State Infertility Coverage at a Glance

Updated January 2013

State	Date enacted	Mandate to cover	Mandate to offer	Includes IVF coverage	Excludes IVF coverage	IVF coverage ONLY
Arkansas	1987	X(1)				X
California	1989		X		X(2)	
Connecticut	1989	X		X		
Hawaii	1987	X				X(3)
Illinois	1991	X		X(4)		
Louisiana	2001				X	
Maryland	1985	X(5)				X
Massachusetts	1987	X		X		
Montana	1987	X(6)				
New Jersey	2001	X		X		
New York	1990				X(7)	
Ohio	1991	X(8)				
Rhode Island	1989	X		X		
Texas	1987		X			X
West Virginia	1977	X(8)				

(1) Includes a lifetime maximum benefit of not less than $15,000.
(2) Excludes IVF, but covers gamete intrafallopian transfer (GIFT).
(3) Provides a one-time only benefit covering all outpatient expenses arising from IVF.
(4) Limits first-time attempts to four oocyte retrievals. If a child is born, two complete oocyte retrievals for a second birth are covered. Businesses with 25 or fewer employees are exempt from having to provide the coverage specified by the law.
(5) Businesses with 50 or fewer employees do not have to provide coverage specified by law.
(6) Applies to HMOs only; other insurers specifically are exempt from having to provide the coverage.
(7) Provides coverage for the "diagnosis and treatment of correctable medial conditions." Does not consider IVF a corrective treatment.
(8) Applies to HMOs only.

Arkansas

This law requires all health insurers that cover maternity benefits to cover the cost of in vitro fertilization (IVF) Health maintenance organizations, commonly called HMOs, are exempt from the law. Patients need to meet the following conditions in order to get their IVF covered:

- The patient must be the policyholder or the spouse of the policyholder and be covered by the policy;

- The patient's eggs must be fertilized with her spouse's sperm;
- The patient and her spouse must have at least a two-year history of unexplained infertility, OR the infertility must be associated with one or more of the following conditions:
    - Endometriosis;
    - Fetal exposure to diethylstilbestrol, also known as DES;
    - Blocked or surgically removed fallopian tubes that are not a result of voluntary sterilization; or
    - Abnormal male factors contributing to the infertility.
- The patient has not been able to achieve a successful pregnancy through any other less costly infertility treatment for which coverage is available under the policy.
- IVF procedure must be performed at a medical facility licensed or certified by the Arkansas Department of Health. Those facilities certified by the Department of Health must conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or meet the American Fertility Society's (sic) minimal standards for programs of in vitro fertilization.

The IVF benefits are subject to the same deductibles and co-insurance payments as maternity benefits. The law also permits insurers to limit coverage to a lifetime maximum of $15,000. (Arkansas Statutes Annotated, Sections 23-85-137 and 23-86-118).

California

The California law requires certain insurers to offer coverage for infertility diagnosis and treatment. That means group health insurers covering hospital, medical or surgical expenses must let employers know infertility coverage is available. However, the law does not require those insurers to provide the coverage; nor does it force employers to include it in their employee insurance plans.

The law defines infertility as:

- The presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility; or
- The inability to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of sexual relations without contraception.

The law defines treatment as including, but not limited to:

- Diagnosis and diagnostic tests;
- Medication;
- Surgery; and
- Gamete Intrafallopian Transfer, also known as GIFT.

The law specifically exempts insurers from having to offer in vitro fertilization coverage. Also, the law does not require employers that are religious organizations to offer coverage for treatment that conflicts with the organization's religious and ethical purposes. (California Health and Safety Code, Section 1374.55).

Connecticut

Individual and group health insurance policies are required to cover medically necessary expenses for infertility diagnosis and treatment. Infertility is defined as the inability to conceive or sustain a successful pregnancy during a one-year period.

Covered treatments include ovulation induction, interuterine insemination, IVF, uterine embryo lavage, embryo transfer, GIFT, ZIFT, and low tubal embryo transfer. Coverage is limited to individuals who have maintained coverage under the policy for at least a year.

Some additional limitations apply:

- The covered individual must be under 40 years of age;
- There is a life-time coverage maximum of four cycles of ovulation induction, three cycles of IUI, and two cycles of IVF, GIFT, ZIFT, or low tubal embryo transfer (with not more than two embryo transfers per cycle);
- Covered treatments must be performed at facilities that conform to standards and guidelines developed by ASRM or SREI.

Individuals seeking coverage must disclose to their insurance carrier any prior infertility treatments for which they received coverage under a different insurance policy. Religious employers are permitted to exclude coverage for treatments that are contrary to their bona fide religious tenets. (Public Act No.05-196)

Hawaii

The Hawaii law requires certain insurance plans to provide a one-time only benefit for outpatient costs resulting from in vitro fertilization. Those plans include individual and group health insurance plans, hospital contracts or medical service plan contracts that provide pregnancy-related benefits. Patients need to meet the following conditions in order to get their IVF covered:

- The patient's eggs must be fertilized with her spouse's sperm;
- The patient or the patient's spouse must have at least a five-year history of infertility;
- The patient has been unable to get and stay pregnant through other infertility treatments covered by insurance;

- The IVF is performed at medical facilities that conform to standards set by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists; and
- The infertility must be associated with one or more of the following conditions:
    - Endometriosis;
    - Fetal exposure to diethylstilbestrol, also known as DES;
    - Blocked or surgically removed fallopian tubes; or
    - Abnormal male factors contributing to the infertility.

(Hawaii Revised Statutes, Sections 431-lOA-116.5 and 432.1-604).

Illinois

This law requires insurance policies that cover more than 25 people and provide pregnancy-related benefits to cover costs of the diagnosis and treatment of infertility. The law defines infertility as the inability to get pregnant after one year of unprotected sex or the inability to carry a pregnancy to term.

Coverage includes, but is not limited to:

- In vitro fertilization (IVF);
- Uterine embryo lavage;
- Embryo transfer;
- Artificial insemination;
- Gamete intrafallopian transfer (GIFT);
- Zygote intrafallopian transfer (ZIFT);
- Intracytoplasmic Sperm Injection (ICSI);
- Four completed egg retrievals per lifetime; and
- Low tubal egg transfer.

Coverage for IVF, GIFT and ZIFT is required only if:

- The patient has used all reasonable, less expensive and medically appropriate treatments and is still unable to get pregnant or carry a pregnancy;
- The patient has not reached the maximum number of allowed egg retrievals;
- The procedures are performed at facilities that conform to standards set by the America Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

The law exempts religious organizations which believe the covered procedures violate their teachings and beliefs. (Illinois Compiled Statutes Annotated, Chapter 215, Sections 5/356m and 125/5-3).

Louisiana

The law prohibits any health insurance policy, contract or plan issued after January 1, 2002 from excluding coverage for the diagnosis and treatment of a correctable medical condition otherwise covered under the plan, solely because the condition results in infertility. Specific exceptions include: coverage of fertility drugs, IVF or other assisted reproductive techniques, reversal of a tubal ligation, a vasectomy, or any other method of sterilization. Employers who self-insure are exempt from the requirements of the law. (Subsection 215.23, Acts 2001, No. 1045, subsection)

Maryland

The Maryland law requires health and hospital insurance policies issued or delivered in Maryland that provide pregnancy-related benefits to also cover the outpatient costs of in-vitro fertilization. HMO's must provide IVF benefits to the same extent as the benefits provided for other infertility services.

Patients need to meet the following conditions in order to get their IVF covered:

- The patient's eggs must be fertilized with her spouse's sperm;
- The patient is unable to get pregnant through less expensive covered treatments;
- The IVF is performed at facilities that conform to standards set by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.
- The patient and his or her spouse must have at least a two-year history of infertility; OR their infertility must be associated with one or more of the following conditions:
    - Endometriosis;
    - Fetal exposure to diethylstilbestrol, also known as DES;
    - Blocked or surgically removed fallopian tubes; or
    - Abnormal male factors, including oligozoospermia.

Coverage may be limited to three in vitro fertilization attempts per live birth and a maximum lifetime benefit of $100,000.

A religious organization may, by request have this coverage excluded from its policies and contracts if the required coverage conflicts with its bona fide religious beliefs and practices.

Regulations that took effect in 1994 exempt businesses with 50 or fewer employees from having to provide the IVF coverage. (Maryland Insurance Article §15-810, Health General Article §19-706).

Massachusetts

This state's law requires health maintenance organizations and insurance companies that cover pregnancy-related benefits to cover medically necessary expenses of infertility diagnosis and treatment. The law defines infertility as "the condition of a presumably healthy individual who is unable to conceive or produce conception during a one-year period."

Benefits covered include:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer;
- Sperm, egg and/or inseminated egg retrieval, to the extent that those costs are not covered by the donor's insurer;
- Intracytoplasmic Sperm Injection (ICSI) for the treatment of male infertility; and
- Zygote Intrafallopian Transfer (ZIFT).

Insurers may, but are not required, to cover experimental procedures, surrogacy, reversal of voluntary sterilization or cryopreservation of eggs. (Annotated Laws of Massachusetts, Chapters 175,§ 47H; 176A,§8K;176B,§4J; and l76G,§4, 211 CMR 37.00).

Montana

This state's law requires health maintenance organizations to cover infertility services as part of basic preventive health care services. The law does not define infertility or the scope of services covered; nor did the state ever draft regulations explaining what infertility services entail.

As for health insurers other than HMOs, the law specifically excludes infertility coverage from the required scope of health benefits those insurers must provide. (Montana Code Annotated, Sections 33-22-1521 and 33-31-102).

New Jersey

The Family Building Act requires insurance policies that cover more than 50 people and provide pregnancy-related benefits to cover the cost of the diagnosis and treatment of infertility. The law defines infertility as the disease or condition that results in the inability to get pregnant after two years of unprotected sex (female partner under the age of 35) or one year of unprotected sex (female partner over the age of 35) or the inability to carry a pregnancy to term.

Coverage includes, but is not limited to:

- Diagnosis & diagnostic tests
- Medications
- Surgery

- In vitro fertilization (IVF)
- Embryo transfer
- Artificial insemination
- Gamete intra fallopian transfer (GIFT)
- Zygote intra fallopian transfer (ZIFT)
- Intracytoplasmic Sperm Injection (ICSI)
- Four completed egg retrievals per lifetime

Coverage for IVF, GIFT and ZIFT is required only if:

- The patient has used all reasonable, less expensive and medically appropriate treatments and is still unable to get pregnant or carry a pregnancy;
- The patient has not reached the maximum number of allowed egg retrievals and the patient is 45 years of age or younger.
- The procedures are performed at facilities that conform to standards set by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

The law allows religious organizations to request an exclusion of this coverage if it is contrary to the religious employer's bona fide religious tenets. (New Jersey Permanent Statutes: 17B:27-46.1X Group Health Insurance Policies; 17:48A-7W Medical Service Corporations; 17:48-6X Hospital Service Corporations; 17:48E-35.22 Health Service Corporations; 26:2J-4.23 Health Maintenance Organizations)

New York

Insurers are required to cover the diagnosis and treatment of correctable medical conditions and shall not exclude coverage of a condition solely because the medical condition results in infertility. Private, group health insurance plans, issued or delivered in the state of New York providing coverage for hospital care or surgical and medical care are required to provide coverage for the diagnosis and treatment of infertility for patients between the ages of 21 and 44, who have been covered under the policy for at least 12 months. Certain procedures are excluded from this requirement, including IVF, GIFT, ZIFT, reversal of elective sterilization, sex change procedures, cloning, and experimental procedures. Plans that include coverage for prescription drugs must include coverage of drugs approved by FDA for use in diagnosis and treatment of infertility. (New York Consolidated Laws, Insurance, Section 3221(k)(6), Section 4303(s).)

Ohio

Ohio's law requires health maintenance organizations to cover basic preventive health services, including infertility The Ohio Insurance Department has no written definition of infertility

services, but states that the procedure must be medically necessary. Experimental procedures are not covered. (Ohio Revised Code Annotated §1751)

1742 was repealed and replaced and the $2,000 General Interpretation no longer applies.

Rhode Island

The Rhode Island law requires insurers and HMO's that cover pregnancy services to cover the cost of medically necessary expenses of diagnosis and treatment of infertility. The law defines infertility as "the condition of an otherwise healthy married individual who is unable to conceive or produce conception during a period of one year." The patient's co-payment cannot exceed 20 percent. (Rhode Island General Laws (§ 27-18-30, 27-19-23, 27-20-20 and 27-41-33).

Texas

This state's law requires certain insurers that cover pregnancy services to offer coverage for in vitro fertilization. That means insurers must let employers know this coverage is available. However, the law does not require those insurers to provide the coverage; nor does it force employers to include it in their health plans. Patients need to meet the following conditions in order to get their IVF covered:

- The patient must be the policyholder or the spouse of the policyholder and be covered by the policy;
- The patient's eggs must be fertilized with her spouse's sperm;
- The patient has been unable to get and stay pregnant through other infertility treatments covered by insurance;
- The IVF is performed at medical facilities that conform to standards set by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists; and
- The patient and her spouse must have at least a continuous five-year history of unexplained infertility, OR the infertility must be associated with one or more of the following conditions:
    - Endometriosis.
    - Fetal exposure to diethylstilbestrol (DES);
    - Blocked or surgical removal of one or both fallopian tubes; or
    - Oligospermia

The law does not require organizations that are affiliated with religious groups to cover treatment that conflicts with the organization's religious and ethical beliefs. (Texas Insurance Code, Article 3.51-6).

West Virginia

West Virginia's law requires health maintenance organizations to cover basic health care services, including infertility services, when medically necessary. The West Virginia Insurance Commissioner does not define infertility services. (West Virginia Code §33-25A-2)