STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC – 64
Originally Issued – September 15, 2005
Revised – January 20, 2006

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

---

NOTE: This bulletin modifies and supercedes Insurance Department Bulletin No. HC-64 issued September 15, 2005, effective January 20, 2006.

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.

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. If any part of the mandated infertility benefit is intended to be offered through a rider, the carrier must include with the filing a certification that such rider will always be sold and renewed in conjunction with that policy. The certification should include the specific form numbers for the policies and riders that will be sold together. If there is no drug benefit, coverage for infertility drugs is governed by the base plan limits. If there is a drug rider that will provide the mandated infertility drugs, any limits on the rider shall not be applied to infertility drugs, nor shall the infertility drug costs apply towards the drug rider maximum.

Coverage Provisions:
The Department interprets that the legislative intent is for the infertility mandate to be a discreet benefit 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.
- Carriers cannot set inside limits specific to infertility treatment other than those specified by the statute.
- Benefits may be subject to prior authorization, but this must be disclosed in the policy.
- If there is a prescription benefit, 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%.
- Only health care centers may limit coverage for services to participating providers.
- If the plan covers out of network benefits, such services must be covered as any other similar out of network service.
- With respect to out of network charges, if a copay is imposed, the carrier 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 fully insured health insurance policy prior to the effective date of the mandate, October 1, 2005.
- The Department has interpreted that the 12 month waiting period referenced in Section 1(b)(7) of the Act is in conflict with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") for group plans. While HIPAA does permit a group plan to have an overall waiting period for the plan enrollee to be eligible for benefits, it does not appear to permit waiting periods for discreet benefits. Therefore, our position is that group carriers should administer benefits without the state legislated waiting period for the infertility benefit to avoid a conflict with HIPAA.

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. The lifetime maximum specified in the Act is intended to be the insured's lifetime, not the lifetime under the specific policy. The Department has interpreted that the look back provision is in conflict with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") for group policies. The Final Regulations for Health Coverage Portability that became effective February 28, 2005 and apply to plan years beginning on or after July 1, 2005, prohibit benefits received under a prior plan from being applied to subsequent plan lifetime maximum limits. The HIPAA regulations consider that to be a pre-existing condition limitation which is prohibited.[1]
- The Act requires that disclosure is to be made on a form and in a manner prescribed by the Insurance Commissioner. The form to be used for individual policies is attached and will be posted at the Insurance Department's website (www.ct.gov/cid). In light of the conclusion above that HIPAA will not permit prior benefits to be applied to current benefit maximums on group policies, the Department's position is that mandated disclosure of prior treatment and benefits is not permitted for group policies.

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:

[1] See 69 Fed. Reg. 78748, December 30, 2004, 26CFR Part 54 (54.9801-3, Example 4)

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.

Any forms that were approved with the statutory language that conflicts with HIPAA should be modified. Endorsements or amendatory riders should be submitted to the Insurance Department for approval.

Please contact the Insurance Department Life & Health Division at ctinsdept.lifehealth@po.state.ct.us with any questions about Public Act 05-196 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 individual 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

COMPLETE THIS FORM AND SEND IT TO YOUR CURRENT HEALTH INSURANCE CARRIER

Full Name of Individual Seeking Treatment_____
(first, middle, last)

Date of Birth:____/____/_____ Social Security Number_____/_____/_____

Covered as: [ ] Insured [ ] Dependent Name of Insured_____

Current Insurance Carrier _____Policy/ID #_____

[ ] Individual Plan [ ] Group Plan Group Name (If applicable):_____

Insured Under this Policy Since: _____/_____/_____

Secondary Carrier Information (if applicable)

Name of Insurance Company:_____ Policy/ID#_____

Name of Insured: _____ Covered as: [ ] Insured [ ] Dependent

[ ] Individual Plan [ ] Group Plan Group Name _____

Group Number (If applicable): _____

Dates of Coverage: _____/_____/_____ through _____/_____/_____

Is this a fully insured or a self-insured plan (see below) [ ] fully-insured [ ]self-insured (MUST CONFIRM WITH YOUR EMPLOYER

State of Connecticut
INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

Prior Carrier Information

Name of Insurance Company:_____ Policy/ID#_____

Name of Insured: _____ Covered as: [ ] Insured [ ] Dependent

[ ] Individual Plan [ ] Group Plan Group Name _____

Group Number (If applicable): _____

Dates of Coverage: _____/____/_____ through _____/_____/_____

Is this a fully insured or a self-insured plan (see below) [ ] fully-insured [ ]self-insured (MUST CONFIRM WITH YOUR EMPLOYER

Under a self-insured arrangement, the employer retains the responsibility to pay directly for health care services of the plan participants. Self-funded plans are subject to *federal law,* not state law. ***Services reimbursed under self-funded plans do not count toward the limits specified under this law.*** Services not reimbursed by any insurance carrier (paid out-of-pocket) also do not count toward the limits specified under this law. If you need additional space to record prior carrier information, please attach a separate sheet of paper.

I have reviewed the information submitted on these and the attached pages, 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)_____

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**_____

State of Connecticut

INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

COMPLETE THIS FORM AND SEND IT TO YOUR CURRENT HEALTH INSURANCE CARRIER

Previous infertility treatment or procedures covered by insurance (do not include treatment or procedures for which no insurance claim was made, submitted or paid). Services reimbursed under self-funded plans, or for which the person receiving treatment received no insurance benefits and paid cash do not count toward the limits specified under this law.

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)