General Assembly

Raised Bill No. 6617

January Session, 2023

LCO No. **3838**

Referred to Committee on HUMAN SERVICES

Introduced by:
(HS)

AN ACT PROMOTING EQUITY IN COVERAGE FOR FERTILITY HEALTH CARE.

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

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

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

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

(3) "Fertility patient" means (A) an individual or a couple experiencing infertility, (B) an individual or a couple who is at increased risk of transmitting a serious inheritable genetic or

chromosomal abnormality to a child, (C) an individual unable to achieve a pregnancy as an individual or with a partner because the individual or couple does not have the necessary gametes to achieve a pregnancy, or (D) an individual or couple for whom fertility preservation services are medically necessary.

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

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

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

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

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

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

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

(1) Fertility diagnostic care;

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

(3) Fertility preservation services.

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

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

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

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

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

surrogacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Any experimental fertility procedure; or

(2) Any nonmedical costs related to procuring gametes, donor

embryos or surrogacy services.

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

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

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

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

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

(4) "Fertility preservation services" (A) means procedures, products, medications and services intended to preserve fertility, consistent with established medical practice and professional guidelines published by the American Society for Reproductive Medicine, its successor organization or a comparable organization for an individual who has a medical or genetic condition or who is expected to undergo treatment

that may directly or indirectly cause a risk of impairment of fertility, and (B) includes, but is not limited to, the procurement and cryopreservation of gametes, embryos and reproductive material, and storage from the date of cryopreservation until the individual reaches the age of thirty, or for a period of not less than five years, whichever is later.

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

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

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

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

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

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

(1) Fertility diagnostic care;

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

(3) Fertility preservation services.

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

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

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

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

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

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

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

(7) Impose different limitations on coverage for, provide different benefits to or impose different requirements on a fertility patient who

is among any of a class of persons whose rights are protected pursuant to chapter 814c of the general statutes.

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

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

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

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

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

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

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

(f) Any insurance company, hospital service corporation, medical service corporation or health care center may issue to a religious

employer an individual health insurance policy that excludes coverage for methods of diagnosis and treatment for services required to be covered under this section that are contrary to the religious employer's bona fide religious tenets. Upon the written request of an individual who states in writing that methods of diagnosis and treatment for services required to be covered under this section are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

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

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

(1) Any experimental fertility procedure; or

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

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

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

federal law.

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

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

HS *Joint Favorable C/R* APP