OFFICE OF FISCAL ANALYSIS
Legislative Office Building, Room 5200
Hartford, CT 06106 ◇ (860) 240-0200
http://www.cga.ct.gov/ofa

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CORRECTION

To Fiscal Note on
sHB-6617, File No. 710

AN ACT PROMOTING EQUITY IN COVERAGE FOR FERTILITY HEALTH CARE.

Additional actuarial information from the Office of the State Comptroller and the administrator of the state health plan has clarified that **Sections 1 and 2** of the bill may result in different costs to the state and municipalities than noted in the fiscal note.

The bill appears to mandate coverage of the medical costs associated with fertility treatment using a surrogate, which is understood to include the cost for in-vitro fertilization (IVF) and related services and prescription drugs for a surrogate that is not a plan member on behalf of a plan member that is a fertility patient. It is not clear if the bill also mandates coverage of additional medical services for the surrogate such as maternity care.

The original fiscal note failed to note the potential cost to the state employee health plan for this surrogacy-related benefit. The original note also used a figure ($0.35 per member per month (PMPM)) that was based on incorrect assumptions to estimate the potential state cost related to exchange enrollees if these services are determined to be a new mandate.

Primary Analyst: NN 6/1/23
Contributing Analyst(s): MP

Potential Costs to the Office of the State Comptroller – Fringe Benefits and Municipalities

It is unclear the extent to which surrogacy benefits will be covered under the bill for non-plan member surrogates under the state employee health plan, but there could be a cost to the state plan beginning in FY 24 and continuing thereafter. Covered members acting as a surrogate currently have access to all the services outlined in the bill resulting in no fiscal impact. Medical benefits coverage for non-covered members acting as surrogates on behalf of covered members is estimated to result in PMPM costs up to $3.48. This estimate includes IVF treatments, related prescription drug coverage, diagnostic care, and maternity care. For only the IVF related benefit, the estimated cost is $1.25 PMPM.

These estimates are based on the state health plan administrator's actuarial model that factors in anticipated changes in behavior on non-frequently used services. Actual fiscal impact may be more or less than the estimated costs depending on actual benefit usage.

The bill also results in a cost to fully insured municipalities and those enrolled in the Connecticut Partnership Plan through increased premiums as determined by the number of enrollees and current coverage.

Potential Costs to State for ACA Defrayal of Mandates on Exchange Coverage

Surrogacy-related coverage. Additional information has also clarified that the potential cost to the state pursuant to the federal ACA to defray additional premium costs for exchange enrollees associated with new surrogacy coverage required under the bill could be as much as $1.25 to $3.35 PMPM according to insurer modeling but may be as low as $0.17 PMPM under alternative assumptions. As IVF for surrogates is a rarely used medical service and the use of assisted reproductive technology (ART), including gestational surrogacy, is growing quickly, it is difficult to predict the utilization of this benefit once it must be covered by insurance.

Depending on the model used to estimate the surrogacy fertility treatment coverage (medical costs only), the potential state cost ranges widely between $225,000 and $1,650,000 per year (for surrogate IVF treatments) or even as high as $4,420,000 (if the bill is interpreted to include maternity coverage for the surrogate as well). This is based on converting the PMPM estimates to an annual per member cost, then applying the annual per member cost to the number of exchange enrollees (109,939 as of the most recent open enrollment period).

The higher estimates reflect modeling based on one insurer's limited claims history for the benefit (taking into account the insurer's entire book of business) and an anticipated increase in utilization when the benefit is covered. The lower alternative estimate (not from the insurer) assumes: (1) an average IVF cycle cost of $15,000 (including prescription drugs and diagnostics), (2) three rounds of IVF treatment per surrogate on average, and (3) five exchange enrollees using the surrogacy benefit (interpreted as only IVF and related services) per year. None of the surrogacy benefit-related estimates include any non-medical costs since they are not required to be covered under the bill.

Changes to Treatment Eligibility. Other new information has clarified that the bill may require additional coverage for certain initial fertility treatment (i.e., rounds of intrauterine insemination (IUI)) for lesbian couples and single females which are not always covered by health plans under current law. While current law includes that population in mandated fertility treatment coverage, plans can require those plan members to receive IUI treatments to establish medical necessity for that treatment, which is not necessarily covered.

To the extent requiring coverage for those initial treatments for that population of enrollees is determined to be a coverage mandate under the ACA, the state will be required to defray any additional premium costs for exchange enrollees associated with that benefit.

Fertility preservation coverage. The estimated cost of the cryopreservation and donor gamete coverage (up to $0.10 PMPM) is unchanged from the original fiscal note at up to $135,000 per year in

potential state cost.

Changes in fertility treatment limits. As described in the fiscal note, there are additional potential costs to the state pursuant to the ACA to the extent changes to and removal of certain limits on fertility treatment are determined to be a mandate for which the state must pay.

Additional information on state defrayal potential costs. If the state is required to pay the defrayal costs, then the state would incur half-year costs in FY 24 due to the bill impacting policies beginning January 1, 2024.

As originally noted, the actual state cost to defray the additional premiums of enrollees on the exchange will be determined by each of the carriers on the exchange using standard actuarial analysis and reporting that amount to the state, should these benefits be determined to be mandates under the ACA. The insurer that provided the data for this estimate is one of the exchange carriers.