STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin HC-104
August 13, 2015

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-64 dated January 20, 2006 and clarifies Connecticut's mandated coverage for infertility treatment under Conn. Gen. Stat. § 38a-509 and § 38a-536 in relation to changes brought about under the Patient Protection and Affordable Care Act. Pub. L. 111-48, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (collectively "ACA").

This Bulletin addresses the use of age-based benefit restrictions in the infertility treatment mandate. Section 1557 of the 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 has reviewed the age limit of 40 and under and has determined infertility treatment may be clinically effective for ages above 40, and is therefore requiring carriers to remove the age limits on infertility benefits for policies issued or renewed on or after January 1, 2016.

Conn. Gen. Stat. § 38a-509 and § 38a-536 specify that individuals receiving infertility treatments must be healthy and the treatment must be medically necessary to be covered. Carriers and physicians may use reasonable medical management to determine if an individual is healthy or if the treatment is medically necessary.

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)

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[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

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 discreet 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 discreet copayments applicable to this benefit, subject to the limits currently allowed by the Department; (iii) allowable copayments are pursuant to Department Bulletin HC-94; allowable coinsurance ranges from 0% - 50%; (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.

Katharine L. Wade
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.