DAVID Y. IGE
GOVERNOR

RACHAEL WONG, DrPH
DIRECTOR

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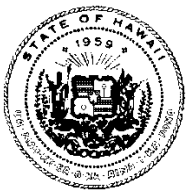
DEPUTY DIRECTOR



STATE OF HAWAII
**DEPARTMENT OF HUMAN SERVICES**
P. O. Box 339
Honolulu, Hawaii 96809-0339

April 7, 2015

Memorandum

TO: The Honorable Sylvia Luke, Chair
House Committee on Finance

FROM: Rachael Wong, DrPH, Director

SUBJECT: **S.B. 768, SD1, HD1 - RELATING TO IN VITRO FERTILIZATION INSURANCE COVERAGE**

Hearing: Wednesday, April 8, 2015; 2:00 p.m.
Conference Room 308, State Capitol

**PURPOSE**: The purpose of this bill is to provide insurance coverage equality for women who are diagnosed with infertility by making available to them expanded treatment options, ensuring adequate and affordable health care services.

**DEPARTMENT'S POSITION**: The Department of Human Services (DHS) provides comments for consideration on this measure as the DHS is unclear if the requirements in this bill would also apply to the Medicaid program, and the DHS asks that the legislature either exempt the Medicaid program from the expansion or provide an appropriation to provide this and related services.

The DHS does not cover treatment for infertility under the Medicaid program and there are no federal funds available for these services through Medicaid. While in vitro fertilization is a covered benefit under Hawaii's benchmark plan, the DHS Medicaid program was allowed, under special rules issued by the Secretary of the federal Department of Health

and Human Services, to substitute in vitro services with personal care services for the disabled that are actuarially equivalent.

To provide clarity in this bill, the DHS respectfully recommends that the measure specify that Medicaid is excluded from this bill's requirements.

If the Medicaid program is required to cover in vitro fertilization services through this measure, federal funds will not be available for this service. The new services would need to be funded with 100% state funds. DHS estimates that the cost could be as high as $12 million as Medicaid considers related services, not just the actual in vitro fertilization procedure, such as increased occurrence of complications during pregnancy and delivery due to multiple fetuses, longer hospital stays, and nursery costs related to premature births,

Thank you for the opportunity to testify on this measure.

HAWAII
STATE
COMMISSION
ON THE
STATUS
OF
WOMEN

Chair
LESLIE WILKINS

COMMISSIONERS:

ELENA CABATU
CARMILLE LIM
AMY MONK
LISA ELLEN SMITH
MARILYN LEE
JUDY KERN

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April 7, 2015

To: Representative Sylvia Luke, Chair
Representative Scott Y. Nishimoto, Vice Chair
Members of the House Committee on Finance

From: Cathy Betts, Executive Director
Hawaii State Commission on the Status of Women

Re: Testimony in Support, SB 768, SD1, HD1, Relating to In Vitro Fertilization Insurance Coverage

On behalf of the Hawaii State Commission on the Status of Women, I would like to express my support my support for SB 768, SD1, HD1, which would revise the current statute to allow equal coverage for in vitro fertilization treatment and procedures.

Women are widely affected by infertility. In fact, 7 million women and their partners are affected by infertility in the United States. Our changing workplace demographics and the breadth of diversity found in families should be reflected in our policies. Women of all ages make personal decisions about whether they will choose to have children. Many women will delay attempting to get pregnant until later in life. Additionally, many medical reasons prevent women from being able to become pregnant. Coverage for fertility treatment should be equal, regardless of marital status or sexual orientation.

The statute, as written, requires a woman to show 5 years of difficulty getting pregnant in order to receive coverage for infertility. By the time many women begin considering fertility treatment, time is of the essence, and waiting five years will eliminate all chances of becoming pregnant. Additionally, as written, the statute prohibits lesbian couples or unmarried couples from obtaining coverage. This is inherently discriminatory on its face.

The Commission supports SB 768, SD1, HD1, and urges this Committee to pass this important measure.

April 8, 2015

To: Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair and
Members of the Committee on Finance

From: Jeanne Y. Ohta, Co-Chair

RE: SB 768 SD1 HD1 Relating to In Vitro Fertilization Insurance
Hearing: Wednesday, April 8, 2015, 2:00 p.m., Room 308

POSITION: Strong Support

The Hawai‘i State Democratic Women’s Caucus writes in strong support of SB 768 SD1 Relating to In Vitro Fertilization Insurance which would end the discrimination of eligible patients based on marital status and bring equality into the insurance coverage for all women who are diagnosed with infertility.

The Hawai‘i State Democratic Women’s Caucus is a catalyst for progressive, social, economic, and political change through action on critical issues facing Hawaii’s women and girls it is because of this mission that the Caucus strongly supports this measure.

This measure will correct outdated language on marital status that was written approximately 28 years ago and is discriminatory based on that status. The current policy penalizes older women and single women by denying coverage under the law and should be amended to provide equal access to medical care.

We ask the committee to pass this measure and we thank the committee for the opportunity to provide testimony.

ADVANCED REPRODUCTIVE MEDICINE & GYNECOLOGY

FERTILITY INSTITUTE OF HAWAII

April 7, 2015

Dear Senators and Committee Members:

This letter is in **SUPPORT** of SB 768.

Approximately 15% of the US population has difficulty conceiving and are given the diagnosis of infertility. For many people with infertility, the dream of having a family will never be realized. The 85% of the US population without infertility are indeed very blessed but often do not realize how blessed they truly are.

Infertility treatments are no longer experimental or taboo. Infertility treatments are no longer kept secret from friends and family. These treatments are the Standard of Care for treating infertility. Over 4 million babies have been conceived using In Vitro Fertilization and many many many more millions of babies have been born using other infertility treatments.

There are many etiologies for infertility. Some are easily diagnosed and treated and others require more advanced technologies. I have been lucky enough to practice in two other states with mandated infertility coverage (Maryland and New Jersey). In those states, patients are able to progress from lesser infertility treatments such as ovulation induction and artificial insemination to In Vitro Fertilization. As an infertility provider, I have seen first hand that the type of coverage that is outlined in SB615 offers patients the greatest chance to achieve their dream of having a family.

Not everyone has success with infertility treatments but for those who are successful –This is truly a gift of life! Thanks to infertility treatment I am a proud parent of 2 boys and 1 girl. My wife and I underwent multiple infertility treatment cycles prior to doing In Vitro Fertilization (IVF). Our first two IVF cycles were unsuccessful and it was not until the third cycle that we had success. We were lucky! Not only because we were successful but because we had the ability to continue to attempt treatments until we were able to conceive. Every day I look at my two boys and I am thankful to all of those healthcare providers who helped make our dreams come true.

As an infertility provider, I see myself in my patients. I understand their hopes and dreams. I understand their despair when not successful. Through my many years of training and practicing, I also understand that many of my patients would achieve their dream of having family if they were allowed to continue treatment.

**I fully and enthusiastically support SB 768.** Without it, many of our friends and families will not be able to experience the privilege of having a family –a privilege that many without infertility take for granted.

Sincerely and Mahalo,

John L. Frattarelli, M.D.
Reproductive Endocrinology and Infertility
Advanced Reproductive Medicine & Gynecology of Hawaii, Inc.
&
Fertility Institute of Hawaii
1401 South Beretania Street, Ste 250, Honolulu HI 96814
www.IVFcenterHawaii.com

An Independent Licensee of the Blue Cross and Blue Shield Association

April 8, 2015

The Honorable Sylvia Luke, Chair
The Honorable Scott Y. Nishimoto, Vice Chair
House Committee on Finance

**Re: SB 768, SD1, HD1 – Relating to In Vitro Fertilization Insurance Coverage**

Dear Chair Luke, Vice Chair Nishimoto and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 768, SD1, HD1, which would require health insurance coverage for women who are diagnosed with infertility by making available to them expanded treatment options. HMSA would like to offer comments on this Bill.

We are aware and empathetic to the situations under which the procedures would be conducted. In fact, HMSA already offers coverage for IVF services, and we agree with the provision in SB 768, SD1, HD1, that deletes the current spousal requirement. We already have eliminated a spousal requirement in our medical policies, and this amendment would comport with practice.

That said, as drafted, this Bill would apply to commercial health insurers and mutual benefit societies, but does not apply to health maintenance organizations. Should the Committee consider passing this measure, equity demands that its provisions be included under Section 432D, HRS, as well.

Thank you for allowing us to testify on SB 768, SD1, HD1, and you consideration of the concerns we have raised is appreciated.

Sincerely,

Jennifer Diesman
Vice President, Government Relations

KAISER PERMANENTE®

Testimony of
John M. Kirimitsu
Legal & Government Relations Consultant

Before:
House Committee on Health
The Honorable Sylvia Luke, Chair
The Honorable Scott Y. Nishimoto, Vice Chair

April 8, 2015
2:00 pm
Conference Room 308

**Re: SB 768 SD1 HD1 Relating to In Vitro Fertilization Insurance Coverage**

Chair, Vice Chair, and committee members, thank you for this opportunity to provide testimony on this measure regarding expanded in vitro fertilization insurance coverage.

**Kaiser Permanente Hawaii supports the intent of this bill, but would like to offer comments.**

It is widely recognized that the ACA was enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding insurance coverage, and reducing the costs of healthcare for individuals and the government. Done correctly, health care reform can reduce costs while simultaneously improving the quality of care. However, this will not happen if the emphasis is shifted to costly mandates that inevitably drive up the price of health insurance.

That being said, Kaiser Permanente has already taken steps to remove the "spouse" requirement for its in vitro fertilization coverage. This benefits modification will allow for non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility for all Kaiser Permanente members.

Thank you for the opportunity to comment.

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E-mail: John.M.Kirimitsu@kp.org

TO: **COMMITTEE ON FINANCE**
The Honorable Sylvia Luke, Chair
The Honorable Scott Y. Nishimoto, Vice Chair

FROM: Na'unanikina'u Kamali'i

SUBJECT: **SB 768 SD1 HD1– RELATING TO IN VITRO FERTILIZATION COVERAGE**

**Hearing: Wednesday, April 8, 2015**
**Time: 2:00 p.m.**
**Place: Conference Room 308**

Thank you for the opportunity to testify. This written testimony is made in my personal capacity in **strong support of SB 768 SD1 HD1**. This measure provides in vitro fertilization coverage equality for all women who are diagnosed with infertility by requiring non-discriminatory coverage. Federal agencies and the Hawaii State auditor's office have reviewed the measure and have provided a written response, which is attached to this testimony.

This federal written response from the U.S. Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) Office of the Center for Consumer Information & Insurance Oversight (CCIIO) representatives provides written guidance and confirms that **this measure imposes no cost liability** to the State of Hawai`i. In part, the CCIIO guidance states:

> "**It is our understanding that the changes made to the IVF coverage law as reflected in SB 768 SD1, the Senate version, removes marriage requirement language, reduces the five year wait time and adopts a wait time consistent with the definition of infertility by the American Society of Reproductive Medicine (ASRM), and adopts the definition of infertility by ASRM. Modifications such as those, that revise a pre-2012 requirement to be consistent with current clinical recommendations and current medical definitions, do not trigger the obligation to defray the cost as long as there are no new benefit coverage requirements inserted.**"

This measure is not for the purpose of expanding health coverage and no new benefit requirements are inserted, rather it is corrective in its purpose expanding availability and applicability to bring the IVF procedure coverage mandate into compliance with the Hawaii State constitution's Privacy Clause and related federal statutes and regulations by removing the marriage requirement, reducing the wait time and adopting a definition of infertility. These amendments are technical, non-substantive amendments for the purpose of clarity and

consistency. As the legislature stated over 28 years ago, this bill limits insurance coverage to a one-time only benefit, thereby limiting costs to the insurers.

This is a corrective measure to expand availability and applicability for all women who are subscribers/members. Premium payments for all members are already included in the underwriting process. Employers pay premiums for all of its male or female employees, unmarried or married, even though only married members are eligible to utilize the IVF coverage benefit. The reduction of the wait time from five years to one year for women 35 years or younger or six months for women 36 years or older and ensuring that coverage is provided for required alternatives is a consideration of utilization and medical management, at no additional cost to the State.

In short, the **cost considerations are nil.** Key considerations are as follows:

A. **Removal of marriage requirement** - *There is no cost consideration for the State of Hawaii.* As reported by the joint committees on Health and Commerce and Consumer Protection, removal of the marriage requirement is a technical, non-substantive amendment for the purpose of clarity and consistency. This discriminatory provision, in violation of the Hawaii Constitution's Privacy Clause, poses no cost increases to bring it into compliance with the Hawai'i Constitution and federal and state statutes. Employers already pay premiums for all of its employees, even though only married employees are eligible for IVF procedure coverage;

**B. Reduced wait time for services** *There is no cost consideration. As* reported by the Senate joint committees on Health and Commerce and Consumer Protection, reducing the wait time for services from five years to one year is a technical, non-substantive amendment for the purpose of clarity and consistency. The House Committee on Health decreased the amount of time a patient must be show to be infertile before in vitro benefits are provided to bring equality to insurance coverage for all women diagnosed with infertility. The arbitrary five year history provision is in violation of the Hawaii Constitution's Privacy Clause in that it arbitrarily infringes on a woman's right to procreative treatment and to bear and beget a child. The measure provides standards consistent with the guidelines and program standards of the American College of Obstetricians and Gynecologists and American Society for Reproductive Medicine, recognized in the measure;

C. **Definition of Infertility.** *There is no cost consideration. As* reported by the Senate joint committees on Health and Commerce and Consumer Protection, the measure was amended to provide the definition of "infertility" to be consistent with the American College of Obstetricians and Gynecologists (ACOG) and American Society for Reproductive Medicine (ASRM). Definitional sections are technical, non-substantive

amendments for the purpose of clarity and consistency. However, the House adopted the "HMSA amendments" which introduced arbitrary exclusions by stating a condition that "infertility shall include voluntary sterilization or natural menopause." These conditions are not part of the definition of infertility by either ASRM or ACOG and must be deleted in conference by adopting true and correct medical definitions.

The American Society of Reproductive Medicine (ASRM) defines infertility as:

> "**a disease, defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years."**
>
> The State Auditor's report 12-09, makes reference to this definition in its study, "according to the U.S. Department of Health and Human Services, Office on Women's Health, **infertility is defined as the inability to become pregnant after one year of trying, or after six months if the woman is 35 or older.** Women who can become pregnant but are unable to remain pregnant may also be infertile;

D. **Affordable Care Act (ACA)** *There is no cost consideration for the state of Hawaii.* The in vitro fertilization coverage benefit has been a mandated health insurance benefit or state-required benefit before December 31, 2011 and is included as an Essential Health Benefit (EHB). As of January 1, 2014 strict federal prohibitions against discriminatory practices apply to EHBs. More importantly, this corrective measure, which brings the IVF procedure coverage mandate into compliance, not only with the ACA, but also with key provisions of the ADA, ERISA and the Hawai'i constitution, at **no cost to the State. See the federal response attached hereto regarding cost considerations and enforcement of discriminatory practices.**

Further, Health plans have already factored compliance changes into underwriting practices. Underwriting practices are separate and distinct from utilization techniques in medical management. Underwriting specifically for a marriage requirement only underscores the current prohibited discriminatory practice by qualified health plans for which sanctions may be imposed. The State of Hawaii has the obligation to enforce discriminatory practices by qualified health plans under the ACA. Note that as of January, HMSA changed its provider policy to address the

marriage requirement and Kaiser reports that it will do so within the year. This measure is necessary to bring the State mandate in compliance with the law, which would require consistent changes of all employer plans;

E. **State Auditor's Office Mandated Health Insurance Study NOT required.** The Hawaii State Auditor's Office was consulted on SB 768 to determine whether a mandated health insurance (MHI) study is required and whether a hearing must be held on related resolutions. The Auditor's Office conclusion, as provided in the attached email, is simply that a MHI study is not required. In part, the response provides:

> **"[t]here is already a law that mandates health insurance for in vitro fertilization. Therefore, it is the Legislature's prerogative to simply amend the existing law (via SB 768 or another appropriate vehicle), without asking for an additional MHI study."**; and

F. **State Medicaid and Medicare plans.** *There is no cost consideration.* The IVF mandate is not part of either the federal Medicare plan or the federal/state 1115 waiver negotiated QUEST plans. The IVF procedure coverage mandate is applicable to employer plans and has been mandated for over 28 years.

**BACKGROUND - General Comments pertaining to Health and Consumer protection:**

**Comments:**

*1.* **Violation of the Privacy Clause.** Under the IVF state-required benefit, the IVF treatment requires that the woman's eggs must be fertilized by her spouse's sperm. The "marital requirement" is unconstitutional and violates the privacy clause of the Hawaii State Constitution. The marital restriction placed on infertility coverage arguably imposes an undue burden on a woman's right to privacy as provided under the privacy clause, which states that "[t]he right of the people to privacy is recognized and shall not be infringed without the showing of a compelling state interest. Haw. Const. of 1978, art. I, §§ 5,6. Under the constitutional right to privacy, "among the decisions that an individual can make without unjustified government interference are personal decisions relating to marriage, procreation, contraception, family relationships, and child rearing and education." *Doe v. Doe,* 172 P.3d 1067 (Haw. 2007). Because the use of infertility treatments to bear a child is protected, the marital status restrictions placed on insurance coverage will be found unconstitutional. Unmarried women, unmarried couples, divorced women, widowed women are all not eligible for coverage under the current IVF mandated benefit and as a result, the state-required benefit imposes an undue burden on their constitutional right of privacy. See generally, Jessie R. Cardinale, *The Injustice of Infertility Insurance Coverage: An examination of Marital Status Restrictions Under State Law, 75 Alb. L. Rev. 2133, 2141 (2012).*

2. **No Compelling State Interest for Marital Status Requirement.** The Hawaii State legislature has provided no compelling state interest for the marriage requirement. When the IVF mandated benefit was enacted in 1987, the legislature stated that purpose of the bill was 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. … The legislature 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. " *SCRep. 1309, Consumer Protection and Commerce on S.B. 1112 (1987).* The cost limitation for insurers is the "one-time only benefit" language. The State of Hawaii fails to show any compelling state interest for limiting eligibility for the IVF coverage benefit to only married couples who use the husband's sperm.

3. **Denial of coverage if not married.** Women who do not meet the marriage requirement are denied IVF coverage irrespective of a diagnosis of infertility and even where the diagnosis is one of the statutorily stated conditions for infertility. As reflected in HMSA's Notice of Medical Denial, attached hereto, the first requirement that must be met is that "the patient and spouse are legally married according to the laws of the State of Hawaii." For personal, cultural and religious purposes, many couples **choose not to marry**. Consent to marriage is also a constitutionally protected right. The Hawaii state government infringes on the constitutional right to consent to marriage, because it requires couples to marry as a condition of eligibility for the IVF coverage benefit. Infringement on a woman's right to marry is practiced during the pre-certification process. Insurance company policy requires the woman's physician to disclose her marital status in the pre-certification process. Further, insurance companies typically inform women who are not married, whether single, coupled or gay, that the treatment is covered if she has a civil union or is legally married to her partner. This "outing" process is an infringement on the woman's right to consent to marriage and privacy. Government in effect defines "family" by requiring a licensed governmentally recognized relationship. The right to consent to marriage is a constitutionally protected right. Member health benefits should never be a conditioned on marriage. All members, whether subscriber or dependent member, shall be provided non-discriminatory health coverage when it is a benefit of an employment.

4. **Equality for all women.** The purpose of **SB 768 SD1** is to provide in vitro fertilization insurance coverage equality for all women who are diagnosed with infertility by requiring non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility. Equality, not just amongst married women, but also for all women who are diagnosed with a condition of infertility. The corrective action by the legislature to eliminate the discriminatory marital

status requirement is long overdue. The overriding corrective measure should prevail, particularly here, where there is no cost consideration for the corrective measure to address prohibited discriminatory practices. The focus must again be on a diagnosis of infertility as a determinant on whether coverage will be provided.

5. **Discriminatory provision violates federal and state laws** The current IVF coverage law wrongfully creates two "classes" of premium paying members and is discriminatory on its face under ERISA, ADA, and ACA and employment practices. Health plans have deliberately upheld discriminatory provisions which have called for a member to be married and use her husband`s sperm and enforced an arbitrary wait time requirement while reaping prohibited premium savings from the practice. In application, employed health plan members who are single, divorced, widowed, partnered or otherwise "not married" women, pay premiums just like married members diagnosed with infertility yet, ARE NOT eligible for the IVF coverage. The "marital status" requirement appears to rest squarely on moral grounds, which violates the Hawaii constitution. The State has not provided any compelling interest for the restrictive and limiting mandated IVF coverage benefit.

6. **Definition of infertility.** In its guidance to patients, the American Society of Reproductive Medicine (ASRM) defines infertility as:

**"a disease, defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years**."

The State Auditor's report 12-09, makes reference to this definition in its study, "according to the U.S. Department of Health and Human Services, Office on Women's Health, **infertility is defined as the inability to become pregnant after one year of trying, or after six months if the woman is 35 or older.** Women who can become pregnant but are unable to remain pregnant may also be infertile.

The Hawaii mandated benefit requires an arbitrary five-year history, which is not founded on medical literature or evidence based practice and is not consistent with the current definition of infertility and treatment protocols. The measure reflects definition of infertility used by ACOG, (a one year wait requirement) and not ASRM, which is desired and supported by the State auditor's office and the U.S. Department of Health and Human Services, Office on Women's Health.

**7. ACA prohibitions on discrimination**

The ACA prohibits discrimination as set forth in Title 45 of Code of Federal Regulations Part 156. Three sections in particular, which prohibit discrimination, are 45 CFR §156.125, §156.200(e), and § 156.225 of the subchapter and also in the Federal Register Vol. 78, No. 37(February 25, 2013). See referenced sections below. The marital status provision in the current IVF coverage law, which

requires that the member be married in order to received treatment, creates two classes of members and is in violation of the prohibitions on discrimination. Even if the legislature disagrees with the assertion that it is in violation with the ACA or other federal laws, marriage should not be a defining factor that prohibits access to this benefit for women who have been diagnosed with infertility disability because it violates the Hawaii state constitution. The arbitrary wait time requirement also violates § 156.225 by discouraging enrollment of individuals with significant health needs. Equal access should be afforded to all women. The statutory sections referenced herein are provided here.

**45 CFR §156.125 Prohibition on discrimination.**

(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

(b) An issuer providing EHB must comply with the requirements of §156.200(e) of this subchapter; and

(c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

**45 CFR §156.200 (e)** ***Non-discrimination.*** A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

***45 CFR § 156.225 Marketing and Benefit Design of QHPs.*** A QHP issuer and its officials, employees, agents and representatives must—

**(a)** ***State law applies.*** Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and

**(b)** ***Non-discrimination.*** Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

**8. No ACA State liability and or Cost Considerations**

According to the federal Health and Human Services (HHS) Office of Legislation, the regulation at 45 CFR §155.170 (a)(2), provides that "state-required benefits enacted on or prior to December 31, 2011 are <u>not considered in addition to the essential health benefit",</u> and thus, are included as an EHB. Further, under 45 CFR §155.170 (b), "states are expected to defray the cost of <u>additional required</u>

benefits specified in paragraph (a)" i.e. state-required benefits enacted on or after January 1, 2012. In HHS's response to comments on the regulation (45 CFR §155.170), HHS clarified that "**only new State-required benefits enacted on or prior to December 31, 2011 are included as EHB, and States are expected to continue to defray the cost of State-required benefits enacted on or after January 1, 2012 unless those State required benefits were required in order to comply with new Federal requirements**." See 80 Fed. Reg. 10750, 10813 (February 27, 2015) [1]

This measure, SB 768 SD1, eliminates discrimination based on marital status, limiting conditions of infertility, and arbitrary wait time requirements. There is no cost liability to the State of Hawaii on this measure for the following reasons:

A. The IVF coverage benefit was enacted before December 31, 2011, and is not considered in addition to the essential health benefit;

B. The measure brings the IVF procedure coverage law, HRS §431:10A-116.5 and §432:1-604, into compliance with the Hawaii State Constitution and new federal requirements prohibiting discrimination under the ACA Non-Discrimination Clause, 45 CFR §156.125 cited herein above; and

C. The measure makes no changes to existing cost limiting language, which provides for a "one-time only benefit for all out patient expenses arising from in vitro fertilization procedures"… . Proposed amendments expand accessibility and availability and do NOT expand treatment options.

Therefore, there is no state liability for costs associated with the measure to bring the law into compliance with the Hawaii State Constitution and the Affordable Care Act. Furthermore, the State of Hawaii is required under federal law to bring all state-required benefit mandates into compliance.

Related Code of Federal Regulations and Federal Register provisions are as follows:

**45 CFR §155.170 Additional required benefits.**
(a) *Additional required benefits.*
(1) A State may require a QHP to offer benefits in addition to the essential health benefits.
(2) A State-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits.

[1] The Notice of Benefit and Payment Parameters, published on February 27, 2015, allows states to elect new benchmarks from the 2014 plan year to serve as the new EHB benchmark plan for the 2017 plan year. See *80 Fed. Reg. 10750, 10813 (February 27, 2015)*.

(3) The Exchange shall identify which state-required benefits are in excess of EHB.

(b) *Payments.*

The State must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following:

(1) To an enrollee, as defined in §155.20 of this subchapter; or

(2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section.

(c) *Cost of additional required benefits.*

(1) Each QHP issuer in the State shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section.

(2) A QHP issuer's calculation shall be:

(i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(ii) Conducted by a member of the American Academy of Actuaries; and

(iii) Reported to the Exchange.

[78 FR 12865, Feb. 25, 2013]

**HHS Comment and Response to concerns raised by States**:

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**Comment:** Several States and other commenters requested further clarification regarding how new benchmark plan selection will affect our policy at § 155.170 pertaining to State required benefits.

**Response:** We did not propose any changes to § 155.170. Therefore, only new State-required benefits enacted on or prior to December 31, 2011 are included as EHB, and States are expected to continue to defray the cost of State-required benefits enacted on or after January 1, 2012 unless those State required benefits were required in order to comply with new Federal requirements. HHS intends to continue to publish a list of non-EHB State required benefits on its Web site on an annual basis. See 80 Fed. Reg. 10750, 10813 (February 27, 2015)

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

**HMSA No:**
**Servicing Provider:**
**Service:**
**Case ID:**

# NOTICE OF MEDICAL DENIAL

On your behalf, . sent us a precertification request for Complete in In Vitro Fertilization. Our review found that In Vitro Fertilization is not eligible for payment. This letter explains why.

*As stated in your Guide to Benefits, Chapter 1: Important Information, your plan covers care that is medically necessary when you are sick or hurt. This means that the service or supply must meet HMSA's Payment Determination Criteria and be consistent with HMSA's medical policies.*

*HMSA has a medical policy for In Vitro Fertilization (IVF). It is covered when all of the following criteria are met:*

1. *The patient and spouse are legally married according to the laws of the State of Hawaii.*
2. *The couple has a five-year history of infertility, or infertility associated with one or more of the following conditions:*
   *a. Endometriosis*
   *b. Exposure in utero to diethylstilbestrol (DES)*
   *c. Blockage or surgical removal of one or both fallopian tubes.*
   *d. Abnormal male factors contributing to the infertility.*
3. *The patient and spouse have been unable to attain a successful pregnancy through other infertility treatments for which coverage is available.*

*Or for female couples:*

1. *The patient and civil union partner are legally joined according to the laws of the State of Hawaii.*
2. *The patient, who is not known to be otherwise infertile, has failed to achieve pregnancy following 3 cycles of physician directed, appropriately timed intrauterine insemination (IUI). This applies whether or not the IUI is a covered service.*

*Our Medical Director, Stephen Lin, M.D., has reviewed the clinical information provided. Documentation does not support that the above criteria have been met. Therefore, we are unable to approve this request.*

A copy of the benefit provision that was the basis for this decision can be provided to you upon request. If you disagree with this decision, you may request an appeal in accordance with the procedures and timeframes described in your participating provider agreement.

Please call Customer Service on Oahu at 948-6111 for PPO members, 948-6372 for HPH members or 1 (800) 776-4672 if you have any questions regarding this matter. Representatives are available Monday through Friday, from 8 a.m. to 4 p.m., Hawaii Standard Time.

Attachment

SL/mri

attributable to good cause or matters beyond HMSA's control: 4) in the context of an ongoing good-faith exchange of information: and 5) not reflective of a pattern or practice of non-compliance.

For more information regarding an external IRO request, including the documents which must be submitted with your request, please contact HMSA at one of the numbers listed above or contact the Insurance Commissioner at (808) 586-2804.

Hawaii Insurance Division
Attn: Health Insurance Branch – External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813

**Arbitration:**
Request arbitration before a mutually selected arbitrator within one year of the decision of your appeal to the address listed below. If you choose arbitration, your request for arbitration shall be voluntary and your decision as to whether or not to arbitrate will have no effect on your right to any other benefits under this plan. HMSA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration. You must have fully complied with HMSA's appeal procedures to be eligible for arbitration, and we must receive your request your request within one year of the decision of your appeal. The following information is provided to assist you in deciding whether submit your dispute to arbitration:

- In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the disagreement.
- You have the right to representation during arbitration proceedings and to participate in the selection of the arbitrator.
- The arbitration hearing shall be in Hawaii.
- HMSA will pay the arbitrators fee.
- You must pay your attorney's or witness' fees, if you have any, and we must pay ours.
- The arbitrator will decide who will pay all other costs of the arbitration.
- The decision of the arbitrator is final and binding and no further appeal or court action can be taken.

HMSA Legal Services
P.O. Box 860
Honolulu, HI 96808-0860

**Lawsuit:**
File a lawsuit against HMSA under section 502(a) of ERISA.

### Information Available From Us
HMSA will provide upon your request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claims as defined by ERISA. You may also request and we will provide the diagnosis and treatment codes, as well as their corresponding meanings, applicable to this notice, if available.

### Information Available From Us
For question about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

# MEMBER APPEAL RIGHTS AND PROCESS

***For more information about your appeal rights, call Customer Service or see your Guide to Benefits handbook.***

## How To File An Appeal

You have a right to appeal any decision not to provider you or pay for an item or service. Your request must be in writing (except for an expedited appeal) and must be received within one year form the date we first informed you of the denial of coverage for any requested service or supply. Your **written request** must be mailed or faxed to the following:

HMSA Member Advocacy & Appeals
P.O. Box 1958
Honolulu, HI 96805-1958
FAX NO.: (808) 952-7546 or (808) 948-8206

If you have any questions regarding appeals, you may call the following numbers:

O'ahu: (808) 948-5090
Toll free: 1 (800) 462-2085

The review of your appeal will be conducted by individuals not involved with the previous decision.

## What Your Request Must Include

To be recognized as an appeal, your request must include all of the following information:

- The date of your request
- Your name
- Your date of birth
- The date of our denial of coverage for the requested service or supply (may include copy of denial letter)
- The subscriber name from your membership card
- The provider name
- A description of facts related to your request and why you believe our decision was in error
- Any other information relating to the claim for benefits including written comments, documents, and records you would like us to review.

To assist us with processing your appeal, please also include your telephone number and the address of member to received services.

You should keep a copy of your request for your records.

## Types of Appeals You Can File

**Standard**

*Pre-certification*- We will respond to your appeal as soon as possible given the medical circumstances of your case but not later than **30 days** after we receive your appeal.

*Post-Service* – We will respond to your appeal as soon as possible but not later than **60 days** after we receive your appeal.

**Expedited**

You may request an expedited appeal if application of the pre-certification (30 days) time period may:

- Seriously jeopardize your life or health,
- Seriously jeopardize your ability to gain maximum function, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You may also request an **expedited** appeal by phone at the following number s:

O'ahu: (808) 948-5090
Toll free: 1 (800) 462-2085

We will respond to your expedited appeal request as soon as possible taking into account your medical condition but not later than **72 hours**
after all information sufficient to make a determination is provided to us.
You may also begin an external review at the same time as the internal appeals process if this is an urgent care situation or you are in an ongoing course of treatment.

## What Your Request Must Include

will Either you or your authorized representation may request an appeal. An authorized representative includes:

- Any person you authorize to act on your behalf provided you follow our procedures, which include filing a form with us.
- A court appointed guardian or an agent under a health care proxy.

To obtain a form to authorized a person to act on your behalf, call on O'ahu 948-5090 or toll free 1 (800) 462-2085.

## What Happens Next

If you appeal, we will review our decision and provider you with a written determination. If you disagree with HMSA's appeal decision, you have additional appeal rights. You may request a review by an Independent Review Organization, request arbitration or file a lawsuit against HMSA. Please see details below.

**Independent Review Organization:**

If the services request did not meet payment determination criteria, did not meet medical policy or was determined to be investigative or experimental, you may request an external review by an Independent Review Organization (IRO) selected by the Insurance Commissioner, who will review the denial and issue a final decision. You must submit your request to the Insurance Commissioner, at the address indicated below, within 130 days of HMSA's decision to deny or limit the service or supply. Unless you qualify for expedited external review of our initial decision, before requesting review, you must have exhausted HMSA's internal appeals process or show that HMSA violated federal rules related to claims and appeals unless the violation was 1)de minimis: 2) non-prejudicial; 3)

This document contains important information about your HMSA health plan. To ensure that you fully understand its contents, you may have it orally interpreted at no charge to you. At your request, this document may be interpreted into several languages: Chinese, Japanese, Korean, Ilocano, Tagalog, Spanish, Navaho or Samoan. Please contact us at 1-800-776-4672.

CHINESE: 中文: 如果您需要中文翻譯，請致電 1-800-776-4672.

JAPANESE (日本語): このレポートにつきまして、日本語による通訳をご利用できま。1-800-776-4672. までお電話ください。

KOREAN 한국어: 1-800-776-4672으로 전화하시면 무료 한국어 통역 서비스를 받으실 수 있으십니다.

ILOCANO Ilocano: No masapul yo a tulong iti ILOCANO arragan yo ti 1-800-776-4672.

TAGALOG Tagalog: Tulong sa pagpapaliwanag sa salitang TAGALOG, tawagan ang numero 1-800-776-4672.

SPANISH Español: Para obtener asistencia en Español, llame al 1-800-776-4672.

NAVAJO Dine: Dinek'ehgo shika at'ohnnol nnasingo, innilgo holne' 1-800-776-4672

SAMOAN: A mana'o mua se fesosoani I le Gagana Fa'asamoa Fa'amolemole valaau mai I le telefoni e 1-800-776-4672.

April 2, 2015

To: Representative Sylvia Luke, Chair of the House Committee on Finance
Representative Scott Nishimoto, Vice Chair of the House Committee on Finance
Senator Josh Green, Chair of the Senate Committee on Health
Senator Glenn Wakai, Vice Chair of the Senate Committee on Health
Sen. Rose Baker, Chair of the Senate Committee on Commerce and Consumer Protection
Senator Brian T. Taniguchi, Vice Chair of the Senate Committee on Commerce and Consumer Protection
Senator Jill N. Tokuda, Chair of the Senate Committee on Ways and Means
Senator Ronald D. Kouchi, Vice Chair of the Senate Committee on Ways and Means
Representative Della Au Belatti, Chair of the House Committee on Health
Representative Richard P. Creagan, Vice Chair of the House Committee on Health
Representative Angus L.K. McKelvey, Chair of the House Committee on Consumer Protection and Commerce
Representative Justin H. Woodson, Chair of the House Committee on Consumer Protection and Commerce

From: Pi`ilani Smith

Re: **SB 768 SD1**
**Confirmation by the Department of Health and Human Services Region IX CCIIO response to Hawaii email 2.2.15 - Imposes No Cost to the State**

Aloha Hawai`i Legislators:

I am pleased to inform the Hawaii legislature that SB 768 SD1 has gone under Federal Review. The U.S. Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) Office of the Center for Consumer Information & Insurance Oversight (CCIIO) representatives have provided written guidance referred to during the 3.27.15 conference call with Senator Maile Shimabukuro, Ms. Na`unanikina`u Kamali`i, and myself. This written response confirms that this measure imposes no cost liability to the State of Hawai`i. In part, the CCIIO guidance stated that:

> ***"It is our understanding that the changes made to the IVF coverage law as reflected in SB 768 SD1, the Senate version, removes marriage requirement language, reduces the five year wait time and adopts a wait time consistent with the definition of infertility by the American Society of Reproductive Medicine (ASRM), and adopts the definition of infertility by ASRM. Modifications such as those, that revise a pre-2012 requirement to be consistent with current clinical recommendations and current medical definitions, do not trigger the obligation to defray the cost as long as there are no new benefit coverage requirements inserted.***

Given this response, the State's concern of cost liability is no longer at issue. Therefore, I ask that:

1) SB 768 SD1 HD1 be heard by and passed out of the House Finance Committee; and
2) The legislature move this measure forward to bring the HRS §431:10A 116.5 and §432:1-604 into compliance with the Hawaii State Constitution Privacy Clause, and the Affordable Care Act Non-Discrimination Provisions.

**One woman, all women.**
**One family, all families.**
**One child, all children.**
**Protected.**

Thank you for your consideration.

Attachment (Email dated 4.2.15 from HHS/CMS)

From: **Bonnie Preston** Bonnie.Preston@hhs.gov
Subject: CCIIO response to Hawaii email
Date: April 2, 2015 at 8:38 AM
To: **Kawaileo Law** kawaileolaw@hawaii.rr.com, **young@capitol.hawaii.gov**, **Maile Shimabukuro** maileshimabukuro@yahoo.com, **Piilani Smith** piilaniproductions@hawaii.rr.com
Cc: **Jon P. Langmead** Jon.Langmead@cms.hhs.gov, **Tom C. Duran** Tom.Duran@cms.hhs.gov, **Allyn Moushey** Allyn.Moushey@hhs.gov, **Leigha Basini** Leigha.Basini1@cms.hhs.gov, **Lisa M. Cuozzo** Lisa.Cuozzo@cms.hhs.gov, **Lisa J. Wilson** lisa.wilson@cms.hhs.gov, **Amanda M. Schnitzer** Amanda.Schnitzer@cms.hhs.gov, **Sharon Y. Yee** Sharon.Yee@cms.hhs.gov, **Melissa Stafford Jones** Melissa.StaffordJones@hhs.gov, **Kenneth Shapiro** Kenneth.Shapiro@hhs.gov

Aloha Hawaii Colleagues:

Please find below per your request, the guidance referred to during our discussion with the U.S. Health & Human Services Centers for Medicare and Medicaid (CMS) Office of the Center for Consumer Information & Insurance Oversight (CCIIO) representatives.

Let me know if you have any further questions/concerns.

Bonnie Preston

Bonnie Preston MSPH
Policy & Outreach Specialist
Office of the Regional Director
Region IX, Health and Human Services
90 Seventh Street
San Francisco, CA 94103
O: (415)437-8503
Cell: (415)470-4574

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Thank you for your recent contact with CMS/CCIIO. We are writing with the information you requested regarding Essential Health Benefits policy, including state-required benefits and discrimination.

1. State-required Benefits

As we discussed, section 1311(d)(3)(B) of the Affordable Care Act explicitly permits a state, at its option, to require QHPs to offer benefits in addition to EHB, but requires the state to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional benefits. In regulation we finalized the policy that state-required

benefits enacted on or before December 31, 2011 (even if not effective until a later date) may be considered EHB, which would obviate the requirement for the state to defray costs for these state-required benefits

45 CFR 155.170 reads as follows:
Additional required benefits. (a) Additional required benefits. (1) A State may require a QHP to offer benefits in addition to the essential health benefits. (2) A State-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits. (3) The Exchange shall identify which state-required benefits are in excess of EHB. (b) Payments. The State must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following: (1) To an enrollee, as defined in § 155.20 of this subchapter; or (2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section. (c) Cost of additional required benefits. (1) Each QHP issuer in the State shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section. (2) A QHP issuer's calculation shall be: (i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies; (ii) Conducted by a member of the American Academy of Actuaries; and (iii) Reported to the Exchange.

We have also released the following clarification on our website:
For purposes of determining EHB, we consider state-required benefits (or mandates) to include only requirements that a health plan cover specific care, treatment, or services. We do not consider provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, to be state-required benefits for purposes of EHB coverage. Similarly, we do not consider state-required benefits to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, we do not consider state anti-discrimination requirements relating to service delivery method (e.g., telemedicine) as state-required benefits.

It is our understanding that the changes made to the IVF coverage law as reflected in SB 768 SD1, the Senate version, removes marriage requirement language, reduces the five year wait time and adopts a wait time consistent with the definition of infertility by the American Society of Reproductive Medicine (ASRM), and adopts the definition of infertility by ASRM. Modifications such as those, that revise a pre-2012 requirement to be consistent with current

clinical recommendations and current medical definitions, do not trigger the obligation to defray the cost as long as there are no new benefit coverage requirements inserted.

2. Discrimination

Section 1302(b)(4) of the Affordable Care Act directs the Secretary to address certain standards in defining EHB, including elements related to balance, discrimination, the needs of diverse sections of the population, and denial of benefits. We have interpreted this provision as a prohibition on discrimination by issuers providing EHB. Within 45 CFR 156.125, which implements these provisions, we finalized in regulation that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

45 CFR 156.200 and 45 CFR 156.225 also apply to all issuers required to provide coverage of EHB, prohibiting discrimination based on factors including but not limited to race, color, national origin, disability, age, sex, gender identity and sexual orientation. Issuers are also prohibited from having marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

Enforcement of the PHS Act provisions codified in 45 CFR 156.125 is governed by section 2723 of the PHS Act, which first looks to states and then to the Secretary where a state has does not substantially enforce. The approach to nondiscrimination will reserve flexibility for both HHS and the states to respond to new developments in benefit structure and implementation and to be responsive to varying circumstances across the states.

The EHB regulations do not prohibit issuers from applying reasonable medical management techniques. An issuer could use a reasonable medical management technique as long as it is not implemented in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and evidence based.

Lisa M. Cuozzo, J.D.
Health Insurance Specialist
Office of Health Insurance Exchanges/Issuer and Plan Policy Branch
Center for Consumer Information and Insurance Oversight (CCIIO)

From: **Rachel Hibbard** rhibbard@auditor.state.hi.us
Subject: **MHI is not required for change to existing in vitro fertilization law**
Date: **March 31, 2015 at 12:15 PM**
To: **Piilani Smith** piilaniproductions@hawaii.rr.com

Aloha, Ms. Smith:

Thank you for your call. To clarify:

1) Section 23-51, Hawai'i Revised Statutes requires that before any legislative measure that mandates health insurance (MHI) coverage for specific health services, specific diseases, or certain providers of health care services as part of individual or group health insurance policies can be considered, there has to be a concurrent resolution passed requesting the Auditor to submit a report that assesses the social and financial effects of the proposed mandated coverage. The resolution must identify a specific bill to be analyzed.

2) The resolution you are referring to is SCR No. 56, which would ask the Auditor to conduct an MHI study on infertility procedure coverage for all individual and group accident and health or sickness insurance policies that provide pregnancy-related benefits.

3) The bill that would be analyzed is SB No. 768, which proposes to amend Sections 431:10A-116.5 and 432:1-604 (*In vitro fertilization procedure coverage*), HRS.

4) Sen. Baker is correct that an MHI study is not necessary (and therefore neither is the hearing on the resolution). However, the reason is not because we have already done a similar study; it is because there is already a law that mandates health insurance for in vitro fertilization. Therefore, it is the Legislature's prerogative to simply amend the existing law (via SB 768 or another appropriate vehicle), without asking for an additional MHI study.

I hope this helps. Mahalo for your interest in our work.

Kind regards,

Rachel Hibbard

Rachel Hibbard, Deputy Auditor, Office of the State Auditor, Honolulu Hawai'i; (808) 587-0800; rhibbard@auditor.state.hi.us; www.auditor.hawaii.gov

LATE

TO: **COMMITTEE ON FINANCE**
The Honorable Sylvia Luke, Chair
The Honorable Scott Y. Nishimoto, Vice Chair

FROM: Pi'ilani Smith

SUBJECT: **SB 768 SD1 HD1– RELATING TO IN VITRO FERTILIZATION COVERAGE**

Hearing: Wednesday, April 8, 2015
Time: 2:00 p.m.
Place: Conference Room 308

> "It is our understanding that the changes made to the IVF coverage law as reflected in SB 768 SD1, the Senate version, removes marriage requirement language, reduces the five year wait time and adopts a wait time consistent with the definition of infertility by the American Society of Reproductive Medicine (ASRM), and adopts the definition of infertility by ASRM. **Modifications such as those, that revise a pre-2012 requirement to be consistent with current clinical recommendations and current medical definitions, do not trigger the obligation to defray the cost as long as there are no new benefit coverage requirements inserted.**"[1]
>
> *U.S. Department of Health and Human Services (HHS) Region IX*
> *Center for Consumer Information and Insurance Oversight (CCIIO) response to Hawaii email 4.2.15*

This testimony is in **strong support of SD 768 SD1 HD1** with considerations**.** The purpose of this measure as stated in SECTION 1 of this measure "is to provide in vitro fertilization coverage equality for women who are diagnosed with infertility by requiring non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility." The Senate version of this measure has passed the Senate, in compliance with State and Federal laws. Federal agencies and the Hawaii States Auditor's Office have reviewed SB 768 SD1, and have provided written response, which is attached in this testimony. The federal response confirms that SB 768 SD1 imposes no cost liability to the state. However, the House Committee on Health in HD1 (HSCR 1180) has adopted discriminatory provisions submitted by HMSA as restrictions, which are prohibited by federal law.

[1] See attachment. *U.S. Department of Health and Human Services (HHS) Region IX Center for Consumer Information and Insurance Oversight (CCIIO) response to Hawaii email 4.2.15*

Despite the discriminatory provisions in this measure, I ask the Finance Committee to pass this measure, and forward it to conference with the Senate, with the following considerations and justifications.

1. **No cost liability to the State of Hawaii**.
   All changes to HRS §431:10A-116.5 and HRS §432:1-604 as created in SB 768 SD1 have gone under federal review, and were found to be in compliance with the non-discrimination clause of the Affordable Care Act (ACA), imposing no cost liability for changes to the Essential Health Benefits (EHB's) as required under the ACA. See attached, Federal Response to SB 768 SD1.

   **Justification**
   Federal:
   Pursuant to the ACA and implementing regulations, the U.S. HHS Region IX CCIIO response to Hawaii email 2.2.15 states:

   > "It is our understanding that the changes made to the IVF coverage law as reflected in SB 768 SD1, the Senate version, removes marriage requirement language, reduces the five year wait time and adopts a wait time consistent with the definition of infertility by the American Society of Reproductive Medicine (ASRM), and adopts the definition of infertility by ASRM. **Modifications such as those, that revise a pre-2012 requirement to be consistent with current clinical recommendations and current medical definitions, do not trigger the obligation to defray the cost as long as there are no new benefit coverage requirements inserted.**"

2. **Constitutionality – Compliance with the Hawaii State Constitution.**

   The Hawaii State Legislature has an obligation to uphold the State's Constitution in the creating of law. However, the State of Hawaii has been violating its own constitution for 28 years, since the enactment of HRS §431:10A 116.5 and HRS §432:1-604 In vitro fertilization procedure coverage. The right of a woman to beget a child is a fundamental right, protected under the State Constitution, and supported in numerous decisions by the Hawaii Supreme Court.

   **Justification**
   State:
   Pursuant to the Hawaii State Constitution Article I §6, it states:

   > "The right of the people to privacy is recognized and shall not be infringed without the showing of a compelling state interest. The legislature shall take affirmative steps to implement this right."

   In State v. Mueller, 66 Haw. 616, 612, 671 P.2d 1351 (1983), the Hawaii Supreme court held:

> "If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusions into matters so fundamentally affecting a person as the decision whether to bear or beget a child."

In Doe v. Doe, 172 P.3d 1078 (Haw. 2007) (quoting State v. Mallan, 950 P.2d at 233), the Supreme Court held under the Constitutional Right of Privacy:

> "among the decisions that an individual may make without unjustified government interference are personal decisions relating to marriage, procreation… ."

In State v. Mueller, 671 P.2d 1351 (Haw. 1983) the court held:

> "Only personal rights that can be deemed fundamental or implicit in the concept of ordered liberty are included in this guarantee of personal privacy."

**Remedy**

The State of Hawaii has not provided a compelling state interest to warrant the infringement of a woman's right to beget a child, yet has imposed numerous discriminatory prohibitions through the enactment of the Hawaii IVF mandate. SB 768 SD1 HD1 is a corrective measure bringing the current statutes in compliance with its State Constitution. This measure does the following:

a. **Removes the discriminatory and unconstitutional marital status requirement**

   A woman's right of privacy protected under Article I § 6 of the State Constitution. **Marital status has no bearing regarding the medical treatment of a woman diagnosed with infertility.** The marital status requirement discriminates against women that are single, coupled yet choose to not marry, and lesbians.

b. **Adopts the American Society of Reproductive Medicine (ASRM) definition of infertility**, which state:

   > "a disease, defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years."

3. **Compliance with ACA**

   Adoption of the ASRM definition of infertility, replaces the arbitrary requirement of a five year history of infertility with a medical standard, as required under 80 Fed. Reg. 10750, 10822 (February 27, 2015), which states:

   > "Issuers are expected to impose limitations and exclusions based on clinical guidelines and medical evidence,"

**Concerns Regarding 3 Discriminatory Provisions Introduced by HMSA and Adopted in HD1**

**HMSA's Amendments #1 - To retain the discriminatory language "that a patient's oocytes be fertilized. [Page 3, Lines 1-2, and Page5, Lines 12-13]**."

Prohibiting a woman from using a donor's oocyte is an arbitrary prohibition with no medical basis. HMSA lobbied in the House, and cited in their written testimony to the Committee on Health that the patient's oocytes to be fertilized … "is a necessary condition for the IVF procedure." **There is no medical definition or medical standard in the medical procedure of IVF that requires the patient's oocytes as a necessary condition.** What is required in the IVF procedure is that an oocyte be fertilized with sperm. To assert that a necessary condition for the IVF procedure is the patient's oocytes, is as preposterous and discriminatory as the marital status requirement in the existing law. Needless to say, HMSA vigorously upheld for 27 years in its delivery of services, until I filed an internal appeal in 2013 with HMSA on this very issue citing discriminatory practices, violating the ACA, the Hawaii Constitution, and federal and state laws prohibiting discrimination.

FACT: "Most of HMSA's plans cover IVF using donor oocytes and sperm, there are a few that do not."[2]

It is discriminatory, to prohibit a woman from accessing her medical benefit of IVF based on her medical condition. HMSA's Amendment #2 discriminates against women with genetic disorders such as spinal muscular dystrophy, or translocation (where the chromosomes are not in proper sequence). The source of these types of conditions of infertility is directly related to the patient's oocytes. The state has provided no compelling interest to impose this arbitrary and prohibitive provision, according to the privacy clause of the Hawaii Constitution. Likewise, HMSA has not provided the clinical guidelines and medical evidence to impose this limitation as required under, 80 Fed. Reg. 10822e. (February 27, 2015). It states:

> "Issuers are expected to impose limitations and exclusions based on clinical guidelines and medical evidence,"

In the internal appeals process with HMSA, HMSA has asserted numerous times that it did not violate any non-discrimination laws. It claimed that the Hawaii IVF mandate allowed the prohibition. Consequently, the marriage requirement was heavily lobbied against by HMSA last session, and in previous sessions.

[2] See attachment. HMSA IVF Policy 4.25.2014

HMSA generously devotes financial support and resources in its lobbying efforts and practices. It systematically and unilaterally opposes and defeats all measures requiring any changes to coverage until HMSA is caught with its pants down, and can no longer justify its unfounded assertions as against statutes, regulations, policies and the threat of sanctions and full litigation. HMSA relies on the likelihood that a member will not bring a cause of action against it. HMSA holds an inherent conflict of interest in its internal appeals process, where the consumer advocate is employed by and answerable to senior corporate management, which upholds and implements the discriminatory practices in question. The result of the appeals is predictably and typically, a denial of the benefit. Consequently, without exhausting the internal appeals process, a member is prohibited from filing a claim in court, for relief. Likewise, few members, if any, can afford the legal fees and expenses to fully litigate.

**Result**
The reason for HMSA's Amendment # is motivated by profit, and not by the quality of care in the delivery of services. The IVF mandate is limited to a one-time lifetime benefit. The underwriting of this mandate generates profits for HMSA, given the numerous prohibitive requirements, and one-time lifetime benefit limitation.

**Remedy**
Provide IVF benefit coverage to all women diagnosed with infertility in a non-discriminatory way, in order to provide quality of care in the delivery of services.

**HMSA's Amendment #2 - The definition of "infertility" should exclude voluntary sterilization or natural menopause.** [Page 4, Lines 11-14; and Page 7, Lines 1-4]

This "HMSA amendment" imposes exclusions of "voluntary sterilization and natural menopause" within the ASRM definition of infertility. These exclusions are arbitrary, and are not based on clinical guidelines and medical evidence. HMSA's amendments alters the true and correct definition of infertility by adding these exclusions and it fails to submit justification with supporting documentation to the legislature explaining how the imposed exclusions are not discriminatory.[3] What is guised as a utilization management technique is clearly a discriminatory practice under the ACA implementing regulations.

"HMSA Amendment #2" is exclusionary, which creates yet, another prohibited and discriminatory practice in violation of the ACA.[4] These exclusions are discriminatory because there is no appropriate non-discriminatory reason for the practice.[5] The exclusions preclude access to the health benefit by imposing a discriminatory utilization limitation, inconsistent with medical guidelines and medical evidence for infertility diagnosis and treatment as provided in the definition of infertility according to the national medical organization standards of ASRM and American Congress of

[3] 80 Fed. Reg. 10750, 10823 (February 27, 2015)

[4] See attachment. HMSA Testimony to the House Committee on Health dated March 25, 2015 at Subsection 2 of Paragraph 3, citing no medical justification for the exclusion.

[5] 80 Fed. Reg. 10750, 10823 (February 27, 2015)

Obstetricians and Gynecologists (ACOG). These national medial standards and definitions of infertility has also been adopted by the U.S. Department of Health and Human Services, Office of Women's Health, as reflected in its definition of infertility, ***"infertility is defined as the inability to become pregnant after one year of trying, or after six months if the woman is 35 or older. Women who can become pregnant but are unable to remain pregnant may also be infertile."*** [6]

Federal Register further notes that other nondiscrimination and civil rights laws may apply, including the Americans with Disabilities Act, section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973 and State law. Compliance with the discriminatory provisions of §156.125 is not determinative of compliance with any other applicable requirements. [7]

> 45 CFR §156.125 (e) § 156.125 Prohibition on discrimination.
>
> **(a)** An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.
>
> **(b)** An issuer providing EHB must comply with the requirements of § 156.200(e) of this subchapter; and
>
> **(c)** Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

> 45 CFR §156.200 (e) Non-discrimination. A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

> 45 CFR §156.225 Marketing and Benefit Design of QHPs. A QHP issuer and its officials, employees, agents and representatives must—
>
> **(a)** ***State law applies.*** Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and
>
> **(b)** ***Non-discrimination.*** Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

> Pursuant to 80 Fed. Reg. 10750, 10822 (February 27, 2015) it states:
>
> "Under §156.125, which implements the prohibition on discrimination provisions, an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individuals

[6] Hawaii State Auditor's Report 12-9.

[7] 80 Fed. Reg. 10750, 10820 (February 27, 2015)

> age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."
>
> "As described in the proposed rule, since we finalized §156.125, we have become aware of benefit designs that we believe would discourage enrollment by individuals based on age or based on health conditions, in effect making those plan designs discriminatory, thus violating this prohibition."

Under the Hawaii State Constitution Privacy Clause, the Hawaii State Legislature is required to provide a compelling state interest to infringe upon a citizen's right to privacy. However, the state has not such compelling interest, yet imposes arbitrary prohibitions of marital status, use of a patients oocytes, a five year history requirement without medical basis as found in HRS §431:10A 116.5 and HRS §432:1-604. The insurance companies have lobbied the legislature relentlessly, to ensure their profit margins are protected through prohibitive and arbitrary restrictions without medical basis. Such is the case with the requirement that a patient uses her own oocyte.

There is no compelling state interest to require a woman diagnosed with infertility to use her own oocytes in order to beget a child, yet HMSA and Kaiser Permanente lobby for the prohibitions. These prohibitions have been enacted, and as a result, HMSA and Kaiser use the discriminatory law as the reason why they provide the medical coverage.

**Remedy to the Discrimination**

The deletion of subsection 3 in its entirety (as introduced in SB 768 and passed as SB 768 SD1) to address the discrimination based on marital status and infertility disability (requiring the patient's oocytes be fertilized), does not create a new benefit requirement, according to the federal response issued on 4.2.2015.[8] Additionally, allowing a woman to use donor oocytes presents no changes to the existing cost limiting language, which provides for a "one-time only benefit for all out patient expenses arising from IVF procedures"… . The underwriting for the benefit is factored as a one-time benefit and therefore, it does not expand the treatment option as all women are paying on the one time benefit premium. Allowing a woman to use donor oocytes, does not exceed the one time benefit, and therefore bears no cost to the state. Furthermore, every woman regardless of her specific infertility diagnosis should be provided this one time lifetime benefit, as there is no difference in the premium given the underwriting practices.

Therefore, HMSA's AMENDMENT #2, requiring a patient to use her own oocyte is arbitrary, bearing no medical standard requirement by definition, discriminatory and prohibitive. Such a **requirement is a profit generating provision, to collect on premiums while prohibiting coverage, and prohibited by law**.

[8] Id.

**HMSA AMENDMENT #3 - "(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"**

HMSA's AMENDMENT #3 reverts back to yet again, another discriminatory provision of the existing mandate – where SB 768 and SB 768 SD1 provided corrective, non-discriminatory provisions equally to all women. This provision currently implemented by HMSA, requires that women with a PPO Plan do three intrauterine insemination (IUI), which are not covered under a PPO, while women with a HMO Plan, which are covered under a HMO are only required to do one IUI.

This provision reduces benefits for a particular group (i.e. PPO), and is not based on clinical guidelines and medical evidence, or use of medical reasonable management, and is implemented in a discriminatory manner. Furthermore, this provision as implemented by HMSA, discriminates against lesbians based on sexual orientation, requiring 3 IUI's. Additionally, single women are also discriminated against, requiring them to do three IUI's.

HMSA's AMENDMENT #3, to require alternatives, for which coverage is not provided, is per se discriminatory.[9] This is liken to the example provided in the Federal Register under the Prohibition on Discrimination (§ 156.125) which states, "refusal to cover a single-tablet drug regimen or extended-release product that is customarily prescribed, and is just as effective as a multi-tablet regimen, absent and appropriate reason for such refusal, … ." [10] This provision is profit generating.

**Remedy**

All women have a right to quality of care in the delivery of health services, regardless of their sexual orientation, marital status, health condition, and age. There is no medical or reasonable and rational basis to require lesbian women to do two more IUI's than women with a male counterpart. Additionally, any requirements involving alternative infertility treatments should be covered, and not based on the insurance contract.

No lesbian or single woman be required to undergo a different standard of care than another woman. This discriminatory provision is based on sexual orientation, marital status, and profit.

[9] Id.

[10] 80 Fed. Reg. 10750, 10822

April 2, 2015

To: Representative Sylvia Luke, Chair of the House Committee on Finance
Representative Scott Nishimoto, Vice Chair of the House Committee on Finance
Senator Josh Green, Chair of the Senate Committee on Health
Senator Glenn Wakai, Vice Chair of the Senate Committee on Health
Sen. Rose Baker, Chair of the Senate Committee on Commerce and Consumer Protection
Senator Brian T. Taniguchi, Vice Chair of the Senate Committee on Commerce and Consumer Protection
Senator Jill N. Tokuda, Chair of the Senate Committee on Ways and Means
Senator Ronald D. Kouchi, Vice Chair of the Senate Committee on Ways and Means
Representative Della Au Belatti, Chair of the House Committee on Health
Representative Richard P. Creagan, Vice Chair of the House Committee on Health
Representative Angus L.K. McKelvey, Chair of the House Committee on Consumer Protection and Commerce
Representative Justin H. Woodson, Chair of the House Committee on Consumer Protection and Commerce

From: Pi`ilani Smith

Re: **SB 768 SD1**
**Confirmation by the Department of Health and Human Services Region IX CCIIO response to Hawaii email 2.2.15 - Imposes No Cost to the State**

Aloha Hawai`i Legislators:

I am pleased to inform the Hawaii legislature that SB 768 SD1 has gone under Federal Review. The U.S. Health & Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) Office of the Center for Consumer Information & Insurance Oversight (CCIIO) representatives have provided written guidance referred to during the 3.27.15 conference call with Senator Maile Shimabukuro, Ms. Na`unanikina`u Kamali`i, and myself. This written response confirms that this measure imposes no cost liability to the State of Hawai`i. In part, the CCIIO guidance stated that:

> ***"It is our understanding that the changes made to the IVF coverage law as reflected in SB 768 SD1, the Senate version, removes marriage requirement language, reduces the five year wait time and adopts a wait time consistent with the definition of infertility by the American Society of Reproductive Medicine (ASRM), and adopts the definition of infertility by ASRM. Modifications such as those, that revise a pre-2012 requirement to be consistent with current clinical recommendations and current medical definitions, do not trigger the obligation to defray the cost as long as there are no new benefit coverage requirements inserted.***

Given this response, the State's concern of cost liability is no longer at issue. Therefore, I ask that:

1) SB 768 SD1 HD1 be heard by and passed out of the House Finance Committee; and
2) The legislature move this measure forward to bring the HRS §431:10A 116.5 and §432:1-604 into compliance with the Hawaii State Constitution Privacy Clause, and the Affordable Care Act Non-Discrimination Provisions.

**One woman, all women.**
**One family, all families.**
**One child, all children.**
**Protected.**

Thank you for your consideration.

Attachment (Email dated 4.2.15 from HHS/CMS)

From: **Bonnie Preston** Bonnie.Preston@hhs.gov
Subject: CCIIO response to Hawaii email
Date: April 2, 2015 at 8:38 AM
To: **Kawaileo Law** kawaileolaw@hawaii.rr.com, **young@capitol.hawaii.gov**, **Maile Shimabukuro** maileshimabukuro@yahoo.com, **Piilani Smith** piilaniproductions@hawaii.rr.com
Cc: **Jon P. Langmead** Jon.Langmead@cms.hhs.gov, **Tom C. Duran** Tom.Duran@cms.hhs.gov, **Allyn Moushey** Allyn.Moushey@hhs.gov, **Leigha Basini** Leigha.Basini1@cms.hhs.gov, **Lisa M. Cuozzo** Lisa.Cuozzo@cms.hhs.gov, **Lisa J. Wilson** lisa.wilson@cms.hhs.gov, **Amanda M. Schnitzer** Amanda.Schnitzer@cms.hhs.gov, **Sharon Y. Yee** Sharon.Yee@cms.hhs.gov, **Melissa Stafford Jones** Melissa.StaffordJones@hhs.gov, **Kenneth Shapiro** Kenneth.Shapiro@hhs.gov

Aloha Hawaii Colleagues:

Please find below per your request, the guidance referred to during our discussion with the U.S. Health & Human Services Centers for Medicare and Medicaid (CMS) Office of the Center for Consumer Information & Insurance Oversight (CCIIO) representatives.

Let me know if you have any further questions/concerns.

Bonnie Preston

Bonnie Preston MSPH
Policy & Outreach Specialist
Office of the Regional Director
Region IX, Health and Human Services
90 Seventh Street
San Francisco, CA 94103
O: (415)437-8503
Cell: (415)470-4574

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Thank you for your recent contact with CMS/CCIIO. We are writing with the information you requested regarding Essential Health Benefits policy, including state-required benefits and discrimination.

1. State-required Benefits

As we discussed, section 1311(d)(3)(B) of the Affordable Care Act explicitly permits a state, at its option, to require QHPs to offer benefits in addition to EHB, but requires the state to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional benefits. In regulation we finalized the policy that state-required

benefits enacted on or before December 31, 2011 (even if not effective until a later date) may be considered EHB, which would obviate the requirement for the state to defray costs for these state-required benefits

45 CFR 155.170 reads as follows:
Additional required benefits. (a) Additional required benefits. (1) A State may require a QHP to offer benefits in addition to the essential health benefits. (2) A State-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits. (3) The Exchange shall identify which state-required benefits are in excess of EHB. (b) Payments. The State must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following: (1) To an enrollee, as defined in § 155.20 of this subchapter; or (2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section. (c) Cost of additional required benefits. (1) Each QHP issuer in the State shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section. (2) A QHP issuer's calculation shall be: (i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies; (ii) Conducted by a member of the American Academy of Actuaries; and (iii) Reported to the Exchange.

We have also released the following clarification on our website:
For purposes of determining EHB, we consider state-required benefits (or mandates) to include only requirements that a health plan cover specific care, treatment, or services. We do not consider provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, to be state-required benefits for purposes of EHB coverage. Similarly, we do not consider state-required benefits to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, we do not consider state anti-discrimination requirements relating to service delivery method (e.g., telemedicine) as state-required benefits.

It is our understanding that the changes made to the IVF coverage law as reflected in SB 768 SD1, the Senate version, removes marriage requirement language, reduces the five year wait time and adopts a wait time consistent with the definition of infertility by the American Society of Reproductive Medicine (ASRM), and adopts the definition of infertility by ASRM. Modifications such as those, that revise a pre-2012 requirement to be consistent with current

clinical recommendations and current medical definitions, do not trigger the obligation to defray the cost as long as there are no new benefit coverage requirements inserted.

2. Discrimination

Section 1302(b)(4) of the Affordable Care Act directs the Secretary to address certain standards in defining EHB, including elements related to balance, discrimination, the needs of diverse sections of the population, and denial of benefits. We have interpreted this provision as a prohibition on discrimination by issuers providing EHB. Within 45 CFR 156.125, which implements these provisions, we finalized in regulation that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

45 CFR 156.200 and 45 CFR 156.225 also apply to all issuers required to provide coverage of EHB, prohibiting discrimination based on factors including but not limited to race, color, national origin, disability, age, sex, gender identity and sexual orientation. Issuers are also prohibited from having marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

Enforcement of the PHS Act provisions codified in 45 CFR 156.125 is governed by section 2723 of the PHS Act, which first looks to states and then to the Secretary where a state has does not substantially enforce. The approach to nondiscrimination will reserve flexibility for both HHS and the states to respond to new developments in benefit structure and implementation and to be responsive to varying circumstances across the states.

The EHB regulations do not prohibit issuers from applying reasonable medical management techniques. An issuer could use a reasonable medical management technique as long as it is not implemented in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and evidence based.

Lisa M. Cuozzo, J.D.
Health Insurance Specialist
Office of Health Insurance Exchanges/Issuer and Plan Policy Branch
Center for Consumer Information and Insurance Oversight (CCIIO)

hmsa

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# In Vitro Fertilization

**Policy Number:**
MM.06.017
**Line(s) of Business:**
HMO; PPO
**Section:**
OB/GYN & Reproduction
**Place(s) of Service:**
Outpatient

**Original Effective Date:**
05/21/1999
**Current Effective Date:**
04/25/2014

## I. Description

In vitro fertilization is a method used to treat infertility. It involves the administration of medications to stimulate the development, growth and maturation of eggs that are within the ovaries. The eggs are retrieved from the follicles when they reach optimum maturation and are combined with sperm in the laboratory before being placed in an incubator to promote fertilization and embryo development. The embryos are then transplanted back into the woman's uterus.

## II. Criteria/Guidelines

A. In vitro fertilization for opposite sex couples is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:
   1. The patient and spouse or civil union partner are legally married or joined according to the laws of the State of Hawaii.
   2. The couple has a five-year history of infertility, or infertility associated with one or more of the following conditions:
      a. Endometriosis
      b. Exposure in utero to diethylstilbestrol (DES)
      c. Blockage or surgical removal of one or both fallopian tubes
      d. Abnormal male factors contributing to the infertility
   3. The patient and spouse or civil union partner have been unable to attain a successful pregnancy through other infertility treatments for which coverage is available.

B. In vitro fertilization for female couples is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:
   1. The patient and civil union partner are legally joined according to the laws of the State of Hawaii.
   2. The patient, who is not known to be otherwise infertile, has failed to achieve pregnancy following 3 cycles of physician directed, appropriately timed intrauterine insemination (IUI). This applies whether or not the IUI is a covered service.

C. The in vitro procedure must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists (ACOG) guidelines for in vitro fertilization clinics or the American Society for Reproductive Medicine's (ASRM) minimal standards for programs of in vitro fertilization.

## III. Limitations/Exclusions

A. Coverage for in vitro fertilization services for civil union couples only applies to groups and individual plans that provide coverage for civil union couples.

B. Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while the patient is an HMSA member. This benefit is limited to one complete attempt at in vitro fertilization per qualified married or civil union couple. If this benefit was received under one HMSA plan, the member is not eligible for in vitro fertilization benefits under any other HMSA plan, except for Federal Plan 87 which has a separate limit of one complete procedure

   1. A complete in vitro attempt or cycle is defined as a complete effort to fertilize eggs and transfer the resulting embryo(s) into the patient. A complete cycle does not guarantee pregnancy. Members are liable for the costs of any subsequent attempts, regardless of the reason for the previous failure.

C. In vitro fertilization services are not covered for married or civil union couples when a surrogate is used. A surrogate is defined as a woman who carries a child for a couple or single person with the intention of giving up that child once it is born.

D. While most of HMSA's plans cover in vitro fertilization using donor oocytes and sperm, there are a few that do not. Providers should check the patient's plan benefits before considering the procedure.

   1. While the patient may be precertified for the IVF procedure, HMSA will not cover the cost of donor oocytes and donor sperm, and any donor-related services, including, but not limited to collection, storage and processing of donor oocytes and donor sperm.

E. Cryopreservation of oocytes, embryos or sperm is not covered.

## IV. Administrative Guidelines

A. Precertification is required. To precertify, please complete the In Vitro Fertilization Precertification and mail or fax the form as indicated. Appropriate documentation to support a clinical diagnosis should be submitted with the precertification request.

B. For claims filing instructions, see Billing Instructions and Code Information. HMSA reserves the right to perform retrospective reviews to validate if services rendered met coverage criteria.

## V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

## VI. References


1. American Society for Reproductive Medicine (SART). Age and Fertility: A Guide for Patients, Revised 2012.
2. Bancsi LF, Broeknas FJ, Eijkemans MJ, et al. Predictors of poor ovarian response in in vitro fertilization: a prospective study comparing basal markers of ovarian reserve. Fertility Sterility 2002 February; 77 (2): 328-36.
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7. Watt AH, Legedza AT, Ginsburg ES, et al. the prognostic value of age and follicle-stimulation hormone levels in women over forty years undergoing in vitro fertilization. Journal of Assisted Reproductive Genetics 2000 May; 17 (5): 264-8.
8. HMSA Guide to Benefits. HPH January 2014 and PPP January 2014.
9. Hawaii Revised Statutes, Sections 431:10A-116.5 and 432.1-604.
10. Hawaii Marriage Equality Act. Senate Bill 1369. Available at: http://www.capitol.hawaii.gov/session2014/bills/SB1369_.pdf. Accessed April 2014.
11. Hawaii Civil Union Law. Senate Bill 232. Available at: http://health.hawaii.gov/vitalrecords/about-civil-unions/. Accessed April 2014.

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March 25, 2015

The Honorable Della Au Belatti, Chair
The Honorable Richard P. Creagan, Vice Chair
House Committee on Health

**Re: SB 768, SD1 – Relating to In Vitro Fertilization Insurance Coverage**

Dear Chair Au Belatti, Vice Chair Creagam and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 768, SD1, which would require health insurance coverage for women who are diagnosed with infertility by making available to them expanded treatment options. HMSA would like to offer comments on this Bill.

We are aware and empathetic to the situations under which the procedures would be conducted. In fact, HMSA already offers coverage for IVF services, and we agree with the provision in SB 768, SD1, that deletes the current spousal requirement. We already have eliminated a spousal requirement in our medical policies, and this amendment would comport with practice.

That said, this Bill raises issues that need to be considered, and we have attached a proposed SB 768, HD 1, for consideration. Specifically, we are concerned that:

(1) While we agree that references to "spouse" should be deleted, the Bill should retain existing language requiring the patient's oocytes to be fertilized. That is a necessary condition for the IVF procedure. [Page 3, Lines 1 – 2; and Page 5, Lines 12 – 13]

(2) The definition of "infertility" should exclude voluntary sterilization or natural menopause. [Page4, Lines 11 – 14; and Page 7, Lines 1 – 4]

(3) We are concerned about the amendments both to Section 431:10A-116.5(4), HRS, [Section 2 of the Bill] and to Section 432:1-604(4), HRS [Section 3 of the Bill]. First, the change from "is available" to "shall be available" may result in an expansion of the coverage mandate to non-IVF services. As such, it would be considered a new mandate under the Affordable Care Act and the cost of such services would be the financial responsibility of the State. [Page 3, Line 17; and Page 6, Line 10]

Additionally, we are concerned about the addition of the phrase, "unless the individual's physician determines that those treatments are likely to be unsuccessful. This amendment effectively diminishes the authority of a plan's medical panel to review medical necessity. [Pages 3, Line 20 to Page, 4 Lines 1 -2; and Page 6, Lines 11 – 13]

Thank you for allowing us to testify on SB 768, SD1, and you consideration of the concerns we have raised is appreciated.

Sincerely,

Jennifer Diesman
Vice President, Government Relations

Attachment

LATE

**Individual Testimony of Nicholas J. Lockwood**
3rd Grade, Punahou School
Re: SB 768, SD1, HD1 (HSCR1180)
Relating to In Vitro Fertilization Insurance Coverage
Wednesday, April 8, 2015, 2:00 p.m.

Madam Chairwoman, and members of the Committee:

My name is Nicholas Lockwood. I am 9 years old, and I am in the third grade at Punahou School. When my mom told me about this hearing, I knew that there would be lots of adults here to talk about the law. I asked to come talk to you about something even more important: the families affected by the law.

I care because I have a single mom and, if things had worked out differently, I wouldn't be here, and neither would my little brother, who is 6. I know some people might wonder whether we should even help single moms have children and I want to tell you this: I have friends with all different types of families. Some have two parents, some have one parent. Sometimes the parents are married, sometimes they aren't. Sometimes they live far apart – sometimes even on the mainland. And sometimes they're not even being raised by their parents, but by their grandparents, aunties or uncles. And what I've learned is this: It's not how many parents you have, or if they're married to each other. What matters is how much love, attention, and support you get. I get more love, attention and support from my single mom and my extended family than I could ever wish for. More, even, than some of my friends get from two, married parents.

So, you don't need to worry about helping single moms have children because, when they want them as bad as my mom wanted me, they make sure they're surrounded by love.

Thank you, and if you have any questions, I'd be glad to answer.