House of Representatives

General Assembly

File No. 399

January Session, 2025

Substitute House Bill No. 7022

House of Representatives, April 1, 2025

The Committee on Human Services reported through REP. GILCHREST of the 18th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT PROMOTING EQUITY IN MEDICAID 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, 2026*) (a) As used in this section:

(1) "Fertility diagnostic care" means procedures, products, medications and services intended to provide information and counseling about an individual's fertility, including, but not limited to, laboratory assessments and imaging studies.

(2) "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.

(3) "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.

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

(5) "Infertility" means (A) the presence of a condition recognized by a licensed physician as a cause of loss or impairment of fertility, based on an individual's medical, sexual and reproductive history, age, physical findings, diagnostic testing or any combination of those factors, (B) an individual's inability to achieve pregnancy after twelve months of unprotected sexual intercourse when the individual and the individual's partner have the necessary gametes to achieve pregnancy, (C) an individual's inability to achieve pregnancy after six months of unprotected sexual intercourse due to the individual's age, (D) an individual's increased risk of transmitting a serious, inheritable genetic or chromosomal abnormality to a child, either through the individual or the individual's partner, or (E) "infertility" as defined by the American Society of Reproductive Medicine, its successor organization or a comparable organization.

(b) The Commissioner of Social Services shall amend the Medicaid state plan to provide coverage for fertility diagnostic care, fertility preservation services and fertility treatment. Such coverage shall provide for:

(1) Any medically necessary ovulation-enhancing drugs and medical services related to prescribing and monitoring the use of ovulation-enhancing drugs that is intended to treat infertility and achieve a pregnancy that results in a live birth, and

(2) At least three cycles of ovulation-enhancing medication treatment.

(c) Not later than July 1, 2026, the Commissioner of Social Services shall, after consultation with the Centers for Medicare and Medicaid Services, submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on the costs and benefits of establishing in-vitro fertilization as a covered benefit under the fee-for-service state medical assistance program and any future model of the state medical assistance program involving managed care organizations. The commissioner shall include in the report (1) any potential Medicaid waivers that may be necessary to establish such covered benefit, and (2) the amount of state funds that may be needed to establish such covered benefit. For purposes of this subsection, "state medical assistance program" has the same meaning as "Husky Health" as defined in section 17b-290 of the general statutes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2026*	New section

Statement of Legislative Commissioners:
In Subsec. (c), "and the budgets of state agencies" was inserted after "appropriations" for statutory consistency and "means the HUSKY Health program" was changed to "has the same meaning as 'Husky Health'" for accuracy.

HS *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 $	FY 27 $
Social Services, Dept.	GF - Cost	at least $200,000	at least $500,000 - $5.2 million

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in a cost to the Department of Social Services (DSS) of at least $200,000 in FY 26 and $500,000 to $5.2 million in FY 27 due to requiring Medicaid coverage for fertility treatment and preservation services, effective 1/1/26.

Medicaid currently covers family planning services that include reproductive health exams and lab tests to detect the presence of conditions affecting reproductive health which include infertility. While DSS does not currently cover infertility treatment services, fertility treatment is a Medicaid coverable service and eligible for up to 90% federal reimbursement.

Cost estimates reflect no-cycle based and medication involved treatment, preservation services, as well as prenatal and labor and delivery costs resulting from such treatments. In FY 27, the cost for treatment and preservation services is estimated to be at least $500,000, which reflects an assumed state share of 10%. The state will incur additional costs of approximately $4.7 million (reflecting an assumed state share of 50%) associated with prenatal, labor and delivery and

postpartum services to the extent these individuals would not otherwise become pregnant except for the fertility treatment coverage provided by the bill.

The bill requires DSS to consult with the Centers for Medicare and Medicaid Services and report (by 7/1/26) to the Appropriations and Human Services committees on the costs and benefits of establishing in-vitro fertilization (IVF) as a covered benefit under Medicaid. IVF costs are therefore not included in the above estimates.

To the extent that the treatment provided under the bill is successful and the children who would not otherwise be born are eligible for coverage under HUSKY A or HUSKY B, the state will incur additional costs.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to Medicaid coverage for fertility related services, utilization rates and success of such treatments.

OLR Bill Analysis

sHB 7022

AN ACT PROMOTING EQUITY IN MEDICAID COVERAGE FOR FERTILITY HEALTH CARE.

SUMMARY

This bill requires the Department of Social Services commissioner to amend the Medicaid state plan to cover fertility diagnostic care, preservation services, and treatment, including:

1. medically necessary ovulation-enhancing drugs and medical services for prescribing and monitoring the use of these drugs intended to treat infertility and achieve pregnancy, and

2. at least three cycles of ovulation-enhancing medication treatment.

The commissioner must consult with the federal Centers for Medicare and Medicaid Services and, by July 1, 2026, report to the Appropriations and Human Services committees on the costs and benefits of providing Medicaid coverage for in-vitro fertilization (IVF). The report must include any potential Medicaid waivers and state costs necessary to establish such coverage.

EFFECTIVE DATE: January 1, 2026

INFERTILITY AND RELATED TREATMENT COVERAGE

Infertility Definition

Under the bill, "infertility" means any of the following:

1. the presence of a condition recognized by a licensed physician as a cause of fertility loss or impairment;

2. a couple's inability to achieve pregnancy after 12 months of

unprotected sexual intercourse when the couple has the necessary gametes to achieve pregnancy;

3. a person's inability to achieve pregnancy after six months of unprotected sexual intercourse due to their age;

4. a person's increased risk of transmitting to a child a serious, inheritable genetic or chromosomal abnormality, either through the person or their partner; or

5. the American Society of Reproductive Medicine's (ASRM) infertility definition (or that of a successor or comparable organization).

Required Coverage

The bill requires Medicaid coverage for the following services:

1. fertility diagnostic care, which is procedures, products, medications, and services that provide information and counseling about a person's fertility (e.g., laboratory assessments and imaging studies);

2. fertility treatments, which are procedures, products, genetic testing, medications, and services intended to achieve pregnancy, consistent with established medical practice and professional ASRM, successor organization, or comparable organization guidelines; and

3. fertility preservation services, which are procedures, products, medications, and services, consistent with established medical practice and professional ASRM guidelines (or those of a successor or comparable organization), provided to a person who has a medical or genetic condition or is expected to undergo treatment that may directly or indirectly cause risk of fertility impairment.

For the latter, these services also include (1) procurement and cryopreservation of gametes (i.e. sperm or egg), embryos, and

reproductive material and (2) storage from the date of cryopreservation for at least five years or until the person reaches age 30, whichever is later.

BACKGROUND

Medically Necessary Services in Medicaid

Under the state's Medicaid program, medically necessary services are those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate a person's medical condition, including mental illness or its effects, to attain or maintain the person's achievable health and independent functioning (CGS § 17b-259b). Medically necessary services must also be:

1. consistent with generally accepted medical practice standards;
2. clinically appropriate in terms of type, frequency, timing, site, extent, and duration and considered effective for the person's illness, injury, or disease;
3. not primarily for the person's or provider's convenience;
4. not more costly than an alternative service likely to produce equivalent therapeutic or diagnostic results; and
5. be based on an assessment of the person and his or her medical condition.

COMMITTEE ACTION

Human Services Committee

Joint Favorable
Yea 16 Nay 6 (03/13/2025)