acute-care hospitals. All involved people under age 65 who were insured at the time by Blue Cross and commercial carriers.

The purpose of the massive guide, which sells for \$275, is not to enable individual consumers to look up the cheapest place to deliver a baby or undergo cardiac surgery. In fact, its authors say they are concerned consumers would use such data to choose the most expensive hospital in the mistaken belief that high price stands for high quality.

HOSPITALS, Page 22

The price guide 'opens up the black box of hospital prices.'

- Debra Lerner,
research director,
Data Consortium

ary widely in state

community hospitals

ison among hospital charges for uncomplicated cases of gallbladder procedures. Other guides have lumped together routine cases and son more difficult, since some hospitals can claim their caseload those other institutions. While the new guide does not eliminate the sachusetts Health Data Consortium. Even in comparing only Median charges for a coronary artery bypass operation involving one spital to \$25,361 at St. Elizabeth's Hospital. The Massachusetts ic surgery programs, charged on the low end of the scale - \$14,607.

ER REMOVAL (Statewide: \$3,800)

	No. of Cases	Median charges
(200-plus beds)		
Regional	24	\$4,781
	17	4,517
	34	4,313
ial	41	4,270
	47	4,249
	65	4,200
	21	4,130
	23	3,599
th Serv.	30	3,508
	28	3,505
	59	3,418
	42	3,397
	36	3,363
	37	3,262
	32	3,256
	59	3,219
	36	3,181
	46	3,073
	22	3,035
	38	2,884
d	65	2,823
	40	2,820
	41	2,710
	32	2,696
	46	2,531
	35	2,404
	31	1,893

(less than 200 beds)

	13	\$6,569
	9	5,113
	9	4,483
y	17	4,411

ABDOMINAL HYSTERECTOMY (Statewide: \$3,930)

Hospital	No. of Cases	Median charges
Nonteaching (200-plus beds)		
Union (Lynn)	19	\$4,989
New England Memorial	54	4,676
Choate-Symmes Health Serv.	25	4,645
Charlton	114	4,379
Morton	36	4,236
Quincy City	36	4,187
Milford-Whittinsville Reg.	33	4,181
Leonard Morse	33	3,990
St. Joseph's	10	3,863
St. Luke's-New Bedford	115	3,794
St. John's	35	3,661
Norwood	67	3,651
Melrose-Wakefield	51	3,646
Winchester	92	3,470
South Shore	108	3,465
Goddard Memorial	93	3,441
Lowell General	77	3,430
Emerson	60	3,312
Cape Cod	83	3,167
Holyoke	28	3,099
Beverly	43	2,830
Lawrence General	58	2,803
Bon Secours	72	2,797
Sturdy Memorial	66	2,739
Mercy	61	2,716
Providence	61	2,527
Cooley Dickinson	72	2,418

Nonteaching (less than 200 beds)

Martha's Vineyard	17	\$7,379
Somerville	10	5,039
Anna Jaques	34	4,954
Farren Memorial	9	4,929

Compromises reached on health plan

HEALTH PLAN

Continued from Page 1

The compromises have apparently won over consumer advocates who were unsure Friday whether they would continue to support the governor's proposal, even though they strongly favor its primary goal - extending health insurance to 600,000 Massachusetts residents who now lack it.

The administration has backed away, for instance, from its attempt to begin the commercialization of Massachusetts Blue Cross-Blue Shield, a nonprofit company that is currently required to offer coverage to the elderly and to people who cannot buy group health insurance.

Advocates for the elderly were upset about the administration's perceived haste to change Blue Cross-Blue Shield's special social function, so that issue has been deleted from the proposal. Attorney General James Shannon had also expressed reservations about proposals relating to Blue Cross-Blue Shield.

It appeared last night that the compromises have had the intended effect on consumer advocates.

"The significant thing is that the parameters of the debate are now set, and the administration has decided that access to care for the elderly, the poor and the disabled will drive its policy decisions," said Susan Sherry of Massachusetts Health Action Alliance. "They have decided to stop trying to satisfy all the interest groups."

In fact, one new provision decided upon yesterday is certain to antagonize the insurance industry lobby. It would bar insurers from refusing coverage to anyone based on preexisting medical conditions.

This is apparently in response

Ludlow Hospital Society	17	4,411	Farren Memorial	9	4,929
Addison Gilbert	12	4,327	St. Luke's-Middleboro	14	4,912
Fairview	9	4,275	Ludlow Hospital Society	9	4,881
Whidden Memorial	21	4,235	Fairview	8	4,788
Anna Jaques	26	4,036	Marlborough	18	4,659
Marlborough	17	4,030	Addison Gilbert	28	4,438
Fairlawn	6	3,877	Whidden Memorial	20	4,448
Franklin Medical Center	14	3,595	Glover Memorial	6	4,104
Brookline	10	3,498	Santa Maria	19	4,034
Harrington Memorial	23	3,477	Brookline	16	3,897
Hubbard Regional	10	3,434	St. Anne's	29	3,621
Wilton	30	3,420	Franklin Medical Center	29	3,611
Haverhill Munic. (Hale)	34	3,356	Amesbury	10	3,602
Santa Maria	6	3,351	Hubbard Regional	8	3,601
Glover Memorial	11	3,284	Milton	25	3,557
Parkwood	7	3,281	Falmouth	20	3,521
St. Anne's	24	3,174	Haverhill Munic. (Hale)	83	3,481
Noble	24	3,084	North Adams Regional	30	3,427
North Adams Regional	17	3,061	Tobey	19	3,294
Leominster	23	2,979	Clinton	8	3,282
Henry Heywood Memorial	21	2,942	Henry Heywood Memorial	14	3,281
Amesbury	6	2,922	Hunt Memorial	49	3,257
Jordan	32	2,891	Wing Memorial	12	3,212
Falmouth	9	2,850	Leominster	44	3,090
Hunt Memorial	31	2,850	Harrington Memorial	20	3,022
Mary Lane	12	2,839	Noble	6	2,947
Tobey	12	2,793	Nashoba Community	17	2,672
Nashoba Community	12	2,151	Jordan	44	2,591
			Mary Lane	14	2,392

ages in fiscal year 1985
were insured by Blue Cross and commercial insurers

Boston teaching hospitals

GALLBLADDER REMOVAL (Statewide: \$3,800)

Hospital	No. of Cases	Median charges
Cambridge	7	\$6,770
Carney	17	6,295
St. Elizabeth's	21	5,757
Beth Israel	37	5,745
Framingham Union	49	5,640
Brigham & Women's	35	5,621
New England Deaconess	17	5,606
Children's	7	5,398
University	8	5,357
Faulkner	26	5,319
New England Medical	15	5,020
Massachusetts General	71	4,874
New England Baptist	24	4,649
Waltham Weston	29	4,304
Mount Auburn	36	4,159
Lahey Clinic	56	3,871
Newton-Wellesley	48	3,571

ABDOMINAL HYSTERECTOMY (Statewide: \$3,930)

Hospital	No. of Cases	Median charges
Boston City	11	\$20,763
University	25	7,896
Cambridge	12	6,849
New England Medical	24	6,686
Beth Israel	65	6,217
Brigham & Women's	303	5,934
St. Elizabeth's	62	5,822
Massachusetts General	103	5,535
Faulkner	25	5,443
St. Margaret's for Women	57	5,395
Carney	11	5,350
Framingham Union	101	5,246
New England Deaconess	50	5,096
New England Baptist	65	4,351
Mount Auburn	74	3,919
Waltham Weston	45	3,917
Newton-Wellesley	73	3,839
Lahey Clinic	93	3,834

ages in fiscal year 1985
were insured by Blue Cross and commercial insurers

This is apparently in response to concerns voiced by the parents of handicapped children that they were left out of the governor's plan, although it would also benefit many others who are currently uninsured or underinsured.

Secretary of Human Services Phillip W. Johnston acknowledged in an interview last night that the insurance industry will not be happy with the ban on preexisting condition clauses, a provision modeled after a proposal by Sen. Edward M. Kennedy that is currently before congress.

"I doubt that [insurers] will like it," Johnston said, "but many of the consumer groups and the disabled groups will. This has been a major issue for many of them, particularly the disabled. We think it makes sense at the state as well as the national level."

Johnston listed some of the changes that the administration will present to the Legislature today and said that others are still being discussed. Still under negotiation, he indicated, is language to "clarify our intent" about the broad powers that would be given to a new Massachusetts Health Partnership.

The administration has abandoned its attempt to make the partnership exempt from civil service requirements, a proposal that outraged labor groups. Johnston said other questions about the partnership's structure and authority are still being discussed.

"We have no monopoly on wisdom on these questions," Johnston said. "We're very interested in continuing to talk with advocates and legislators regarding these concerns."

Among the other compromises already reached, the administration has agreed to delete parts of the plan that would have required out-of-pocket payments from Medicaid patients and permitted the state to seize the property of nursing home residents, Johnston and consumer advocates said.

The administration has also agreed to an amendment that would entitle low-income elderly people, those whose incomes are under 200 percent of the federal poverty level, access to the state-mandated fund to finance hospital free care. Advocates for the elderly were especially anxious to get such guarantees because of a recently announced increase of 38 percent in federal Medicare premiums plus existing Medicare coinsurance and deductibles.

Johnston said the administration is still interested in addressing the status of Blue Cross-Blue Shield, the state's dominant health insurer, in the interest of a more competitive insurance market. He said this will be addressed in separate legislation "after this bill is passed."

The human services secretary said he believes the governor's health proposal will pass, with further changes, despite growing opposition to it among major business leaders, insurers and hospitals.

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For the record

Correction: Because of an editing error, a news analysis in Sunday's Metro/Region section about objections to Gov. Dukakis' proposed health plan incorrectly stated that the insurance industry favors granting the state authority to inspect individuals' bank and insurance records. The industry does not think the authority should have the power to inspect those records.

■ Comedian **Soupy Sales** says his infamous television ploy of the 1960s, when he jokingly told children watching his show to send him the "green pieces of paper" from their parents' pockets, has had lasting influence. "**Jim and Tammy Bakker** probably saw that show, and that's where they got the idea" for the PTL television ministry they founded, he said in a speech over the weekend at his alma mater, Marshall University in Huntington, W. Va. After Sales, whose nickname-Soupy is from a play on his real name, Milton Supman, told station officials that he received \$80,000 from the ploy, they suspended him for a week, he said. "If I'd have received all the money people said they sent me, I wouldn't be here talking to you," he said.

Kooped up

■ US Surgeon General **C. Everett Koop** and his wife, **Betty**, dropped in on "The Golden Girls" and sat around a table with the stars of the popular NBC-TV show after the taping of a new episode. Koop posed for pictures with **Bea Arthur**, **Betty White**, **Rue McClanahan** and **Estelle Getty**, who appear in the series as two widows, a divorcee and one of the women's mother. Koop remarked that he can't get his wife to go out on Saturday nights because she likes to watch the show, but he doesn't mind because he also likes it.

Symphonic pitch

■ Actor **John Hillerman**, who plays the cultured Higgins on the popular television series "Magnum P.I.," is pitching in to help the Houston Symphony in his home

to raise money for the symphony, according to a public relations firm handling the campaign. Hillerman, who has agreed to act as principal spokesman for the fundraising campaign, also will record radio spots urging Texans to send money to the orchestra, says publicist **Jim Schell**.



AP Photo

Wheels - Millionaire publisher **Malcolm Forbes** watches **Liz Taylor** try out the 1988 Harley Davidson motorcycle he gave her yesterday at his Bedminster, N.J., estate.

RO/REGION

Comics 28,29
TV & Radio 31

rally around magistrate town bigotry; charge unfair treatment

growing up Japanese in blue-collar Charlestown during World War II.

iano say he is the last
enter of a controversy
his sensitivity toward.

They say members of his family were once held in California internment camps during the war. And, they say, a generation later, Hamano's children endured taunts and racial slurs.

magistrate at Charles-
and bigotry firsthand,

But Hamano, friends and acquaintances say, is liv-
HAMANO, Page 32



Health bill advances

House panel adds \$192m for hospitals; sends it to floor

By Richard A. Knox
Globe Staff

Gov. Dukakis' universal health care plan whisked through the House Ways and Means Committee yesterday after the panel made significant changes and threw in an extra \$192 million in new 1988 revenues for the hospital industry.

The panel's action clears the way for floor debate on the measure beginning next Monday. But Democratic legislators warned that Dukakis had better start to lobby by House members personally on the controversial proposal if he wants to avoid its getting mired in weeks or months of delay.

Legislators said the political stakes for the governor's health legislation - which were already high - increased sharply yesterday after the resignation of John Sasso as Dukakis' presidential campaign manager. Sasso confessed to leaking material that caused Sen. Joseph Biden to withdraw from the race for the Democratic nomination.

"Now more than anything else [Dukakis] has to show a win on this to avoid the appearance that everything is unraveling," said one House Democratic leader. "If a motion to postpone this for 90 days prevails, his whole thrust and timing are off."

Dukakis hopes to make his proposal to guarantee health coverage for all Massachusetts residents a cornerstone of his campaign for the Democratic presidential nomination.

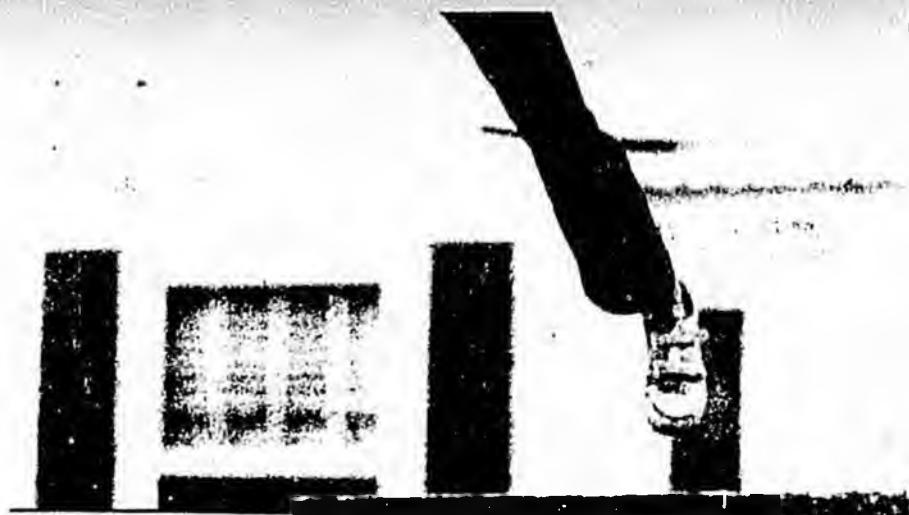
Rep. Richard Voke (D-Chelsea), chairman of the House Ways and Means committee, said in an interview yesterday that the proposal would not be a drag on the state's economy, as business leaders have argued.

"This is a good time to address these issues," he said. "I think we can provide these benefits to people and do it realistically. Other states probably couldn't. Here it's difficult but it's doable."

Voke had previously refrained from endorsing the governor's proposal, which is supported by House Speaker George Keverian (D-Everett).

The chairman added that he has "never seen as many constituencies involved in a bill - never."

The proposal, as reworked by the Ways and Means Committee chairman and staff in the last 10 days, maintains the main elements of the massive Dukakis



Dorchester takes a short leap off a fence post on his way home from school. Globe staff photo/David L. Ryan

many considerations involved in a bill. The proposal, as reworked by the Ways and Means Committee chairman and staff in the last 10 days, maintains the main elements of the massive Dukakis bill. The central idea is to push Massachusetts businesses to provide health insurance for 433,800 workers and dependents who can't buy it through the workplace. The House version also considerably enriches the proposal for hospitals, tries to meet some objections from the business community and trims the powers of a new state agency that would purchase or provide health coverage for 1.5 million or more people left uninsured by their employers. In one provision that has caused some confusion, the committee's version would permit Massachusetts businesses and municipalities that already provide insurance to pay 50 percent of the premium. Instead of the 75 percent required by the Dukakis bill, as long as the difference were offset by higher benefits. HEALTH INSURANCE, Page 30.

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City Council fires two Scondras aides

By Peggy Hernandez
Globe Staff

Two aides to a Boston city councillor were fired by the City Council yesterday because of their participation in a group that advocates the rights of people accused of, or victims of, homosexual activity between adults and minors.

The two men, Gary Dotterman and Junis French Wall, said yesterday that they are consulting attorneys and they vowed to continue working for Councilor David M. Scondras (Back Bay-Beacon Hill-Fenway-Mission Hill).

Because each councillor has retained hiring and firing controls over his or her staff by longstanding practice, yesterday's action was considered rare.

The dismissals were called for 11 days ago by Councilor at Large Albert L. O'Neil, who said that if Dotterman and Wall were retained, the council would appear to be indicating to the public that it tolerates child molestation.

Scondras labeled the 9-2 council vote "a witch hunt" and said he believes the two men were slandered and their civil rights violated. Scondras also accused his staff of "gross negligence." CITY COUNCIL, Page 48

Plaza in Bridgeport, construction workers in April. Concrete floor tore loose of steel beams and workers had to wrench up a section of the floor. Sources investigating the collapse said that numerous hydraulic jacks were used to support the floor - set off a chain reaction in less than 10 minutes.

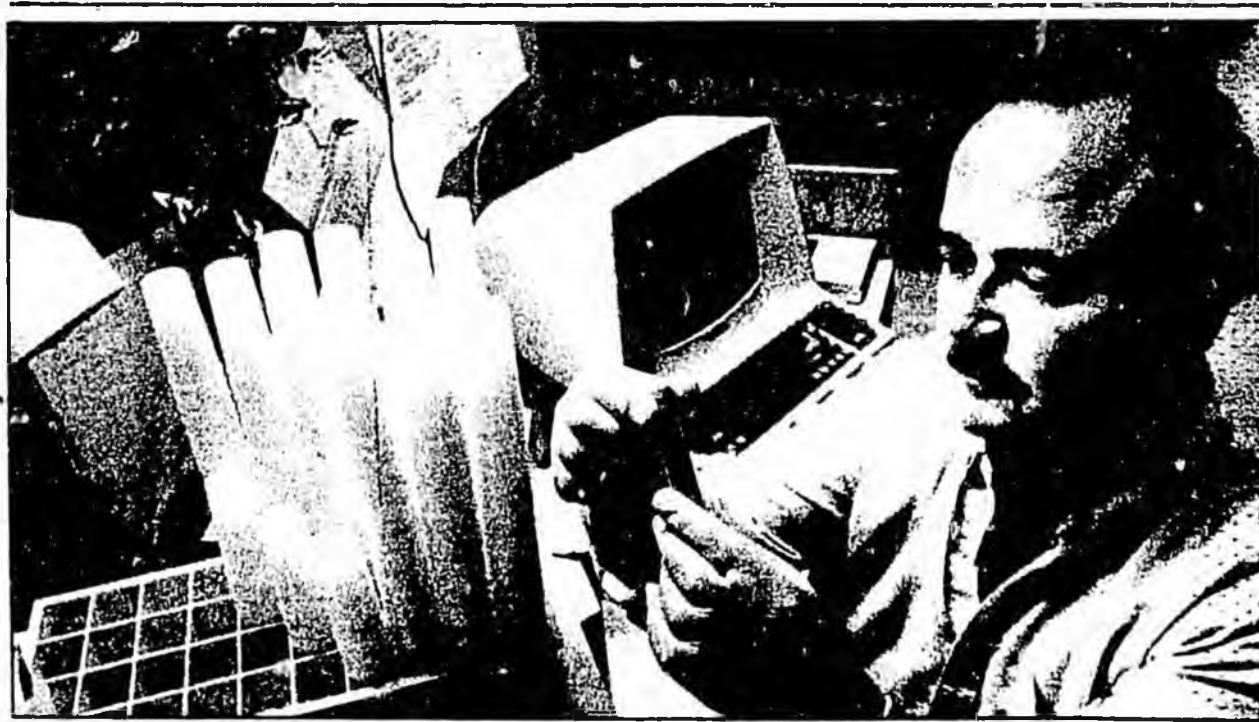
Investigation into the collapse said that numerous hydraulic jacks were used to support the floor - set off a chain reaction in less than 10 minutes.

ly to go. The structure was damaged by the collapse.

case is the worst in the state's history. The collapse was about 60 percent complete with seven floors complete and the rest of the floors under way. An adjoining wing was also under way.

being shifted into place above the seventh floor.

constructed using a controlled "lift-slab" method in which concrete was poured on top of steel columns by jacks and



A worker at the Fenway Community Health Center. Globe photo/John Moran

Fenway center in forefront of AIDS fight

By Joanne Ball
Globe Staff

A once-filthy basement of a former Fenway antiques store that a handful of neighborhood volunteers cleaned and renovated has emerged 16 years later as a

drome epidemic has tripled patient needs at the center's busiest neighborhood agency.

Last year the center, at the corner of Haviland Street and Edgerly Road, had 12,000 medical visits. About 20 percent of those were from AIDS patients. That percentage

Committee advances health care bill

■ HEALTH INSURANCE
Continued from Page 25

"This will allow a lot of existing insurance plans to keep what they have," said committee budget director David Lord.

Hospital lobby

Hospitals, which have lobbied House members intensely in recent days, convinced the committee to grant them about \$315 million in additional 1988 revenues, according to committee analysts. By comparison, administration officials have said their bill offered

hospitals about \$256 million more.

The committee also voted for a separate, six-month-old bill that would ensure an additional \$100 million in revenues for 39 hospitals deemed underfunded by the previous state hospital reimbursement law, which expired today.

The committee earmarked \$127.5 million of the increased revenues for wage increases of patient-care workers.

The \$415 million in new hospital revenues approved by the committee translates into about 18.5 percent more on the hospital bills

paid by Blue Cross-Blue Shield and commercial insurers, according to a committee analyst.

However, Massachusetts Hospital Association president Steven Hegarty said yesterday that his organization was still unsatisfied with the \$415 million in new hospital revenues approved by the committee. He said the \$5 billion-a-year industry must have an additional \$488 million in 1988.

Dukakis said yesterday referring to the Ways and Means package: "I certainly hope the line can now be held at these levels."

Delay attempts

Republican members of Ways and Means yesterday led several unsuccessful attempts to delay committee action on the governor's bill by 90, 30 and five days. "It's pretty clear that the Republicans will vote as a bloc next week to postpone action," said one majority member, adding that it was unclear how many Democrats might go along.

However, Rep. Iris K. Holland (R-Longmeadow), who voted for delay, predicted after the session that the House "will pass a bill that provides for universal access to health care, without question. The leadership has spoken.

"No one," Holland added in an interview, "wants to vote against universal access."

Judging from yesterday's committee session, numerous amendments will be proposed next week from both sides of the House chamber. Voke predicted that House debate on the bill will consume "a minimum of two and probably three to four days."

Both Dukakis and business spokesmen expressed concern that floor amendments would further inflate the proposal's cost, which the committee has already increased by hundreds of millions of dollars.

Dukakis said in a press statement that the cost of insuring the uninsured in the House panel's version "seemed to be close to those in our legislation." The administration says that provision would cost between \$588 million and \$636 million.

Voke called the administration's cost estimate "conservative" but said "we don't have a number" for the committee version's cost.

Welcom

By Ed Slegel
Globe Staff



NEW SEASON
9 p.m. Thursdays, Ch

Lord Peter Wimsey "Mystery's" got him. we saw the Roaring criminological cutup, and he was played by chael in a "Masterpiece series so popular it pre the impetus for WGBH to create "Mystery" a series.

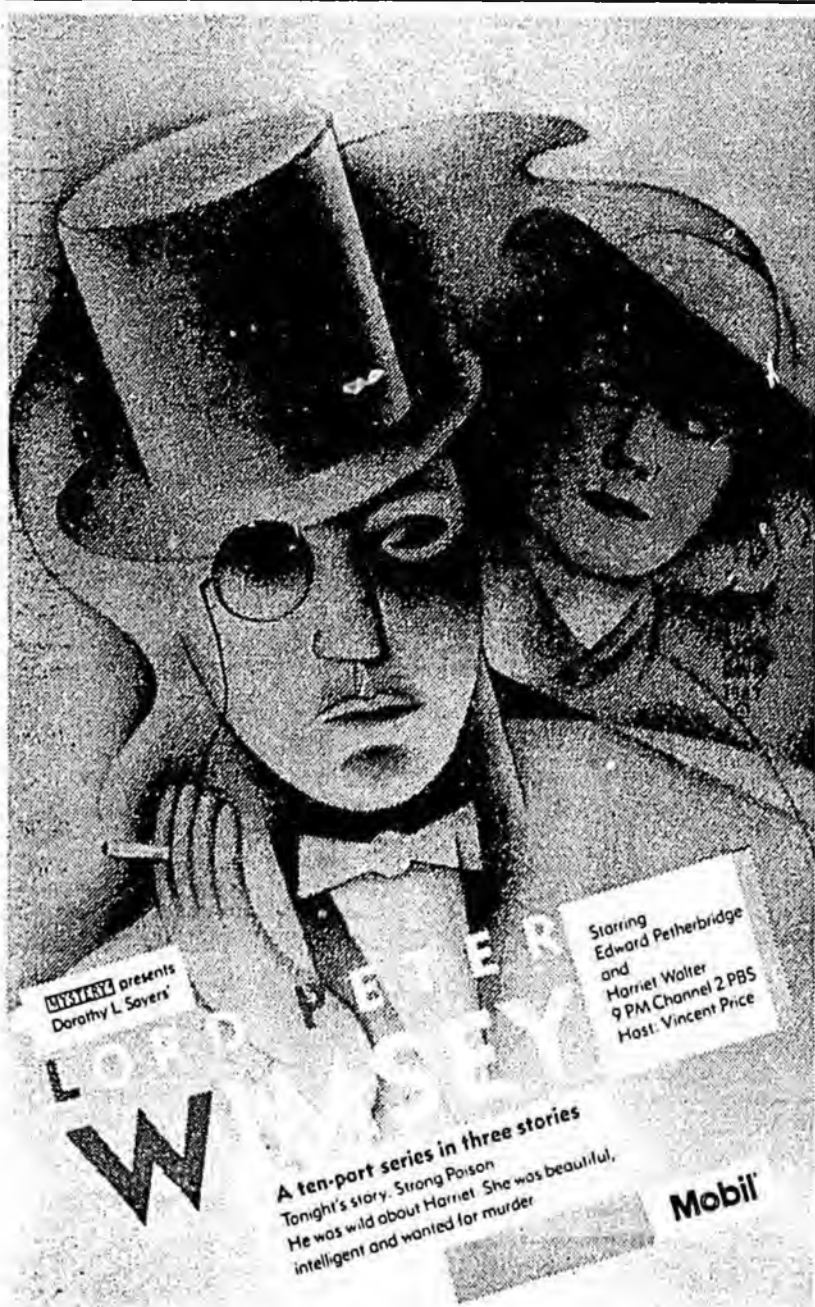
Carmichael has given Edward Petherbridge, locally noble Newmarket "Nicholas Nickleby." Timillar with both Dickensers, it may seem like a ble leap from Noggs but Petherbridge, like r British cohorts, has th make the jump comfort

Petherbridge brings but more substance to t ter than Carmichael. It understated performan seems in danger of di in the role, which was of his predecessor. On hand, there's more whi Wimsey, an everyman wardness that grants h mythic aura and there his pursuit of Harriet \ believable and affecting

WEATHER

Cloudy,

National Weather Service
Boston area: Considerable cloudiness, north west winds 15-25 m.p.h., highs 60-65 (16-18 C). Tonight, clear, lows 40-45 (4-7 C). Tomorrow, partly sunny, highs in mid-60s (18-19 C).



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Leo Dennis, ski director at the Killington Ski Area in Vermont, last night was considering opening temporarily one lift and one trail this morning for free skiing.

Globe photo/Vyto Starinskas

reached over 50 miles per hour and where more than 1½ inches of rain fell. The winds, said police at Boston Harbor, tore a handful of boats loose from their moorings in the harbor and the Charles River.

The weather service replaced forecasts of

rain and light snow with winter advisories yesterday morning for areas between the Hudson Valley and western New England.

"We weren't expecting the storm to be as strong as it was," said Wyllie. Cold air from SNOW, Page 8

le as court convenes

to be heard in new term

erin Hatch said yesterday President Reagan withdrew Robert H. nomination. Page 4.

That is an unsatisfactory outcome to an important case and the justice such cases a second front of a full court.

President Reagan nominated in July to replace the late Justice F. Powell Jr., Bork's nomination have argued that he should take the court to the right. Bork's nomination, often provided a fifth vote especially in upholding affirmative action.

It has a pivotal role and the nomination is presented by an eight-

member court were illustrated when Powell fell ill in early 1985 and missed nearly three months of the court's term. Of the cases heard during his absence, the justices issued five 4-4 decisions and ordered new arguments in three others.

Bork's potential impact on the court is significant. He has criticized scores of decisions expanding constitutional rights for women and minorities, reserving some of his most scathing commentary for rulings — including the one upholding the right to an abortion — that have been based on a constitutional right to privacy. Before the Senate Judiciary Committee, Bork said he would respect precedent.

He has also stated that capital SUPREME COURT, Page 4

Reagan salutes accord on trade with Canadians

From Wire Services

WASHINGTON — President Reagan yesterday hailed a new US-Canadian free trade agreement designed to eliminate tariffs over 10 years and cut restrictions on commerce between the North American neighbors. The accord was reached Saturday just before midnight under pressure of a congressional deadline.

"Now, in addition to sharing the world's largest undefended border, we will share membership in the world's largest free trade area," Reagan said in a statement released at the White House.

A Canadian official, however, warned that the pact could "easily unravel" in the next six months. CANADA, Page 7

the union would file an unfair labor practice charge with the National Labor Relations Board, and that if Wilson makes the drivers public employees, the union would sue to annul that move.

"What kind of education does Laval Wilson present to the world," Barrett asked. "Should workers no longer have the rights to bargain?"

Γ RIVERS, Page 31

A dilemma for state's hospitals

By Richard A. Knox
Globe Staff

The Massachusetts hospital industry, which has led the fight against Gov. Dukakis' proposal for universal health insurance, now finds itself in a political quandary.

Hospitals have been so successful in getting the Legislature to enrich the governor's proposal that it appears they cannot afford for it to lose.

The calculus works this way.

The House of Representatives, which begins debate on the proposal today, has several choices: Accept the current version, which Dukakis supports; prolong consideration for weeks or months, which could result in a stalemate like one that occurred last spring; or merely "roll over" the state's current hospital payment system, which expired last Wednesday.

If the House passes the plan and the Senate leaves its hospital payment provisions intact, the \$5 billion-a-year industry will be richer by \$252 million to \$348 million in the coming year, depending on whose estimate one believes.

But if the House kills the bill and merely extends the current hospital payment system — as many in the business community strongly advocate — hospitals will be poorer in 1988 by anywhere from \$60 million-\$75 million (an industry analyst's estimate) to \$124 million (the administration's estimate).

There are indications that the Massachusetts Hospital Association understands this. "We say HOSPITALS, Page 9

A political dilemma for the state's hospital industry

■ HOSPITALS
Continued from Page 1

that House 6068 [the current bill] would produce \$65-\$70 million more than if the current law were extended," said Larry Seck, an analyst on the association staff.

Many hospital administrators say privately the industry must begin to make hard choices about which institutions should survive rather than pursue the old strategy of raising the tide for everybody. But many add there is strong pressure not to break ranks at this critical juncture.

Publicly the industry group has stuck to its claim that it needs an additional \$544 million in revenue in 1988. This would require an additional \$200 million to \$300 million in the payment formulas within H6068.

"We do not feel the cost figures we've put forward are in any way unreasonable," hospital association president Steven Hegarty said last week. "Those are our legitimate needs."

"I'm perplexed by the hospitals' strategy," one Rate Setting Commission analyst said Saturday. "They are risking scuttling the bill, whereas they'd get more money from it than from the current system."

Nelson Gifford, chairman of the Massachusetts Business Roundtable's health care committee, agrees that hospitals would be considerably better off under the governor's proposal.

That is why Gifford, as a representative of employers who would pay increases in hospital bills through insurance premiums, called for a one-year rollover of the current system in an interview Friday. "We've got to hold the line

hospital efficiency. That has led many - inside and outside the industry - to question whether the public and business community ought to continue subsidizing inefficient and failing institutions.

There is broad agreement among industry analysts that previous and current hospital payment systems have protected such hospitals. New statistics from the state Rate Setting Commission and other sources, obtained by the Globe, reveal some of these wide disparities publicly for the first time.

They show, for instance, that the cost per inpatient hospital case, adjusted for severity of illness, is higher at many community hospitals than it is at the big-league Boston teaching hospitals. In nearly every case, these high-cost community institutions have very low occupancy rates but they have been able to jack up their charges to compensate for the loss of business.

Thus, the 1986 average cost per case at Norwood Hospital (\$5,134), Union Hospital of Lynn (\$5,341) and New England Memorial Hospital in Stoneham (\$5,528) is considerably higher than at Massachusetts General Hospital (\$4,985).

This is especially striking when one considers that MGH's sicker patients require care that is about 50 percent more intense, on average, than those community hospitals. MGH also has considerable teaching, technology and standby costs that the community hospitals do not have.

Similarly, 26 nonteaching hospitals had higher costs per case in 1986 than Harvard-affiliated Beth Israel Hospital.

Massachusetts hospital profile

The fewer patients, the more expensive occupancy and cost per case* in 1986

	Occupancy rate avg.	Cost per case*
All major teaching hospitals	72.3%	\$5,227
All minor teaching hospitals	65.6%	\$4,782
All community hospitals	58.4%	\$4,716
High-cost community hospitals	53.0%	\$5,657

*Cost per case is adjusted for severity of illness to make up for the fact that some hospitals admit more complex cases than others
Source: Massachusetts Rate Setting Commission, 1987

Globe staff chart

The real problem, Roper said, is that "there are a lot of hospitals in Massachusetts - more than necessary. We need to wring out the excess capacity."

Some hospitals will gain

A closer examination of the Medicare payment shift, however, also reveals that many institutions would actually gain from the new Medicare rates if their previous costs were below the national average.

Medicare gains for many of these low-cost hospitals range from 2 to 12 percent, with an average gain of 3 percent, according to state Rate Setting Commission estimates. Combined with a 17-percent jump in private payers' payments under H6068, these 39 low-cost hospitals should enjoy a 10 percent increase in 1988 revenues.

Teaching hospitals, on the other

hand, will probably lose from 4 to 7 percent in direct Medicare payments during the coming year, though this loss may be offset by slight increases in indirect costs, such as teaching and capital allowances.

Because teaching hospitals will suffer in the Medicare payment shift, the hospital association or a group of hospitals is expected to offer an amendment to H6068 this week that would redistribute some of the Medicare funds to teaching hospitals.

Since community hospitals are not expected to appreciate this, the hospital association is also pushing for enactment of a separate proposal before the House, H4692, that would funnel an extra \$83 million to \$100 million to low-cost hospitals.

The administration's main worry now is that the hospitals'

Mass. hospital costs

Inpatient expenses per admission in 1985 made Massachusetts hospital costs the most expensive among 12 industrial states of which the average cost per admission was \$3,025.64.

	Per admission
1. Massachusetts	\$4,193.71
2. California	\$4,049.96
3. New York	\$3,929.98
4. Michigan	\$3,666.40
5. Illinois	\$3,607.22
6. Ohio	\$3,427.50
7. Pennsylvania	\$3,412.17
8. Florida	\$3,381.46
9. Maryland	\$3,237.37
10. Indiana	\$2,911.64
11. New Jersey	\$2,914.07
12. Texas	\$2,798.88

Source: American Hospital Association and Health Planning Council of Greater Boston

Globe staff chart

money demands will sink the bill, and with it the opportunity to enact "health care for all." They argue this would not be in hospitals' interest.

As one analyst said this weekend: "I think hospitals should remember what Medicare and Medicaid has done for them and think twice about killing this bill."

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The Boston Globe

S U P E R S H U T T L E

pitals back from the gorging they've been doing," he said. "It's an orgy."

The House Ways and Means chairman, Richard A. Voke (D-Chelsea), and his staff also believe hospitals would do better under his committee's version of the bill than under the status quo.

Dukakis and his top officials argue that the extra 1988 money for hospitals is the short-term price the state must pay in order to pass universal entitlement to health care. But the governor is expected to plead with legislators this morning to "hold the line" on further hospital cost increases.

If the hospital association's strategy appears perplexing, the explanation may lie in the internal dynamics of the hospital industry, according to many observers.

Disparities revealed

Though hospitals have successfully presented a united public front in the past weeks and months, the debate over the governor's proposal has deepened schisms within the industry.

The debate has highlighted, for instance, the wide disparities in

Systemwide problems

These are major systemwide problems in the Massachusetts hospital industry, not isolated examples. Seven out of every 10 Massachusetts hospitals had occupancy rates below 70 percent in 1986, the most recent data. Lower occupancy tends to be associated with high costs per case.

Another major point of confusion in the recent debate concerns the failure of the federal Medicare program to increase payments to Massachusetts hospitals in 1988, despite rising costs for personnel, equipment, supplies and new burdens such as the costs of treating patients with acquired immune deficiency syndrome.

The hospital association argues that Massachusetts payers should make up for Medicare "shortfalls."

Medicare's chief administrator at the federal level, William Roper, said in an interview Friday that Massachusetts hospitals will lose about \$100 per Medicare inpatient case in the coming year as the program begins to pay them on national rather than regional rates.

Most expensive community hospitals in Mass.

	1986 figures	
	Occupancy rate avg.	Cost per case*
Marlborough Hospital	55.1%	\$4,834
J.B. Thomas Hospital	66.9%	\$4,853
Leonard Morse Hospital	63.8%	\$4,870
Fairview Hospital	9.0%	\$4,877
Hahnemann of Boston	67.2%	\$4,925
Somerville Hospital	51.1%	\$4,965
Parkwood Hospital	49.1%	\$5,021
Norwood Hospital	59.7%	\$5,134
Hale-Haverhill Hospital	69.2%	\$5,143
Lawrence Memorial Hospital	55.1%	\$5,164
Union of Lynn Hospital	55.0%	\$5,341
**Mary A. Alley Hospital	50.6%	\$5,392
Central Hospital	67.9%	\$5,525
New England Memorial	56.4%	\$5,528
Brookline Hospital	15.5%	\$7,355
Huntington General	26.0%	\$7,500
Southwood Hospital	53.7%	\$9,753
Average	53.0%	\$5,657

*Cost per case is adjusted for severity of illness to make up for the fact that some hospitals admit more complex cases than others

**Has since ceased inpatient services

Source: Massachusetts Rate Setting Commission, 1987

Globe staff chart



"Your mind is one of nature's most precious creations. You owe it to

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...ing off US oil purchases from that country, depriving it of currency that could be used to buy arms to fuel the Iran-Iraq war and attacks on shipping in the Persian Gulf, where a US task force is on duty escorting oil tankers.

It was the second time in a week that the Senate voted such a

...ents in the gulf. The action is considered somewhat symbolic because Iranian oil not purchased by the United States could easily be sold elsewhere.

The House measure, which differs slightly from the Senate version, also urges the United States to persuade Japan and US allies

EMBARGO, Page 4

Bus drivers, Wilson agree to arbitration

By Patricia Wen
Globe Staff

Superintendent of Schools Laval S. Wilson and striking bus drivers agreed last night to enter binding arbitration to end the 28-day walkout, leading both sides to predict buses may roll as early as tomorrow.

This proposed solution to the strike — which came as Wilson was starting the arduous task of hiring replacements — must be approved by the Boston School Committee to become effective. Committee President John A. Nucci

has scheduled an emergency meeting for 5 p.m. today.

The proposal unfolded when union members emerged from a three-hour membership meeting in Dorchester last night to say they would return to work as soon as school officials agreed to enter binding arbitration.

"There will be a return to work as soon as the document is signed," said Warren Pyle, an attorney representing the United Steelworkers of America, Local

DRIVERS, Page 12

Judge refuses to free mother

By Steve Curwood
and Diego Ribadeneira
Globe Staff

Essex County Probate Judge Haskell Freedman yesterday gave custody of Nicole LaLonde to his court's probation department and rescinded an order that granted temporary custody to her father after her mother, Virginia LaLonde, fled the state with her in June 1986.

Freedman made the ruling at a hearing at which Virginia LaLonde's lawyers asked the judge to give custody of the child to the Archdiocese of Boston and to free Mrs. LaLonde from prison, where she has been held for contempt since March 31.

Freedman did not explain why he chose to award custody of the child to the probation department of the Essex County Family and Probate Court. He said a written order will be released later.

Freedman added, "The child will be held at a hospital and evaluated by three court-appointed experts" to determine whether she has been sexually abused.



Judge Haskell

At the same bridge courtroom a request for temporary custody of the child to the archdiocese and LaLonde.

Mrs. LaLonde Herr, said yesterday appeal the ruling in the Massachusetts Court of a hearing has been Friday before Warner. Another

Inside

Today: Food

Cardinals beat Giants, 5-3

The Cardinals topped the Giants last night, 5-3, in the National League play-off opener. Page 79.

Development outlook



Officials said yesterday that private development in the center city in the early 1990s will have to take a back seat to public construction. Page 21.

Reagan shift on Latin plan

President Reagan, in a strategy shift, will voice support today for the Central American peace plan, aides said yesterday. Page 3.

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Classified 37-50, 89-100

Health bill faces overhaul

By Richard A. Knox
and Frank Phillips
Globe Staff

Gov. Dukakis' beleaguered health care bill faces a major overhaul after House leaders yesterday assessed the political damage from the first floor debate on the proposal Monday. State House sources said last night.

The governor got the bad news last night from a delegation of House leaders headed by House Speaker George Keverian (D-Everett). Emerging from a half-hour meeting, Dukakis acknowledged that more time will be needed to overcome strong opposition to the proposal.

Keverian and other leaders reportedly told Dukakis that the bill is in such trouble that fundamental changes may be needed. The governor and his chief secretary, Hale Champion, reportedly suggested some alterations in the proposal, "but nothing was resolved," one source said.

"It may not be something we'll be able to do overnight," Dukakis told a group of reporters as he left his office for a presidential campaign trip to Baltimore and Washington. "It may take time. But everybody knows that we've got to act on these issues."

At stake is Dukakis' high-visibility push to HEALTH, Page 37

The mirror



Robert Lewis (left) and Stuart Kermer at the site of a century-old Jamaican club

Dukakis' health bill faces overhaul

■ HEALTH
Continued from Page 1

make Massachusetts the first state to guarantee health insurance to all its citizens. The 155-page bill also attempts to control hospital costs.

The bill's fate is also wrapped up with Dukakis' presidential ambitions, not only as a bold initiative but also as demonstration of his managerial and political abilities. Before Monday, the administration, House leaders and even the Massachusetts Hospital Association were predicting that the health care bill would pass the lower chamber this week.

Last night, however, Dukakis left open the possibility that House consideration of the bill would be delayed beyond next Tuesday. The bill was postponed until then by a vote of 126-29 after it became evident that it would fail on a direct vote.

House leaders will be polling members today to determine how much support exists for Dukakis' "health care for all" proposal. Although Keverian declined comment, sources close to the leadership said last night that "something will be done tomorrow. There will certainly be some news about the bill tomorrow."

Others speculated this means the complicated proposal would be returned to the House Ways and Means Committee for a major re-drafting. The chairman of that committee, Rep. Richard A. Voke (D-Chelsea), made substantial changes in the original bill in an unsuccessful attempt to placate opposition from the hospital industry and business community.

"Strongly committed"

The governor said he needed to "get a better sense of what concerns legislators have and some of the

ways we can respond to that. If it takes a little longer than we thought, then we'll spend the time at it. We're all strongly committed to getting a good health care bill."

Some House leaders were critical of the administration's political strategy on the bill, saying the governor and his staff failed to counter the barrage of opposition from the hospital industry and small businesses to major features. The impact of small-business opposition in particular was underestimated, several said.

"Every one of us has been to the dry cleaners and barber shops and harangued about this. Our local people are crying survival," said one House leader. The administration "didn't give us the answers. We didn't have the ammunition to answer it."

One feature of the proposal would have required all businesses to provide health insurance for their employees or pay a 12 percent surcharge on the unemployment insurance premiums. This provision would hit small businesses especially hard, critics argued, since they often do not provide health insurance benefits now.

Critics in both parties yesterday placed the blame for the bill's troubles on Dukakis and his staff. They charged that the governor relied on House leaders to round up the votes he needed to pass the proposal and failed to lobby legislators personally to overcome stiff opposition from local hospitals and businessmen.

"There was a tremendous void in reacting to what was obviously going on on the House floor," said Rep. John Flood (D-Canton), chairman of the Joint Taxation Committee.

Sasso's absence

Flood and others said the bill's difficulties show that Dukakis is

suffering from the absence of long-time aide John Sasso, who had served as his chief secretary until resigning to become chief of his presidential campaign earlier this year.

"Sasso was always valuable in sensing the pitfalls," said Flood, whose relationship with Sasso was stormy. "The guy was very tuned in and anticipated the resistance and tensions. They didn't do it in this instance and they fell on a big one."

Sasso resigned from the campaign post last week after he admitted leaking a videotape that helped sink Sen. Joseph Biden's presidential bid.

Flood said he has had no contact at all with Champion, Sasso's successor as chief secretary and the main architect of the complex health care bill. "I've never met the man nor talked to him," Flood said.

Republican leader Steven D. Pierce (R-Westfield) charged that Dukakis' failure to move the health bill, which the governor identified as his highest legislative priority, reflects "how out of touch he really is."

"This really clashes with the overall campaign theme of managerial and political competence," Pierce said. "He talks over and over again of his great relationship with the Democratic Legislature. This really pulls the plug on that."

Champion last night brushed aside criticism that he failed to lay the political groundwork for the health care bill in the Legislature.

"Nobody is somebody else, and I have no aspirations to be somebody else," Champion said, referring to criticism that he had not been as politically skillful in moving the bill as Sasso might have been. "People have different styles, and I'd be the last to say that criticism of me is unwarranted."

However, one top legislative staffer argued that Sasso - and Dukakis - had never had to push such a complicated and controversial issue through the Legislature. "John Sasso never had to do anything like this," the staffer said.

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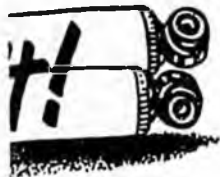
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House turns down GOP measure to shorten hospital fund extension

By Richard A. Knox
Globe Staff

Democratic leaders of the Massachusetts House won the first vote yesterday in their attempt to break the current legislative deadlock over Gov. Dukakis' massive health care reform proposal.

House Speaker George Keeverian (D-Everett) and other majority leaders are trying to extend the state's current hospital financing system until April. The move would put pressure on hospitals to compromise on their demands for up to \$544 million in additional revenue during the fiscal year that began Oct. 1.

At one point during yesterday's debate, Keeverian was on the floor lobbying individual House members — an unusual step for the speaker, observers said.

The House voted 103 to 41 against a Republican-sponsored motion to shorten the extension period to 60 days.

Although the issue seems procedural, State House observers said its outcome may decide the scope and the future chances of the Dukakis health plan, which includes a proposal to guarantee health insurance for all citizens as well as provisions to control hospital costs.

Time factor said crucial

The length of an extension is considered crucial by both sides, since a longer-term extension puts greater financial pressure on hospitals to compromise. Thus, if hospitals succeed in shortening the extension, their position in fur-

'I don't understand why we think we'll solve the problem by extending the current system six months. We're just going to exacerbate it.'

— Rep. Marjorie Clapprood

ther negotiations over cost control and other issues would be strengthened.

The House is scheduled to take up the extension bill again today, when legislators sympathetic to hospitals are again expected to offer amendments that would shorten the 6-month extension.

Hospital industry representatives said they were alarmed yesterday morning when they saw the language of the House leadership extension proposal, which they interpreted as a six-month freeze on hospital charges at the rates in effect on Aug. 1.

Confusion over this point led to heated exchanges on the House floor between Rep. Marjorie Clapprood (D-Sharon) and other hospital supporters and Richard A. Voke (D-Chelsea), chairman of the House Ways and Means Committee, author of the extension proposal.

"It's not a freeze and does not say that it is a freeze," Voke insisted.

"A freeze is a freeze is a freeze," responded Clapprood, saying she had been informed by Voke's own staff and members of the Ways and Means Committee that the proposal had that effect.

"I don't understand why we

they would like to avoid the need for substantive amendments, which they fear could lead to protracted procedural wrangling.

By extending the hospital financing system that expired Oct. 1, House leaders said, the measure would allow hospitals to raise their charges only about 4 percent. An increase of about 16 percent was contained in a Dukakis-House proposal that the hospital industry helped stave off last week. Hospital representatives said that proposal was not generous enough to cover their 1988 fiscal needs.

Rep. Peter Forman (R-Plymouth) argued that a six-month extension would put many hospitals "in serious financial difficulties."

"I understand that some have to send a message to the hospital community," Forman said. However, he added, "we have got to keep hospitals financially sound. We do that by a short-term extension" of the financing mechanism that expired Oct. 1.

Voke countered that a six-month extension, by applying pressure for a negotiated solution, would "save this system from chaos and, frankly, keep this legislative body from chaos with so many [legislators] running around with little pieces of a bill."

Could be shortened

Voke noted that a six-month extension of the current system could be considerably foreshortened if the involved parties could agree on a compromise before then.

Meanwhile, the governor's staff vowed to keep fighting for the administration's proposal to guarantee health insurance coverage for all Massachusetts citizens.

"We're still for health care for all," said Hale Champion, the governor's chief secretary. Dukakis will meet today with representatives of small business, a sector whose opposition was instrumental last week in persuading House leaders to withdraw the proposal from the floor before it was amended to death.

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responded Clapprood, saying she had been informed by Voke's own staff and members of the Ways and Means Committee that the proposal had that effect.

"I don't understand why we think we'll solve the problem by extending" the current system six months, Clapprood said. "We're just going to exacerbate it." Clapprood also said she favored splitting the universal health insurance part of the Dukakis plan from its hospital cost-control provisions - a step that most agree would kill the governor's health-care-for-all proposal.

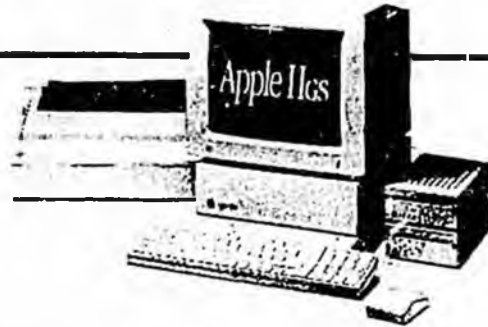
Want to avoid wrangling

Voke said in a subsequent interview he will attempt today to allay House members' concern about the freeze issue. "We don't think the bill is flawed," Voke said. If the proposal needs clarifying language, he said, it might be added today on the House floor. Voke and other House leaders said

will meet today with representatives of small business, a sector whose opposition was instrumental last week in persuading House leaders to withdraw the proposal from the floor before it was amended to death.

Sen. Patricia McGovern (D-Lawrence), chairman of the Senate Ways and Means Committee, also said she remains committed to the universal health insurance part of the legislation, though she is "not wedded to any particular way of doing it in terms of the strategy or the tactics." The Senate must await House action on the proposal, since it includes new state revenue-raising authority, and all tax matters must originate in the House.

"People need to keep speaking out that universal access to care is an achievable goal in this legislative session," said McGovern, who will speak about the subject this noon before statewide Community Action Program representatives.



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Dukakis health proposal may hitch a ride

McGovern exploring whether to use House bill as vehicle for universal health insurance

By Richard A. Knox
Globe Staff

The Massachusetts House yesterday passed and sent to the Senate a measure that might become a vehicle for Gov. Dukakis' universal health insurance proposal.

The House bill, passed on a voice vote, merely extended the state's six-year-old hospital financing system for another six months.

Sen. Patricia McGovern, chairman of the Senate Ways and Means Committee, said she is exploring whether some version of the governor's proposal could be loaded onto the limited House measure.

McGovern (D-Lawrence) said in an interview that she hopes the hospital financing extension bill could legally become the vehicle for universal health care access as well as hospital cost-containment reform, "but it has to be looked into." It might take a few days to decide, she added.

"Basically I think we should proceed right now to see what we can accomplish," McGovern said. "I think we should try to go as ag-

gressively at this as we can. . . . If we don't seize this moment, we'll deeply regret it, we'll lose the moment."

There was widespread speculation at the State House yesterday that McGovern would grab the initiative on the universal health insurance issue.

During House floor debate on the extension bill, Rep. Iris K. Holland (R-Longmeadow) asked the House Ways and Means chairman, Richard A. Voke (D-Chelsea), if the bill could be remodelled into a full-scale universal health insurance proposal in the Senate. "I have no idea what, if anything, would return from that chamber," Voke said.

"I believe this is what is going to happen: When this bill comes back to us, it will have attached to it Pat McGovern's version of a universal health insurance bill," Holland said in an interview. "What I anticipate is that we will have a universal health care bill this year and that it will be revised by Sen. McGovern."

Told about Holland's statement, McGovern laughed. "Let's see if Iris Holland is indeed cor-

rect," she said. "I wish Pat McGovern knew the answers."

The House also gave preliminary approval, also without a roll-call vote, to another bill that would provide an estimated \$100 million in additional 1988 revenue to 39 "underfunded" hospitals.

The second bill was reported out of the House Ways and Means Committee on Oct. 13 but had been held in the clerk's office until yesterday. The Massachusetts Hospital Association has pressed House Speaker George Keeverian for the bill's release. One hospital association leader said last week that Keeverian had pledged his support for the bill.

Catherine Dunham, the governor's director of human resources, speculated yesterday evening that the second bill, House 4692, "might become a vehicle too" for the universal health insurance package if the extension bill is deemed procedurally inappropriate.

"We're not that far away" from legislative approval of "the whole thing," Dunham said, referring to a proposal that would be-

gin the process of insuring the 600,000 Massachusetts residents without health insurance.

One important issue concerns the flow of money to about 30 hospitals that provide the bulk of the state's "free care." These funds, totalling more than \$315 million a year, are raised through a 13.25 percent surcharge on all hospital bills; the money is transferred from hospitals with low volumes of "uncompensated care" to hospitals with high volumes, such as Boston City Hospital, Carney Hospital and Brigham and Women's Hospital.

The state hospital financing law that expired Oct. 1 provided for the transfer of these funds. Until the extension bill is passed by the Senate and signed into law by the governor, there is no legal mechanism for the transfer.

Today — the 15th of the month — is when the accumulated funds are ordinarily paid to the hospitals with a high amount of free care. Thus, those institutions will begin to suffer financially from the current legal hiatus.

Dunham said the administration has been trying to persuade the hospital association to organize a voluntary transfer of the funds, but is not sure whether the hospitals will go along. Since hospitals strongly oppose a six-month extension of the old system, she said, the administrator has argued that they "should not give the Senate any excuse to pass the

extension bill."

Ten days ago, the House leadership abruptly withdrew the measure from floor debate in the face of overwhelming opposition from small-business representatives concerned that the Dukakis plan was too expensive and the hospital industry, which argued that it did not provide them enough money.

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