



House of Representatives

General Assembly

File No. 710

January Session, 2023

Substitute House Bill No. 6617

House of Representatives, May 4, 2023

The Committee on Appropriations reported through REP. WALKER of the 93rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT PROMOTING EQUITY IN COVERAGE FOR FERTILITY HEALTH CARE.

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

1 Section 1. (NEW) (*Effective January 1, 2024*) (a) As used in this section:

2 (1) "Experimental fertility procedure" means a procedure for which
3 the published medical evidence is not sufficient for the American
4 Society for Reproductive Medicine, its successor organization or a
5 comparable organization to regard the procedure as established medical
6 practice.

7 (2) "Fertility diagnostic care" means procedures, products,
8 medications and services intended to provide information and
9 counseling about an individual's fertility, including laboratory
10 assessments and imaging studies.

11 (3) "Fertility patient" means (A) an individual or a couple
12 experiencing infertility, (B) an individual or a couple who is at increased

13 risk of transmitting a serious inheritable genetic or chromosomal
14 abnormality to a child, (C) an individual unable to achieve a pregnancy
15 as an individual or with a partner because the individual or couple does
16 not have the necessary gametes to achieve a pregnancy, or (D) an
17 individual or couple for whom fertility preservation services are
18 medically necessary.

19 (4) "Fertility preservation services" (A) means procedures, products,
20 medications and services intended to preserve fertility, consistent with
21 established medical practice and professional guidelines published by
22 the American Society for Reproductive Medicine, its successor
23 organization or a comparable organization for an individual who has a
24 medical or genetic condition or who is expected to undergo treatment
25 that may directly or indirectly cause a risk of impairment of fertility, and
26 (B) includes, but is not limited to, the procurement and cryopreservation
27 of gametes, embryos and reproductive material, and storage from the
28 date of cryopreservation until the individual reaches the age of thirty,
29 or for a period of not less than five years, whichever is later.

30 (5) "Fertility treatment" means procedures, products, genetic testing,
31 medications and services intended to achieve pregnancy that result in a
32 live birth and that are provided in a manner consistent with established
33 medical practice and professional guidelines published by the American
34 Society for Reproductive Medicine, its successor organization or a
35 comparable organization.

36 (6) "Gamete" means a sperm or egg.

37 (7) "Infertility" means (A) the presence of a condition recognized by a
38 licensed physician as a cause of loss or impairment of fertility, (B) a
39 couple's inability to achieve pregnancy after twelve months of
40 unprotected sexual intercourse when the couple has the necessary
41 gametes to achieve pregnancy, or (C) an individual's inability to achieve
42 pregnancy after six months of unprotected sexual intercourse due to
43 such individual's age.

44 (8) "Oocyte" means an ovum or egg cell before maturation.

45 (9) "Religious employer" means an employer that is a "qualified
46 church-controlled organization", as defined in 26 USC 3121, or a church-
47 affiliated organization.

48 (b) Except as provided in subsections (e), (f) and (h) of this section,
49 each individual health insurance policy providing coverage of the type
50 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
51 the general statutes, delivered, issued for delivery, amended, renewed
52 or continued in this state on or after January 1, 2024, shall provide
53 coverage for:

54 (1) Fertility diagnostic care;

55 (2) Fertility treatment if the enrollee is a fertility patient; and

56 (3) Fertility preservation services.

57 (c) A policy that provides coverage for the services required under
58 this section, may not:

59 (1) Impose any limitations on coverage for a fertility patient solely on
60 the basis of such patient's age.

61 (2) Require that a pregnancy loss, including, but not limited to, a
62 miscarriage or stillbirth, suffered during the periods referenced in
63 subparagraphs (B) and (C) of subdivision (7) of subsection (a) of this
64 section shall result in the commencement of a new twelve-month or six-
65 month period in which to determine whether an individual or couple is
66 experiencing infertility.

67 (3) Use any prior diagnosis or fertility treatment as a basis for
68 excluding, limiting or otherwise restricting the availability of coverage
69 required under this section.

70 (4) Impose any limitations on coverage required under this section
71 based on an individual's use of donor gametes, donor embryos or
72 surrogacy.

73 (5) Impose any copayments, deductibles, coinsurances, benefit

74 maximums, waiting periods or other limitations on coverage that are
75 different than any maternity benefits provided by the health insurance
76 policy.

77 (6) Impose any exclusions, limitations or other restrictions on
78 coverage of fertility medications that are different from those imposed
79 on any other prescription medications.

80 (7) Impose different limitations on coverage for, provide different
81 benefits to or impose different requirements on a fertility patient who is
82 a part of any of a class of persons whose rights are protected pursuant
83 to chapter 814c of the general statutes.

84 (8) Base any limitations imposed by the policy on anything other than
85 the medical assessment of an individual's licensed physician and clinical
86 guidelines adopted by the policy.

87 (d) Any clinical guidelines used for a policy subject to the
88 requirements of this section shall (1) be based on current guidelines
89 developed by the American Society for Reproductive Medicine, its
90 successor organization or a comparable organization, (2) cite with
91 specificity any data or scientific reference relied upon, (3) be maintained
92 in written form, and (4) be made available to an individual in writing
93 upon request.

94 (e) A policy that provides coverage for the services required under
95 this section may:

96 (1) Limit such coverage to four completed oocyte retrievals, with
97 unlimited embryo transfers;

98 (2) Limit such coverage for intrauterine insemination to a lifetime
99 maximum benefit of six cycles;

100 (3) Limit coverage for in-vitro fertilization to those individuals who
101 have been unable to achieve or sustain a pregnancy to live birth through
102 less expensive and medically viable infertility treatment or procedures
103 covered under such policy; and

104 (4) Require that treatment or procedures that must be covered as
105 provided in this section be performed at facilities that conform to the
106 standards and guidelines developed by the American Society of
107 Reproductive Medicine or the Society for Reproductive Endocrinology
108 and Infertility.

109 (f) Any insurance company, hospital service corporation, medical
110 service corporation or health care center may issue to a religious
111 employer an individual health insurance policy that excludes coverage
112 for methods of diagnosis and treatment for services required to be
113 covered under this section that are contrary to the religious employer's
114 bona fide religious tenets. Upon the written request of an individual
115 who states in writing that methods of diagnosis and treatment for
116 services required to be covered under this section are contrary to such
117 individual's religious or moral beliefs, any insurance company, hospital
118 service corporation, medical service corporation or health care center
119 may issue to or on behalf of the individual a policy or rider thereto that
120 excludes coverage for such methods.

121 (g) Any health insurance policy issued pursuant to subsection (b) of
122 this section shall provide written notice to each insured or prospective
123 insured the methods of diagnosis and treatment of infertility that are
124 excluded from coverage pursuant to this section. Such notice shall
125 appear, in not less than ten-point type, in the policy, application and
126 sales brochure for such policy.

127 (h) Any health insurance policy issued pursuant to subsection (b) of
128 this section shall not be required to provide coverage for:

129 (1) Any experimental fertility procedure; or

130 (2) Any nonmedical costs related to procuring gametes, donor
131 embryos or surrogacy services.

132 (i) Nothing in this section shall be construed to deny the coverage
133 required under this section to any individual who foregoes a particular
134 infertility treatment or procedure if the individual's physician

135 determines that such treatment or procedure is likely to be unsuccessful
136 or the individual seeks to use previously retrieved oocytes or embryos.

137 Sec. 2. (NEW) (*Effective January 1, 2024*) (a) As used in this section:

138 (1) "Experimental fertility procedure" means a procedure for which
139 the published medical evidence is not sufficient for the American
140 Society for Reproductive Medicine, its successor organization or a
141 comparable organization to regard the procedure as established medical
142 practice.

143 (2) "Fertility diagnostic care" means procedures, products,
144 medications and services intended to provide information and
145 counseling about an individual's fertility, including laboratory
146 assessments and imaging studies.

147 (3) "Fertility patient" means (A) an individual or a couple
148 experiencing infertility, (B) an individual or a couple who is at increased
149 risk of transmitting a serious inheritable genetic or chromosomal
150 abnormality to a child, (C) an individual unable to achieve a pregnancy
151 as an individual or with a partner because the individual or couple does
152 not have the necessary gametes to achieve a pregnancy, or (D) an
153 individual or couple for whom fertility preservation services is
154 medically necessary.

155 (4) "Fertility preservation services" (A) means procedures, products,
156 medications and services intended to preserve fertility, consistent with
157 established medical practice and professional guidelines published by
158 the American Society for Reproductive Medicine, its successor
159 organization or a comparable organization for an individual who has a
160 medical or genetic condition or who is expected to undergo treatment
161 that may directly or indirectly cause a risk of impairment of fertility, and
162 (B) includes, but is not limited to, the procurement and cryopreservation
163 of gametes, embryos and reproductive material, and storage from the
164 date of cryopreservation until the individual reaches the age of thirty,
165 or for a period of not less than five years, whichever is later.

166 (5) "Fertility treatment" means procedures, products, genetic testing,
167 medications and services intended to achieve pregnancy that results in
168 a live birth and that are provided in a manner consistent with
169 established medical practice and professional guidelines published by
170 the American Society for Reproductive Medicine, its successor
171 organization or a comparable organization.

172 (6) "Gamete" means a sperm or egg.

173 (7) "Infertility" means (A) the presence of a condition recognized by a
174 licensed physician as a cause of loss or impairment of fertility, (B) a
175 couple's inability to achieve pregnancy after twelve months of
176 unprotected sexual intercourse when the couple has the necessary
177 gametes to achieve pregnancy, or (C) an individual's inability to achieve
178 pregnancy after six months of unprotected sexual intercourse due to an
179 individual's age.

180 (8) "Oocyte" means an ovum or egg cell before maturation.

181 (9) "Religious employer" means an employer that is a "qualified
182 church-controlled organization", as defined in 26 USC 3121, or a church-
183 affiliated organization.

184 (b) Except as provided in subsections (e), (f) and (h) of this section,
185 each group health insurance policy providing coverage of the type
186 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
187 the general statutes, delivered, issued for delivery, amended, renewed
188 or continued in this state on or after January 1, 2024, shall provide
189 coverage for:

190 (1) Fertility diagnostic care;

191 (2) Fertility treatment if the enrollee is a fertility patient; and

192 (3) Fertility preservation services.

193 (c) A policy that provides coverage for the services required under
194 this section, may not:

195 (1) Impose any limitations on coverage of a fertility patient solely on
196 the basis of such patient's age.

197 (2) Require that a pregnancy loss, including, but not limited to, a
198 miscarriage or stillbirth, suffered during the periods referenced in
199 subparagraphs (B) and (C) of subdivision (7) of subsection (a) of this
200 section shall result in the commencement of a new twelve-month or six-
201 month period in which to determine whether an individual or couple is
202 experiencing infertility.

203 (3) Use any prior diagnosis or fertility treatment as a basis for
204 excluding, limiting or otherwise restricting the availability of coverage
205 required under this section.

206 (4) Impose any limitations on coverage required under this section
207 based on an individual's use of donor gametes, donor embryos or
208 surrogacy.

209 (5) Impose any copayments, deductibles, coinsurances, benefit
210 maximums, waiting periods or other limitations on coverage that are
211 different than any maternity benefits provided by the health insurance
212 policy.

213 (6) Impose any exclusions, limitations or other restrictions on
214 coverage of fertility medications that are different from those imposed
215 on any other prescription medications.

216 (7) Impose different limitations on coverage for, provide different
217 benefits to or impose different requirements on a fertility patient who is
218 among any of a class of persons whose rights are protected pursuant to
219 chapter 814c of the general statutes.

220 (8) Base any limitations imposed by the policy on anything other than
221 the medical assessment of an individual's licensed physician and clinical
222 guidelines adopted by the policy.

223 (d) Any clinical guidelines used by a policy subject to the
224 requirements of this section shall (1) be based on current guidelines

225 developed by the American Society for Reproductive Medicine, its
226 successor organization or a comparable organization, (2) cite with
227 specificity any data or scientific reference relied upon, (3) be maintained
228 in written form, and (4) be made available to an individual in writing
229 upon request.

230 (e) A policy that provides coverage for the services required under
231 this section may:

232 (1) Limit such coverage to four completed oocyte retrievals, with
233 unlimited embryo transfers;

234 (2) Limit such coverage for intrauterine insemination to a lifetime
235 maximum benefit of six cycles;

236 (3) Limit coverage for in-vitro fertilization to those individuals who
237 have been unable to achieve or sustain a pregnancy to live birth through
238 less expensive and medically viable infertility treatment or procedures
239 covered under such policy; and

240 (4) Require that treatment or procedures that must be covered as
241 provided in this section be performed at facilities that conform to the
242 standards and guidelines developed by the American Society of
243 Reproductive Medicine or the Society for Reproductive Endocrinology
244 and Infertility.

245 (f) Any insurance company, hospital service corporation, medical
246 service corporation or health care center may issue to a religious
247 employer a group health insurance policy that excludes coverage for
248 methods of diagnosis and treatment for services required to be covered
249 under this section that are contrary to the religious employer's bona fide
250 religious tenets. Upon the written request of an individual who states in
251 writing that methods of diagnosis and treatment for services required
252 to be covered under this section are contrary to such individual's
253 religious or moral beliefs, any insurance company, hospital service
254 corporation, medical service corporation or health care center may issue
255 to or on behalf of the individual a policy or rider thereto that excludes

256 coverage for such methods.

257 (g) Any health insurance policy issued pursuant to subsection (b) of
258 this section shall provide written notice to each insured or prospective
259 insured the methods of diagnosis and treatment of infertility that are
260 excluded from coverage pursuant to this section. Such notice shall
261 appear, in not less than ten-point type, in the policy, application and
262 sales brochure for such policy.

263 (h) Any health insurance policy issued pursuant to subsection (b) of
264 this section shall not be required to provide coverage for:

265 (1) Any experimental fertility procedure; or

266 (2) Any nonmedical costs related to procuring gametes, donor
267 embryos or surrogacy services.

268 (i) Nothing in this section shall be construed to deny the coverage
269 required under this section to any individual who foregoes a particular
270 infertility treatment or procedure if the individual's physician
271 determines that such treatment or procedure is likely to be unsuccessful
272 or the individual seeks to use previously retrieved oocytes or embryos.

273 Sec. 3. (NEW) (*Effective January 1, 2024*) The Commissioner of Social
274 Services shall amend the Medicaid state plan to provide fertility
275 treatment coverage in accordance with sections 1 and 2 of this act,
276 provided such coverage is medically necessary and permissible under
277 federal law.

278 Sec. 4. Sections 38a-509 and 38a-536 of the general statutes are
279 repealed. (*Effective January 1, 2024*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2024</i>	New section
Sec. 2	<i>January 1, 2024</i>	New section
Sec. 3	<i>January 1, 2024</i>	New section
Sec. 4	<i>January 1, 2024</i>	Repealer section

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:

Agency Affected	Fund-Effect	FY 24 \$	FY 25 \$
Social Services, Dept.	GF - Cost	See Below	See Below
Resources of the General Fund	GF - Potential Cost	At Least 300,000	At Least 600,000
State Comptroller - Fringe Benefits	GF - Cost	At Least 136,000	At Least 139,000

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 24 \$	FY 25 \$
Various Municipalities	STATE MANDATE ¹ - Cost	Indeterminate	Indeterminate

Explanation

Sections 1 and 2 result in a per member per month cost of at least \$0.10 for the expansion of fertility diagnostic, treatment, and preservation services. The total cost to the State Employee Health Plan account is at least \$136,000 for FY 24 and \$139,000 for FY 25.

The bill will result in a cost to fully insured municipalities for increased premiums associated with the mandates outlined in the bill as determined by the number of enrollees and current coverage.

¹ State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

The bill will result in a cost to the state pursuant to the federal Affordable Care Act (ACA), to the extent certain provisions of the bill are determined to be new state benefit mandates that require defrayal of exchange enrollees' premium increases.

While states are allowed to mandate benefits in excess of the essential health benefits (EHB), federal law requires the state to defray the cost of additional benefits related to specific care, treatment or services mandated by state action after December 31, 2011, for all plans sold on the exchange (i.e., Access Health CT). States themselves must identify which state-required benefits are in addition to the EHB, and then states must defray the additional costs by reimbursing the carriers or the insureds for the excess coverage. The costs would be quantified by each carrier and reported to the state. It is not clear how or when these federal rules will be enforced.

The bill requires plan coverage beyond the current state mandate (which predates the ACA) for fertility preservation and surrogacy. As such, there could be a cost to defray additional premiums for the 107,833 individual market exchange enrollees and the 2,106 small group market exchange enrollees associated with these benefits, estimated to total approximately \$600,000 annually².

The bill also makes changes related to the minimum covered cycles of intrauterine insemination (IUI), in-vitro fertilization (IVF) and other services. To the extent those changes are determined to require defrayal, there will be additional costs, which could be significant³.

As the bill's provisions take effect on January 1, 2024, potential costs in FY 24 reflect six months of estimated premium defrayals (approximately \$300,000 for the fertility preservation and surrogacy

² The surrogacy benefit is estimated to have a per member per month cost of approximately \$0.35, assuming an additional 10% increase in IVF utilization and a \$25,000 lifetime maximum.

³ For context, the existing "infertility diagnosis and treatment" mandate was estimated to have a \$1.32 pmpm cost for 2016 projected claims in the most recent report completed under the Insurance Department's Health Benefit Review Program in 2014.

mandates). Actual costs would depend on actuarially determined premium impacts reported to the state by the exchange carriers.

Section 3 results in a cost to the Department of Social Services (DSS) associated with amending the Medicaid state plan to include fertility treatment coverage. Connecticut Medicaid does not currently cover related services and does not have a relevant fee schedule or service utilization for reference. Fertility treatment is a coverable service under the Medicaid state plan, family planning services benefit category and eligible for up to 90% federal reimbursement. The extent of the cost is based on the scope of services established, associated rates, and service utilization.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, Medicaid rates, and service utilization, as well as whether or not the coverage requirements of the bill are considered mandates pursuant to the ACA and the experience of exchange plan members.

Sources: Office of the State Comptroller

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)