STATE OF NEW YORK

8441--B

IN SENATE

May 7, 2018

Introduced by Sens. PHILLIPS, HELMING, AKSHAR, BONACIC, LITTLE, MARCHIONE, O'MARA, YOUNG -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to insurance coverage of in vitro fertilization and other fertility preservation treatments; and to amend part K of chapter 82 of the laws of 2002 amending the insurance law and the public health law relating to coverage for the diagnosis and treatment of infertility, in relation to grants for infertility services

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Paragraph 13 of subsection (i) of section 3216 of the insurance law is amended by adding three new subparagraphs (C), (D) and (E) to read as follows:

(C) Every policy delivered or issued for delivery in this state that provides coverage for hospital, surgical or medical care shall provide a maximum lifetime limit of fifty thousand dollars coverage for:

(i) in vitro fertilization used in the treatment of infertility; and

(ii) standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.

(D) For the purposes of subparagraph (C) of this paragraph:

(i) "Infertility" means a condition or disease characterized by the incapacity to impregnate another person or to conceive, as diagnosed or determined (I) by a physician licensed to practice medicine in this state, or (II) by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse, or after six months of regular, unprotected sexual intercourse in the case of a female over age thirty-five.

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

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(ii) "Iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

(iii) Coverage for prescription drugs necessary as part of in vitro fertilization or standard fertility preservation services is only available where the policy otherwise provides coverage for prescription drugs.

(iv) Notwithstanding any other provision of law, a policy may impose cost sharing, deductibles or coinsurance obligations that exceed the dollar amount of cost sharing, deductibles or coinsurance obligations for non-preferred brand name drugs or their equivalent.

(E) For services provided pursuant to subparagraph (C) of this paragraph, policies may:

(i) Require that services be performed by clinics or medical centers that conform to guidelines issued by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists (ACOG);

(ii) Require, notwithstanding network adequacy requirements, that all services be performed at designated providers identified by the insurer as meeting specified credentialing and quality standards and which participate in the insurer's provider network;

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

(iv) For purposes of calculating the lifetime limit, require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy issued by the same insurer or by another insurer; or

(v) Limit coverage related to in vitro fertilization services to persons whose ages range from twenty-one through forty-four years.

§ 2. Paragraph 6 of subsection (k) of section 3221 of the insurance law is amended by adding four new subparagraphs (E), (F), (G) and (H) to read as follows:

(E) Every group policy delivered or issued for delivery in this state that provides hospital, surgical or medical coverage shall provide a maximum lifetime limit of fifty thousand dollars of coverage for:

(i) in vitro fertilization used in the treatment of infertility; and

(ii) standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.

(F) For the purposes of subparagraph (E) of this paragraph:

(i) "Infertility" means a condition or disease characterized by the incapacity to impregnate another person or to conceive, as diagnosed or determined (I) by a physician licensed to practice medicine in this state, or (II) by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse, or after six months of regular, unprotected sexual intercourse in the case of a female over age thirty-five.

(ii) "Iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

(iii) Coverage for prescription drugs necessary as part of in vitro fertilization or standard fertility preservation services is only available where the policy otherwise provides coverage for prescription drugs.

(iv) Notwithstanding any other provision of law, a policy may impose cost sharing, deductibles or coinsurance obligations that exceed the dollar amount of cost sharing, deductibles or coinsurance obligations for non-preferred brand name drugs or their equivalent.

(G) Notwithstanding any other provision of this subsection, a religious employer may request a contract without coverage for in vitro fertilization used in the treatment of infertility and standard fertility preservation services that are contrary to the religious employer's religious tenets. If so requested, such contract shall be provided without coverage for services.

(i) For purposes of this subsection, a "religious employer" is a group or entity for which each of the following is true:

(I) The inculcation of religious values is the purpose of the group or entity.

(II) The group or entity primarily employs persons who share the religious tenets of the group or entity.

(III) The group or entity serves primarily persons who share the religious tenets of the group or entity.

(IV) The group or entity is a nonprofit organization as described in Section 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

(ii) Every religious employer that invokes the exemption provided under this subparagraph shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the treatment of infertility and standard fertility preservation services the employer refuses to cover for religious reasons.

(H) For services provided pursuant to subparagraph (E) of this paragraph, policies may:

(i) Require that services be performed by clinics or medical centers that conform to guidelines issued by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists (ACOG);

(ii) Require, notwithstanding network adequacy requirements, that all services be performed at designated providers identified by the insurer as meeting specified credentialing and quality standards and which participate in the insurer's provider network;

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

(iv) For purposes of calculating the lifetime limit, require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different

health insurance policy issued by the same insurer or by another insurer; or

(v) Limit coverage related to in vitro fertilization services to persons whose ages range from twenty-one through forty-four years.

§ 3. Subsection (s) of section 4303 of the insurance law, as amended by section 2 of part F of chapter 82 of the laws of 2002, is amended by adding four new paragraphs 5, 6, 7 and 8 to read as follows:

(5) Every contract issued by a medical expense indemnity corporation, hospital service corporation or health service corporation for delivery in this state that provides hospital, surgical or medical coverage shall provide a maximum lifetime limit of fifty thousand dollars of coverage for:

(A) in vitro fertilization used in the treatment of infertility; and

(B) standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.

(6) For the purposes of paragraph five of this subsection:

(A) "Infertility" means a condition or disease characterized by the incapacity to impregnate another person or to conceive, as diagnosed or determined (i) by a physician licensed to practice medicine in this state, or (ii) by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse, or after six months of regular, unprotected sexual intercourse in the case of a female over age thirty-five.

(B) "Iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

(C) Coverage for prescription drugs necessary as part of in vitro fertilization or standard fertility preservation services is only available where the policy otherwise provides coverage for prescription drugs.

(D) Notwithstanding any other provision of law, a policy may impose cost sharing, deductibles or coinsurance obligations that exceed the dollar amount of cost sharing, deductibles or coinsurance obligations for non-preferred brand name drugs or their equivalent.

(7) Notwithstanding any other provision of this subsection, a religious employer may request a contract without coverage for in vitro fertilization used in the treatment of infertility and standard fertility preservation services that are contrary to the religious employer's religious tenets. If so requested, such contract shall be provided without coverage for services.

(A) For purposes of this subsection, a "religious employer" is a group or entity for which each of the following is true:

(i) The inculcation of religious values is the purpose of the group or entity.

(ii) The group or entity primarily employs persons who share the religious tenets of the group or entity.

(iii) The group or entity serves primarily persons who share the religious tenets of the group or entity.

(iv) The group or entity is a nonprofit organization as described in Section 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

(B) Every religious employer that invokes the exemption provided under this paragraph shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the treatment of infertility

and standard fertility preservation services the employer refuses to cover for religious reasons.

(8) For services provided pursuant to paragraph five of this subsection, policies may:

(A) Require that services be performed by clinics or medical centers that conform to guidelines issued by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists (ACOG);

(B) Require, notwithstanding network adequacy requirements, that all services be performed at designated providers identified by the insurer as meeting specified credentialing and quality standards and which participate in the insurer's provider network;

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

(D) For purposes of calculating the lifetime limit, require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy issued by the same insurer or by another insurer; or

(E) Limit coverage related to in vitro fertilization services to persons whose ages range from twenty-one through forty-four years.

§ 4. Subparagraph (C) of paragraph 6 of subsection (k) of section 3221 of the insurance law, as amended by section 1 of part K of chapter 82 of the laws of 2002, is amended to read as follows:

(C) Coverage of diagnostic and treatment procedures, including prescription drugs, used in the diagnosis and treatment of infertility as required by subparagraphs (A) and (B) of this paragraph shall be provided in accordance with the provisions of this subparagraph.

(i) Coverage shall be provided for persons whose ages range from twenty-one through forty-four years, provided that nothing herein shall preclude the provision of coverage to persons whose age is below or above such range.

(ii) Diagnosis and treatment of infertility shall be prescribed as part of a physician's overall plan of care and consistent with the guidelines for coverage as referenced in this subparagraph.

(iii) Coverage may be subject to co-payments, coinsurance and deductibles as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(iv) [~~Coverage shall be limited to those individuals who have been previously covered under the policy for a period of not less than twelve months, provided that for the purposes of this subparagraph "period of not less than twelve months" shall be determined by calculating such time from either the date the insured was first covered under the existing policy or from the date the insured was first covered by a previously in-force converted policy, whichever is earlier.~~

~~(v)~~] Coverage shall not be required to include the diagnosis and treatment of infertility in connection with: (I) [~~in vitro fertilization,~~] gamete intrafallopian tube transfers or zygote intrafallopian

tube transfers; (II) the reversal of elective sterilizations; (III) sex change procedures; (IV) cloning; or (V) medical or surgical services or procedures that are deemed to be experimental in accordance with clinical guidelines referenced in clause [~~(vi)~~] (v) of this subparagraph.

[~~(vi)~~] (v) The superintendent, in consultation with the commissioner of health, shall promulgate regulations which shall stipulate the guidelines and standards which shall be used in carrying out the provisions of this subparagraph, which shall include:

(I) The determination of "infertility" in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;

(II) The identification of experimental procedures and treatments not covered for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;

(III) The identification of the required training, experience and other standards for health care providers for the provision of procedures and treatments for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine; and

(IV) The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine.

§ 5. Paragraph 3 of subsection (s) of section 4303 of the insurance law, as amended by section 2 of part K of chapter 82 of the laws of 2002, is amended to read as follows:

(3) Coverage of diagnostic and treatment procedures, including prescription drugs used in the diagnosis and treatment of infertility as required by paragraphs one and two of this subsection shall be provided in accordance with this paragraph.

(A) Coverage shall be provided for persons whose ages range from twenty-one through forty-four years, provided that nothing herein shall preclude the provision of coverage to persons whose age is below or above such range.

(B) Diagnosis and treatment of infertility shall be prescribed as part of a physician's overall plan of care and consistent with the guidelines for coverage as referenced in this paragraph.

(C) Coverage may be subject to co-payments, coinsurance and deductibles as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

[~~(D) Coverage shall be limited to those individuals who have been previously covered under the policy for a period of not less than twelve months, provided that for the purposes of this paragraph "period of not less than twelve months" shall be determined by calculating such time from either the date the insured was first covered under the existing policy or from the date the insured was first covered by a previously in force converted policy, whichever is earlier.~~

~~(E)~~] (D) Coverage shall not be required to include the diagnosis and treatment of infertility in connection with: (i) [~~in vitro fertilization,~~] gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; (ii) the reversal of elective sterilizations; (iii) sex

change procedures; (iv) cloning; or (v) medical or surgical services or procedures that are deemed to be experimental in accordance with clinical guidelines referenced in subparagraph [~~(F)~~] **(E)** of this paragraph.

[~~(F)~~] **(E)** The superintendent, in consultation with the commissioner of health, shall promulgate regulations which shall stipulate the guidelines and standards which shall be used in carrying out the provisions of this paragraph, which shall include:

(i) The determination of "infertility" in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;

(ii) The identification of experimental procedures and treatments not covered for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;

(iii) The identification of the required training, experience and other standards for health care providers for the provision of procedures and treatments for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine; and

(iv) The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine.

§ 6. Section 4 of part K of chapter 82 of the laws of 2002, amending the insurance law and the public health law relating to coverage for the diagnosis and treatment of infertility, is amended to read as follows:

§ 4. The commissioner of health, subject to the availability of funds pursuant to section 2807-v of the public health law, shall establish a program to provide grants to health care providers for the purpose of improving access to infertility services, treatments and procedures. At least one such provider shall be located in the city of New York and one such provider shall be located in an upstate region.

Such program shall be targeted to assist individuals in meeting the cost of infertility services not covered pursuant to sections 3221 and 4303 of the insurance law as such sections are amended by sections one and two of this act relating to expanded coverage of infertility services. Services, treatments and procedures paid for pursuant to the grant program shall be limited to**: (a)** those who meet the criteria for such expanded coverage provided pursuant to the insurance law but for whom the covered services are not effective for treating infertility**, and those who are unable to access coverage for the expanded procedures enacted pursuant to a chapter of the laws of 2018; and (b) those who are not enrolled in a commercial health care plan but who would otherwise meet the criteria of subdivision (a) of this section**. Services, treatments and procedures paid for pursuant to the grant program shall be further limited to assisted reproductive technology utilizing in vitro fertilization and gamete intrafallopian tube transfer, and shall be made available only in accordance with standards, protocols and other parameters as shall be established by the commissioner, which shall include but not be limited to ASRM and ACOG standards for the appropriateness of individuals, providers and treatments, and standards relating to cost-sharing based on income. Services, treatments and procedures under the grant program, except for those specified herein, shall not include

those services, treatments and procedures explicitly excluded under the expanded coverage provided for in the insurance law as amended by sections one and two of this act. Notwithstanding sections 112 and 163 of the state finance law, grants provided pursuant to such program may be made without competitive bid or request for proposal.

The commissioner of health shall promote public awareness of this program.

§ 7. The superintendent of financial services in consultation with the commissioner of health, shall reassess the coverage requirements of this act and regulations promulgated thereunder pursuant to a review of the comprehensive report funded pursuant to appropriation by chapter 50 of the laws of 2018 and the request for quote number C000457.

§ 8. This act shall take effect January 1, 2020 and shall apply to all policies issued, renewed, altered or modified on or after such date; provided, however, that should this act be determined to be a mandate pursuant to section 1311 (d)(3)(B) of the Patient Protection and Affordable Care Act, then this act shall not apply to coverage offered in the individual and small group market unless the state appropriates funds sufficient to cover the full cost of such coverage, as determined by the department of financial services and independently verified by an independent actuarial firm certified by the American academy of actuaries. In addition, the superintendent of financial services shall permit insurers and other organizations subject to this act to establish a minimum factor attributable to the services covered pursuant to this chapter that may be incorporated into rates for large group policies issued on or after January 1, 2020. Provided further, however, that should this act be determined not to be a mandate pursuant to section 1311(d)(3)(B) of the Patient Protection and Affordable Care Act, then the superintendent of financial services shall include in the approved small group and individual rates a factor attributable to the cost of services covered pursuant to this chapter and consistent with the actuarial cost, as projected by the applicant, of such coverage that shall be incorporated into rates for policies issued on or after January 1, 2020.