ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4566 HHES HB 440 (FILE 2)

OR - Denturists (80)

TN - School Psychologists (82)

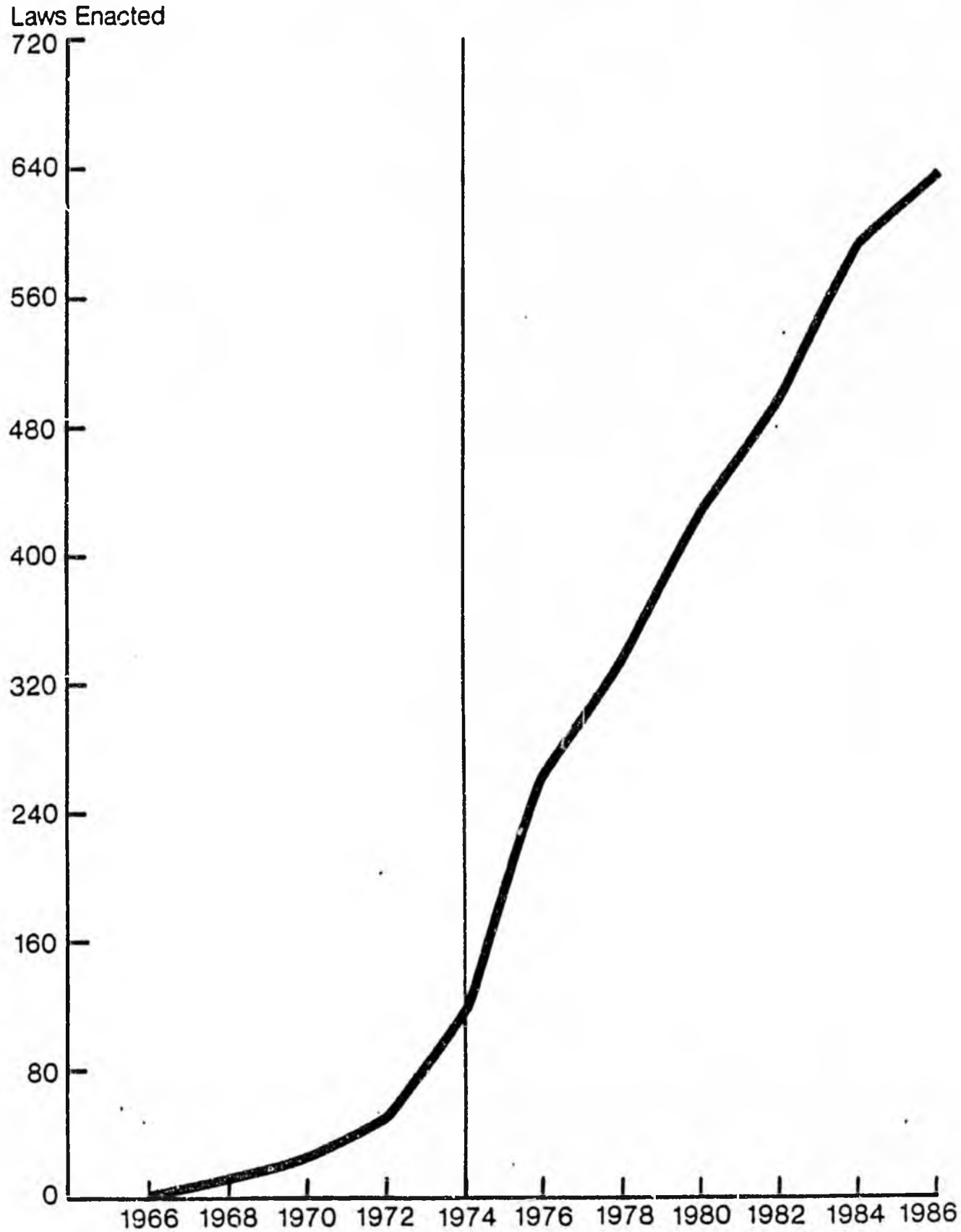
TX - OP Psychiatric Centers (83); Dietician (87)

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

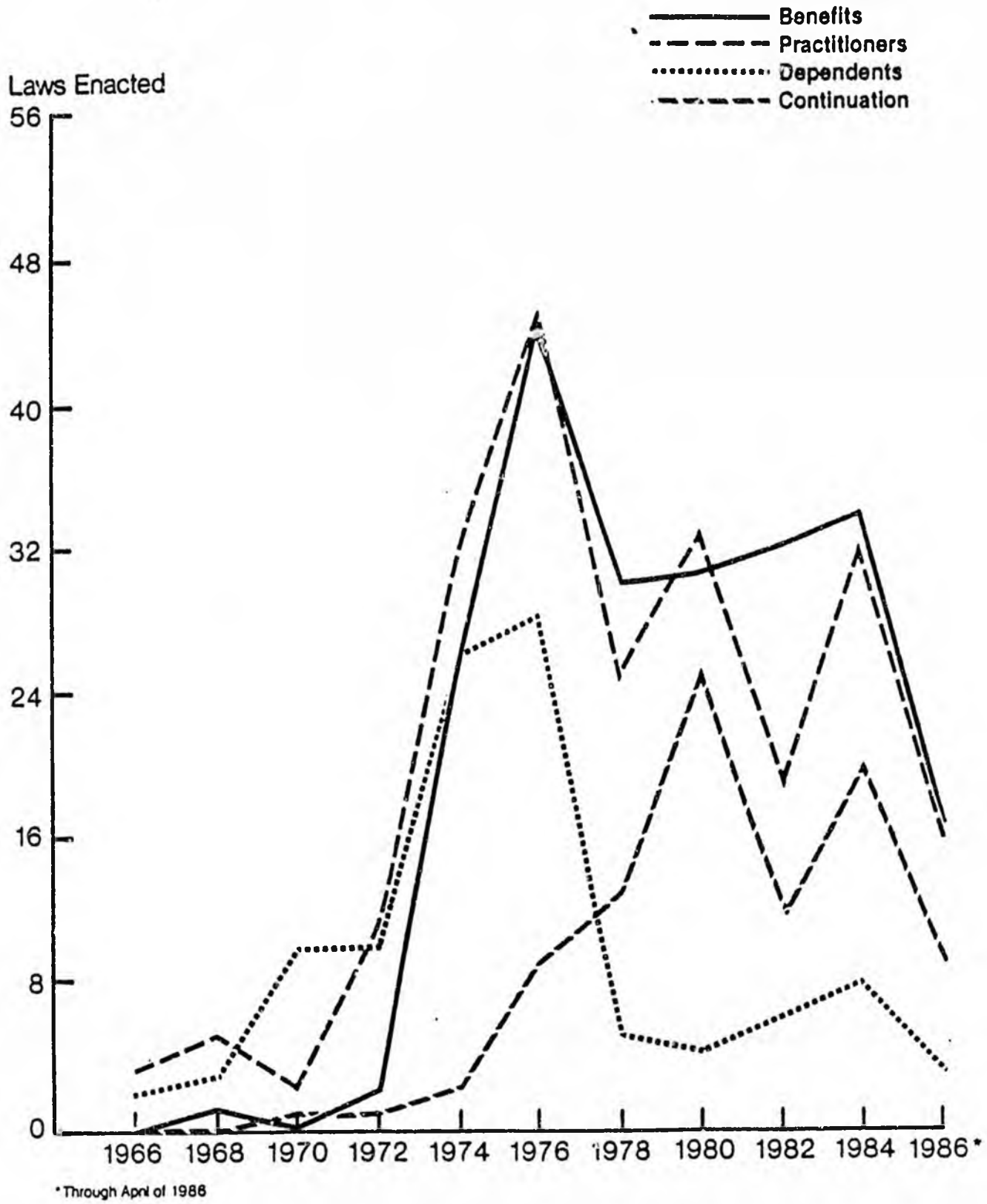
WA - Removal of a rider (87)

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

MANDATED COVERAGES
ALL TYPES
1965-1986 (APRIL)

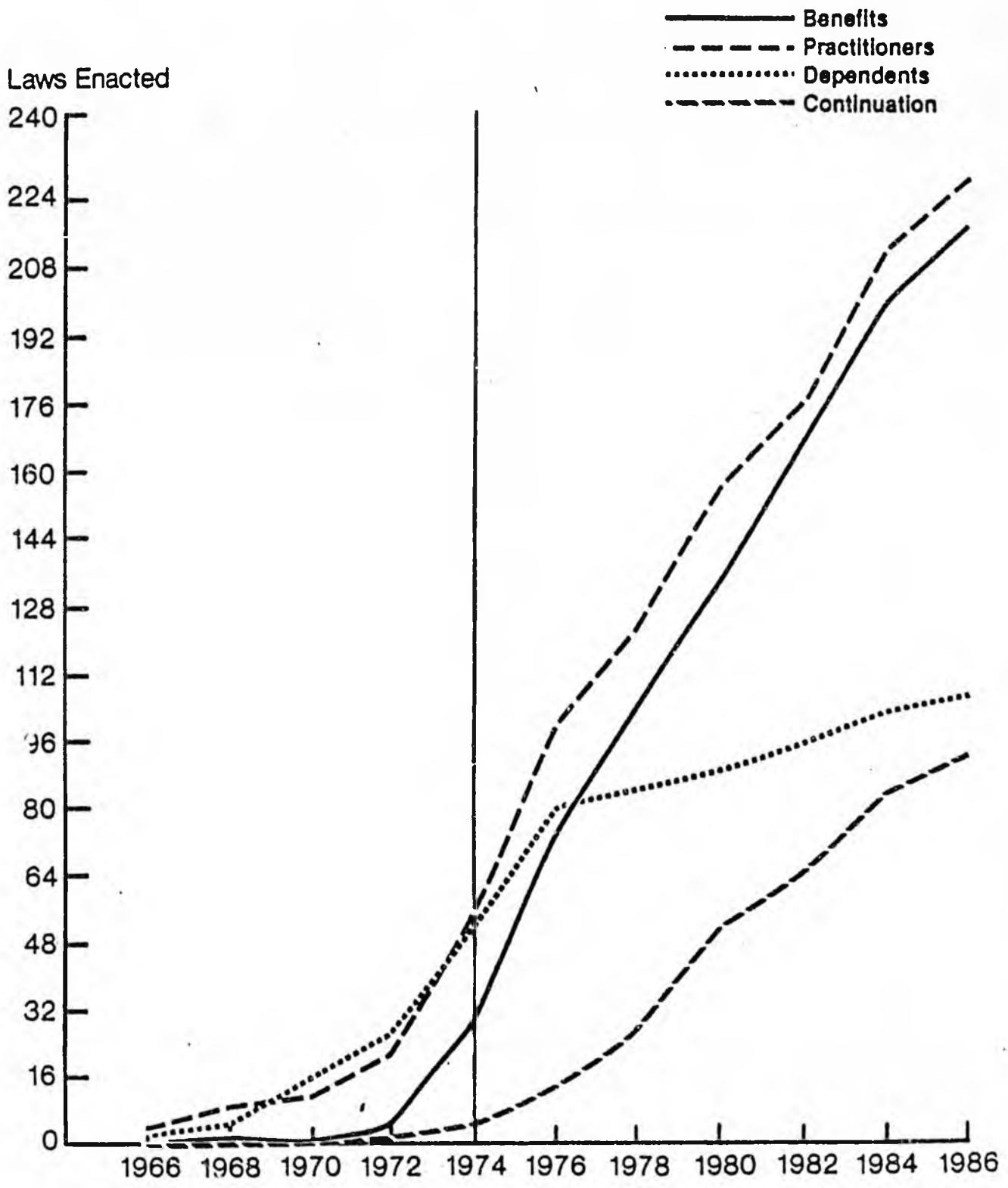


MANDATED COVERAGES PASSED PER BIENNIUM 1965-1986



*Through April of 1986

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



(7)

HOUSE COMMITTEE REPORT

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
[X] no recommendation
[ ] individual recommendations
[ ] additional referral to the ______ Committee

ADOPTS: [ ] ______letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact
[X] zero fiscal note
[ ] zero with analysis

[ ] same as previous fiscal note published ______
[ ] same as previous zero fiscal note published ______

SIGNING DO PASS:

[signature]

SIGNING OTHER RECOMMENDATIONS:

Walt Dooley - NO REC
Ellis - NO REC
Davidson (NO REC)
Whitmore
Burke No Rec
Kozma no rec

Walt Dooley
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

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
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.
BRU: Insurance
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 Phone: 465-2515
Division: Division of Insurance Date: February 25, 1988

Approved by Commissioner: 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)

dg10666K/022588a

STATE OF ALASKA
1988 LEGISLATIVE SESSION

Bill Version: HB 440
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to insurance coverage for treatment of infertility
Sponsor: Menard
Requestor:

Agency Affected: Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

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
Division: Retirement and Benefits
Phone: 465-4460
Date: February 18, 1988

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

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

Rev: 01/11/88

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 3/8/88

Commissioner John M. Andrews
Department of Administration

Date 3/9/88

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION
DIVISION OF RETIREMENT & BENEFITS
PLEASE REPLY TO:

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JUNEAU, ALASKA 99811-0203
PHONE: (907)465-4460

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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:

Note: Please Include Your Social Security Number In All Correspondence & Requests Concerning Your Benefits.

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

acog 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 (oligozoosperic 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 performed 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 laparascopy 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

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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.

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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
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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
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10. Personal Communication, Howard W. Jones, MD, 1983
11. Unpublished data, Richard P. Marrs, MD, 1983

April 1984

acog 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-

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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 OF 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 postfertilization 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

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 NEWS

(205) 251-9764

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

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

THE AMERICAN FERTILITY SOCIETY NEWS

(205) 251-9764

2131 Magnolia Avenue
Suite 201
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THE AMERICAN FERTILITY SOCIETY

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STATE MANDATED INSURANCE COVERAGE FOR INFERTILITY SERVICES

ARKANSAS

HAWAII

MARYLAND

MASSACHUSETTS

TEXAS

2/24/88

FERTILITY AND STERILITY
Vol. 41, No. 1, January 1984

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.

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*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 to 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
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.

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

ECTION 1.

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

ion 47H.

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

ECTION 2.

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

ion 8K.

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

CTION 3.

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

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.

Blue Cross
Blue Shield
of Massachusetts

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,

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 Isreal 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 Isreal 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 Isreal 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	Research Estimate
b.	Blue Shield Costs for Infertility	$0.08	$0.16	

211 CMR 37.00

INFERTILITY BENEFITS

Section:

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 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 ~~(7)~~ 14 amp. Pergonal	~~238.00~~ 476.00	
Ten (10) tabs Clomid (pharmacy charges)	40.00	
Estradiol x2	~~173.60~~ 185.80	
Ultrasound x1	~~50.00~~ 60.00	
TOTAL	$ ~~816.60~~ 1076.80	$ 816.60

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

Anchorage Obstetrics & Gynecology

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

Robert G. Thompson, M.D.
[illegible]

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	6.35		
				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.	56.00		
				272.00
	E. Emergency Room (3 injections)	61.50		61.50
	F. Operating room			
	OR 1¼ 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.	16.50		
				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	74.25		
				724.00
	TOTAL HOSPITAL COSTS:			$2,012.60

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

Anchorage Obstetrics & Gynecology

Richard T. Nist, M.D.
Diplomate of the American Board,
[illegible] American College
[illegible] and Gynecology

Robert G. Thompson, M.D.
[illegible]

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.)	996.00	
		$1,803.00
B. Anesthesiology	325.00	325.00
C. Radiology (U/S x4)	60.00	60.00
TOTAL AUP CHARGES		$2,188.00
TOTAL CYCLE CHARGES		$4,200.60
PAYMENT TO UNIVERSITY		$3,700.00
SAVINGS		$1,200.69

TOTAL CYCLE CHARGES (Day 1 through 8)	$1,836.60
(Day 9 through 16)	3,700.00
	$5,536.60

Resolve

Expenses - Infertility

$185.00 ↑ First Visit - not including blood work up.

$25.00 ↑ Semen Analysis

$1,700.00 (1979) Vericoceil

$55.00 day Artificial Insemination

$50.00 Sperm Washing

$110.00 Follicular Study (per day)
$50.00 (after first time)

$175.90 Progesterone Level (once per cycle)

$3,000-3,500 Laparoscope

$250.00 Blood Work up ~~Testosterone~~ Prolactine DHEA

$70.00 Sperm Antibody Test

$1,000 Source - (per cycle)

$30.00-60.00 Ovulation Predictor Test

$400.00-500.00 Lupron Injections (per month)

$25.00 Clomid - 50 mil @ 5 pills per month

$476.00 Pergonol

$300.00 Hysterosalpingogram

$165.00 ↑ Pap Smear

6
+ft

Anchorage Obstetrics & Gynecology

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

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

March 16, 1988

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

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

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.

Bob Larson

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 ½ 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 6%.

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 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.)

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.

(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

University of Washington School of Medicine, Seattle

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, 19 87
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:

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

"§431- In vitro fertilization procedure coverage. All individual and group health insurance policies 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 insured or the insured'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 the insured or covered dependent of the insured;

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

spouse's sperm;

(4) The:

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

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

(i) Endometriosis;

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

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

(iv) Abnormal male factors contributing to the infertility.

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

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

dependent of the subscriber or member;

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

(4) The:

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

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

(i) Endometriosis;

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

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

(iv) Abnormal male factors contributing to the infertility.

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

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

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 1 1 1987

E0854

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.

E8723
HRO/1323m

Respectfully submitted,

MAZIE HIRONO, Chairman

KENNETH HIRAKI, Vice Chairman

MARK J. ANDREWS, Member

REB BELLINGER, Member

ROMY M. CACHOLA, Member

DAVID HAGINO, Member

JOAN HAYES, Member

WAYNE METCALF, Member

HENRY H. PETERS, Member

MITSUO SHITO, Member

DWIGHT Y. TAKAMINE, Member

DWIGHT L. YOSHIMURA, Member
excused

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

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To Nome
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IDITAROD '88

MIDWEEK
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Frontiersman

25¢

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Weatherlines

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)

House Bill 440
Bill File

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 cure 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 insurance 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 benefitting 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 though several such surgeries and at least a half dozen artificial 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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on, she said.
tate is also trying to get
ts from Hudson's Bay, an
ional marketer of furs, and
s from Chocktaw.
es of cruelty to animals
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State Troopers Fish and
e Protection office, said
chard Graham. Charges, if
ould be filed in about 10
e said.
plight of the foxes and the 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 officers found the farm Friday with carcasses of skinned foxes strewn about the property and cages uncleaned for months. The animals had been poorly looked after and some died either from thirst, starvation or disease.

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

phenomenon seems to have
ied during a freak snow-
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descended on the area for
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shine as quickly as it came.
flash storm apparently set
perfect conditions to devel-
snow rollers," said Mark
gelista, a meteorologist with
ational Weather Service. A
roller recipe requires a very
wind in the upper air, that
break apart snowflake
es, along with stronger wind
20 feet above the ground.

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 seconds before it cools down.

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

"They're probably rare in Minnesota 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 insurance companies, who don't like the "mandatory coverage" wording and the extra costs they will have to pass on.

The cost to the state for the change would be minimal, Menard said. A rough guess of the cost to insurance companies is $36 per year per individual covered. The legislation is aimed at group insurance plans which already offer pregnancy coverage.

Menard could give the bill no better than a "fair" prognosis this term. Supporters might have to settle for a compromise suggesting, rather than requiring, companies provide the coverage.

"If nothing else, we've surfaced the issue this year and we can regroup 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 treatments and transplant operations—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 Cottles. 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 biological clock is ticking.

"Everything else revolves around it," Toni said of their infertility. "It affects your life every day. But the worst time is Christmas 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 limited number of years to conceive even one child.

In the meantime, they agree adoption isn't an acceptable alternative.

"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 into it already. There's an $8,000 to $10,000 adoption fee and a three year wait for a Caucasian baby."

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 ampligen.
- **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, 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.

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.

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

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

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April 19, 1988

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Patricia Brawley
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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[1]Lori B. Andrews, J.D., New Conceptions: A Consumer's Guide to the Newest Infertility Treatments, Including In Vitro Fertilization, Artificial Insemination, and Surrogate Motherhood (New York: St. Martin's, 1984), p. 3.

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]

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[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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[3]Lewis J. Lord, et al., "Desperately Seeking Baby: Ten Million Americans are Struggling to Have Children," U.S. News & World Report, October 5, 1987, p. 58 (6).

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.)

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

[5]This comparison will exclude Arkansas: the Insurance Department Legislative Liaison was unable to provide any information about it within the time constraints of this project.

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 costhad 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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[6]Gail Harris, Senior Analyst in Medical Policy Development, Blue Cross-Blue Shield of Maryland indicates that no charges of discrimination have yet arisen over either aspect of the law.

[7]This figure represents costs for IVF and AIH only. Services and treatments related to these procedures, such as blood work, ultrasound, and laparoscopy--each of which costs over $1,000--would not be included in this figure because they are generally already covered and because there is no system to document the relationship to IVF or AIH.

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
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(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

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[1]Lori B. Andrews, J.D., New Conceptions: A Consumer's Guide to the Newest Infertility Treatments, Including In Vitro Fertilization, Artificial Insemination, and Surrogate Motherhood (New York: St. Martin's, 1984), p. 3.

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]

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 A.

The American Fertility Society currently lists 263 clinics which are certified by the American College of Obstetricians and Gynecologists. "Certification" indicates that at least one staff member has a subspecialty in reproductive endocrinology and has passed the American College of Obstetricians and Gynecologists' board exam. (I will forward this list upon its arrival.) 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.

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[2]"The Grueling Baby Chase," Newsweek, November 30, 1987, pp. 79-81.

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 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.

Arizona, 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.

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[3]Lewis J. Lord, et al., "Desperately Seeking Baby: Ten Million Americans are Struggling to Have Children," U.S. News & World Report, October 5, 1987, p. 58 (6).

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

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. (I will forward a copy of this statute to you upon its arrival.)

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 B for full text.)

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

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[5]This comparison will exclude Arizona: the Insurance Department Legislative Liaison was unable to provide any information about it within the time constraints of this project.

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 C 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 D 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 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.)

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[6]Gail Harris, Senior Analyst in Medical Policy Development, Blue Cross-Blue Shield of Maryland indicates that no charges of discrimination have yet arisen over either aspect of the law.

[7]This figure represents costs for IVF and AIH only. Services and treatments related to these procedures, such as blood work, ultrasound, and laparoscopy--each of which costs over $1,000--would not be included in this figure because they are generally already covered and because there is no system to document the relationship to IVF or AIH.

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 E.) I have also included a report by the Alan Guttmacher Institute, entitled "Infertility Services in the United States: Need, Accessibility and Utilization," (Attachment F); a Research Note from Family Planning Perspectives, entitled "The Need and Unmet Need for Infertility Services in the United States," (Attachment G); and "Desperately Seeking Baby," from U.S. News and World Report, (Attachment H).

* * *

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:

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

☒ *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

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 prosthetis 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.

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

Sincerely,

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 99697
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.

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:

Note: Please Include Your Social Security Number In All Correspondence & Requests Concerning Your Benefits.

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

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 IMPERIATIVE 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

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

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

NAME: CAROL WATERS
TITLE:
ADDRESS: 10300 HILLSIDE DR.
CITY: ANCHORAGE ZIP: 99516
PHONE: 346-3148
BILL NO: HB 440
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

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ADAMS
BOUCHER
BROWN
COLLINS
DAVIDSON
DONLEY
FRANK
GOLL
GRUSSENDORF
HERRMANN
HUDSON
LARSON
MILLER
PEARCE
PHILLIPS
RIEGER
SPRINGER
SWACKHAMMER
ULMER
ZAWACKI

BARNES
BOYER
CATO
COTTEN
DAVIS
ELLIS
FURNACE
GRUENBERG
HANLEY
HOFFMAN
KOPONEN
MARTIN
NAVARRE
PETTYJOHN
POURCHOT
SHULTZ
SUND
TAYLOR
WALLIS

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

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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PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

RECEIVED

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

NAME: JENALEE HEIKES
TITLE:
ADDRESS: P O BOX 520529
CITY: BIG LAKE ZIP: 99652
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.

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

COM

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE MENARD

NAME: MICHAEL O'BRIEN
TITLE:
ADDRESS: PO BOX 995
CITY: PALMER ZIP: 99645
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.

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 ZIP: 99511
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.

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

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DAVIDSON	DAVIS	ELIASON
DONLEY	ELLIS	FAHRENKAMP
FRANK	FURNACE	FAIKS
GOLL	GRUENBERG	FANNING
GRUSSENDORF	HANLEY	FISCHER
HERRMANN	HOFFMAN	HALFORD
HUDSON	KOPONEN	HENSLEY
LARSON	MARTIN	JONES
MILLER	NAVARRE	JOSEPHSON
PEARCE	PETTYJOHN	KELLY
PHILLIPS	POURCHOT	KERTTULA
RIEGER	SHULTZ	RODEY
SPRINGER	SUND	STURGULEWSKI
SWACKHAMMER	TAYLOR	SZYMANSKI
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 emcompass 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."