NEIL ABERCROMBIE
GOVERNOR

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KEALI`I S. LOPEZ
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JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

TO THE SENATE COMMITTEES ON HEALTH AND
COMMERCE AND CONSUMER PROTECTION

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Friday, February 7, 2014
9:00 a.m.

TESTIMONY ON SENATE BILL NO. 2909 – RELATING TO IN VITRO FERTILIZATION INSURANCE COVERAGE.

TO THE HONORABLE JOSH GREEN AND ROSALYN H. BAKER, CHAIRS, AND MEMBERS OF THE COMMITTEES:

My name is Gordon Ito, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department takes no position on this bill, and submits the following comments on this bill.

The purpose of this bill is to provide in vitro fertilization insurance coverage equality for women who are diagnosed with infertility by requiring non-discriminatory coverage. The bill, however, limits lifetime benefits for treating infertility to three in vitro fertilization cycles or live birth. Existing law provides for a one-time benefit.

We thank the Committee for the opportunity to present testimony on this matter.

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

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

February 7, 2014

TO: The Honorable Josh Green, M.D., Chair
Senate House Committee on Health

The Honorable Rosalyn H. Baker, Chair
Senate Committee on Commerce and Consumer Protection

FROM: Patricia McManaman, Director

SUBJECT: **S.B. 2909 - RELATING TO IN VITRO FERTILIZATION INSURANCE COVERAGE**

Hearing: Friday, February 7, 2014; 9:00 a.m.
Conference Room 229, State Capitol

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

DEPARTMENT'S POSITION: The Department of Human Services (DHS) provides the following comment on this measure.

It is unclear if the requirements of this bill would also apply to Medicaid. Medicaid does not cover treatment for infertility so federal funds will not be available for this service. If Med-QUEST is required to cover these services, they would be state-only funded, and the DHS would require an additional appropriation. To provide clarity, the DHS respectfully recommends that the measure specify that Medicaid is excluded from this bill's requirements.

Thank you for the opportunity to testify.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	jlee@cochawaii.org
Subject:	Submitted testimony for SB2909 on Feb 7, 2014 09:00AM
Date:	Tuesday, February 04, 2014 4:00:46 PM
Attachments:	2-07-2014 Sen HTH-CPN SB 2909 - In Vitro Ins. Coverage.docx

SB2909
Submitted on: 2/4/2014
Testimony for HTH/CPN on Feb 7, 2014 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Jenny Lee	The Chamber of Commerce of Hawaii	Oppose	No

Comments: This testimony is submitted by Jenny Lee on behalf of Sherry Menor-McNamara for The Chamber of Commerce of Hawaii. Thank you.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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The Chamber of Commerce of Hawaii
The Voice of Business in Hawaii

Testimony to the Senate Committee on Health and Committee on Commerce and Consumer Protection
Friday, February 7, 2014 at 9:00 A.M.
Conference Room 229, State Capitol

RE: SENATE BILL 2909 RELATING TO IN VITRO FERTILIZATION INSURANCE COVERAGE

Chairs Green and Baker, and Vice Chairs Baker and Taniguchi, and Members of the Committees:

The Chamber of Commerce of Hawaii ("The Chamber") **opposes** SB 2909 Relating to In Vitro Fertilization Insurance Coverage.

The Chamber is the largest business organization in Hawaii, representing over 1,000 businesses. Approximately 80% of our members are small businesses with less than 20 employees. As the "Voice of Business" in Hawaii, the organization works on behalf of members and the entire business community to improve the state's economic climate and to foster positive action on issues of common concern.

While we understand that persons may need additional health care services, we do not believe that business should be the group responsible for paying for this mandated benefit. Ninety percent of the cost of an employee's health care premium is paid for by the employer. Most employers would be unable to pass this new cost onto the consumer. Please keep in mind that this would be in addition to the already annual increase in health care premiums of 7-10% each year.

Thank you for the opportunity to testify.

From:	mailinglist@capitol.hawaii.gov
To:	HTHTestimony
Cc:	john.m.kirimitsu@kp.org
Subject:	Submitted testimony for SB2909 on Feb 7, 2014 09:00AM
Date:	Tuesday, February 04, 2014 5:09:29 PM
Attachments:	SB 2909 Senate House and CPC Re Invitro Insurance Coverage .pdf

SB2909
Submitted on: 2/4/2014
Testimony for HTH/CPN on Feb 7, 2014 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
John	Kaiser Permanente	Support	Yes

Comments: Support intent, but request auditor study.

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KAISER PERMANENTE®

Testimony of
John M. Kirimitsu
Legal & Government Relations Consultant

Before:
Senate Committee on Health
The Honorable Josh Green, M.D., Chair
The Honorable Rosalyn H. Baker, Vice Chair

and

Senate Committee on Commerce and Consumer Protection
The Honorable Rosalyn H. Baker, Chair
The Honorable Brian T. Taniguchi, Vice Chair

February 7, 2014
9:00 am
Conference Room 229

Re: SB 2909 Relating to In Vitro Fertilization Insurance Coverage

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

Kaiser Permanente Hawaii supports the intent of this bill, but requests an auditor study.

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

Under the ACA, the health plans are already mandated to include ten essential benefits, from care for pregnant mothers to substance abuse treatment, with an emphasis on prevention to keep costs down. The ACA's goal of reducing healthcare costs is being sought by improving American's health by emphasizing health care that prevents illnesses from becoming serious, long-term health problems, thus reducing avoidable hospitalizations. The hope is that this

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reduction in preventable illness through new prevention coverage will result in significant health care savings to everyone. Therefore, any additionally mandated benefits beyond those required under the essential benefits, notwithstanding the fact that the state may be required to defray such costs of newly mandated benefits, will undoubtedly hinder the goal of decreasing health care spending and health care insurance premiums.

That being said, Kaiser supports the intent of this bill to provide insurance coverage equality for women diagnosed with infertility, but requests that the legislative auditor conduct an impact assessment report, as required pursuant to Sections 23-51 and 23-52 of the Hawaii Revised Statutes, to assess among other things:

a) the extent to which this mandated insurance coverage would be reasonably expected to increase the insurance premium and administrative expenses of policy holders; and

b) the impact of this mandated coverage on the total cost of health care.

Thank you for the opportunity to comment.

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N
Quality Healthcare For All

Senate Committee on Health
Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

Senate Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Brian T. Taniguchi, Vice Chair

Friday, February 7, 2014
Conference Room 229
9:00 a.m.
Hawaii State Capitol

Testimony Supporting Senate Bill 2909, Relating to In Vitro Fertilization Insurance Coverage. Provides insurance coverage equality for women who are diagnosed with infertility by making available to them expanded treatment option, ensuring adequate and affordable health care services.

Alice M. Hall
Acting President and Chief Executive Officer
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporate Board of Directors, thank you for the opportunity to present testimony in support of SB 2909.

We believe that insurance companies should provide coverage for patients diagnosed and who need treatment for this disease affecting the reproductive system.

We appreciate the Committee's focus on improving healthcare for our island communities. Thank you for the opportunity to testify before this committee.

HMSA
Blue Cross Blue Shield of Hawaii
An Independent Licensee of the Blue Cross and Blue Shield Association

February 7, 2014

The Honorable Josh Green, Chair
Senate Committee on Health
The Honorable Rosalyn H. Baker, Chair
Senate Committee on Commerce and Consumer Protection

Re: SB 2909 – Relating to In Vitro Fertilization Insurance Coverage

Dear Chair Green, Chair Baker and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2909 which would require health insurance coverage for women who are diagnosed with infertility by making available to them expanded treatment options. HMSA supports one specific provision of this legislation and offer comments on the remainder of the Bill.

HMSA certainly is aware and empathetic to the situations under which in vitro fertilization (IVF) procedures would be conducted. To that end, HMSA does not believe marital status should be a condition for which this medical service is provided. Consequently, we support that specific provision of this Bill that eliminates reference to the term, "spouse" in Section 432:1-604, Hawaii Revised Statutes.

HMSA does have concerns with other provisions of this Bill. We offer a one-time only coverage for IVF procedures. In seeking to expand the coverage level, this legislation raises issues that need to be clarified. For example:

(1) If three in IVF procedures are performed under coverage by one plan and the member transfers to another plan, would the individual be eligible for three additional IVF cycle procedures in the new plan?

(2) If a woman has a successful IVF procedure resulting in a live birth, would she still be eligible for two remaining procedures?

(3) As written, the purpose of the Bill is to provide IVF insurance coverage equality for women who are diagnosed with infertility. This suggests that the woman would not have previously had a child. If a woman has had a child, it is unclear whether she could be diagnosed with infertility by meeting the requirement of "failure to achieve a successful pregnancy after twelve months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination for women thirty-five years or younger or six months for women over thirty-five years."

(4) There will be cost implications to contend with. We are advised that a global IVF fee costs about $16,000 per case. And, the required drugs run approximately $8,000 per case.

Thank you for allowing us to testify on this Bill We hope the Committee considers these issues as you proceed to review this measure.

Very truly yours,

Jennifer Diesman
Vice President
Government Relations

TESTIMONY to Senate Committees on Health and Commerce and Consumer Protection

S.B. 2909 Relating to In Vitro Fertilization Insurance Coverage

Friday, February 7, 2014

9:00 AM -- State Capitol Conference Room 229

Submitted in **OPPOSITION** by: Mary Smart, Mililani, HI 96789

Chairs Green and Baker, Vice-Chair Taniguchi

1. I most strongly OPPOSE S.B. 2909. This bill increases the number of "treatments" from one to three and removes the requirement for marriage. My opposition is on many grounds but mostly I am opposed to making one human a "slave" to others. During the In Vitro Fertilization, human beings are treated as commodities. Instead of increasing the number of treatments, I recommend you discontinue the funding of these treatments altogether. During the early years of our founding, slavery was mostly a racial issue. Now, the slavery of our day is mostly children. The slave owners of the past didn't think they were doing anything wrong and abolitionist were not taken seriously for many years. Righteousness eventually prevails. Ua Mau ke Ea o ka Aina i ka Pono

2. It is very sad when a couple cannot have their own children. I have great empathy for them. However, there are ethical and unethical ways to resolve that problem. Reports have shown that babies born from the IVF process are more likely to get childhood cancer by 33% and have other problems at a 50% higher rate. Knowing this, can we consider the process is a good choice for the parents, the child, and society? Most people are unaware of these statistics and only know the "good" side of the story.

3. There doesn't appear to be a limit on how many babies are created. More babies (fertilized ovum) are transferred to the womb than babies desired because many of them will not initiative what has been medically classified as a "pregnancy". When multiples succeed, a process called "selective reduction" is often executed -- which is essentially the "execution" of one or more babies. Killing babies is unethical.

4. The "Octomom" had eight babies at once. With three attempts, an entrepreneur, with luck, could have 24 children to make available for adoption/sell. There appears to be no residency or citizenship requirement. Hawaii could become the place to come to create the babes who will be used for human trafficking. It is bad enough to have pimps in our State. Let's not lure other seedy character into our state to take advantage of our "free" In Vitro Fertilization services.

5. When marriage taken out of the equation as this bill proposes, the creation of children could easily be done for pernicious reasons. More people want to adopt than there are available newborns. With no restrictions other than having as many as three attempts,

this may be the perfect law for those who want to adopt/sell babies. I know of perspective adoptive parents who narrowly escaped being involved in an adoption scam.

6. There is no requirement to prove that the babies will be raised by financially secure parents. If they are not, there is a strong possibility that the children could be neglected or abused. Nadya Suleman (Octomom) used her children for fame and hopefully fortune but she has fallen into bankruptcy and a life that many consider deviancy (stripping and porn). This is not a good environment to raise a child. Her children do not have a father. It is well known that the best way out of poverty is to be raised in an intact family with a mother and a father. People living in poverty are often single parent households. To remove the marital requirement is like an open request to condemn children to a life of poverty which will ultimately stress State services.

7. The goal of In Vitro Fertilization as described in S.B. 2909 is to result in a living human being. The baby lived in the Petri dish, then the womb for approximately nine months before delivery. DNA confirms, the baby is no less human once the ovum is fertilized by the sperm than when his or her head appears and begins crying. The selection of which baby lives (implanted) and which dies (discarded) can be decided based on sex, hair color, handicap, and other rationale that is normally protected by equal opportunity laws. There is no attempt to preserve and protect all created life.

8. The "intent" to exempt religious institutions and organizations is not good enough. This bill makes unethical demands on anyone and any organization that understands In Vitro Fertilization callously creates and destroys life. Conscience rights and religious liberty must be protected. Hawaii Catholic Conference, in testimony opposing the companion bill H.B. 2355 stressed that Catholic documents specify, Catholics may not morally participate in this procedure. No individual, company (including insurance) or institution should be required to participate in any way in the In Vitro Fertilization Process nor be required to refer for such procedures. The State has no authority to take away first amendment rights. If this bill passes, it **MUST** include religious liberty exemptions for all.

9. Request you Vote AGAINST S.B.2909. Doctors can tell the sex, hair and eye color of a baby in a Petri dish because it is a person. Ultrasound machines provide "windows into the womb" and can show babies sucking their thumbs, scratching, kicking etc. while still in utero. In the future, when technology is even better, will our descendents consider us barbarians for the way we treated humanity?

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: geesey@hawaii.edu
Subject: Submitted testimony for SB2909 on Feb 7, 2014 09:00AM
Date: Tuesday, February 04, 2014 9:12:24 PM

SB2909
Submitted on: 2/4/2014
Testimony for HTH/CPN on Feb 7, 2014 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Yvonne Geesey	Individual	Comments Only	No

Comments: Aloha Health and Consumer Protection Committee: Please consider amending HRS 431:10A-116.5 (a) (4) to include Advanced Practice Registered Nurses so that we can be authorized to complete the care we provide. "individual's physician or advanced practice registered nurse" in 2 places. mahalo! Yvonne Geesey JD, Advanced Practice Registered Nurse

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HAWAII CATHOLIC CONFERENCE
6301 Pali Highway
Kaneohe, HI 96744-5224

Submitted: **Online**
Hearing on: **Friday, February 7, 2014 @ 9:00 a.m..**
Conference Room: **229**

DATE: February 4, 2014

TO: Senate Committee on Health
Senator Josh Green, Chair
Senator Rosalyn Baker, Vice Chair

Senate Commerce & Consumer Protection
Senator Roslyn Baker, Chair
Senator Brian Taniguchi, Vice Chair

From: Walter Yoshimitsu, Executive Director

Re: Opposition to SB 2909 Relating to In Vitro Fertilization Insurance Coverage

Honorable Chairs and members of the Senate Committee on Health & the Senate Committee on Commerce and Consumer Protection , I am Walter Yoshimitsu, **representing the Hawaii Catholic Conference**. The Hawaii Catholic Conference is the public policy voice for the Roman Catholic Church in the State of Hawaii, which under the leadership of Bishop Larry Silva, represents Roman Catholics in Hawaii. **We oppose this bill because although it mentions an intent to exempt religious institutions in Section 1, there is no specific language to that effect.**

As problems of infertility and sterility become more evident, people turn to medical science for solutions. Modern science has developed various techniques such as artificial insemination and in vitro fertilization. In addition, there are also ancillary techniques designed to store semen, ova, and embryos. The fact that these techniques have been developed and have a certain success rate does not make them morally acceptable. The ends do not justify the means. In this case, the ends are very noble: helping an infertile couple to become parents. The Church, however, cannot accept the means.

The "Catechism of the Catholic Church" addresses those cases where the techniques employed to bring about the conception involve exclusively the married couple's semen, ovum, and womb. Such techniques are "less reprehensible, yet remain morally unacceptable." They dissociate procreation from the sexual act. The act which brings the child into existence is no longer an act by which two persons (husband and wife) give themselves to one another, but one that "entrusts the life and identity of the embryo into the power of the doctors and biologists, and establishes the domination of technology over the origin and destiny of the human person. Such a relationship of domination is in itself contrary to the dignity and equality that must be common to parents and children" (#2377).

In vitro fertilization puts a great number of embryos at risk, or simply destroys them. These early stage abortions are never morally acceptable. Unfortunately, many people of good will have no notion of what is at stake and simply focus on the baby that results from *in vitro* fertilization, not adverting to the fact that the procedure involves creating many embryos, most of which will never be born because they will be frozen or discarded.

The Church's teaching on the respect that must be accorded to human embryos has been constant and very clear. The Second Vatican Council reaffirms this teaching: "Life once conceived must be protected with the utmost care." Likewise, the more recent "Charter of the Rights of the Family," published by the Holy See reminds us that: "Human life must be absolutely respected and protected from the moment of conception." SB 2909, without a clear religious exemption, would force the Catholic Church to provide services which are contrary to the tenets of our faith.

TO: COMMITTEE ON HEALTH
The Honorable Josh Green, Chair
The Honorable Rosalyn H. Baker, Vice Chair

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
The Honorable Rosalyn H. Baker, Chair
The Honorable Brian T. Taniguchi, Vice Chair

SUBJECT: **SB 2909 – RELATING TO IN VITRO FERTILIZATION COVERAGE**

Hearing: Friday, February 7, 2014
Time: 9:00 a.m.
Place: Conference Room 229

FROM: Na`unanikinau Kamali`i

This testimony is submitted in **strong support** of this measure.

This measure provides in vitro fertilization coverage equality for women who are diagnosed with infertility by requiring non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility. For over 27 years the in vitro fertilization law in Hawaii provided coverage within a discriminatory framework, which must be corrected by the legislature. Further, diagnosis and treatment should be brought in alignment with the national standards of the Center for Disease Control and in compliance with the American Disabilities Act and the Affordable Care Act. I am submitting testimony in my individual capacity in support of SB 2909 for several reasons.

Summary:

The measure:

1. Finds that infertility is a disease of the reproductive system that impairs and substantially limits an individual's major life activity of reproduction and recognizes infertility as a disability.
2. Requires a diagnosis of infertility before treatment.
3. Proposes IVF coverage as a "life time" benefit as opposed to a "one time" only benefits, however, the ACA prohibits such lifetime limits with respect to essential health benefits after January 1, 2014 and either old or proposed language must be deleted.
4. Focuses on the success of having a child by providing cost effective measurable limitations of three in vitro fertilization cycles or a live birth.
5. Mandates in vitro fertilization coverage equality for all women diagnosed with a medical condition of infertility by removing discriminatory language based on marital status.

6. Requires a reasonable history of infertility based on national medical standard (ASRM) instead of an arbitrary five-year history.
7. Is consistent with Center for Disease Control national standards of infertility diagnosis categories.
8. Requires coverage for other applicable treatments for infertility, unless the individual's physician determines that those treatments are likely to be unsuccessful.
9. Provides the American Society of Reproductive Medicine definition of "infertility".

Expanded Comments:

1. A diagnosis of infertility is a disability under the American Disability Act. Courts have held that women suffering from a diagnosis of infertility meet the definition of "disability" set forth in 42 U. S. C. § 12102(2)(A): a physical or mental impairment that substantially limits one or more major life activities. In examining the definition of physical impairment, the Courts have also concluded that women suffering from a diagnosis of infertility suffer from a physical impairment which is defined as "any physiological disorder, or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body system:….reproductive …" 29 C.F.R. §1630.2 (h)(1).

2. Under the current law, patients are not precluded from exhausting the IFV coverage benefit under one health plan, then switching to another health carrier to obtain coverage for another cycle. The measure makes it clear that the benefit is a lifetime benefit as applies to the IVF coverage as mandated.

3. The focus of the measure is on ensuring a live birth and not simply that one "try" is afforded the patient. Other states have also enacted language, which focuses the success of a live birth. Illinois IVF coverage law, for example, contains language similar to SB 2909 which provides coverage for more than one oocyte retrieval and is limited if a live birth follows. Coverage is required subject to the following conditions: … "(B) the covered individual has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered"… A few other states laws are included as well. (Attachment 1)

4. The current IVF coverage law is discriminatory on its face and must be revised to be in compliance with the American Disabilities Act and the Affordable Care Act and general constitutional protections. While an auditor's report may be called because of the proposed changes in articulated in the measure pose potential implications of cost, the overriding discrimination should prevail over any cost consideration to correct Hawaii's discriminatory law. The Hawaii Revised Statutes on in vitro fertilization

currently requires that the health plan member be married and use her husbands sperm. This means that health plan members who are single women, pay premiums just like the married members and who are diagnosed with infertility are not eligible for the benefit. Although health plans are precluded from discriminatory practices under ERISA, ADA, and ACA, such practices also offend the equal protection clause, the and the current state mandate is used to discriminate based on marital status with no rational relation to the diagnosis of infertility and treatment. The legislature and State has not provided any rational basis for this requirement and it rests loosely on moral grounds. The purpose of this Act is to provide in vitro fertilization insurance coverage equality for women who are diagnosed with infertility by requiring non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility. The corrective action by the legislature taken in SB2909 to eliminate the marital status requirement is long overdue. The focus must again be on a diagnosis of infertility as a determinant on whether coverage will be provided.

5. The measure is consistent with national published guidelines. In its guidance to patients, the American Society of Reproductive Medicine states that generally, infertility is typically defined as the inability to achieve pregnancy after one year of unprotected intercourse. If the individual has been trying to conceive for a year or more, she should consider an infertility evaluation. However, if she is 35 years or older, she should begin the infertility evaluation after about six months of unprotected intercourse rather than a year, so as not to delay potentially needed treatment.

6. The Center for Disease Control reports for year 2011 is attached. (Attachment 2). Any age limitations would violate the ACA. (45 CFR §156.125; 45 CFR §156.200 (e))

Affordable Care Act (ACA) Considerations:

Since the enactment of the Affordable Care Act (ACA), the Department of Health and Human Services has issued several implementing regulations and rules, which have since been codified in Title 45 Code of Federal Regulations. The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act and ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. Because there are general and specific provisions of the ACA which apply to States, general and specific preemption considerations also apply.

In consideration of this measure there appear to be ACA considerations as well that are instructive on the bill as well as statements of HHS or CMS concerning Essential Health Benefits.

1. Essential Health Benefits

In Vitro Fertilization Coverage is an Essential Health Benefit (EHB), which imposes no state liability under the ACA. By way of testimony in March 2011, the Hawaii Association of Health Plans ("HARP") raised the concern of the potential liability that the State would be facing by mandating even more extensive infertility treatments because the ACA is still in flux. This assertion is of no consequence and concern at this time post January 1, 2014 since the federal government has since issued two regulations and a final regulation at Federal Register, Vol. 78, No. 37, February 25, 2013 which has been codified in 45 CFR §156 which address these concerns. Also, CMS has published on its web site each states Essential Health Benefits and IVF coverage is included as an EHB.

Generally the ACA provides that if a State requires issuers to cover benefits in excess of EHB, the Affordable Care Act directs the state to defray the costs of these benefits in Qualified Health Plans. States may include as part of their benchmark plan state benefit requirements, avoiding costs associated with these provisions. Because In Vitro Fertilization is a Hawaii State Required Benefit that is an Essential Health Benefit, there is no State liability. Other general considerations regarding the affect of the ACA on states are provided at the CMS or CCIO website at CMS.gov (Attachment 3)

2. **The ACA prohibitions on discrimination.**

The ACA prohibits discrimination as set forth in Title 45 of Code of Federal Regulations Part 156. Two sections in particular, which prohibit discrimination, are 45 CFR §156.125 and §156.200(e) of the subchapter and also in the Federal Register Vol. 78, No. 37(February 25, 2013). The marital status provision in the current IVF coverage law, which requires that the member be married in order to received treatment creates two classes of members and is in violation of the prohibitions on discrimination. Even if you disagree with its violation with any laws, marriage should not be the defining factor, which prohibits access to this benefit for women who have been diagnosed with infertility disability. Equal Access should be afforded to all.

45 CFR §156.125 Prohibition on discrimination.

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

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

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

45 CFR §156.200 (e)

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

SB2909 should pass out of committee. The Hawaii State legislature is a leader in health care with the historic passage of the Prepaid Health Care Act and should also be the same in the implementation of the Affordable Care Act and provision of this Essential Health Benefit for its citizens. The legislature should not be intimidated or persuaded by insurance companies who will go to any length to make an argument to hold the bill such as: 1) it costs to much, calling for an auditors report to confuse the necessary elimination of discriminatory language, 2) that it needs to be held for further study, when it holds 27 years of claims data on the benefit; or 3) that it would have difficulty administering the benefit even though it is a national health plan or partnered with national health plan networks in states which already administer similar plans or 4) that the State will have to pay for what is an the essential health benefit, which CMS confirms that there is no state liability.

For over 27 years, since the passage of the IVF mandate, the women in Hawaii have been bearing the cost to treat their disease of infertility even with IVF Coverage, the cost financially, the indescribable pain emotionally and left with the life long scars that poor legislation creates. For over 27 years the providers of infertility treatment have become leaders in the nation in treatment of assisted reproductive technologies, are highly regulated by CDC and leaders in our state by increasing IVF success rates in Hawaii from about 10% when the IVF coverage law was enacted to over %65 today. This is the legislatures responsibility to correct discriminatory provisions and treatment provisions for all women diagnosed with infertility. Have the courage to pass the measure out of committee and provide ALL women suffering from infertility disability equal access to quality affordable treatment.

Illinois IVF LEGSLATION

Sec. 356m. Infertility coverage.

(a) No group policy of accident and health insurance providing coverage for more than 25 employees that provides pregnancy related benefits may be issued, amended, delivered, or renewed in this State after the effective date of this amendatory Act of 1991 unless the policy contains coverage for the diagnosis and treatment of infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer.

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

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

(A) the covered individual has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the policy, plan, or contract;

(B) the covered individual has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered; and

(C) the procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

(2) The procedures required to be covered under this Section are not required to be contained in any policy or plan issued to or by a religious institution or organization or to or by an entity sponsored by a religious institution or organization that finds the procedures required to be covered under this Section to violate its religious and moral teachings and beliefs.

(c) For purpose of this Section, "infertility" means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

(Source: P.A. 89-669, eff. 1-1-97.)

ADVANCED REPRODUCTIVE CENTER OF HAWAII
HONOLULU, HAWAII

A comparison of clinic success rates may not be meaningful because patient medical characteristics and treatment approaches vary from clinic to clinic. For more details about how to interpret the statistics in this table, see pages 13–23.

2011 ART CYCLE PROFILE

Type of ART and Procedural Factors[a]

IVF	100%	With ICSI	78%
Unstimulated	2%	Used PGD	3%
Used gestational carrier	<1%		

Patient Diagnosis[b]

Tubal factor	15%	Uterine factor	<1%	*Multiple Factors:*	
Ovulatory dysfunction	2%	Male factor	90%	Female factors only	1%
Diminished ovarian reserve	55%	Other factor	6%	Female & male factors	70%
Endometriosis	5%	Unknown factor	0%		

2011 ART SUCCESS RATES[c,d]

Number of cycles in table:[e] 154 Data verified by Christopher T. Huang, MD

Type of Cycle	Age of Woman <35	35–37	38–40	41–42	43–44	>44
Fresh Embryos from Nondonor Eggs						
Number of cycles	30	25	27	26	7	8
Percentage of cancellations	30.0	28.0	11.1	11.5	0 / 7	1 / 8
Average number of embryos transferred	2.0	2.3	3.0	3.5	3.7	2.2
Percentage of embryos transferred resulting in implantation	27.8	32.4	21.4	0.0	0.0	1 / 11
Percentage of elective single embryo transfer (eSET)	0 / 15	0 / 15	0.0	0 / 16	0 / 6	0 / 4
Outcomes per Cycle						
Percentage of cycles resulting in singleton live births	20.0	12.0	25.9	0.0	0 / 7	1 / 8
Percentage of cycles resulting in triplets or more live births	0.0	0.0	0.0	0.0	0 / 7	0 / 8
Percentage of cycles resulting in live births	26.7	24.0	33.3	0.0	0 / 7	1 / 8
Percentage of cycles resulting in pregnancy	26.7	32.0	44.4	3.8	0 / 7	1 / 8
Outcomes per Transfer						
Number of transfers	18	16	23	17	6	5
Percentage of transfers resulting in singleton live births	6 / 18	3 / 16	30.4	0 / 17	0 / 6	1 / 5
Percentage of transfers resulting in triplets or more live births	0 / 18	0 / 16	0.0	0 / 17	0 / 6	0 / 5
Percentage of transfers resulting in live births	8 / 18	6 / 16	39.1	0 / 17	0 / 6	1 / 5
Percentage of transfers resulting in pregnancy	8 / 18	8 / 16	52.2	1 / 17	0 / 6	1 / 5
Outcomes per Pregnancy						
Number of pregnancies	8	8	12	1	0	1
Percentage of pregnancies resulting in singleton live births	6 / 8	3 / 8	7 / 12	0 / 1		1 / 1
Percentage of pregnancies resulting in triplets or more live births	0 / 8	0 / 8	0 / 12	0 / 1		0 / 1
Percentage of pregnancies resulting in live births	8 / 8	6 / 8	9 / 12	0 / 1		1 / 1
Frozen Embryos from Nondonor Eggs						
Number of cycles	7	3	4	2	1	0
Number of transfers	5	3	3	2	1	0
Average number of embryos transferred	2.0	2.0	3.7	3.5	3.0	
Percentage of embryos transferred resulting in implantation	6 / 10	3 / 6	0 / 11	0 / 7	0 / 3	
Percentage of transfers resulting in singleton live births	2 / 5	1 / 3	0 / 3	0 / 2	0 / 1	
Percentage of transfers resulting in triplets or more live births	0 / 5	0 / 3	0 / 3	0 / 2	0 / 1	
Percentage of transfers resulting in live births	4 / 5	1 / 3	0 / 3	0 / 2	0 / 1	
Percentage of transfers resulting in pregnancy	4 / 5	2 / 3	0 / 3	1 / 2	0 / 1	

Donor Eggs	All Ages Combined[f] Fresh Embryos	Frozen Embryos
Number of cycles	8	6
Number of transfers	6	6
Average number of embryos transferred	2.0	2.2
Percentage of embryos transferred resulting in implantation	8 / 12	9 / 13
Percentage of transfers resulting in singleton live births	1 / 6	4 / 6
Percentage of transfers resulting in live births	4 / 6	5 / 6
Percentage of transfers resulting in pregnancy	4 / 6	6 / 6

CURRENT CLINIC SERVICES AND PROFILE

Current Name: Advanced Reproductive Center of Hawaii

Donor egg?	Yes	Gestational carriers?	Yes	SART member?	Yes
Donor embryo?	Yes	Embryo cryopreservation?	Yes	Verified lab accreditation?	Yes
Single women?	Yes			*(See Appendix C for details.)*	

[a] Reflects features of fresh nondonor cycles. If IVF is <100%, the remaining cycles are GIFT, ZIFT or a combination of these procedures with IVF.
[b] Total patient diagnosis percentages may be greater than 100% because more than one diagnosis can be reported for each cycle.
[c] A multiple-infant birth is counted as one live birth if at least one infant is live born.
[d] When denominator is <20, rates are shown as fractions. Calculating percentages from these fractions may be misleading.
[e] Number excludes 0 oocyte/embryo banking cycle(s). (If 0, no banking cycles were reported.)
[f] All ages are reported together because previous data show that patient age does not materially affect success with donor eggs.

ADVANCED REPRODUCTIVE MEDICINE & GYNECOLOGY OF HAWAII, INC.
HONOLULU, HAWAII

A comparison of clinic success rates may not be meaningful because patient medical characteristics and treatment approaches vary from clinic to clinic. For more details about how to interpret the statistics in this table, see pages 13–23.

2011 ART CYCLE PROFILE

Type of ART and Procedural Factors [a]

IVF	100%	With ICSI	93%
Unstimulated	0%	Used PGD	0%
Used gestational carrier	0%		

Patient Diagnosis [b]

Tubal factor	21%	Uterine factor	3%	*Multiple Factors:*	
Ovulatory dysfunction	12%	Male factor	78%	Female factors only	4%
Diminished ovarian reserve	28%	Other factor	1%	Female & male factors	46%
Endometriosis	11%	Unknown factor	2%		

2011 ART SUCCESS RATES [c,d]

Number of cycles in table: [e] **224**

Data verified by John L. Frattarelli, MD

Type of Cycle	Age of Woman <35	35–37	38–40	41–42	43–44	>44
Fresh Embryos from Nondonor Eggs						
Number of cycles	59	52	38	22	8	6
Percentage of cancellations	3.4	3.8	2.6	9.1	1 / 8	0 / 6
Average number of embryos transferred	2.3	2.4	2.6	2.7	3.3	2.0
Percentage of embryos transferred resulting in implantation	35.0	24.3	13.0	9.3	0.0	1 / 4
Percentage of elective single embryo transfer (eSET)	0.0	0.0	0.0	0 / 17	0 / 7	0 / 1
Outcomes per Cycle						
Percentage of cycles resulting in singleton live births	49.2	26.9	18.4	22.7	0 / 8	0 / 6
Percentage of cycles resulting in triplets or more live births	0.0	0.0	0.0	0.0	0 / 8	0 / 6
Percentage of cycles resulting in live births	59.3	38.5	21.1	22.7	0 / 8	0 / 6
Percentage of cycles resulting in pregnancy	61.0	46.2	34.2	31.8	0 / 8	1 / 6
Outcomes per Transfer						
Number of transfers	54	47	36	20	7	2
Percentage of transfers resulting in singleton live births	53.7	29.8	19.4	25.0	0 / 7	0 / 2
Percentage of transfers resulting in triplets or more live births	0.0	0.0	0.0	0.0	0 / 7	0 / 2
Percentage of transfers resulting in live births	64.8	42.6	22.2	25.0	0 / 7	0 / 2
Percentage of transfers resulting in pregnancy	66.7	51.1	36.1	35.0	0 / 7	1 / 2
Outcomes per Pregnancy						
Number of pregnancies	36	24	13	7	0	1
Percentage of pregnancies resulting in singleton live births	80.6	58.3	7 / 13	5 / 7		0 / 1
Percentage of pregnancies resulting in triplets or more live births	0.0	0.0	0 / 13	0 / 7		0 / 1
Percentage of pregnancies resulting in live births	97.2	83.3	8 / 13	5 / 7		0 / 1
Frozen Embryos from Nondonor Eggs						
Number of cycles	6	9	4	0	1	0
Number of transfers	6	9	4	0	1	0
Average number of embryos transferred	2.0	1.6	2.5		3.0	
Percentage of embryos transferred resulting in implantation	4 / 12	4 / 14	4 / 10		2 / 3	
Percentage of transfers resulting in singleton live births	2 / 6	4 / 9	3 / 4		0 / 1	
Percentage of transfers resulting in triplets or more live births	0 / 6	0 / 9	0 / 4		0 / 1	
Percentage of transfers resulting in live births	3 / 6	4 / 9	3 / 4		1 / 1	
Percentage of transfers resulting in pregnancy	4 / 6	6 / 9	3 / 4		1 / 1	

Donor Eggs	All Ages Combined [f] Fresh Embryos	Frozen Embryos
Number of cycles	15	4
Number of transfers	15	4
Average number of embryos transferred	2.2	2.0
Percentage of embryos transferred resulting in implantation	48.5	4 / 8
Percentage of transfers resulting in singleton live births	3 / 15	0 / 4
Percentage of transfers resulting in live births	9 / 15	2 / 4
Percentage of transfers resulting in pregnancy	10 / 15	2 / 4

CURRENT CLINIC SERVICES AND PROFILE

Current Name: Advanced Reproductive Medicine & Gynecology of Hawaii, Inc.

Donor egg?	Yes	Gestational carriers?	Yes	SART member?	Yes
Donor embryo?	Yes	Embryo cryopreservation?	Yes	Verified lab accreditation?	Yes
Single women?	Yes			*(See Appendix C for details.)*	

[a] Reflects features of fresh nondonor cycles. If IVF is <100%, the remaining cycles are GIFT, ZIFT or a combination of these procedures with IVF.
[b] Total patient diagnosis percentages may be greater than 100% because more than one diagnosis can be reported for each cycle.
[c] A multiple-infant birth is counted as one live birth if at least one infant is live born.
[d] When denominator is <20, rates are shown as fractions. Calculating percentages from these fractions may be misleading.
[e] Number excludes 17 oocyte/embryo banking cycle(s). (If 0, no banking cycles were reported.)
[f] All ages are reported together because previous data show that patient age does not materially affect success with donor eggs.

This clinic provided ART services during 2011 and is therefore required to submit ART cycle data under the provisions of the Fertility Clinic Success Rate and Certification Act.

This clinic either did not submit 2011 ART cycle data or the clinic's Medical Director did not approve the clinic's 2011 ART cycle data for inclusion in this report.

IVF HAWAII
HONOLULU, HAWAII

A comparison of clinic success rates may not be meaningful because patient medical characteristics and treatment approaches vary from clinic to clinic. For more details about how to interpret the statistics in this table, see pages 13–23.

2011 ART CYCLE PROFILE

Type of ART and Procedural Factors[a]

IVF	100%	With ICSI	85%
Unstimulated	0%	Used PGD	2%
Used gestational carrier	0%		

Patient Diagnosis[b]

Tubal factor	49%	Uterine factor	0%	*Multiple Factors:*	
Ovulatory dysfunction	26%	Male factor	49%	Female factors only	47%
Diminished ovarian reserve	45%	Other factor	18%	Female & male factors	44%
Endometriosis	73%	Unknown factor	0%		

2011 ART SUCCESS RATES[c,d]

Number of cycles in table:[e] 110 Data verified by Benton Chun, MD

Type of Cycle	Age of Woman <35	35–37	38–40	41–42	43–44	>44
Fresh Embryos from Nondonor Eggs						
Number of cycles	19	12	34	10	8	2
Percentage of cancellations	2 / 19	0 / 12	17.6	2 / 10	2 / 8	0 / 2
Average number of embryos transferred	2.1	2.7	3.0	3.1	4.5	3.5
Percentage of embryos transferred resulting in implantation	41.9	25.0	15.0	9.1	3.7	0 / 7
Percentage of elective single embryo transfer (eSET)	1 / 14	0 / 11	0.0	0 / 5	0 / 6	0 / 1
Outcomes per Cycle						
Percentage of cycles resulting in singleton live births	6 / 19	2 / 12	17.6	1 / 10	0 / 8	0 / 2
Percentage of cycles resulting in triplets or more live births	0 / 19	0 / 12	0.0	0 / 10	0 / 8	0 / 2
Percentage of cycles resulting in live births	9 / 19	5 / 12	23.5	1 / 10	0 / 8	0 / 2
Percentage of cycles resulting in pregnancy	10 / 19	6 / 12	29.4	2 / 10	1 / 8	0 / 2
Outcomes per Transfer						
Number of transfers	15	12	27	7	6	2
Percentage of transfers resulting in singleton live births	6 / 15	2 / 12	22.2	1 / 7	0 / 6	0 / 2
Percentage of transfers resulting in triplets or more live births	0 / 15	0 / 12	0.0	0 / 7	0 / 6	0 / 2
Percentage of transfers resulting in live births	9 / 15	5 / 12	29.6	1 / 7	0 / 6	0 / 2
Percentage of transfers resulting in pregnancy	10 / 15	6 / 12	37.0	2 / 7	1 / 6	0 / 2
Outcomes per Pregnancy						
Number of pregnancies	10	6	10	2	1	0
Percentage of pregnancies resulting in singleton live births	6 / 10	2 / 6	6 / 10	1 / 2	0 / 1	
Percentage of pregnancies resulting in triplets or more live births	0 / 10	0 / 6	0 / 10	0 / 2	0 / 1	
Percentage of pregnancies resulting in live births	9 / 10	5 / 6	8 / 10	1 / 2	0 / 1	
Frozen Embryos from Nondonor Eggs						
Number of cycles	4	9	5	2	0	0
Number of transfers	4	7	5	2	0	0
Average number of embryos transferred	2.3	2.1	2.0	4.0		
Percentage of embryos transferred resulting in implantation	2 / 9	3 / 15	2 / 10	0 / 8		
Percentage of transfers resulting in singleton live births	2 / 4	1 / 7	2 / 5	0 / 2		
Percentage of transfers resulting in triplets or more live births	0 / 4	0 / 7	0 / 5	0 / 2		
Percentage of transfers resulting in live births	2 / 4	2 / 7	2 / 5	0 / 2		
Percentage of transfers resulting in pregnancy	2 / 4	3 / 7	3 / 5	0 / 2		

Donor Eggs	All Ages Combined[f] Fresh Embryos	Frozen Embryos
Number of cycles	4	1
Number of transfers	2	1
Average number of embryos transferred	2.5	3.0
Percentage of embryos transferred resulting in implantation	0 / 5	0 / 3
Percentage of transfers resulting in singleton live births	0 / 2	0 / 1
Percentage of transfers resulting in live births	0 / 2	0 / 1
Percentage of transfers resulting in pregnancy	0 / 2	1 / 1

CURRENT CLINIC SERVICES AND PROFILE

Current Name: IVF Hawaii

Donor egg?	Yes	Gestational carriers?	No	SART member?	No
Donor embryo?	No	Embryo cryopreservation?	Yes	Verified lab accreditation?	Yes
Single women?	Yes			*(See Appendix C for details.)*	

[a] Reflects features of fresh nondonor cycles. If IVF is <100%, the remaining cycles are GIFT, ZIFT or a combination of these procedures with IVF.
[b] Total patient diagnosis percentages may be greater than 100% because more than one diagnosis can be reported for each cycle.
[c] A multiple-infant birth is counted as one live birth if at least one infant is live born.
[d] When denominator is <20, rates are shown as fractions. Calculating percentages from these fractions may be misleading.
[e] Number excludes 0 oocyte/embryo banking cycle(s). (If 0, no banking cycles were reported.)
[f] All ages are reported together because previous data show that patient age does not materially affect success with donor eggs.

PACIFIC IN VITRO FERTILIZATION INSTITUTE
HONOLULU, HAWAII

A comparison of clinic success rates may not be meaningful because patient medical characteristics and treatment approaches vary from clinic to clinic. For more details about how to interpret the statistics in this table, see pages 13–23.

2011 ART CYCLE PROFILE

Type of ART and Procedural Factors[a]

IVF	100%	With ICSI	71%
Unstimulated	0%	Used PGD	2%
Used gestational carrier	0%		

Patient Diagnosis[b]

Tubal factor	18%	Uterine factor	<1%	*Multiple Factors:*	
Ovulatory dysfunction	8%	Male factor	39%	Female factors only	11%
Diminished ovarian reserve	33%	Other factor	6%	Female & male factors	25%
Endometriosis	38%	Unknown factor	1%		

2011 ART SUCCESS RATES[c,d]

Number of cycles in table:[e] 421 Data verified by Thomas S. Kosasa, MD

Type of Cycle	Age of Woman <35	35–37	38–40	41–42	43–44	>44
Fresh Embryos from Nondonor Eggs						
Number of cycles	63	48	53	38	21	11
Percentage of cancellations	7.9	12.5	17.0	18.4	19.0	3 / 11
Average number of embryos transferred	2.2	2.6	3.4	2.9	3.6	2.0
Percentage of embryos transferred resulting in implantation	35.6	20.4	11.1	5.1	1.9	0 / 12
Percentage of elective single embryo transfer (eSET)	2.3	0.0	0.0	0.0	0 / 13	0 / 3
Outcomes per Cycle						
Percentage of cycles resulting in singleton live births	19.0	10.4	9.4	5.3	0.0	0 / 11
Percentage of cycles resulting in triplets or more live births	0.0	0.0	0.0	0.0	0.0	0 / 11
Percentage of cycles resulting in live births	31.7	20.8	15.1	7.9	0.0	0 / 11
Percentage of cycles resulting in pregnancy	38.1	31.3	28.3	7.9	4.8	0 / 11
Outcomes per Transfer						
Number of transfers	45	36	40	27	15	6
Percentage of transfers resulting in singleton live births	26.7	13.9	12.5	7.4	0 / 15	0 / 6
Percentage of transfers resulting in triplets or more live births	0.0	0.0	0.0	0.0	0 / 15	0 / 6
Percentage of transfers resulting in live births	44.4	27.8	20.0	11.1	0 / 15	0 / 6
Percentage of transfers resulting in pregnancy	53.3	41.7	37.5	11.1	1 / 15	0 / 6
Outcomes per Pregnancy						
Number of pregnancies	24	15	15	3	1	0
Percentage of pregnancies resulting in singleton live births	50.0	5 / 15	5 / 15	2 / 3	0 / 1	
Percentage of pregnancies resulting in triplets or more live births	0.0	0 / 15	0 / 15	0 / 3	0 / 1	
Percentage of pregnancies resulting in live births	83.3	10 / 15	8 / 15	3 / 3	0 / 1	
Frozen Embryos from Nondonor Eggs						
Number of cycles	27	21	19	5	1	2
Number of transfers	25	21	18	4	1	2
Average number of embryos transferred	2.1	2.1	2.5	1.3	2.0	2.0
Percentage of embryos transferred resulting in implantation	36.5	34.1	22.2	1 / 5	1 / 2	0 / 4
Percentage of transfers resulting in singleton live births	44.0	14.3	2 / 18	1 / 4	0 / 1	0 / 2
Percentage of transfers resulting in triplets or more live births	0.0	0.0	0 / 18	0 / 4	0 / 1	0 / 2
Percentage of transfers resulting in live births	52.0	33.3	4 / 18	1 / 4	0 / 1	0 / 2
Percentage of transfers resulting in pregnancy	64.0	61.9	7 / 18	1 / 4	1 / 1	0 / 2

Donor Eggs	All Ages Combined[f] Fresh Embryos	Frozen Embryos
Number of cycles	80	32
Number of transfers	69	26
Average number of embryos transferred	2.0	2.1
Percentage of embryos transferred resulting in implantation	47.4	40.7
Percentage of transfers resulting in singleton live births	24.6	23.1
Percentage of transfers resulting in live births	52.2	34.6
Percentage of transfers resulting in pregnancy	60.9	61.5

CURRENT CLINIC SERVICES AND PROFILE

Current Name: Pacific In Vitro Fertilization Institute

Donor egg?	Yes	Gestational carriers?	Yes	SART member?	Yes
Donor embryo?	Yes	Embryo cryopreservation?	Yes	Verified lab accreditation?	Yes
Single women?	Yes			*(See Appendix C for details.)*	

[a] Reflects features of fresh nondonor cycles. If IVF is <100%, the remaining cycles are GIFT, ZIFT or a combination of these procedures with IVF.
[b] Total patient diagnosis percentages may be greater than 100% because more than one diagnosis can be reported for each cycle.
[c] A multiple-infant birth is counted as one live birth if at least one infant is live born.
[d] When denominator is <20, rates are shown as fractions. Calculating percentages from these fractions may be misleading.
[e] Number excludes 1 oocyte/embryo banking cycle(s). (If 0, no banking cycles were reported.)
[f] All ages are reported together because previous data show that patient age does not materially affect success with donor eggs.

TRIPLER ARMY MEDICAL CENTER IVF INSTITUTE
TRIPLER AMC, HAWAII

A comparison of clinic success rates may not be meaningful because patient medical characteristics and treatment approaches vary from clinic to clinic. For more details about how to interpret the statistics in this table, see pages 13–23.

2011 ART CYCLE PROFILE

Type of ART and Procedural Factors [a]

IVF	100%	With ICSI	57%
Unstimulated	0%	Used PGD	0%
Used gestational carrier	0%		

Patient Diagnosis [b]

Tubal factor	56%	Uterine factor	8%	*Multiple Factors:*	
Ovulatory dysfunction	8%	Male factor	36%	Female factors only	4%
Diminished ovarian reserve	8%	Other factor	0%	Female & male factors	16%
Endometriosis	4%	Unknown factor	16%		

2011 ART SUCCESS RATES [c,d]

Number of cycles in table: [e] 25 Data verified by Nia Middleton, MD

Type of Cycle	Age of Woman <35	35–37	38–40	41–42	43–44	>44
Fresh Embryos from Nondonor Eggs						
Number of cycles	11	1	5	4	0	0
Percentage of cancellations	2 / 11	0 / 1	2 / 5	1 / 4		
Average number of embryos transferred	2.0	2.0	4.0	4.0		
Percentage of embryos transferred resulting in implantation	7 / 16	0 / 2	2 / 4	0 / 12		
Percentage of elective single embryo transfer (eSET)	0 / 8	0 / 1	0 / 1	0 / 3		
Outcomes per Cycle						
Percentage of cycles resulting in singleton live births	1 / 11	0 / 1	0 / 5	0 / 4		
Percentage of cycles resulting in triplets or more live births	0 / 11	0 / 1	0 / 5	0 / 4		
Percentage of cycles resulting in live births	4 / 11	0 / 1	1 / 5	0 / 4		
Percentage of cycles resulting in pregnancy	5 / 11	0 / 1	1 / 5	1 / 4		
Outcomes per Transfer						
Number of transfers	8	1	1	3	0	0
Percentage of transfers resulting in singleton live births	1 / 8	0 / 1	0 / 1	0 / 3		
Percentage of transfers resulting in triplets or more live births	0 / 8	0 / 1	0 / 1	0 / 3		
Percentage of transfers resulting in live births	4 / 8	0 / 1	1 / 1	0 / 3		
Percentage of transfers resulting in pregnancy	5 / 8	0 / 1	1 / 1	1 / 3		
Outcomes per Pregnancy						
Number of pregnancies	5	0	1	1	0	0
Percentage of pregnancies resulting in singleton live births	1 / 5		0 / 1	0 / 1		
Percentage of pregnancies resulting in triplets or more live births	0 / 5		0 / 1	0 / 1		
Percentage of pregnancies resulting in live births	4 / 5		1 / 1	0 / 1		
Frozen Embryos from Nondonor Eggs						
Number of cycles	1	1	2	0	0	0
Number of transfers	1	1	2	0	0	0
Average number of embryos transferred	2.0	2.0	3.0			
Percentage of embryos transferred resulting in implantation	0 / 2	0 / 2	5 / 6			
Percentage of transfers resulting in singleton live births	0 / 1	0 / 1	0 / 2			
Percentage of transfers resulting in triplets or more live births	0 / 1	0 / 1	1 / 2			
Percentage of transfers resulting in live births	0 / 1	0 / 1	2 / 2			
Percentage of transfers resulting in pregnancy	0 / 1	1 / 1	2 / 2			

Donor Eggs	All Ages Combined [f] Fresh Embryos	Frozen Embryos
Number of cycles	0	0
Number of transfers	0	0
Average number of embryos transferred		
Percentage of embryos transferred resulting in implantation		
Percentage of transfers resulting in singleton live births		
Percentage of transfers resulting in live births		
Percentage of transfers resulting in pregnancy		

CURRENT CLINIC SERVICES AND PROFILE

Current Name: Tripler Army Medical Center IVF Institute

Donor egg?	No	Gestational carriers?	No	SART member?	Yes
Donor embryo?	No	Embryo cryopreservation?	Yes	Verified lab accreditation?	Yes
Single women?	Yes			*(See Appendix C for details.)*	

[a] Reflects features of fresh nondonor cycles. If IVF is <100%, the remaining cycles are GIFT, ZIFT or a combination of these procedures with IVF.
[b] Total patient diagnosis percentages may be greater than 100% because more than one diagnosis can be reported for each cycle.
[c] A multiple-infant birth is counted as one live birth if at least one infant is live born.
[d] When denominator is <20, rates are shown as fractions. Calculating percentages from these fractions may be misleading.
[e] Number excludes 0 oocyte/embryo banking cycle(s). (If 0, no banking cycles were reported.)
[f] All ages are reported together because previous data show that patient age does not materially affect success with donor eggs.

The Center for Consumer Information & Insurance Oversight

Additional Information on Proposed State Essential Health Benefits Benchmark Plans

Background

Beginning in 2014, the Affordable Care Act requires non-grand fathered health plans to cover essential health benefits (EHB), which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services;(3) hospitalization; (4) maternity and newborn care;(5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices;(8) laboratory services;(9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The essential health benefits should be equal in scope to a typical employer health plan.

In the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule ("EHB Rule"), HHS defines EHB based on state-specific EHB-benchmark plans. This page contains information on EHB-benchmark plans for each of the 50 states, the District of Columbia (D.C.), and the U.S. territories. Two documents are provided for each EHB-benchmark plan in the 50 states, D.C. and Puerto Rico: (1) a summary of the plan's specific benefits and limits, and list of covered prescription drug categories and classes; and (2) state-required benefits.

The summaries of the covered benefits and limits, and lists of prescription drug categories and classes have been compiled based on the EHB-benchmark plan selection process described in 45 CFR 156.100 and 156.110. These summaries describe the EHB-benchmark plans that have been selected by states, as well as those that have been developed by HHS using the default benchmark plan selection process described in 45 CFR 156.100(c) and the supplementation methodology in 45 CFR 156.110.

Because EHB-benchmark plan benefits are based on 2012 plan designs, and include state-required benefits that were enacted before December 31, 2011, some of the benchmark plan summaries may not reflect requirements effective for plan years starting on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan, beginning in 2014, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations.

A list of each state's required benefits has also been compiled to help states and issuers determine the state-required benefits in excess of EHB. We consider state-required benefits (or mandates) to include only specific care, treatment, or services that a health plan must cover. We do not consider provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, to be state-required benefits for purposes of EHB coverage. Similarly, we do not consider state-required benefits to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, we do not consider state anti-discrimination requirements, and state requirements relating to service delivery method (e.g., telemedicine) to be state-required benefits.

• **Guide to Reviewing Essential Health Benefits Benchmark Plans**

Essential Health Benefits Benchmark Plans

Alabama | Alaska | American Samoa | Arizona | Arkansas | California | Colorado | Connecticut | Delaware | District of Columbia | Florida | Georgia| Guam |Hawaii | Idaho | Illinois | Indiana | Iowa | Kansas | Kentucky | Louisiana | Maine | Maryland | Massachusetts | Michigan | Minnesota | Mississippi | Missouri | Montana | Nebraska | Nevada | New Hampshire | New Jersey | New Mexico | New York | North Carolina | North Dakota |Northern Mariana Islands | Ohio | Oklahoma | Oregon | Pennsylvania | Puerto Rico | Rhode Island | South Carolina | South Dakota | Tennessee | Texas | Utah | Vermont | Virgin Islands| Virginia | Washington | West Virginia | Wisconsin | Wyoming |

Alabama

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 333 KB)

- State-required benefits (PDF – 65 KB)

Alaska

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 446 KB)
- State-required benefits (PDF – 78 KB)

American Samoa

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB)

Arizona

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 442 KB)
- State-required benefits (PDF – 74 KB)

Arkansas

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 514 KB)
- State-required benefits (PDF – 79 KB)

California

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 364 KB)
- State-required benefits (PDF – 67 KB)

Colorado

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 306 KB)
- State-required benefits (PDF – 74 KB)

Connecticut

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 250 KB)
- State-required benefits (PDF – 77 KB)

Delaware

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 340 KB)
- State-required benefits (PDF – 70 KB)

District of Columbia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 226 KB)
- State-required benefits (PDF – 68 KB)

Florida

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 397 KB)
- State-required benefits (PDF – 73 KB)

Georgia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 444 KB)
- State-required benefits (PDF – 74 KB)

Guam

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB)

Hawaii

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 430 KB)
- State-required benefits (PDF – 69 KB)

Idaho

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 341 KB)
- State-required benefits (PDF – 63 KB)

Illinois

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 261 KB)
- State-required benefits (PDF – 78 KB)

Indiana

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 482 KB)
- State-required benefits (PDF – 72 KB)

Iowa

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 448 KB)
- State-required benefits (PDF – 71 KB)

Kansas

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 371 KB)
- State-required benefits (PDF – 69 KB)

Kentucky

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 330 KB)
- State-required benefits (PDF – 74 KB)

Louisiana

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 573 KB)
- State-required benefits (PDF – 73 KB)

Maine

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 363 KB)
- State-required benefits (PDF – 79 KB)

Maryland

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 387 KB)
- State-required benefits (PDF – 86 KB)

Massachusetts

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 278 KB)
- State-required benefits (PDF – 80 KB)

Michigan

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 310 KB)
- State-required benefits (PDF – 68 KB)

Minnesota

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 314 KB)
- State-required benefits (PDF – 89 KB)

Mississippi

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 376 KB)
- State-required benefits (PDF – 69 KB)

Missouri

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 432 KB)
- State-required benefits (PDF – 74 KB)

Montana

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- State-required benefits (PDF – 67 KB)

Nebraska

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Nevada

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- State-required benefits (PDF – 74 KB)

New Hampshire

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 492 KB)
- State-required benefits (PDF - 114 KB)

New Jersey

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 400 KB)
- State-required benefits (PDF – 77 KB)

New Mexico

- Guide to reviewing EHB benchmark materials
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- State-required benefits (PDF – 71 KB)

New York

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- State-required benefits (PDF – 90 KB)

North Carolina

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- State-required benefits (PDF – 72 KB)

North Dakota

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- State-required benefits (PDF – 69 KB)

Northern Mariana Islands

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage(PDF - 333 KB)

Ohio

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 262 KB)
- State-required benefits (PDF – 65 KB)

Oklahoma

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 275 KB)
- State-required benefits (PDF – 77 KB)

Oregon

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 462 KB)
- State-required benefits (PDF – 74 KB)

Pennsylvania

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 254 KB)
- State-required benefits (PDF – 69 KB)

Puerto Rico

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB)
- State-required benefits(PDF - 213 KB)

Rhode Island

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 357 KB)
- State-required benefits (PDF – 78 KB)

South Carolina

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- State-required benefits (PDF – 69 KB)

South Dakota

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- State-required benefits (PDF – 66 KB)

Tennessee

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- State-required benefits (PDF – 68 KB)

Texas

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- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 274 KB)
- State-required benefits (PDF – 80 KB)

Utah

- Guide to reviewing EHB benchmark materials

- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 476 KB)
- State-required benefits (PDF – 64 KB)

Vermont

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 416 KB)
- State-required benefits (PDF – 106 KB)

Virgin Islands

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB

Virginia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 354 KB)
- State-required benefits (PDF – 78 KB)

Washington

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 356 KB)
- State-required benefits (PDF – 74 KB)

West Virginia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 403 KB)
- State-required benefits (PDF – 75 KB)

Wisconsin

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 372 KB)
- State-required benefits (PDF – 81 KB)

Wyoming

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 391 KB)
- State-required benefits (PDF – 71 KB)

Guide to Reviewing EHB Benchmark Plans

- Printable version (PDF – 128 KB)

Essential health benefits (EHB)-benchmark plans are based on 2012 plan designs, and therefore do not necessarily reflect requirements effective for plan years beginning on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan beginning January 1, 2014, issuers may need to design plan benefits, including coverage and limitations, to comply with these requirements and limitations, including but not limited to, the following:

Annual and Lifetime Dollar Limits

The EHB-benchmark plans displayed may include annual and/or lifetime dollar limits; however, in accordance with 45 CFR 147.126, these limits cannot be applied to the essential health benefits. Annual and lifetime dollar limits can be converted to actuarially equivalent treatment or service limits.

Excluded Benefits

Pursuant to 45 CFR 156.115, the following benefits are excluded from EHB even though an EHB-benchmark plan may cover them: routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and/or non-medically necessary orthodontia. Please also note that although the EHB-benchmark plan may cover abortion services, pursuant to section 1303(b)(1)(A) of the Affordable Care Act, a QHP issuer is not required to cover these services. Section 156.115(c) provides that no health plan is required to cover abortion services as part of the requirement to cover EHB. Nothing in this provision impedes an issuer's ability to choose to cover abortion services or limits a state's ability to either prohibit or require these services under state law.

Habilitative Services

If the EHB-benchmark plan does not cover any habilitative services and the state does not define those benefits, then pursuant to 45 CFR 156.115(a)(5), the issuer determines which habilitative services to offer as a part of a two year transitional policy.

Coverage Limits

Pursuant to 45 CFR 156.115(a)(2), with the exception of coverage for pediatric services, a plan may not exclude an enrollee from coverage in an entire EHB category, regardless of whether such limits exist in the EHB-benchmark plan. For example, a plan may not exclude dependent children from the category of maternity and newborn coverage.

State-Required Benefits

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

Mental Health Parity

The EHB-benchmark plans displayed may not comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). However, as described in 45 CFR 156.115(a)(3), EHB plans must comply with the standards implemented under MHPAEA.

EHB-Benchmark Plan Prescription Drugs by Category and Class

Please note that in some cases a category is listed without a United States Pharmacopeia (USP) class because there are some drugs within the category that have not been assigned to a specific class.

Please also note that where the EHB-benchmark plan does not include coverage in a USP category and/or class, pursuant to 45 CFR 156.122, one drug would have to be offered in that USP category and/or class.

In conjunction with the policy that plans must offer the greater of one drug in every USP category and class or the number of drugs in each USP category and class offered by the EHB-benchmark, HHS is considering developing a drug counting service to assist states and issuers with implementation of the proposed prescription drug policy, as described in the following methodology document:

- EHB Rx Crosswalk Methodology (PDF - 52 KB)

Preventive Services

The EHB-benchmark plans displayed may not offer the preventive services described in 45 CFR 147.130. However, as described in 45 CFR 156.115(a)(4), EHB plans must comply with that section.

Hawaii - State Required Benefits

Benefit	Name of Required Benefit	Market Applicability	Citation Number
Hospice Services	Hospice care	Individual, small group, large group, HMO	431:10A-119; 432:1-608; 432D-23
Infertility Treatment	In-vitro fertilization	Individual, small group, large group, HMO	431:10A-116.5 432:1-604 432D-23
Delivery and All Inpatient Services for Maternity Care	Newborn children	Individual, small group, large group, HMO	431:10A-115 432:1-602 432D-23
Mental/Behavioral Health Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Mental/Behavioral Health Inpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Inpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Specialty Drugs	Chemotherapy services	Individual, small group, large group, HMO	432:1-616
Preventive Care/Screening/Immunization	Mammography	Individual, small group, large group, HMO	431:10A-116 432:1-605 432D-23
Preventive Care/Screening/Immunization	Contraceptive services	Individual, small group, large group, HMO	431:10A-116.6 431:10A-116.7 432:1-604.5 432D-23
Preventive Care/Screening/Immunization	Child health supervison service	Individual, small group, large group, HMO	431:10A-115.5 432:1-602.5 432D-23
Preventive Care/Screening/Immunization	Colorectal screening	Individual, small group, large group, HMO	431:10A-122

Benefit	Name of Required Benefit	Market Applicability	Citation Number
Diabetes Care Management	Diabetes	Individual, small group, large group, HMO	431:10A-121 432:1-612 432D-23
Inherited Metabolic Disorder - PKU	Medical foods and low protein modified food products	Individual, small group, large group, HMO	431:10A-120 432:1-609 432D-23
Prescription Drugs Other	Chemotherapy services	Individual, small group, large group, HMO	432:1-616

To: The Honorable Della Au Belatii, Chair
House Committee on Health

From: Gina Gormley, on behalf of myself and husband

Subject: Hearing on January 31, 2014; Testimony in Support of SB 2909, RELATING TO IN VITRO FERTILIZATION INSURANCE COVERAGE

Thank you for the opportunity to testify in support of this measure. I am testifying on behalf of myself and my husband.

I graduated from law school when I was 28 years old. I bought a house when I was 34. I got married when I was 35. What would naturally come next was to have a baby. It was at that time that my husband and I found out that we suffer from infertility. Although my husband suffers from infertility issues himself, my Doctor has also informed me that my age (I am now 36) is a contributing factor to my inability to conceive naturally.

Last year my husband and I underwent our first IVF cycle utilitzing our "one-time benefit" that is allowed under the statute. We were not successful.

Amending HRS § 431:10A-116.5 to allow a lifetime benefit of three IVF cycles would increase the chance for success in having a single live birth. While some couples are successful on their first attempt, many couples must undergo IVF numerous times before reaching success. This measure, if passed, would help a lot of couples reach their dream of having a child.

As young children, we are encouraged to go to college, post graduate school, get married, and buy a house, before having children. Well, I did that. And now, notwithstanding my husband's fertility issues, it appears our "waiting until we can afford children" plan has diminished our chances of conceiving naturally.

We have explored paying out of pocket. Simply put, we can't afford it. The prices are astronomical. We have also considered moving to the mainland because we have found IVF to be cheaper there. It's frustrating and heartbreaking. Adoption is also more expensive than one IVF cycle.

Infertility is not a choice. We do not choose to have this happen.

For these reasons, we ask that you support this measure.

Thank you very much. RELATING TO IN VITRO FERTILIZATION INSURANCE COVERAGE

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: teresa.parsons@hawaii.edu
Subject: Submitted testimony for SB2909 on Feb 7, 2014 09:00AM
Date: Tuesday, February 04, 2014 11:12:09 PM

SB2909
Submitted on: 2/4/2014
Testimony for HTH/CPN on Feb 7, 2014 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Teresa Parsons	Individual	Support	No

Comments: Senators, As a Women's Health Nurse Practitioner, I see young couples struggle with a diagnosis of cancer. With the advancements in treatment, many can live many years after a cancer diagnosis. Unfortunately, their lives may not be complete due to the loss of fertility due to the type of cancer and/or treatment. For many young couples, this is another blow to their ability to feel like a contributing member of society. I urge you to SUPPORT this bill to afford some measure of support to couples who wish to bear children after cancer treatment. This isn't an endless financial burden to insurance companies, but it will significantly improve the chances of a couple to successfully create a family through expanded insurance options. Mahalo for allowing the opportunity to submit testimony in SUPPORT of this measure.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov