



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin HC-125
March 19, 2019

TO: All Health Insurance Companies and Health Care Centers Authorized to Conduct Business in Connecticut

RE: Health Insurance Coverage for Infertility Treatment and Procedures—Conn. Gen. Stat. § 38a-509 and § 38a-536

This Bulletin repeals and replaces Bulletin HC-104 dated August 13, 2015, and clarifies Connecticut’s mandated coverage for infertility treatment under Conn. Gen. Stat. § 38a-509 and § 38a-536 in relation to changes under Public Act 17-55.

Conn. Gen. Stat. § 38a-509 and § 38a-536, as amended by PA 17-55, provide that medically necessary expenses of the diagnosis and treatment of infertility shall be covered by health insurance companies. Public Act 17-55 removed the requirement that patients be “otherwise healthy” when receiving infertility treatment or diagnosis. Legislative intent provides that the removal of the “otherwise healthy” requirement was to allow for individuals who were otherwise healthy at the time, but who were about to undergo treatment that could render them infertile, including, but not limited to treatment for cancer, to have their eggs or sperm extracted for future use in the case that treatment rendered them infertile. This Bulletin clarifies that harvesting of eggs and sperm is a covered benefit in cases where patients will undergo treatment that has the potential to render them infertile. Carriers and physicians may continue to use reasonable medical management to determine if the treatment is otherwise medically necessary. Freezer storage of sperm, eggs, and/or embryos, is not a covered benefit because storage is not treatment for or diagnosis of infertility.

This Bulletin also addresses the use of age-based benefit restrictions in the infertility treatment mandate. Section 1557 of the Affordable Care Act (ACA) broadly prohibits discrimination in benefit design based on age. The U.S. Department of Health and Human Services (HHS) has provided guidance on what is considered a discriminatory benefit design. In proposed regulations issued November 21, 2014,¹ HHS writes: “We caution both issuers and States that age limits are discriminatory when applied to services that have been found clinically effective at all ages.”²

Based on this federal guidance, the Insurance Department had previously reviewed the age limit of 40 and under and has determined infertility treatment may be clinically effective

¹ Proposed HHS Notice of Benefit and Payment and Payment Parameters for 2016, 79 Fed. Reg. 228, 70674 – 70760 (November 26, 2014) <http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf>

² Proposed HHS Notice of Benefit and Payment and Payment Parameters for 2016, 79 Fed. Reg. 228, 70723 (November 26, 2014) <http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf>

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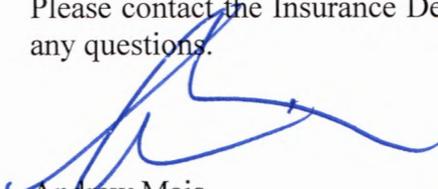
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for ages above 40, and has therefore required carriers to remove the age limits on infertility benefits for policies issued or renewed on or after January 1, 2016. The Department, through this Bulletin, continues to require carriers to remove age limits on infertility benefits.

Finally, the Centers for Medicare and Medicaid Services (CMS) as well as the United States Department of Labor (DOL) advised that lifetime limits function as an impermissible preexisting condition exclusion under HIPAA. See ERISA §701(b)(1)(A) and regulations at 29CFR 2590.701-3 and 45 CFR 146.111.³ As noted by the recently received federal guidance, HIPAA requires the preexisting condition exclusion period for an employee to run from the employee's enrollment date in a plan. It is possible that an employee may be covered under multiple plans during his or her lifetime. If that occurs, the limits on benefits per lifetime of that insured will in effect limit benefits under any plan after the initial plan, based on the existence of the condition (and benefits received) prior to the insured's enrollment date in such subsequent plan. The Department notes that non-lifetime limits are permissible. The Department is requiring carriers to remove the look-back provisions and disclosure requirements associated with the lifetime maximum.

As stated in the previous Bulletin, the Department interprets that the legislative intent is for the infertility mandate to be a discrete benefit subject to the terms of the policy. The Department does believe that: (i) carriers may apply plan level cost sharing mechanisms (copayments, deductibles, and coinsurance); (ii) carriers may have discrete copayments applicable to this benefit, subject to the limits currently allowed by the Department; (iii) allowable coinsurance ranges from 0% - 50% for the member; (iv) carriers cannot set inside limits specific to infertility treatment other than those specified by the statute; (v) benefits may be subject to prior authorization, but this must be disclosed in the policy; and (vi) male infertility treatment is covered under this mandate.

Please contact the Insurance Department Life and Health Division at cid.lh@ct.gov with any questions.



Andrew Mais
Insurance Commissioner

³ ERISA § 3(1) defines "employee welfare benefit plan" as any plan fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947.

ERISA § (3)(16)(B) defines "plan sponsor" as (i) the employer in the case of an employee benefit plan established or maintained by a single employer; (ii) the employee organization in the case of a plan established or maintained by an employee organization; or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers or employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.