By Senator Geller

29-115-01

A bill to be entitled

An act relating to health insurance coverage for infertility; creating ss. 627.64062 and 627.65742, F.S., and amending s. 641.31, F.S.; requiring coverage by health insurance policies, group, franchise, and blanket health insurance policies, and health maintenance contracts for diagnosis and treatment of infertility under certain circumstances; providing requirements and criteria; providing limitations; providing definitions; providing an exception for certain religious organizations; providing application; excluding payments for donor eggs or certain medical services; amending ss. 627.651, 627.6515, and 627.6699, F.S.; providing for application to group contracts and plans of self-insurance, out-of-state groups, and standard, basic, and limited health benefit plans; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.64062, Florida Statutes, is created to read:

627.64062 Coverage of diagnosis and treatment of infertility.--

(1) Any health insurance policy that provides coverage for pregnancy-related benefits shall also provide coverage for the diagnosis and treatment of infertility, including all

nonexperimental assisted reproductive technology procedures and artificial insemination with partner or donor sperm.

(2) The coverage required under this section is subject to the following conditions:

(a) Coverage shall be subject to any deductible and coinsurance conditions and all other terms and conditions applicable to other benefits.

(b) Coverage for procedures for in vitro fertilization, gamete intrafallopian transfer, or zygote intrafallopian transfer shall be required only if:

1. The covered individual has been unable to carry a pregnancy to live birth.

2. The covered individual has been unable to carry a pregnancy to live birth through less costly medically appropriate infertility treatments for which coverage is available under the policy, plan, or contract.

3. The covered individual has not undergone 4 complete oocyte retrievals.

4. The procedures are performed at medical facilities that conform to the standards of the American Society for Reproductive Medicine, the Society for Assisted Reproductive Technology, and the American College of Obstetricians and Gynecologists.

5. The laboratory or facility has received accreditation from the Reproductive Laboratory Accreditation Program of the College of American Pathologists or another accreditation organization approved by the Society for Assisted Reproductive Medicine.

(c) In order to undergo in vitro fertilization, gamete intrafallopian transfer, or zygote intrafallopian transfer, a second opinion is required by a certified reproductive

endocrinologist who is actively experienced in assisted reproductive technologies but is not in the same group as the treating physician.

(d) The provider must include at least one certified reproductive endocrinologist or a physician with fellowship training and subspecialty board eligibility in reproductive endocrinology and infertility.

(3) As used in this section, the term:

(a) "Pregnancy-related benefits" means benefits that cover any related medical condition that may be associated with pregnancy, including complications of pregnancy.

(b) "Infertility" means a disease or condition affecting the reproductive system that interferes with the ability of a man or woman to achieve a pregnancy or of a woman to carry a pregnancy to live birth. The duration of the failure to conceive should be 12 or more months before an investigation is undertaken unless medical history and physical findings dictate earlier evaluation and treatment.

(c) "Nonexperimental procedure" means any clinical treatment or procedure the safety and efficacy of which is recognized as such by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

(4) This section does not apply to any health insurance policy that is purchased by an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices the tenet that drug therapy for infertility or in vitro fertilization services are contrary to the moral principles that the religious denomination considers to be an essential part of its beliefs.

(5) This section applies to benefits for the state group insurance program under s. 110.123.

(6) This section does not apply to payment for donor eggs or medical services rendered to a surrogate for purposes of child birth.

Section 2. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

627.651 Group contracts and plans of self-insurance must meet group requirements.--

(4) This section does not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.65742,627.6575, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(6). This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 3. Paragraph (c) of subsection (2) of section 627.6515, Florida Statutes, is amended to read:

627.6515 Out-of-state groups.--

(2) This part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if:

(c) The policy provides the benefits specified in ss. 627.419, 627.6574, 627.65742,627.6575, 627.6579, 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675, 627.6691, and 627.66911.

Section 4. Section 627.65742, Florida Statutes, is created to read:

627.65742 Coverage of diagnosis and treatment of infertility.--

(1) Any group, franchise, or blanket health insurance policy that provides coverage for pregnancy-related benefits shall also provide coverage for the diagnosis and treatment of infertility, including all nonexperimental assisted reproductive technology procedures and artificial insemination with partner or donor sperm.

(2) The coverage required under this section is subject to the following conditions:

(a) Coverage may not be subject to copayments or deductible requirements that are greater than those applied to pregnancy-related benefits under the insured's policy, plan, or contract.

(b) Coverage for procedures for in vitro fertilization, gamete intrafallopian transfer, or zygote intrafallopian transfer shall be required only if:

1. The covered individual has been unable to carry a pregnancy to live birth.

2. The covered individual has been unable to carry a pregnancy to live birth through less costly medically appropriate infertility treatments for which coverage is available under the policy, plan, or contract.

3. The covered individual has not undergone 4 complete oocyte retrievals.

4. The procedures are performed at medical facilities that conform to the standards of the American Society for Reproductive Medicine, the Society for Assisted Reproductive

Technology, and the American College of Obstetricians and Gynecologists.

5. The laboratory or facility has received accreditation from the Reproductive Laboratory Accreditation Program of the College of American Pathologists or another accreditation organization approved by the Society for Assisted Reproductive Medicine.

(c) In order to undergo in vitro fertilization, gamete intrafallopian transfer, or zygote intrafallopian transfer, a second opinion is required by a certified reproductive endocrinologist who is actively experienced in assisted reproductive technologies but is not in the same group as the treating physician.

(d) The provider must include at least one certified reproductive endocrinologist or a physician with fellowship training and subspecialty board eligibility in reproductive endocrinology and infertility.

(3) As used in this section, the term:

(a) "Pregnancy-related benefits" means benefits that cover any related medical condition that may be associated with pregnancy, including complications of pregnancy.

(b) "Infertility" means a disease or condition affecting the reproductive system that interferes with the ability of a man or woman to achieve a pregnancy or of a woman to carry a pregnancy to live birth. The duration of the failure to conceive should be 12 or more months before an investigation is undertaken unless medical history and physical findings dictate earlier evaluation and treatment.

(c) "Nonexperimental procedure" means any clinical treatment or procedure the safety and efficacy of which is recognized as such by the American Society for Reproductive

Medicine or the American College of Obstetricians and Gynecologists.

(4) This section does not apply to any group, franchise, or blanket health insurance policy that is purchased by an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices the tenet that drug therapy for infertility or in vitro fertilization services are contrary to the moral principles that the religious denomination considers to be an essential part of its beliefs.

(5) This section does not apply to payment for donor eggs or medical services rendered to a surrogate for purposes of child birth.

Section 5. Paragraph (b) of subsection (12) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.--

(12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.--

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan and a basic health benefit plan that meets the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan" and "basic health benefit plan" mean policies or contracts that a small employer carrier offers to eligible small employers that contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; and

b. A procedure for preauthorization by the small employer carrier, or its designees.

3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the department, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for handicapped children pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.65742, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.

Section 6. Subsection (39) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(39)(a) Any health maintenance contract that provides coverage for pregnancy-related benefits shall also provide coverage for the diagnosis and treatment of infertility, including all nonexperimental assisted reproductive technology procedures and artificial insemination with partner or donor sperm.

(b) The coverage required under this subsection is subject to the following conditions:

1. Coverage shall be subject to any deductible and coinsurance conditions and all other terms and conditions applicable to other benefits.

2. Coverage for procedures for in vitro fertilization, gamete intrafallopian transfer, or zygote intrafallopian transfer shall be required only if:

a. The covered individual has been unable to carry a pregnancy to live birth.

b. The covered individual has been unable to carry a pregnancy to live birth through less costly medically appropriate infertility treatments for which coverage is available under the policy, plan, or contract.

c. The covered individual has not undergone 4 complete oocyte retrievals.

d. The procedures are performed at medical facilities that conform to the standards of the American Society for Reproductive Medicine, the Society for Assisted Reproductive Technology, and the American College of Obstetricians and Gynecologists.

e. The laboratory or facility has received accreditation from the Reproductive Laboratory Accreditation Program of the College of American Pathologists or another accreditation organization approved by the Society for Assisted Reproductive Medicine.

3. In order to undergo in vitro fertilization, gamete intrafallopian transfer, or zygote intrafallopian transfer, a second opinion is required by a certified reproductive endocrinologist who is actively experienced in assisted reproductive technologies but is not in the same group as the treating physician.

4. The provider must include at least one certified reproductive endocrinologist or a physician with fellowship training and subspecialty board eligibility in reproductive endocrinology and infertility.

(c) As used in this subsection, the term:

1. "Pregnancy-related benefits" means benefits that cover any related medical condition that may be associated with pregnancy, including complications of pregnancy.

2. "Infertility" means a disease or condition affecting the reproductive system that interferes with the ability of a man or woman to achieve a pregnancy or of a woman to carry a pregnancy to live birth. The duration of the failure to conceive should be 12 or more months before an investigation is undertaken unless medical history and physical findings dictate earlier evaluation and treatment.

3. "Nonexperimental procedure" means any clinical treatment or procedure the safety and efficacy of which is recognized as such by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

(d) This subsection does not apply to any health maintenance contract that is purchased by an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices the tenet that drug therapy for infertility or in vitro fertilization services are contrary to the moral principles that the religious denomination considers to be an essential part of its beliefs.

(e) This subsection applies to benefits for the state group insurance program under s. 110.123.

(f) This subsection does not apply to payment for donor eggs or medical services rendered to a surrogate for purposes of child birth.

Section 7. This act shall take effect October 1, 2001.

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SENATE SUMMARY

Requires coverage by health insurance policies, group, franchise, and blanket health insurance policies, and health maintenance contracts for diagnosis and treatment of infertility. Provides an exception for religious organizations. Applies the requirement to group contracts and plans of self-insurance, out-of-state groups, and standard, basic, and limited health benefit plans. (See bill for details.)