State Implementation of Fertility Preservation Laws

State-focused advocacy efforts to secure health insurance coverage for medically necessary fertility preservation have generated significant momentum in recent years. Fertility preservation measures have become law in ten states since 2017 and more than thirteen other states had similar legislation introduced during that time.

While the intent of these new state laws is the same, each one has important distinctions relating to coverage inclusions, limitations, and exemptions. Since the first bills in Connecticut and Rhode Island took effect less than two years ago, we are still gathering data on the impact that these statutes are having on patients’ ability to preserve their fertility before treatment where coverage laws have been enacted.

According to statistics from the National Association of Insurance Commissioners (NAIC) and the California Health Benefits Review Program (CHBRP), more than 31 million individuals in these states now have health insurance policies that must include fertility preservation coverage. As fertility preservation laws are enacted across the United States, it is critically important to monitor their implementation and interpretation to ensure that qualified patients, in fact, gain access to this coverage. We are seeking to identify how affected insurers include this new coverage in their policies and how they communicate this new coverage to their insureds. We also seek to identify gaps in coverage and/or internal processes that might limit or frustrate the laws’ purpose. To do this it will be important to track utilization patterns over time to measure the actual impact of these coverage laws.

Connecticut

Connecticut was the first state to pass fertility preservation coverage legislation for those facing prospective infertility caused by a medical treatment. HB 5968, as introduced, sought to provide coverage specifically for cancer patients who may be left infertile due to their cancer treatments. The bill was ultimately passed as HB 7124, and was signed into law by Governor Dannel Malloy on June 20, 2017 (Public Act No. 17-55). In its final form, the bill amended Connecticut’s existing law mandating coverage for infertility treatments (including IVF). The amended law altered the underlying definition of “infertility” by striking the previous requirement that insureds be “otherwise healthy” and adding broad language allowing access to infertility treatments when “medically necessary.” The law went into effect on January 1, 2018, and applies to individual, small, and large group health insurance policies in the state, resulting in 651,134 lives covered.

Covered services include, but are not limited to, ovulation induction, intrauterine insemination, IVF, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer (as per existing statutory language). The law allows insurers to impose limitations, including: (1) a lifetime maximum of four cycles of ovulation induction, (2) a lifetime maximum of three cycles of intrauterine insemination, (3)
two cycles of IVF, (4) may only apply to individuals who have maintained coverage under policy for 12 months.

The Connecticut law also contains a religious exemption clause. Any insurance company, hospital service corporation, medical service corporation or health care center may issue an individual health insurance policy to a religious employer that excludes coverage that is contrary to the religious employer’s bona fide religious tenets.

Based on our research, the Connecticut Insurance Commissioner did not issue any Bulletin or other official statement regarding or interpreting HB 7124. However, in 2019, a related bill, SB 975, was introduced. This bill sought: removal of the statutory age limitations for infertility treatment; and the study of barriers limiting access for iatrogenic infertility patients. On March 19, 2019, shortly after a hearing on this bill, Connecticut Insurance Commissioner Andrew Mais issued Bulletin HC-125 for Public Act No. 17-55. This bulletin clarified several key points about the statute:

- The removal of the “otherwise healthy” language was intended to extend access to infertility treatments to those facing fertility-threatening medical treatment;
- Harvesting of eggs and sperm is a covered benefit in cases where patients will undergo treatment that has the potential to render them infertile;
- Age limits are impermissible and must be removed for policies issued or renewed on or after January 1, 2016;
- Storage of sperm, eggs, and/or embryos is not a covered benefit because storage is not treatment for or diagnosis of infertility;
- Lifetime limits are an impermissible form of preexisting condition exclusions and must be removed; and
- Carriers and physicians may continue to use reasonable medical management to determine if the treatment is otherwise medically necessary.

Rhode Island

Rhode Island’s fertility preservation bill (2017-S 0821A, 2017-H 6170A) was signed into law by Governor Gina Raimondo on July 5, 2017, and was to be effective immediately. However, as per a Bulletin (see below) issued on August 3, 2017, the effective date was July 5, 2018 – one year after signing. The law requires private insurers to cover standard fertility preservation services when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility and amends the IVF coverage mandate that first became law in 1989\(^1\).

The new fertility preservation law applies to individual, and small and large group health insurance policies including HMOs, covering 241,582 lives. It does not apply to Medicare or

Medicaid or policies that provide supplemental coverage to Medicare or other governmental programs.

The existing infertility law limited coverage to those between the ages of 25-42, and it allowed insurance companies to limit coverage by imposing a lifetime benefits cap of $100,000. It is unclear whether those restrictions (particularly the age limits) will apply to fertility preservation coverage. Anecdotally, based on conversations AFP had with the only IVF clinic in Rhode Island, this age limitation has not been invoked to date to deny coverage for fertility preservation to patients under age 25.

On August 3, 2017, the Rhode Island Department of Insurance released Insurance Bulletin 2017-2, detailing the laws passed during the 2017 session of the Rhode Island General Assembly which will impact the state insurance industry, including H6170A and S0821A. This bulletin was issued in compliance with R.I. Gen. Laws § 27-71-14(a), imposing a duty to publish notice on an annual basis of new and amended insurance laws and regulations to “ensure compliance.”

According to the Providence Journal, Blue Cross Blue Shield of Rhode Island voluntarily began covering fertility preservation for anyone who is undergoing medical treatment that is likely to cause infertility in 2017.

Maryland

Maryland Governor Larry Hogan signed SB 271 into law on May 15, 2018. The law went into effect on January 1, 2019 and requires large group plans to cover standard fertility preservation procedures that are medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. It is estimated that 926,446 lives are now covered under large group plans in Maryland.

Maryland’s fertility preservation benefit is linked to the state’s IVF mandate which first became law in 1985 and was later amended in 2000. Fertility preservation coverage must include sperm and oocyte cryopreservation and associated evaluations, lab assessments, medications, and treatments, but not storage of sperm or oocytes.

On January 1, 2019, the Maryland Insurance Administration issued a handout on mandated benefits for large group plans and grandfathered plans which included this description of the fertility preservation benefit:

Coverage for “standard fertility preservation procedures” that are medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly

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cause iatrogenic infertility. Standard fertility preservation procedures are those that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Gynecologists, or the American Society of Clinical Oncology. Coverage includes sperm/oocyte cryopreservation and associated laboratory assessments, medications, and treatments, but does not include the storage of sperm or oocytes. Health coverage provided through a religious organization may exclude this mandated health benefit if it conflicts with the organization’s bona fide religious beliefs and practices.

Delaware

On June 30, 2018, Delaware Governor John Carney signed the Fertility Care and Preservation Law (SB 139/SA 1) which requires all individual, group, and blanket health insurers to provide IVF and medically necessary fertility preservation coverage in the state. All health insurance plans issued on or after this date must now provide this benefit, which is estimated to cover 120,438 individuals in the state.

For fertility preservation, the law requires coverage for standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility (an impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment).

The law outlines sixteen covered services, including: cryopreservation and thawing of eggs, sperm, and embryos; cryopreservation of ovarian tissue and testicular tissue; IVF; storage of oocytes, sperm, embryos, and tissue. Any of these services that are considered “experimental,” e.g., some types of tissue cryopreservation, are exempt from coverage.

Certain exemptions are allowed, including bona fide religious beliefs and practices of religious organizations and employers who self-insure or who have fewer than 50 employees. Insurers are not required to cover experimental fertility care services, provide monetary payments to gestational carriers or surrogates, or cover the reversal of voluntary sterilization in certain circumstances.

On October 5, 2018, Delaware Insurance Commissioner Trinidad Navarro issued Insurance Bulletin 103, “Coverage for Fertility Care Services,” to all insurers providing health insurance coverage in Delaware which outlined these new requirements under the law.

Illinois

Former Illinois Governor Bruce Rauner signed Illinois’s fertility preservation bill (HB 2617) into law on August 27, 2018. The law went into effect on January 1, 2019, and requires individual, small and large group, and Medicaid health insurance policies in the state to provide fertility preservation benefits, thereby covering 5.3 million Illinoisans.
The law requires medically necessary expenses for standard fertility preservation services to be covered when a necessary treatment may directly or indirectly cause iatrogenic infertility. The statute also has a robust nondiscrimination clause that prohibits discrimination based on an individual’s expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, or marital status.

Illinois’s fertility preservation statute is the only law that has passed to date that also includes coverage for Medicaid patients. Based on conversations with professionals affiliated with Northwestern University, we have heard that implementation of this benefit under Medicaid has been a challenge because most fertility providers are not enrolled in the state Medicaid system and/or fertility drugs are not covered under these policies. This issue will be explored in our follow up phase of this project.

The Illinois Department of Insurance (IDOI) included fertility preservation on its Large Group PPO and Individual PPO checklists that were released in May 2019 and July 2019, respectively.

**New York**

On April 12, 2019, the New York State Legislature and Governor Andrew Cuomo finalized the state’s [2020 budget](https://www2.dol.ny.gov/), which provided for the coverage of all medically necessary fertility preservation procedures by all commercial insurers in the state. This action will also require large group health insurers in New York to provide coverage for IVF as well.

The New York fertility preservation benefit requires every large group, small group and individual policy issued or delivered in New York State to provide coverage for standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility. Standard services include the collecting, preserving, and storage of ova or sperm.

This benefit will apply to policies and contracts issued, renewed, modified, altered, or amended on and after January 1, 2020, and will provide coverage to approximately 4.7 million residents according to the New York State Department of Financial Services.

The New York State Department of Financial Services released a [Q&A Guidance](https://www2.dol.ny.gov/) document on the new law in December 2019. The guidance clarified a number of key points related to the new law:

- Cost-sharing such as deductibles, co-payments and coinsurance may be imposed as long as they are consistent with other benefits in the policy;
- Insurers may not impose annual or lifetime limits on fertility preservation services;
- Insurers may not impose age restrictions for fertility preservation services;
- Insurers may require preauthorization;
- Issuers may review fertility preservation services based on medical necessity, but they are prohibited from discriminating based on a number of factors;
• There is no limit on the duration of storage for ova or sperm, but issuers may review based on medical necessity;
• HMOs and EPOs may limit coverage to in-network providers only if the issuer has an in-network provider with the appropriate training and expertise;
• Fertility preservation services may be reviewed for medical necessity;
• If an insured changes insurers, the new insurer would be responsible for storage costs;
• The cost of prescription drugs to collect ova are considered to be a part of standard fertility preservation services and should be covered even if the plan does not have a prescription drug benefit;
• Issuers may impose formulary requirements but any plan that limits coverage to those prescription drugs on the issuer’s formulary drug list must comply with the federal formulary exception process; and
• Fertility preservation in advance of medical treatment for gender dysphoria should be covered.

New Hampshire

New Hampshire Governor Chris Sununu signed SB 279 into law on August 1, 2019, making the state the seventh to enact a fertility preservation law. The statute requires small and large group plans in New Hampshire to provide coverage for fertility preservation and IVF, thereby covering 208,515 individuals in the state once it went into effect on January 1, 2020.

Fertility preservation benefits are required when an enrollee is expected to undergo surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment of fertility.

Coverage will include:

• Evaluations, lab assessments, medications and treatments associated with the procurement of donor eggs, sperm, and embryos;
• Standard fertility preservation services including the procurement of cryopreservation of embryos, eggs, sperm, and reproductive material (non-experimental); and
• Storage covered from the time of cryopreservation for the duration of the policy term.

According to SB 279, the New Hampshire Insurance Commissioner will adopt necessary rules and, until that time, insurance carriers are required to fulfill their obligations by conforming to American Society of Reproductive Medicine (ASRM) standards.

California

Over the last two years, the AFP assisted several California residents who were denied medically-necessary fertility preservation coverage by their insurers while facing the risk of
iatrogenic infertility. The AFP helped these patients file requests for Independent Medical Reviews (IMRs) with California’s Department of Managed Health Care (DMHC). Their prior coverage denials were ultimately overturned through this form of external appeal. As a result of these determinations, the DMHC recognized medically-necessary fertility preservation as a “basic healthcare service,” which, according to state law, must be covered.³

On October 12, 2019, California Governor Gavin Newsom signed SB 600, recognizing fertility preservation as a covered benefit for all health care service plans licensed and regulated by the DMHC. The bill specifically stated that this was a reflection of “existing law” rather than a new benefit mandate. The law went into effect on January 1, 2020 and ensures that 16.9 million people in the state of California will now have access to this coverage, if needed.⁴

The law notes that standard fertility preservation services are a basic health care service when surgery, chemotherapy, radiation, or other medical treatment may directly or indirectly cause iatrogenic infertility. Standard fertility preservation procedures include those that are consistent with established medical practices and professional guidelines published by ASCO or ASRM.

On January 15, 2020, the DMHC issued an All Plan Letter outlining newly enacted statutory requirements for all health plans regulated by the agency. The Letter requires insurers to affirm their plans to cover standard fertility preservation services as a basic health care service when a covered treatment may directly or indirectly cause iatrogenic infertility.

**New Jersey**

In January, New Jersey became the ninth state to require insurers to provide medically necessary fertility preservation coverage when a medically necessary treatment may directly or indirectly cause iatrogenic infertility. Governor Phil Murphy signed S. 2133 into law on January 13, 2020, and Public Law 2019, Chapter 306 went into effect on April 12, 2020.

The new law applies to the following policies that provide benefits to groups of more than 50 people: hospital, medical, or health service corporation policies, group health insurance policies, or HMO policies. The law also applies to all state health benefits contracts and school employees' health benefits contracts. It is estimated that 1.179 million New Jerseyans will be covered under S. 2133.

The law does not require storage to be covered. It also stipulates that plans cannot discriminate based on a covered person's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, or based on personal characteristics, including age, sex, sexual orientation, marital status, or gender identity.

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³ Knox-Keene Health Care Service Plan Act of 1975, California Health & Safety Code, § 1340 et seq.
⁴ California Health & Safety Code, § 1374.551
Colorado

Colorado Governor Jared Polis signed HB 20-1158, the Colorado Building Families Act, into law on April 1, 2020. The bill requires all individual and group health benefit plans issued or renewed in the state on or after January 1, 2022, to provide coverage for IVF and fertility preservation services. The bill also includes a religious exemption available to employers.

With respect to the fertility preservation coverage, the language in the Colorado law differs from many of the other state bills which have been signed into law. HB 20—1158 does not rely on “medical necessity” to trigger coverage, but rather requires insurers to cover standard FP services for:

A person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

In addition, the legislation included language that was added at the Polis Administration’s request and was emphasized in his signing statement. This language notes that in the event that the Colorado Division of Insurance finds that the state will be required to defray any increase in costs if fertility treatment is deemed a new mandate under the Affordable Care Act, the provisions of the bill impacting the small group and individual market will not take effect.