

Legislative History for Connecticut Act

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Calendar 219, File 228, 765, Substitute for S.B. 508,
An Act Concerning Health Insurance Coverage for
Infertility Treatment and Procedures, Favorable
Reports of the Committees on Insurance,
Appropriations, and Public Health. Clerk is in
possession of amendments.

THE CHAIR:

Could I ask the Senate to calm down and quiet
down so we can hear Senator Crisco, who's going to
bring this bill out. Senator Crisco.

SEN. CRISCO:

Thank you, Mr. President. You're very gracious.
Mr. President, I move acceptances of the Joint
Committees' Favorable Report and passage of the bill.

THE CHAIR:

On acceptance and passage, will you remark?
Senator Crisco.

SEN. CRISCO:

Yes, Mr. President. Mr. President, the Clerk has
LCO 6860. I request that it be called.

THE CHAIR:

Mr. Clerk.

THE CLERK:

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LCO 6860, which will be designated Senate
Amendment Schedule "A." It is offered by Senator
Crisco of the 17th District.

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Thank you, Mr. President. Mr. President, I move
for adoption of the amendment. I asked that the
reading be waived, I be given permission to summarize.

THE CHAIR:

On adoption, will you remark? Senator Crisco.

SEN. CRISCO:

Thank you, Mr. President. Mr. President, the
basis of this amendment is to limit the lifetime
benefits in this particular bill to two cycles with
not more than, you know, two of specific procedures
that are needed for infertile treatment.

THE CHAIR:

On the amendment, will you remark further? On
the amendment? If not, I'll try your minds. All
those in favor, please say "aye".

SENATE ASSEMBLY:

Aye.

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THE CHAIR:

Those opposed, "nay".

SENATE ASSEMBLY:

Nay.

THE CHAIR:

The ayes have it. The amendment is adopted.

Senator Crisco.

SEN. CRISCO:

Thank you, Mr. President. This basically brings us to the bill, in summary, that this bill requires certain individual and group health insurance policies to cover the medically necessary costs of diagnosing and treating infertility.

Now, it had certain specific permissible coverage limitation requirements. It also permits individuals and religious employers to exclude infertility coverage in its, if it's contrary to their religious tenets.

And the bill repeats current law, which requires an insurance HMO to all, only offer infertility coverage to group plan sponsors, who can reject or accept it.

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And, Mr. President, this is far reaching coverage in regards to an issue that is so dear to so many people, and I accept the fact that there may be different philosophical approaches to this and also different opinions in regards to what we have insurance companies provide coverage for.

But this bill requests that these insurance companies provide this coverage and addresses an issue that, to date, has only been possible for people with very high incomes to pursue infertility treatment.

It kind of sets up a class system that I believe that all of us are very concerned about, and it gives people hope.

I also accept the fact that there are other options, such as adoption and foster children. And I am just pleased that just the discussion of this bill has also increased awareness of other options and provides more thinking for all of us as individuals.

And with that, Mr. President, I'd like to yield to Senator Slossberg.

THE CHAIR:

Senator Slossberg.

SEN. SLOSSBERG:

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Thank you, Mr. President. And thank you, Senator Crisco, for your leadership on this, on this bill and on this issue, along with Representative Olson and Representative O'Connor in the House.

Infertility is one of those things that we don't tend to talk about. It's a private, marital matter, and most people really just don't talk about it. And it's amazing that once you start talking about it, how many people come up to you and say, gee, I know somebody or I've had, I've had some experience with this myself. Or, gee, my child is only here because of some infertility treatments.

Just some basic background facts with regard to infertility. First of all, infertility is a disease. It affects 69,000 couples in Connecticut annually. The treatment for this disease is very successful. Eighty percent of the couples who go for treatment, who get actual treatment, what their doctors are requiring or asking them to do, have successful experiences.

Currently, half of our New England states cover infertility treatments, in a far broader way than what

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we are planning on doing today, if this should go forward.

Finally, on low-tech treatments, there is a whole continuum of treatments available for people with infertility problems. Only 3% to 5% of all couples seeking an infertility evaluation require IVF, or in vitro, which is your more involved treatment or other high technology.

And I know that a lot of times that's what people talk about. Infertility means IVF. And it really doesn't. That's just one thing in a whole, long line of treatment that is available to couples who are suffering from infertility issues.

For anybody who knows people going through infertility problems, it is a long, tortuous process. And it is fraught with emotional ups and downs of a monthly cycle.

It involves your entire family, or sometimes couples are by themselves dealing with it very privately, but a lot of ups and downs. It can devastate a couple. It can devastate a family. But it also can bring great and wonderful joy.

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I know that in my, in my family, I have a niece and a nephew are only here as a result of infertility treatments.

But we live in a society that says to people, have kids. You turn on the TV, everything is about babies and children and, you know, mommies and being pregnant and getting married and having children. That's, that's the message we give to people.

And so many people do want to have children and go through all sorts of trials and tribulations to have children. I know, in my district, I have a friend and a constituent who has nearly bankrupt her family paying for infertility treatments.

This bill makes so much sense, and I'm so pleased that it is here before us today because it's not just a blanket mandate. It actually makes good healthcare sense.

And I know everyone in this Circle is very concerned with the quality of healthcare in our state and the efficiency of the healthcare delivery system in our state. And this bill makes a lot of sense because it provides a number of limitations.

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It limits the coverage to an individual into the date of that person's 40th birthday. It limits the coverage for ovulation induction to a lifetime maximum benefit of four cycles.

It limits coverage for intrauterine insemination to a lifetime maximum benefit of three cycles. And it limits coverage for in vitro and some of the other high-tech processes to a benefit of two cycles, but with not more than two embryo implantations per cycle.

What this bill does, amongst other things, is it gives couples the best chance of success in a very reasonable and responsible way.

Finally, and probably the least exciting part of this, but very, very important is economically this bill makes a lot of sense. And I know we all worry about the cost of healthcare in this state.

But what this bill actually does is helps us economically. It is a fiscally responsible way to improve the healthcare for people in our state.

Right now, what happens, because of our insurance framework in Connecticut, is that people who have infertility problems, they're covered under their major medical benefits, generally, but they're not

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covered for the low-technology treatments, things like the medicines or the intrauterine insemination.

So what they do is they go for procedures that are covered under major medical, that cost a lot of money, but they're not necessarily the most effective way.

But that's the first thing the doctor sends them to, is, well, what do you have coverage for? And, therefore, that's what we're going to send you to.

Rather than looking at what is the best way for this person to be treated for this particular problem, the answer is, what are you covered for? Well, if you're only covered for major medical, and that's where your basic coverage is, then you end up spending a lot more money going after that.

But what's even more heartbreaking about this is that it's a very inefficient use of our resources, both medically and scientifically. Because when people go and they spend their time just going for what's covered, and not for what is the best treatment for them, the clock is ticking. And the time goes by. And people end up in a worse position than they would be otherwise.

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Sometimes people have to make bad decisions because of the finances. So for example, one of my constituents, who has been battling infertility for the last ten years, was covered for intrauterine insemination. And that was \$3,000 every time she went.

But after six treatments the doctor said, what you really need to do is go for IVF. But IVF was \$15,000 a treatment, and so she didn't have the money for that.

So instead, she continued to save her money, and every time she had \$3,000, she would have the money to go and do an IUI. And after ten of those treatments that were unsuccessful, she had already mortgaged her house and practically bankrupt her business.

Yet, under this bill, if she were covered and this bill was law, she would have gone for three treatments. The doctor would have said, go for IVF. She would have gone for IVF, and at that time she would have had a 75% chance of success.

Now she has gone for IVF twice. Because now she is older, it has been unsuccessful, and the doctor gives her a less than 1% chance of having successful

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treatment. And unfortunately, if she had had this treatment, the result may have been, very well been different.

Because this targets women who are under 40, people who are under 40, what we do is we say to the medical community, in a very reasonable way, use your resources as efficiently as possible, and give people the best chance of success that they're going to have.

One of the other ways we don't look at the whole picture, and everybody says, oh, it's a mandate. A mandate costs more money. This is going to cost more money if we do that.

Although the reality is that in the United States we have an epidemic of multiple births. And one of the reasons we have an epidemic of multiple births is because of the treatments that people go through. And they don't go through it in a way that's going to produce either a single birth or perhaps even a twin.

Right now, if you were to have one child, the cost is \$6,000. If you were to have twins, the cost is \$40,000. A triplet birth is \$350,000. And let's not forget that once someone achieves pregnancy, they're, if they've got insurance, they're going to be

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covered. They're going to have coverage for that pregnancy.

So what we're doing in this bill, by limiting the amount of embryos that can be transferred, we are limiting, we are decreasing the number of multiple births.

And when you look at the entire economic picture, if people are making low-tech treatments instead of high-tech treatment decisions, they're making better, more focused decisions, and they're, we're not going to be having as many multiple births. What we are actually doing is providing a more efficient use of our healthcare resources.

And we need to be looking at the whole picture. And what this does, at the end of the day, is this provides coverage for people who are otherwise going to be paying out-of-pocket or not paying out-of-pocket or bankrupting their homes for something that we say in this society is very important.

And while I am so sensitive to all of the other options out there, just yesterday I stood in a room with a group full of people on Memorial Day. And we looked around the room and realized that 50% of the

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people in that room had personal experiences with infertility.

And so I urge adoption of this bill. And I hope that my colleagues in the Circle will support me and give hope to so many people who are out there today and actually improve the quality of our healthcare system as a result. Thank you.

THE CHAIR:

Will you remark further on the bill as amended?
Will you remark further? Senator DeLuca.

SEN. DELUCA:

Thank you, Mr. President. I rise in opposition to this because it still is a mandate, and I have opposed all mandates. Each and every one of the 55 we now currently have on our books in itself does something and doesn't cost much. But a cumulative, over the years, they have added to the cost of health insurance and healthcare in the country and in our state.

I've mentioned this before. We've had an expert before the Insurance Committee twice, who said one of the major reasons for the increased cost in health insurance is mandates.

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This mandate, which I heard also will save money, I've heard that argument about almost every other mandate that was presented in the last 15 years that I have been here.

This mandate actually saves money. If all 55 of those mandates saved money, we wouldn't be paying for healthcare insurance. But instead, it's gone astronomically high and has become a major problem.

We've talked about this in the Insurance Committee at least 10 or 12 years that I know of. And the Insurance Committee, in previous years, had said because of the extreme cost of this, that it would be a burden on the cost of healthcare insurance.

And if and when it does pass, as any other mandate in the State of Connecticut, I heard the number 69,000 couples in the State of Connecticut suffer from this, and this would help them.

If and when it does pass, it will help approximately half of them. Because those that are in self-funded plans, that is regulated by the Federal Government under ERISA, would not be affected by this.

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So to say that all people that are suffering or have this condition would be helped would not be true because of ERISA.

Many insurance plans now cover it. And that is because of the decision made by the corporation, the company, or, in this case, the State of Connecticut that pays for the insurance, that makes that decision to add it to the mandates. They do that because they feel it's important to the people they insure and that they can afford it.

Under the State of Connecticut, we have the Cadillac of all plans. It covers everything and, of course, cost is no object.

I believe that any mandate affects the cost of healthcare insurance, which eventually makes small businesses have to make a decision. And over my 15 years in this, on this Insurance Committee, I have seen the number of uninsured rise dramatically. Not just the cost of insurance, but the number of people that are uninsured.

And we hear this every year. We have so many hundreds of thousands of people who have no health insurance. Ladies and gentlemen, the cost of health

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insurance to small businesses contributes to that number because they have to make a decision on whether they can afford it. And many small companies today, with the cost, because of the mandates, decide they can't afford it. This adds to the number of uninsured.

There's no question that this benefits many. But in my opinion, it hurts more by the costs and how it affects small businesses and the people that work for those small businesses.

I'm sure there are a number of people that will support this today. It will probably pass. But as in all mandates, I believe that in the long run it hurts the people of the State of Connecticut and hurts small business. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator DeLuca. Will you remark further? Senator Finch.

SEN. FINCH:

Thank you, Mr. President. I rise in opposition of the bill. At the same time, would like to compliment all those that worked so diligently and so

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hard on this bill, because half the bill does accomplish, I believe, a laudable, public policy.

What it does is it sets up a protocol, if you will, and I'm not a medical terminologist, so I'm not sure that's the right phrase. But it says, let's have some logic to the system right now, which is definitely too expensive for most people.

It's definitely out of reach for most people, and it sets up some logic. And how could we argue with the logic? The logic says, start at step one, proceed to step two, proceed to step three, go to step four.

The problem is that we're saying that now everyone else has to pay for it. And every time we mandate a coverage, and some mandates I probably would have supported had I been here in the earlier times when HMOs were in their shakeout period, and there were things that I'm sure there was even bipartisan support to put into coverage.

But having had this situation among those who I love as well, I can attest to the fact that after the realization is made that a healthy conception is not possible, and the family moves on and talks about the

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option of adoption, that the health and the happiness of the family returns.

We always move adoption in this Chamber, adoption of bills. But I rarely hear discussion of moving adoption as a great option for people. And that is the heart at which I oppose this bill.

It would be easy to vote for the bill because I've had a number of constituents call me and tell me the heart-wrenching cases that they have. Terrible situations where a husband and wife truly love each other, and have tried to conceive a baby, and it isn't in the cards for them without Herculean efforts.

Now, I wish that I could make it better for them. I wish that I could allow them to have nature proceed its natural course and give them a loving, caring family that they create. But I haven't seen any difference between those families, by and large, and those that are created through other arrangements.

The reason why I stood here aggressively and argued so passionately for gay civil unions was because I saw many gay couples create a family through love. That was the essential. Love did make a

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family. I saw it with my own two eyes. I witnessed it.

And now we're being asked to extend the cost of healthcare. And you know, I guess it's, maybe the perspective you come from. But in my district, there are a lot of people that don't have healthcare. This is moving it that much further away from them.

Because no matter what you argue, and the advocates have given me this number, at the top of the limit for this policy, the cost would rise to \$40,000. It's not \$40,000 for them to undergo cancer treatment to save their life. It's not \$40,000 for them to be screened to prevent a disease. It's \$40,000 for them to conceive a child.

And that's a beautiful thing and a wonderful thing, but it isn't fair to push healthcare beyond the limits for other middle-class families and other small business to be able to afford because there is another solution.

Now, we aren't saying here, as a matter of public policy, let's take that \$40,000 and let's give that as a bounty on some of the 5,000 children who wallow in our care at this moment.

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I don't know if you're aware of it, but there are 5,000 children who you and I are responsible for that are in the foster care system.

Do you, does anyone want to rise and say that we're doing the best that we can for them? No one will. Because they are, in many cases, without any hope of ever being loved by a parent. Imagine that. Children in our care who never will be loved by a parent.

I've been exposed to many things since taking this job on. I have never, ever seen anything that made my eyes well up with tears as the night I was at a DCF slideshow, and I saw these children, granted some of them have a few emotional problems. But other than that, I mean, who doesn't?

Who's born into this world with a guarantee? Nobody. These children are almost throwaways, and they are under our care right now.

What if we had a debate about finding \$40,000 for one of those kids, to give to the adoptive families for counseling? What if we had \$40,000 to give to a set of adoptive, potential adoptive parents, who were thinking of mortgaging their house?

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What if we gave them \$40,000 of counseling for them and for that child? What if we said we're going to take that same \$40,000, and we'll guarantee that that kid could go to college? We could go to UConn for that.

I know it's different pots of money, but our priorities are backwards. We are well-meaning. We are well-intentioned. We want to make right what we see is wrong. We want to give the people who are infertile the chance to have a baby. There isn't a better gift. There isn't a better gift.

When we have our family get-together on Memorial Day, what do we celebrate? Births. We celebrate pregnancies. We celebrate the love that binds us together in our families. That's what we fight for. That's what our country defends.

We are going to increase the expense of healthcare for the average citizen. We are not doing anything to work on the children who have already been born that we're ignoring.

I just think that maybe our priorities ought to be those children first. I just think that we could mandate a protocol of logic, of a logical procession

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for people, with a step for adoption counseling, with a step that talks about those little kids in the slideshow at DCF that no one loves. But we don't do that.

We put so much pressure on couples to do it the natural way. And we don't, we do not promote adoption. We do not talk about the children who are already in our care.

This is well-meaning legislation. I do not rise to cast dispersions on this at all, because I know how much great effort went into this. Half the work, I agree with. But the part that is public policy, that shifts resources toward, which I think they could be spent elsewhere, and increases healthcare, a scarce commodity.

About half our country doesn't have healthcare. Over 300,000 people in Connecticut don't have healthcare. This will not decrease the number of people without healthcare. This will increase the number of people without healthcare, and it will compound the problem that we already have. Thank you, Mr. President.

THE CHAIR:

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Thank you, Senator Finch. Will you remark further? Will you remark further? Senator Slossberg.

SEN. SLOSSBERG:

Thank you, Mr. President. I just, I'd just like to say, with deep, I have deep respect for what the previous speaker just, my colleague just spoke about with regard to adoption.

And my hope is that, you know, if you know people who have gone through this procedure, this is something that a lot of couples feel they have to do. And it is my shared hope with my colleague that couples who are unsuccessful in getting pregnant on their own would consider adoption.

But I actually don't think that that's what this bill is really about. It really is about reallocating the resources that we already spend in this area.

I've heard, you know, this discussion about this adds to the uninsured. Well, not covering people for this adds to the uninsured.

In my district, one of my friends, a constituent, a small-business owner, tried to get coverage for infertility for her and her four employees and their families. And she was not able to get it. And as a

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result, what she did over time, having to pay out-of-pocket for her own infertility treatments, was she downsized her office. And she is now down to one staff member.

So 13 people who currently used to have insurance now have no health insurance because this business owner chose to terminate her health insurance policy so that she could pay, out of her pocket, and downsize her business and change her entire life around to try to make this happen.

And again, with unfortunate and unsuccessful results, because the way our framework is, in our insurance framework, we send people to do the wrong things right now. And what this bill does is it allocates our resources in the most efficient way.

When we talk about the cost, the cost being \$40,000, if you were to run the gamut, the cost of going for major medical surgery to have fibroids removed or to have some of the other major medical surgeries to deal with this, cost an awful lot more than that.

So what we're really talking about is reallocating your resources. When you have someone

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who is pregnant with triplets, and they are on bed rest in the hospital, that's covered by insurance, and that costs an awful lot more than \$40,000 to be in the hospital, not to speak of what happens when those babies are actually born.

So what this bill does is reallocates our resources in a reasonable way. Massachusetts has had this coverage for many years now, and the studies in Massachusetts have shown no increase in their healthcare costs as a result of this. And I urge adoption of this proposal, of this bill, and I thank you.

THE CHAIR:

Will you remark further on the bill as amended?
Senator Freedman.

SEN. FREEDMAN:

Thank you, Mr. President. A question, through you, to the proponent of the bill.

THE CHAIR:

Please proceed, Senator.

SEN. FREEDMAN:

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I'm sorry, he may have mentioned this, but through you, does he know how many people might be affected by this if it goes forward?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Through you, Mr. President, to Senator Freedman, I believe that Senator DeLuca mentioned a total population of 69,000 individuals. How to quantify that in regards to how many we'd cover by this is just unknown at this time.

THE CHAIR:

Senator Freedman.

SEN. FREEDMAN:

Again, through you, Mr. President, 69,000 people in the State of Connecticut?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Through you, Mr. President, to the Senator, yes.

THE CHAIR:

Senator Freedman.

SEN. FREEDMAN:

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Yes, and once again through you, how do we arrive at the cost of \$40,000? I have had a family member who has gone through this, and I believe it started at like \$10,000. So through you, Mr. President, could the proponent please explain where the \$40,000 figure may come from?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Thank you, Mr. President. I believe that Senator Slossberg was the one who reported that figure. But I also have documentation in regards that the maximum, according to the information I received, for treatment, is \$24,000. Now, it could all be depending upon how you count.

Remember, there was, we, a lifetime maximum removed from the bill through an amendment. But we believe that the figure that we mentioned, I believe, is \$24,000. And I think Senator Slossberg will want to comment on that too. And I would yield to Senator Slossberg.

THE CHAIR:

Senator Slossberg, for purposes of response.

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SEN. SLOSSBERG:

Thank you, Mr. President. It really, you know, the \$40,000 number was the number that I just echoed from my colleague. But again, it does depend upon what actual treatments you are going to be going for. Ovulation induction is \$75 per cycle, generally.

SEN. FREEDMAN:

\$75?

SEN. SLOSSBERG:

And, of course, from person to person and from doctor to doctor it's going to depend. And it will also depend on whether you are talking about a number based on if you were to walk in and pay out-of-pocket versus the negotiated rate if you are under your insurance plan.

Intrauterine insemination is about \$2,500 per cycle. And in vitro, at the high end, is \$13,000 per cycle. And again, with some of these things, you may have one cycle of one, one cycle of another, be successful or otherwise.

So it really just depends upon what your doctor actually chooses, and that's, and I think that answers the question.

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THE CHAIR:

Senator Freedman.

SEN. FREEDMAN:

Thank you, Mr. President. I think my questions have been answered, and I appreciate the detail for which I was just given. I have been supportive of this, and I will continue to support it.

I do believe that its time has come in this state. It was something that was on the table about 18 years ago. It keeps getting pushed on the back burner.

But I do believe that the families in this state, and although there is the option, always, of adopting, that this is something that, unless you've gone through it, it's very difficult for people to really understand.

And it is one of those mandates that can only have a positive presence for the people of this state. So I would encourage my colleagues to please support this.

THE CHAIR:

Will you remark further on the bill as amended?

Senator Crisco.

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SEN. CRISCO:

Thank you, Mr. President, for the second time. Mr. President, I'm always proud to be a Member of the Circle, and there are some days I'm more proud here than ever.

I think the discussion of last week on the uninsured, it was just, it was outstanding. And the discussion today on this particular, this particular issue, is also very inspiring. And I'm just proud to be a Member of the Circle and to share these issues with my colleagues.

The thing I just want to add, Mr. President, is I share the concern by any of my colleagues in regards to the health of the insurance industry. This weekend, I spent a couple of days reviewing Weiss reports. And the Weiss reports really talked about the financial health of the property casualty industry and the health industry.

And while I commend those companies who do a remarkable job, there are sometimes, our comments just don't add up. If you look at the income, the profit of the health companies for the past two years, you'll

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be amazed at the hundreds of millions of dollars that have been experienced.

So I'm kind of torn, where I respect my colleagues for their concern in regards to the word mandate. And yet, when you look at the Weiss reports, things just don't add up.

And I'm not saying that we shouldn't continue to be very cognizant of the health of our insurance industry. Because at one time, when Connecticut was the industry center of the world, we all benefited from it, and we should continue to benefit from it.

And my hope is that in the future, as we look at the cost-benefit analysis of various mandates, and I have a temptation to call them requests, because mandates are then, I think, a word that we've used too often, but it is a mandate, that we will come to a consensus in regards to there are some that save money, that save lives, that save pain and suffering, and we should respect those [inaudible].

And there may be some, I just don't know because we haven't done the review yet, that maybe should be eliminated. But we'll cross that bridge when it comes to.

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But this legislation, as worked on by so many people, as Senator Slossberg mentioned, Representative O'Connor and Olson and both sides of the aisle, addresses a need that is so important to people.

And as we talked about stem cell research last week, in regards to the hope that it gives, this gives more positive hope, and I appreciate my colleagues and their support of this very important issue. Thank you, Mr. President.

THE CHAIR:

On the bill as amended, will you remark further? Will you remark further? If not, the Clerk will announce that a roll call is in progress. The machine is open. Please vote.

THE CLERK:

An immediate roll call vote has been ordered in the Senate. Will all Senators please return to the Chamber.

An immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber.

THE CHAIR:

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Have all Members voted? Senator Hartley.

Senator Daily. If all Members have voted, the machine will be closed. The Clerk will announce the results.

THE CLERK:

Motion is on passage of S.B. 508 as amended.

Total number voting, 34; necessary for passage, 18. Those voting "yea", 27; those voting "nay", 7. Those absent and not voting, 2.

THE CHAIR:

The bill is passed. Just an announcement that we will probably take a little longer on some of the roll calls today. There are meetings related to a, an important topic going on in other parts of the building, and we ought to allow folks the opportunity to get up a flight of stairs. Mr. Clerk.

THE CLERK:

Turning to the Calendar. Favorable Reports, Calendar Page 3, Calendar 312, File 383, Substitute for S.B. 876, An Act Concerning Mercury Warnings, Favorable Reports of the Committees on General Law and Public Health. Clerk is in possession of amendments.

THE CHAIR:

Senator Colapietro. Senator Murphy, sorry.

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If all the Members have voted, the machine will be locked and the Clerk will take a tally. The Clerk please announce the tally.

CLERK:

Senate Bill Number 794, in concurrence with the Senate.

Total Number Voting	136
Necessary for Passage	69
Those voting Yea	136
Those voting Nay	0
Those absent and not voting	15

SPEAKER AMANN:

The Bill passes. Will the Clerk please call Calendar Number 611.

CLERK:

On Page 13, Calendar Number 611, Substitute for Senate Bill Number 508, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR INFERTILITY TREATMENT AND PROCEDURES, Favorable Report of the Committee on Public Health.

SPEAKER AMANN:

Representative Olson.

REP. OLSON: (46th)

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Thank you, Mr. Speaker. I move acceptance of the Joint Committee's Favorable Report and passage of the Bill.

SPEAKER AMANN:

The question is on acceptance of the Joint Committee's Favorable Report and passage of the Bill. Will you remark, Madam, you have the floor.

REP. OLSON: (46th)

Thank you, Mr. Speaker, and good morning.

SPEAKER AMANN:

Good morning.

REP. OLSON: (46th)

Infertility is a disease. We know it's an abnormal function of the human reproductive system, and it affects over 70,000 couples in the State of Connecticut.

Significant medical advances have been made in the treatment of the disease of infertility. These treatments are available through what's called the Assisted Reproductive Technologies Continuum of Care, and they include treatment such as ovulation induction, intrauterine insemination, and IVF and related therapies.

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The Bill that we have before us today increases coverage to include those treatments, which are highly effective, more efficient and less invasive and can certainly be less costly than risky surgeries that are now undertaken under major medical benefit plans.

It also does not expose the patients to the inherent risks of surgery.

The language that we have before us is a result of work done by both the Public Health and Insurance Committees and requires coverage for these treatments, however, establishes limits.

We have indicated that in the Bill before us. We have drug therapy treatment, which is ovulation induction. That's limited to four treatments per lifetime.

Intrauterine insemination is limited to three treatments per lifetime and IVF and related therapies is limited to two treatments per lifetime, with two implants per procedure.

We also indicate that this coverage is available to people up to the age of 40 and we have given the insurance companies an opportunity to do what's called a look back.

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To clarify some of the procedures that we have before us, we have Senate Amendment "A". The Clerk is in possession of LCO Number 6860. I ask that he call the Amendment and I be allowed to summarize.

SPEAKER AMANN:

The Clerk please call LCO Number 6860 which was previously designated Senate Amendment "A".

CLERK:

LCO Number 6860, Senate "A", offered by Senator Crisco and Representative O'Connor.

SPEAKER AMANN:

The Representative seeks leave of the Chamber to summarize the Amendment. Is there objection on summarization? Is there objection? If not, Madam, you can proceed with summarization.

SPEAKER AMANN:

Thank you, Mr. Speaker. This Amendment is a technical Amendment. It is our intention in Lines 23 through 26 and again, Lines 100 to 103. We wanted to make sure that the intent is clear that certain procedures are limited to a maximum lifetime benefit.

These procedures are in vitro fertilization, gamete intrafallopian transfers, zygote interfallopian

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transfer or low tubal ovum transfer. They're simply limited to two procedures per lifetime. We wanted to make sure that was clear in the intent of this legislation and I move adoption.

SPEAKER AMANN:

The question is on adoption. Will you remark?
Will you remark on adoption?

If not, let me try your minds. All in favor please signify by saying Aye.

REPRESENTATIVES:

Aye.

SPEAKER AMANN:

All opposed, Nay. The Ayes have it. The
Amendment is adopted. Will you remark further?

Representative Olson.

REP. OLSON: (46th)

Yes, thank you, Mr. Speaker. I simply wanted to say that this has been a long time collaborate effort, and I want to thank you, Mr. Speaker, for your long time and hard work on this, beginning with your time as Chairman of the Insurance Committee, so thank you, Mr. Speaker.

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And I also want to recognize the hard work and the collaborative effort of Deputy Speaker Mary Fritz, Representative John Geragosian, Representative Chris Perone, Representative Themis Klarides, and Representative DebraLee Hovey.

I also want to thank both the Chairs of Public Health, Peggy Sayers, Representative Peggy Sayers and the Chair of Insurance, Representative Brian O'Connor for all his help.

With that, I want to yield to the distinguished Chair of the Insurance and Real Estate Committee, Representative Brian O'Connor.

SPEAKER AMANN:

Representative O'Connor, do you accept the yield, Sir?

REP. O'CONNOR: (35th)

Yes, I do, Mr. Speaker.

SPEAKER AMANN:

You may proceed.

REP. O'CONNOR: (35th)

Thank you, Mr. Speaker. I rise in support of the Bill as amended. I think it's a good compromise

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between what the Insurance Committee put out and what the Public Health passed earlier this year.

For those who didn't know, the Insurance Committee put a hard cap of \$10,000 on the Bill, and the Public Health bill left it open-ended. So we tried to strike a compromise and I think we were successful in doing that.

And limiting the cost, but also at the same time providing a benefit that was needed at the time.

And it's a de facto cap in a sense, as described by Representative Olson, by limiting the maximum benefits in the life, or the cycles by which they are able to be covered.

Also, I think one of the key provisions of the Bill, so we can better target and have coverage utilization, there is going to be, some clinical practices are going to be asked to provide reports that will hopefully make the success of infertility much greater.

So again, I ask for the Chamber to support this. I think it's a, even though it may be a mandate in some people's eyes, I think it's a necessary one and one that has some proper caps in place so that it

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doesn't cost our businesses as much money, and I ask
for your support. Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Sir. Will you remark further?

Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. Mr. Speaker, it's truly
with a heavy heart that I rise in opposition to this
legislation.

I know too well both sides of this issue. You
see, two years ago our family was blessed with a
nephew that was born through some of these procedures
that we are speaking about today.

And I remember how our family prayed that my
brother-in-law would be able to have this child, and
the good news that when we found out that they were
indeed pregnant, and then finally when our nephew was
born, and the joy that he's brought to our family.

But I can't dismiss the part, as a small business
owner, what this legislation truly does, and what it
does is raises the price of health care insurance for
all of us.

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I can't tell you how many employers I know that are struggling with the issue of health care costs. They don't even offer it to their employees because they just simply can't afford it and they don't even cover themselves.

This is a well-intentioned Bill. It's very difficult to stand up here and oppose something like this. I know that we've been dealing with this on the Insurance and Real Estate Committee for several years.

I believe that the Bill that came out this year is probably in one of the better forms. But we can't discard the fact that there are many people in this state that have no health insurance because of the cost.

And it's the very mandates as this one here that drives those costs up, and we can't forget about that. I mean, it's a real thing, that every time that we impose a mandate there's a cost to the insurance industry, and who bears that cost but us, the people that need health insurance and pay for it.

So, as I mentioned, it's a very difficult issue. I know both sides of it well, but I would urge my

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colleagues to really look at this issue from both sides. Thank you.

SPEAKER AMANN:

Thank you, Sir. Will you remark further?

Representative Perone.

REP. PERONE: (137th)

Hello. Thank you very much, Mr. Speaker. First of all, I'd like to echo the sentiments of Representative Olson. I wanted to thank you for supporting this important piece of legislation.

This is a Bill that is a long time coming. It's had a lot of work done on it. Earlier on in this Bill's history going back several years, this Bill would sometimes arrive with very modest cost controls or none at all.

This time around, it's a very different animal. We're looking at about seven or eight caps and price controls on this Bill. It's a responsible Bill that a lot of people worked really hard on. We've had a lot of input from HMOs. The insurance industry hasn't been fighting this.

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I think that this is a very responsible, fiscally responsible Bill and you know, I, too, look at it from a couple of different ways.

I look at it from someone who is being pragmatic as I don't feel that we should you know, put too much of a burden on business, but at the same time, I feel that this is something that there is a need for in this state.

A lot of people do go through this, somewhere in the neighborhood of 70,00, and the fact of the matter is, I, myself, went through this for four years.

Each day was brutal trying to deal with this, but you know, we knew the cards that we were dealt and we worked with our endocrinologist. I happened to be fortunate.

I was working in New York City so I had my insurance through a New York State plan, which is largely what this Bill is based on. It has the same kinds of controls.

And it, we were able to again, the diagnosis component of this, which was really critical. We needed to find out what was really wrong with us so we could try to act accordingly.

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Okay. I'm speaking up. So this, it enabled us to figure out what the problem was, and we were then in turn, able to seek treatment and we were covered. And I think that this, this is the kind of Bill that's going to help go a long way toward helping people become pregnant.

But I think that it's also, I'd like to just point out that, you know, in the end, this is a very good compromise Bill. Like I said, a lot of people worked on this. It has the kind of controls that we are looking for and I think it's a responsibility and I urge its adoption. Thank you very much.

SPEAKER AMANN:

Will you remark further? Representative Sherer.

REP. SHERER: (147th)

Thank you very much, Mr. Speaker. Through you to the Chairman of the Insurance Committee, I wish to ask a question.

SPEAKER AMANN:

Please proceed, Sir.

SPEAKER AMANN:

Thank you very much. Mr. Chairman, through you, Mr. Speaker, with regard to the de facto cap of two

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procedures per lifetime, there is a list in the Amendment where it talks about embryo implantations, in vitro fertilization, gamete intrafallopian transfers, zygote intrafallopian transfer, or a tubal ovum transfer.

For legislative intent, is your understanding of the limit of two, is that any one of those, or two of each. Through you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Sir. Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, that's what the Amendment was designed to do was to clarify that, and what we're going to say, or what the intent is, is that it is two out of the, if you were to count two out of each of those, it would be two out of the eight.

So if you did one in vitro, you would only have one other cycle available to you, depending on the care that is recommended by your physician.

And I think the other thing, too, that I'd want to add is that it's, I guess basically, we're trying

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to say that out of a lifetime you'd only be able to
use two out of those. So, through you, Mr. Speaker.

SPEAKER AMANN:

Representative Sherer.

REP. SHERER: (147th)

Yes, thank you, Mr. Speaker. Through you to the
Chairman. Oftentimes in the field of infertility,
it's not only the problem with the woman, it could be
a problem with the man also.

There is issue of low motility of the sperm.
There are issues of not enough sperm count, and even
the issues of the ability to consummate the sexual
act.

Is there any provision in this, Mr. Speaker,
through you to the Chair for including in any of these
procedures, any necessary medical procedures which
would affect the male if necessary, even to the point
of paying a sperm bank for a sperm specimen. Would
that be contemplated as being inclusive in the cycle
in order to have a zygote intrafallopian tube transfer
or that type of procedure?

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, this is also intended--

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SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

--the male, if he was unable to conceive as well,
or is infertile, I should say. I'm sorry.

SPEAKER AMANN:

Representative Sherer.

REP. SHERER: (147th)

Thank you very much, Mr. Chairman, through you,
Mr. Speaker. And through you, Mr. Speaker, I'd just
like to offer some, what I feel is a very necessary
support of this Bill.

You know, over the years, about 20, 25 years ago,
this Bill was in its truly, in its infancy and no pun
intended there. But the success rate was 5% and the
expenses were extraordinary.

But 20, 25 years ago, or 30 years ago, actually,
when Dr. Jones in Norfolk, Virginia, began the first
program to deal with these infertility problems and it
was licensed by the federal government.

At the time, couples were having families and
children at an early age. My generation had children
at 22, 24 years of age.

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Over the ensuing years, so many more couples are two-party working in the couple, and they put their careers ahead of their family development without even recognizing or realizing that the biological clock is ticking.

And then comes time to start a family and they're unable to, and more often than not, it is a procedure such as the one contemplated in this Bill that would allow this couple to have their dream of having a child.

The problem is though, over the years, with the success now at about 65% of these fertility procedures, the cost of these procedures has not gone down, but in fact gone up.

So that when couples, or an individual, seeks to have a fertility procedure, each cycle could be at least \$10,000 and oftentimes it requires many more than one cycle.

With this Bill, and if we all support this Bill, Mr. Speaker, we know there will be a negotiated price, just like all other procedures done in network.

The insurance will pay only what's reasonable and necessary and I believe that it will actually reduce

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the cost of these procedures, that the cap will be much, much less than if they were paying \$20,000 for two cycles, and I think in the end you will have more people avail themselves who cannot afford the standard price for the procedure, but will rather wait and if they can have the medical coverage it will be built in.

And as a matter of fact, I think with recognizing the negotiated pricing with the professionals who do the procedure, you will find that insurance rates, as my colleague was worrying about, will probably not go up as much.

And we do recognize that the way the Amendment is, it's only limited to those people 40 years old or less.

So I believe that this will have an excellent effect on assisting those with infertility problems and will not be as expensive as some people would imagine and it's just an excellent bill and I urge your success, your support. Thank you.

SPEAKER AMANN:

Will you remark further on the Bill as amended?

Will you remark further? Representative Klarides.

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Representative Klarides.

REP. KLARIDES: (114th)

Thank you, Mr. Speaker. I also rise in support of this Bill and certainly agree with all the comments of my colleagues. I'd like to thank everybody for all the great work they've done, including you.

I think a lot of people that have problems with this Bill, have problems because of the mandate, which I certainly understand. And it's certainly more expensive than a lot of other ones, and I think we can all see that that's the reality of it.

But this Bill went through a lot of changes that other bills that we deal with should have gone through. In the past five years, this Bill has changed so many times, and it has changed to take into account the problems that people that were against it had as far as the age limit, the amount of cycles, the maximum amount that can be had on this, and I think it really, really addressed a lot of the issues people had.

As far as the mandate issue, you know, a lot of people just disagree with mandates for mandate's sake,

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and although I respect that, I don't really agree with that.

I think we really need to look at each mandate we have on a case by case basis and say to ourselves, what purpose does it serve and how necessary is it. And clearly, clearly this Bill takes those things into account.

I don't have the personal experience, but from speaking to a lot of people that had, this is something that you don't understand until you've gone through. There are people that have mortgaged their homes, had to move out of state, had to leave jobs, because they couldn't afford it.

And even though this Bill will certainly not solve everyone's problems, and some people may need more than this Bill gives them, but it is certainly a great start and it meets in the middle of the road between the people that need it and want it, and the people that think it's too expensive.

For those reasons, I certainly urge your support.

SPEAKER AMANN:

Thank you, Madam. Will you remark further on the Bill as amended? Representative Farr.

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REP. FARR: (19th)

Thank you, Mr. Speaker. Mr. Speaker, a few questions to Representative O'Connor, concerning this Bill. Through you, Mr. Speaker.

SPEAKER AMANN:

Please frame your question.

REP. FARR: (19th)

Representative O'Connor, as a gentleman of the Insurance Committee, there was one prior Representative comment is that the industry supports this. Is that accurate? Did the industry actually support this?

REP. O'CONNOR: (35th)

They did not publicly support--

SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, I would not say that the industry supported this, no.

REP. FARR: (19th)

And Representative O'Connor--

SPEAKER AMANN:

Representative Farr.

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REP. FARR: (19th)

Could you tell me, how much on average, we've heard of people having to sell their homes, mortgage their homes. My understanding this treatment can be extraordinarily expensive.

Do we know how much this treatment actually costs on average? Was there testimony about the actual cost that insurance companies would be incurring in order to provide this coverage? Through you, Mr. Speaker.

SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, IVF treatments, or in vitro fertilization cost about \$13,000 per cycle. Some of the other areas where we put limits, they're as low as \$75 and that is the ovulation induction. And if you look at the intrauterine insemination, that's \$2,500 per cycle.

And if you look at what we've done, most of the success is early on with the less costly procedures. And if you were to max out and do everything, I think you would top out about \$40,000 to \$45,000. Through you, Mr. Speaker.

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REP. FARR: (19th)

Thank you--

SPEAKER AMANN:

Representative Farr.

REP. FARR: (19th)

--Representative O'Connor. And again, through you, Mr. Speaker, are there insurance policies that currently cover these procedures? Through you, Mr. Speaker, to Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker.

SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

There probably are.

REP. FARR: (19th)

Through you, Mr. Speaker, to Representative O'Connor. Was there any testimony as to what percentage of the industry, what percentage of the policies that are out there currently cover this procedure, and was there any testimony about the increased costs of getting, obtaining coverage under current law?

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REP. O'CONNOR: (35th)

Through you, Mr. Speaker, some of the, through
you, Mr. Speaker.

SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

Some of these coverages are already covered as
major medical surgeries, so I think it's fair to say
that many of these policies are covered by insurers.
Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Farr.

REP. FARR: (19th)

Through you, Mr. Speaker, to Representative
O'Connor, but is it your testimony, then, that people
can already obtain this coverage and this Bill would
simply prohibit anybody from having a policy which
excludes the coverage? Is that accurate, and if so,
what would be the additional cost for obtaining the
coverage?

REP. O'CONNOR: (35th)

Through you, Mr. Speaker.

SPEAKER AMANN:

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Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, I apologize to Representative Farr. Could you please repeat the question please?

REP. FARR: (19th)

Yes, through you, Mr. Speaker, to Representative O'Connor. My understanding is that you've indicated that people may already be covered for some of this under some policies.

Can an individual already obtain a policy which includes coverage for these types of treatments at the current time, and if so, if you have any indication as to how much the extra coverage costs?

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, the state offers many of these plans and they can obtain it through them if they're a state employee.

As far as individuals, they can buy individual policies that may have this benefit. What occurs oftentimes is that an employer may not offer this coverage and those are the individuals that will have to pay out of pocket. Through you, Mr. Speaker.

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REP. FARR: (19th)

Again, through you, Mr. Speaker, to
Representative O'Connor.

SPEAKER AMANN:

Representative Farr.

REP. FARR: (19th)

You indicated that the state offers this
coverage. Does the state health care plan already
cover these types of procedures? Through you, Mr.
Speaker, to Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker.

SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

Some of their plans do have this, Representative
Farr. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Farr.

REP. FARR: (19th)

Yes. I guess I'm just a little bit concerned
when we're starting off with a Bill that we're told is
going to cost, we need coverage because it costs an

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extraordinary amount to get the coverage, an
extraordinary amount to pay for the service.

And so we're going to mandate every policy covers
the service, and yet we don't have any evidence or any
testimony about how much that's going to drive up the
cost of health insurance.

I'm just sort of surprised. I had assumed that
in the Insurance Committee that they would have had
some evidence as to the cost to providing this
coverage and its affect upon coverage, the cost of
obtaining current policies.

Could I also ask you, at the present time,
welfare recipients in Connecticut are covered under
HMOs. Am I correct in assuming that any health care
coverage we have for recipients, for DSS recipients,
would also cover this, these procedures. Is that
correct? Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, I believe it depends
on the plan that they're covered under.

REP. FARR: (19th)

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Through you, Madam Speaker to Representative O'Connor. Doesn't this require every plan to cover this type of procedure.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, yes, it does, so therefore they would be offered this coverage.

Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

REP. FARR: (19th)

And Representative O'Connor, there was testimony, or a statement made that this had a limitation by limiting it to two procedures, two cycles.

But am I correct in reading this, that it's not limited while one procedure may be limited to two cycles, that you could use multiple procedures so that in fact you might have someone who was treated on a variety of different ways, so that instead of just two treatments, you may actually end up having eight treatments, but of a different nature.

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Through you, Madam Speaker to Representative
O'Connor.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, if you look at it, I
mean, yes, you could use more than the two cycles.
What it is, it's saying for those specific treatments,
again, for ovulation induction there would be four
cycles.

For the intrauterine insemination there would be
three cycles, and then the IVF, JFT and ZIP, there
would be two cycles.

And again, if you add those all up and were to
max out, you would probably be costing, it would
probably cost about, again, \$40,000 to \$45,000 and if
you want to break it down with the different
infertility mandates that have been implemented
throughout the country, it could be between \$.25 per
member per month up to \$2 per member per month, just
to put it in perspective. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

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REP. FARR: (19th)

I'm sorry, through you, Madam Speaker, to Representative O'Connor. You're indicating that it would be \$2 per member per month for every insurance policy in the State of Connecticut in order to get the added, in order to pay for the cost of coverage. Is that correct?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, I said it was a range based on the most limited benefit to a benefit that is unfettered and I believe Connecticut would fall well below the \$1 per member per month. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

REP. FARR: (19th)

Representative O'Connor, why didn't we put a cash limit on the amount of benefits under this Bill?

Through you, Mr. Speaker, Madam Speaker, to

Representative O'Connor.

DEPUTY SPEAKER KIRKLEY-BEY:

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Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, the cap that we had on originally, the \$10,000 cap was deemed to be too low and actually would not offer treatment.

And as far as the continuum of care by the professions, or the physicians rather, I should say the reproductive endocrinologists, we didn't want to limit their treatment, basically. We wanted them to be successful and we thought the \$10,000 hard cap was probably too low.

And also, we didn't want to have to come back to the Legislature each and every year to raise that level. I think that would have been problematic. We wanted to do something that could be put in place permanently and something that provided a little bit more flexibility. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

REP. FARR: (19th)

Yes, thank you, Representative O'Connor. Another question is, through you, Madam Speaker to Representative O'Connor, this Bill talks about a

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lifetime cap. It's a little bit confusing to me, since this is a limit on a particular insurance policy.

If an employer changed the coverage and now had another, coverage with another company, am I correct in assuming that that individual could now begin, could now begin getting coverage again with another company because they never received any benefits with that company policy? Through you, Madam Speaker to Representative O'Connor.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, that is correct. It would be a look back where they would be asked to provide information as far as prior coverage, and they would be obligated to provide that.

So if they have one cycle, let's say with Anthem, they would only, and this is on the IVF, they would only have one cycle remaining if they were to change to Aetna. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

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REP. FARR: (19th)

Again, I'm, you know, troubled by what's happening with this Bill. What we're in essence saying that we're going to give people a benefit and we're not going to worry about the fact that it's driving up the cost, and we have to give them that benefit because the cost is extraordinary, of the benefit.

And we're not going to worry about the fact that everybody's health insurance is going to go up to do that.

To me, this is the, you know, it's nice to tell people there is a free lunch, and it's nice to tell people that we will provide them unlimited health care benefits because that's essentially what we do every time we add a new procedure for coverage.

But in this particular case, we're adding what has been described as an extraordinary, expensive procedure. And I understand that that's the case, and I fully understand the desire for people to get coverage.

But what we have to trade off is the fact that you're talking about substantially increasing the cost

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of medical coverage, of medical insurance, of health insurance policies in the State of Connecticut.

Now, I'm a little concerned that we didn't have more input and more data on some of the impacts here and I'm concerned about the fact that we did not have, as I see it, there's no requirement that the individual contribute to this cost.

So if it's a \$40,000 cost, as I understand the Bill, the health insurance company will have to pay the \$40,000. The individual no longer has to contribute anything to that cost.

I don't see, and maybe I'm wrong, but I don't see any question of deductibility coverage in here. It seems to me to go from what we currently have to saying we're going to fully cover the cost, is not an unreasonable approach to dealing with this issue.

And also, Representative O'Connor indicated at some, there is some coverage to have major medical. So for many people, they already have some coverage.

The other concern I have, is the fact that as I understand what we're doing today, we're going to say that if somebody is a welfare recipient, if they're receiving assistance from the State of Connecticut,

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we're going to assist them in having additional children.

Now, I'm not sure that it makes a lot of sense that we're going to provide infertility coverage for people who are receiving benefits from the state so that we can expand the cost of those benefits.

Obviously, if someone is a recipient of the state, of state benefits, if they have additional children, we're now going to have to pay for those children as well. I'm not sure that makes an awful lot of sense from a public policy point of view and I certainly think we should have addressed, and should address those issues.

I'm not sure what we're doing here today, but I understand the concern about people out there, that this is an extraordinarily expensive procedure.

Had we come up with some moderate bill that assisted people instead of fully covered the cost, it might have been a more reasoned approach to it.

I don't think this that this is, I think this Bill is just another bill that represents we're going to give something to someone and there will be no cost, when in fact there is going to be a cost, a

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substantial cost and it's going to be a cost to us as a state, and it makes little sense for me to do this and support this in this form. Thank you.

DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative. Representative Hovey of the 112th District, you have the floor, Madam.

REP. HOVEN: (112th)

Thank you, Mr. Speaker. I rise in support of this legislation. We do a lot of things in this Hall, this very hallowed Hall, that we claim is in support of families and of the individual.

Nothing negatively impacts on a family as much as wanting to have a child and being unable to. It not only impacts on the couple, but it impacts on their extended family and all the people who know them. In fact, it can tend to become an obsession.

The will to bear a child when you reach a certain age is sometimes overwhelming, and to have a fertility issue that is beyond your control, I think that's the piece of this that we really need to be reflective upon.

Infertility is something that's beyond your control. Now, we insure people who smoke. We insure

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people who eat crap and get, you know, different diseases. We insure people who have very bad habits that are well within their control.

But someone who is infertile has no control over that, and I would say that we should definitely insure them. I urge all of my colleagues to support this legislation.

DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative. Representative Wasserman of the 106th District, you have the floor, Madam.

REP. WASSERMAN: (106th)

I don't know if this thing is working, now. It is now. Through you, Mr. Speaker, to Representative Olson.

DEPUTY SPEAKER ALTOBELLO:

Please proceed, Madam.

REP. WASSERMAN: (106th)

Through you, Mr. Speaker. Representative Olson, during our Public Health Committee meetings, there was some discussion about this issue and a lot of questions were asked about the financing.

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And at one point, somebody said this is going to cost millions of dollars as an overall coverage. Would you care to answer that, please?

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Thank you, Mr. Speaker. Through you. As we heard from Representative O'Connor as well. When Representative O'Connor mentioned some of the prices of some of these treatments, in fact, those prices are a few pay for fee for service.

Certainly when we incorporate coverage under different group and individual health policies, the cost for these services decreases dramatically because we're talking about risk pool and we're talking about the cost sharing of different policies and different pools. So that's where the cost saving kind of occurs.

There's also a cost saving in understanding the idea that surgeries are going on right now under major medical benefits. There are surgeries that are highly ineffective, they're highly invasive, and they also

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include inherent risks that are usual and common with surgery.

So certainly, people are undergoing these types of surgeries at this point and not getting a good benefit. They're doing them multiple times because they're not effective, and those are the kinds of surgeries that are really Draconian in nature.

They're old-fashioned and we're looking now to implement, moving forward with medical technical and implement the different procedures that are available under assisted reproductive technologies that our reproductive endocrinologists are working on and are perfecting.

So that, that's kind of some of the discussion that I remember we had in the Public Health Committee regarding those issues.

DEPUTY SPEAKER ALTOBELLO:

Representative Wasserman.

REP. WASSERMAN: (106th)

Through you, Mr. Speaker, thank you very much. Representative Olson, you've been dealing with this issue intensively for some time. And we're talking

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not in numbers. Can you give us an estimate of what the program would cost in the State of Connecticut?

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Yes, through you, Mr. Speaker. As Representative O'Connor stated, he had mentioned the cost for the services. We have eight different procedures that you're eligible to receive.

Certainly, the idea is that if a doctor determines that a particular procedure is not useful for you or would not be efficient or effective for you, you wouldn't use that particular procedure. So it's kind of a menu of what the doctor feels is available, or is appropriate for you.

If they were to go for each and every procedure, the fee for service cost would be somewhere around \$40,000. But that is the fee for service cost, and that's what I would like to make clear. That's the cost that if you were going in off the street and paying with your own dollars. That's kind of the estimate that we have heard.

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But again, when you put it in the risk pool idea, and you put it in the management of numerous people on a policy, then that cost decreases dramatically and that's when the mention was that there had been some estimates that it could be as low as \$1 per person per policy, so that's where we're looking at that. Thank you, Mr. Speaker, through you.

DEPUTY SPEAKER ALTOBELLO:

Representative Wasserman.

REP. WASSERMAN: (106th)

Again, through you, Mr. Speaker, the, I understand that the insurance companies have given an estimate of a number. I was never able to find out what their numbers were in total. Are you privy to that number?

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker, no I don't.

DEPUTY SPEAKER ALTOBELLO:

Representative Wasserman.

REP. WASSERMAN: (106th)

Thank you very much, Representative Olson.

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Again, this is a very difficult decision because the procedures are very important to many people on the one hand.

On the other hand, we have so many needs in this state, social needs that it's very hard to balance that out. But I thank you for the information.

DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative. Representative Hamzy of the 78th District, you have the floor, Sir.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. Through you, a couple questions to the proponent of the Bill as amended.

DEPUTY SPEAKER ALTOBELLO:

Please proceed.

REP. HAMZY: (78th)

Through you, Mr. Speaker, just following up on some of the questions that Representative Wasserman had asked.

Are there other states that mandate this coverage? Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

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Through you, Mr. Speaker, yes. As of October, 2004 I believe there were 14 states.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

And through you, Mr. Speaker, do we have information as to the estimated costs per procedure in those states that mandate this coverage?

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker, if you could hold on one moment, I'd like to look through my notes for a second.

DEPUTY SPEAKER ALTOBELLO:

Take your time, Madam.

REP. OLSON: (46th)

Through you, Mr. Speaker. It's somewhat difficult to compare that in a sense that each state has kind of diverse coverage offerings.

Our coverage is actually somewhere not as rich as the plan of Massachusetts, which is something that we were looking at to try to figure out how to create

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reasonable limits, understanding that some of this coverage is costly coverage.

So our plan, we came in at less than Massachusetts and that's kind of the benchmark that they were using. I believe we have some indications that the Massachusetts plan is at the cost of \$2. So with our coverage and other processes that we offer, that's where we came up with a lesser cost for that.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Let me rephrase my question. I guess my question is more directed at the cost of the procedure, as opposed to the cost of the insurance.

Through you, Mr. Speaker, do we have an idea of what the costs of the procedures are in those states that mandate this coverage?

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker. The estimates that I have are the cost of the procedures. Quite honestly,

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I'm not sure that they are an average of the states that offer these different procedures.

But the costs that we have are estimated that an IVF procedure when you do it through a fee for service, has a range, we've given a range of everywhere from \$8,500 to \$13,000, and that's again, under the fee for service arrangement instead of having it through a risk pool.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Through you, Mr. Speaker. And that's, the reason why I asked the question of what the cost is of the procedure in those states that are mandating to coverage, was to try to get a sense of the differences, if there is a difference in cost between those states that don't mandate the coverage and those states that do. I'm not sure if Representative Olson has that information or not.

Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

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Through you, Mr. Speaker, I don't have that exact information.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. Through you, Mr. Speaker, what percentage of insurance companies would this mandate cover?

In other words, it's my understanding that those companies that are, that are not subject to our ERISA laws, are the companies that would be mandated to adhere to the laws that we pass in our state. Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker, in fact I'd like that question to be directed to the Chairman of the Insurance Committee if I may?

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Certainly. Through you, Mr. Speaker.

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DEPUTY SPEAKER ALTOBELLO:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, if I may. If Representative Hamzy would be kind to restate the question, please.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Through you, Mr. Speaker, there are some companies, and I'll explain it. There are some companies that are self-insured, which I don't believe are required to adhere to the mandates that we pass in our state.

Through you, Mr. Speaker, do we have a sense of how many, or what percentage of insurance companies that offer insurance in our state would be subject to this new mandate? Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, if I understand correctly, I think you're asking the number of

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companies that would not be required to offer this mandate because they're either self-insured and were exempt by ARISA, and the answer to that is approximately 50%. Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. And I ask that because this Bill is being portrayed as a, sort of an end all or be all to a lot of people who suffer with the issue of infertility. I'm not sure that's actually the case.

Just a couple of questions, and I understand that a lot of the provisions that were included in this, in this Bill, were meant to address the issue of cost, and I appreciate that, because that was one of the major concerns of a lot of people.

How many cycles, through you, Mr. Speaker, to Representative Olson, how many cycles are usually required on average, to achieve pregnancy? Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

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REP. OLSON: (46th)

Through you, Mr. Speaker. Actually, that's a very good question and you're going to get different answers from different reproductive endocrinologists. It really depends on the individual.

For instance, if I may give an example of how much it depends on an individual. When we put a limit in this Bill that this coverage would be limited to someone up to the age of 40, that was because it was a result of having doctors report to us that this coverage was, you know, useful up to, you know, the age of 38, but also then other doctors said up to the age of 44 that these treatments would continue to be effective.

So certainly, that depends very much on what individual doctor is kind of prescribing and what kind of work that they are doing.

But certainly when we talk about some of these procedures, a doctor, some of the doctors that we spoke with said, look after three IVFs, you know, that's just not going to be something that's useful. More treatment is not going to result in a successful pregnancy, and those are, that's the information that

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we based some of the compromises on when we limited
the number of procedures.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Thank you for the response. And just, another
question with regard to the lifetime benefit, and I
know Representative Farr asked this earlier, but I
wasn't clear on the answer.

If well, let me step back. In order to qualify
for this coverage, I believe the Bill says that
someone has to be on a certain policy for at least 12
months. Through you, Mr. Speaker, is that accurate?

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker, yes.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

And once the person meets the 12 month, I guess
probationary period, or however you want to term it,
then they qualify for this benefit.

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If they go through two cycles on a particular insurance plan, they leave their place of employment and go to another place of employment that has a different health insurance plan.

Through you, Mr. Speaker, do they now qualify for an additional two cycles?

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker, no. We included in this Bill the look back provision, in which we indicated that this is a lifetime maximum benefit.

Therefore, if an individual had made him or herself avail themselves of these procedures at their first employer, leaving that employer and moving to another employer does not then create a whole new set of benefits.

That's the entire purpose of the look back provision, to give that kind of finality to the maximum benefits. Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

And through you, Mr. Speaker, with the increased emphasis on privacy and HIPPA laws, how would that be tracked? Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker. HIPPA laws, under my understanding, is a prohibition on the mandatory sharing of information without a patient's consent.

In fact, in this particular legislation, as with quite often with genetic testing and that sort of coverage, this is not some kind of mandatory sharing without consent.

We're asking the patient, prior to availing themselves of this coverage, whether or not they've had this coverage before, or availed themselves of this coverage before. Through you.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Through you, Mr. Speaker, so it's up to the individual to affirmatively disclose whether or not they've had this procedure? Through you, Mr. Speaker.

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DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker. Yes, that's the case, but it's also the case that we have that with all sorts of pre-existing conditions. The individual is required to disclose that kind of information for insurance coverage. Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

And through you, Mr. Speaker, if that is not disclosed, is there a penalty?

DEPUTY SPEAKER ALTOBELLO:

Representative Olson.

REP. OLSON: (46th)

Through you, Mr. Speaker, I am not aware of the insurance regulation penalties. In this Bill, we indicate that the insurance, Commissioner of Insurance can create the form in which to require this information, and that we can take a look at that particular form, but I'm not privy to insurance regulation of the Commissioners.

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DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Through you, Mr. Speaker, if I might redirect that question to the Chairman of the Insurance Committee.

DEPUTY SPEAKER ALTOBELLO:

Please proceed, Sir.

REP. HAMZY: (78th)

Through you, Mr. Speaker, to Representative O'Connor, is there, or is there a penalty if someone does not affirmatively disclose a previous condition or the fact that they have already availed themselves of this coverage under a different policy? Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, there is not a penalty as far as let's say, you know, fine or any kind of charge against that individual.

But the insurer, the insurer will be able to deny that benefit coverage. Through you, Mr. Speaker.

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DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

Through you, Mr. Speaker, how would the insurer be aware of the fact that someone has already had this treatment? Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker. With the look back provision, it's my understanding that if it were to come to their attention that they did have this and had that knowledge then they would be able to deny that benefit.

As far as, you know, people misleading and lying, as far as their history, I think you might be able to look at some of their medical records and seek information from their past coverage and physicians.

Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Hamzy.

REP. HAMZY: (78th)

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Thank you, Mr. Speaker. And I thank Representative Olson and Representative O'Connor for their answers to the questions that I had.

And, Mr. Speaker, as a couple other people have said when addressing this Bill, this is a difficult issue and it's difficult for me personally, because I understand the issue and I understand the sentiments that people who have had to go through infertility treatments have.

But at the same time, I'm also aware of the fact that there are a lot of uninsured people in our state, and when I go to different businesses in my district, the number one complaint that businesses have is the high cost of health insurance.

And there's a misconception that insurance companies pay health benefits. It's not insurance companies that pay health benefits. They offer benefits to their employees, but it's employers and employees that pay for the cost of health insurance.

And the fact of the matter is that when health insurance premiums increase, the rate of people who are uninsured increases as well and unfortunately, that is the fact of the matter.

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And as a small business owner, I'm very cognizant of the fact that health insurance costs are extremely high, as we all know. And to add another mandate that everyone has acknowledged is going to be extremely costly.

And as well intentioned and as good a job as the proponents of the Bill have tried to institute some cost controls, I believe that this is, this is the foot in the door.

And I believe that eventually future Legislatures, once this is not sufficient to help people it's meant to help, are going to make it an unlimited mandate, which unfortunately is going to further increase the cost of insurance.

And as difficult as a decision this is for me, I am also going to oppose the Bill as amended. Thank you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Representative Frey of the 111th District, you have the floor.

REP. FREY: (111th)

Thank you, Madam Speaker. One of the aspects of being in the Legislature the last seven years I've

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enjoyed the most, being a member of the Insurance and Real Estate Committee.

While I have a real estate background, it's really the Insurance Committee because we do very little dealing with real estate. It's been interesting and it's been educational to me.

One of the most heartbreaking things to go through up here is some of these Insurance public hearings where we hear about these families who are desperately trying to, are parents, who want to be parents desperately trying to start a family.

And we hear about families going through difficulties dealing with breast cancer screenings which we approved a couple of years ago as a mandate. Colon cancer was one that came up two years ago, I believe. Diabetic testing supplies, which we approved I think six years ago.

This year, the public hearings were no different than years past. We had a bill that was introduced dealing with mandatory coverage of prosthetics.

We had two little babies, who I think were about nine months old each, just by coincidence delivered by the same doctor, the same hospital, who had naturally

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amputated limbs while they were, during the pregnancy,
and they, both of them, arms were, the limbs ended
just above the elbow.

And it's estimated that the cost for prosthetic
devices for these little babies would exceed \$300,000
over the course of their lives.

We had another gentleman who came and spoke on
that bill who had cancer in his leg, he was a young
man about 30 years old who was a mechanic, and he
spent \$60,000 on a prosthetic leg that was not covered
by insurance. I think he received \$2,500 from the
insurance company.

Two years ago we had a bill covering ostomy
supplies, a very basic need. The cost is between
\$1,600 and \$2,200 a year to cover those supplies.
Those aren't covered.

We have an increasing number of uninsured in
Connecticut and I can't help thinking that these
mandates are contributing to that large number, why we
have to increase the funding for HUSKY adult program
that we're probably going to be up in the budget in
the next few days.

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Coming up yesterday I was listening to the radio and a business segment came on and the news announcer was saying how GM and Ford were both downgraded by the bond markets, each going through difficult times.

And it was said that GM insures one million people in this country, and the biggest difficulty they're facing is the cost of health insurance for these million insured.

When you purchase a GM vehicle, \$1,600 out of every vehicle, the price of the vehicle, goes to cover the health insurance cost of their current employees or former employees.

I think Representative Wasserman was trying to get a handle earlier on the cost of this to the individual premiums, and it's hard because the Amendment has changed somewhat.

But one major insurance company here in Connecticut is estimating that for a \$20,000 lifetime maximum benefit, it would add \$4.22 per month for the insurer, or \$50.64 per year. That's a lot of money.

Is that going to price it out where business won't be able to offer insurance to their employees because of the extra costs.

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Many companies, we heard during the public hearing, do cover fertility treatments and fertility treatments and that's great. But should it be a mandate? That's what we're debating here today, and I just don't think it should.

We all have friends and families who have gone through this and our heart goes out to them. We heard at the public hearing, extended family chipping in to cover this treatment.

But should this be a mandate on every insured in Connecticut at a cost of \$50 a month, and probably increasing the number of insured, which we've seen dramatically rise in the last 14 years here in Connecticut. I don't think so, and unfortunately, I would urge rejection of the Bill. Thank you.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Representative Feltman of the 6th District, you have the floor, Sir.

REP. FELTMAN: (6th)

Thank you, Madam Speaker. First, I'd like to commend the Chairman of the Insurance Committee, Representative O'Connor for bringing out this Bill or

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bringing it to us today, and the very spirited defense of this Bill by Representative Hovey.

I rise in support of this Bill, and I think it's important, and I think as technology changes in this country, as medical technology improves and we're able to treat more diseases and to treat more problems that people have, that our health care system and our insurance system need to change with it.

I know there's been some who argued that it's going to increase the cost for people who do not have these difficulties with getting pregnant.

But I would argue that that's the fundamental principal of insurance and always has been, going back to the 19th and 18th century, that you spread the risk among a large number of people for a small number of people who have an extreme expense. That is what insurance is about.

And I think it's incumbent upon us, the lucky ones who are able to reproduce, to assist those and to help pay for those who are not so fortunate.

And I realize that there's some cost involved, but yet the individuals who are infertile are paying the cost as well, not only through their insurance

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premiums, but also through their co-pays and deductibles.

Another expense, the emotional expense as well, of going through these procedures.

Madam Chair, it's been said before that our heart goes out to those people who are infertile or are having difficulty with fertility. I think our wallets need to go out to them as well. Thank you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative Feltman. You have the floor, Representative Belden of the 113th District.

REP. BELDEN: (113th)

Thank you, Madam Speaker. Madam Speaker, I believe that everyone who has spoken today has added something to the debate and to our education for all of us.

I do have some concerns regarding that go before us and if I might, through you, to the proponent, a couple of questions, Madam Speaker.

DÉPUTY SPEAKER KIRKLEY-BEY:

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Representative O'Connor prepare yourself for questioning. Representative Belden, please frame your question.

REP. BELDEN: (113th)

Thank you, Madam Speaker. In Section 1 of the Bill, it talks about insurance policies issued, etc. in the state, for the State of Connecticut.

Through you, Madam Speaker, are those insurance policies issued for any person in the State of Connecticut, or are they only for companies that issue insurance policies in the state?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, those are both individual and small group plans. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Belden.

REP. BELDEN: (113th)

Madam Speaker, we're in quite a quandary, and not only in the State of Connecticut, but nationally,

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regarding medical insurance coverage for all of our
citizens.

And there's another bill floating around here
called pay to play, etc. Would this particular
legislation require Wal-Mart, or any national company
that has insurance for its employees, not only
nationally, but internationally, would this require
that their policies be amended in the State of
Connecticut for this coverage for those who are
employed in the State of Connecticut?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, no. The companies
that you mention, while I don't know for certain, but
I would assume, are exempt through federal ARISA laws.
Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Belden.

REP. BELDEN: (113th)

Thank you. I thank the gentleman. Does the
gentleman, through you, Madam Speaker, have any idea
of the three and a half million people in the State of

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Connecticut who would be affected by passage of this legislation, not just those who might be infertile, but those that are covered under insurance. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, by my estimation with 50% of the companies, small businesses that would have to offer this, you know, based on the total number of insured, I believe we have about 350,000 people that are not insured, so I'm trying to do some quick math here.

Potentially one and a half million people would be affected as far as paying through their policies. But as far as the number of individuals, I can give a for instance of the number of people that would actually seek IVF treatment, if that might help clarify one of the answers.

And I guess it's the number of people that are actually seeking treatment, 3% of part of their treatment is IVF, which is roughly 1,500 women in the State of Connecticut. So hopefully that puts it in

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perspective for the Representative from Shelton.

Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Belden.

REP. BELDEN: (113th)

Thank you, Madam Speaker. If I think I got that straight, and I realize these are magnitude numbers. The gentleman said roughly a million and a half people are covered under policies that are cited in this particular proposal before us and the number was somewhere in the 10,000, 11,000 people?

Through you, Madam Speaker, am I in the right categories?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor, would you repeat the answer for Representative Belden.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, yeah, the information that the Representative from Shelton had just mentioned was correct, and 3% of patients that are seeking, that are seeking infertility treatment, that's 1,500 people.

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So it would roughly be, from looking at this again correctly, 50,000 people would be seeking some kind of infertility treatment. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Belden.

REP. BELDEN: (113th)

I thank the gentleman for his responses. Madam Speaker, we've got to make very, very difficult decisions here with regard to our citizens in the State of Connecticut.

And clearly, we heard about life threatening and non-life threatening, and even if something is non-life threatening such as what was before us today, emotionally and many other aspects, it has an effect on those particular citizens.

On the other side of the issue is, we're talking here about a mandate that would cover a portion of Connecticut's population that would, or could, in fact, and we've heard this discussion.

We've seen actual experience where the number of those offering insurance is reduced, and employers for good reason if they want to compete in a worldwide

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system that many other areas did not offer these kinds of coverage, say, well, I'm not going to be able to afford to offer insurance coverage any more. That's the quandary we're in today, Madam Speaker, at least as far as I'm concerned.

And as much as I appreciate the issue before us and what not, it is not a physically life-threatening issue and it is a mandate and I'm probably not going to be able to support it. Thank you.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Representative Fritz of the 90th District, you have the floor.

REP. FRITZ: (90th)

Thank you, Madam Speaker. I stand in very strong support of this amended Bill before us. The first change or the first go at infertility for the State of Connecticut happened in 1987 and that has been on the books until today, which said that companies, businesses may offer infertility insurance.

And you know what? Surprise, surprise. Most of our school systems have this coverage. Many of our private schools have this coverage.

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Religious schools, in fact have this coverage, and they have the full boat, not like this Bill before us today, which actually sets that infamous word cap on the number of procedures you would have.

I have testified over and over and over again before the Public Health Committee and the Insurance Committees, trying to get to this place today.

It's not about money. It's about people, and that's what we should remember we're here for. I urge strong support for this Bill.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Representative Sawyer of the 55th District, you have the floor.

REP. SAWYER: (55th)

Thank you, Madam Speaker. A question to the Chairman of the Insurance Committee, please.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor, prepare yourself for questioning. Representative Sawyer please frame your question.

REP. SAWYER: (55th)

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Thank you, Madam Speaker. This is a very complicated issue and one that has me torn as to which way I'm going to vote on it.

But I want to just ask for a point of clarification to see if I understand everything that could possibly be covered.

Through you, Madam Speaker, a question, in looking at a situation, oftentimes when a couple is not able to have a child, it many times is because of the woman's inability to be able to carry an implantation of an embryo.

We have seen in a lot of the documentation, that embryo implantation for women is tried over and over repeatedly before a pregnancy can occur.

So my question would be, in the extreme case where, in the case of a couple where the woman is not able to carry a child, would this legislation permit the coverage of in vitro fertilization of a third party? Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

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Through you, Madam Speaker. I'm having trouble understanding the question. Can you rephrase that please? I know you went through a long talk on it.

REP. SAWYER: (55th)

Absolutely.

REP. O'CONNOR: (35th)

Thank you. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Sawyer, please restate the question.

REP. SAWYER: (55th)

Yes, Ma'am. In the case where a couple, a husband and wife couple, and they are unable to conceive a child because the woman cannot carry the pregnancy, the fertilization has not worked.

Would this coverage allow the in vitro fertilization of a third party carrier? A third person, obviously a woman, who is not a member of the couple.

REP. O'CONNOR: (35th)

Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Yes, Representative O'Connor, please proceed.

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REP. O'CONNOR: (35th)

The question is, or the answer is, I should say,
is that no, that would not be mandated under this
Bill.

Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Sawyer.

REP. SAWYER: (55th)

Would not be mandated? Is that, through you,
Madam Speaker?

REP. O'CONNOR: (35th)

Through you, Madam Speaker, that is correct.

REP. SAWYER: (55th)

Thank you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Excuse me for a moment. Thank you.

Representative Farr of the 19th, you have the floor.

REP. FARR: (19th)

Thank you, Madam Speaker. For the second time.
A couple of questions, follow up questions to
Representative O'Connor.

One was co-pays. Am I correct in assuming that
if a couple were to, or an individual were to avail

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themselves of the provisions here, that the insurance company could not require any co-pays? Through you, Madam Speaker, to Representative O'Connor.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, they could still offer co-pays. What they couldn't do is offer excessive co-pays and deductibles that would make it prohibitive and would not be in line with what other products they offer. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

REP. FARR: (19th)

Thank you, Madam Speaker. I guess I'm confused by that. If an individual wanted to spend, go through a procedure that could cost \$40,000, could the insurance policy say that the first \$5,000 of that would be paid for, that 25% of any coverage, any cost for these treatments would be covered by the individual, or is it going to be covered from dollar one?

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And I'm not talking about a, obviously, there can be deductible on an insurance policy so that if you went to your doctor four times, some policies say the first \$100 is not covered.

But assuming the person has already expended their deductible, their standard deductible when they went for these treatments, would there be any way that the insurance company could say that 25% or 50% of the cost would be borne by the individual seeking the treatment?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker. When the insurance companies file their plans, they would have to be approved by the Department and they would be the judge of whether or not it's appropriate.

And also, I just want to correct for the record, the Representative from West Hartford mentioned that one of the, you know, a cycle or procedure was \$40,000.

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The information that we've heard in the Insurance Committee and that we have looked in our research, no procedure costs \$40,000.

What we were talking about earlier when I was talking about the cost, if someone were to max out every single cycle and were to maximize the benefit, the total cost would be \$40,000.

The evidence that I have is that an IVF treatment would top out at approximately \$13,000, as the other procedure is a GIFT and a ZIFT. If you look in the Bill, you'll see them spelled out as far as the acronyms.

So I just wanted to state that for the record so it was clear to the Membership. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

REP. FARR: (19th)

Yes, thank you, Madam Speaker. I guess Representative O'Connor still hasn't answered the question, though.

If an individual is, wanted to go through every procedure, eight procedures, and expended the \$40,000,

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can the insurance company say that if you're going to get these types of treatment you have to pay 25% is going to be borne by the individual?

I'm simply seeking an answer to the question of whether there can be a co-pay for this type of procedure or not? Through you, Madam Speaker, to Representative O'Connor.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, there could be a co-pay. Whether it's 25% or not, again, that would be depending on the filing and acceptance by the Insurance Department. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

REP. FARR: (19th)

Well, thank you, Representative O'Connor. I guess I'm not getting much guidance. I don't know how the Insurance Department could possibly determine whether a policy were appropriate or not.

If we don't have any guidance in the legislation and there's no way for which, under which they could

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determine whether a co-pay of 25% or 50% is appropriate.

The second question is, the 50% of the companies that plans that are not covered by, that will be affected by this, am I correct in assuming that this will primarily affect small businesses, that the large businesses are the ones that are, that comprise the 50% of the plans that will not be covered?

Through you, Representative, Madam Speaker, to Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

It would apply to plans that are not self-insured, of which the majority are small businesses.

Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Farr.

REP. FARR: (19th)

Yes, thank you. Thank you, Representative O'Connor. Again, just a comment on this.

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I believe we could have come up with a bill that had some more realistic controls on it. This Bill has no monetary control.

And while the testimony is that we didn't want to do that because every year we'd have to increase it, if in fact the passage of the Bill is going to drive down costs, then obviously, we wouldn't have to do that because the cost would be diminished.

Secondly, I believe we could have done something with co-pays. I don't see any language about co-pays. It seems to me what we're doing is, we're saying to people, well, you've had to, those people who had to mortgage their houses in order to go through this treatment because it's so expensive.

Well, guess what, in the future it's going to cost you nothing. It seems to me a reasonable approach would not be to go from \$40,000 worth of treatment to zero.

But instead to have a procedure whereby we could assist people if that's the will of the body in receiving these types of treatment, but put some kind of cap, some kind of control on in terms of the

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overall expenditure, and thus reduce the amount of impact on everyone else's health care coverage.

The problem with the plan, as Representative Frey has pointed out, that we had to make some difficult decisions here.

And what we're doing is, we're giving, requiring a very large cost to health care plans in order to cover one group of people and not covering a lot of other people who would desire to have some coverage.

I think if we were going to do this, and there are plenty of arguments why, we could have done it in a more controlled fashion and not driven up the cost the way I believe this Bill will do, and for those reasons I'll oppose it. Thank you.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Representative Hetherington of the 125th District, you have the floor, Sir.

REP. HETHERINGTON: (125th)

Thank you, Madam Speaker, if I may, I have a question or two, to, I believe, the Chairman of the Insurance Committee.

DEPUTY SPEAKER KIRKLEY-BEY:

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Representative O'Connor prepare yourself for questioning. Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Madam Speaker. Through you, is there any consideration that an insurance company may give in limiting this coverage to the number of successful pregnancies that an insured has experienced? Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, it doesn't necessarily limit it, but what we are doing, if you look at Section 3, we're trying to get better evidence, and so that the insurers will be able to recommend or basically, based on the successes at different hospitals or different health care centers, that they would be able to have more successful surgeries and procedures done.

And that's why we put Section 3 in place so that we're not wasting effort and also wasting valuable dollars. Through you, Madam Speaker.

REP. HETHERINGTON: (125th)

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Thank you.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Madam Speaker, if I may, again, I believe I failed to make the question clear.

Is the number of successful pregnancies that a woman has experienced, a factor that an insurance company may consider in limiting this type of coverage. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, the limit is just based on the number of cycles and you know, not on the number of children. If maybe one, you had some success with the first child, after going through four cycles on the, let me get that information for you.

As far as let's say, an ovulation induction where maybe you had a child with that, you'd still have three cycles left with the intrauterine insemination, and the two cycles that are in item 4 of Section 2.

Through you, Madam Speaker.

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DEPUTY SPEAKER KIRKLEY-BEY:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Madam Speaker. Through you, so is it, through you, Madam Speaker, is it fair to say that the public policy of this state is that in spite of what we know about the limitations of our resources and environmental concerns, that we will assist people with an unlimited procreation of children? Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, I do not believe it would be unlimited, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you. Through you, Madam Speaker, what is the limitation? Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

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The limitation is the number of cycles. Also, there's a limitation on the age of 40. What we've seen is that there's a precipitous drop the older you get, and that's why we put the age limit in there.

I think those are some of the mechanisms that we put in place to control costs. Also, to limit the number of procedures done by limiting the number of cycles.

So again, I believe it's a de facto without having a hard number or cap on the number of children. And that's why we also have the look back provision put in place as well. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Madam Speaker. Through you, but it seems to me through you, Madam Speaker, that the fact remains that if an insured has had, for example, eight successful pregnancies and eight children alive, never that would be no consideration in whether or not to extend, whether to extend fertility benefits.

Through you, Madam Speaker, is that correct?

DEPUTY SPEAKER KIRKLEY-BEY:

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Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker. I think, you know, just by the way the cultures of all families that are having eight children and some of the decisions that they're making as far as the number of children that they want to have, I think it would be highly unlikely and rare that you would have a child after each of these cycles. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Hetherington.

REP. HETHERINGTON: (125th)

I think the answer is clearly yes. Thank you, Madam Speaker. And thank you to the Chairman of the Insurance Committee, through you.

If I may just extend to comment with no additional questions, I am certainly sympathetic to those who are in this difficult situation.

However, I am strongly challenged in voting for this. It seems to me we know precious little about the cost.

We know little about its impact on the availability of insurance and with so many people

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without insurance to cover what might be called the basic life-threatening challenges, health challenges of life, we are extending, we are making existing plans richer for those who are already covered, and I think that perhaps we should have some reluctance to do that.

I am also concerned that we seem to, as the colloquy established, that we are, in effect, saying that regardless of the number of children one has, one may still obtain this benefit for increasing the number of children one has.

I don't think that's a responsible statement for us to make as the Legislature of this state. Thank you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Representative Fahrbach of the 61st District, you have the floor.

REP. FAHRBACH: (61st)

Thank you, Madam Speaker. I rise reluctantly to oppose this legislation. And I say reluctantly because I understand what people are going through when they're trying to have a family.

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I've talked to many of them and I do truly know that they sincerely feel that they need to have this coverage.

However, we have people out there in this state that can't afford insurance coverage. And they can't afford insurance coverage because year after year we keep putting more and more mandates on the coverage.

We don't offer them a basic policy that says it will cover their basic medical needs. We offer them only the top of the line policy that covers all kinds of medical conditions. And that's not fair to those individuals who have good jobs but can't afford to buy their own insurance.

And I think this state needs to, if they're not going to allow the choice of a policy, a basic health care coverage policy, I think the state needs to take a serious look at the mandates that we have on our policies and eliminate some of them.

We heard many complaints about the high cost of insurance in this state and the high cost of the coverage that is required by our mandates, and we're not doing anything about that. We're just making it worse.

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And as I said, I reluctantly oppose this piece of legislation, but I do so because I do feel that we need to do something for other individuals who don't even have basic insurance coverage. Thank you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Representative Bacchiochi of the 52nd District, you have the floor.

REP. BACCHIOCHI: (52nd)

Thank you, Madam Speaker, through you, a question to the proponent of the Bill, please.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor, prepare yourself for a question. Representative Bacchiochi, please frame your question.

REP. BACCHIOCHI: (52nd)

Yes. I was wondering if a woman needed to be legally married to avail herself of that benefit?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, there is no marriage cap, so to speak. Through you, Madam Speaker.

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DEPUTY SPEAKER KIRKLEY-BEY:

Representative Bacchiochi.

REP. BACCHIOCHI: (52nd)

Would two women in a civil union also be able to avail themselves of that benefit?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, since it is not defined as an exclusion, they, too, would have this benefit available to them. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Bacchiochi.

REP. BACCHIOCHI: (52nd)

Would I be correct that in that last situation, if the first woman were not successful after two tries, the other woman would be able to also have the two tries?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

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Through you, Madam Speaker, if they, if she had her own health plan, she would have that same opportunity. Through you.

DEPUTY SPEAKER KIRKLEY-BEY:

Representative Bacchiochi, you have the floor.

REP. BACCHIOCHI: (52nd)

If the two women in the civil union shared the same health plan, for example, the business covered both of them, then they would only have the two opportunities?

DEPUTY SPEAKER KIRKLEY-BEY:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Madam Speaker, that is correct.

REP. BACCHIOCHI: (52nd)

Okay. Thank you for the answers. Through you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Representative Johnston of the 51st District, you have the floor.

REP. JOHNSTON: (51st)

Thank you, Madam Speaker. Madam Speaker, with a heavy heart, and quite conflicted as I think most of

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us are whichever way we vote on this, I stand thinking that this is not the best avenue for the state to go down.

And I do so, Madam Speaker, sitting on the Insurance Committee and listening to the hours of testimony and the stories that we heard from people all over the state. I'm sure each one of us knows someone in our family or a dear friend, or even ourselves, who have been faced with this issue.

And I guess I finally, as we make choices in this building, and we weigh good versus bad and do we create more good by passing a bill versus, you know, alleviating some bad.

And what I, where I finally weigh in on this Bill is that there is the unintended consequences. And I think in this building too often we forget about unintended consequences of our action.

And as we help people who have infertility problems, we are doing a wonderful good. But on the other hand, when the cost of that is passed on to every other person who has health insurance and every other employer who covers their employees with a

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health insurance plan, we rise the price of those premiums and the cost of that plan.

And at some point we push that pendulum a little too far for some businesses and some smaller businesses and in most cases that pushes them to the point where they can no longer afford to provide health insurance coverage for their employees.

Or we push them to the point where maybe they thought this was the year that their business had become profitable enough that they could begin to offer health insurance to those employees.

And therefore, at the same time, that we provide a better benefit to some people, I think that a fair amount of other people will have no opportunity through their employment of having health insurance coverage.

So when I weigh the unintended consequence against the good of the Bill, and it clearly is a good Bill, Madam Speaker, I come down on the side that we create more problems with the unintended consequences and therefore will not be supporting the Bill today.

Thank you, Madam Speaker.

DEPUTY SPEAKER KIRKLEY-BEY:

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Thank you, Representative. Representative
Harkins of the 120th District, you have the floor.

REP. HARKINS: (120th)

Thank you, Madam Speaker. I, too, rise in
opposition of the Bill, also with a heavy heart. And
you know, sitting on the Insurance Committee, whenever
there is a mandated health coverage that comes up
before us, it's always difficult to listen to the
people come forward and tell us about their issues.

This year we had a mandate on obesity, which
would allow people to have surgery to restrict their
food intake. Obesity was discussed a lot in this
Chamber, particularly with school children.

We had adults come in and talk about the
procedures that they had and how it was life changing
and how their health improved. Obesity, you know, let
us not forget is something that kills.

The other mandate we had that came forward before
us was one that covered prosthetics, and when you
heard people come forward and tell you they didn't
have coverage, they couldn't afford their prosthetics
and of course we want people to have prosthetics, or
access to them, because with that their life improves.

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They can function in a better mode and they can go to work and be a productive citizen.

And then of course we had infertility treatment that came up and we listened to people that couldn't have children, both men and women, and it's a heart-wrenching experience to have to listen to the testimony of these individuals, knowing that some companies do, in fact, offer some sort of coverage and others don't.

The infertility made it out of the Insurance Committee, but the other two mandates didn't.

I can't help but just think about the amount of people that will be impacted by this Bill. On the Insurance Committee our concern is to make sure that people have access to health care.

Here in the State of Connecticut, particularly in this Chamber, I think at times we become disconnected with what's actually going on in the real world.

I own a small business. I have employees. I provide health care to the employees. Well, what I'm finding out is, is that a lot of the companies aren't hiring full-time. They have part-time employees.

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I even go into some doctors offices and I always, one question I like to ask them is, what kind of health coverage do you have?

And what I find out, disturbing enough, is a lot of times they don't even provide coverage for their own employees, yet they come before our Committee and always looking for their issues to be addressed.

If this Bill passes, it will increase costs to insurance premiums. Here in the State of Connecticut, we enjoy some wonderful health care options. Three dollars, generic drug coverage. Six dollars, name brand.

Here in the State of Connecticut employees can have a great policy for I think like \$60 a month, \$180 for a family. This isn't going on in the real world.

And who's paying for it? The taxpayers. So state employees are subsidized for their health care, but people, small businesses, companies looking to move in here and companies that exist right now, don't have that privilege of having the taxpayer foot the bill. They have to pay for it.

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What I'm concerned about is companies that have to make tough decisions whether to expand, what type of coverage to provide.

You know, if this is passed, it will be a mandate. My fear is the coverage will suffer and the employees will suffer.

Earlier on, I heard it's about families and you know, this is going to benefit families. I actually think this is going to hurt families because it means that less families will have insurance coverage.

Families where their children get sick, they won't be able to afford to take them to the doctor's. So I just wish we'd take a step back and really look at what we're trying to achieve.

Are we trying to provide affordable health care to individuals in the State of Connecticut, to make sure that our companies do the right thing to provide health care to their employees.

Are we going and cherry picking those issues which we believe should be covered, and a lot of times they probably should. But we have to realize, what is the final impact, what is the net result?

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Is it to cover less people or to provide better coverage? My concern is that it's going to be less coverage.

So, Madam Speaker, unfortunately, I will be opposing this Bill. Thank you.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you, Representative. Will you remark? Will you remark further on the Bill as amended? Will you remark further on the Bill as amended?

If not, staff and guests please come to the Well. Members take your seats. The machine will be opened.

CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber. The House is voting by Roll Call. Members to the Chamber, please.

DEPUTY SPEAKER KIRKLEY-BEY:

Will Members please check the machine and check the board to make sure your vote has been properly cast. Will Members please check the board to make sure your vote has been properly cast.

The machine will be locked and the Clerk will prepare the tally. The Clerk will announce the tally.

CLERK:

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Senate Bill Number 508, as amended by Senate
Amendment Schedule "A", in concurrence with the
Senate.

Total Number Voting	145
Necessary for Passage	73
Those voting Yea	104
Those voting Nay	41
Those absent and not voting	6

DEPUTY SPEAKER KIRKLEY-BEY:

The Bill as amended passes.

SPEAKER AMANN:

Are there any announcements or introductions?
Announcements or introductions? Are there any
announcements or introductions? Representative
Dillon.

REP. DILLON: (92nd)

Thank you, Mr. Speaker. Just a quick
announcement. During our extended debate there was a
group waiting to be introduced which had to leave due
to child care obligations, but I want you to know
about them.

It's a group of Afghani refugees who live in my
district. They're not citizens yet. They fled the

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We also support Senate Bill 130, AN ACT TO STUDY HEALTH INSURANCE COVERAGE FOR TREATMENT OF OBESITY. Again PCSW and the Connecticut Woman's Health Campaign have worked on this issue recently. This bill would establish a task force to determine the need for health insurance coverage for treatment of obesity.

As you know, obesity has become a major public health concern in this country and it leads to other more serious and more expensive medical conditions that are prevalent among women such as diabetes and heart disease. Any efforts to address this increase and epidemic would be helpful to the citizens of this state.

And finally, we support House Bill 508, AN ACT CONCERNING HEALTH INSURANCE BENEFITS FOR THE DIAGNOSIS AND TREATMENT OF INFERTILITY. This would require health insurance policies to provide coverage for medically necessary expenses of the diagnosis and treatment of infertility.

Infertility is a disease of the reproductive system which affects 6.1 million Americans, or 10% of the reproductive age population. Unfortunately couples today not only face the emotional pain associated with not being able to have a child but they also face health insurance obstacles.

We support reproductive choice for all women and we do not believe that infertility treatment should be limited to those with the economic means to pay for it out-of-pocket.

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This legislation would allow infertile couples to take advantage of modern treatments and therefore provide reproductive choice and access to all.

We thank you for letting us testify on these matters and we urge your passage of these bills.

REP. O'CONNOR: Thank you, Natasha. Just one of the questions regarding the bill on providing health insurance coverage in the case of a divorce--

NATASHA PIERRE: Yes.

REP. O'CONNOR: Would you consider or have you HB6277 thought about a duration or time limit upon this or what was your expectation? Would it go on forever? Let's say a person never remarries.

NATASHA PIERRE: Actually, we haven't asked, the Committee that [inaudible] with this, we have not identified them timeframe. I saw from the bills that one had a ten year timeframe and one didn't have anything.

When we were discussing it we were talking about it in the framework of COBRA so I'm not sure but Kate Haakonsen who's an attorney that's working on this issue and what's on the committee with us is testifying in the public portion.

She's the first person in that portion so I know they've had further discussions since

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Some of them have different occupational risks depending on what part of the industry they're working in.

REP. MINDER: Thank you.

REP. DILLON: Thank you.

REP. O'CONNOR: Thank you very much. Next speaker is Representative Mary Fritz.

REP. FRITZ: Good morning everyone. I'm beginning to think I'm spending too much time in this Committee.

REP. O'CONNOR: Do you want to become a Member?

REP. FRITZ: Maybe, you never know. However, I'm finding the testimonies amazing today. And just as an aside, I think the Representative from Norwalk kind of told a great story and I think we're all so very happy for him.

And also as another aside, Representative Fontana, I'm going to have this copied and delivered to all of the Members of the Committee because it takes us across the country with regard to what infertility levels there are in terms of coverage etc., okay?

Good morning, Senator Crisco, good morning Representative O'Connor, and all the honorable Members of the Insurance and Real Estate Committee.

I appear before you today in support of Proposed Senate Bill 508, AN ACT CONCERNING

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then. But I don't think we thought it would be forever.

I mean, definitely not forever but definitely during the period of transition because you have other financial matters going on and to have to pay for COBRA which could be \$300 to \$400 per month is really taking away from the whole family.

REP. O'CONNOR: Very good. And what happens if the individual, let's say a working family and they have coverage at their place of employment, but it's not as rich as the other spouse's, would they automatically have to go with the health insurance plan where their employer is or would they still have the option of going with the spouse's plan?

NATASHA PIERRE: okay, so you mean if they were covered under one spouse's and then they divorced and then they go to another one? I mean, our whole, if they have, the biggest thing is having access to insurance because sometimes both parties don't have access through their health insurance company but we would encourage access to the one that is less expensive for coverage.

So it would really be up to the family. If the cost of the insurance outweighs the amount of services you get, because you don't want to have a plan where you have limited services but you're paying out of pocket a lot either because you still have the same effect of the money coming out of the household.

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HEALTH INSURANCE BENEFITS FOR THE DIAGNOSIS AND
TREATMENT OF INFERTILITY.

For the record, I'm State Representative Mary Fritz of the 90th District, happily representing parts of the towns of Wallingford and Cheshire. I testified before you on this same issue in 2003, 2004 and every year that this issue has been before us in the General Assembly.

Last year's bill, which was House Bill 5206, made it all the way to the Appropriations Committee where it died on a tie vote. Hopefully, this bill will not suffer the same fate.

And as an aside, let me tell you the reason that it died. Because in the note from Fiscal Analysis, it said that the retiree benefits would change for the State employees.

And when I called Comptroller Wyman and told her what that fiscal note said, you could have heard her laughing from down at Lewis Circle all the way up here at the LOB.

Anyway, as you know, infertility affects approximately 8% of the population and yet only 2% require the in-vitro fertilization stage of treatment. So, overall, this is not very many people.

I respectfully request this Committee to fully draft this proposal and to please include the provisions of last year's bill, House Bill 5206, which exempts a religious employer from

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REP. O'CONNOR: Thank you. Any other questions of Committee Members? Thank you.

NATASHA PIERRE: okay, and as I say, Kay is coming later so she'll have a lot more of these answers. Thank you.

REP. O'CONNOR: Next speaker is Vanessa Burns.

VANESSA BURNS: Good morning, Senator Crisco, Representative O'Connor and Members of the Committee. My name is Vanessa Burns and I'm the African-American, I come from the African-American Affairs Commission.

Today the Commission testifies in support of the following bills, Senate Bill 28, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR BREAST CANCER SCREENING, Senate Bill 30, AN ACT CONCERNING COVERAGE FOR BREAST CANCER SCREENING FOR INDIVIDUALS WITH A FAMILY HISTORY OF BREAST CANCER, Senate Bill 5712, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR BREAST CANCER SCREENING USING MRIs, whatever it is, and Senate Bill 130, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR THE TREATMENT OF OBESITY.

I will begin by saying that the issue of breast cancer has perked the interest of the Commission considering that breast cancer is the most common cancer among African-American women.

Approximately 20,000 new cases of breast cancer are diagnosed among African-American women each year. We know that African-American women from

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including infertility coverage in their benefit package.

I thank you for listening and if you would like I'd put a copy of House Bill 5206 with this other chart and have it delivered to all the members of the Insurance and Real Estate Committee.

REP. O'CONNOR: Thank you, Representative Fritz. I just have a quick question on the continuum of-- [Changing Tape 1A to Tape 1B.]

--Representative Perone went three or four years, is there a point of diminishing returns where there should be no more coverage at that point?

REP. FRITZ: I understand what you're saying and I'm sure you understand that when it starts in terms of infertility treatment the first stage, there's a lot of testing then you take all kinds of different drugs, and hormone treatments. and everything else.

The last stage is really the in vitro and what they often do from my knowledge is that you may have a couple of in vitro treatments and then they just, the doctors tell you to kind of step back and just wait awhile, and then they will try again.

But in the end, it always ends up being a decision made between the doctor and the patient. When is enough enough? I don't know. I don't know. I think that's something that

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REP. PERONE: Morning everybody. Good morning,
Mr. Chair and Members of the Insurance and Real
Estate Committee.

My name is Chris Perone and I'm a
Representative from the 137th District in
Norwalk. I'm here today to support Proposed
Senate Bill 508, AN ACT CONCERNING HEALTH
INSURANCE BENEFITS FOR THE DIAGNOSIS AND
TREATMENT OF INFERTILITY.

Four years ago, my wife and I decided to have
children. We were in our early 30's, healthy
and knew that we would provide a safe and happy
environment for a child. It had been something
we had planned to do ever since we became a
couple.

Once we decided to go ahead, we began planning
for the birth of our future prince or princess
of Norwalk.

My wife dutifully took her folic acid, along
with a handful of prenatal vitamins every
morning in order to prepare, while I began
saying goodbye to my friends because I knew the
impending lack of free time would greatly limit
my access to them.

Needless to say my parents and my in-laws were
also thrilled at the mere hint that they might
become grandparents at some point.

For two years, we tried, but without much
success, and we started asking a few questions.
We thought we were doing everything right so we
wanted to know what we were doing wrong.

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again the person and your doctor have to decide.

REP. O'CONNOR: Very good thanks. And would you be willing or would you consider any way kind of a sharing of that cost beyond the drug treatments and the initial testing as far as the surgeries and the in vitro?

That way there's a partner between the insurance carriers and you know also the small businesses that are supplying the coverage and the person seeking treatment.

REP. FRITZ: Well, don't forget we already have that law on the books from 1989 that says, you know, may offer, okay, and it doesn't specify, it doesn't limit what the treatment will be. I think if you limit or are you talking about doing a deductible?

REP. O'CONNOR: Correct.

REP. FRITZ: A deductible. I don't see that people, I don't know. I guess I don't see that that would be a problem as long as it is, there is coverage.

And what's interesting is, for the most part, most of the insurance companies and most of the employers already offer it, the full coverage, the full nine yards.

So we don't want to go backwards, Representative O'Connor, and say, well, now, you're going to have to do a \$500 deductible or

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We began visiting fertility doctors. Because I was in New York City, my company had Empire Blue Cross, and we were covered under their plan and didn't have to worry about the cost of artificial insemination treatments if it came to that.

Being under that coverage allowed us to talk to several doctors who were all tops in their field and enabled us to get a baseline understanding of what the real trouble was.

In the end, our quest took us to three different reproductive endocrinologists in Stanford, Norwalk and finally in New York City.

All three recommended artificial insemination with the caveat that our chances weren't very good based on my wife's estrogen levels. In fact, the news from all three was basically the same and it was all bad.

Two of the doctors told us that we had a less than 5% chance of conceiving, with the last doctor putting our odds at about one in 100. In fact, his quote to us was, I don't see how it's possible.

The third year of trying to conceive, knowing that the numbers weren't on our side, was to say the least, daunting. While not trying to over-dramatize our situation, we had in fact gone into a sense of mourning for a child we couldn't have.

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something like that. Do you know what I'm saying?

I think it needs to be carefully worked out and I thought that the bill that we had last year really got into it and really did a great job.

REP. O'CONNOR: Thank you very much. Any other questions? Representative Johnston.

REP. JOHNSTON: Thank you, Mr. Chairman. Good morning, Representative. On the religious beliefs, if an employer wanted to up the [inaudible], how does that practically work, if you can explain that to me?

REP. FRITZ: Well, the practicality of it was it went into, as in the bill, I believe to get more people to vote for the bill, frankly, in this world that we live in up here, but there is an analysis of the bill that's attached to it.

It might be that like a hospital, say, Saint Francis or Saint Raphael's or Saint Mary's in Waterbury might choose not to offer that kind of treatment and that's basically where it would come down.

REP. JOHNSTON: And if I can follow up, what if a John Smith who runs Smith Automotive says that's against my religion, I've got three employees, I provide healthcare coverage, I don't want to pay for that.

REP. FRITZ: I think they can opt out as well. And yet I do know some Catholic private schools

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The realization that we were going to be childless, despite how much we prepared and how badly we knew we wanted to have a baby when weighed against medical realities was a lot to manage.

On top of that, due to a corporate merger, I was downsized which stressed us out. Not because we were worried about how we were going to pay the bills, but because we knew that to lose our insurance at this critical point would effectively wipe out our chances of conceiving.

However, because we were still exploring options, I COBRA-ed the insurance and paid full price out of pocket to maintain the coverage we had until we decided whether to try with a donor egg, which my insurance didn't cover or to adoptive a child.

In support groups later on, I found that we weren't alone in doing whatever it took to ensure that we had adequate coverage. My wife and I would hear stories of people taking a second mortgage against their home in order to pay for treatments.

We've heard stories of women quitting jobs in Connecticut to take jobs sometimes at a reduced salary in New York State in order to be covered by a plan that covered infertility treatments and of people selling jewelry and other valuables just to pay for one more round of artificial insemination.

I'm asking this Committee to weigh very seriously the thought of requiring health

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that happen to have this kind of coverage for their employees.

REP. JOHNSTON: And lastly, is there any proof that they have to provide that it's because of religious beliefs or could they just say I don't want to pay for it, it's going to raise my insurance rates and so I'm just strictly going to say it's because of religious beliefs.

REP. FRITZ: I don't believe there is anything in the bill that specified that but I would think that it would be a matter of conscience as well.

REP. JOHNSTON: Thank you, Mr. Chairman. Thank you, Mary.

REP. O'CONNOR: Any other questions? The next speaker is Representative Willis and I believe also signed up with you is Senator Roraback.

REP. WILLIS: We may have lost him but he may join me.

REP. O'CONNOR: No problem, thank you.

REP. WILLIS: Good morning, Senator Crisco, Representative O'Connor, and Members of the Insurance and Real Estate Committee.

For the record, I am State Representative Roberta Willis of the 64th District. I represent Torrington, Goshen, Cornwall, Sharon, and Salisbury.

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insurance policies to provide coverage for medically necessary expenses for the diagnosis and treatment of infertility.

In short, what I would like, couples who are going through what my wife and I went through is coverage similar to what I have now as a State employee under Anthem Blue Cross, coverage that cover at least the IUI treatments and the fertility drug treatments that are in play beforehand to improve the chances of the conception. I believe that infertility coverage should be part of healthcare.

I do not see it as a luxury item or an elected treatment like Botox. This is a very significant health issue that affects couples in profound ways and should be treated like any other serious health crisis.

I have nothing but praise for our insurance company, not only because they covered our fertility drug treatments but because they were there because thanks to them, we had one less headache to worry about. It allowed us to focus on what was important.

We could focus on trying to conceive and as proof of what having an eased state of mind can do, I can't express to you enough how, when by having that added stress off we could just focus on trying and trying and then, we just got lucky in the end and I thank you. If you have questions, be happy to entertain them.

REP. O'CONNOR: Thank you for sharing your story.
Are there any questions of Representative

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REP. O'CONNOR: We will now go back to the public official, Representative Debra Lee Hovey.

REP. HOVEY: Good morning. How are you all? I'm State Representative Debra Lee Hovey of the 112th which is Monroe and Newtown.

Good morning, Chairman O'Connor, and fellow colleagues. It's my pleasure to be here this morning. I'm here to encourage you to vote positively on Senate Bill 508, AN ACT CONCERNING HEALTH INSURANCE BENEFITS FOR THE DIAGNOSIS AND TREATMENT OF INFERTILITY.

And I just had a couple of things that I wanted to add to the testimony. You'll hear from women who have much more experience in this area than I do and also professionals who know much more about the intricacies of the issue than I do, but the one thing that I wanted to bring to your attention is that this is not a woman's issue, even though most of the testimony you'll hear is from women.

This is a family issue, and it impacts on the men in our lives as much as it does the women. And so not only is it just the woman's issue, and her husband's issue, it then becomes her family's issue, and it broadens out into the whole community, so it's something that we should be very, very concerned about.

As insurers, the insurance companies insure many diseases that I personally feel are preventable, diabetes being one of them, and

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Perone? Thank you. Congratulations by the way. Next speaker is Representative Melissa Olson.

REP. OLSON: Good, morning Representative O'Connor, Senator Crisco, and distinguished Members of the Insurance and Real Estate Committee.

I appear before you today in support of Senate Bill 508, AN ACT CONCERNING HEALTH INSURANCE BENEFITS FOR THE DIAGNOSIS AND TREATMENT OF INFERTILITY.

For the record, I am State Representative Melissa Olson of the 46th District representing the Town of Norwich.

I think it is time that we have a frank discussion about infertility. Infertility is a disease however infertility can be treated economically and effectively.

In 1998 the Supreme Court held in Bragdon v. Abbott that reproduction is a major life activity. Therefore, a substantial limitation on reproduction is a qualifying condition under the Americans with Disability Act.

You know, there is a perception out there I think that infertility results as your lot in life. And I think that perception is incorrect for many reasons.

Most of all, however, infertility can result from so many different things, particularly results of the need for medical treatment or medical treatment that an individual has

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the interventions are available for those individuals.

Infertility is something that is totally beyond the control of the individual, and I believe we need to provide services for women and men that are, that give them many options and don't require them to take the option that then puts their life at risk because they know they have one shot to do it, and if it doesn't work, then that's going to be the limit of their insured.

So I would urge you all to look at this very, very carefully. Listen to the stories of the women and remember there are many men behind those women and other women probably that they're related to because infertility does seem to have some familial genetic predispositions also.

I also while I'm here would like to add my support to Senate Bill 30, which is the breast cancer insurance bill, and as a breast cancer survivor, I would urge you all to provide as much early intervention as possible. Thank you.

REP. O'CONNOR: Thank you very much Representative. Any questions? Thank you. We will go back to the public portion and the next speaker is Dr. Joe Bentivegna.

DR. JOE BENTIVEGNA: Thank you so much for having me here. It's a pleasure to be here. Good afternoon, morning. Good afternoon, Senator Crisco, Representative O'Connor, and Members of the Insurance Committee.

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received. It can result from taking certain medications. It can also result from surgical intervention.

If you are persuaded by the perception that it is your lot in life, when has it been our policy to not treat a disease for which we know there is a cure?

We acknowledged and recognized the need to treat the disease of infertility, when in 1989, the Legislature required Connecticut health insurers to cover and offer coverage for the diagnosis and treatment, including in vitro.

With the tremendous advancements in science and in our understanding of the disease, doctors can now provide highly effective and less costly medical care and treatment.

Currently our health insurance carriers do provide coverage for infertility through a major medical benefit.

Now, major medical benefit covers less effective treatments, for instance, surgeries to remove uterine fibroids as well as a man's varicose veins.

Many times these surgeries do not cure the disease of infertility or they must be repeated. Not only is this costly, but is unnecessarily exposes the patient to the additional and unnecessary risks inherent to surgery.

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Now, there is an effective and established continuum of care for treating infertility through assisted reproductive technology. Couples suffering from infertility are referred to doctors specializing in reproductive endocrinology.

This avoids repeated trips to doctors who do not have the expertise in treating infertility and therefore cuts down on unnecessary costs which are currently being borne by insurance carriers.

Moreover, hormonal therapy and intrauterine insemination cures infertility in about 97% of all cases. In-vitro fertilization is the cure in only about 3% of these cases.

All of these treatments are more highly effective and less costly than the Draconion surgeries that are already covered under insurance policies called major medical benefits.

For an example, tubal surgery ranges from about \$12,500 for women to \$6,500 for men and is generally covered although it has one of the lowest success rates and poses a greater risk of complications.

We know that in-vitro fertilization, the most expensive of the assisted reproductive technologies has the same cost as one tubal surgery, has a far greater success rate and yet is seldom covered.

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REP. O'CONNOR: We will now be moving onto Senate Bill 28 and the first speaker is Bill O'Brien.

BILL O'BRIEN: Thank you, Mr. Chairman, Members of the Committee. My name is Bill O'Brien from Wolcott. I'm Legislative Vice President for Connecticut Right to Life Corporation.

SB 28
SB 30
HB 5712
SB 508

I'm here to speak regarding the four bills concerning breast cancer, in particular the one to mandate insurance coverage.

These four bills as written will not help a large group of women who will not go for an MRI or an ultrasound because they do not know they have an elevated risk of developing breast cancer.

There are apparently many possible risk factors for breast cancer, some known, some unknown. Some women are born with a risk factor such as being in a family with a history of breast cancer, over which they have no control.

But there is one risk factor that is within their control, which most women are not aware and they are not being told. This risk factor is a surgical abortion.

At least 28 studies worldwide have shown a link between abortion and breast cancer and 18 of those studies are statistically significant.

A mega-analysis of all the studies available at one time concluded that not only that there is a link between abortion and breast cancer, but concluded that an estimated 5,000 to 8,000

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Over 70,000 Connecticut citizens aged 18 to 45 are infertile. For years we have been covering treatments that are ineffective and quite frankly, medically irrelevant. It is time that we invest in treatments that actually cure the disease of infertility.

Today you're going to hear a lot of information about what these coverages cost and what the increased cost will be to our employers and our insurance providers.

The Connecticut Bill of Insurance mandated a benefits study that was conducted by the Mercer Company and completed in October of 2003, and they found that the direct cost for an infertility benefit would be .22% of premium.

This translates to about 88 cents per member per month on a \$400 monthly policy and I ask you, that as you're listening to testimony today about the costs of offering additional infertility treatments or the assisted reproductive technology, I want you to keep in mind what services are currently being covered by these insurance policies.

How many treatments are being covered under major medical, therefore are being paid for by the insurance carriers anyway?

What surgeries are being covered at this point? What are the costs of these surgeries and what are the success rates? How many times are these surgeries repeated, and again, at what success rate?

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women die in the United States each year because of the higher risk factor caused by abortion and the number of deaths is expected to increase each year.

Thirteen to 16 of U.S. studies showed an increased risk and 10 of those were at least partially funded by the National Cancer Institute.

Over 40 million women in the United States and an estimated 400,000 women in Connecticut have had an abortion.

Few women were informed of the increased risk of breast cancer at the time that they had their or sought their abortion.

Currently, I believe that insurance, if it covers a woman for a mammogram, usually starts at about age 50.

Based on the studies I've mentioned, I would recommend that the age be lowered to at least 25 and for this reason.

In one of the studies, there was a subgroup of 12 women. Each of those 12 women came from a family with a history of breast cancer.

And each first became pregnant, her first pregnancy, before the age of 18 and for each of those 12 women, that first pregnancy ended in an abortion.

Now, of those 12 women, using the regular statistics, over a lifetime, you would expect

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Is the offering of these different services, these more medically advanced, these services that have been proven to be more highly successful, is that simply just a cost shift, thereby leaving behind the Draconian surgeries that aren't working and employing instead a better technology that better serves the people who are undergoing this treatment?

And I just ask you to keep that in mind as you're listening to the testimony today because I think that will be very revealing.

I thank you for your time, I thank you for raising this issue, and would be happy to answer any questions if you have them.

REP. O'CONNOR: Thank you, Representative Olson. Representative Fontana.

REP. FONTANA: Thank you, Mr. Chairman. Good morning, Representative.

REP. OLSON: Good morning.

REP. FONTANA: This question may or may not be something that you can answer as readily, but I'd like to put it out there for the basis of discussion by you and other people who testify today.

One of the difficulties I have with this particular proposal, and I've heard it for several years going back is trying to get my hands around the philosophical or the parameters of such a benefit or a coverage.

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that about 1, maybe 2 of those 12 women would get breast cancer over a lifetime, but it wasn't 1 or 2.

All 12 got breast cancer and it wasn't over a lifetime, it was in the first half of their life, all by the age of 45.

The biological method of action is clear. In a young woman, her first pregnancy stimulates undeveloped breast cells to start to differentiate into milk producing cells.

It is well-accepted in the medical community that a first pregnancy that goes full term gives a woman a lifelong protective factor from breast cancer, lowers their lifetime risk of developing breast cancer by about almost one-third.

But when a first pregnancy is abruptly ended by abortion, the developing cells stop growing, remaining in an immature stage, and are more susceptible to become cancerous.

Thus, instead of gaining a protective factor from her first full term pregnancy, instead she increases her risk and the studies show that.

Based on these studies, two of your sister states, Minnesota and Texas, now require women going for an abortion to be informed that the abortion will increase their risk of breast cancer.

Last month, the second abortion/breast cancer lawsuit in the United States, the first to

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In talking to some people who have been faced with the unfortunate situation of being infertile, they've often talked about how one method may work or may not work.

But sometimes it could work, if they tried more than once or if that doesn't work, they want to do another effort.

And what emerges for me is the sense that, for many of them, what they want is to be covered until they succeed and that's a laudable goal, but not necessarily one that we can accommodate within a benefit structure where we're trying to accomplish the most good for greater number of people.

I guess my question is are you or are others that you know of trying to come up with a way of expressing what kind of coverage or what kind of benefit could be provided as a standard?

In the sense that are other states coalescing around a particular standard saying we're going to replace tubal surgeries with hormonal therapy and that's the standard, or is it that you get one shot at whatever technique you want whether its hormonal therapy or in vitro, you know, you get your one shot and that's it?

Again, I'd like to sort of hear your sort of comments on that sort of general line of thought and then look forward to any other comments from others in the future on that subject. That's my difficulty.

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receive a judgment, was successfully prosecuted with the All Women's Health Center abortion clinic in Portland, Oregon, which signed a confidential judgment on January 24, 2005, just a few weeks ago.

The lawsuit charged the clinic and the physician performed an abortion on a 15-year-old girl without informing her of the psychological risks and the increased risk of breast cancer. She had a family history of breast cancer and they indicated that on the clinic intake form.

You have a choice to protect the abortionists or to protect women. As you consider the breast cancer bills before you, please add protections for women so they will know of the dangers of breast cancer when they consider abortion.

And so that the women who have had an abortion will have the insurance coverage they need to be properly screened. Thank you.

REP. O'CONNOR: Thank you. Representative Clemons.

REP. CLEMONS: Thank you, Mr. Chairman. Good morning. Question in regards to cost. What is the difference between the cost of an ultrasound and a mammography, as opposed to cancer screening phase? Do you know what I'm saying? Is there--

BILL O'BRIEN: Cost between?

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REP. OLSON: Sure. Thank you for that question, Representative. It's a long one and we could probably have a discussion for many hours on that issue. I start by simply indicating that involving the doctor in the process is where we start with the continuum of care.

Certainly we need to make sure that the doctor, you know, the doctors are the ones who know what is the treatment that would be necessary for curing the disease of infertility.

The continuum of care is just that, it's the continuum. And we know that hormonal therapy treatments and the intrauterine insemination, like I said, are effective in nearly 97% of cases.

Those are very low cost alternatives and they are still less costly than the tubal surgeries that are currently being covered or the other kinds of surgeries that are being covered.

So I think involving the doctor in that process tells us what kind of treatment is necessary, what kind of treatment is appropriate and quite honestly when it might be time to quit.

In fact, I've read some information that most doctors will not recommend more than four IVF treatments. I mean, that's pretty much it.

Now, certainly other people are going to have far more substantial on that issue and I know you'll be hearing from them, but I think it's very important that we understand that that continuum of care is replacing, could replace

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REP. CLEMONS: Right. What is the cost of ultrasound and mammography, as opposed to just an exam that requires or that's going to do screening?

BILL O'BRIEN: The mammography, I believe, would certainly be cheaper, but I don't have figures on that.

REP. CLEMONS: And then, a follow-up question, would the ultrasound and mammography being given, would that, in your estimation, would that be an effective process in terms of identifying or possible breast cancer candidates, as opposed to the screening? You know what I'm saying?

Does the ultrasound and mammography, in essence, give you a better indication or does it tell you that a woman is more apt to developing breast cancer through those procedures of a mammography and ultrasound?

BILL O'BRIEN: okay, I'm really not the right person to answer those questions for you. My concern is that the woman gets screening.

If the Committee decides to pass one of those bills, that the younger women from 25 on be included in that. As far as the technical aspects, that would be beyond me.

SEN. CRISCO: Representative Geragosian.

REP. GERAGOSIAN: Mr. O'Brien, so you're testifying in favor of this bill?

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or could be an alternative to what is currently being covered at no additional cost, it simply is shifted to better technologies.

REP. FONTANA: Good. Thank you, Representative. Thank you, Mr. Chair.

REP. OLSON: Sure.

REP. O'CONNOR: Thank you. Any other questions? Thank you.

REP. OLSON: Thank you very much for your time.

REP. O'CONNOR: Representative Don Sherer. Don's not here. We'll move on to Representative Pat Dillon. Yes, we did.

REP. DILLON: Thank you very much and I'm sorry I didn't hear. My remarks will be much briefer, but I'm here to testify on Proposed House Bill 5028, AN ACT CONCERNING AFFORDABLE HEALTH CARE FOR ARTISTS, and I guess I want to explain the, what was behind it and also point out some flaws in the languages that exist.

The language as it exists is technically accurate but misleading, and I assume that happened in the rush of bill development.

The intent of the proposal is not really to look at publicly funded healthcare for artists, but to actually work at trying to change the agenda so that we could look at private sector development of healthcare for artists.

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BILL O'BRIEN: That it would be amended if it's passed to include, particularly the one that would include screening generally and the one that would include the risk factor of family history, that they also include the risk factor of abortion.

REP. GERAGOSIAN: I think this, I mean, this particular piece of legislation has to do with treatment options as it relates to breast cancer screenings.

And I'm not sure if I even agree with having to inform the insured about the treatment options such as letting the physicians know that they're an option.

But I'm just trying to ascertain, I know I can ascertain from your testimony you're against abortion, but I can't, I'm not sure, I just want to clarify your position on this particular bill.

BILL O'BRIEN: I believe that you all received a letter from a young woman from in this State earlier this week and an e-mail as well. She has had an abortion at age 21, I believe.

At 29, she came down with breast cancer and she's now 32, I believe. When she went to her physician and asked for a, you know, a test, the physician said, no, you're too young, and she had to fight to get that test which ultimately showed that she has breast cancer.

So my main point is that we have to include these younger women. Breast cancer was

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traditionally known as an older woman's disease, but with the breast, with abortion now legal for the last 30 or so years, it's becoming a much younger woman's disease and that's what we need to confront in these bills.

REP. GERAGOSIAN: okay. So you're in support of this legislation, I take it then?

BILL O'BRIEN: If it would include younger women, right.

REP. GERAGOSIAN: Thank you.

REP. O'CONNOR: It's my understanding, aren't the doctors aware if these studies are statistically significant as you have stated, wouldn't they be making this diagnosis and if they order the mammogram, they would have access to that kind of coverage?

BILL O'BRIEN: There seems to be a lot of hesitancy, maybe is a good word, on the part of the doctors and the medical community in general to admit that these studies are legitimate studies.

That seems to be changing. These, the meta-analysis I mentioned was done about 12 years ago that studied all the studies worldwide at the time.

In that last 12 years, in the pro-life community, it's become general knowledge, but it doesn't seem to be general knowledge or at least admitted to be general knowledge in the medical community, even though *The Lancet*, the

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British medical journal, said that the meta-analysis study itself could not be disregarded.

But when that, it took two years for that to get into the papers in Britain, and when it did, *The Lancet* then started to backtrack because of the backlash they got from the women who called up their doctors.

The, in Washington, there's been three changes in the NCI's web page over the last four or five years.

At first it said that there is no link, that the study's only been done in animals and that they do not correspond with the increase in human studies, even though this meta-analysis had been done 12 years ago showing there is all, not all, but 28 human studies did show a link.

It took 20 Congressman to protest to the NCI to get that web page changed and they've had to change it again a third time.

REP. O'CONNOR: Thank you. Any other questions of Committee Members? Thank you for your testimony. The next bill is Senate Bill 434 and the speaker, I don't know if you want to come up together, but Nancy and Joseph Cappello.

NANCY CAPPELLO: Good morning, Representative O'Connor and Members of the Committee. My name is Nancy Cappello. I live in Woodbury, and I am determined to be a breast cancer survivor.

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that's, but the BIRADS was not used in my report but the term extremely dense tissue was.

REP. FREY: No, I, again I appreciate what the other members have said. I appreciate it. I've been a Member of this Committee for seven years and this is the first time I recall testimony particularly geared toward this, so I appreciate you bringing it to our attention.

REP. O'CONNOR: Now, we will move on to Senate Bill 508 and the first speaker is Pamela Pepe.

PAMELA PEPE: Good morning, Chairman O'Connor, Members of the Committee. My name is Pamela Pepe. I'm the Executive Director of Government Policy for Serono. I appreciate the opportunity to speak today in favor of Senate Bill 508.

Just so you know, Serono is the world leader in the manufacturing of infertility treatments, the majority of which are injectable products composed of recombinant DNA proteins and small molecules.

When I listened to the patients dealing with infertility last week during the Public Health Committee, I found myself wondering whether, if the opponents were listening as well and if so, whether they shouldn't possibly be more supportive of this bill and here's why.

The patients that you will hear from this afternoon are going to demonstrate for you that they have a lot of health insurance.

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The significance for you to hear from their testimony today is that, boy, are they using it.

If you pay attention today, you'll hear the patients talk about their very basic desire to have a child and in the process, you'll also hear them talk about being in the healthcare system for years.

You heard one of your colleagues testify earlier three years he and his wife were in the system accessing healthcare treatments trying to have a child.

These folks are in the system for years accessing every covered treatment they can in pursuit of their dream.

Now, if I were the employer, and I tried to put myself in the shoes of the opponents, I'd want my employees at work.

I wouldn't want them spending years in the healthcare system accessing ineffective, costly treatments like the tubal surgery available through the major medical benefit plans that they have now.

As a payer of premiums, employers are better, I think, paying for the correct treatment for their employees rather than treatment that their employees don't need.

So if they need an intrauterine insemination and not a tubal surgery, let's get them the intrauterine insemination and move on.

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That way my premium dollars go to the care they need rather than care they don't, they're able to conceive a child and quite frankly after that they can get back to work which is what I would want as an employer.

If I were the insurer, here's what I'd want. I'd my insured diagnosed properly. I'd want them treated properly and I'd want them out of the healthcare system as expeditiously as possible. The longer people are in the system, the more costly they are.

If I were the patient, I'd want everything the insurers and the employers want plus, I'd like to be spared the co-payments, the deductibles, the co-insurance and time out of work that comes with having coverage for costly, less effective treatments versus those I really need.

Even more important, I'd rather not spend three to five years in the healthcare system and again if you listen to the patients that talk today about their infertility, you'll be struck by how many years they're trying to work to have a child.

I've attached a chart to my testimony. This came up last week when people asked me what are we talking about in terms of what's covered now versus what isn't covered. My copy is not in color but yours is.

Everything in blue is coverage that most people in an employer-sponsored plan have access to

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now. It's only the two categories that are in red that are things that pertain to this bill and would be added to coverage in lieu of other coverage that's already there.

As I said, you'll see that these patients now have health insurance for all kinds of healthcare including diagnostics, procedures and surgeries, generally through the major medical benefit.

If Senate Bill 508 is enacted into law, patients would have access essentially to three new technologies, generally referred to as assisted reproductive technology. These are hormonal therapy, intrauterine insemination, or if both of those fail, in-vitro fertilization.

Covering ART, which is what we call it, covering ART would create access to the full continuum of fertility care and those treatments would either work, and more than 90% of the time they do, or they wouldn't after which these patients can frankly get out of the healthcare system and if they so desire, move on to considering adoption.

The most expensive form of ART which is in-vitro fertilization is equal to the cost of a single tubal surgery. The others cost a fraction of a single tubal surgery.

It's also important to recognize that whether their infertility was treated with assisted reproductive technology or not, patients now have pregnancy, maternity and delivery benefits so that care is all covered as well.

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In brief, all Senate Bill 508 adds is ART. Coverage which now would be paid for by reducing utilization of treatments covered elsewhere in their current benefit plans. It's really quite that simple.

I know CBIA said in their recent newsletter that they oppose mandates because they automatically drive up insurance premiums for the employers.

I urge you to ask them today how the employers feel about how their premium dollars are being spent now.

I have to believe that employers would rather spend their premiums on equally or less costly, more effective care that occurs over a shorter period of time than they are now. To me that just makes sense.

As for the insurers, I sincerely appreciate that they oppose mandates. It's understandable.

None of like to be told what to do, but in this particular case, is it really credible to suggest that paying for eight endometriosis removal surgeries at a cost of say, \$80,000, which is what's happening, you will hear the patients tell you that today, that's what they're doing now because it's what's covered.

Is that better than covering a \$1,500 intrauterine insemination or even a \$12,000 cost cycle of in vitro in those limited cases

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where IVF is the only answer? Honestly, I just don't think it is.

What's clear to me is that the insurers are not taking their insured's behavior into account and what the insureds are able to access through their current coverage. This is definitely a case of pay now or pay later but you're going to pay.

I hope you'll ask the insurers who last week said this bill would cost \$4.84, I believe that's what they said, per member per month.

If that would still be the case, if the major medical benefit covered for instance 1 tubal surgery and three cycles of IVF for a total cost of approximately \$48,000, rather than 8 tubal surgeries at a cost of about \$80,000.

To me, it seems like the cost of treatment and the corresponding premiums for those treatments would actually go down.

Equally important, isn't there a huge financial benefit to getting patients treatment and out of the healthcare system in a year rather than say, in four or five?

So while there are many things I'm sure you might have questions about what is ART, anything else I'd be happy to answer.

It seems like we are largely having this debate on the grounds of cost so I tried to focus my testimony on that today.

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But if there's anything else you'd like to ask me I'd be happy to take your questions and thank you for letting me appear.

REP. O'CONNOR: Thank you. Are there questions of Committee Members? I have a couple. As far as, you know cost is an issue of this Committee and also for some of the small employers providing the health insurance, would some of the procedures be eliminated as far as the continuum of care if ART was allowed?

PAMELA PEPE: Yes. If you talk to both the physicians who treat the patients and the patients, it's almost, in states where infertility treatments such as ART are not covered, it becomes, it's like it's in the water.

The docs will say to the patients, to be honest, I can tell by your condition that you're really a patient who should just go straight to IVF.

You have blocked fallopian tubes, an egg is not going to make it through your tubes, like it, don't like it, sad, happy, it's not going to work for you.

There are other treatments that are better used to treat your infertility and allow you to conceive and then the next statement that comes out of the physician's mouth is but I know you don't have health insurance for that so we'll try tubal surgery to remove your endometriosis.

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And if you try to get pregnant immediately after that surgery, you have a 10% chance give or take of the tube being open enough for the egg to pass.

What ends up happening, I mean, even, I went through infertility myself and decided not to have some of the treatments because I frankly wasn't sure I had the emotional constitution to do that.

I didn't get married until I was 32 so enough of my friends had beaten me to the infertility world and I'd seen marriages fall apart and mortgages taken for treatments that didn't work.

And I really wasn't sure I had the constitution for that, but I have been amazed at talking to patients who tell me, oh, yes, I've had 12 endometriosis removal surgeries because that was my only hope.

I don't have access to intrauterine insemination for instance so I keep going in every other month and I have my endometriosis removed, my insurance covers that.

I have you know a \$2,000 lifetime cap or a \$500 a year deductible so I pay that I absorb that and then I hope for the best.

So that's really what we're talking about is stop doing the 12 endometriosis removal surgeries, have a couple of cycles of IUI, if that doesn't work, have a cycle of IVF and get on with your life.

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REP. O'CONNOR: And as far as, and I'm going to have trouble pronouncing, endometriosis, you know is there like a cap or a limit where maybe you know there's a law of diminishing returns like your chances of becoming pregnant are basically nil?

PAMELA PEPE: The current literature suggests that endometriosis removal, which is a legitimate method for trying to clear the fallopian tubes with the hope that an egg will pass. It's not wild and wooly medicine, so to speak.

It is an option, but generally it has about a 10% rate of effectiveness, meaning that if you are fortunate enough to conceive in the following month you have about a 10% chance of having had that endometriosis removal allowing an egg to pass.

So it's slim and it's painful and it's uncomfortable. The one thing I do want to be clear about is there are women who need to have their endometriosis removed because it can be incredibly painful, just whether you're trying to conceive a child or not.

Endometriosis is sort of a web-like growth and it just webs into your fallopian tubes and so many times for women as they go through their menstrual cycle it expands and contracts and it can be incredibly painful.

So I wouldn't want to see people not have the surgery for pure medical reasons but if you're

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using it as a mechanism by which you hope to conceive a child, it's not very effective.

REP. O'CONNOR: okay, and as far as the continuum of care what are your thoughts on maybe limiting it to a number of instances like you know the number of cycles for IVF or just different stages, where after a while you're like you have to bear some of the cost because I know age is a factor as far as ovulation, is there an age cap like say beyond 40 years old, you know, you don't offer this?

PAMELA PEPE: Excuse me, I'm reading your mind so I know where you're trying to go I didn't mean to cut you off.

Yes, and one of the things I guess I was surprised about when I came here to talk to the legislators and to testify, there doesn't seem to be any understanding whatsoever that there are very clear clinical practice guidelines in place for assisted reproductive technology that are produced by the American Society of Reproductive Medicine, the physician group that represents reproductive endocrinologists and then a sort of a sister group of that organization called The Society for Reproductive Endocrinology and Infertility I think is what it's properly called.

They have produced an algorithm both it is a treatment algorithm on what to do with a patient they present at a certain age, they have, depending on their particular medical condition like maybe they have very high, they call it high FSH, follicle stimulating hormone,

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if the patient tests for that in an initial diagnostic workup, the current algorithm in place as part of clinical practice guidelines would say you go this way for treatment.

If you have endometriosis, you go this way for treatment, but the clear standard among the physician, community who performs infertility treatments, specifically the more expensive one, IVF, will tell you that more than four procedures is generally tilting at windmills.

And certainly I would say to you that if you, and I certainly will hope that you will consider passing this bill, it's, I know it sounds silly to say but we're way past time that you should be covering this stuff.

It'd be like not covering oral antiemetics for chemo patients and making them continue to take intravenous medicine for not throwing up when they get chemo.

I mean, we're just past the need for people to have to do that. You can take an oral pill, it's not as troublesome to the system so, I mean, we just kind of need to like move this ball forward.

But absolutely I would encourage this Committee to reference the Society for Reproductive Medicine's clinical practice guidelines.

I know we would feel comfortable with that and I think everybody who's a stakeholder has worked very closely with the physician

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community to make sure that there are standards because you want to know.

I mean, as a patient I want to know how far do I have to go, what's it going to cost me, how long am I going to be in the system.

And I think one of the things you'll hear from patients today is that they're pursuing treatments that are covered because they really want to have a child.

As somebody said earlier, it's not Botox. They just want to have a child but that is an incredibly motivated patient population. You'll be surprised.

I mean, the Representative who testified earlier said you know we were doing this for three years.

Can you imagine if every day you went home and over your dinner table what you were talking about was are we pregnant? Am I ovulating? What's my temperature today? How's this going? How's that? It's incredibly demoralizing--
[Changing from Tape 2A to Tape 2B.]

--to reinvent that wheel.

REP. O'CONNOR: And as far as those guidelines, do they have costs of the treatments as well? Is that included because I think that'll help us formulate some--

PAMELA PEPE: An opinion? I don't, I can't think off the top of my head, I can picture the book.

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I don't know if they assign cost to that or not.

I can tell you just because this is my field. You can have an in-vitro cycle, in in-vitro fertilization cycle performed in Upstate New York, I'm not sure if you're aware, but two years ago the state of New York decided actually to cover in vitro for any patients who don't have insurance for it they actually pay for in vitro out of public funds.

It's the wildest piece of legislation I've ever seen. But they got bids from clinics that wanted to participate in this state program and they have clinics all over the State that participate.

You can have an IVF cycle in Upstate New York, say Buffalo, for \$6,000, an IVF cycle in Manhattan is probably more in the \$13,000 to \$15,000 range.

And that's pretty standard and again mostly what it comes down to is where are you living, what's the cost of living where you are and that gets reflected but I think six is low and I think 15 is high if that gives you a decent answer.

REP. O'CONNOR: Do you have any numbers on Connecticut?

PAMELA PEPE: Of what?

REP. O'CONNOR: Basically the cost--

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PAMELA PEPE: Oh, what the cycles cost here? We have estimated here \$8,000 to \$12,000. It sort of depends because you have the infamous Gold Coast further south where those folks tend to go into the Manhattan clinics more than they'll come to a Connecticut clinic, so they pay a little more even though they're Connecticut residents but they're going somewhere else to get it.

The founders of IVF in particular, Zethrows and Wax, I mean, he practices in New York and some people if they're going to do it, let's just go to the best guy, the guy who really is known for basically inventing it and if he charges a little bit more that's okay because I'm getting the best guy.

So for people who can afford to pay out-of-pocket and/or who have insurance, that's an option but the clinics here in Connecticut are excellent really.

REP. O'CONNOR: Thank you. Any other questions of Committee Members? Thank you very much for your testimony.

PAMELA PEPE: Oh, you're most welcome. Thank you for having me testify today.

REP. O'CONNOR: Next speaker is Julie Greenstein. I apologize. If people are okay with this, we'll have Representative Don Sherer speak, please. HB 508

REP. SHERER: Thank you very much. I would otherwise be patient but I have a caucus I'm a ranking member of the Higher Ed and I called the caucus

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for 12:30 so I feel that I should be there.
Thank you very much for allowing me to speak
this morning.

I do wear another hat besides representing the
147th District. As a practicing attorney, I am
a fellow of the American Academy of Adoption
Attorneys and am considered an expert in the
field of assisted reproductive law, you've
heard that today perhaps for the first time.

It's a new field of law and it encompasses all
aspects of the ARTs field from the beginning
doing the agreements whether they're sperm
donor or egg donor agreements, surrogate or
gestational carrier agreements, embryo donation
agreements and finally to the birth parentage,
pre-birth parentage court proceedings.

We have a very active state in the field of
assisted reproductive technology. We are in
the tri-state area along with Massachusetts,
one of the most legally favorable places to
participate in this field. New York is
probably the worst.

We also, we are blessed with some very fine
doctors and clinics that handle this in
Connecticut.

I just want to tell you that there is no
question that this is as much the root of the
infertility problem is as much an illness,
disease, as any other illness or disease
covered by medical insurance.

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30 years ago I sat in the position of Representative Perone, except 30 years ago IVF and those associated procedures were unheard of.

As a matter of fact, Drs. Jones and Jones in Norfolk, Virginia were the preeminent founders of the IVF proceedings in America and I was invited to be on the first test panel for the IVF procedures 30 years ago.

In those days, the chances of success were slim. Today the chances of success are excellent.

And, therefore, by allowing these payments to be made under the medical insurance, you are not wasting money, and as you just heard from the previous speaker, there are oftentimes under the present circumstances where the payments are being made and they are totally being wasted.

It's an option that if they had other options they would not have taken in the first place.

My wife's had blocked tubes, went through the surgery, if we had been through today's day and age, been able to have in vitro or other procedures under the ARTs field, we would have chosen that and not spent thousands and thousands of dollars for surgery which turned out to be unsuccessful, which we could have been guaranteed it was unsuccessful, but we had to give it a shot and then we ended up adopting children because in those days IVF was not an option.

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Well, today it is. Today it's successful and it's the modern world, just like there's a new field of law, there's been a new field of medicine and it's getting better every day.

The people who are suffering through infertility are suffering. They want a family as much as anyone else. We consider in the adoption community as a very viable means for family creation.

I would suggest that the, in reference to some of the questions you asked, Mr. Chairman, with regard to capping benefits, I think that is something that you could do.

I think the insurance companies by contract can do that. You can cap it either in number of, the average I see in my practice is about, in all my agreements is no more than four IVF cycles so certainly there's a way to cap it after while it doesn't work as you have indicated.

You can also cap it to either spend x number of dollars on infertility whether it's surgery or assisted reproductive technology is another way to do it.

And the only thing that I would request that you consider when you promulgate this is that to remember that there are some people who can go through the assisted reproductive procedures for their own purpose of carrying a child but oftentimes they cannot carry and that's their problem.

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They reject the eggs or the embryo does not attach, I'm not a doctor although over the years I've learned more about reproduction than I ever thought I would.

But you have to remember that there are many instances where they seek outside carriers and so that the IVF coverage has to cover the procedure for both the intended parents and as the procedure relates to the implantation in the gestational carrier.

And so I urge you to consider this as a very modern but serious issue and hope that you will pass this House Bill 508. Thank you.

REP. O'CONNOR: Thank you for your testimony. Any questions? Thank you. Let's go back to Julie and, Julie, I apologize.

JULIE GREENSTEIN: Good afternoon. My name is Julie Greenstein, and I am the Director of Government Relations for RESOLVE, The National Infertility Association. I appreciate the opportunity to testify today in support of Senate Bill 508.

On behalf of RESOLVE, I would first like to thank Chairman Crisco for introducing this legislation that is critically important to Connecticut residents trying to build a family.

RESOLVE is a national nonprofit organization that has for 30 years providing compassionate support to those suffering from the disease of infertility.

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Infertility is a medically recognized disease that affects men and women equally. Infertility is defined as the inability to conceive or retain a pregnancy during a one-year period. No one expects to receive the diagnosis of infertility, yet one in 10 couples do.

No one expects that their insurance company will deny them coverage for this medical condition, but most insurance companies are denying this treatment.

A major impediment to infertility treatment is the lack of insurance coverage. The reason for opposition to including infertility as a covered benefit is the fear that it will increase insurance premiums and this was stated in Anthem Blue Cross and Blue Shield's testimony last week at the Public Health Committee.

Some of you may hear this but still remain skeptical but let me take a moment to present the case.

Many couples facing infertility today are compelled to choose treatment within the boundaries of their insurance coverage rather than what is medically appropriate.

For example, a woman having trouble conceiving because of blocked fallopian tubes or scarring on her tubes may receive tubal surgery, a covered treatment, which costs between \$8,000 and \$13,000 per surgery.

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This patient would receive tubal surgery even though in-vitro fertilization, IVF, a procedure that bypasses the tubal problem and costs the same, is much more likely to result in a successful pregnancy.

Insurance companies that provide infertile patients with inappropriate and outdated procedures such as tubal surgery, instead of IVF, which has a higher pregnancy success rate, may be paying the price.

According to the Maine Bureau of Insurance's mandated benefit study conducted by The Mercer Company in 2003, there could be as much as \$1 per member per month already hidden in claims cost for infertility, such as tubal surgery procedures, that could offset any premium increase of adding in an infertility benefit.

Therefore insurance companies could save money by adding an infertility benefit to their existing coverage.

The prestigious New England Journal of Medicine has reported that in states with full coverage for infertility treatment, multiple birth rates have been found to be lower than in states with no insurance mandates.

Why? Because couples with insurance coverage are free to make purely medical decisions while pursuing some infertility treatments, as opposed to other couples who must also weigh financial considerations that often result in medical risk taking, multiple births and a high

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rate of complications during and post-pregnancy.

Lower multiple birth rates translate to cost savings for insurance companies. It's that simple.

For those of you who are still unsure of your support for Senate Bill 508, I ask you to consider the evidence of the Maine Bureau of Insurance study and the New England Journal of Medicine study.

Both of these studies indicate that appropriate infertility treatment coverage does not necessarily translate to higher premiums.

Attached to the Anthem Blue Cross and Blue Shield testimony from last week is a 1998 Pennsylvania Health Care Cost Containment Council study that concluded that there was a lack of evidence for a recommendation of an infertility coverage bill in Pennsylvania. This study is seven years old and no longer provides a sufficient basis for rejecting infertility coverage.

In the Executive Summary, the Council states that they were unable to find needed proof that comprehensive coverage of infertility services would be cost effective.

However, in 1998, the Pennsylvania Council did not have the benefit of the data we now have that shows comprehensive coverage of infertility is cost-effective.

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Armed with this new data, this year we are asking the Pennsylvania Council to once again review infertility coverage legislation. We believe they will have a different response than they did seven years ago.

Infertility exacts an enormous toll on the affected individuals and on society. Couples in their most active years are distracted by the physical and emotional hardships of this disease.

Infertility impacts a couple's general health, their marriage, job performance and social interactions.

It brings a deep sense of loss, sadness and for some, depression. And if this is not enough, individuals touched by infertility are frequently affected by financial hardships that result from trying to build a family.

Infertility is a painful club that no one wants to belong to. I know this from personal experience.

Some members of this Committee may have been inflicted with infertility, or it is likely that someone you care deeply has been inflicted.

Because of the stigma associated with infertility it is also likely that someone close to you is suffering with infertility and has not told you.

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I applaud the RESOLVE members who have come forward today to tell their personal stories. It is not an easy thing to do and they should be recognized.

I ask for your support of this important piece of legislation and once again thank Senator Crisco for his leadership and commitment to this issue. Thank you.

REP. O'CONNOR: Thank you very much for your testimony. Any questions? Representative Geragosian.

REP. GERAGOSIAN: Thank you, Mr. Chairman. Hi, how are you today? You stated in your testimony that most insurance companies are denying this treatment. Do you have any numbers on percentages being denied or percentage of patients or covered lives out there that are being denied?

JULIE GREENSTEIN: I think there are 25% of insurance companies that do cover this so I think it's 75% of insurance companies that do not but I will double-check those numbers and can get back to you.

REP. GERAGOSIAN: And if, do you have any data as to how many of the insured out there have coverage, do the big companies cover this treatment or is it you know a mix?

JULIE GREENSTEIN: I think it's a mixed bag. Some do and some do not. And even some that do will cover a limited benefit.

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REP. O'CONNOR: Thank you. Any other questions?
Thank you. Next speaker is Janice Falk.

JANICE FALK: Senator Crisco, Representative
O'Connor, and Committee Members, my name is
Janice Falk, and I reside in Windsor. I'm here
to ask for your support of Senate Bill 508.

For nearly three years, I've been the President
of RESOLVE of Greater Hartford, which is
RESOLVE's local chapter, and this makes me
fully aware of the anguish face by
approximately 70,000 individuals in Connecticut
who have the disease of infertility, a medical
problem due to a flaw in the male or female
reproductive systems.

The courts have established infertility as an
illness and, according to the U.S. Supreme
Court, a disability that falls under the
guidelines of the Americans with Disabilities
Act.

The Connecticut Legislature passed a law in the
late 80's that was meant to help Connecticut
couples by requiring insurance companies to
offer coverage but this well-intentioned
legislation has not led to improved access to
treatment of an illness that has more than an
80% success rate.

We need to improve the access to treatment
already available to state and most municipal
employees and to residents in nearby states
including Massachusetts, New Jersey, New York,
and Rhode Island.

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I believe my own story helps illustrate why it's important for you to support this bill. I first started trying to conceive a baby when I was 32, soon after finished graduate school.

After about a year, we learned that our difficulties were due to a combination of male and female factors due to a varicosele, which is a varicose vein in the testicle and Polycystic Ovarian Syndrome, and endocrine disorder that causes other medical problems as well including diabetes, heart disease and endometrial cancer.

Despite the fact that over 95% of couples seeking infertility services do not require assisted reproductive technology, a specialist soon told us that we had essentially no chance of having a baby the old-fashioned way but excellent chances with in-vitro fertilization.

It was hard enough that we were desperately trying to have a baby but learning that our insurance coverage no treatment and that each round of IVF would cost us about \$12,000, made what was a bad situation almost unbearable. However we did learn that our insurance would cover surgery to repair my husband's varicosele.

Despite the physician's pessimism regarding the potential outcome, he had the surgery at a cost equal to an IVF cycle.

It was completely unsuccessful, and to be clear, this was covered by our insurance which

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requires a premium payment by my employer and me, yet it was money wasted.

My husband tried to keep my spirits up by reminding me that we were, in fact, lucky. We were able to, with the help of family, scrape together over \$23,000 to pay for 2 rounds of IVF.

However, infertility affects everyone, people of all backgrounds and socioeconomic levels. Most people in our state therefore can simply not access the medical treatment that is available.

On our second round of IVF we transferred three embryos, and on April 18th, 2000, we learned I was pregnant.

Three weeks later that elation turned to fear and anxiety when we saw three beating heartbeats on the first ultrasound. Triplets, when all we had ever wanted was one healthy baby.

Absent from this debate is an appreciation that everything from here on was covered by insurance, under a pregnancy or maternity benefits.

For everyone involved it would have been better to implant only one or two embryos therefore completely eliminating the chance of higher order multiples, as well as the associated insurance and premium costs that resulted.

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We would've never been put in this position if our insurance had paid for our treatment because we would never have taken the risk of transferring three embryos.

In states with comprehensive coverage, the rates of multiple births have been found to be lower than in states with no coverage.

This is because couples do not feel forced to take unnecessary risks but after over \$20,000 it was our last chance of having our own biological baby and we needed for it to work.

I lost one of the babies at ten weeks. I went on however to have two beautiful little girls and I have their pictures here.

They just told me this morning that they want to be mommies when they grow up and I'm not here for myself, we are happy with our two daughters.

You will hear testimony putting a real face on the heartbreaking ordeal suffered by infertile patients and their families. Additional written testimony is submitted. Multiply these stores by ten thousand.

The burden of these patients is increased by the inconsistent patchwork of insurance coverage in Connecticut which does cover some treatment but this coverage is arbitrary and based on antiquated concepts of treatment.

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Senate Bill 508 will allow citizens of Connecticut to work with their physicians to treat their infertility properly.

I've seen success rates of ART increase dramatically over my short lifetime. To deny potentially successful treatment of the disease of infertility is wrong, especially since it has been demonstrated that the cost is minimal or cost-neutral. Thank you.

REP. O'CONNOR: Thank you very much for your testimony. Any questions? Thank you very much. Next speaker is Michelle Mudrick.

MICHELLE MUDRICK: Good afternoon, Senator Crisco, Representative O'Connor, and Members of the Insurance and Real Estate Committee.

My name is Michelle Mudrick, and I live in Glastonbury. I am here today to ask for everyone's support for Senate Bill 508, AN ACT CONCERNING HEALTH INSURANCE BENEFITS FOR THE DIAGNOSIS AND TREATMENT OF INFERTILITY.

On June 29, 2004, my husband and my life changed forever. Our son was placed in our arms for the first time. He was three and a half months old and we were in South America. We adopted our son from Columbia. The whole experience was incredible.

My husband and I have been dealing with infertility for several years. I was diagnosed with unexplained infertility.

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Just over a year ago the doctors recommended IVF, which is in-vitro fertilization but we didn't have insurance to cover this procedure so my husband and I decided we would put our energy and money into adopting a baby.

Many people respond to people suffering with infertility saying why don't you just adopt? I think adoption is a wonderful option, but that does not mean that infertility shouldn't be covered and adoption is not for everyone.

From my reading and conversations with friends, it is rare for both partners to agree on adoption, usually one partner does not feel comfortable adopting.

My husband and I want to raise more than one child is exorbitant. We spent \$28,438 in fees to adopt our son, and we are still paying fees for post-adoption paperwork. To adopt again or to pay for IVF would be a great financial burden for us.

We currently have Anthem Blue Cross Blue Shield and it only covers 50% up to a maximum lifetime benefit of \$5,000.

My husband's firm even tried to buy a rider for IVF coverage and this is all they could purchase.

Since the firm has less than 50 employees, they were not even given the option to buy more coverage for IVF, even if they wanted.

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After personally talking to their insurance broker about getting a policy that would cover for IVF I was told there were none.

Many of you probably have children or plan to have children. Just think for a moment, what would your life be like if your son or daughter was not in it? What would your life be like if you and your partner found out you could not have a biological child?

Dealing with infertility is extremely emotional, invasive, uncertain, disappointing, prolonged, stressful and very time consuming with endless trips to the doctors for daily blood work and ultrasounds.

To add the additional stress of finances is just not fair. I have friends in Massachusetts going through infertility and IVF and they cannot even imagine the idea of going through the stress of taking out a second mortgage or cashing in their 401k plans to pay for what is medically necessary to have a baby.

Please consider seriously what we are all saying here today. I think this bill is long overdue.

I think if the CEO of Anthem or HealthNet or any other insurance company was dealing with infertility, they wouldn't think twice about adding this coverage to their policies.

Think about if your son or daughter had infertility problems and could not have given you your grandson or granddaughter.

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How do we put a price tag on a priceless gift?
Please support Senate Bill 508. Thank you very
much.

REP. O'CONNOR: Thank you. I just have one quick
question. Would you be willing to share in
some of those costs or look at the number of
instances as far as the continuum of care?
What are some of your thoughts on that?

MICHELLE MUDRICK: Can you please repeat the
question?

REP. O'CONNOR: I guess basically what I'm getting
at is would you be willing to share in some of
those costs if there were mandated coverage and
would you be looking at the number of instances
which after that you would bear the rest of the
cost.

MICHELLE MUDRICK: Absolutely, yes, and I apologize
it was Representative Sherer, the gentleman
that was the attorney that spoke before, his
suggestion or someone else made the suggestion
of possibly covering up to four IVF attempts
and after that being you know, holding myself
accountable to pay for the balance, absolutely,
absolutely.

REP. O'CONNOR: Thank you. Any other questions of
Committee Members? Thank you for your
testimony. Next speaker is Julie Lucia. Is
Julie here? If not we will go to Gerald Lucia?
Okay, Jennifer Kanios? Is that correct? And
if not, if you could, thank you, sorry about
that.

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JENNIFER KANIOS: My name is Jennifer Kanios. My husband Jim and I live in Windsor, Connecticut. As Jim and I look to soon celebrate our tenth wedding anniversary, we are both here for your support of Senate Bill 508 and thank you for letting me join you on my lunch hour.

Jim began his career as a correction officer for the State in December of 1995. I also work full time, however, in the private sector for a small law firm.

We know firsthand the impact that the disease of infertility has on those experiencing it and as we continue to face obstacles in our attempts to build a family, we also have many friends who have endured the highs and lows of infertility.

As a result of our own parenthood pursuit over the past four years, we have been diagnosed with both male and female factors and have pursued just about every treatment available to us.

Due to my primary diagnosis of polycystic ovarian syndrome, we have attempted fully monitored cycles of Clomid as well as eight different injectable medications, with each of these medications combined with IUIs.

Additionally, this past October we experienced our first IVF cycle which was ultimately unsuccessful.

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If not for our present unlimited insurance coverage through the State's Anthem Blue Cross Blue Shield PPO, we estimate our out-of-pocket expenses from 2001 through today would be in the \$30,000 range.

Our medical expense co-pays since 2001 have been approximately \$3,300. Please find attached a copy of Anthem's most recent letter concerning our infertility coverage. Please note that our prescriptions are coverable with an unlimited maximum per calendar year.

For the sake of today's discussion, my husband and I are obviously not here to request reasonable coverage for ourselves.

We are here, however, on behalf of those individuals who do not have the coverage we enjoy. We are asking that you think about those individuals.

Not everyone diagnosed with infertility will require the extreme need for IVF treatment. I am here asking for your help to encourage the insurance companies to develop some form of infertility coverage which could be made available at a reasonable cost to Connecticut residents suffering from infertility.

I am submitting this testimony on behalf of those individuals who do not even know that they are infertile, men and women who have no idea that they will not be able to have a biological child without medical assistance.

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In 2001, the state of New Jersey was able to determine reasonable limits to infertility coverage with certain restrictions, specifically covering up to four IVF cycles.

My husband and I are well-aware that our family building options include adoption, foster care or to choose to be child free.

The costs associated with adoption are at present, out of reach for us and we frankly wish to pursue all of our possibilities that are covered by our insurance.

We are in the middle of our second IVF attempt which again we would never have dreamed of pursuing if not for our current Anthem coverage.

We do not understand why all couples do not have access to this or similar reasonable coverage.

Simply put, infertile couples pay the same insurance premiums as fertile couples but are not able to access needed care.

Most diseases and medical conditions are covered by insurance. The disease of infertility is often singled out for exclusion and we find this to be discriminatory.

We are both here to speak on behalf of a silent minority, individuals currently or recently in treatment, those on the roller coaster ride of their lives, experiencing the emotional highs and lows of hoping, cycle after cycle after

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cycle that they will achieve their dream, a child.

We are bombarded almost endlessly, through the media and living our daily lives with visions of babies, children and happy families.

We are a happy couple. We speak on behalf of your constituents, your family members, your friends and all Connecticut residents who silently live with this disease.

Please support Senate Bill 508 and kindly join us on our roller coaster. Thank you for your time. This is the only time I've given testimony, well twice.

REP. O'CONNOR: Well, you did a great job. I was going to say thank you for telling your story.

MICHELLE MUDRICK: Thank you. Hopefully, he'll sound better than I did.

REP. O'CONNOR: Any questions? Thank you very much for coming out today. The next speaker is Monica Grabowy.

MONICA GRABOWY: Good afternoon, Senator Crisco, Representative O'Connor, and the Members of the board. My name is Monica Grabowy. I'm from Bristol. I am one of the many faces of infertility and I will stay that way unless I can count on your support for Senate Bill 508.

It breaks my heart to say that but it is the truth. Last year around this time, my doctor told my husband Mark and I that the best chance

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for us to get pregnant was to go with IVF or egg donation.

The reason is that at the age of 29 I was diagnosed with the disease of premature ovarian failure. What is that? Premature menopause at 29 years old. I do not think that my face is the face that you would connect with menopause.

Now let me turn back the hands of time. Mark and I met 15 years ago when I was 14 years old. After a two year friendship we became a couple.

For many this relationship might have resulted in a teenage pregnancy but we wanted more for ourselves and we both attended college and married shortly after graduation.

We made the conscious effort not to have children immediately so that we could build a strong and lasting marriage.

Three years ago, Mark and I decided that our relationship was strong enough to nurture a family and so our quest to become pregnant began.

My physician told us that we needed to try for a year on our own and, well, as you can imagine it didn't happen for us and that began six more months of painful testing and we still did not have answers and we still were not pregnant.

On to the fertility specialists and the long nights of trying to decipher our insurance policies to see what coverage we actually had.

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I never realized that every doctor's visit also included sitting with a financial counselor. The first thing I needed to start any infertility procedure was a zero balance on my account.

Without limited coverage I had to spend several hours searching the internet for the most inexpensive way to get my medication.

I soon realized that you either had to be independently wealthy or have insurance coverage that was good enough to pursue anything but the simplest of procedures.

For over a year Mark stayed with a job that made him miserable so that we could keep the insurance coverage that we had. Our monthly premium was \$300 for 2 of us and our coverage was a 50/50 split, meaning that if the insurance company was out \$5,000, so were we.

Giving Mark and I a grand total of over \$8,600, plus co-pays, plus the cost of medication for one year and we had no more coverage.

We had hit our lifetime maximum within a few procedures. Looking back I realize that the only thing the insurance coverage really gave us was access to their negotiated rates.

Recently, Mark and I became a licensed adoptive family through DCF mainly because we have depleted our finances due to my infertility and we can no longer afford private adoption.

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At 30 years old I never thought I would be facing a childless life because I did not have the means to attain my greatest desire, biological children.

Please help us and the result of the population that desperately want to have a child of their own.

This strong desire to build a family gives Mark and I the strength to face the obstacles ahead but we also need your support. Please support Senate Bill 508. Thank you.

REP. O'CONNOR: Thank you very much for your testimony. Any questions of the Committee Members? Thank you. Next speaker is James, and I'm going to mispronounce again, Kanios?

JAMES KANIOS: Senator Crisco, Representative O'Connor, and other distinguished guests, my name is James Kanios, and I am here writing to ask you for your support of Senate Bill 508.

Today you will read and hear a lot of testimony about this bill. The insurance companies and other opponents will tell you how much it will cost to offer this coverage but what they will not tell you is how much a family spends on it.

Since our own infertility diagnosis in 2001, my wife and I have learned that we are among the lucky few in Connecticut.

Due to my job as a correction officer we have, as Anthem Blue Cross' customer service

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representatives remind us, we have the Cadillac of coverage.

Currently \$144.22 is deducted from my State paycheck every two weeks which brings our total to \$3,749.72 for the fiscal year for this coverage.

Since 2001, our co-pays for doctor visits, procedures and medications have totaled \$3,300 while all diagnostic testing has been covered by Anthem.

Before a couple gets married should they have to ask each other if they can have children? I hope not.

As an uncle of 11 nieces and nephews plus many friends whose children call Uncle Jim, we could not wait to have a child and start our own family.

When I first met my wife I did not ask her if she was fertile. I married her because I loved her then as I do to this day.

Is this disease going to ruin our marriage? I would hope not and I think not, but I do think about all these marriages this disease has destroyed in the past and it will destroy in the future unless covered by insurance.

We live in the best country in the world and it is a shame that in the State of Connecticut individuals cannot get insurance coverage for infertility because insurance companies and

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business associations say it costs too much to offer.

Do you feel a couple should take out a second, third, and possibly a fourth mortgage on their home, borrow money from friends and family and go so far into debt just to have a family?

Connecticut residents are spending from \$13,000 plus per IV cycle trying to have a family because they have the disease of infertility. Sometimes IVF works on the first try and sometimes IVF fails altogether.

From my understanding only two to five percent of those diagnosed with infertility ever need to even consider IVF.

The majority of people seeking treatment usually achieve a successful pregnancy with medications plus artificial insemination. I am here to expand your view of the full picture of infertility.

The peace of mind my and I have because of our insurance coverage is priceless. We have been able to make informed medical decisions based not on how much money we have but on our doctor's expertise and advice, as well as our own instincts.

My wife and I feel strong that all Connecticut individuals should be free to pursue their infertility treatments with that same peace of mind, to be able to focus on their healthcare. Thank you for your time and your consideration

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on this important, again, I ask you to support
Senate Bill 508.

REP. O'CONNOR: Thank you very much for your
testimony. Any questions? Thank you very
much. Next speaker is Margi Goode.

MARGI GOODE: Hello. My name is Margi Good. I'm a
resident of East Haven, Connecticut. I'm the
mother of a beautiful little boy who will turn
two years old next week. I am testifying today
in favor of Senate Bill 508, AN ACT CONCERNING
HEALTH INSURANCE BENEFITS FOR THE DIAGNOSIS AND
TREATMENT OF INFERTILITY

My husband and I began trying to conceive in
1999. I was 29 years old and we had no reason
to believe we'd have any problems conceiving,
so we weren't terribly worried when it didn't
happen immediately, but the months of trying
began to stretch out and I still wasn't getting
pregnant.

And the worrying and wondering if something
were wrong started. After about 18 months of
trying with no success, my obstetrician
referred me to a reproductive endocrinologist
at the University of Connecticut.

Still, we were young and healthy and we figured
that soon we'd have the baby we wanted so
desperately.

My doctor started with a huge assortment of
tests to find out what was wrong. I underwent
several difference surgical procedures, most of

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which were covered by insurance. The first few months weren't terribly expensive.

I was taking Clomid which cost roughly \$60 per cycle. Many couples get pregnant with Clomid alone but it didn't work for us. After two cycles of Clomid, my doctor recommended that we try Clomid along with artificial insemination.

Now each cycle was costing roughly \$500 out-of-pocket. We tried a few cycles of that, still with no success.

Next, we moved on to injectable fertility medications such as Gonal-F, combined with artificial insemination. Now we were paying roughly \$4,000 out of pocket for every cycle and still I wasn't able to conceive.

At this point we were running out of options and out of money. We couldn't afford to continue paying thousands of dollars per month for treatment that was not working and we definitely couldn't afford the cost of in-vitro fertilization which was the next step of treatment.

We were losing hope. We actually considered the possibility of moving to a different state, one which required infertility coverage and we also researched national companies that offer insurance benefits packages that included infertility treatment.

Just as we were at the end of our ropes, both financially and emotionally, a company based on Massachusetts purchased the company that my

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husband worked for. Our health insurance coverage changed to a company based in Massachusetts.

The Legislature in Massachusetts, as you probably are aware, has required the disease of infertility to be covered by insurance.

We felt as if we had won the lottery, and in a way we had. With our new insurance coverage we were able to continue our medical treatment.

I did my first round of IVF in April of 2002 and it failed. I was absolutely devastated and ready to stop trying but we decided to give it one more try.

And we did a second round of IVF in June of 2002 and I conceived the miracle that we had waited so long for. This is our little boy that'll turn two next week. He's our in vitro miracle.

I know to the rest of the world he's just another kid but to us he is the world. There's not enough words to explain the tremendous amount of joy that my little boy has brought into our lives.

I thank God the doctors at UCONN, the Massachusetts Legislature, and the insurance coverage that made him possible, each and every day for bringing him to me.

Our family's complete and I won't be pursuing fertility treatment again in the future, so

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whether or not we ever get mandated coverage here in Connecticut is a moot point for me.

However, I know firsthand how completely devastating, consuming, emotionally and financially draining infertility treatment can be.

And I'd love to see others here in Connecticut be able to realize their dreams of building a family without bankrupting themselves in order to do so. I urge your support for Senate Bill 508. Thank you.

SEN. CRISCO: You're welcome. Thank you. Any other questions? Thank you very much. Anita Lipski, followed by Anita Steenson, Anita one and Anita two.

ANITA LIPSKI: Good afternoon, distinguished Members. I am Anita Lipski from Bristol, Connecticut. You may wonder why I'm here. I'm with my lovely daughter, Monica, who spoke previously. Infertility didn't affect me or has it?

I've been witness to the fallout of infertility. Infertility doesn't have a singular victim.

I've dried tears and watched my daughter wither under the weight of self-loathing because she cannot give her husband a child.

Slowly, I've watched their friends evaporate because they've moved on to birthday parties and play dates.

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I've heard the whispers in my ears, the apologies, and from those who are rude enough, questions about the latest failed attempts.

I've prayed, said novenas, lit candles, encouraged, cried, been optimistic and have ridden this tortuous roller coaster every month with my daughter and her husband.

I've even gone so far as to take classes with Mark and Monica from DCF hoping that there might be the possibility of babysitting a foster child, but still no baby.

The disease of infertility has a wave of victims. This disease is costing some insurance company somewhere.

Multiply those 40,000 infertile couples times four those parents of the infertile, who are older and less resistant to stress.

Rising blood pressures, severe changes in diabetes because of stress eating, repeat visits to the doctors, that's what this problem has cost our insurance company.

I'm begging you to step up to the plate and do the right thing. I'm here as living proof of the hidden cost of the disease of infertility.

We, as parents of infertile couples pay a price also. They don't live in a bubble. This problem deserves full coverage.

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It's not more or less important than erectile dysfunction. In closing, I am Anita Lipski from Bristol, a wannabe Grandma.

SEN. CRISCO: Thank you, Anita. Any questions?
Anita two.

ANITA STEENSON: Good afternoon Representative Cisco and other Members of the Committee. I submitted a package of testimony, and I just wanted to let you know I wasn't going to read from the whole thing. Most of it is articles about studies and so on and so forth.

Basically, all I want to tell you today, Sir, is my name is Anita Flannigan Steenson and I live in Milford, Connecticut. I'm here today to support Senate Bill 508 which mandates infertility coverage for treatment and diagnostic.

I have to tell you it's a bit surreal for me to be here in front of you gentlemen and all of the members of the public to discuss such a painful and intimate matter. However that's the nature of the disease of infertility. It involves sex, bodily functions, or the lack thereof, emotion, pain, grief, humiliation and discomfort.

The disease affects, as you've heard, one in six couples, yet it's so stunning and unexpected, as it has no advanced warning that most couples would never talk about it in public. My husband comes from a family of ten. I have 30 nieces and nephews.

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Everybody's been wondering when Jim and Anita will have their family. Anita's too busy building her career, so on and so forth. Anita and Jim have been trying to have a child for ten years. I sit here before you today, 41 years old and when I finally got the courage to seek the treatment of doctors, some five years ago, when I got out of my denial of pain and humiliation that I was a failure as a woman, I began infertility treatments.

Now, no one has talked about what an infertility treatment consists of. An infertility treatment consists of daily vaginal ultrasounds, injecting yourself with needles, I was up to six a day, going in every other day to have blood work and these invasive vaginal ultrasounds. It's very invasive and very humiliating and I guarantee you no one who had any other choice or option would ever put themselves through that sort of procedure.

You don't know you need it until you find out. On top of that, the financial ramifications are staggering and I just want to switch over, because you've heard enough and I'm sure you're all very well aware of the grief and pain but I want to tell you that I'm four generations living in New Haven, Connecticut.

I'm a product of the New Haven public school system. I'm the first person in my family to go to college. I did everything I was supposed to do. I got a job to pay for my college education, I worked hard, I got scholarships.

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I then went on to law school. I got a degree, I took a year off, I paid for that. I didn't have a teenage romance or pregnancy. I married my husband, we worked hard together for five years to build a life and to build some security.

We both took jobs. I took a job as a public servant in the state of Florida working for the court system there, got paid \$30,000 because that's what was important.

And here I am now, in my home state, where I'm ashamed to say I'm being made to feel like a pariah. I'm shunned from every aspect of life because every aspect of life involves children.

The last thing I want to say because I know my time is up, is what about the equities of the fact that I pay property taxes which-- [Changing from Tape 2B to Tape 3A.]

--the fact that people get medical treatment when they voluntarily disease their lungs with cigarette smoke, yet I have a disease that I don't know I have.

The numbers that the insurance companies have quoted are soundly refuted by the attachments, and as I said I'm not going to go through those medical studies.

And I think that the scare tactics of the insurance companies rolling out these big million, billion dollar numbers need to be looked into, Sir, because they're not accurate

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and they don't show all of the costs
infertility imposes on our society.

SEN. CRISCO: Thank you, Anita. Any questions?
Yes, Representative Geragosian.

REP. GERAGOSIAN: Thanks for coming here today. You
know, and it's not necessarily just for you,
but all the testimony that we've had today
talks about the individual cost.

Yet spread out, it's a very nominal, if not a
[inaudible] savings to cover this which is
like, you know, so frustrating to me as a
policy maker and what insurance should be
about, spreading risk throughout the entire
population.

ANITA STEENSON: It is, Sir, and the interesting
thing is that the unnecessary treatments, my
insurance only covered intrauterine
inseminations. They covered nine of those. My
doctor recommended IVF after three, but I
couldn't go on to that because I couldn't
afford it.

I actually went through 12 IUI procedures which
were known in advance would not work, and then
paid out of my pocket because that's all I
could do until my husband and I refinanced our
house and drew down from our retirement account
to pay for, we did four cycles of IVF out of
our own pocket.

Until my husband, Sir, moved out of the State
of Connecticut and took a job in Massachusetts

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so that we could get insurance coverage to have our child.

The numbers that the insurance company have put out there are totally false, and it's scare tactics and you all have probably heard about this when people come in here and beg for preventative medicine.

I mean, if, and the interesting thing is we're trying to create future taxpayers here, our children. There's a goal which will have a benefit that will be reaped.

REP. GERAGOSIAN: I mean, I've been on this Committee for ten years now and it just never cease, it always frustrates me when they, the companies come in and oppose mandates that most of the time would save them money down the line just because they oppose mandates.

ANITA STEENSON: Exactly. The company would've sent, saved tens of thousands of dollars if I hadn't had to do nine covered IUI cycles and I could've just done the one IVF cycle which is what my doctor said I needed.

I looked at the testimony that the CBIA put and they listed the number of mandated insurance bills and basically what I say is that should be the list of shame, the fact that people have to come here before the Legislature and ask for coverage for women that have lost their hair due to breast cancer radiation.

The fact that this Legislature has to mandate coverage for things, to me, is a shame and

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thank God we have you here because without you the insurance companies would put us in the grave early, basically is what it comes down to.

REP. GERAGOSIAN: I thank you for coming here today.

SEN. CRISCO: Any other questions? Thank you very much for that enlightening testimony. We proceed now to Senate Bill 509, Dr. Pagano?

DR. MATTHEW PAGANO: Senator, Members of the Insurance Committee, thanks for having me. I'm Dr. Matt Pagano. I have a private practice in Winsted.

And I'm the First Vice President of the Connecticut Chiropractic Association and I'm here today to discuss Proposed Senate Bill 509, AN ACT CONCERNING COMPENSATION FOR CHIROPRACTORS.

There is a longstanding inequity we seek your help in rectifying. For some time, perhaps as long as there has been insurance coverage for chiropractic services, we have not been reimbursed fairly.

Particularly, when it comes to reimbursements for performing examinations, we have not enjoyed a comparable pay for performing the same service as our allopathic and osteopathic colleagues.

In this state, chiropractors are licensed under the Connecticut Healing Art Statutes and are primary portal of entry practitioners. We,

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CBIA

Connecticut Business & Industry Association

TESTIMONY
BEFORE THE
INSURANCE AND REAL ESTATE COMMITTEE
LEGISLATIVE OFFICE BUILDING
FEBRUARY 17, 2005
Offered by:

Berlin Chamber of Commerce
Bridgeport Regional Business Council
Greater Bristol Chamber of Commerce
Connecticut Business & Industry Association
Greater Danbury Chamber of Commerce
East Hartford Chamber of Commerce
MetroHartford Chamber of Commerce
Greater Meriden Chamber of Commerce
Middlesex County Chamber of Commerce
National Federation of Independent Businesses
New Britain Chamber of Commerce
Greater New Haven Chamber of Commerce
New Haven Manufacturers' Association
Greater New Milford Chamber
Northwest Connecticut's Chamber of Commerce
Plainville Chamber of Commerce
Prospect Chamber of Commerce
Quinnipiac Chamber of Commerce
Greater Waterbury Chamber of Commerce
Chamber of Commerce – Windham Region

We, the above-named Connecticut business organizations, offer the following testimony in opposition to the following bills: **SB 28, SB 30, SB 434, HB 5712, SB 130** and **SB 508**. The first four of these bills (SB 28, SB 30, SB 434 and HB 5712) would mandate that health plans cover breast cancer screening. In addition, SB 130 would require that the State study whether treatment for obesity should be mandated and SB 508 would mandate coverage for infertility treatment in health plans. We believe that additional health insurance mandates will only act to further drive up the cost of healthcare benefits in Connecticut and jeopardize access to health insurance for Connecticut citizens.

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Adding new coverage mandates provides a benefit for some individuals. But the cost of that benefit is paid by all consumers of health insurance – employers, employees, and taxpayers. And in Connecticut, employers, employees and state and municipal governments are all struggling under the weight of increasing health insurance costs.

Consider this recent data:

- “Affordable healthcare” has emerged as Americans’ leading concern, after the economy and jobs. (Survey of 2,000 Americans, conducted by Public Opinion Strategies and Greenberg Quinlan Rosner Research, January 14, 2004.)
- Rising healthcare costs are “a major impediment to hiring,” a problem particularly pronounced in manufacturing. (Analysis from www.economy.com, November 3, 2003.)
- The number of small companies providing health insurance for their workers fell from 67% in 2001 to 61% in 2002. (Kaiser Family Foundation Study.)
- 73% of survey-participating Connecticut businesses identified “employee healthcare benefit costs” as either their first or second choice to the question of “which costs of doing business cause your company the greatest concern.” (2004 CBIA Annual Membership Survey.)

With respect to other responses received from employers as a part of CBIA’s own annual survey of Connecticut employers substantiates these national studies:

- While 97% of participating employers provide healthcare benefits for their employees, 82% have reported that rising healthcare costs are affecting their decisions to hire additional workers.
- Nearly 97% of participating employers are experiencing health benefit cost increases over the past year.
- While employers continue to pay the lion’s share of health benefit costs, the majority of employers are also asking their employees to pay a greater share of premium costs and increased out-of-pocket costs.

And, as employees are asked to share the increasing burden, will they be able to afford it? The national Health Interview Survey indicates that the main reason that employed, uninsured family heads report for not being covered by health insurance is not that health insurance is unavailable through their employer, but that it’s too expensive.

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("Private Health Insurance, Continued Erosion of Coverage Linked to Cost Pressures," U.S. General Accounting Office Report).

How should the legislature respond to this growing crisis? The clear response is: **Refrain from taking actions that would further drive up costs.** And this means refraining from adopting new health benefit mandates or cost-driving regulation.

A study by PriceWaterhouseCoopers found that government mandates and regulations are major drivers of rising healthcare premiums, accounting for 15% of the overall increase in 2001 ("The Factors Fueling Rising Healthcare Costs," April 2002). The report states "*each mandate adds its own cost, and collectively they have significantly increased healthcare costs.*" As noted in a national survey of healthcare costs, "when legislative and regulatory changes require plans to cover services that were not covered previously . . . , those changes add to the future claim cost of employee health plans." (2003 Segal Health Plan Cost Trend Survey)

Connecticut currently requires health insurance plans to cover over 60 mandated benefits and services – more than almost any other state in the nation. **Starting with the 1999 legislative session – and just as healthcare premiums began an upward spiral – Connecticut has passed twenty-five new health insurance mandates!***

The cost implications of health insurance mandates are a top concern of Connecticut employers. These mandates increase costs for your employer and worker constituents as directly as any tax increase. ***And the consequences are reduced access to health insurance for everyone.***

We urge you to reject SB 28, SB 30, SB 434, HB 5712, SB 130 and SB 508.

***Mandates passed in 1999:**

- HB 5950 Prescription birth control
- HB 7032 Expanded mental health parity
 - Experimental treatments
 - Drugs a health plan removes from its formulary
 - Antibiotic treatment for Lyme Disease
 - Prostate cancer screening
 - Diabetes management
 - Inpatient anesthesia for dental treatment

Mandates passed in 2000:

- HB 5120 Care and treatment of ostomy Patients

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- SB 435 Expanded portability
- HB 5911 Pain management

Mandates passed in 2001:

- SB 524 Specialized formula for children
- SB 325 Patient care costs associated with cancer clinical trials
Hearing aids for children under age 13
Pap smears
Colorectal cancer screening procedures
Annual mammograms for women between 40 and 50 years old
Certain drugs not in a drug formulary used for treating mental illnesses

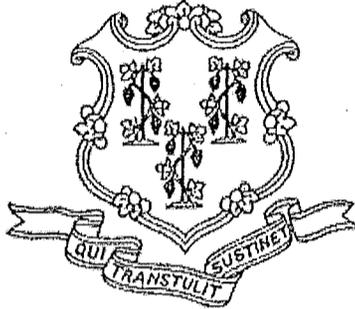
Mandates passed in 2003:

- SB 1 Alliances and equipment for treating craniofacial disorders.
- SB 4 Extension of continuation-of-coverage.
- SB 918 In-hospital cost for complex dental procedures
- SB 2001 Early intervention services for children birth to age 3
Welfare fees to fund the state's immunization/vaccination program

Mandates passed in 2004:

- HB 5201 Medically necessary formula
- HB 5464 Wigs for chemotherapy patients

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AFRICAN-AMERICAN AFFAIRS COMMISSION
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Testimony before the Insurance and Real Estate Committee

Thursday, February 17th, 2005

10.00 AM in Room 2D of the LOB

Good morning/afternoon Senator Crisco, Representative O'Connor and ranking members on this Committee. My name is Vanessa Burns and I represent the African-American Affairs Commission (AAAC). The Commission is a non-partisan state agency committed to advocating on issues impacting the well being of African-Americans in the state. Today the Commission testifies in support of the following bills.

Senate Bill (SB) - 28 An act concerning health insurance coverage for breast cancer screening,

(SB) - 30 An act concerning health insurance coverage for breast cancer screening for individuals with a family history of breast cancer and

(SB) - 5712 An act concerning health insurance coverage for breast cancer screening using magnetic resonance imaging.

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(SB) -130 An act concerning health insurance coverage for the treatment of obesity

I will begin by saying that the issue of breast cancer screening has perked the interest of the Commission considering that breast cancer is the most common cancer among African-American women. Approximately 20,000 new cases of breast cancer are diagnosed among African-American women each year. We also know that African-American women ages 25 to 40 have higher incidence rates and have shorter survival times than other groups, once diagnosed. Such disparities may result from multiple factors, such as diagnosing the disease at a later stage, barriers to health care access, lower socio-economic status, and history of other diseases, biologic and genetic differences in tumors, health behaviors, and the presence of risk factors. More research is needed to understand differences in cancer deaths among racial and ethnic populations, as well as on ways to better target prevention efforts to reach the underserved and those at highest risk. However here in Connecticut we know that overall African-Americans experience higher mortality rates due to cancer than any other group. In the fall of last year the Commission received a grant from the Centers Disease and Control (CDC) to hold a Public Health Conference to increase awareness on health concerns including breast cancer and other illnesses common to communities of color and to further educate the public. Over all the Conference was a success and the Commission as part of its mandate will continue reaching out to the community on health related matters.

In reference to ***Senate Bill (SB) – 5712 and Senate Bill (SB) – 30*** research shows that mammography is not perfect in diagnosing breast cancer. According to the Institute of Medicine, routine screening in clinical trials resulted in a 25 to 30 percent decrease in breast cancer mortality among women between the ages of 50 and 70. However new research has determined that in some cases other methods such as magnetic resonance imaging (MRI's) are more effective or accurate in diagnosing breast cancer especially for women who have a family

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history and those who are at higher risk. More importantly MRI's are very expensive running anywhere from \$1000 to \$1,500 compared to \$100 to \$500 for mammograms. Its not surprising then that women from low-income backgrounds find it unaffordable. The Commission is hopeful that all women have access to existing and future detection methods and treatments so that breast cancer deaths are reduced. Accordingly the Commission is supportive of any efforts in the state to provide health insurance coverage for improved alternatives in breast cancer screening for early detection.

Finally the Commission is equally supportive of health insurance coverage for obesity as raised in **Senate Bill (SB) – 130**. It's becoming increasingly obvious that obesity is now a national health crisis. Last week the Commission testified in support of bill aimed at establishing a child prevention program to increase awareness in communities at higher risk. We will say that exploring the idea of a task force to examine the need of health insurance coverage for the treatment of obesity is positive public policy in addressing obesity in the state. The time has come for the state to take a critical look at this growing health crisis. Whether funding is available or not is another matter but the Commission is pleased that more attention is been given to the obesity crisis, considering that historically as a group African-Americans experience higher rates of obesity together with other poorer health outcomes.

We thank you all for your attention to these matters.

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Endnotes

1. American Cancer Society, *MRI Finds Breast Cancer in High-Risk Women*
2. National Cancer Institute and American Cancer Society, *African-American Women and Breast Cancer*

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Marshall R. Collins & Associates

TESTIMONY OF THE
LUMBER DEALERS' ASSOCIATION OF CONNECTICUT
BEFORE THE LEGISLATURE'S
INSURANCE & REAL ESTATE COMMITTEE
THURSDAY, FEBRUARY 17, 2005, 10:00AM
ROOM 2D, LEGISLATIVE OFFICE BUILDING
HARTFORD, CONNECTICUT

Good Morning. My name is Marshall R. Collins. I am the Counsel for Government Relations for the Lumber Dealers' Association of Connecticut ("LDAC"). I am here this morning to testify on behalf of LDAC regarding Proposed SB 29 AA Requiring A Cost-Benefit Analysis Of Health Insurance Benefits Mandated In This State and Proposed HB 5711 AAC The Impact Of Health Insurance Mandates On Premium Costs.

There are approximately 100 independent retail lumber dealers and building material suppliers across the state that are members of LDAC. Many of these companies have been an integral part of our communities' growth and prosperity for more than 100 years. LDAC members are extremely concerned with the rising cost of doing business in Connecticut and the cost of health insurance is one of those costs.

SB 29 would require that the Insurance Commissioner conduct a cost-benefit analysis of health insurance benefits mandated in Connecticut. LDAC believes that this review should be conducted prior to legislative passage of any new insurance mandates. There is no question that mandated insurance coverage is a cost driver regarding health insurance. The only question is to what extent?

LDAC believes that just as the legislature requires the information contained in a fiscal note before it adopts legislation, the legislature should fully understand the cost effect of new insurance mandates **before** their adoption.

If the SB 29 and HB 5711 analysis is required before final consideration of new mandates, more informed debate may occur and that is in the public interest. If such analysis were performed after passage of new insurance mandates, it would amount to little more than closing the door after the horse is out of the barn.

The LDAC supports adoption of SB 29 and HB 5711 with the suggested modification.

This completes my testimony. Thank you for your consideration.

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STATEMENT OF JULIE SALZ GREENSTEIN
DIRECTOR OF GOVERNMENT RELATIONS
RESOLVE: THE NATIONAL INFERTILITY ASSOCIATION

February 17, 2005

Chairman Crisco, Chairman O'Connor, Members of the Insurance and Real Estate Committee, my name is Julie Salz Greenstein and I am the Director of Government Relations for RESOLVE: The National Infertility Association. I appreciate the opportunity to testify today in support of S.B. 508, "An Act Concerning Health Insurance Benefits For The Diagnosis And Treatment Of Infertility."

On behalf of RESOLVE, I would first like to thank Chairman Crisco for introducing this legislation that is critically important to Connecticut residents trying to build a family.

RESOLVE is a national nonprofit organization that has for 30 years been providing compassionate support to those suffering from the disease of infertility. RESOLVE works to increase awareness of the issues surrounding infertility and the various family building options available to those working to overcome their infertility.

Infertility is a medically recognized disease that affects men and women equally.

Infertility is defined as the inability to conceive or retain a pregnancy during a one-year period.

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No one expects to receive the diagnosis of infertility. Yet 1 in 10 couples do.

No one expects that their insurance company will deny them coverage for this medical condition. But most insurance companies are denying this treatment.

A major impediment to infertility treatment is the lack of insurance coverage. Currently those with access to treatment are a small subset of infertility sufferers; those residing in one of the fifteen states, such as neighboring Massachusetts, that have passed laws requiring some level of infertility coverage; those who work for the small number of employers who voluntarily provide such a benefit, or those who have the financial ability to finance the treatment out of pocket.

The reason for opposition to including infertility as a covered benefit is the fear that it will increase insurance premiums, as stated in Anthem Blue Cross and Blue Shield's testimony. In fact, however, the evidence indicates that premiums will not increase. Some of you may hear this but still remain skeptical, but let me take a moment to present the case.

Many couples facing infertility today are compelled to choose treatment within the boundaries of their insurance coverage rather than what is medically appropriate. For example, a woman having trouble conceiving because of blocked fallopian tubes or scarring on her tubes, may receive tubal surgery, a covered treatment, which costs between \$8,000- \$13,000 per surgery. This patient would receive tubal surgery **even though in-vitro fertilization (IVF)**, a procedure that bypasses the tubal problem and costs the same, **is more likely to result in a successful pregnancy.**

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Insurance companies that provide infertile patients with inappropriate and out-dated procedures such a tubal surgery, instead of IVF, which has a higher pregnancy success rate, may be paying the price. According to The Maine Bureau of Insurance's mandated benefit study conducted by The Mercer Company in 2003, **there could be as much as a \$1 per member/per month already hidden in claims cost for infertility (such as tubal surgery procedures) that could offset any premium increase of adding an infertility benefit. Therefore, insurance companies could save money by adding an infertility benefit to their existing coverage.**

The prestigious New England Journal of Medicine has reported that, **in states with full coverage for infertility treatment, multiple birth rates have been found to be lower than in states with no insurance mandates.** (New England Journal of Medicine, August 2002) Why? Because couples with insurance coverage are free to make purely medical decisions while pursuing some infertility treatments, as opposed to other couples who must also weigh financial considerations that often result in medical risk taking, multiple births and a high rate of complications during and post-pregnancy. **Lower multiple birth rates translate to cost savings for insurance companies. It's that simple.**

For those of you who are still unsure of your support for S.B. 508, I ask you to consider the evidence of the Maine Bureau of Insurance study and the New England Journal of Medicine study. Both of these studies indicate that appropriate infertility treatment coverage, does not necessarily translate to higher premiums.

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Attached to the Anthem Blue Cross and Blue Shield testimony is a 1998 Pennsylvania Health Care Cost Containment Council study that concluded that there was a lack of evidence for a recommendation of an infertility coverage bill in Pennsylvania. This study is seven years old, and no longer provides a sufficient basis for rejecting infertility coverage. In the Executive Summary, the Council states that they "...were unable to find needed proof..." that comprehensive coverage of infertility services would be cost effective. However, in 1998, the Pennsylvania Health Care Cost Containment Council did not have the benefit of the data we now have (as indicated above) that shows comprehensive coverage of infertility is cost effective. Armed with this new data, this year we are asking the Pennsylvania Council to once again review infertility coverage legislation. We believe they will have a different response than they did seven years ago.

Infertility exacts an enormous toll on the affected individuals and on society. Couples in their most active years are distracted by the physical and emotional hardships of this disease. Infertility impacts a couple's general health, their marriage, job performance and social interactions – it brings a deep sense of loss, sadness and for some depression. And if this is not enough, individuals touched by infertility are frequently affected by financial hardships that result from trying to build a family.

Infertility is a painful club that **NO ONE** wants to belong to - I know this from personal experience. Some members of this Committee may have been inflicted with infertility; or it is likely that someone you care deeply has been affected. Because of the stigma

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associated with infertility, it is also likely that someone close to you is suffering with infertility and has not told you. I applaud the RESOLVE members who have come forward today to tell their personal stories. It is not an easy thing to do and they should be recognized.

I ask for your support of this important piece of legislation and once again thank Senator Crisco for his leadership and his commitment to this issue.

Thank you.

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February 17, 2005

The Honorable Senator Joseph J. Crisco, Jr., Co-Chair
The Honorable Representative Brian O'Connor, Co-Chair
The Honorable Senator Joan Hartley, Vice Chair
The Honorable Representative Charles Clemons, Vice Chair
Members of the Insurance & Real Estate Committee

Re: S.B. 508 "An Act Concerning Health Insurance Benefits for the Diagnosis and Treatment of Infertility"

Dear Senator Crisco, Representative O'Connor, Senator Hartley, Representative Clemons and Committee Members:

My name is Janice Falk and I reside in Windsor. I am here to ask for your support of S.B. 508. For nearly three years I have been the President of Resolve of Greater Hartford, the local chapter of an organization that provides support, education and advocacy for individuals facing infertility. This makes me fully aware of the anguish faced by the approximately 70,000 individuals in Connecticut who have the DISEASE of infertility, a medical problem due to a flaw in the male or female reproductive systems. The courts have established infertility as an illness¹, and according to the US Supreme Court, a disability that falls under the guidelines of the Americans with Disabilities Act². The Connecticut legislature passed a law in the late 1980's that was meant to help Connecticut couples by requiring insurance companies to "offer" coverage. This well-intentioned legislation has not led to improved access to treatment of an illness that has more than an 80% success rate. We need to improve the access to treatment already available to state and most municipal employees, and to residents in nearby states including Massachusetts, New Jersey, New York and Rhode Island.

Although I am only one of the thousands whose coverage of infertility services in Connecticut has not proven adequate, I believe my own story illustrates why it is important for you to support this bill. I first started to try to conceive a baby when I was 32, soon after I completed a graduate degree and secured employment in my field. After about a year, we learned that our difficulties were due to a combination of male and female factors due to a varicocele, which is a varicose vein in the testicle, and Polycystic Ovarian Syndrome (PCOS), an endocrine disorder which also causes other medical problems including diabetes, heart disease and endometrial cancer. Despite the fact that over 95% of couples seeking infertility services do not require assisted reproductive technology, a specialist soon told us we had "essentially no chance" of having a baby the "old fashioned way" but that we had excellent chances with in-vitro fertilization (IVF). It was hard enough that we were desperately trying to have a baby. But learning our insurance covered NO treatment and that each round of IVF would cost us about \$12,000 made what was a bad situation almost unbearable. However, we did learn that our insurance would cover surgery to repair my husband's varicocele. Despite my physician's pessimism regarding the potential outcome, he had the surgery, at a cost equal to an IVF cycle. It was completely unsuccessful. To be clear, this was covered by insurance, which requires a premium payment by my employer and me, yet it was money wasted on less effective treatment.

My husband tried to keep my spirits up by reminding me that we were, in fact, lucky. We were able to, with the help of family, scrape together over \$23,000 to pay for two rounds of IVF. However, infertility affects everyone - people of all backgrounds and socioeconomic levels. Most people in our state therefore simply cannot access the medical treatment that is available. On our second round of IVF, as

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recommended by our doctor, we transferred three embryos and on April 18, 2000 we learned that I was pregnant. Three weeks later that elation turned to fear and anxiety when we saw three beating heartbeats on the first ultrasound. Triplets. When all we ever wanted was one healthy baby.

Absent from this debate is an appreciation that everything from here on was covered by insurance – under a pregnancy or maternity benefits. For everyone involved, it would have better to implant only one or two embryos, thereby completely eliminating the chance of higher order multiples, as well as the associated insurance and premium costs that resulted.

We would have never been put into this position if our insurance had paid for our treatment because we would have never taken the risk of transferring three embryos. In states with comprehensive coverage for infertility, the rate of multiple births has been found to be lower than in states with no coverage.³ This is because couples do not feel forced to take unnecessary risks. But after over \$20,000, it was our last shot of having our own baby, and we needed for it to work.

I lost one of my babies at ten weeks. I went on however to have two beautiful little girls. I am not here for myself; we are happy with our two daughters. You will hear testimony putting a real face on the heartbreaking ordeals suffered by infertile patients and their families. Additional written testimony is submitted. Multiply these stories by ten thousand: there are an estimated 70,000 patients dealing with infertility in Connecticut each year. Their burden is increased by the inconsistent patchwork of insurance coverage in Connecticut, which does cover some treatment, but this coverage is arbitrary and based on antiquated concepts of treatment. SB 508 will allow citizens of Connecticut to work with their physicians to treat their infertility properly.

I have seen success rates of Assisted Reproductive Technology increase dramatically over my relatively short lifetime; to deny potentially successful treatment of the disease of infertility is wrong, especially since it has been demonstrated that the cost of adding uniform infertility coverage is minimal, or cost neutral.

I am requesting that you vote favorably on SB 508.
Thank you.

Janice Falk
39 Ethan Drive
Windsor, CT 06095
(860) 683-0006

1. Witcraft v Sundstand Health & Disability Benefit Plan, Iowa Supreme Court, 1988.
2. Bragdon v Abbott, US Supreme Court, 1998.
3. Jain et al, New England Journal of Medicine, 2002

000843

February 17, 2005

The Honorable Senator Joseph Crisco, Co-Chair
The Honorable Representative Brian O'Connor, Co-Chair
Honorable Members of the Insurance and Real Estate Committee
Legislative Office Building
Hartford, CT

Re: S.B. No. 508: An Act Concerning Health Insurance Benefits for the
Diagnosis and Treatment of Infertility.

Senator Crisco, Representative O'Connor and Members of the Insurance and
Real Estate Committee:

I am here today to ask for your support of S.B No 508, An Act Concerning
Health Insurance Benefits for the Diagnosis and Treatment of Infertility.

On January 29, 2005, my husband's life and my life were changed forever
when our son was placed in our arms for the first time. He was 3 ½ months
old and we were in South America. We adopted our son from Colombia.
The whole experience was incredible.

My husband and I have been dealing with infertility for several years. I was
diagnosed with unexplained infertility. Just over a year ago, our doctors
recommended IVF (in vitro fertilization), but we do not have insurance to
cover this procedure, so my husband and I decided that we should put our
energy and money into adopting a baby.

Many people respond to people suffering with infertility by saying, "why
don't you just adopt?" I think adoption is a wonderful option, but that does
not mean that infertility shouldn't be covered AND adoption is not for
everyone. From my reading and conversations with friends, it is rare for
both partners to agree on adoption, usually one partner does not feel
comfortable adopting.

My husband and I want to raise more than one child and the cost for us to
have another child is exorbitant. We spent \$28,430 in fees to adopt our son,
and we are still paying fees for post adoption paperwork. To adopt again or
to pay for IVF would be a great financial burden for us. We currently have
Anthem Blue Cross Blue Shield and it only covers 50% up to a maximum

000844

lifetime benefit of \$5,000. My husband's firm even tried to buy a rider for IVF coverage and this is all they could purchase. Since the firm has less than 50 employees, they are not even given the option to buy more coverage for IVF, even if they wanted to. After talking to their insurance broker about getting a policy that would cover IVF, I was told there were none.

Many of you who probably have children or plan to have children, just think for a moment, what would your life be like if your son or daughter was not in it? What would your life be like if you and your partner found out you could not have a biological child? Dealing with infertility is extremely emotional, invasive, uncertain, disappointing, prolonged, stressful and very time consuming with endless trips to the doctors for daily blood work and ultrasounds, to ADD the additional stress of FINANCES, is just not fair. I have friends in Massachusetts going through infertility and IVF and they can not even imagine the idea of going through the stress of taking out a second mortgage or cashing in their 401K plans to pay for what is medically necessary to have a baby.

Please consider seriously what we are all saying here today. I think this bill is long overdue, I think if the CEO of Anthem or HealthNet or any other insurance company was dealing with infertility, they wouldn't think twice about adding this coverage to policies. Think about if your son or daughter had infertility problems and could not have given you your grandson or granddaughter. How do you put a price tag on a priceless gift?

Please support S.B. 508.

Respectfully Submitted,

Michele Mudrick
79 Laurel Trail
Glastonbury, CT 06033

000845

February 17, 2005

The Honorable Senator Joseph J. Crisco, Co-Chair
The Honorable Representative Brian O'Connor, Co-Chair
Honorable Members of the Insurance & Real Estate Committee

Re: S.B. 508: An Act Requiring Health Insurance Benefits for the Diagnosis and Treatment of Infertility

Senator Crisco, Representative O'Connor and Members of the Insurance & Real Estate Committee:

My name is Jennifer Kanios. My husband Jim and I live in Windsor, CT. As Jim and I look to soon celebrate our tenth wedding anniversary, I am writing to ask for your support and stewardship of SB 508. Jim began his career as a Correction Officer for the State Department of Corrections in December 1995. I also work full-time, however in the private sector for a small law firm. We know first-hand the impact that the disease of infertility has on those experiencing it as we continue to face obstacles in our attempts to build a family. We also have many friends who have endured the highs and lows of infertility.

As a result of our own parenthood pursuit over the past four years, we have been diagnosed with both male and female factors and have pursued just about every treatment available to us. Due to my primary diagnosis of polycystic ovarian syndrome (PCOS), we have attempted fully monitored cycles of Clomid as well as 8 different injectable medications, with each of these medications combined with intrauterine inseminations (IUIs). Additionally this past October we experienced our first in vitro fertilization (IVF) cycle which was ultimately unsuccessful.

If not for our present unlimited insurance coverage through the State's Anthem Blue Cross and Blue Shield PPO, we estimate our out-of-pocket expenses from 2001 through today would be in the \$30,000 range. Our bi-weekly medical insurance premium deducted every other week from Jim's State paycheck is currently \$144.22. We both consider this money very well spent. Our medical expense co-pays since 2001 have been approximately \$3,300. Please find attached a copy of Anthem's most recent letter concerning our infertility coverage which states that this plan has 100% coverage for our in-network providers minus a \$20 co-payment for each visit to our reproductive endocrinologist as well as \$200 co-payments for any infertility surgical procedures. Please also note that our prescriptions are coverable with an unlimited maximum per calendar year.

For the sake of today's discussion, my husband and I are obviously not here to request reasonable infertility coverage for ourselves. We already have the ultimate best in insurance coverage, and as our Anthem Evidence of Coverage plan language reminds us, we currently have Unlimited Lifetime Maximum Benefits. We are here, however, on behalf of those individuals who do not have the coverage we enjoy. We are asking that you think about those individuals.

Not everyone diagnosed with infertility will require the extreme need for IVF treatment. Most infertility sufferers are able to achieve a healthy pregnancy using the lower spectrum of the assisted reproductive technologies (ART) from Clomid to injectable medications all combined with IUIs. I am here asking for your help, to encourage the insurance companies to develop some form of infertility coverage which could be made available at a reasonable cost to the estimated 70,000 Connecticut residents ages 18-45 suffering from infertility.

I am submitting this testimony on behalf of those individuals who do not even know that they are infertile: men and women who have no idea that they will not be able to have a biological child without medical assistance. To experience the emotional blow of finding out you

000846

have a disease is one thing, but to then learn that your disease is excluded or has unbelievably low annual limits in insurance coverage is unfair. In 2001, the State of New Jersey was able to determine reasonable limits in infertility coverage with certain restrictions, specifically covering up to 4 IVF cycles. My sincere hope is that the State of Connecticut will join the other mandate to cover states and shed its mandate to offer status. I also hope that you will encourage Connecticut insurers to re-evaluate the procedures that they recognize as appropriate treatment for this disease.

Another area of concern when discussing infertility involves twins and larger order multiple births. From our own experience, our doctors have carefully explained the risks associated with multiple births and we have had several ART cycles canceled because our own multiples risk was higher than anticipated. We feel strongly that all Connecticut couples should be free to make the same medical decisions we have been afforded when pursuing their treatment, as opposed to weighing only the financial concerns.

My husband and I are well aware that our family building options include adoption, foster care or to choose to be childfree. The costs associated with adoption are at present out of reach for us, and we frankly wish to pursue all of our possibilities that are covered by our insurance.

We are in the middle of our second IVF attempt, which again, we would never have dreamed of pursuing if not for our current Anthem coverage. We do not understand why all couples do not have access to this or similar reasonable coverage. We find ourselves as exceptions to the norm, where our friends and others who have experienced infertility have exhausted all options after completely tapping out their insurance and/or all of their financial resources. Simply put: Infertile couples pay the same insurance premiums as fertile couples, but are not able to access needed care. Most diseases and medical conditions are covered by insurance. The disease of infertility is often singled out for exclusion and we find this to be discriminatory.

We are here to speak on behalf of a silent minority: individuals currently or recently in treatment, those on the roller coaster ride of their lives, experiencing the emotional highs and lows of hoping cycle after cycle that they will achieve their dream: a child.

We are bombarded almost endlessly, through the media, living our daily lives, with visions of babies, children and happy families. We speak on behalf of your constituents, your family members, your friends, and all Connecticut residents who silently live with this disease. Please support SB 508 and kindly join us on our roller coaster.

Thank you for your time and consideration.

Respectfully Submitted,

Jennifer Kanios
1139 Matianuck Avenue
Windsor, Connecticut
W: 860-241-7700 x237

Attachment:

Anthem Blue Cross & Blue Shield letter dated February 10, 2005

Anthem Blue Cross and Blue Shield
370 Bassett Road
North Haven, Connecticut 06473-4201
Tel 203-239-4911

000847

February 10, 2005

Jennifer Kanios
1139 Matianuck Avenue
Windsor, CT 06095-3213

Anthem 

HB508

Re: Infertility

Dear Mrs. Kanios:

Thank you for contacting Anthem Blue Cross and Blue Shield regarding coverage for infertility services. According to the terms of your State Preferred health benefit plan in network infertility services are coverable at 100% of the reasonable and customary amount minus a co-payment of \$20 for each visit. A \$200 co-payment applies for all infertility surgical procedures.

If services are rendered with a non-participating provider an individual per calendar year deductible of \$300 applies. Claims reimburse 80% of the reasonable and customary amounts. The member will be responsible for the deductible, 20% cost share and the difference between the charge and the allowance.

Your State Preferred health plan excludes coverage for:

- (1) Sperm and donor related services including but not limited to, the procurement, storage/banking or purchase.
- (2) All services related to surrogate parenting
- (3) Cryopreservation of the sperm or the embryo
- (4) Gamete, Zygote or Intrafallopian Transfer (G.I.F.T., Z.I.F.T)

Prescriptions coverable under your plan are:

- | | |
|----------------------------|-------------------|
| (1) Pergonal | (10) Progesterone |
| (2) Metrodin | (11) Humegon |
| (3) Profasi | (12) Reponex |
| (4) Clomid | (13) Fertinex |
| (5) Serophene | |
| (6) Pergnyl | |
| (7) Chorionic Gonadotropin | |
| (8) Clomiphene Citrate | |
| (9) Lupron Kit | |

Prescriptions are coverable through a participating retail pharmacy minus the applicable copayment with an unlimited maximum per calendar year. This letter does not act as a guarantee or authorization for any services rendered. Coverable services are dependent on member eligibility along with any policy changes set forth by the employer. As always, all claims are subject to the terms, limitations and conditions of your health benefit plan. We hope this information is helpful. If you have any additional questions please contact customer service at (800) 922-2232.

Sincerely,

Member Services
Anthem Blue Cross and Blue Shield

000848

February 17, 2005

Dear Committee Members:

I regret I cannot be in person to give my testimony but I am currently dealing with the loss of my Mother and find that writing this testimony will hopefully help the effort to pass this bill. As a constituent and a person who has suffered from infertility, I would like to ask for your support of SB 508, "An Act Concerning Health Insurance Benefits For the Diagnosis and Treatment of Infertility". I have been dealing with infertility since I was 25 - when my first husband and I tried to have a family and the main reason my first marriage ended in divorce. Since then, I have had 3 miscarriages and my current husband and I have our miracle child that is so special to both of us and we are due to have a little boy around Mid May of this year. As one who has faced what seems to be significant obstacles to build a much-wanted family, including a lack of insurance coverage (and also a lack of proper coverage), I know first-hand the impact that the disease can have on those experiencing it.

Infertility is a medically recognized disease. As various studies point out, some limits can be placed on coverage, but the limits should be consistent with the goal of helping couples with their medical concerns as they take effective steps to overcome their infertility. By including infertility insurance coverage in a health plan (making sure that the coverage is reasonable and not an amount that may not even cover one cycle of treatment), medical concerns can be effectively managed and costs can be contained. Unless patients are directly referred to infertility physicians, unnecessary tests and more expensive invasive procedures may be implemented, ultimately resulting in increased costs for the insurer. The ruling by the Supreme Court supports the need for infertility insurance coverage so that those with infertility are not unfairly discriminated against when denied coverage for this disease while most other diseases are covered.

In the study, "**Infertility as a Covered Benefit**," data is presented which makes clear the cost effectiveness of providing infertility insurance coverage. Without coverage, including coverage of in vitro fertilization, patients are often forced to access repetitive procedures or invasive surgery simply because these options are covered. Well-managed insurance coverage will not place a large burden on insurance companies. Studies have shown that coverage adds just a few dollars per year to an insurance premium. Most Infertile couples pay the same premiums as fertile couples, but are not able to access needed care. Most diseases and medical conditions are covered by insurance. The disease of infertility is often singled out for exclusion and that is discriminatory.

Insurers argue that bearing children is a lifestyle choice. In fact it is. But people do not choose to have a disease that prevents them from having the option to bear children. Insurers raise concerns about some treatments and the possibility of multiple births and the associated costs. Reproductive doctors are careful to help couples minimize the risks associated with multiple births. A study published in the *New England Journal of Medicine* (Aug 29, 2002) concludes that the incidence of multiple births is actually lower in states that have enacted an infertility insurance requirement than in states without coverage. Why? Because couples with insurance coverage are free to make purely medical decisions when pursuing some infertility treatments, as opposed to other couples who must also weigh financial considerations that often result in medical risk taking.

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In 1998, the United States Supreme Court ruled that reproduction is a major life activity under the "Americans with Disabilities Act." This ruling demonstrates the importance of reproduction and the impact that infertility, in which the ability to reproduce is impaired, has on the lives of men and women.

I've also been reading the testimony that Anthem Blue Cross Blue Shield has presented with regard to opposing this legislation. You don't have to be a rocket scientist to see that Massachusetts which has a mandate similar to what is being proposed here, don't you think more couples would move to Massachusetts for the hope of having a child? Maybe if more states had these mandates, people would not have to uproot themselves to have families as their friends and relatives do. It is funny to me that the Anthem testimony also tries to pull the heartstrings of all of you by using the fact that there is a deficit and how that would affect State employees (as if there aren't any other participants that it would affect in this way). Are they thinking that every single member is going to use the infertility benefit? Are they thinking that there might be a medical condition that may be causing infertility but because they are female or male problems, they get grouped under the infertility category reducing the amount that could be available to even go through and IVF procedure? Do they mention that there are couples who would benefit more from using IVF than any other procedure? I'm not naïve. I know having an unlimited benefit would be expensive but the benefit HAS to allow a couple the opportunity to TRY what is available. A couple shouldn't have to worry if there is any benefit left in their plan as the woman is under anesthesia for the doctors to retrieve as many eggs as possible to hopefully result in the birth of a healthy child. It amazes me that CBIA and Anthem Blue Cross Blue Shield are against this bill. For my husband and I, we HAD to try to have a baby last year because I knew my company was going to change the coverage for infertility. So many women (including myself) put having a family on hold for careers thinking we had so much time to have children when we really didn't. If I would have known what I know now, I would have started trying to have children in my 20s and I probably would have wound up getting on some type of assistance to care for however many children I decided to have. I guess these companies feel as long as the Government is burdened with young mothers having kids then they won't have to pay anything.

Many affected by infertility do not feel comfortable speaking publicly about this very private struggle, but infertility knows nothing about a person's race, religion, or ethnic group, as well as both sexes. Couples dealing with infertility just want to experience the joy of raising a family, an experience that so many fertile couples take for granted.

Thank you for your consideration. I hope that you will support HB 5206.

Sincerely yours,
Valerie D. Thaxter-Grant
4 Stillman Road
Wethersfield, CT 06109

000850

**TESTIMONY OF JULIE K. LUCIA
80 BIRD ROAD, NAUGATUCK, CT 06770
203-723-1104 HOME; 860-945-6600 WORK**

Honorable Co-Chairs and Members of the Insurance Committee, I first want to express my thanks to Senator Crisco for proposing several infertility bills and to all you past and future supporters of SB 508.

I have been involved with infertility treatment for the past seven years. It has definitely been an emotional roller coaster, not to mention a very trying and draining experience. I was diagnosed with "unexplained infertility". Many tests and procedures were performed on me the last several years. Luckily it all revealed that both my husband and I are able to conceive but for some unknown reason it has not yet occurred.

My husband and I have lived in Connecticut all our lives and both worked since we were 16 years old. I presently work for a small law firm in Watertown and have health insurance through Connecticare. Unfortunately, my insurance only covers a maximum of \$1,500.00 per year for infertility coverage. However, one month of an injectable medication for insemination is well over \$1,500.00. The cost of in vitro fertilization is approximately \$13,000.00. This is surely a financial burden for any couple needing the above treatment with the minimal insurance coverage that is presently offered.

In fact, my employer was extremely kind and offered to purchase an infertility plan for me, however the insurance company did not offer this coverage to a small group of employees. The only plan that was offered had too many restrictions, i.e. maximum benefit of \$5,000.00 payable at 50%. That is surely an injustice. Why should I be penalized for not working for a large company? If the insurance industry affords this coverage for larger corporations, then it should also be offered to small businesses or individual policies as well.

There are presently 12 other states that require the insurance industry to cover infertility procedures and I strongly feel that Connecticut should incorporate the same. I do not want to have to leave our fine state to have this coverage elsewhere.

My physician at UCONN has recommended that I have in vitro fertilization, as there is more of a success rate than the 7 previous procedures/inseminations that have failed for me. I have cried after each and every negative result. It has been disappointment after disappointment for both my husband and me as well as our friends and family who supported us all along. Since I will be 37 this summer, I am afraid the longer I wait, the less chance I will have of conceiving our own child.

My husband and I want nothing more than to have a family of our own and for my parents to have a grandchild in this State. Their only grandchild presently lives in the State of Florida. It would appear that my best chance of conceiving is through the assistance of our modern technology of in vitro fertilization. I want nothing more than to add to the 5th generation of our family.

I therefore respectfully request your support for SB 508. Thank you for your time and consideration.

000851

**TESTIMONY OF GERALD S. LUCIA, JR.
80 BIRD ROAD, NAUGATUCK, CT 06770
203-723-1104**

Honorable Co-Chairs and Members of the Insurance Committee, my name is Jerry Lucia and I am here today for your support on SB 508.

My wife, Julie, and I have been struggling with infertility for several years now. As a husband and best friend to her, it has been difficult for me to see my wife go through such pain and disappointment both physically and emotionally. It breaks my heart to see her cry after every negative result. The only thing I can do is to be there for her, hold her as she cries, and try to lift her spirits. At the same time, I need to hide how much it hurts me because I need to be strong for her. I have watched her go through countless tests, surgeries and procedures. Our health insurance does not cover advanced infertility treatments such as in vitro fertilization. Therefore, she has to undergo many inseminations that so far have failed each time. For the past several months, I had to give her injections into her stomach five days in a row each month. The hospital showed us how to do the injections and my wife had requested that I give them to her, as she was too afraid to do it to herself. However, I am not a healthcare professional and I do not like to see the bruises that the needles cause sometimes. I would like to ask each and every one of you to take a moment and think about how you would feel if you were going through a similar situation with a spouse or loved one. If any of you are, my heart goes out to you.

Unfortunately, our health insurance only covers \$1,500.00 a year for infertility treatment. In turn, we had to wait until the end of last year to start the injections. With this new calendar year, we have already maxed out these benefits and all future treatment will be at our own personal expense. Our physician at UCONN highly recommends in vitro for Julie and I given the high success rate it has. If our insurance company covered in vitro, my wife and I would not have to suffer each month and instead of being here today, we would most likely be raising our own son or daughter.

Believe me, I want nothing more than to be a father and experience the joy of a child I feel we so rightfully deserve. It pains me to hear some of my friends and family tell me what wonderful parents my wife and I would be. I would love to be able to give my mother and father-in-law another grandchild. The only grandchild they have lives in Florida. We live right around the corner from them. I know they would be devastated if we had to move out of state to get the insurance coverage not to mention my wife and I have lived in this State all our lives.

In closing, I want to thank all of you for your time and ask that you support SB 508.

000852

Testimony
Of
Adriana Manning

HB508

My name is Adriana Manning and I am here today to speak in support of SB508, **AN ACT CONCERNING HEALTH INSURANCE BENEFITS FOR THE DIAGNOSIS AND TREATMENT OF INFERTILITY**

The legislation before you is an important step for the state of Connecticut to take in recognizing the real issues presented by infertility. It is important for you to understand that infertility is a disease of the reproductive system that affects one in five couples at one time or another in their lives and should be treated as such by the insurance industry. Please note that infertility issues are very private for a majority of couples and individuals, and as a result you may not receive a ton of phone calls and letters supporting this issue, this issue nonetheless is an extremely important one.

Unfortunately, I am the one in five that it did affect. In order for this bill to seem more real and less of a money issue for the insurance industry I will share my story with you. In March of 2002 I testified before the Insurance and Real Estate Committee on behalf of a similar bill; I was just about to start my first In-Vitro Fertilization cycle, because of the limited amount of insurance coverage my husband and I had at that point in time, we had to choose the more aggressive treatment that would hopefully give us a more favorable outcome. My insurance company Blue Cross and Blue Shield limited infertility coverage to a lifetime maximum of \$5,000.00; we took out a loan to pay for the balance of the treatment and medication. While sitting with finance department at the Doctors office, I found out many things about my coverage, one was that it was considered generous and that I was lucky to have even that. And then while waiting for blood work to be done, I had a conversation with a lady that worked for the State of Connecticut and found out that she had full coverage for infertility treatment. But yet the majority of the general public had none. My cycle gave us 5 viable embryos out of 9; we implanted 2 and froze the remaining 3 for future use. That cycle did not work. We were devastated to say the least. We saved up the money for a Frozen Embryo Transfer and tried again in August, out of the 3 embryos only 2 made it through the thaw and of the 2 only one looked good, but it worked! I am now the very proud mother of a very healthy 22 month old boy. Three years later the lingering memories of going through that all of that are still in my mind but the ones that still sting are the financial ones, the shots, the blood work, the invasive ultrasounds, the whole roller coaster ride seems bearable something that I can handle again. The concern on how to pay for medical treatment that should be paid for by the insurance industry through our premiums is the worse feeling, the unfairness of it all is very degrading. The ironic part of my story is that thanks to New Jersey passing their infertility insurance coverage, I now have coverage for future treatment up to a lifetime maximum of 25K. My husband's company is based in NJ the insurance coverage is based there too, which is a great thing considering I have maxed out my insurance coverage for future fertility treatments.

SB508 will help to correct this situation. With this legislation, Connecticut would join states like Massachusetts, New York, New Jersey and Rhode Island where coverage for the diagnosis and treatment of infertility is already mandated. Obviously the costs cannot be so significant to insurers if our neighboring states have recognized the significance of this issue and required its coverage.

Presently, the out of pocket costs associated with the diagnosis and treatment of infertility make it impossible for many to access the very services that would most likely enable them to have a child. For those individuals that have the financial resources this is less of an issue. The question becomes whether or not it is fair to allow only those that have the financial resources to access treatment? Having a baby is one of life's most important decisions and that decision should be made by the couple not the insurance industry. Without this legislation infertile couples unable to pay will be prevented from taking advantage of the great strides made in medical treatments available today.

I am happy to live and work in Connecticut, but often wonder why our own neighbors have recognized the importance of ensuring that their residents have access to essential medical treatments while we have not. This is an important and emotional issue for many people in this state and we are all looking to this committee to do the right thing and support SB508. Thank you for your consideration.

000853

Chairman Crisco
Chairman O'Connor
Members of the Insurance and Real Estate Committee

Hi, my name is Erica Marcinczyk ("Mar-sin-zik") from Seymour, Connecticut and I am addressing you today in full support of Senate Bill 508.

Last year, I was diagnosed with infertility stemming from a medical ailment called Poly Cystic Ovarian Syndrome (PCOS). Although, this disease can lead to diabetes and heart disease, it also causes infertility. Because PCOS causes infertility, my health insurance covers only a small portion of the high costs for treating the disease to help my husband and me conceive a child. It definitely DOES NOT cover In-Vitro Fertilization, which would be the most cost effective and offer the highest probability of success. It is also the healthiest and safest mode of treatment for myself, as well as significantly decrease the chance of multiples births. In the long term this would help keep health care costs down by avoiding secondary problems of treating premature infants and caring for the mother going through a high risk pregnancy with multiples. This treatment is unfortunately very difficult for me to attain, as its costs are great. I have already met dozens of women who are in similar situations and more women who are in worse situations than my husband and me. On behalf of ALL the infertile citizens of Connecticut, I am asking you, URGING you, to PLEASE STRONGLY support Senate Bill 508 and help allow us to obtain the medical treatment we so rightfully deserve!

Respectively,
Erica Marcinczyk
2 Charles Road
Seymour, CT 06483

000854

February 17, 2005

Senator Joseph Crisco
Representative Brian O'Connor
Distinguished Members of the Insurance & Real Estate Committee

Re: SB 508

Senator Crisco, Representative O'Connor and Members of the Insurance & Real Estate Committee

I am one of the many faces of infertility! And I will stay that way unless I can count on you to support SB 508. It breaks my heart to say that, but it is the truth. Last year around this time my doctor told my husband Mark and I that the best chance for us to get pregnant was to go with egg donation. The reason; is that at the age of 29 I was diagnosed with disease of premature ovarian failure...what is that? Menopause! I do not think that my face is the face that you would connect with menopause.

Now let me turn back the hands of time. Mark and I met 15 years ago, when I was 14 years old. After a 2-year friendship we became a couple. For many, this relationship might have resulted in a teenage pregnancy, but we wanted more for ourselves and both attended college and married shortly after graduation. We made the conscious effort not to have children immediately, so that we could build a strong and lasting marriage. We had great pride in knowing that we had worked hard and done things right.

Three years ago, Mark and I decided that our relationship was strong enough to nurture a family and so our quest to become pregnant began. We were told by my physician that because of our young age that we need to try and become pregnant on our own for a year and if it didn't happen by then to speak with her again. Well as you can imagine it did not happen for us and after 6 more months of painful testing we still did not have many answers and were still not pregnant. It was at that point Mark and I realized that we were going to have a rough road ahead.

On to the fertility specialists and the long nights of trying to decipher our insurance policies to see what coverage we actually had. I never realized that every doctor's visit also included sitting with a financial counselor. The first thing I needed to start any infertility procedure was a "0" balance on my account. Realizing that we were so limited on our insurance coverage I spent many hours searching the Internet for the most inexpensive way to get my medication. I soon realized that you either had to be independently wealthy or have insurance coverage that was good enough to pursue anything but the simplest procedures.

For over a year Mark stayed in a job that made him miserable so that we could keep the insurance coverage he had. Our monthly premium was \$300.00 and our coverage was a 50/50 split. Meaning if the insurance company was out \$5000.00 we were also out \$5000.00. Giving Mark and I a grand total of \$8,600.00 for the year and no more

000855

coverage. We had hit our lifetime maximum within a few procedures. Looking back I realize that the only thing that the insurance coverage gave us was access to their negotiated rates. I can honestly say that I am jealous of those who have 100% infertility coverage because I know that they will be able to pursue their dreams of having a family.

Recently Mark and I became a licensed adoptive family through the Department of Children and Families mainly because we have depleted our finances due to my infertility and we can no longer afford private adoption. There has to be a more balanced approach with the issue of infertility. At 30 years old I never thought that I would be facing a childless life because I did not have the means to attain my greatest desire, biological children. Please help us, and the rest of the population, that desperately want to have or try to have a child(ren) of their own. This strong desire to build a family gives Mark and I the strength to face these obstacles, but we also need your support. PLEASE, support SB 508!

Respectfully Submitted,

Monica & Mark Grabowy
435 Hart Street
Bristol, CT 06010

000856

February 17, 2005

The Honorable Senator Joseph Crisco, Co-Chair
The Honorable Representative Brian O'Connor, Co-Chair
Honorable Members of the Insurance and Real Estate Committee

Re: S.B. No. 508: An Act Concerning Health Insurance Benefits for the
Diagnosis and Treatment of Infertility.

Senator Crisco, Representative O'Connor and Members of the Insurance and Real Estate
Committee:

My name is James Kanios and I am writing to ask for your support of SB 508. Today you will hear and read a lot of testimony about this bill. The insurance companies and other opponents will tell you how much it will cost to offer this coverage, but what they will not tell you is how much a family spends without it.

Since our own infertility diagnosis in 2001, my wife and I have learned that we are among the lucky few in Connecticut. Due to my job as a Correction Officer we have, as Anthem Blue Cross's customer service representatives remind us whenever we call to check our coverage, the "Cadillac of coverage offered to State employees and their families." Currently \$144.22 is deducted from my State paycheck every two weeks, which brings our total to \$3,749.72 for this fiscal year of excellent insurance coverage. Since 2001 our co-pays for doctor visits, procedures and medications have totaled \$3,300 while all diagnostic testing have been fully covered by Anthem.

Before a couple gets married, should they have to ask each other if they can have children? I would hope not. As an uncle of 11 nieces and nephews plus many friends whose children call me "Uncle Jim," we could not wait to have a child and start our own family. When I first met my wife, I did not ask her if she was fertile. I married her because I loved her then as I do to this day. Is this disease going to ruin our marriage? I think not, but I do think about all of the marriages this disease has destroyed and will destroy.

We live in the best country in the world. It is a shame that in the State of Connecticut, individuals cannot get insurance coverage for infertility because the insurance companies and business associations say it costs too much to offer.

Do you feel a couple should take out a second and possibly third mortgage on their home, borrow money from friends and family or go so far into debt just to have a family? Connecticut residents are spending from \$13,000 plus per IVF cycle trying to have a family because they have the disease of infertility. Sometimes IVF works on the first try, and sometimes IVF fails altogether. From my understanding, only 2 to 5% of those diagnosed with infertility ever need to even consider IVF. The majority of people seeking treatment usually achieve a successful pregnancy with medications plus artificial insemination. I am here today to expand your view of the full picture of infertility.

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The peace of mind my wife and I have because of our insurance coverage is priceless. We have been able to make informed medical decisions based not on how much money we have but on our doctors' expertise and advice as well as our own instincts. My wife and I feel strongly that all Connecticut individuals should be free to pursue their infertility treatments with that same peace of mind, to be able to focus on their health care. Thank you for your consideration of this important issue. Again, I ask you to support SB 508.

Respectfully Submitted,

James Kanios
1139 Matianuck Avenue
Windsor, Connecticut

000858

My name is Margi Goode. I'm a resident of East Haven, Connecticut. I am the mother of a beautiful little boy who will turn 2 years old this month. I am testifying today in favor of Senate Bill 508, "An Act Concerning Health Insurance Benefits for the Diagnosis and Treatment of Infertility."

My husband and I began trying to conceive in 1999. I was 29 years old and we had no reason to believe we'd have any problems conceiving, so we weren't terribly worried when it didn't happen immediately. But the months of trying began to stretch out, and I still wasn't getting pregnant. And the worrying and wondering if something were wrong started. After about 18 months of trying with no success, my obstetrician referred me to a Reproductive Endocrinologist at the University of Connecticut. Still, we were young and healthy, and figured that soon we'd have the baby we wanted so desperately.

My doctor started with a huge assortment of tests to find out what was wrong. I underwent several different surgical procedures – most of which were covered by insurance. We began using fertility medications, none of which were covered by insurance. The first few months weren't terribly expensive. I was taking Clomid, which cost roughly \$60.00 per cycle. It's amazing how many couples get pregnant with Clomid alone. It didn't work for us. After 2 cycles of Clomid, my doctor recommended we try Clomid along with Artificial Insemination. Now each cycle was costing roughly \$500.00 out of pocket. We tried a few cycles of that, still with no success. Next we moved on to injectable fertility medications, such as Gonal-F, combined with Artificial Insemination. Now we were paying roughly \$4000.00 out-of-pocket for every cycle, and still I wasn't able to conceive.

At this point, we were running out of options, and out of money. We couldn't afford to continue paying thousands of dollars per month for treatment that wasn't working, and we definitely couldn't afford the cost of in-vitro fertilization, which was the next step of treatment. We were losing hope. We couldn't afford the cost of adoption, nor could we afford the cost of further infertility treatment. We actually considered the possibility of moving to a different state – one with required infertility coverage. We also researched national companies that offer insurance benefits packages that include infertility treatment.

Just as we were at the end of our ropes – both financially and emotionally – a company based in Massachusetts purchased the company my husband worked for. Our health insurance benefits changed – to a company based in Massachusetts. The legislature in Massachusetts, as you probably are aware, has required the disease of infertility to be covered by insurance. We felt as if we'd won the lottery – and in a way, we had.

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With our new insurance coverage, we were able to continue our medical treatment. I did my first round of IVF in April 2002 – and it failed. I was absolutely devastated and ready to stop trying. We decided to give it one more try, and did a second round of IVF in June 2002 – and I conceived the miracle we had waited so long for.

There aren't enough words to explain the tremendous amount of joy that my little boy has brought into our lives. I thank God, the doctors at UCONN, the Massachusetts Legislature and the insurance coverage that made him possible each and every day for bringing him to me. My son would not exist today if we hadn't been lucky enough to get health insurance through a Massachusetts based company; we simply could not have afforded to continue paying for the treatment that I needed to conceive him.

My family is complete, and I won't be pursuing fertility treatment again in the future, so whether or not we ever get mandated infertility coverage here in Connecticut is a moot point for me. However, I know firsthand how completely devastating, how consuming, how emotionally and financially draining infertility treatment can be, and I'd love to see others here in Connecticut be able to realize their dreams of building a family without bankrupting themselves in order to do so.

I urge your support for Senate Bill 508.

Margi Goode
47 Victor Street
East Haven, CT 06512
(203) 410-8308

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My name is Kim Griswold, and I am a resident of Suffield, Connecticut. I would like to present written testimony about why health insurance coverage of infertility treatments is important to the residents of Connecticut. My husband and I do not have coverage for infertility treatments. We both have great jobs that we love, own our home, and have 2 dogs and 2 cats.

I was severely injured in a skiing accident in 1994 at age 30, and had to delay childbearing for about 8 years, while my liver fully recovered from the trauma. During that time, my 6-inch round hematoma reabsorbed leaving a "thing" the size of a grape. Doctors were fairly convinced I had an adenoma and worked hard to rule it out. An adenoma is a pre-cancerous lesion that must be removed before attempting pregnancy. However, no test (multiple MRIs, CT scans, ultrasounds, bloodwork) provided conclusive evidence of the lesion left behind in my liver. The best test was "time" to see if the lesion grew, because the position of the "lesion" was near a part of my liver where I could easily bleed out and surgery would be very risky. It shrank instead. Finally, doctors concluded with 99% certainty in late 2001, that I had scar tissue, and it would be safe to attempt pregnancy.

My husband and I started trying to conceive. In February 2003, my husband was shipped to the Middle East to serve in Iraqi Freedom. After his return, and in September 2003, I went to see a Reproductive Endocrinologist fearing that my time was running out. Well, it was beginning to run out. I found out that I have early onset of diminished ovarian reserve. The doctor recommended immediately going to IVF, because my laboratory results indicated that I might have a window where IVF could help.

However, we also found out that we do not have health insurance coverage for Assisted Reproductive Technologies (ART). One IVF cycle would cost about \$10,000. My doctor also recommended that we use a type of medication that consists of FSH (a newer gonadotropin manufactured from recombinant DNA technology) only, but this medication would cost us about \$4,000.00 out of pocket. However, she said if money was an issue we could do an Intra-uterine insemination (IUI), which would cost us only around \$400.00 for the procedure, but the odds of success would be much less. We could also use a much cheaper medication consisting of FSH and LH derived from the urine of post-menopausal women. She cautioned us that the LH was not ideal for my medical situation, but cost-wise would cost about half as much.

Instead of doing IVF with a recombinant DNA form of FSH, the ideal therapy, we felt that due to the cost, we had to choose the IUI with the FSH and LH derived from the urine of post-menopausal women. While I did produce eggs, the protocol failed to support a pregnancy because as predicted by the doctor, the medications caused other problems associated with my condition. Due to the side effects from the sub-optimal medications, I experienced a massive migraine and other side effects, which prevented me from going to work for 3 days.

I changed health insurance coverage, and found the best coverage through my employer covered some medications, but still none of the ART procedures. However, I had to wait

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Written Testimony by Kim Griswold
February 17, 2005

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2 months without any treatment, because the new health coverage was not effective until January 2004. My doctor reminded me that time was critical, because I would turn 40 years old on February 19, 2004. In January 2003, we started a different protocol using more medically appropriate medications. However, an IUI will still not increase my chances of successful pregnancy much over "relations," but it was all we could afford. The results came back negative for pregnancy. Against the doctor's recommendations, we tried one more IUI, but I ended up with an 8 cm ovarian cyst and no pregnancy.

My husband and I realized we were faced with a dilemma. If I lived in Massachusetts, my doctor (who practices in Massachusetts) opined that I would have been covered for about 3 IVF procedures when I first presented to her Office, because I had a good window of opportunity. But that window was quickly closing and my husband and I have limited funds for infertility treatments or adoption. We had to choose between IVF (\$10,000.00 per cycle and 10-20% chance of pregnancy), donor egg IVF (\$20,000-\$25,000 plus donor fees per donor egg retrieval with the opportunity for more than one transfer with embryo freezing and about 50% chance of pregnancy per egg transfer) and adoption (\$15,000 to \$35,000).

It was a terrible decision. The doctors encouraged me to try IVF with my own eggs, but all agreed that considering our financial issues, donor egg was a reasonable option due to the very high odds. We made our decision based heavily on finances, not medical advice. My husband said he would support me in whatever I felt I needed to do...IVF, donor egg IVF or adoption. My husband said that it was only important to have a family with me, no matter how we got there. It was at that point I realized that I needed our child more than I needed a child with my genetic information.

We chose to use donor egg IVF and began our incredible journey to parenthood. Not including the donor fees, the medical cost was about \$21,000. We were fortunate to have donated medications, which saved us about \$3,000. The total cost with donor fees was \$29,000. We were fortunate we could take out a second mortgage, deplete our \$6,000 savings, and max out my credit card. We knew we could do this once, but we couldn't risk 7 IVFs like Brooke Shields. We couldn't even risk 3 failed IVFs. Had there been mandated insurance for the medical portion of the procedure, the negotiated costs would have been significantly less. Our reproductive endocrinologists are in Massachusetts, and I've seen the negotiated costs and compared them to what my husband and I paid. The difference is significant. Regardless, our decision to try donor egg IVF paid off and I am now 8 months pregnant with our son. We feel incredibly fortunate that our choice resulted in this pregnancy with our son.

Do I regret choosing donor egg IVF? No, I'm grateful for the doctors who helped us, because we will soon have our son in our arms. What I regret are the painful decisions and procedures that we endured as a couple. I regret the painful shock and disbelief that treatment for my medical condition was not covered by my insurance, when I believed that we had good insurance. I regret that we endured those treatments, not because they

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Written Testimony by Kim Griswold
February 17, 2005

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were medically appropriate treatments, but because it was all we could afford based on our insurance.

What I've learned is that, in reality, these infertility treatments and Assisted Reproductive Technologies are only available to the very rich. For example, Brook Shields underwent 7 IVF procedures (\$70,000) before her one successful pregnancy. If insurance coverage of infertility treatments was mandated in Connecticut, the risk would be shared, better prices could be negotiated with the stronger buying power of insurance companies, and the additional cost for each insurance policy would be minimal. But more importantly, doctors could make decisions about the best treatments and medications for their infertility patients based on their medical expertise and knowledge, and not on how much money the patient can cough up. Less time would be lost from work, because infertility treatments would be optimized for each patient. I completed three cycles using sub-optimal medications with no successful pregnancy and a large ovarian cyst, not to mention the emotional distress and depression. I do not know the long term cost to my overall well-being due to the substandard treatments. We chose donor egg IVF, not based on medical advice, but based the odds of success for the money. We were fortunate to have the resources to find the money for the infertility procedures.

Regardless of the cost, the drive to have children is a fundamental human right. Infertility is a disease that affects a major life function—procreation, and affects couples from all walks of life. Having children is a privilege that should not be granted based on wealth.

Thank you for your consideration of my testimony.

Sincerely,

Kim and Keith Griswold
1275 North Street
Suffield, Connecticut 06078

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Quality is Our Bottom Line

Connecticut Association of Health Plans

**Testimony in Opposition to Proposed Bill 508
AAC Health Insurance Benefits for the Diagnosis and Treatment of Infertility.**

**Insurance Committee Public Hearing
Thursday, February 17, 2005**

The Connecticut Association of Health Plans urges the Committee's rejection of Proposed Bill 508 AAC Health Insurance Benefits for the Diagnosis and Treatment of Infertility. Mandates of this nature add significant pressure to an already overburdened health care delivery system. Connecticut has over 40 mandates currently on the books. Each one is laudable in its intent, however, taken together there is no doubt that these mandates have driven up the cost of health insurance and have exacerbated the accessibility and affordability crisis we now face. Some studies have shown that nationwide for every 1% increase in premium, 300,000 people lose coverage. Consider that a Milliman & Robertson analysis of a similar proposal concluded that an infertility mandate of this type would increase premiums from 3% to 5%.

Given the wide spectrum of infertility treatments and options available, the high cost of associated prenatal care and the high cost often associated with births after infertility treatment, passage of this mandate will be among the most expensive in the state's history. Small employers will bear the brunt of these costs since most large employers generally self-insure their employees and are therefore not subject mandates of this nature. These are the same small employers that the legislature is currently struggling to assist in providing health care coverage.

Several states have considered similar infertility mandates and recommended against their passage. Two such states have independent mandate review commissions that undertake in-depth cost/benefit analysis of proposed mandates. The State of Washington found the following with respect to a proposed infertility mandate: "Increased utilization can increase the cost of insurance coverage. While savings could be assumed for psychological and productivity costs, it is not measurable. Additional costs for multiple births resulting from infertility treatment need to be considered. Overall, coverage will result in additional insurance premiums which would be borne by all plan members without offsetting benefits." The Pennsylvania Health Care Cost Containment Council which undertook a similar review stated that, "While this issue is emotionally compelling, we were unable to find needed proof in the review of the bill that

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comprehensive coverage of infertility services would be cost effective.....Infertility treatments are costly and have a relatively low rate of success in comparison to treatments for many medical conditions.”

The Connecticut Association of Health Plans concurs with the findings of these reviews and respectfully cautions the legislature against moving in this direction by passing PB 508. Thank you for your consideration.

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February 17, 2005

SB508

You may wonder why I am here. I am with my daughter Monica. Infertility didn't affect me, or has it!

I've been witness to the fall out of infertility. Infertility doesn't have a singular victim. I've dried tears, and watched my daughter wither under the weight of self loathing because she can not give her husband a child. Slowly, I've watched their friends evaporate because they have moved onto birthday parties and play dates. I've heard the whispers in my ears, the apologies, and from those who are rude enough questions about the latest failed attempts.

I've prayed, said novenas, lit candles, encouraged, cried, been optimistic, and have ridden this tortuous rollercoaster every month with my daughter and her husband. I've even gone so far as to take classes with Monica and Mark from DCF hoping that there might be a possibility of babysitting a foster child...but still no baby.

The disease of infertility has a wave of victims. This disease is costing some insurance company somewhere. Multiply those 40,000 infertile couples times four. Those parents of the infertile who are older and less resistant to stress. Rising blood pressures, severe changes in diabetes because of stress eating, repeat visits to the doctor, that is what this problem has cost our insurance company.

I am begging you to step up to the plate and do the right thing. I'm here as living proof of the hidden cost of the disease of infertility. We, as parents of infertile couples, pay a price also. They don't live in a bubble. This problem deserves full coverage. It is not more or less important than erectile dysfunction.

In closing, I am Anita Lipski, from Bristol, a wanna be Grandma.

Respectfully submitted,

Anita Lipski
6 Aldbourne Drive
Bristol, CT 06010

000866



State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE MELISSA OLSON
FORTY SIXTH DISTRICT

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MEMBER
JUDICIARY COMMITTEE
GENERAL LAW COMMITTEE
LABOR PUBLIC EMPLOYEES COMMITTEE

February 17, 2005

Representative O'Connor, Senator Crisco and distinguished members of the Insurance and Real Estate Committee, I appear before you today in support of SB508, An Act Concerning Health Insurance Benefits for the Diagnosis and Treatment of Infertility.

For the record, I am State Representative Melissa Olson of the 46th District, representing the town of Norwich.

I think it is time that we have a frank discussion about infertility. Infertility is a disease. However, infertility can be treated effectively and economically.

In 1998, the U.S. Supreme Court held in *Bragdon v. Abbott*, 524 U.S. 624, that reproduction is a major life activity, therefore, a "substantial limitation" on reproduction is a qualifying condition under the American with Disability Act.

We acknowledged and recognized the need to treat the disease of infertility when, in 1989, this legislature required Connecticut health insurers to offer coverage for diagnosis and treatment, including in vitro fertilization (C.G.S. Section 38a-536). With

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the tremendous advancements in science and in our understanding of the disease, doctors can now provide highly effective and less costly medical care and treatment.

Most health insurance carriers already provide for infertility coverage through a "major medical benefit". This "major medical benefit" covers less effective treatments, for instance, surgeries to remove uterine fibroids or a man's varicose veins. Many times, these surgeries do not cure the disease of infertility or must be repeated. Not only is this costly but it unnecessarily exposes the patient to the risks inherent to surgery.

There is an established and effective continuum of care for treating infertility through assisted reproductive technology.

- Couples suffering from infertility are referred to doctors specializing in reproductive endocrinology. Repeated trips to doctors who do not have the expertise in treating infertility create unnecessary costs currently born by insurance carriers.
- Hormonal therapy or intrauterine insemination cure infertility in approximately 97% of all cases. In vitro fertilization is the cure in about 3% of all infertility cases. All of these treatments are more highly effective and less costly than the draconian surgeries already covered under major medical. For example, tubal surgery ranges from \$12,500 for women to \$6,500 for men and is generally covered although it has one of the lowest success rates and poses a greater risk of complications. We know that in vitro fertilization, the most expensive of the assisted reproductive technologies, has the same cost as one tubal surgery, has a far greater success rate yet is seldom covered.

Over 70,000 Connecticut citizens aged 18-45 are infertile. For years, we have been covering treatments that are ineffective and quite frankly medically irrelevant. It is time that we invest in treatments that actually cure the disease of infertility.

Thank you for holding this public hearing. I ask for your support of this legislation.

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Quality is Our Bottom Line

**Testimony of the Connecticut Association of Health Plans
In Opposition to Senate Bill 434**

***“An Act Concerning Health Insurance Coverage for Ultrasound Breast Cancer
Screening”***

Insurance and Real Estate Committee

February 17, 2005

The Connecticut Association of Health Plans respectfully opposes Senate Bill 434 because the scope of covered services is extensive enough to meet the diagnostic needs of all consumers, based on the best available scientific information and the medical complexity of the individual case. To mandate both mammography and ultrasound breast screens for a particular condition, in this case a diagnosis of dense breast tissue, is to automatically increase cost, regardless of the medical appropriateness of the diagnostic tool.

All members of the Connecticut Association of Health Plans are committed to the most effective diagnosis and treatment of their consumers; this proposal undermines their ability to accomplish that goal by legislating particular methods of medical diagnosis, which may or may not be medically appropriate. We urge your rejection.

The Connecticut Association of Health Plans is comprised of Aetna Inc., CIGNA, Community Health Network of Connecticut, Inc., ConnectiCare Inc. and Affiliates, First Choice/Wellcare, Health Net, Oxford Health Plans LLC a United Health Care Company and Yale Health Plan.

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Anthem Blue Cross and Blue Shield of Connecticut
370 Bassett Road
North Haven, Connecticut 06473-4201
203-239-4911



February 17, 2005

**Statement
Of
Anthem Blue Cross and Blue Shield
On
SB 508 An Act Concerning Health Insurance Benefits for the Diagnosis and
Treatment of Infertility.**

Good Morning Senator Crisco, Representative O'Connor and members of the Insurance Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in Connecticut. I am here today to speak against **SB 508 An Act Concerning Health Insurance Benefits for the Diagnosis and Treatment of Infertility.**

Anthem Blue Cross Blue Shield opposes **SB 508** because it does not provide a dollar threshold on the infertility treatments. This bill would require insurers to cover all medically indicated services or procedures used to treat infertility or induce pregnancy. I would like to state for the record that many of our products already provide benefits for the diagnosis and treatment of infertility; however, they contain certain dollar maximums per member for those procedures. Infertility treatments can be extremely costly. Costs that will be passed by all those insured through increased premiums. We do have other states to look at for experience. In Massachusetts, which has an almost identical mandate already enacted into law for 5 years, in vitro fertilization (IVF) utilization rose to a level that was approximately 5 times higher than in the rest of the United States and Canada. I am attaching a report from the Pennsylvania Health Care Cost Containment Council, which review this mandate for the State of Pennsylvania. I think you will find its conclusion helpful as you deliberate this legislation.

In Connecticut, Anthem Blue Cross and Blue Shield members would see an increase of \$4.48 dollars per member per month. While that may not seem like a significant number, Anthem has more than 1.4 million members, so this mandate would represent an overall increase of 1% in the total premium. Our research also shows that this mandate is utilize by less than 1% of all the members; however the cost is assumed by all members.

Our plan is to keep you healthy.SM

Anthem Blue Cross and Blue Shield of Connecticut is a trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association.
*Registered marks of the Blue Cross and Blue Shield Association.
**Service mark of Anthem Blue Cross and Blue Shield of Connecticut.

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Coupled with the State's concern about the growing number of uninsured individuals in Connecticut, it is important to remind ourselves of the role mandated benefits play in this critical problem. Each time that the Legislature passes a bill mandating another benefit, the cost of insurance increases, making it even more difficult for a customer, particularly small employers to purchase insurance. **This mandate alone will cost Anthem's fully insured customers, excluding the state of Connecticut employees, \$34 million dollars in increased premium.**

We understand that infertility is an emotional and heart wrenching issue for all those affected, but mandating this benefit is not the solution and can exacerbate the growing problem of uninsured people in Connecticut by passing another mandate.

We urge the members of the committee to defeat this bill or consider amending this legislation to include a threshold or cap on the amount of services covered and Anthem Blue Cross and Blue Shield are available to assist legislators in your deliberation of this legislation and provide further information.

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Chairman Crisco, Chairman O'Connor, Members of the Insurance and Real Estate Committee,

my name is Angela Coy, my husband is Ryan Coy. We are writing this testimony in support of Senate Bill 508. We will be married for 4 years this coming May. For three of our four married years together we have been desperately trying to have a baby. I was 25 years old and Ryan was 28 years old when we had our first appointment with our Reproductive Endocrinologist.

I have what is known as PCOS also known as Polycystic Ovary Syndrome. I simply do not ovulate on my own. We have no other fertility issues that we are aware of. We have done four clomid cycles, with no success, not even a spark of something. We then were moved on to injectables medications and IUI's (intrauterine inseminations), with no success. I respond very well to the medicine but for some unexplainable reason I do not get pregnant. Our doctor advised us that our next option would be IVF, which has been very successful. So after much consideration, Ryan and I decided to do the IVF procedure. This was not an easy decision for us because as you all know IVF is not covered for many people in this state. I have been at my job for about eight years and was able to establish a 401k plan. We decided to withdraw the money from there to pay for our IVF cycle. Our IVF cycle cost us \$13,000. In November of 2004, we started our IVF cycle. It went very well. I responded great, no other issues arose. I was inseminated with two beautiful embryos. I did not get pregnant that cycle. Our doctor is very optimistic and does not want us to give up trying to have a baby. Some people just do not get pregnant the first time. We were devastated and are now taking some time to heal. We just invested \$13,000 of our retirement for something that didn't work. I do not regret that we did the IVF cycle, it was just a big blow to handle.

My infertility has definitely changed my life. Never in a million years did I think I would have to try so hard for a baby. Everyone in my family can pop out babies. Why can't I? All I have wanted since I was a little girl was to be a mommy. I didn't care about some big fancy career. I just wanted to be a mom. As time passes by, I find it harder and harder to be around people with children. As the years pass by the sting burns a little more each time. I don't want to feel like that, it just happens. It takes all my self control not to breakdown when I see a baby in the store cooing and smiling at it's mommy or a toddler just learning to walk and reaching out for his daddy's arms. It is such a shame that infertility has to put such a strain on a couple's marriage. Our emotional well being and financial stress is just the icing on the cake. There are so many excellent advanced reproductive measures out there that have been proven to be very successful. Why do we have to make the process harder by restricting coverage? Isn't being infertile enough to handle without the added stress of figuring out how to pay for it or not being able to even do it because money is an issue. Anyone that desires to be a parent should be given an opportunity to do what they can to make that possible.

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Infertility is a disease. Just like heart disease, diabetes and breast cancer. Except heart disease, diabetes, and breast cancer are all covered by insurance to treat. There was nothing I could have done to prevent my infertility. It just happened! I feel like I am discriminated against because I am infertile - just because I cannot have a baby the old fashioned way.

I honestly do not think I will ever have peace and real happiness without a child of mine and my husband's. I feel like something is missing in our lives. We have so much love to give that sometimes I think I will just burst open.

Please support insurance coverage for this devastating disease by voting in favor of SB 508.

Angela and Ryan Coy
10 Amy Dr
Windsor, CT

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Bill Number SB 508 - An Act Concerning Health Insurance Benefits for the Diagnosis and Treatment of Infertility;

I am a parent of three children conceived through IVF. The first child was the result of three attempts, and fortunately our insurance covered most of these expenses. The second time around we had twins, but no insurance coverage, and fortunately we only had to go through IVF once to become pregnant.

It is increasingly common for insurance plans to lack IVF coverage, even among the biggest employers where the risk can be spread across a large pool. It is also increasingly common for people going through IVF to transfer multiple embryos to increase their odds of becoming pregnant. This also increases the chances of becoming pregnant with multiple embryos. This, in turn, increases the risk to the pregnancy's success and increases the probability of pre-term complications such as premature birth and measures to prevent premature birth. The costs of treatment for pre-term labor and birth can rapidly exceed the cost of IVF, itself. Of course, no one would think to curtail these benefits. If IVF coverage were the rule and not the exception then people going through IVF transferring multiple embryos would become the exception, not the rule.

We love our twins, and love having three children, but the decision to risk having twins was forced on us by the fact that our insurance provided no IVF coverage. We racked up mammoth bills, all paid for by the same insurance company that did not pay for IVF, when my wife had pre-term labor and endured life-threatening complications that had me staring straight in the face at the prospect of having three children, two of whom would have been born premature, and with no mother to help raise them.

The cost of providing IVF coverage is not insignificant, but the cost of not providing IVF coverage is not insignificant, either. In fact, it may be more costly in terms of dollars. In terms of patient safety, it is decidedly more costly, and I would ask you to seriously consider all the costs of denying families the coverage they need to fulfill the basic need to have children.

John Kilian
210 Ridge Road
Middletown, CT 06457

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Chairman Crisco, Chairman O'Connor, members of the Insurance and Real Estate Committee,

I am writing as a Psychologist and Resolve member in support of Senate Bill 508. I reside and practice in Glastonbury.

Infertility is one of the most severe and enduring crises an individual or couple may ever face. It effects one in six couples--and their extended families--over ten million people. It is simultaneously a biological, psychological and social crisis. Biologically it is a shocking surprise. Psychologically it strikes at the very root an enormous longing--to bear and parent a child. Socially, the individual or couple isolate because of their pain and to avoid pregnant friends and family or child-centered activities. The reverberations of infertility are pervasive, affecting all aspects of the individual's and couple's functioning.

Developmentally, most men and women mature with the expectation that they will one day become parents. An inability or difficulty in conceiving leads to a sense of inadequacy, powerlessness and loss of control. In most cultures procreation is viewed as a "given right." It is eagerly anticipated, and even expected by the couple and their families.

Since the couple's developmental cycle parallels the individual life cycle, infertility interrupts the important task of generativity, a significant life goal of young adulthood. Having children represents a significant right of passage to adulthood.

When an individual or couple's desire to become pregnant is thwarted, they become hopeless or despondent. The frustration, anxiety or depression can be intense and long-lasting. If we consider the cost of psychotherapy over a protracted time compared to the possible medical interventions to treat infertility, treating the infertility is a much more sound, efficient investment.

In addition, the current lack of insurance coverage for the treatment of infertility discriminates against those without adequate financial resources. It certainly is unacceptable to consider that only those with means should be allowed to access medical treatment for the "given right" to have a child.

It is in consideration of these factors that I request that you support passage of **SB 508**. Thank you for your kind consideration.

Beth Cooper, Ph.D.
381 Hubbard St.
Glastonbury, CT 06033

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SENATE BILL 508

WRITTEN TESTIMONY OF VICKI L. BALDWIN

PRESIDENT AND CEO OF IN VITRO SCIENCES, INC.,

AND BOARD CHAIR, RESOLVE: THE NATIONAL INFERTILITY ASSOCIATION

SUBMITTED TO THE INSURANCE AND REAL ESTATE COMMITTEE OF THE
CONNECTICUT GENERAL ASSEMBLY

FEBRUARY 17, 2005

The Honorable Senator Joseph Crisco, Co-Chair
The Honorable Representative Brian O'Connor, Co-Chair
Honorable Members of the Insurance and Real Estate Committee

Re: SB 508: An Act Concerning Health Insurance Benefits for the Diagnosis and
Treatment of Infertility

Dear Senator Crisco, Representative O'Connor and Committee Members:

I welcome the opportunity to share information with this Committee. I am the president and CEO of In Vitro Sciences, Inc., the subsidiary of Avon-based Women's Health USA, Inc. which provides healthcare management services to advanced reproductive centers in Connecticut, including the Center for Advanced Reproductive Services which is part of the University of Connecticut Health Center. Also, I have served as the chair of the board of RESOLVE: The National Infertility Association, since October, 2001. The national office of RESOLVE and its chapters, including RESOLVE of Greater Hartford and RESOLVE of Fairfield County, provide education, advocacy and support to individuals experiencing infertility. I have experienced infertility personally and am the mother of children conceived through in vitro fertilization (IVF). I reside in Darien.

I am writing in support of SB 508: An Act Concerning Health Insurance Benefits for the Diagnosis and Treatment of Infertility. Recognizing that added mandates in Connecticut, a state in which healthcare costs are high, may be damaging to job retention and growth, I will focus my comments on how the insurance industry can cover infertility treatment and improve outcomes and member satisfaction while reducing spending on obstetrical and neonatal complications following infertility treatment, thereby reducing the spending increase, if any, and enhancing quality of care.

Annual healthplan and member spending on infertility diagnosis, treatment, injectible medications, and resulting obstetrical and neonatal services is growing, despite the absence of comprehensive insurance coverage for many infertility services. In Vitro

Sciences has identified an unmet need for better management of this spending by healthplans. To better understand this need, we analyzed spending for several years by healthplans in states that mandate comprehensive coverage for infertility diagnosis and treatment. From a large sample of commercial members, we looked more closely at data on members who were diagnosed with infertility, including data on spending on their infertility treatment and resulting obstetrical and neonatal services, if any.

Of the average spending on all of these infertility cases, or episodes of care, we found 38% of the spending was attributable to infertility diagnosis and treatment, 20% to injectible medications, 22% to obstetrical care and delivery, and 20% to newborn and neonatal services, even though, of course, not all cases resulted in a pregnancy and birth. In other words, 42% of all spending associated with the infertility episode of care was attributable to resulting obstetrical and neonatal services which are in any event covered benefits, and another 20% was associated with injectible medications which are usually covered benefits also.

In addition, a study by the William M. Mercer actuarial team shows that a significant number of non-covered infertility diagnostic and treatment services are reimbursed in states that do not mandate insurance coverage for infertility because services are coded for underlying diseases.¹ If we apply the information from the Mercer study to our work, we can conclude that commercial insurance is already covering about 20% to 40% of the spending associated with the infertility diagnosis and treatment portion of the episode of care. Adding this to the estimates above, commercial insurance is already paying between 70% and 80% of total episode of care spending.

There are strategies for compensating for the 20% to 30% of spending that would arguably be added to the episode of care by a state mandate. Multiple pregnancies, especially triplets and higher, are known to drive high spending on obstetrical, delivery, and neonatal services. The New England Journal of Medicine reported in an August, 2002 article that states that do not require insurance coverage for IVF have reported a higher number of embryos transferred per procedure, which in turn is associated with higher rates of multiple pregnancies. We believe that spending associated with triplet and higher pregnancies can be significantly reduced if the mandate is implemented in conjunction with a well-managed infertility benefit.

The CDC reported in 2000, an increase from 37 triplet or higher per 100,000 newborns in 1980 to 173.6 triplet or higher per 100,000 newborns in 1997 and estimated that only 18% of these triplet and higher newborns were spontaneous with the remainder attributable to infertility treatment.² The annual CDC National Summary and Fertility Clinics Report shows a wide variation in triplet and higher rates among about 400 IVF clinics reporting nationally. The Society for Assisted Reproductive Technology (SART) of the American Society for Reproductive Medicine has issued guidelines aimed at reducing the rate of triplet and higher pregnancies.

Right here in Connecticut we can show a theoretical example of potential savings if SART guidelines were followed by all providers. In 2004, the Center for Advanced

Reproductive Services was commended for placing among the best 10% of IVF centers nationwide for achieving high pregnancy rates coupled with low rates of triplet and higher pregnancies³. This was achieved through skill coupled with adherence to SART guidelines with regard to the number of embryos transferred during an IVF cycle. Our further analysis shows that savings on IVF-related obstetrical and neonatal services would be about 25% of current episode of care spending, if healthplans ensured that all of their infertility cases were directed to centers that follow SART guidelines and achieve birth outcomes among the best 10% vs. to those with outcomes among the worst 10%. Additional savings can be realized from the reduction in long term care spending for dependents associated with triplet and higher births.

We have assumed that an insurance mandate for infertility will not increase the overall number of episodes of care, but rather change the mix of services that members receive within the episode. Demand for services requiring hospitalization, such as tubal reconstructive surgery, that are sometimes currently chosen based on insurance coverage rather than efficacy, should decrease while demand for IVF should increase. Demand for intra-uterine insemination cycles, which are often covered by insurance but less effective and more difficult to manage with regard to triplet and higher pregnancies than IVF, should also decrease.

In summary, we believe that a mandate which is implemented in conjunction with a well-managed infertility benefit aimed at ensuring patients are treated according to SART guidelines can be put in place without a significant increase, if any, in overall spending, and with an increase in member satisfaction and long term well being. Such a benefit ensures that members without insurance coverage are not self-referring to providers with outcomes that drive high cost complications, and can be implemented by healthplans with these suggested steps:

1. Include in networks only centers of excellence with quality providers who follow SART guidelines and institute infertility management processes.
2. Identify each infertility case early to ensure proper coding and timely referral, if indicated, from the OBGYN to a full service center of reproductive endocrinologists to avoid over utilization of ineffective treatment and repetitious testing.
3. Ensure all treatment plans are pre-certified and follow SART guidelines.
4. Integrate pharmacy benefits for injectible medications into the pre-certification process to ensure they are ordered as needed and according to formulary.
5. Ensure network providers submit outcomes data to the healthplan showing results.
6. Institute pay for performance programs and monitor outcomes to reward quality providers.

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Thank you for considering this information. I welcome the opportunity to respond to any questions and ask that you support SB 508.

Respectfully submitted:

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Attachments:

¹ Blackwell, Richard E., PhD, MD and the William M. Mercer Actuarial Team, "Hidden costs of infertility treatment in employee health benefits plans", Am J Obstet Gynecol, Vol 182, Number 4

² MMWR, June 23, 2000 49(24);535-8, Morbidity and Mortality Weekly Report, a publication of the Centers for Disease Control and Prevention (CDC)

³ 2004 SART analysis of 2001 data reported to the CDC for fresh, non-frozen ART cycles for women <35



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June 23, 2000 / 49(24):535-3

Contribution of Assisted Reproductive Technology and Ovulation-Inducing Drugs to Triplet and Higher-Order Multiple Births --- United States, 1980--1997

In the United States, pregnancies associated with assisted reproductive technology (ART) or ovulation-inducing drugs are more likely to result in multiple births than spontaneously conceived pregnancies (1). In addition, triplet and higher-order multiple births are at greater risk than singleton births to be preterm (≤ 37 completed weeks' gestation), low birthweight (LBW) (i.e., ≤ 500 g), or very low birthweight (i.e., < 1500 g), resulting in higher infant morbidity and mortality (2). Because preterm and LBW infants often require costly neonatal care and long-term developmental follow-up, the continuing increase in triplet and higher-order multiple births causes concern among health-care providers and policymakers (3). This report provides estimates of the contribution of ART and ovulation-inducing drugs to these birth outcomes for 1996 and 1997, and summarizes trends during 1980--1997, which indicate that the ratio of triplet and higher-order multiple births has more than quadrupled and that a large proportion of this increase can be attributed to ART or the use of ovulation-inducing drugs.

The CDC's National Center for Health Statistics (NCHS) provided data on live-born infants of triplet and higher-order multiple deliveries (4), and the Society for Assisted Reproductive Technology (SART) reporting system for ART clinics provided the clinical outcomes of ART-associated pregnancies. The 1992 Fertility Clinic Success Rate and Certification Act requires that every U.S. medical center that performs ART report to CDC data for every ART cycle* initiated annually to calculate clinic-specific pregnancy success rates (5). This report uses data from 1996, the first full year CDC collected ART data, and 1997, the latest year of completed data collection. In NCHS and SART, multiple births are counted as individual births rather than sets of triplet and higher-order multiple births.

Triplets constituted most triplet and higher-order multiple births: 5298 (89.2%) of 5939 in 1996 and 6148 (91.2%) of 6737 in 1997 (4). ART-related triplet and higher-order multiple births for 1996 and 1997 were expressed as a ratio (i.e., the proportion of ART-related triplet and higher-order multiple births to all live-born infants). The impact of ovulation-inducing drugs not associated with an ART procedure was estimated by subtracting both ART-related births (from the SART reporting system) and spontaneously occurring triplet and higher-order multiple births (6) from the total number of these births. To account for the upward shift in maternal age distribution since 1971 and the increase in spontaneously occurring triplets and higher-order multiple births in women of reproductive age, the ratios for spontaneously occurring outcomes were adjusted for the maternal age distribution of 1997 using the relevant ratios for 1971 (2). This adjustment resulted in a 10% increase in spontaneously occurring outcomes.

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4924a4.htm

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occurring triplet and higher-order multiple births from 29 per 100,000 live-born infants in 1971 to 32 per 100,000 live-born infants in 1997.

The ratio of triplet and higher-order multiple births for all age groups increased from 29 in 1971 to 37 in 1980; this trend began after the Food and Drug Administration approved two ovulation-inducing drugs, one in 1967 and another in 1970. Following the introduction of ART approximately in 1980, the ratio more than quadrupled to 174 in 1997 (Table 1). Among mothers aged <20 years, the ratio increased from 15 to 21; among mothers aged 35--39 years, the ratio increased from 48 to 403.

The contribution of ART to the overall triplet and higher-order multiple birth ratio was estimated to be 38.7% in 1996 and 43.3% in 1997, a substantial increase from the estimated 22% for 1990 and 1991 (Table 2). For both years, approximately 20% were attributable to spontaneously occurring triplets and higher-order multiple births and approximately 40% were attributable to ovulation-inducing drugs without ART.

Reported by: Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; Div of Applied Public Health Training, Epidemiology Program Office, Div of Vital Statistics, National Center for Health Statistics; and an EIS Officer, CDC.

Editorial Note:

Despite small variations in fertility rates throughout the 1930s--1960s, the ratio for triplet and higher-order multiple births remained stable at approximately 30 per 100,000 live-born infants (6). The reported increase in the ratio of triplet and higher-order multiple births in subsequent decades illustrates the impact of ART and other infertility treatments.

The findings in this study are subject to at least three limitations. First, reliable information could not be obtained on the availability and use of ovulation-inducing drugs in the United States. Such information might have been useful in determining the contribution of these drugs to the reported increased ratios and to the increase in triplet and higher-order multiple births affecting all age groups. Second, because ART data were available for only 2 full years (1996 and 1997), trend analysis was not possible. Third, bias might have been introduced using 1971 triplet and higher-order multiple birth ratios for direct age adjustment, which were based on a 50% sample of birth certificate data compared with 100% of data for 1985--1997.

Because of the risk factors associated with multifetal births, continued surveillance of pregnancies associated with infertility treatments is important. Although the impact of ART on overall triplet and higher-order multiple births can be estimated using SART data, no reporting system has information on the use of ovulation-inducing drugs not associated with ART. Modifying birth certificate registration to include the type of infertility treatment used to achieve pregnancy would provide such information. Massachusetts has implemented this modification.

Given the increased morbidity and mortality associated with multifetal pregnancies, efforts are needed to monitor patients receiving ovulation-inducing drugs and to limit the number of embryos transferred for patients receiving ART (7). These approaches should be preceded by evaluation and specific diagnosis of the infertility status of each patient, and should follow guidelines issued by organizations such as the American Society for Reproductive Medicine and the American College of Obstetricians and Gynecologists (8,9). Strategies to reduce the risk for multifetal gestation have important public health implications that must be integrated with patient needs and concerns, provider practices, and rapidly changing technology.

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* A cycle begins when a woman starts taking ovulation-inducing drugs or starts ovarian monitoring with the intent of having oocytes harvested for in vitro fertilization or other assisted reproductive technique. In most fresh, nondonor cycles, usually one of the following procedures is used: in vitro fertilization involves retrieving a woman's oocytes, fertilizing them in the laboratory, and transferring the resulting embryo(s) into the uterus through the cervix; gamete intra fallopian transfer involves placing unfertilized oocytes and sperm laparoscopically into the woman's fallopian tubes through a small abdominal incision; and zygote intra fallopian transfer involves fertilizing the woman's oocytes in the laboratory and then transferring the resulting zygotes into her fallopian tubes.

Table 1

TABLE 1. Rate* of triplet and higher-order multiple births, by mothers' age --- United States, 1980 and 1997

Age group (yrs)	Triplet and higher-order multiple births	
	1980	1997
<20	14.8	20.7
20-24	31.4	46.8
25-29	42.8	151.0
30-34	58.3	293.6
35-39	47.6	403.2
40-44	†	315.4
45-49	†	2100.2
All ages	37.0	173.6

* Per 100,000 live-born infants.

† Numbers do not meet standards of reliability or precision.

Source: Reference 4.

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Table 2

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TABLE 2. Contribution of assisted reproductive technology (ART) to triplet and higher-order multiple births (≥ triplets) — United States, 1989–1997

Year	Total no. live-born infants*	No. of ≥ triplets	% ≥ triplets of total no. live-born infants	≥ Triplets ratio†	% ≥ triplets by spontaneous conception	% ≥ triplets using ART	Estimated % ≥ triplets using ovulation drugs
1989	4,040,958	2,798	0.07	69.2	—	—	—
1990	4,158,212	3,028	0.07	72.8	—	22.0‡	—
1991	4,110,907	3,346	0.08	81.4	—	22.0‡	—
1992	4,065,014	3,883	0.09	95.6	—	—	—
1993	4,000,240	4,168	0.10	104.2	—	—	—
1994	3,952,767	4,594	0.12	116.2	—	—	—
1995	3,899,589	4,973	0.13	127.2	—	—	—
1996¶	3,891,494	5,939	0.15	152.6	20.9	38.7	40.4
1997¶	3,880,894	6,737	0.17	173.6	18.4	43.3	38.2

* Source: Reference 4.

† Number of ≥ triplets per 100,000 live-born infants.

‡ Based on number of ART-associated triplets and total number of triplets, 1990 and 1991 (3).

¶ Percentage of triplets by spontaneous conception, percentage of triplets using ART, and estimated percentage of ≥ triplets using ovulation drugs add up to 100% overall ≥ triplet ratio.
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May 25, 2004

John Nulsen, M.D.
Center for Advanced Reproductive Services
UConn Health Center, Dowling South
3rd Floor, 263 Farmington Avenue
Farmington CT 06030-6221

Dear Dr. Nulsen;

The Society for Assisted Reproductive Technology (SART) is dedicated to representing and maintaining the highest standards of patient care in the field of Assisted Reproductive Technology. As a member of this organization, your program is expected to "set the standards" for ART in your community.

The Quality Assurance Committee is charged with recognizing opportunities for improving quality of care, and making recommendations to the Executive Council of SART regarding implementation of these recommendations. The purpose of this letter is to draw your attention to the nation wide problem of high order multiple pregnancies.

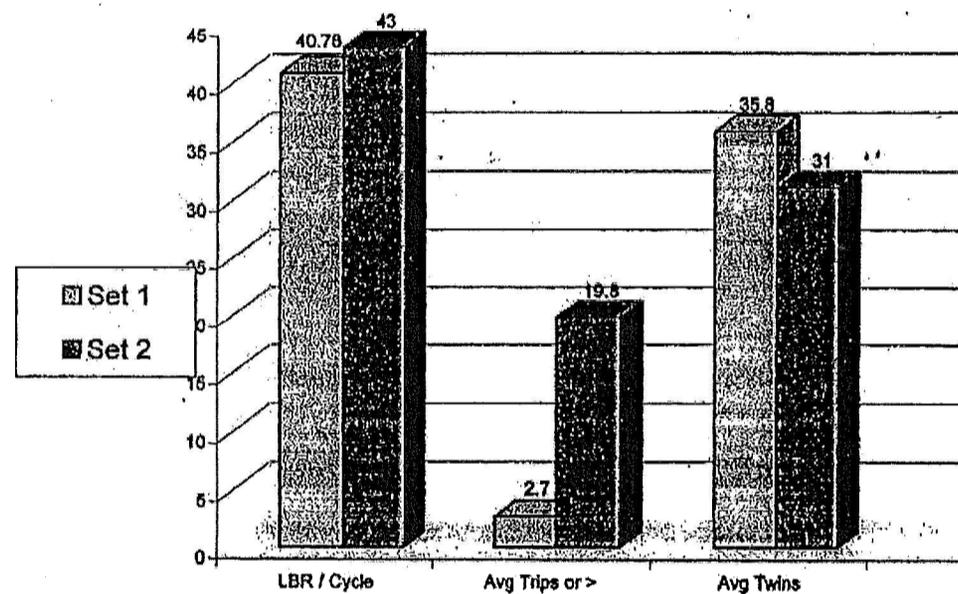
The SART feels that this issue is of utmost importance. As you all know, there is a strong push for federal regulation of assisted reproductive technologies. Clearly, one impetus for this movement is the economic and societal burden of high order multiple pregnancies that result from IVF. There is also a pervasive opinion in government (and perhaps the public) that "self-regulation" by our society will be ineffective.

Because of these issues, the Executive Council requested that the QA Committee evaluate the 2001 published report from the CDC with specific attention to multiple pregnancy rates. We recognize the limitations of the data from which these observations are drawn. However, the magnitude of the deviations from "acceptable" (or average, which may in fact not be "acceptable") warrants immediate attention.

Programs with success rates (live birth rates per cycle in the under 35 age group) above the mean (35%), that performed greater than 50
Setting the Standards for ART

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cycles per year, with a triplet or higher rate less than 5.3% (Set 1) were compared to programs of similar size with greater than 15% triplets or higher pregnancies (Set 2). We chose the triplets or higher rate of 5.3% because, in the national dataset, this is the rate seen when 3 embryos were transferred (Figure 23, page 35); based on SART guidelines for numbers of embryos to transfer, no more than 3 embryos *should* be transferred in this group of patients.



There are three main points to learn from this information. First, programs having a high percentage of pregnancies with triplets or higher on average transferred 3.29 embryos as compared to 2.52 embryos for programs with a low triplets or higher rate (recall that this group of patients are all less than 35 years of age). Second, this increase in the numbers of embryos transferred resulted in a *seven-fold* increase in the high order multiple pregnancy rate. Lastly, the overall live birth rate was not significantly higher for programs with excessively high multiple pregnancy rates.

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Your program is one of 37 programs included in Set 1 of the above analysis. As Chair of the Quality Assurance Committee for SART, I would like to congratulate your program for what I consider excellence in patient care. The SART Executive Council has requested the programs in Set 2 to respond to the following questions:

1. In your program, what percent of pregnancies in the <35 age group resulted in triplets or higher in 2002?
2. What was the average number of embryos transferred in this group in 2002?
3. What are the specific reasons that your program used for transferring more than two embryos in this group of patients?
4. In detail, what steps will your program take (or has taken) to decrease your high order multiple pregnancy rate?

I am asking if you would be willing to spend a few minutes and respond to the same questions (obviously, helping us to learn more about "best practices" in ART).

The SART considers lowering the percent of pregnancies resulting in triplets or higher a priority. As a self-regulating body, we must address this important issue. Any further suggestions that you have that will help ameliorate this problem will be greatly appreciated, and will be passed on to the membership. Thank you for your consideration of this very important issue. If possible, a timely response would be appreciated (within thirty days). For your convenience, a return envelope is enclosed.

Sincerely,

David A. Grainger MD

David A. Grainger MD, MPH
Chair, Quality Assurance Committee

Hidden costs of infertility treatment in employee health benefits plans

Richard E. Blackwell, PhD, MD, and the William M. Mercer Actuarial Team
Birmingham, Alabama, and Washington, D.C.

OBJECTIVES: Many employers exclude infertility treatment from coverage under their health benefits plans. However, infertility treatment is often provided under other diagnoses or in association with therapy rendered for other disease processes. This study attempted to estimate those hidden costs and to determine what the impact would be of providing coverage for infertility treatment.

STUDY DESIGN: A 1-year retrospective analysis was carried out to isolate the hidden costs of infertility treatment from specific medical claims data gathered from a large representative employer with no infertility benefit provided. Data were analyzed in the context of the claims experience of a health plan covering approximately 28,000 employees. Infertility treatment was excluded under this plan. Medical claims for specific procedures and diagnoses in 1998 were analyzed by using *Current Procedural Terminology* codes in conjunction with *International Classification of Diseases, Ninth Revision* codes to estimate the hidden costs of infertility treatment. Forty-one *Current Procedural Terminology* codes and 68 *International Classification of Diseases, Ninth Revision* codes were used for the analysis. Clinical practice experience was used to set boundaries (conservative and moderate estimate) regarding the likelihood of a given treatment being associated with infertility. This was compared with 100% covered charges to generate claims per employee per month. Procedures covered operative, diagnostic, and laboratory services. These figures were used to compute a range of cost for infertility treatment per member per month.

RESULTS: Forty-one *Current Procedural Terminology* codes were identified that indicated possible infertility treatment. These covered the areas of laparoscopic and hysteroscopic surgery, lysis of adhesions, neosalpingostomy, cyst drainage, oocyte retrieval or embryo transfer, echography, and various hormonal analyses. Sixty-eight *International Classification of Diseases, Ninth Revision* codes indicated the possibility of infertility treatment. These included endocrine disorders, various uterine pathologic conditions, pelvic pain, endometriosis, pregnancy loss, irregular menses, and various ovulatory dysfunctions. The retrospective analysis found that 35 *Current Procedural Terminology* codes were involved in claims highly indicative of infertility services, such as 56353, hysteroscopic division of uterine septum, and 58345, transcervical fallopian tube catheterization. According to the 35 *Current Procedural Terminology* codes, \$603,807.95 would have been paid if 100% of the charges had been covered; this would have resulted in a claim per employee per month of \$1.12 by conservative estimate to \$0.60 by moderate estimate. Computed cost figures per member per month showed the hidden costs of infertility to range between \$0.27 and \$0.50.

CONCLUSION: On the basis of various cost studies, rate filings, and employee data, the cost of providing coverage for infertility treatment has previously been shown to vary between \$0.20 and \$2.00 per member per month. Through appropriate cost sharing, managed care, and algorithms, infertility coverage can be offered at a cost of \$0.40 to \$0.50 per member per month. This analysis indicates that at least some employers already pay this much even when infertility is specifically excluded under the plan. (*Am J Obstet Gynecol* 2000;182:891-5.)

Key words: *Current Procedural Terminology* codes, infertility benefit, *International Classification of Diseases, Ninth Revision* codes, per member per month

Many employers exclude infertility treatment from coverage under their health benefits plans. However, infer-

tility treatment is often provided under other diagnostic categories or in association with therapy rendered for other disease processes.¹ At times infertility treatment is difficult to dissociate from other specialty and primary care services, because patients often have multiple diagnoses.² As a result an alternate diagnosis may assume a position of greater importance when *International Classification of Diseases, Ninth Revision (ICD-9)* codes are selected for billing. This is considered to be a legitimate billing practice; however, it makes it extremely difficult for a benefits manager or

From the Department of Obstetrics and Gynecology, University of Alabama at Birmingham, and William M. Mercer, Incorporated. Received for publication June 4, 1999; revised September 16, 1999; accepted December 13, 1999. Reprint requests: Richard E. Blackwell, MD, PhD, University of Alabama at Birmingham, Department of Obstetrics and Gynecology, 618 S 20th St, 555 Old Hillman Bldg, Birmingham, AL 35233-7333. Copyright © 2000 by Mosby, Inc. 0002-9378/2000 \$12.00 + 0 6/1/105050 doi:10.1067/mob.2000.105050

Table I. CPT codes associated with procedures that indicate possible infertility treatment

CPT code	Description
50390	Pelvic cyst—aspiration/injection
56300	Pelvic laparoscopy; diagnosis
56307	Laparoscopy; remove adnexa
56309	Laparoscopy; remove myoma
56343	Laparoscopic salpingostomy
56350	Hysteroscopy; diagnostic
56351	Hysteroscopy; biopsy
56353	Hysteroscopy; resect septum
56354	Hysteroscopy; remove myoma
56355	Hysteroscopy; remove impact
56399	Laparoscopy procedure
58340	Inject for uterus/tube x-ray
58345	Reopen fallopian tube
58800	Ovary cyst—incision and drainage
58805	Ovary cyst—incision and drainage
58925	Ovarian cyst excision
58970	Retrieval of oocyte
58974	Transfer of embryo
58976	Transfer of embryo
72196	Pelvis—magnetic resonance imaging
72198	Pelvis—magnetic resonance angiography
74740	X-ray female genital tract
76856	Echographic examination of pelvis
76857	Echographic examination of pelvis
80418	Luteinizing hormone
80418	Follicle-stimulating hormone
80418	Thyroid-stimulating hormone
80426	Luteinizing hormone
80426	Follicle-stimulating hormone
82626	Dehydroepiandrosterone
82627	Dehydroepiandrosterone sulfate
82671	Estrogens; fractionated
82672	Estrogens; total
83002	Luteinizing hormone
84144	Progesterone
84270	Sex hormone-binding globulin
84402	Testosterone; free
84403	Testosterone; total
93001	Follicle-stimulating hormone

payor to determine whether infertility services are being rendered and, if so, at what cost. This study therefore attempted to estimate costs that might be assigned to infertility services and to determine the potential impact of providing coverage for infertility treatment.

Material and methods

On the basis of clinical experience and a review of *Current Procedural Terminology (CPT)* codes in conjunction with *ICD-9* codes, a list of medical descriptions was developed that would indicate whether infertility therapy might have been rendered during treatment. Forty-one CPT codes and 68 ICD-9 codes were isolated and subsequently used for the analysis. The William M. Mercer Actuarial Team analyzed the claims experience of a plan covering 28,000 employees that excluded coverage of infertility treatment. All claims records with CPT codes on the list of procedures that indicated

possible infertility treatment were isolated. This represents the maximum possible hidden infertility cost for the plan. Each claim record in the database also contained at least three *ICD-9* codes. All claims records that had both a CPT code and at least one *ICD-9* code that indicated possible infertility treatment were totaled. This represents the conservative hidden cost estimate for infertility treatment. The conservative cost figure divided by the maximum possible cost of treatment was calculated as the conservative percentage of claims for the hidden costs of infertility treatment. Subsequently the list of CPT codes with a conservative percentage of claims for infertility was evaluated by the principal author (Richard E. Blackwell, PhD, MD). This resulted in an estimate of the percentage of these procedures that were thought to represent infertility treatment. The conservative percentages were then multiplied by the corrected percentages, which resulted in the moderate percentage of claims associated with hidden costs for infertility treatment. Subsequently, the conservative and moderate percentages of claims indicating infertility treatment were multiplied by the claim and divided by the number of employees to derive the hidden cost of infertility treatment per employee. These figures were subsequently recalculated to generate the estimated cost per member per month for the plan.

Results

Forty-one CPT codes were identified that indicated possible infertility treatment. These covered the areas of laparoscopic and hysteroscopic surgery, lysis of adhesions, neosalpingostomy, cyst drainage, oocyte retrieval for embryo transfer, echography, and various hormonal analyses (Table I). Sixty-eight *ICD-9* codes indicated the possibility of treatment. These included endocrine disorders, various uterine pathologic conditions, pelvic pain, endometriosis, pregnancy loss, irregular menses, and various ovulatory dysfunctions (Table II). The retrospective analysis found that 35 CPT codes highly indicative of infertility services, such as CPT 56353 (hysteroscopic division of uterine septum) and CPT 58345 (transcervical fallopian tube catheterization) had been associated with claims (Table III). According to the 35 CPT codes, \$603,807.95 would be paid if 100% of the charges were covered; this results in a claim per employee per month of \$1.12 (conservative estimate) to \$0.60 (moderate estimate). Computed cost figures per member per month show the hidden costs of infertility to range between \$0.27 and \$0.50 (Table IV).

Comment

According to various cost studies, rate filings, and employee data, the cost of providing coverage for infertility treatment has been shown to vary between \$0.20 and

000906

Table II. ICD-9 codes for diagnoses that indicate possible infertility treatment

ICD-9 code	Description
16.7	Tuberculosis of genitourinary system; other female genital organs
194.3	Pituitary gland and craniohypophyseal duct
218.0	Submucous leiomyoma of uterus
218.1	Intramural leiomyoma of uterus
218.2	Subserous leiomyoma of uterus
218.9	Leiomyoma of uterus, unspecified
227.3	Pituitary gland and craniohypophyseal duct (pouch)
234.8	Other specified sites
237.0	Pituitary gland and craniohypophyseal duct
239.7	Endocrine glands and other parts of nervous system
253.1	Other and unspecified anterior pituitary hyperfunction
253.2	Panhypopituitarism
253.3	Pituitary dwarfism
253.4	Other anterior pituitary disorders
253.8	Other disorders of the pituitary and other syndromes of diencephalohypophysial origin
256.1	Androgen excess
256.3	Other ovarian failure
256.4	Polycystic ovaries
256.8	Other ovarian dysfunction
259.9	Unspecified endocrine disorders
606.0	Infertility, male; azoospermia
606.1	Infertility, male; oligospermia
606.8	Infertility, male; due to extratesticular causes
606.9	Infertility, male; unspecified
608.89	Dyspareunia (male)
614.2	Salpingitis and oophoritis not specified as acute, subacute, or chronic
614.6	Pelvic peritoneal adhesions, female (postoperative, postinfection)
616.7	Endometriosis, site unspecified
617.0	Endometriosis of uterus
617.1	Endometriosis of ovary
617.2	Endometriosis of fallopian tube
617.3	Endometriosis of pelvic peritoneum
617.4	Endometriosis of rectovaginal septum and vagina
617.5	Endometriosis of intestine
617.6	Endometriosis in scar of skin
617.8	Endometriosis of other specified sites
620.0	Follicular cyst of ovary
620.1	Corpus luteum cyst of hematoma
620.2	Other and unspecified ovarian cyst
625.2	Dyspareunia (female)
625.3	Dysmenorrhea
625.4	Premenstrual tension syndrome
625.8	Other specified symptom associated with female genital organs
625.9	Unspecified symptom associated with female genital organs
626.0	Absence of menstruation
626.4	Irregular menstrual cycle
626.6	Metrorrhagia
626.8	Other
626.9	Unspecified
628.0	Associated with anovulation
628.1	Of pituitary-hypothalamic origin
628.2	Of tubal origin
628.3	Of uterine origin
628.4	Of cervical or vaginal origin
628.8	Of other specified origin
628.9	Of unspecified origin
629.9	Unspecified disorder of female genital organs
634.9	Spontaneous abortion without mention of complication
646.3	Habitual aborter
648.1	Thyroid dysfunction
704.1	Hirsutism
752.0	Anomalies of ovaries
752.1	Anomalies of fallopian tubes and broad ligaments
752.2	Doubling of uterus
752.3	Other anomalies of uterus
761.8	Other specified maternal complications of pregnancy affecting fetus or neonate

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Table III. CPT codes associated with claims and an estimate that their use indicated infertility treatment

CPT code	CPT name	Procedures covering infertility treatment (%)	
		Conservative estimate	Moderate estimate
50390	Pelvic cyst—aspiration/injection	100	50
56300	Pelvic laparoscopy; diagnostic	79	47
56307	Laparoscopy; remove adnexa	49	20
56309	Laparoscopy; remove leiomyoma	100	50
56343	Laparoscopy; salpingostomy	32	32
56350	Hysteroscopy; diagnostic	49	12
56351	Hysteroscopy; endoscopy; bilateral; polyp	61	31
56353	Hysteroscopy; resect septum	100	100
56354	Hysteroscopy; remove myoma	96	48
56355	Hysteroscopy; remove foreign body	31	8
56399	Unlisted laparoscopy; hysteroscopy; peritoneoscopy	2	2
58340	Injection for hysterosalpingography	81	81
58345	Transcervical fallopian tube catheterization	100	100
58800	Ovary cyst—incision and drainage	100	10
58805	Ovary cyst—incision and drainage	100	10
58925	Ovarian cyst excision	86	0
58970	Oocyte retrieval	40	40
58974	Embryo transfer	100	100
58976	Gamete transfer	100	100
72196	Pelvis—magnetic resonance imaging	18	0
72198	Pelvis—magnetic resonance angiography	100	0
74740	Hysterosalpingogram	86	86
76856	Echographic examination of pelvis	63	32
76857	Echographic examination of pelvis	68	34
80418	Combination; repeated anterior pituitary evaluation; prolactin	100	50
80426	Gonadotropin-releasing hormone stimulation; prolactin	100	100
82626	Dehydroepiandrosterone	51	25
82627	Dehydroepiandrosterone sulfate	29	14
82671	Estrogens; fractionated	45	28
82672	Estrogens; total	41	26
83002	Gonadotropin—luteinizing hormone	50	25
84144	Progesterone	59	59
84270	Sex hormone-binding globulin	12	6
84402	Testosterone; free	28	14

\$2.00 per member per month.³⁻⁶ Through the use of appropriate cost sharing, managed care, and algorithms, infertility coverage can be offered at a cost of \$0.40 to \$0.50 per member per month. This analysis indicates that the studied employer already paid this much even though infertility was specifically excluded under the studied plan. Under a well-managed infertility treatment program an employer might not need to pay as much as is already being provided in hidden costs. The employee or spouse would not have to seek shortcut or backdoor infertility treatment approaches, which are more likely to result in failure or in multiple births. Provision of infertility coverage should result in less mental anguish for the employee and spouse, which would equate to fewer days lost on the job and more productive employees.⁷⁻⁹ The employer likewise benefits from this relationship in being viewed as proactive and as assisting an employee or an employee's spouse through a difficult life transition. Further, being consid-

ered a family-oriented company appears to be an advantage in attracting exceptional employees during periods of low unemployment.

Although any retrospective cost analysis and the use of subjective utilization rates produce less than optimum results, to our knowledge no other information has been released regarding this subject matter. Insurance carriers are extremely reluctant to open their databases for cost analysis or utilization studies. This material is considered proprietary, and its public knowledge is considered to put the particular business entity at a disadvantage in the marketplace. Nevertheless, the availability of these particular data has opened the way for negotiation to undertake a large prospective evaluation of the hidden costs of infertility, which should be presented in future publications. Despite the current unavailability of such prospective data, the retrospective material presented here should prove useful in allowing reproductive endocrinologists

000908

Table IV. Analysis of hidden cost of infertility treatment for 1996 (27,811 estimated covered employees)

CPT code*	Procedures covering infertility treatment (%)			Claims per employee per month	
	Conservative estimate	Moderate estimate	100% Covered charges	Conservative	Moderate
50390	100	50	—	—	—
56300	79	47	\$89,073.83	\$0.2109	\$0.1265
56307	49	20	\$41,506.40	\$0.0809	\$0.0244
56309	100	50	\$7,449.00	\$0.0223	\$0.0112
56343	32	32	\$8,513.56	\$0.0082	\$0.0082
56350	49	12	\$18,135.86	\$0.0266	\$0.0087
56351	61	31	\$62,501.93	\$0.1142	\$0.0571
56353	100	100	\$825.00	\$0.0025	\$0.0025
56354	96	48	\$11,757.25	\$0.0337	\$0.0169
56355	31	8	\$1,242.69	\$0.0011	\$0.0003
56399	2	2	\$12,997.88	\$0.0006	\$0.0006
58340	81	81	\$16,490.58	\$0.0401	\$0.0401
58345	100	100	\$487.00	\$0.0014	\$0.0014
58800	100	10	\$1,456.00	\$0.0044	\$0.0004
58805	100	10	—	—	—
58925	86	0	\$22,318.24	\$0.0575	—
58970	40	40	\$494.00	\$0.0006	\$0.0006
58974	100	100	—	—	—
58976	100	100	—	—	—
72196	18	0	\$13,712.69	\$0.0074	—
72198	100	0	—	—	—
74740	86	86	\$9,099.31	\$0.0233	\$0.0233
76856	63	32	\$168,874.89	\$0.3188	\$0.1594
76857	68	34	\$46,284.25	\$0.0943	\$0.0472
80418	100	50	\$66.02	\$0.0002	\$0.0001
80426	100	100	\$664.00	\$0.0020	\$0.0020
82626	51	25	\$1,700.62	\$0.0026	\$0.0013
82627	29	14	\$4,783.92	\$0.0041	\$0.0021
82671	45	28	\$168.29	\$0.0002	\$0.0001
82672	41	26	\$2,075.65	\$0.0026	\$0.0016
83002	50	25	\$15,134.37	\$0.0227	\$0.0113
84144	59	59	\$27,397.63	\$0.0484	\$0.0484
84270	12	6	\$342.17	\$0.0001	\$0.0001
84402	28	14	\$3,695.78	\$0.0031	\$0.0015
84403	20	10	\$14,579.18	\$0.0087	\$0.0044
TOTAL			\$603,807.99	\$1.12	\$0.60
Per member per month				\$0.50	\$0.27

*For corresponding CPT descriptions see Tables I and III.

and gynecologists to negotiate with health care plans to expand the infertility benefit.

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Testimony of Serono, Inc. in support of
Senate Bill No. 508, An Act Concerning Health Insurance Benefits
For The Diagnosis And Treatment Of Infertility
Insurance and Real Estate Committee - February 17, 2005

000909

Good morning, Chairmen Crisco and O'Connor, and members of the Insurance and Real Estate Committee. My name is Pamela Pepe, and I am the Executive Director of Government Policy for Serono, Inc. I appreciate the opportunity to speak today in favor of S.B. 508, "An Act Concerning Health Insurance Benefits For The Diagnosis and Treatment of Infertility."

Serono is the world leader in the treatment of infertility . . . our vision is to develop and market innovative products to help infertile couples at every stage of the reproductive cycle in making their dream of having a child come true.

Infertility is a disease that affects about 6 million men and women in the United States, and is a qualifying condition under the Americans with Disabilities Act. Important strides have been made in the past 25 years to treat infertility – treatments that are life altering for couples that 25 years ago would have had to forego the chance of having their own child

Therefore, I am pleased to be here today to support the patients – represented by the Greater Hartford Chapter of Resolve – along with the physicians who treat them, in their efforts to improve infertility insurance coverage.

Having met this past summer with representatives of the Connecticut insurance industry, I offer the following insights into their concerns, with the hope of seeing this bill enacted into law.

First, S.B. 508 does not require all new insurance coverage. Actually, most health insurance already provides some infertility coverage – be it through the:

- "Major medical" benefit – for costly, less effective tubal surgery, such as removal of a woman's endometriosis, cysts, or fibroid tumors, or a man's varicose veins;
- "Pregnancy benefit" from the time conception is achieved; or
- "Maternity benefits," the cost of delivery, nursery or neo-natal intensive care.

TO BE CLEAR, ALL OF THIS INSURANCE IS PROVIDED NOW IN A TYPICAL EMPLOYERS SPONSORED HEALTH PLAN, WHETHER THE PARENTS HAD ONE OF THREE INFERTILITY TREATMENTS OR NOT (see attached chart for what is and is not routinely covered now).

Primarily at issue here, is coverage for infertility treatment known as ART – assisted reproductive technologies, such as hormonal therapy, intrauterine insemination and in vitro fertilization (IVF). ART is a critically important part of the complete continuum of infertility care.

Proponents of SB 508 urge this committee to recognize that ART coverage can be paid for through existing premiums, by redesigning benefit plans.

000910

Perhaps insurers don't realize this, but most patients who need ART are successfully treated and able to conceive with the use of inexpensive hormone treatments or intrauterine insemination. Only about 1% needs in vitro fertilization, the cost of which parallels a *single* tubal surgery – in the range of \$8,000 - \$13,000. However, tubal surgery has a 9 – 10 % chance of aiding conception, while IVF has a 20 - 60% chance. Also, patients frequently have 6 – 12 tubal surgeries, while physicians strongly discourage more than 4 IVF cycles.

- We urge the committee to recognize that covering ART as part of the infertility treatment continuum would:
 - Save money by eliminating repeat surgeries, and the attendant risks, as ART requires no surgery; and
 - Reduce the financial pressure to implant multiple embryos in for instance, the one cycle of IVF a couple can afford, thereby resulting in fewer “multiple births” of 3, 4 or 5 children.

A second concern of the insurers: with new coverage, patients will come out of the woodwork for treatment, and drive up costs.

Infertility patients are not a typical disease population. As their testimony before the Public Health Committee *clearly* demonstrated, despite their illness, these patients are otherwise young, healthy, and highly focused on having a child. **Currently, this patient population is repeatedly accessing every covered treatment option – for years – costing employers high premiums, patients high co-pays, deductibles and co-insurance, and insurers cost payments for services.** We believe it's in *everyone's* best interest to get patients the right treatment, as quickly as possible after a diagnosis of infertility, and get him or her out of the health care system.

And finally, the insurers are concerned that improved access to and coverage for ART will result in higher numbers of multiple births, particularly triplets and quadruplets, which puts everyone involved at greater risk, and results in high neonatal intensive care unit costs.

To be clear, insurers, employers and patients in Connecticut are paying now for high-order multiple births. Indeed, a study conducted in 2003 by the Maine Bureau of Insurance found that, “The cost per delivery resulting from IVF pregnancies was about \$39,000 for pregnancies with one or two fetuses [versus] **\$340,000** per pregnancies with triplet and quadruplets.”

It is well documented that **states requiring health insurance for ART have far fewer multiple births than states without it.** In no small part because patients and physicians have less financial pressure to implant multiple embryos, the risk of which is “high order” multiple births of three, four or five children.

Better access to ART would reduce the chances for high order multiples – which maternity benefits cover now whether the parents had ART or not – and save insurers, employers and patients the associated cost.

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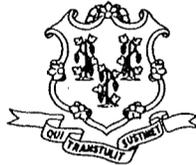
THE INFERTILITY TREATMENT CONTINUUM

Man and Woman decide to try to have a baby	Begin to have unprotected intercourse for 6 months to one year	No success? Diagnostic workup – Basel temp, ovulation kits, sperm count/motility test	No success - Female? i.e., Hysterosalpinogram, diagnostic laparoscopy
No success – Male? Testicular surgery, varicose veins	No success - Female? Tubal surgery for fibroids, cysts, polyps, endometriosis	No Success? Hormonal Therapy, Intrauterine Insemination	No Success? In-Vitro Fertilization – female, Intracytoplasmic Sperm Injection - male
No matter how conception occurs:	Pregnancy Benefit covers the full pregnancy	Maternity/Delivery benefit covers delivery and attendant costs	

Blue = Typically covered now by the basic major medical
 Red = Typically not covered by the basic major medical benefit;

SB 508 would allow coverage, at no additional cost, for the items in red, based on a reduction in consumption of services shown in blue

000912



State of Connecticut

HOUSE OF REPRESENTATIVES
LEGISLATIVE OFFICE BUILDING
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE MARY G. FRITZ
NINETIETH DISTRICT

43 GROVE STREET
YALESVILLE, CONNECTICUT 06492
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DEPUTY SPEAKER

MEMBER
EDUCATION COMMITTEE
EXECUTIVE AND LEGISLATIVE NOMINATIONS COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
JUDICIARY COMMITTEE
SCREENING COMMITTEE - CO-CHAIR

TESTIMONY

Representative Mary G. Fritz
90th District

February 17, 2005

Senator Crisco, Representative O'Connor and honorable members of the Insurance and Real Estate Committee, I appear before you today in support of Proposed Bill 508, An Act Concerning Health Insurance Benefits For The diagnosis And Treatment Of Infertility.

For the record, I am State Representative Mary Fritz of the 90th District, happily representing parts of the towns of Wallingford and Cheshire.

I testified before you on this same issue in 2003 and 2004 and every year that this issue has come to your attention.

SERVING CHESHIRE / WALLINGFORD



000913

Proposed Bill 508

-2-

February 17, 2005

Last year's bill—H.B. 5206—made it all the way to the Appropriations Committee where it died on a tie vote. Hopefully, this bill will not suffer the same fate.

As you know, infertility effects approximately 8% of the population. Of that 8% only 2% requires the invitro fertilization stage of treatment. So, overall, this is not many people.

I respectfully request this committee to fully draft this proposal and to please include the provisions of last year's bill—H.B. 5206—which exempts a religious employer from including infertility coverage in their benefit package.

Thanks for listening!

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000914

Testimony of Katherine Traver
16 Spruce Dr.
Naugatuck, Ct. 06770
203-729-1744

RE: Bill #SB508
Honorable Co-Chairs and Members of the Insurance Committee

I apologize for not being able to attend today's hearing and thank you for taking the time to review and consider my testimony. I wish to support my daughter, Julie Lucia regarding the mandate for Insurance Companies to include infertility coverage. I too have felt the impact of disappointment in every fiber of my body my daughter has endured for many years.

I have seen on TV and read in the newspapers heartbreaking stories of unwanted, abused babies and children that their parents were responsible for so many extremely intolerable reasons. It is terribly sad to hear of these horrendous cases. There are a small percentage of couples who have infertility disease and they want nothing more than to have children, to raise them in a loving environment and watch them grow an mature.

It would break my heart if Julie and her husband, Jerry would have to move out of State to have their child, our grandchild.

Our family roots have been here in Connecticut for generations. My husband and myself are both retired and not only yearn for another grandchild that we can nurture and spoil but also can be an integral part of their growing years here in Connecticut.

I ask that you support Raised Bill SB508

Thank you.

000915

Amy and Brian Smith
6 Mountain View Drive
Kensington, CT 06037
(860)-828-7967

February 17, 2005

The Honorable Senator Joseph J. Crisco, Jr.
The Honorable Representative Brian O'Connor
Members of the Insurance and Real Estate Committee
Legislative Office Building, Room 2800
Hartford, CT 06106-1591

Subject: Requesting support of SB 508-An act concerning health insurance benefits for the diagnosis and treatment of infertility.

We are writing you today to request that you support proposed SB-508, which requires health insurers to provide coverage for the diagnosis and treatment of infertility. We are under the assumption that the term 'Treatment' would include coverage for a procedure called In-Vitro Fertilization. Without IVF coverage, my wife and I will not have the opportunity to share in our dream of one day being parents and having a family.

Amy and I have known each other for the past seventeen years, been married for the past seven and have been trying unsuccessfully to have children for the past five years. We have both been diagnosed as having infertility problems and have been told by our doctors that the only possible way that we would be able to have children is by utilizing a procedure called In-Vitro Fertilization. The problem presented to us and many other couples is that most health plans do not cover In-Vitro Fertilization. If you support this legislation and this Bill passes, you will give Amy and me, along with thousands of other couples, a fighting chance to fulfill that dream and one day have a family.

I understand that the debate about whether or not to require coverage for IVF is an emotional one from a member's perspective and a cost issue from the Insurance Industry's perspective. I've researched what impact this legislation would have on member's premium per month and there are figures out there ranging from \$0.88 PMPM all the way up to around \$4.48 PMPM. If Amy and I had children, we would be happy to have \$4.48 taken out of our paycheck each month just so another couple that is struggling with infertility could have the opportunity to utilize the IVF coverage and give them a chance to have a family. I am sure there are plenty of other people in Connecticut that share this same point of view as well.

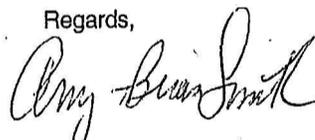
Additionally, there are a number of states that provide some sort of Infertility Coverage. These states are: Massachusetts, Illinois, Rhode Island, New Jersey, Arkansas, Colorado, Delaware, Maryland, Minnesota, Montana, New York, and West Virginia.

If all these states can pass legislation that provides some form of infertility coverage then so can Connecticut. Please take some time and consider supporting this legislation and give those couples struggling with infertility in this great state of Connecticut a fighting chance to have a family.

I urge you to support SB 508.

Thank you for your time.

Regards,



Amy and Brian Smith

000916

**Testimony In Support of SB 508 (HB 6588)
February 17, 2004 before the the Members of the Insurance & Real Estate
Committee:**

Anita Flannigan Steenson
12 Smith Point
Milford, CT 06460
Hm:(203) 877-9095
Off: (203) 874-8184

Mr. Chairman and members of the committee, my name is Anita Flannigan Steenson and I live in Milford, Connecticut. I am here today to speak in support of SB 508 (and HB 6588), Mandatory Insurance Coverage for Infertility Treatment.

It is actually a bit of a surreal experience for me to be here before all of you and in front of the public discussing such a painful and intimate subject matter. However, that is the nature of the disease of infertility, as it involves sex, bodily functions (or the lack thereof), emotions, pain, humiliation, discomfort and grief. This disease affects 1 out of 6 couples, yet it is so stunning, unexpected (as it has no advanced "symptoms") and devastating, most couples never talk about it, especially not in public. That is why, I am speaking out in detail, as unfortunately, I am a "typical" infertility patient, with a often heard history which brought me to this place. Until, my disease and treatment options were discovered, I knew nothing of this world of infertility despite the fact that it affects so many people, now I know why. Wanting a child, caring, educating and nurturing our children is the basic function of society and the reason why everything else, every law, every program is created and prided by a community. Having to come before the Committee to ask for a Mandate for Insurance Coverage for Infertility Treatment, something so basic and fundamental and core to life, is almost like pointing out that the "Emperor Has No Cloths."

For an amazingly accurate demonstration of the impact of this disease, please go to this web page, make sure your sound is on as a track of music plays and is important:

http://www.vocalicious.com/empty_arms/empty_arms_mod.html

The insurance industry had a legitimate position when infertility treatments began to develop in the 1980's. (see Article attached, "A History of IVF Statistics"). The medical and science community, and the community of patients have all acknowledged the flaws in the early infertility treatments but through pain, effort, expense and dedication all of those "concerns" have been addressed and overcome.

000917

Now, without even a real effort to research or justify this continued stance outrageous given that current state of technology and research the insurance industry is taking advantage of people who are vulnerable, weakened, humiliated and embarrassed to discuss their disease. Attached are abstracts/summaries of the results of two studies from 2002, "Insurance coverage and outcomes in in vitro fertilization", Jain, T, Harlow, BL, Hornstein, MD; and from 1998, "The economic cost of infertility-related services: an examination off the Massachusetts Infertility insurance Mandate", GriffinM, Panak, WF. The State of Massachusetts passed Mandatory Infertility Coverage in 1987 (see attached legislation and regulations), and a study of the economic impact of this law directly contradicts the predictions of doom and gloom of the Connecticut Providers presenting testimony before this Committee. The facts of the conclusions in 1998 and again in 2002 respectively were, "State-mandated insurance coverage for in vitro fertilization services is associated with increased utilization of the service but with decreases in the number of embryos transferred per cycle, the percentage of cycles resulting in pregnancy, and the percentage of pregnancies with three or more fetuses"...and... "Mandated infertility coverage was associated with increased use of ART (Assisted Reproductive Technology), but not with excessive increases in consumer cost for infertility insurance coverage." Also attached is a survey/study by the American Society of Reproductive Medicine which concludes that the increased cost of mandating infertility coverage per contract in the State of Massachusetts was an additional \$2.41 per year, a national survey, concluded \$2.71 per contract per year!

Ironically and tragically, the currently unfounded and antiquated position taken by the insurance industry is actually adding more expense and draw down of finite resources in that the most serious and costly "side effect" of infertility treatment is multiple births. This causes a strain and more expensive treatment to the mother during pregnancy (treatment which is covered by insurance), increased risk of premature birth and the need for extremely costly medical care (again covered by insurance). Unlike most covered infertility treatments (Clomid and IUIs), the use of IVF therapy, when medically indicated, actually provides a measure of control pertaining to the issue of multiple birth.

It should be clearly understood that for the vast majority of patients, infertility is simply not elective but acquired – they do not choose it. One would not say that a patient chooses to have cardiovascular disease. In reality, patients may contribute to their risks through sedentary life-styles, obesity, smoking and alcohol consumption. Still, infertility patients are relatively innocent bystanders to a disease process. Infertility is really no different.

By the time the objected to treatments are recommended, most couples have been through numerous tests and procedures and are worn down, distraught

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and financially drained. As the current posture signifies that infertility treatment is considered "elective" couples feel pressure and desperate and insist on the transfer of a high number of embryos since they are cash paying (or credit at this point) customers. If the insurance industry worked with the medical community and adopted its recommendations which are based upon sound facts and research, the resources, including for IVF treatment could be better allocated with a goal at providing the most cost effective and appropriate treatment with a successful conclusion, bringing home a healthy baby. (The State of Massachusetts does just this, See Regulation 211 CMR 37.03 which defers to the experts in this field, the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology (ACOG) or another infertility expert recognized as such by the [Insurance] Commission.)

This is why I am going to tell you my story.

I am 41.5 years old as I sit here today. My husband and I have been trying to conceive for over 5 (five) years through Assisted Reproductive Technology. Actually, we stopped trying to prevent a pregnancy after we were married 5 years when I was 30 years old in 1994 (we were married June 3, 1989).

My family has lived for 4 generations in New Haven, in the area of Legion Ave. and/or Congress Ave. I am the first person in my family to go to college. I am a product of the New Haven Public School system. I attended Boston University for 1 year of college and then took advantage of a scholarship offered by Albertus Magnus College and graduated, cum laude, in May of 1985. I took a year off to work and earn money to pay for law school and then attended the University of Bridgeport School of Law, graduating in May of 1989, right before I got married to my husband James Steenson.

We relocated to his home state of Nebraska, then relocated to the State of Florida. Jim worked as an electrician and I became a member of the Florida Bar Association and took a job as a public servant working for the court system and then the prosecutor's office in Fort Lauderdale, Florida. When we wanted to start our family in 1994, we saw our medical providers, bought books and proceeded with married life as "usual". We did everything we "were supposed to do", and when consulting our doctors about no pregnancy, we were routinely told, "relax, it will happen, you are young".

We relocated to London, England when I was named an American Scholar by the American Inns of Court to participate in an all expense paid fellowship for 6 months in 1995, before returning to my home state of Connecticut later that same year to be near my friends, family, parents, sisters, cousins, aunts, uncles.

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We sold our house in Florida, purchased a home in Milford, Connecticut in 1997, and I became a member of the Connecticut Bar Association, my husband obtained his Master Electrician's Connecticut License. We again consulted an OB/GYN regarding our attempts to start a family. The prevailing advice was that "we were young, had been traveling, moving, relax, it will happen." I was 34 years old, my husband 37 years old at this time. We went about the business of life, I took a position as an Assistant Corporation Counsel for the City of New Haven, another public service position for a short time, then opened my own private practice and became self-employed.

After several more years of trying to conceive, in 1999-2000, we began undergoing the first round of "testing" and treatment. This was invasive (so I thought) and overwhelming, some life situations developed, and we took a "break" from active treatment, still never preventing a pregnancy.

Finally in 2001, age 38 years old, I "stepped up" my level of treatment with my OB/GYN, even though the prevailing advice was, "you are still young, don't worry, it will happen). My OB/GYN referred me to a fertility specialist, a Reproductive Endocrinologist (RE) and described some of the advanced infertility evaluations, testing and treatments. I got scared, was overwhelmed, besides, "I was young, it would happen."

It took me almost another year, when I turned 39 years old, before I forced myself out of denial and sought out a consultation at the Yale Reproductive Clinic in August of 2001. Totally overwhelmed and ignorant (blissfully it turns out) we never gave a thought to the fact that our health insurance would not pay for this medical treatment. Our doctor's office took our insurance information, contacted the insurance company and was advised as to what our coverage was. We were lucky, we had some it appears. As an employer, I purchased a health insurance policy for myself and my employees and believed I had "good insurance" since I purchased it for my own benefit in addition to my employees.

We began treatment in September of 2001, and as our efforts were not successful, our doctor, gradually increased the intensity of the treatment. We became pregnant in December of 2001, but miscarried in a matter of weeks. After I recovered from that surgery, I needed another to correct a problem in my uterus discovered during prior proceedings. Recovery took until April, 2002, and we began treatment again, IUI with injected medications with negative results, April, May, June, 2002. My doctor recommended we advance treatment to IVF. We had no insurance coverage for this procedure and, in fact ran out of coverage and since we had to pay ourselves in July, August and September of 2002 we continued the same treatment as we could not afford more expensive

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treatment. In October of 2002, we did achieve pregnancy and the pregnancy progressed with no complications.

In December of 2002, we had a Level II ultrasound due to my "advanced maternal age", I was 40 years old at this point and tragically learned that our baby son was severely deformed and would not survive and we had to end that pregnancy. Again, my doctor recommended IVF, we could not afford and once I recovered tried IUI again in February, 2003. After no success, my age meant we could not afford to wait and we paid out of pocket for 4 IVF cycles on credit cards and home equity loans with no success, my last treatment was September of 2004. During this whole time period, as an employer, I researched and tried to buy insurance coverage, but, none was available to a small employer such as myself (so much for Connecticut's Mandate to Offer). My husband took a job out of state, in the State of Massachusetts where infertility coverage is available and mandated.

I am ashamed the great State of Connecticut, my family home of over 4 generations, has denied me the opportunity to have my disease of infertility treated as recommended by my doctor. My condition is (or was) treatable and the fact that I can not pursue my basic biological imperative to have a baby is vile.

The testimony of the two insurance providers follows the same tried and true tactic of the past by citing to unsupported scare tactics and unrealistic dollar signs. The numbers cited are not realistic in that many factors which logically offset those figures are not mentioned. For example, what about the discount the insurance company would be able to negotiate for its members with providers and pharmacies? What about the other costs this disease, left untreated causes such as stress, depression, lowered resistance to fight illness, the inability to work which affects the amount of income added to the economy in taxes and consuming? What about the withdrawal of volunteer services to the community based upon feelings of isolation and lack of support of that very community as represented by the legislature? What about all the unnecessary and predictably ineffective, yet covered by insurance company, treatments? What about the fact that if women are banished from IVF procedures when medically indicated, become desperate and are relegated to treatments where multiple births are less controllable and become high risk, expensive, yet covered by insurance, costs? What about the cost to society of my husband and I drawing down on our retirement to pay for treatments to simply have a family, and the fact that we will be more in need of support from the state and/or community in our elder years? What about all the couples who much finance treatments and then declare bankruptcy, what about that drain on our economy and community? What about the treatment insurance will and does cover when women, desperate for the fundamental basic biological goal of having their own

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child resort to treatments outside of medical supervision (see article attached, as an example)?

In the arguments about inequitably absorbing insurance company resources, what about the fact that I have had no children drawing down on insurance resources my entire adult life? What about the fact that I have paid property taxes for over 15 years, a substantial percentage of which goes to support the school system, yet I have never had children in that system? What about the fact that by minimizing smoking, obesity and alcohol related illnesses; the costs of health care would diminish to an amazing degree? The costs incurred with one day of intensive care treatment for a dying patient would go a long way towards paying for pediatric, prenatal and reproductive health care. From a purely economic standpoint, infertility treatments are an investment in the future of the state, begetting little "future taxpayers." It can be argued that it is more cost effective to assist in the process of creating life than in the prolongation of the dying process.

What about the fact that I "did everything I was supposed to do", I went to school, got an education, became self sufficient, married, worked as a public servant, contributed to my community on many levels, yet in my time of need, women in my position are in essence shunned by the community.

Infertile couples have suffered and lost so much before they even get to the point where they seek Assisted Reproductive Technology:

Loss of the "normal" and natural course of life and building a family;
Loss of intimacy and self confidence,;
Loss of dignity and control over the course of one's life;
Loss of being part of the community and "normal" life everyone else takes for granted. Can anyone argue that bearing children isn't a driving force in the vast majority of the population?

Infertility treatments are a tortuous process, no one wants to go through it. We all dream of conceiving our children in the context of a loving relationship, in the normal way. If there were any way to avoid needing these medical procedures, everyone subject to them would avoid them. Just going through the treatment strips you of your privacy and dignity, your "regular" life.

Infertility treatment involve invasive procedures on an ongoing consistent basis in order to succeed. Trips to the doctor's office to have vaginal ultrasounds or examinations, blood tests drawn to determine when and what treatment to start can be 2-3 times a week, sometimes daily trips, for 14-20 days a month. The day you find out that months treatment did not work (no pregnancy), is also the

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first day of your next cycle when more treatment decisions are necessary before the grief of failure can be processed and absorbed.

Here is an example of what one of the lesser serious (IUI – Inter Uterine Insemination) cycle of infertility treatment is like where actual fertilization done inside the body:

1. Cycle day 1 is the first day of menstruation. The clinic must be called and advised that your cycle has started. You are then instructed to come into the clinic on cycle day 3 for baseline testing consisting of a vaginal ultrasound and several vials of blood being drawn. All tests on all patients must be completed by 8:30 a.m. in order for same day results to be obtained. The clinic is open 7 days a week.
2. Cycle day 3, you go to the doctor's office and check in at the front desk, pay for the services about to be rendered or an insurance co-pay (sometimes you have to wait in line). You are then given lab slips and other paperwork. You proceed from the check-in lobby area to the blood draw station, again usually waiting in line for your turn. The nurse collects your other paperwork. Once you have several vials of your blood drawn, you go back to the waiting area to wait for an exam room to be ready. The nurse calls your name, directs you to an exam room, instructs you to undress from the waist down, get on the exam table and wait for the doctor and she hand you a clip board so that the results of the doctor's exam can be recorded. The doctor comes into the exam room, you are waiting with a sheet over the bottom half of your body, feet in the stirrups. The doctor then inserts a ultrasound probe into your vagina and you both watch the screed. Several parts of your reproductive anatomy are examined. The doctor tells you the thickness of your uterine lining which you record on the clip board. The doctor then locates your ovaries by maneuvering the probe inside your vagina to the left and right sides. Once the ovaries are located, the follicles which are on the "end" of the ovary are measured. You are told how many follicles you have on each side and how big they are and instructed to write these findings down on the clip board. The ideal results of the findings are a thin lining and no or very small follicles on your ovaries. This means you may proceed with the treatment that month, if your hormone blood levels are also low. You leave the clinic and the nurse calls you late that afternoon with the results of your blood work and the doctor's instructions on how or if to proceed with treatment after test results have been reviewed. Usually you are instructed to start self-injecting medications daily and to come back to the clinic in 2 or 3 days for monitoring. If your test results are not good, you must wait the entire month until you menstruate again and start over with a Cycle day 3 baseline testing.
3. Cycle day 5, is the same routine as in paragraph 2. The results of the exam are hopefully that you do have follicles (fluid sacks which encase

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developing eggs) growing to a certain size on the end of your ovaries and that your hormone levels from your blood work rises to a certain level. When the nurse calls with the results of your tests and the doctor's instructions, you can be told to continue as previously instructed, increase medications, decrease medications, add medications or stop treatment and return to the clinic in 1 or 2 days (depending on how your body is responding) for a repeat of the process described in Cycle day 2, paragraph 2 above.

4. Cycle day 7, same as cycle day 5, paragraph 3 above. Instructions could be to come in every morning at this point as well as to keep self injecting, adding or decreasing or stopping depending on how the size of the follicles are progressing and the hormone levels are rising.
5. Cycle day 9, same as above.
6. Cycle day 10, same as above. Now at this point, you are being monitored daily as some women are ready to ovulate between Cycle day 10 and 14.
7. Cycle day 11, same as above
8. Cycle day 12, same as above
9. Cycle day 13, same as above
10. Cycle day 14. If your doctor has determined your follicles have grown to a desired size and your hormone levels have risen to a certain levels and you are instructed to move to the next phase of the treatment. The nurse will call you in that afternoon and instruct you to take a different injected medication that evening at a precise time and to have your partner/husband report to the clinic the next morning by 7 a.m. and the female (you) are to report at 8:45 a.m.
11. Cycle day 15 (it could be cycle day 11-15). The man go to the doctor's office by 7 am, get a brown paper bag with a "collection cup" inside from the receptionist and is directed to go to the "collection" room. While there he must masturbate until he ejaculated into the collection cup. He then place the cup in the bag and return the bag to the laboratory for processing. I would arrive at the clinic within 2 hours and wait in line for my name and bracelet ID tag number to be called. I then would proceed to the examination room, undress from the waist down, place a sheet over my half-naked body, climb onto the examination table, place my feet in the stirrups and wait my turn. A doctor and nurse then entered the room carrying a test tube with my husband's sperm in it. The ID on the tube label and my wrist band are compared and identification is verified. The doctor then advises of the results of the analysis of the sperm sample,

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reporting volume, content and mobility of the sperm. The nurse verifies all of the above and we all sign a consent/identification verification form on a clip board. A speculum is then inserted into the vagina. A high powered small spot light is then directed to the exposed vaginal area. The doctor draws the sperm sample into a siring with a long thin plastic catheter on the end. The doctor then places the catheter into the vagina, up passed the cervix into the uterus and then injects the sperm directly into the uterus. You are then instructed to rest for 10 minutes for so and then you can get dressed and leave. You are instructed not to take hot baths, hot tubs, no alcohol and only Tylenol for discomfort, do not fly in an airplane, but otherwise go about your normal life.

12. Cycle day 16, you wait.

13. Cycle day 17, you wait.

14. Cycle day 18, you wait.

15. Cycle day 19, you wait.

16. Cycle day 20, you wait.

17. Cycle day 21, you wait.

18. Cycle day 22, you wait.

19. Cycle day 23, you wait.

20. Cycle day 24, you wait.

21. Cycle day 25, you wait.

22. Cycle day 26, you wait.

23. Cycle day 27, you wait.

24. Cycle day 28, you can finally take a home pregnancy test. If it is negative, you take the test daily for the next 2 days. If it is positive, you call the clinic and are instructed to come in the next day for a blood test to confirm pregnancy. If the home pregnancy test continues to be negative you can expect to menstruate any day.

25. The day you begin menstruation, you call the clinic and go back to paragraph 1 and begin again.

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The standard IVF protocol:

1. You actually start the cycle before your stimulation and retrieval cycle.
2. On CD3 of that cycle, your FSH level is measured. Then you wait
3. On CD21, you do a progesterone test to see if you have ovulated. (If you have not, you will be put on birth control pill regimen to give you a predictable cycle and start all over again). If you have ovulated, then you start Lupron shots once a day. The dosage stays the same for 5 days
4. On CD 26, you lower the dosage of this medication and your period should arrive close to its due date.
5. On Cycle Day 28-30 you should menstruate and the cycle continues.
6. On Cycle day 31 or 32 (now call cycle day 1 or 2 again, but it is the same cycle) , you are tested to ensure that Lupron has shut down your own hormone system, so that they can use drugs for stimulation and have a more predictable cycle. Suppression is determined primarily by your estrogen level, but your doctor may also check progesterone and LH. If you are adequately suppressed and an ovarian scan shows no cysts, you will usually start injectables on CD3
7. This is really cycle day 33 and you take 2 to 6 injections a day for three days.
8. Cycle day 36, the follicles and hormone levels will be checked by vaginal ultrasound and blood draw procedure described above. If needed, your medications will be adjusted.
9. Cycle day 38, you will go in a few days later for a second round of blood work and a follicle check as previously described.
10. Cycle day 39 you will go to the doctor's office for a follicle check and blood work;
11. Cycle day 40 you will go to the doctor's office for a follicle check and blood work. This will continue can be until cycle day 42-48 daily. Once

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your follicles have reached an appropriate size and your E2 levels are good, you stop the stims and Lupron, and are given the hCG shot.

12. Cycle day 45-51, 34 hours later the retrieval of eggs is scheduled. Retrieval is generally an out patient procedure. It can be done with a local anesthetic or an IV anesthetic. The eggs are retrieved using an ultrasound probe that has a needle at the end of it. They put the needle through the vaginal wall and aspirate the follicles in a sterilized out-patient procedure.
13. Cycle day 51 through Cycle day 54 or 56, you begin taking pain full progesterone shots, progesterone suppositories and antibiotics and steroids.
14. Cycle day 52, 53, 54, 55, you will be given daily updates by the laboratory as to whether or not your eggs have fertilized and if they are growing and developing. Transfer of fertilized eggs (embryos) if any, can be transferred 3 or 5 days after retrieval of the eggs back to the uterus.
15. Cycle day 54 or 56 transfer of the embryos takes place. The transfer itself is much like an IUI, although most doctors use u/s to guide the catheter in, because placement is so critical.
16. Cycle day 57, continue with progesterone shots and progesterone suppositories.
17. Cycle day 58, continue with progesterone shots and progesterone suppositories.
18. Cycle day 59, continue with progesterone shots and progesterone suppositories.
19. Cycle day 60, continue with progesterone shots and progesterone suppositories.
20. Cycle day 61, continue with progesterone shots and progesterone suppositories.
21. Cycle day 62, continue with progesterone shots and progesterone suppositories.

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22. Cycle day 63, continue with progesterone shots and progesterone suppositories.
23. Cycle day 64, continue with progesterone shots and progesterone suppositories.
24. Cycle day 65, continue with progesterone shots and progesterone suppositories.
25. Cycle day 66, continue with progesterone shots and progesterone suppositories.
26. Cycle day 67, continue with progesterone shots and progesterone suppositories.
27. Cycle day 68, continue with progesterone shots and progesterone suppositories.
28. Cycle day 69, continue with progesterone shots and progesterone suppositories.
29. Cycle day 70, continue with progesterone shots and progesterone suppositories.
30. Pregnancy tests are generally done somewhere between 12 and 14 days after transfer. If negative, you start all over again.

In conclusion, what person or couple, with the availability of any other option, would put themselves through this physical and emotional torture, but for anything less than creating life itself? To be denied insurance coverage for necessary, proven and effective medical treatment for a disease having such devastating consequences to the individual and society as a whole is incomprehensible.

Thank you for your time and attention. Please vote in favor of this legislation.
(Attachments incorporated herein)

The authors concluded that infertility insurance mandates do lower the multiple birth rate in IVF. They theorize that the reasons for the lowered multiple birth rate could be due to decreased pressure from patients to achieve pregnancy at any cost by transferring more embryos and due to pressure from the insurance companies to reduce the multiple birth rate.

According to J. Benjamin Younger, M.D., Executive Director of the ASRM, "We have long been advocating for adequate insurance coverage for all those suffering from the disease of infertility. This study is important because it shows it is an effective means of lowering the troubling multiple birth rate associated with ART. The time has come for a federal infertility insurance mandate to ensure that those suffering from infertility are given the same insurance coverage as those suffering from any other disease."

The American Society for Reproductive Medicine (ASRM), based in Birmingham, Alabama has more than 9,000 members who are devoted to advancing knowledge and expertise in reproductive medicine and biology, including obstetricians-gynecologists, urologists, endocrinologists, research scientists, medical technologists, and allied health professionals.

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2002

ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES
National Summary and Fertility Clinic Reports

Preface

For many people who want to start a family, the dream of having a child is not easily realized; about 15% of women of childbearing age in the United States have received an infertility service. Assisted reproductive technology (ART) has been used in the United States since 1981 to help women become pregnant, most commonly through the transfer of fertilized human eggs into a woman's uterus. However, for many people, deciding whether to undergo this expensive and time-consuming treatment can be difficult.

The goal of this report is to help potential ART users make informed decisions about ART by providing some of the information needed to answer the following questions:

- What are my chances of having a child by using ART?
- Where can I go to get this treatment?

The Society for Assisted Reproductive Technology (SART),* an organization of ART providers affiliated with the [American Society for Reproductive Medicine \(ASRM\)](#),* has been collecting data and publishing annual reports of pregnancy success rates for fertility clinics in the United States and Canada since 1989. In 1992, the U.S. Congress passed the [Fertility Clinic Success Rate and Certification Act](#). This law requires the Centers for Disease Control and Prevention (CDC) to publish pregnancy success rates for ART in fertility clinics in the United States. Since 1995, CDC has worked in consultation with [SART](#) and [ASRM](#) to report ART success rates.

The 2002 report of pregnancy success rates is the eighth to be issued under the law. This report is based on the latest available data on the type, number, and outcome of ART cycles performed in U.S. clinics.

The 2002 ART report has four major sections:

- ***Commonly asked questions about the U.S. ART clinic reporting system.*** This section provides background information on infertility and ART and an explanation of the data collection, analysis, and publication processes.
- ***A national report.*** The national report section presents overall

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success rates and shows how they are affected by certain patient and treatment characteristics. Because the national report summarizes data from all 391 fertility clinics that reported, it can give people considering ART a good idea of the average chance of having a child by using ART.

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- **Fertility clinic tables.** Success also is related to the expertise of a particular clinic's staff and the quality of its laboratory. The fertility clinic table section displays ART results and success rates for individual U.S. fertility clinics in 2002.

- **Appendixes:**

Appendix A contains technical notes on the interpretation of 95% confidence intervals and findings from the data validation visits to selected fertility clinics.

Appendix B (Glossary) provides definitions for technical and medical terms used throughout the report.

Appendix C includes the names and addresses of all reporting clinics along with a list of clinics known to be in operation in 2002 that did not report their success rate data to CDC as required by law.

Appendix D includes the names and addresses of national consumer organizations that offer support to people experiencing infertility.

Success rates can be reported in a variety of ways, and the statistical aspects of these rates can be difficult to interpret. As a result, presenting information about ART success rates is a complex task. This report is intended for the general public, and the emphasis is on presenting the information in an easily understandable form. CDC hopes that this report is informative and helpful to people considering an ART procedure. We welcome any suggestions for improving the report and making it easier to use.

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A History of IVF Statistics

In the United States, one of the richest and most technically advanced nations on earth, millions of couples remain involuntarily childless. A conservative estimate places the number of U.S. couples that grapple with infertility annually at 5,000,000, yet less than 20% of those couples will undergo some form of definitive treatment. The high cost of infertility treatment, especially the advanced Assisted Reproductive Technologies (ART) such as In Vitro Fertilization (IVF), has resulted in reluctance on the part of most insurance companies to provide benefits for infertility and therefore, has rendered such medical intervention financially inaccessible to the general infertile population. Although a few states have enacted legislation requiring health insurance providers to offer or provide infertility benefits, such coverage is often limited, or absent altogether due to regulatory loopholes. The majority of employer groups as well as health insurance providers continue to avoid voluntarily including infertility benefits. They recognize that such benefits would spawn an increase in the demand for these specialized services. This fuels their fear of the spiraling costs that might be brought about by a disproportionate increase in the demand for expensive ART, and the costly neonatal services required to deal with the potential influx of premature babies resulting from IVF-related multiple births.

These facts notwithstanding, it is inevitable that the strong and rising tide of consumer demand in response to compelling scientific evidence in support of IVF and other non-experimental ART's as valid treatment options for a legitimate disease, will ultimately force a much needed change. It is our contention that unless medical and insurance providers abandon the existing stalemate and work together to reach agreement that leads to the rapid introduction of voluntary, universal insurance benefits for infertility, including ART, there will occur a rising tide of consumer discontent that will become a catalyst for a government-imposed resolution. It would be preferable by far for medical and insurance providers to commit to working in unison to resolve this problem, rather than having heavy-handed bureaucratic legislation thrust upon us. The development of a strategy that would enable insurance providers to control costs and quality by monitoring utilization and treatment outcome, while discouraging abuses of the system, could put voluntary universal infertility insurance coverage well within reach.

Background

Historically, the insurance industry has resisted the provision of voluntary infertility benefits on the basis of the following:

- (1) lack of accountability in reporting of ART/IVF success rates,
- (2) fear of precipitating adverse enrollee selection,
- (3) the significantly high incidence of high-order multiple births (triplet pregnancies or greater) and the associated medical costs and social consequences and,
- (4) significant disparity in success rates among ART programs.

1) Lack of Accountability in Reporting IVF Success Rates

The field of ART, which involves in vitro fertilization and related procedures, has repeatedly been the focus of heated debate and controversy. Is this due to the fact that this area of medicine that deals with the initiation of life is regarded as sacrosanct, or is it because the practice of ART is so prone to misrepresentation and lack of accountability that it is regarded by many as fraudulent? Why is it that a couple researching their chances of undergoing successful IVF in two different ART clinics in the United States will often find that the live birth rate in one center is 2-3 times higher than in the other? And why, with a reported national average birth rate for IVF in

women under age 39, using their own eggs, of about 30% per egg retrieval procedure, do these couples encounter outcome statistics that range from single digits in alleged poor programs to more than 50% in better ones? Making matters worse, why, when turning to professional medical oversight bodies such as the Society for Assisted Reproductive Technology (SART) and the Center for Disease Control (CDC) to answer these questions and help them identify and select an IVF program on the basis of its proven track record, do consumers find themselves stone-walled?...Because there is currently no verifiable system of outcome-based IVF reporting in America. Furthermore, the current practice by SART of reporting conventional IVF statistics under a single broad category--the woman's age--is of little value to the individual IVF candidate. The multitude of variables that influence IVF outcome renders any attempt at interpreting IVF outcome based upon such a broad generalization misleading, and possibly even deceptive. Despite sixteen years of repeated promises to implement verifiable reporting of clinic-specific IVF success rates, SART's current system of "quality assurance" falls far short of achieving this objective, and as such, does not protect the consumer from manipulation.

The current criteria for clinic-specific reporting by SART-member programs are unenforceable. For the most part, the SART report consists of self-generated data submitted by ART programs and published unaudited and/or unvalidated, largely upon the basis of "good faith". In the virtual absence of oversight and accountability, it is a relatively simple matter for any IVF program to overstate their number of IVF "successes", understate their number of "failures", and/or "improve" their success rates by selectively performing IVF on only those cases most likely to succeed (e.g., younger women, women with few or no prior IVF failures, and women who, based upon testing, are most likely to respond optimally to fertility drugs). Given that the practice of IVF in the United States is highly competitive and consumers understandably prefer to undergo treatment at the most successful centers, it should come as no surprise that with little or no risk of being detected and minimal consequences if they are, some IVF programs do indeed overstate their success rates.

A historical perspective may provide further insight. SART was originally established in New Orleans at the annual meeting of the American Fertility Society in 1984. At that time it was perhaps more aptly named the "IVF Special Interest Group". For several years it was the policy of the IVF Special Interest Group to annually report only pooled data, i.e., the collective results of its entire ART-program membership. In fact, each member program that submitted its annual statistics for inclusion in what was then known as the IVF Registry was given assurance by the custodians of the Registry that only pooled data would be made public. Further, Registry members were actually advised not to disclose their clinic-specific outcome data based upon the belief that it would make it less likely that IVF programs would overstate their success rates in order to be competitive.

In 1986, responding to numerous complaints regarding exploitation and unscrupulous practices in the arena of infertility in general, and IVF in particular prompted the United States Congress took action. Hearings were held under the auspices of the Office of Technology Assessment (OTA) to address consumer concerns. In 1989 the proceedings and the conclusions were published in the "Wyden Report". Congress subsequently mandated, under threat of prosecution, that all IVF programs in the United States report their outcome statistics for 1987 and as a result, the first report of clinic-specific ART outcome statistics in the United States was published. This was followed by passage of the "IVF Success Rate Certification Act of 1992" which was implemented in 1997. The explicit intent of this act was to compel honest disclosure of IVF success rates and the implementation of quality assurance in all IVF programs in the United States.

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A History of IVF Statistics

In 1994, sensing a growing consternation among IVF consumers regarding its continued non-accountability, SART gave tacit support to the introduction of an "audit" of all its member programs. The national accounting firm of Peat Marwick & Company was engaged to develop and help implement a clinic-specific, IVF-outcome based reporting process. Disinterest on the part of ART centers, coupled with SART's lack of resolve to enforce compliance, resulted in this attempt at a verification process being abandoned before the year ended. Perhaps not unexpectedly, subsequent gestures on the part of SART to introduce alternate methods for the appropriate verification of IVF outcome reporting have led to nothing more than the virtual "self reporting process" that currently exists, and which is supported by "token" random and sporadically conducted onsite reviews. The ultimate complete failure of this process became self evident in July, 2002, when SART sent a letter to all IVF Program Directors in the U.S. stating that as a result of a "lack of financial and human resources", random onsite reviews would be foregone with respect to outcome data for the year 2000. Instead, SART directed all Medical Directors of its member programs to perform a specified "self-review" of the medical and laboratory records of ten (10) pre-selected IVF cases. Upon receipt of such information in the required format, the center would pass certification and thereupon would undertake to publish the program's total, self generated IVF outcome data for the year 2000 on the Center for Disease Control's (CDC's) official web site.

As long as SART refuses to demonstrate a commitment to fulfill their obligation to assure honesty in reporting of IVF outcome data, the insurance industry will likely remain skeptical and reluctant to pay for IVF.

2) Fear of Adverse Enrollee Selection

There is concern on the part of individual insurance companies and employer groups that a decision to provide benefits for ART would cause infertile couples to take rapid, excessive, and possibly ill-advised advantage of the coverage and ultimately result in an unreasonable financial liability. In this report, we will demonstrate that the implementation of a reporting system based on outcome (the Outcome Based Reporting System-OBRS) will work to avoid these concerns. We will show further that this approach will serve to minimize risks to insurance companies and actually work to help them to enroll otherwise healthy families, whom it is anticipated will become loyal members for a substantial period of time into the future.

3) High Incidence of IVF-related Multiple Births

In an attempt to optimize success rates, many IVF programs in the United States still transfer relatively high numbers of embryos with the hope that at least one will result in a pregnancy. The result has been an unacceptable increase in the incidence of high-order multiple births. High-order multiple pregnancies, because they compound the incidence and severity of most pregnancy-induced complications and are associated with a high risk of premature delivery, are prejudicial to the health of both the mother and her offspring. Premature birth leads to a high perinatal mortality and morbidity with complications that can prevail throughout the life of the offspring. Such prematurity-related, life-long morbidity establishes an enormous potential financial burden for insurance providers and thus creates a strong disincentive to provide benefits for ART services. Although the ASRM has published guidelines relating to the numbers of embryos to be replaced in a given patient, there is currently no reasonable method to mandate the maximum number of embryos that may be transferred. Consequently the insurers have no control over this variable. This problem can only be solved through penalizing IVF providers whenever a high-order multiple pregnancy occurs as the direct consequence of transferring an inappropriately high number of embryos.

4) Disparity in IVF Success Rates

The wide disparity in IVF success rates reported by ART programs in the United States has understandably led providers of health insurance to question and investigate the varying levels of expertise with respect to these services. This disparity in IVF success rates, coupled with an awareness that there is currently no way of accurately verifying reported success rates, has eroded confidence in the entire ART industry and has contributed to reluctance on the part of insurance companies to fund such services.

In those states that mandate IVF coverage, leaving insurance payors with little choice but to comply, costs have spiraled out of control and have led to a progressive reduction in the reimbursement for IVF services. ART programs have been forced to respond by increasing their productivity in order to remain profitable. To achieve this, many physicians have "cut corners" by involving more paramedical and/or technical personnel in the performance of procedures that they themselves would ordinarily do (e.g., such as ultrasound monitoring of follicle growth)--and by devoting less time to the individual patient. Predictably, such actions have led to a decline in the standard of care and reduced IVF success rates.

The time has come for an immediate commitment to solve this problem, otherwise heavy-handed bureaucratic legislation and regulation is bound to be thrust upon us? The development of a strategy must include development of a verification process that would permit real monitoring of IVF utilization and outcome. One that rewards for good performance in terms of outcome in well defined categories of clinical complexity (so as to allow outcome to be evaluated in comparable patients), discourages and penalizes abuses of the system, including but not limited to the reckless transfer of large numbers of embryos, and does all this in real time providing easy access of results to all interested parties (consumers, governing bodies and insurance providers). If this is done, universal IVF insurance coverage could well become within reach since there could be a significant financial upside for insurance companies, through tapping into the large infertility community. Remember, aside from reproductive problems, the infertile population in the United States is relatively young and healthy, comprising individuals, who are less likely to require costly medical care and whose need to keep their insurance coverage current at all times, would likely ensure their being fiscally responsible. Moreover employers could offer access to infertility coverage as an added benefit, by which they could attract high quality employees.

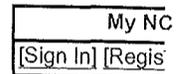
The first step towards attaining the worthy objective of universal infertility coverage requires introduction of a method that will allow for reliable verification of clinic-specific outcome data (birth rates per cycle of treatment) for every possible demographic category. A computerized data collection system could be placed in every participating ART program, with the requirement that only those procedures that are fully entered within 72hrs of completion would be eligible for insurance reimbursement. This would permit accurate and verifiable outcome reporting along with oversight relative to the number of eggs/embryos being transferred. All ART programs could be required to meet specific performance standards in order to qualify for insurance reimbursement and be rewarded and/or incentivised financially if performance exceeded required standards. In this way, by shifting the focus from service to outcome, there would evolve a strong incentive to upgrade standards of care, improve outcomes and minimize the number of treatment cycles necessary to achieve a live birth.

It imperative that health insurance providers be embraced as part of the solution rather than being part of the problem. An all-inclusive multi-institutional "Think Tank", comprising physicians, consumers, and insurance providers should be convened without delay, to discuss the feasibility of introducing universal infertility insurance coverage in the United States. The goal must be to have the insurance industry join all interested parties in the immediate establishment and enforcement of a workable regulatory process.

Change is sometimes difficult to accept and implement. It is anticipated that the novel approaches, will create anxieties and objections from established, albeit outdated and inadequate, data collection programs such as the ones currently in place and overseen by SART and the CDC. It is believed however, that it is time to take the cause for optimal, safe and affordable infertility care, to the ones who need it the most - the consumers. It is anticipated that approach outlined above, would create necessary checks and balances to provide cost-effective, voluntary, universal insurance benefits for advanced ART's, with widespread and far reaching advantages for the employer, the pharmaceutical companies, the physicians and above all prospective and existing patients.

We have to make a start.... And there is no time like the present.
INCIID is now testing the Outcome Based Reporting System here:
<http://www.ivfstats.org>

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The economic cost of infertility-related services: an examination of the Massachusetts infertility insurance mandate.

Griffin M, Panak WF.

College of Nursing, University of Rhode Island, Kingston 02881-0814, USA

OBJECTIVE: To examine the costs and outcomes of infertility-related services in Massachusetts during a time of expanded use of assisted reproductive technology (ART). **DESIGN:** Cost data were obtained from the Massachusetts Department of Insurance Rate-Setting Commission and 9 large group insurance plans for the period 1986-1993. Utilization and success rates of ART were examined, and the cost per live delivery with the use of ART in 1993 was estimated. **SETTING:** The state of Massachusetts, in which access to infertility-related services has been mandated by law since 1989. **PATIENT(S):** The study population consisted of 8 large health maintenance organization plans and the Blue Cross/Blue Shield indemnity plan. **INTERVENTION(S):** None. **MAIN OUTCOME MEASURE(S):** Per capita infertility-related expenditures, infertility-related expenditures as a percentage of total expenditures, live deliveries per initiated ART cycle, and cost per live delivery. **RESULT(S):** Expenditures for infertility services increased at a rate similar to or slower than inflation during the years 1988-1992. Increases were slowest in health maintenance organizations, probably as a result of provider arrangements. Infertility services accounted for 0.41% of total expenditures within the indemnity plan in 1993 (approximately \$1.71 per contract-month). Examination of ART utilization showed no evidence of overutilization by patients with a 1 chance of success. The cost per live delivery with the use of ART in 1993 was \$59,484. **CONCLUSION(S):** Mandated infertility coverage was associated with increased use of ART but not with excessive increases in consumer cost for infertility insurance coverage.

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- N Engl J Med. 2003 Mar 6;348(10):958-9; author reply 958-9.

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Insurance coverage and outcomes of in vitro fertilization.

Jain T, Harlow BL, Hornstein MD.

Department of Obstetrics and Gynecology, Brigham and Women's Hospital a Harvard Medical School, Boston 02115, USA.

BACKGROUND: Although most insurance companies in the United States do not cover in vitro fertilization, a few states mandate such coverage.

METHODS: We used 1998 data reported to the Centers for Disease Control Prevention by 360 fertility clinics in the United States and 2000 U.S. Census data to determine utilization and outcomes of in vitro fertilization services according to the status of insurance coverage. **RESULTS:** Of the states in which in vitro fertilization services were available, 3 states (31 clinics) required complete insurance coverage, 5 states (27 clinics) required partial coverage, 37 states plus Puerto Rico and the District of Columbia (302 clinics) required no coverage. Clinics in states that required complete coverage performed more in vitro fertilization cycles than clinics in states that required partial or no coverage (3.35 vs. 1.46 and 1.21 transfers per 1000 women of reproductive age, respectively; $P < 0.001$) and more transfers of frozen embryos (0.43 vs. 0.30 and 0.20 per 1000 women of reproductive age, respectively; $P < 0.001$). The percentage of cycles that resulted in live births was higher in states that did not require any coverage than in states that required partial or complete coverage (25.7 percent vs. 22.2 percent and 22.7 percent, respectively; $P < 0.001$), but the percentage of pregnancies with three or more fetuses was also higher (11.2 percent vs. 8.9 percent and 9.7 percent, respectively; $P = 0.007$). The number of fresh embryos transferred per cycle was lower in states that required complete coverage than in states that required partial or no coverage ($P = 0.001$ and $P < 0.001$, respectively). **CONCLUSIONS:** State-mandated insurance coverage for in vitro fertilization services is associated with increased utilization of the services but with decreases in the number of embryos transferred per cycle, t

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percentage of cycles resulting in pregnancy, and the percentage of pregnancies with three or more fetuses. Copyright 2002 Massachusetts Medical Society

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211 CMR: DIVISION OF INSURANCE

211 CMR 37.00: INFERTILITY BENEFITS

Section

- 37.01: Authority
- 37.02: Purpose
- 37.03: Definitions
- 37.04: Scope of Coverage
- 37.05: Required Infertility Benefits
- 37.06: Prescription Drugs
- 37.07: Optional Infertility Benefits
- 37.08: Prohibited Limitations on Coverage
- 37.09: Permissible Limitations on Coverage
- 37.10: Recognition of Additional Non-Experimental Procedures
- 37.11: Effective Date
- 37.12: Severability

37.01: Authority

211 CMR 37.00 is issued under the authority of M.G.L. chs. 175; 176A; 176B; 176D and 176G.

37.02: Purpose

The purpose of 211 CMR 37.00 is to implement St. 1987, c. 394, an Act Providing a Medical Definition of Infertility.

37.03: Definitions

The following words as used in 211 CMR 37.00 shall be defined as follows:

Commissioner: The Commissioner of Insurance or his or her designee.

Experimental infertility procedure: A procedure not yet recognized as non-experimental as defined below.

Infertility: The condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

Insured: A subscriber, member, policy holder, certificate holder or his or her covered spouse or other covered dependent.

Insurer: Any company as defined in M.G.L. c. 175, § 1 and authorized to write accident and health insurance; any hospital service corporation as defined in M.G.L. c. 176A, § 1; any medical service corporation as defined in M.G.L. c. 176B, § 1; or any health maintenance organization as defined in M.G.L. c. 176G, § 1.

Non-experimental infertility procedure: A procedure which is:

- (a) Recognized as such by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology (ACOG) or another infertility expert recognized as such by the Commission; and
- (b) Incorporated as such in 211 CMR 37.00 by the Commissioner pursuant to M.G.L. c. 30A.

37.04: Scope of Coverage

Insurers shall provide benefits for required infertility procedures, as described in 211 CMR 37.05, which are furnished to an insured, covered spouse and/or other covered dependent.

Insurers shall not be required to provide benefits for services furnished to a spouse or dependent if the spouse or dependent is not otherwise covered by the insurer, except as provided in 211 CMR 37.05(4).

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211 CMR: DIVISION OF INSURANCE

37.05: Required Infertility Benefits

Subject to any reasonable limitations as described in 211 CMR 37.08, insurers shall provide benefits for all non-experimental infertility procedures including, but not limited to:

- (1) Artificial Insemination (AI);
- (2) In Vitro Fertilization and Embryo Placement (IVF-EP).
- (3) Gamete Intra fallopian Transfer (GIFT).
- (4) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any.
- (5) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility.
- (6) Zygote Intrafallopian Transfer (ZIFT).

37.06: Prescription Drugs

Insurers shall not impose exclusions, limitations or other restrictions on coverage for infertility-related drugs that are different from those imposed on any other prescription drugs.

37.07: Optional Infertility Benefits

No insurer shall be required to provide benefits for:

- (1) Any experimental infertility procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner;
- (2) Surrogacy;
- (3) Reversal of Voluntary Sterilization;
- (4) Cryopreservation of eggs.

37.08: Prohibited Limitations on Coverage

(1) No insurer shall impose deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for required infertility benefits which are different from those imposed upon benefits for services not related to infertility.

(2) No insurer shall impose pre-existing condition exclusions or pre-existing condition waiting periods on coverage for required infertility benefits. No insurer shall use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting or otherwise restricting the availability of coverage for required infertility benefits.

37.09: Permissible Limitations on Coverage

Insurers may establish reasonable eligibility requirements, based upon the insured's medical history, and reasonable provider contracting standards. Eligibility requirements based solely on arbitrary factors including, but not limited to, number of attempts or dollar amounts, shall be presumed invalid. These requirements and standards shall be maintained in written form and shall be available to any insured and/or the Commissioner upon request. Standards or guidelines developed by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology may serve as a basis for these eligibility and contracting requirements.

37.10: Recognition of Additional Non-Experimental Procedures

Any person may petition the Commissioner for the recognition of a procedure as non-experimental, as that term is defined in 211 CMR 37.03.

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211 CMR: DIVISION OF INSURANCE

37.11: Effective Date

211 CMR 37.00 shall apply to any contract, policy or plan offering hospital, surgical or medical expense coverage as described in M.G.L. c. 175, §§ 108 and 110, M.G.L. c. 176A, M.G.L. 176B, and M.G.L. c. 176G, and which is issued or renewed, within or without the Commonwealth, on or after January 6, 1988, and providing coverage for any Massachusetts resident. The promulgation of 211 CMR 37.00 is necessary to preserve the public health, safety and general welfare and to afford full coverage to those with an need for infertility benefits, thereby implementing the public policy of the Commonwealth as evidenced by St. 1987, c. 394.

37.12: Severability

If any section or portion of a section of 211 CMR 37.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 37.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 37.00: M.G.L. chs. 175, 176A, 176B, 176D and 176G; St. 1987, c. 394.

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10 Central Ohio's News Leader

**10 Investigates
Uncovering The Black Market of Fertility Drugs**

10 Investigates found that hundreds of desperate couples are making risky and illegal deals because they are desperate to have a child. People seem willing to risk it all, from jail time to hospitalization in pursuit of the goal.

While the agony of infertility stands in the way for thousands of couples, some are willing to go outside the accepted channels of medical care to try improving their chances of fulfilling their dream.

10TV watched Chris and Maggie Pullins set up profiles on the Internet. They weren't looking for just any drugs... injectable fertility drugs were the target.

They are very expensive and in most cases. And like for the Pullins, the drugs are not covered by insurance.

A one-month cycle of fertility drugs from the pharmacy can cost between \$2,000 and \$3,000. Online, couples can find what they think are the same drugs for between \$500 and \$1,000.

In this black market world of fertility drugs, the sellers are people claiming to be "finally pregnant"... "pregnant with twins"... or "babies on the way" according to the subject lines of their email offers. And those supposed couples have leftover drugs for which they paid full price, the claim goes.

The buyers are desperate, literally begging for cheaper fertility therapy because their insurance won't pay for the medication.

"When you want a child so bad - you'll do practically anything," Maggie Pullins admits.

But what these couples are doing online is against the law.

"Every one of these transactions - it looks to me - the way they're written, are flat out illegal," Bill Winsley, the executive director of the Ohio Pharmacy Board says.

And Winsley says these couples are stepping into some pretty risky territory not only legally, but also where their health is concerned.

"The concern that we have is: is the patient even getting the real drug or are they getting a counterfeit drug."

"I do know that people do it - they've told me they've done it," Dr. Beth Kennard says.

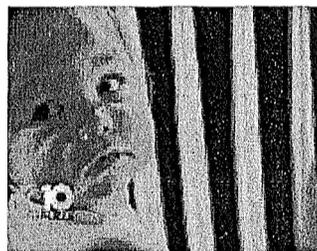
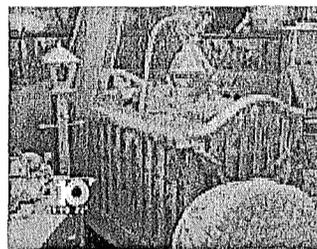
Dr. Kennard works with couples struggling with infertility at Ohio Reproductive Medicine. And patients ask her about buying the drugs online.

"I tell them as far as I know, it's illegal. And I can't give them a lot of advice about getting drugs for their medical treatment that way."

But for some, it's their "last hope." They use names like "wishing and hoping," "baby clouds," and "from here to maternity" as their email addresses and screen names.



Chris and Maggie Pullins admit shopping for fertility drugs on the Internet



But there's also proof of the risk, along with warnings of scam artists and rip offs.

And adding to the risk, Winsley says, is that most of these drugs involve needles and people inexperienced in using them.

"You're bypassing all your natural defense mechanisms. So if that product is not what it's supposed to be or if you have accidentally contaminated it when you dilute it, you're injecting it right into your body," Winsley explains.

The Pullins' admit it feels risky. But they say they don't know where else to go.

"I mean I cry about every time I talk to our insurance. It's like, 'why won't you cover this?'"

Here in Ohio, health insurance coverage of infertility varies widely, with levels of coverage set by employers. And like many other drugs, injectable fertility drugs sell in other countries for a fraction of what they sell for in the United States.



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Drive for Insurance Coverage Of Infertility Treatment Raises Questions of Equity, Cost

By Adam Sonfield

In 1998, the U.S. Supreme Court ruled that individuals suffering from a disability related to their reproductive capacity are protected from discrimination under the federal Americans with Disabilities Act (ADA). Advocates for individuals and couples suffering from infertility are seeking to use this decision as leverage in their long-standing attempts to alter how infertility is viewed and addressed in the United States—particularly in the realm of insurance coverage. Not unexpectedly, however, these efforts face opposition from those who question the economic and societal costs of infertility treatment.

Infertility and Its Treatment

Typically defined as the inability to become pregnant after one year of sexual intercourse without contraception, infertility affects over six million U.S. couples. One-third of diagnosed cases stem from male factors (such as low sperm count or malformed sperm cells) and another third from female factors (such as irregular or abnormal ovulation or blocked fallopian tubes); the remaining cases either involve both partners or are of unknown causes. The major preventable cause of infertility can be pelvic inflammatory disease, which in turn can be caused by chlamydia and other sexually transmitted infections.

Treatment for infertility is just as varied, including hormonal therapy to stimulate ovulation, artificial insemination, surgery on the fallopian tubes and in vitro fertilization (IVF) and related techniques. Significantly, although current tech-

nologies can successfully treat more than half of couples experiencing infertility, most couples do not seek or receive treatment. Of those who do, most do not end up using advanced treatment; in fact, only one-third go beyond medical advice and diagnostic tests. According to the 1995 National Survey of Family Growth, 15% of the 60 million women of reproductive age have received some form of infertility services during their lifetime, including 3% using ovulation drugs and 1% using artificial insemination, IVF or other advanced procedures.

One major deterrent to infertility treatment is the cost of services.

A 1998 survey by human resources consulting firm William M. Mercer found that only about one-quarter of employer-sponsored health plans cover any of the costs of infertility treatment. Moreover, the extent of coverage in these plans varies considerably, with IVF, in particular, included in only about one in 10. As the cost of one cycle of IVF is often more than \$10,000—and as an individual cycle is successful only one-quarter of the time—couples with no or limited insurance coverage may be unable to afford such treatment, or may incur substantial debt in their attempts.

Infertility as Disability

In the mid-1980s, a number of state legislatures took up the question of requiring coverage—or at least the offer of coverage—for infertility services. According to the American Society for Reproductive Medicine (ASRM), which represents providers of infertility services, and RESOLVE,

an advocacy group for infertility patients, mandates of one type or the other are in place in 13 states (see box). The movement seemed to stall, however, after the last of these measures were enacted in 1991. Then, in June 1998, the Supreme Court in *Bragdon v. Abbott* held that an HIV-positive woman must be considered disabled under the ADA because the disease interferes with reproduction. Enacted in 1990, the ADA prohibits discrimination on the basis of disability—defined as a physical or mental impairment that substantially limits a “major life activity”—in a variety of arenas, including employment.

Bragdon dealt specifically with HIV, but by identifying reproduction as a major life activity on the same level as walking, seeing or hearing, the Court may have been indicating that employers must make reasonable modifications to their policies and

Only about one-quarter of employer-sponsored health plans cover any of the costs of infertility treatment.

practices to avoid discrimination against individuals with impaired reproductive capacity. Indeed, although *Bragdon* did not specifically address either infertility or insurance coverage, groups such as ASRM and RESOLVE assert that the decision, in fact, covers infertility and that employer-sponsored health care benefits may not discriminate against those suffering from the condition.

These assertions found a hint of government support when the New York district office of the Equal Employment Opportunity Commission (EEOC) issued a “determination letter” in May of this year stating that a company’s denial of coverage for an employee’s infertility treatment may be a violation of both the ADA and the 1978 Pregnancy Discrimination Act,

STATES REQUIRING INSURERS TO COVER OR OFFER TO COVER INFERTILITY-RELATED SERVICES	
REQUIRE TO COVER	REQUIRE TO OFFER
ARKANSAS HAWAII ILLINOIS MARYLAND MASSACHUSETTS MONTANA NEW YORK OHIO RHODE ISLAND VIRGINIA	CALIFORNIA CONNECTICUT TEXAS

Laws vary widely in the range of treatments covered and restrictions that apply. Sources: ASRM and RESOLVE.

which prohibits discrimination on the basis of pregnancy or "related medical conditions." Such a letter is a preliminary step in what can be an extended process; moreover, it involves only one specific case and does not represent an official EEOC position—or even one upon which officials will publicly comment. Nevertheless, infertility coverage advocates have applauded the letter as a logical application of *Bragdon*.

Debating Costs and Benefits

"There is quite a lack of knowledge about the typical infertility experience," contends Deborah Wachenheim of RESOLVE. As a result, she says, "infertility treatment is sometimes lumped together with cosmetic surgery as a 'life-style' type procedure," rather than considered "serious medicine." In fact, Wachenheim emphasizes, infertility is recognized as a disease by the medical community, and it is one that can be devastating to an affected couple, both financially and psychologically.

Still, many employers and insurers have expressed concern that increased coverage of infertility treatment will have a major impact on insurance costs. Echoing the traditional defense by the insurance

industry against coverage mandates of all sorts, they argue that requiring employers to cover infertility treatment will force some employers to eliminate health benefits entirely and increase the already considerable number of uninsured Americans. These cost concerns have been heightened by the role played by infertility drugs and IVF—by stimulating ovulation and implanting multiple embryos to enhance the chance of a successful pregnancy—in fueling a major increase in the rate of multiple births. This, in turn, has increased costs at delivery, the need for expensive neonatal intensive care and the incidence of birth defects.

Several of the existing state coverage mandates have built-in utilization controls. The Illinois law, for example, requires coverage for IVF and two related forms of treatment only after less-costly but medically appropriate forms of covered treatment have failed; furthermore, it limits the number of IVF attempts allowed under the required coverage. Moreover, data from some recent studies indicate that the costs of infertility coverage may be overstated. One analysis, published in 1995 in *Fertility and Sterility*, calculated the total expense of all IVF treatment in the United States at that time and projected that coverage of this expense would increase premiums by \$3.14 per employee per year. The major uncertainty was how much increased insurance coverage might lead to greater utilization—and thus drive up the actual costs.

Two studies of insurers in Massachusetts—which passed an infertility coverage mandate in 1987—address that question. An evaluation published in *The Journal of Reproductive Medicine* in 1997 of one health plan's experience found that despite a utilization rate substantially higher than the U.S. average, the annual cost per employee was still around \$3. A broader study of insurers in the state, published in

Fertility and Sterility in 1998, found that expenditures did not outpace overall inflation, despite an increase in coverage and utilization. The authors cited increased treatment success rates, cost-effective advances in treatment technology

Data from recent studies indicate that the costs of infertility coverage may be overstated.

and, most importantly, discounts for services under managed care provider arrangements and capitation plans as factors contributing to these stable costs.

Moreover, Sean Tipton of ASRM contends that comprehensive coverage can act to reduce incentives to seek inappropriate, and expensive, treatment. For example, he says, patients in plans that do not cover IVF may opt for repeated attempts at covered tubal surgery—which can be twice as expensive as one attempt at IVF, is more invasive and is less effective for some patients. In addition, a paper presented in October 1998 at ASRM's annual meeting indicates that coverage of infertility treatment may mitigate the problem of multiple births by eliminating the financial incentive to maximize the chance of a successful pregnancy in each treatment cycle. The authors found that IVF programs in states with mandated coverage of infertility treatment transferred fewer embryos per procedure and had significantly lower rates of multiple births per transfer cycle.

Legislative Responses

How this debate over the merits of infertility coverage will play out over time remains uncertain, but even as they hope for the courts and the EEOC to validate their legal position more clearly, advocates of infertility coverage are pressing their arguments vigorously in both the private and public sectors. RESOLVE's

(Continued on page 14)

Wachenheim has been working to educate employers about the extent and effects of infertility in the American workforce—and about the advantages to an employer of provid-

Proponents of infertility coverage are clearly taking a leaf from the strategies of the contraceptive coverage movement.

ing “family friendly” benefits in a competitive employment environment. And RESOLVE and other advocacy groups are working closely with lawmakers at both the state and federal levels to enact requirements that insurance plans cover infertility-related services.

This year—the first since the *Bragdon* decision, the highly publi-

cized initial successes of the contraceptive coverage movement and the approval of the impotence drug Viagra—legislation related to infertility coverage was introduced in at least 16 states, up from 10 states in 1998 and six in 1997. Moreover, in four of these states—Indiana, New Hampshire, New York and Virginia—measures were approved by one legislative chamber; only Indiana considered legislation that seriously in the prior two years.

In Congress, meanwhile, proponents of infertility coverage are clearly taking a leaf from the strategies of the contraceptive coverage movement. In early August, two infertility-related bills were introduced. One, sponsored by Rep. Anthony Weiner (D-NY), basically parallels the Equity in Prescription Insurance and Contraceptive Coverage Act

(EPICC), which was introduced in 1997 by Sens. Olympia Snowe (R-ME) and Harry Reid (D-NV) in the Senate and by Reps. Jim Greenwood (R-PA) and Nita Lowey (D-NY) in the House. As EPICC would for contraceptives, the Weiner bill would achieve comprehensive private-sector coverage for infertility treatment by amending a range of federally regulated insurance plans. As a precedent for that measure, the other bill, sponsored by Rep. Marty Meehan (D-MA), would mandate coverage by plans participating in the Federal Employees Health Benefits Program (FEHBP). Congressional proponents of contraceptive coverage successfully pressed for such a requirement for FEHBP plans as part of the annual appropriations process in 1998, and they were able to do so again this year.

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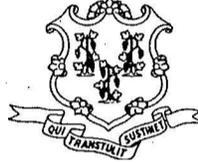
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Testimony of
Natasha M. Pierre, JD, MSW
Associate Legislative Analyst
Permanent Commission on the Status of Women
Before the
Insurance Committee
Thursday, February 17, 2005

In Support of:

HB 6124 AAC The Extension of Health Insurance Benefits for Divorced Spouses

HB 6277 AAC Continuation of Health Insurance Coverage for Divorced Spouses

SB 28 AAC Health Insurance Coverage for Breast Cancer Screening

**SB 30 AAC Health Insurance Coverage for Breast Cancer Screening for Individuals
with a Family History of Breast Cancer**

SB 434 AAC Health Insurance Coverage for Ultrasound Breast Cancer Screening

**HB 5712 AAC Health Insurance Coverage for Breast Cancer Screening Using
Magnetic Resonance Imaging**

SB 130 AA To Study Health Insurance Coverage for Treatment of Obesity

HB 508 AAC Health Insurance Benefits for the Diagnosis and Treatment of Infertility

Good afternoon Senator Crisco, Representative O'Connor and members of the Committee. My name is Natasha Pierre and I am the Associate Legislative Analyst for the Permanent Commission on the Status of Women. Thank you for this opportunity to testify in support of several bills before you today.

HB 6124 AAC The Extension of Health Insurance Benefits for Divorced Spouses

HB 6277 AAC Continuation of Health Insurance Coverage for Divorced Spouses

PCSW supports passage of HB 6124 and HB 6277, which would continue eligibility for a former spouse to maintain group health insurance coverage in the case of a divorce.

Currently, an insured individual cannot continue to provide coverage for an ex-spouse under an existing plan. Instead, the individual must pay for COBRA benefits or other insurance. Both these mechanisms are extremely expensive, resulting in loss of income to the household or lack of insurance coverage if the individual cannot afford to pay for a separate policy. Additionally, the COBRA option is only for three years.

However, if families could continue coverage under a group plan, it is roughly estimated that the cost would be an insurance premium increase of 1.5% to 1.7%, and only a 3% increase in the number of eligible adults.¹ Thus, families will save money by having access to a group health insurance plan, rather than buying COBRA or being uninsured. It is in the best interest of the entire family to have health insurance coverage, especially during a time of family transition.

SB 28 AAC Health Insurance Coverage for Breast Cancer Screening
SB 30 AAC Health Insurance Coverage for Breast Cancer Screening for Individuals with a Family History of Breast Cancer
SB 434 AAC Health Insurance Coverage for Ultrasound Breast Cancer Screening
HB 5712 AAC Health Insurance Coverage for Breast Cancer Screening Using Magnetic Resonance Imaging

PCSW and the Connecticut Women's Health Campaign, a group of other thirty organizations with expertise on public policy matters related to women's health care, support passage of these bills, which would provide alternative means of testing for the presence of cancerous tumors. Specifically, the bills would require health insurers to offer mammograms, MRIs, and ultrasounds for high risk patients or patients with a family history of breast cancer and/or fatty or dense breast tissue.

Although the mammogram has been the most widely used technique for detecting cancerous tumors, it may not be effective for certain age groups. For example, with a mammogram bone shows up as white on an x-ray, fat shows up as gray, and a cancerous tumor will appear as light gray or white.² However, younger women are more likely to have dense breast tissue which shows up on an MRI as a light gray and could lead to a false positive report.³ In this case, an ultrasound could have augmented the MRI results because it could show more angles.

Each individual's body and family history is different, and the more alternatives we have to screen breast cancer, the better chances we will have to detect and treat it earlier.

¹ Analysis by Community Catalyst based on U.S. Census Bureau data regarding the number of working, uninsured, divorced adults.

² Susan G. Komen Breast Cancer Foundation, available at www.komen.org.

³ *Ibid.*

SB 130 AA To Study Health Insurance Coverage for Treatment of Obesity

PCSW and the Connecticut Women's Health Campaign also support passage of SB 130, which would establish a task force to determine the need for health insurance coverage for treatment of obesity. As you know, obesity has become a major public health concern in this country, and it leads to other more serious—and more expensive—medical conditions that are prevalent among women such as diabetes and heart disease. Any efforts to address this increasing epidemic would be helpful to the citizens of this state.

HB 508 AAC Health Insurance Benefits for the Diagnosis and Treatment of Infertility

Finally, PCSW supports passage of HB 508, which would require health insurance policies to provide coverage for medically necessary expenses of the diagnosis and treatment of infertility. Infertility is a disease of the reproductive system, which affects 6.1 million Americans, or 10% of the reproductive age population.⁴ Unfortunately, couples today not only face the emotional pain associated with not being able to have a child, but they also face health insurance obstacles. We support reproductive choice for all women, and we do not believe that infertility treatment should be limited to those with the economic means to pay for it out of pocket. This legislation would allow infertile couples to take advantage of modern treatments, thereby truly providing reproductive choice and access to all.

We urge passage of this bills and thank you for your attention and allowing us to testify on this matter.

⁴ Spigel, Saul. *Infertility-Causes, Treatment, Insurance and Disability Status*. OLR Research Report 2005-R-0145, February 3, 2005, available at www.cga.ct.gov.