Senate

General Assembly

File No. 765

January Session, 2005

Substitute Senate Bill No. 508

Senate, May 17, 2005

The Committee on Public Health reported through SEN. MURPHY of the 16th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR INFERTILITY TREATMENT AND PROCEDURES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2005*) (a) Subject to the limitations set forth in subsection (b) of this section and except as provided in subsection (c) of this section, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state on or after October 1, 2005, shall provide coverage for the medically necessary expenses of the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. For purposes of this section, "infertility" means the condition of a presumably healthy individual who is unable to conceive or produce

conception or sustain a successful pregnancy during a one-year period.

(b) Such policy may:

(1) Limit such coverage to an individual until the date of such individual's fortieth birthday;

(2) Limit such coverage for ovulation induction to a lifetime maximum benefit of four cycles;

(3) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of three cycles;

(4) Limit such coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer to a lifetime maximum benefit of two cycles, with not more than two embryo implantations per cycle;

(5) Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful;

(6) Require that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;

(7) Limit coverage to individuals who have maintained coverage under such policy for at least twelve months; and

(8) Require disclosure by the individual seeking such coverage to

such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. Such disclosure shall be made on a form and in the manner prescribed by the Insurance Commissioner.

(c) (1) Any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital or medical service corporation, or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

(d) Any health insurance policy issued pursuant to subsection (c) of this section shall provide written notice to each insured or prospective insured that methods of diagnosis and treatment of infertility are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

(e) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization.

Sec. 2. Section 38a-536 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

[Any insurance company, hospital service corporation or medical service corporation authorized to do the business of health insurance in this state shall offer to any individual, partnership, corporation or unincorporated association providing group hospital or medical

insurance coverage for its employees a group hospital or medical service plan or contract providing coverage for the medically necessary expenses of the diagnosis and treatment of infertility, including in-vitro fertilization procedures.**]**

(a) Subject to the limitations set forth in subsection (b) of this section and except as provided in subsection (c) of this section, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after October 1, 2005, shall provide coverage for the medically necessary expenses of the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. For purposes of this section, "infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception **[**, or retain a**]** or sustain a successful pregnancy during a one-year period.

(b) Such policy may:

(1) Limit such coverage to an individual until the date of such individual's fortieth birthday;

(2) Limit such coverage for ovulation induction to a lifetime maximum benefit of four cycles;

(3) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of three cycles;

(4) Limit such coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer to a lifetime maximum benefit of two cycles, with not more than two embryo implantations per cycle;

(5) Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to

those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful;

(6) Require that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;

(7) Limit coverage to individuals who have maintained coverage under such policy for at least twelve months; and

(8) Require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. Such disclosure shall be made on a form and in the manner prescribed by the Insurance Commissioner.

(c) (1) Any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer a group health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital or medical service corporation, or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

(d) Any health insurance policy issued pursuant to subsection (c) of this section shall provide written notice to each insured or prospective insured that methods of diagnosis and treatment of infertility are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

(e) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization.

Sec. 3. (NEW) (*Effective October 1, 2005*) (a) Any clinical practice in this state that performs in-vitro fertilization, gamete intra-fallopian transfer or zygote intra-fallopian transfer procedures that are covered by insurance shall report the following information to the Department of Public Health, not later than February first following any year such procedures were performed:

(1) The number of such procedures performed;

(2) The number of multiple births or conceptions with a breakdown of the number of births or conceptions per pregnancy;

(3) The number of procedures attempted before a successful implantation (A) per patient on average, and (B) grouped by the number of attempts required;

(4) The number of embryos implanted (A) per patient on average, and (B) grouped by the number of attempts required;

(5) The pregnancy rate (A) per patient on average, and (B) grouped by the number of attempts required; and

(6) The rates of complications.

(b) Such information shall be submitted on such forms as the department prescribes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2005*	New section
Sec. 2	*October 1, 2005*	38a-536
Sec. 3	*October 1, 2005*	New section

PH *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
State Comptroller - Fringe Benefits	Various – Potential Future Cost
Public Health, Dept.	None

Municipal Impact:

Municipalities	Effect
Various Municipalities	Potential Cost

Explanation

The bill requires certain health insurance policies to cover medically necessary infertility diagnosis and treatment and specifies permissible coverage limitations and requirements. It is not possible at this time to determine if the bill will have any future impact to the state employee health insurance premium, according to the Office of the State Comptroller. Any state impact is not anticipated to occur until FY 08 when the state enters into new employee health insurance contracts.

It is anticipated that the Department of Public Health will be able to provide forms for use by clinical practices when reporting data required within Section 3 of the bill without requiring additional resources.

The bill's impact on municipal insurance costs will vary based on existing municipal coverage. To the extent that the coverage mandated under the bill is not currently provided under a municipality's employee health insurance policy, there could be increased municipal

premium costs to provide it.

OLR Bill Analysis
sSB 508

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR INFERTILITY TREATMENT AND PROCEDURES

SUMMARY:
This bill requires certain individual and group health insurance policies to cover the medically necessary costs of diagnosing and treating infertility. It specifies permissible coverage limitations and requirements. It also permits individuals and religious employers to exclude infertility coverage if it is contrary to their religious tenets. The bill repeals current law, which requires insurers and HMOs to only offer infertility coverage to group plan sponsors, who can reject or accept it.

The bill requires a clinical practice that performs insurance-covered in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), or zygote intra-fallopian transfer (ZIFT) procedures to report certain information to the Department of Public Health (DPH) on forms it prescribes by February 1 following any year it performs the procedures.

The bill applies to policies delivered, issued, amended, renewed, or continued on and after October 1, 2005 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including HMOs.

EFFECTIVE DATE: October 1, 2005

INFERTILITY COVERAGE

The bill requires health insurance policies to cover medically necessary expenses incurred for the diagnosis and treatment of infertility, including ovulation induction, intrauterine insemination, IVF, uterine embryo lavage, embryo transfer, GIFT, ZIFT, and low tubal ovum transfer. The bill defines "infertility" as the inability of a presumably healthy person to conceive or produce conception or sustain a successful pregnancy during a one-year period.

COVERAGE LIMITATIONS AND REQUIREMENTS

A policy can:

1. limit coverage to people under age 40;

2. limit ovulation induction coverage to four cycles;

3. limit intrauterine insemination coverage to three cycles;

4. limit IVF, GIFT, ZIFT, or low tubal ovum transfers to two cycles and two embryo implantations per cycle;

5. require covered services be performed at facilities that conform to the standards and guidelines developed by the American Society for Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;

6. limit coverage to people who have been covered by the policy for at least 12 months;

7. require a person seeking infertility coverage to disclose to her insurer on a form developed by the insurance commissioner any previous infertility treatment or procedures for which she received coverage under a different health insurance policy; and

8. limit IVF, GIFT, ZIFT, and low tubal ovum transfers to people who have used less expensive and medically viable treatments or procedures covered under the policy but remain infertile. But, coverage cannot be denied if a person forgoes a particular treatment when her doctor determines that it is unlikely to be successful.

RELIGIOUS EXEMPTION

An insurer or HMO can issue a religious employer a health insurance policy that excludes infertility diagnosis and treatment coverage that is contrary to the religious employer's bona fide religious tenets.

If a person states in writing that infertility diagnosis and treatment is contrary to his religious or moral beliefs, an insurer or HMO can issue

him a policy or rider that excludes such coverage.

An insurer or HMO that issues a policy excluding the infertility coverage because of the religious exemption must give written notice of the exclusion to each insured or prospective insured. The notice must appear in the policy, application, and sales brochure and be in at least 10-point type.

A "religious employer" is a "qualified church-controlled organization," as defined in federal law, or a church-affiliated organization. Federal law defines "qualified church-controlled organization" as a church-controlled tax-exempt organization, other than one that (1) offers goods, services, or facilities for sale to the general public, other than those sold at a nominal charge that is substantially less than the actual cost and (2) normally receives more than 25% of its support from either (a) government sources or (b) receipts from admissions, merchandise sales, services performed, or facilities furnished (26 USC § 3121).

REPORTABLE INFORMATION

A clinical practice must report to DPH the (1) number of insurance-covered IVF, GIFT, and ZIFT procedures performed; (2) total number of multiple births or conceptions; (3) number of births or conceptions per pregnancy; and (4) rates of complications. It must also report, per patient on average and by the number of attempts required, the (1) number of procedures attempted before a successful implantation, (2) number of embryos implanted, and (3) pregnancy rate.

BACKGROUND

Infertility Procedures

Ovulation induction is the use of medication to stimulate development of one or more mature follicles (where eggs develop) in a woman's ovaries. IVF involves using a drug to stimulate a woman's egg production. Once mature, the eggs are removed to a culture dish and fertilized with sperm. After fertilization, embryos are placed in the woman's uterus.

In GIFT, egg and sperm are placed in a woman's fallopian tubes where fertilization can occur naturally. ZIFT involves placing embryos in a

woman's fallopian tubes. Low tubal ovum transfer involves transferring eggs past a blocked or damaged section of the fallopian tube to an area closer to the uterus. Uterine embryo lavage is a procedure by which the uterus is flushed to recover a preimplantation embryo from a donor and transferred to the woman who is to bear the child.

Related Bill

sHB 6588 (File 462), reported favorably by the Public Health Committee, requires individual and group health insurance policies to cover medically necessary infertility diagnosis and treatment expenses for people under age 44, subject to specified conditions and limitations.

Legislative History

On April 26, the Senate referred the bill to the Appropriations Committee, which reported it favorably on May 2. On May 4, the Senate referred it to the Public Health Committee, which reported a substitute bill on May 9. The substitute bill revised the coverage limitations that an insurer may include in a policy.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 9 Nay 7

Appropriations Committee

Joint Favorable Report
Yea 32 Nay 8

Public Health Committee

Joint Favorable Substitute
Yea 19 Nay 6