



# House of Representatives

General Assembly

**File No. 35**

January Session, 2015

House Bill No. 5500

*House of Representatives, March 10, 2015*

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

***AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR FERTILITY PRESERVATION FOR INSURED DIAGNOSED WITH CANCER.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective January 1, 2016*) (a) (1) Subject to the  
2 limitations set forth in subsection (b) of this section, each individual  
3 health insurance policy providing coverage of the types specified in  
4 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general  
5 statutes delivered, issued for delivery, renewed, amended or  
6 continued in this state shall provide coverage for embryo, oocyte and  
7 sperm cryopreservation procedures, in accordance with guidelines  
8 established by the American Society of Clinical Oncology, for an  
9 insured who is at least eighteen years of age and has been diagnosed  
10 with cancer but has not started cancer treatment, including  
11 chemotherapy, biotherapy or radiation therapy treatment.

12 (2) The coverage required under this section shall include expenses  
13 for evaluations, laboratory assessments, medications and treatments

14 associated with the embryo, oocyte and sperm cryopreservation  
15 procedures, but shall not include costs for initial or annual storage of  
16 embryos, oocytes or sperm.

17 (b) Such policy may:

18 (1) Limit such coverage to an individual until the date of such  
19 individual's fortieth birthday;

20 (2) Limit such coverage for a female insured to a lifetime benefit of  
21 one procedure for either embryo cryopreservation or oocyte  
22 cryopreservation; and

23 (3) Limit such coverage for a male insured to a lifetime benefit of  
24 one sperm cryopreservation procedure.

25 Sec. 2. (NEW) (*Effective January 1, 2016*) (a) (1) Subject to the  
26 limitations set forth in subsection (b) of this section, each group health  
27 insurance policy providing coverage of the types specified in  
28 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general  
29 statutes delivered, issued for delivery, renewed, amended or  
30 continued in this state shall provide coverage for embryo, oocyte and  
31 sperm cryopreservation procedures, in accordance with guidelines  
32 established by the American Society of Clinical Oncology, for an  
33 insured who is at least eighteen years of age and has been diagnosed  
34 with cancer but has not started cancer treatment, including  
35 chemotherapy, biotherapy or radiation therapy treatment.

36 (2) The coverage required under this section shall include expenses  
37 for evaluations, laboratory assessments, medications and treatments  
38 associated with the embryo, oocyte and sperm cryopreservation  
39 procedures, but shall not include costs for initial or annual storage of  
40 embryos, oocytes or sperm.

41 (b) Such policy may:

42 (1) Limit such coverage to an individual until the date of such  
43 individual's fortieth birthday;

44 (2) Limit such coverage for a female insured to a lifetime benefit of  
45 one procedure for either embryo cryopreservation or oocyte  
46 cryopreservation; and

47 (3) Limit such coverage for a male insured to a lifetime benefit of  
48 one sperm cryopreservation procedure.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2016</i>	New section
Sec. 2	<i>January 1, 2016</i>	New section

**INS**      *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

**OFA Fiscal Note**

**State Impact:**

<b>Agency Affected</b>	<b>Fund-Effect</b>	<b>FY 16 \$</b>	<b>FY 17 \$</b>
State Comptroller - Fringe Benefits (State Employee and Retiree Health Accounts)	GF, TF - Cost	Approximately \$73,896	Approximately \$147,791
The State	Indeterminate - Cost	Approximately \$36,464	Approximately \$72,929

GF & TF = General Fund and Special Transportation Fund

**Municipal Impact:**

<b>Municipalities</b>	<b>Effect</b>	<b>FY 16 \$</b>	<b>FY 17 \$</b>
Various Municipalities	STATE MANDATE - Cost	Approximately \$44,949	Approximately \$89,899

**Explanation**

The bill will result in a cost to the state employee and retiree health plan<sup>1</sup>, municipalities, and the state, for providing coverage for cryopreservation procedures and all associated treatment for individuals 18 and older who have been diagnosed with cancer but who have not undergone treatment.<sup>2</sup> The total estimated cost to the state in FY 16 is approximately \$110,360 and \$220,720 in FY 17. This

<sup>1</sup> The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

<sup>2</sup> The state plan currently provides coverage for medically necessary infertility diagnosis and treatment, and currently excludes cryopreservation procedures. Current infertility treatment involving outpatient or inpatient procedures are covered with no cost sharing for members enrolled in the Health Enhancement Program (HEP); a standard office visit copay applies for office visits. Non-HEP members must satisfy plan deductibles. Members enrolled in point of service plans who utilize out of network providers must satisfy the plan deductible and coinsurance.

cost is attributable to (1) the estimated cost to the state plan in FY 16 and FY 17 of approximately \$73,896 and \$147,791 respectively and (2) the cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) in FY 16 and FY 17 of approximately \$36,464 and \$72,929 respectively. The cost to fully insured municipalities in FY 16 and FY 17 is approximately \$44,949 and \$89,899 respectively.<sup>3</sup>

If adopted by the state plan, the actual cost to the plan will depend on the cost of services, the utilization of services by the plan's population, which may differ from the per member per month cost estimate used to calculate the state impact, and the amount of member cost sharing. The cost to the state pursuant to the ACA may be underrepresented as it is uncertain at this time if the enrollment information reported reflects the total number of covered lives by exchange plans or the number of individuals who purchased a policy. Lastly, the bill allows the following policy limits: (1) coverage for people under the age of 40, and (2) a lifetime limit of one procedure. These limits and any member cost sharing imposed by plans may mitigate the estimated cost to the state plan, the state under the ACA, and municipalities.

### **Municipal Impact**

As previously stated, the bill may increase costs to certain fully insured municipal plans that do not currently provide coverage for cryopreservation in accordance with the bill. The coverage requirements may result in increased premium costs when

---

<sup>3</sup> The estimated cost is based on the per member per month (PMPM) impact of \$.059 as estimated by Optum actuaries in the 2013, *Review and Evaluation of Certain Health Benefit Mandates in Connecticut*, p. 66. (University of Connecticut Center for Public Health and Health Policy, issued December 31, 2013, REVISED). The cost estimate for the state employee plan is based on the plan membership as of January 2015; municipal impact is based on Dept. of Labor employment information as of December 31, 2014; state impact based on Exchange enrollment is as of February 2015. Exchange enrollment excludes Medicaid enrollees totaling 382,021. The pmpm cost basis is based on a fully insured model which includes treatment costs and utilization trends. This may be different than the actual cost to the state plan which is self-insured and therefore pays the actual cost of claims incurred as opposed to a set premium to insurers.

municipalities enter into new health insurance contracts after January 1, 2016. In addition, many municipal health plans are recognized as “grandfathered” health plans under the ACA.<sup>4</sup> It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

### **The State and the federal ACA**

Lastly, the ACA requires that, the state’s health exchange’s qualified health plans (QHPs)<sup>5</sup>, include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan<sup>6</sup> to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan.<sup>7</sup> However, neither the agency nor the mechanism for the state to pay these costs has been established.

### **The Out Years**

The annualized ongoing fiscal impact identified above would continue into the future subject to 1) medical inflation, 2) the number of covered lives in the state, municipal and exchange health plans, and

---

<sup>4</sup> Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

<sup>5</sup> The state’s health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.

<sup>6</sup> The state’s benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.

<sup>7</sup> Source: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

3) the utilization of services.

Sources: *Department of Labor  
Office of the State Comptroller  
Office of the State Comptroller State Health Plan, Health Benefit Document as of  
July 2013, p. 56-57.  
University of Connecticut Center for Public Health and Health Policy Review and  
Evaluation of Certain Health Benefit Mandates in Connecticut, 2013 (REVISED)*

**OLR Bill Analysis****HB 5500*****AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR FERTILITY PRESERVATION FOR INSURED INDIVIDUALS DIAGNOSED WITH CANCER.*****SUMMARY:**

This bill requires certain health insurance policies to cover embryo, oocyte, and sperm cryopreservation procedures for insured people who are at least age 18 and diagnosed with cancer but have not started cancer treatment (e.g., chemotherapy, biotherapy, or radiation). The covered cryopreservation procedures must be in accordance with the American Society of Clinical Oncology's guidelines.

Under the bill, coverage must (1) include cryopreservation-related evaluations, laboratory assessments, medications, and treatments and (2) exclude the initial or annual storage of embryos, oocytes, and sperm. The bill also allows a policy to limit cryopreservation coverage to (1) people under age 40 and (2) one procedure per lifetime (i.e., one embryo or oocyte cryopreservation procedure per female insured and one sperm cryopreservation procedure per male insured).

The bill applies to individual and group policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2016

**BACKGROUND**

**Related Federal Law**

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state’s health insurance exchange to offer benefits beyond those included in the required “essential health benefits,” provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates a state enacts after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 10 Nay 5 (02/26/2015)