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)