STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC - 64
September 15, 2005

TO: All Health Insurers Authorized To Conduct Business In Connecticut

RE: Public Act 05-196 – An Act Concerning Health Insurance Coverage for Infertility Treatment and Procedures

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Public Act 05-196 ("Act"), requires certain individual and group health policies to cover medically necessary costs of diagnosing and treating infertility. The Act is applicable to individual and group health policies that cover basic hospital expenses; basic medical-surgical expenses; major medical expenses; hospital or medical service plans contracts; and, hospital and medical coverage provided to subscribers of a health care center that are delivered, issued, amended, renewed or continued on or after October 1, 2005.

The Insurance Department ("Department") is issuing this bulletin to provide guidance in implementing and administering this mandate.

Summary

The Act defines infertility as "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". The Act provides that covered medically necessary expenses of the diagnosis and treatment of infertility include, but are 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.

The Act specifies permissible policy limitations, maximums and requirements as follows:

(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 lifetime benefits to a maximum of two cycles, with not more than two embryo implantations per cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as one 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.

(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.

The Act permits individuals and religious employers to submit a written statement indicating the methods of diagnosing and treating infertility are contrary to their bona fide religious beliefs. Upon receipt of such requests, 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. Any health insurance policy issued without coverage for the diagnosing and treatment of infertility must 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. The Act defines a religious employer as "an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization".

Interpretive Issues:

This Act has raised a number of questions regarding coverage application and claim handling. The following will provide guidance in administering this new provision.

The mandate requires coverage for medically necessary expenses of the diagnosis and treatment of infertility in the **base policy**. The relevant part of Public Act 05-196 reads:

> 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 (IVF), uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT)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. (***Emphasis added***)

We read this to mean that the mandate in Section 1 of the Act applies to the health policy. The infertility mandate **cannot** be offered through a rider. If applicable benefits are offered through a carve-out or a rider, or if there are no such type of benefits even offered in the base policy, the policy must still provide coverage with respect to the diagnosis and treatment of infertility. If there is no drug benefit, coverage is governed by the base plan limits.

Coverage Provisions:
The Department interprets that the legislative intent is for the infertility mandate to be a discreet benefit with its own limitations and maximums subject to the terms of the policy. The Department does believe that:

- Carriers may apply plan level cost sharing mechanisms (copays, deductibles, coinsurance).
- Carriers may have discreet copays applicable to this benefit, subject to the limits currently allowed by the Department.
- Carriers must cover services at parity with all other medical services.
- Benefits may be subject to prior authorization, but this must be disclosed in the policy.
- If there is a prescription benefit in the base policy, carriers may establish a separate and distinct tier associated with infertility drugs; however, the associated cost sharing provision may not exceed currently acceptable ranges allowed by the Department Allowable copays range from $0 - $40; allowable coinsurance ranges from 0% - 50%.
- Managed care organizations may limit this coverage to participating providers unless the plan covers out of network benefits. Plans with out of network benefits must cover out of network purchases as they would any other out of network service.
- With respect to out of network charges, if a copay is imposed, the company must pay balance of the billed charge.
- Male infertility treatment is covered under this mandate.

Maximums and Limitations:
- The Act provides that a policy may limit the mandated coverage to an individual until the date of the individual's fortieth birthday. Carriers may strictly administer this limit and forego coverage under the mandate for expenses incurred after that birth date regardless of where the member is in the treatment cycle.
- The Department has interpreted that the 2-cycle limit is for IVF, GIFT, ZIFT and low tubal ovum transfer combined.
- Because of the disclosure requirements and the look back provisions, the Department has interpreted that the lifetime maximum contemplated in the Act includes treatment covered by any health insurance policy prior to the effective date of the mandate, October 1, 2005.

Look Back Provision for Lifetime Maximum and Disclosure Requirement

- The Act requires individuals seeking infertility coverage to disclose prior treatment paid for when covered under prior health insurance.
- Because of this look back provision, the Department concludes that this lifetime maximum specified in the Act is intended to be the insured's lifetime, not the lifetime under the specific policy.
- Because the Act requires disclosure of prior treatment covered under different or prior health insurance, the Department has concluded that **expenses paid for by the individual in cash or benefits provided under a self-insured plan are not applicable to the lifetime maximum and does not have to be disclosed**.
- The Act requires that disclosure is to be made on a form and in a manner prescribed by the Insurance Commissioner. A copy of the form to be used is attached. The form will be posted on the Insurance Department website (www.ct.gov/cid) under "FORMS".

Not covered:

The Department interprets the following are not mandated coverages of this Act:

- Donor costs.
- The expense related to the pregnancies and deliveries that may result from the infertility treatment.
- Reversal of surgical sterilization (male or female).
- Gestational carriers/surrogate parenting arrangements.

Medical Determinations:

The Department believes that there are many aspects of this mandate which will require medical/clinical interpretations. These are questions related to treatment protocols and medical necessity and should be addressed by the carriers' medical directors. Since the Act requires that all 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, we also suggest that questions of medical treatment protocols and medical necessity be reviewed in light of those same standards and guidelines.

Please contact the Insurance Department Life & Health Division at ctinsdept.lifehealth@po.state.ct.us with any questions about Public Act 04-173 or this bulletin.

Susan F. Cogswell
Insurance Commissioner

State of Connecticut

INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

Effective October 1, 2005, Public Act 05-196 requires any individual seeking health insurance coverage for infertility treatment and procedures to disclose to the individual's existing health insurance carrier any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. For more information, please see Public Act 05-196 which can be accessed at the Connecticut General Assembly website at http://www.cga.ct.gov/2005/act/Pa/2005PA-00196-R00SB-00508-PA.htm

THIS FULLY COMPLETED FORM IS TO BE SENT TO CURRENT HEALTH INSURANCE CARRIER

Name of Individual Seeking Treatment_____

Date of Birth:_____ Social Security Number_____

Current Insurance Carrier _____Policy/ID #_____

Insured under this policy since:_____

[ ] Individual Plan [ ] Group Plan Name of Group:_____ Policy/ID #_____

Covered as: [ ] Insured [ ] Dependent

Insured Name_____

Prior Insurance Carrier:_____Dates of coverage:_____

[ ] Individual Plan [ ] Group Plan Name of Group:_____ Policy/ID #_____

Was this plan insured or self-funded? [ ] Insured [ ] Self-funded

Rx Carrier:_____ Policy/ID#:_____

Covered as: [ ] Insured [ ] Dependent (Name if different:_____)

Prior Insurance Carrier:_____Dates of coverage:_____

[ ] Individual Plan [ ] Group Plan Name of Group:_____ Policy/ID #_____

Was this plan insured or self-funded? [ ] Insured [ ] Self-funded

Rx Carrier:_____ Policy/ID#:_____

Covered as: [ ] Insured [ ] Dependent (Name if different:_____)

Attach separate sheet if more space is needed to answer any question fully.

State of Connecticut

INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

Previous infertility treatment or procedures covered by insurance (do not include treatment or procedures for which no insurance claim was made, submitted or paid) :

Treatment or Procedure (including drug therapy)	Number of Cycles	Dates Received	Name, Address, Phone of Provider Providing Treatment	Health Insurance Coverage Provided By

Other infertility treatment or procedures received: (please describe and provide dates and name of health insurer)

State of Connecticut

INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

I have reviewed the information submitted in accordance with Public Act 05-196, and attest that the information is true and accurate. I hereby certify that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief. I acknowledge that I understand that a person who knowingly makes or causes to be made, or used, a false record or statement will be considered to commit insurance fraud for the purposes of receiving benefits to which the person is not entitled.

_____ _____

(Signature of Insured Individual Seeking Treatment) (Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____day of _____,

20_____ By _____, and:

☐ who is personally known to me, or ☐ who produced the following identification:

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Authorization to Release Medical Information

I, _____ hereby authorize the release of medical records necessary to verify previous infertility treatment and procedures. I understand that these records may be obtained from any and all previous health insurers and/or any relevant medical provider(s) and will be utilized solely for the purpose of determining previous infertility treatment and procedures applied towards the maximums identified in Connecticut Public Act 05-196.

_____ _____

Signature of Patient **Date**