
OLR Bill Analysis

sHB 6617

AN ACT PROMOTING EQUITY IN COVERAGE FOR FERTILITY HEALTH CARE.

SUMMARY

This bill generally broadens requirements for individual and group health insurance policies to cover services to diagnose and treat infertility. It does so by (1) broadening the definition of infertility, (2) expanding required coverage to include fertility diagnostic care and fertility preservation services, (3) prohibiting policies from including certain limits and requirements, and (4) narrowing the types of limits and requirements that policies may apply. The bill does not require policies to cover nonmedical costs or experimental procedures.

The bill also requires a policy's clinical guidelines to include the scientific data it relies upon and be available in writing upon request, among other things.

The bill applies to policies delivered, issued, amended, renewed, or continued on and after January 1, 2024, that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, and (4) hospital or medical services, including HMOs. (Because of the federal Employee Retirement Income Security Act (ERISA), state insurance mandates do not apply to self-insured benefit plans.)

Separately, the bill requires the Department of Social Services (DSS) to provide Medicaid coverage for services in the same way as required under the bill for private insurers, so long as the coverage is medically necessary and permissible under federal law.

EFFECTIVE DATE: January 1, 2024

INDIVIDUAL AND GROUP HEALTH INSURANCE

Infertility Definition

The bill generally broadens the circumstances constituting infertility. Current law defines “infertility” as a person’s inability to conceive or produce conception or sustain a successful pregnancy during a one-year period.

Under the bill, “infertility” means any of the following:

1. the presence of a condition recognized by a licensed physician as a cause of fertility loss or impairment,
2. a couple’s inability to achieve pregnancy after 12 months of unprotected sexual intercourse when the couple has the necessary gametes to achieve pregnancy, or
3. a person’s inability to achieve pregnancy after six months of unprotected sexual intercourse due to age.

Required Coverage

Current law requires policies to cover medically necessary expenses incurred for the diagnosis and treatment of infertility, including ovulation induction, intrauterine insemination, in-vitro fertilization (IVF), uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer (GIFT), or zygote intra-fallopian transfer (ZIFT), and low tubal ovum transfer.

The bill instead requires plans to provide coverage for the following services:

1. fertility diagnostic care, which is procedures, products, medications, and services intended to provide information and counseling about a person’s fertility (e.g., laboratory assessments and imaging studies);
2. if the enrollee is a fertility patient, fertility treatment, which is procedures, products, genetic testing, medications, and services intended to achieve pregnancy that (a) result in a live birth and

(b) are provided in a way that is consistent with established medical practice and professional guidelines published by the American Society for Reproductive Medicine (ASRM) (or a successor or comparable organization); and

3. fertility preservation services, which are procedures, products, medications, and services intended to preserve fertility, consistent with established medical practice and professional ASRM, successor organization, or comparable organization guidelines, provided to a person who has a medical or genetic condition or who is expected to undergo treatment that may risk fertility impairment.

Under the bill, fertility preservation services also include (1) procurement and cryopreservation of gametes (i.e., sperm or egg), embryos, and reproductive material and (2) storage from the date of cryopreservation for at least five years or until the person reaches age 30, whichever is later.

Under the bill, a “fertility patient” is an individual or couple (1) experiencing infertility, (2) at increased risk of transmitting a serious inheritable genetic or chromosomal abnormality to a child, or (3) for whom fertility preservation services are medically necessary. A fertility patient also includes an individual or couple unable to achieve a pregnancy because the individual or couple lacks the necessary gametes to achieve a pregnancy.

Prohibited Policy Limits and Requirements

The bill prohibits plans that provide coverage for these services from taking any of the following actions:

1. limiting coverage for a fertility patient based solely on the patient’s age;
2. requiring that the six- or 12-month period used to determine infertility (described above) start over due to a pregnancy loss (e.g., miscarriage or stillbirth);

3. excluding, limiting, or otherwise restricting coverage availability based on prior diagnosis or fertility treatment;
4. limiting coverage based on a person's use of donor gametes, donor embryos, or surrogacy;
5. imposing copayments, deductibles, coinsurances, benefit maximums, waiting periods, or other coverage limitations that differ from any maternity benefits the policy provides;
6. imposing exclusions, limitations, or other restrictions for fertility medication coverage that differ from those imposed on any other prescription medication;
7. implementing different coverage limitations, benefits, or requirements on a fertility patient who is a part of any protected class under state law (e.g., race, sex, gender identity or expression, or marital status); or
8. basing any limitations imposed by the policy on anything other than (a) the person's licensed physician's medical assessment and (b) the policy's clinical guidelines.

Both current law and the bill generally prohibit denying coverage to someone who foregoes a particular infertility treatment or procedure if the person's physician determines it is unlikely to be successful.

Clinical Guidelines

The bill requires that a policy's clinical guidelines (1) be based on current ASRM guidelines (or guidelines developed by a successor organization or comparable organization), (2) cite with specificity any data or scientific reference relied upon, and (3) be maintained in writing and available in writing upon request.

Authorized Policy Limits and Requirements

The bill allows policies that provide coverage as required under the bill to limit required coverage in the following ways:

1. limit coverage to four completed oocyte (i.e., ovum or egg cell

- before maturation) retrievals with unlimited embryo transfers;
2. limit coverage for intrauterine insemination to a lifetime maximum benefit of six cycles (current law allows a three-cycle lifetime maximum benefit); and
 3. limit coverage for IVF to those couples who have been unable to achieve or sustain a pregnancy to live birth through less expensive and medically viable covered infertility treatment or procedures (current law additionally allows plans to limit coverage in this circumstance for gamete intra-fallopian transfer, zygote intra-fallopian transfer, and low tubal ovum transfer, which the bill eliminates).

To generally conform the coverage provision to the federal Affordable Care Act and codify the Insurance Department's Bulletin HC-104 (2015), the bill also eliminates the ability of a policy to (1) limit infertility coverage to those (a) under age 40 and (b) who had coverage under the policy for at least 12 months and (2) require an insured to disclose any previous infertility treatment covered under a different policy.

The bill also eliminates provisions in current law that allow policies to (1) limit coverage for ovulation induction to a lifetime maximum benefit of four cycles or (2) limit lifetime benefits to a maximum of two cycles, with not more than two embryo implantations per cycle, for IVF, GIFT, ZIFT, or low tubal ovum transfer.

Both the bill and current law allow plans to require that treatment or procedures included in required coverage under the bill be performed at facilities that conform to standards developed by ASRM or the Society for Reproductive Endocrinology and Infertility.

Excluding Coverage for Religious Employers

Under current law and the bill, insurers, medical or hospital service corporations, or HMOs may issue a religious employer a health insurance policy that excludes otherwise required coverage. (Under current law, this applies to diagnosis and treatment of infertility, rather

than any services required to be covered under the bill.) The bill otherwise retains the process and requirements in current law for issuing policies or riders that exclude this coverage to religious employers who state in writing that diagnosis and treatment methods are contrary to the employer's religious or moral beliefs.

Experimental Procedures and Nonmedical Costs

The bill explicitly specifies that health insurance policies are not required to provide coverage for any (1) nonmedical costs related to procuring gametes, donor embryos, or surrogacy or (2) experimental fertility procedure, which, under the bill, is a procedure that does not have sufficient medical evidence for the ASRM (or a successor or comparable organization) to regard the procedure as established medical practice.

MEDICAID

The bill requires the DSS commissioner to amend the Medicaid state plan to provide fertility treatment coverage in accordance with the bill's private health insurance policy requirements, so long as the coverage is medically necessary (see BACKGROUND) and allowed under federal law. Connecticut's Medicaid program does not currently cover fertility treatment, though some diagnostic services may be covered as a family planning service.

BACKGROUND

Medically Necessary Services in Medicaid

For Medicaid, by law, medically necessary services are those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate an individual's medical condition, including mental illness or its effects, to attain the individual's achievable health and independent functioning (CGS § 17b-259b). Medically necessary services must also meet the following requirements:

1. be consistent with generally accepted standards of medical practice;
2. be clinically appropriate in terms of type, frequency, timing, site,

extent, and duration and considered effective for the individual's illness, injury, or disease;

3. not primarily for the individual's or provider's convenience;
4. not more costly than an alternative service likely to produce equivalent therapeutic or diagnostic results; and
5. be based on an assessment of the individual and his or her medical condition.

Related Bill

sSB 1039, §§ 11 & 12, (File 385) favorably reported by the Insurance and Real Estate Committee, makes changes in the infertility coverage requirements for private health insurance policies to conform with federal law and generally prohibits policies from discriminating between people based on gender identity or expression, sex, or age.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Change of Reference - APP
Yea 19 Nay 2 (03/28/2023)

Appropriations Committee

Joint Favorable
Yea 36 Nay 13 (04/21/2023)