TESTIMONY OF GLBTQ LEGAL ADVOCATES & DEFENDERS
On HB 5374
An Act Concerning Health Coverage Mandates For Certain Health Conditions
Insurance and Real Estate Committee

Dear Co-Chair Wood, Co-Chair Cabrera, Vice Chair Barry, Vice Chair Anwar, and esteemed members of the Insurance and Real Estate Committee:

My name is Patience Crozier, and I am the Director of Family Advocacy at GLBTQ Legal Advocates & Defenders (GLAD Law). I write with my colleague Hannah Hussey to urge this committee to take action to update the private infertility insurance mandate in Connecticut to provide better access to coverage to all paying members and to ensure that Connecticut law reflects the standard of care and avoids unlawful language. Additionally, GLAD Law respectfully requests that this committee act to preserve access to medically necessary healthcare by ensuring coverage for supplies of hormone prescriptions for up to twelve months.

Infertility Insurance

As you know, GLAD Law is New England's leading legal rights organization dedicated to ensuring equality for LGBTQ people and people living with HIV. At GLAD Law, much of my work focuses on the well-being and needs of children and families, including family building and the protection of parent-child relationships. Stable and secure parent-child relationships are core to a thriving, interconnected and intergenerational community.

Access to fertility treatments to build a family is critically important for comprehensive health care, yet across the United States, there is a dearth of access.[1] This dearth of access is particularly troubling in light of efforts to restrict access to fertility health care in other states and attacks on LGBTQ families.

Connecticut's fertility insurance law does not reflect the current medical standard of care as articulated by the American Society of Reproductive Medicine. This gap in access is especially burdensome for LGBTQ individuals and couples who, like all others, aspire to create loving families and are left unprotected by coverage they pay for. As a result, LGBTQ people and single people who need to access fertility care and are paying for coverage can be excluded from care or face additional financial burdens to access care.

[1] American Society for Reproductive Medicine, *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion* (2021), https://www.asrm.org/globalassets/_asrm/practice-guidance/ethics-opinions/pdf/disparities_in_access_to_effective_treatment_for_infertility_in_the_us-pdfmembers.pdf. (As of 2021, only nine states provided comprehensive or near-comprehensive coverage for infertility treatment to at least some residents through state law mandates, focused on private insurers.)

Since 2023, the ASRM has defined infertility to include, among other things: "The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors" and "[t]he need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner."[2] Connecticut is overdue to align its statutory definition with the ASRM standard and, by doing so, reflect best practice and truly support Connecticut residents in building their families.

Our suggested update – attached to this testimony – would be an incremental step forward and would help to alleviate the significant barriers faced by LGBTQ people attempting to access fertility care, who might otherwise be unable to afford out-of-pocket fertility treatments. Without insurance coverage, fertility care is out of reach for many.[3] Prospective parents might go into debt, face bankruptcy, or delay home purchases and other economic milestones to pay for fertility care.[4] Racial disparities persist as well—Black women are approximately twice as likely as white women to experience infertility, yet less likely to receive fertility care. Updating the insurance coverage definition for fertility treatment will alleviate economic burdens, promote early, medically appropriate intervention and can even lower long-term healthcare costs.

This bill would also bring Connecticut into closer alignment with several other states that have updated their fertility insurance laws to reflect the current standard of care. Six states (California, Colorado, Illinois, Maine, New York, and New Jersey) and Washington, D.C. have done this work which also explicitly includes LGBTQ people in their laws requiring private insurers to cover fertility healthcare.[5] In 2024, even the Department of Veterans Affairs expanded their IVF coverage policy to include LGBTQ couples and allow for the use of donor gametes.[6]

Even as some localities expand access to fertility services, this form of healthcare has increasingly come under attack. Last year, Arkansas adopted the RESTORE Act, a bill which requires insurers to cover "Restorative Reproductive Medicine" (RRM), a non-medical practice that falls outside the standard of care. The U.S. Department of Health and Human Services also announced plans to introduce RRM into its clinics for low-income women. These actions divert resources from evidence-based fertility care, undermining access to safe and effective treatment. It is clear that

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[2] Practice Committee of the American Society for Reproductive Medicine, *Definition of Infertility: A Committee Opinion* (2023), https://www.asrm.org/globalassets/_asrm/practice-guidance/practice-guidelines/pdf/definition-of-infertility.pdf.

[3] *Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion*, The American Society for Reproductive Medicine (July 2021), https://www.asrm.org/globalassets/_asrm/practice-guidance/ethics-opinions/pdf/disparities_in_access_to_effective_treatment_for_infertility_in_the_us-pdfmembers.pdf.

[4] A. Bosworth et al., *Health Insurance Coverage and Access to Care for LGBTQ+ individuals: Current Trends and Key Challenges* (2021), https://aspe.hhs.gov/sites/default/files/2021-07/lgbt-health-ib.pdf.

[5] *Fertility Healthcare,* Movement Advancement Project, https://www.lgbtmap.org/equality-maps/healthcare/fertility_coverage (last accessed Feb. 20, 2026).

[6] "VA expands in vitro fertilization for Veterans," U.S. Department of Veterans Affairs (March 11, 2024), https://news.va.gov/press-room/va-expands-in-vitro-fertilization-for-veterans/.

states that wish to promote children and families must act to protect and secure access to standard of care fertility health care.

GLAD Law urges the Committee to amend H.B. 5374 Section 4 from a study to updating our state law, which is outdated and does not reflect the standard of health care, so more Connecticut residents have access to the essential medical care they need to build their families.

Coverage for Hormone Treatment

In an increasingly turbulent landscape in which medically necessary healthcare is under attack, Connecticut has a critical role to play in ensuring continuity of treatment for its residents who rely on hormone medications. We are requesting that the Committee amend H.B. 5374 Section 4 to ensure coverage for patients who obtain up to twelve months of a prescribed hormone medication from their pharmacy.

While prescriptions may permit patients to pick up many months of refills at once, many insurers only cover the cost of the medication if patients pick up their refills more slowly over time. To obtain a medication supply that will last for a longer period, patients often need to pay out-of-pocket. For many patients and their families, this is financially burdensome or simply not possible.

This legislation would ensure that patients have a stop-gap option for continuity of treatment, in the event of an interruption to their access to medically necessary medications. It would not require insurers to cover new or different medications than they do now, it would not limit the discretion of providers to prescribe medications in the amount they deem medically indicated, and it explicitly provides for compliance with applicable controlled substance laws.

The language we recommend is attached to this testimony. Adopting it would build on Connecticut's leadership in protecting access to essential healthcare. It would also follow the example set by Washington state in passing similar language into law last year with bipartisan support.

With coordinated political efforts seeking to prevent access to medically necessary care, no patient should have to choose between their health and their financial stability. GLAD Law urges this Committee to remove that calculus by amending this bill to include the recommended language.

Conclusion

Thank you for your work. Please do not hesitate to contact GLAD Law to provide further information and support.

Respectfully submitted,

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AN ACT EXPANDING HEALTH INSURANCE COVERAGE FOR FERTILITY TREATMENT.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

That chapter 700c of the general statutes be amended to require individual and group health insurance policies to expand coverage for fertility treatment and to define infertility to mean:

1. The inability to establish a pregnancy or to carry a pregnancy based on an individual's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This includes infertility arising from disabilities or from medical treatments or conditions associated with disability.

2. The need for medical intervention to establish a pregnancy either as an individual or with a partner;

3. An individual's inability to establish a pregnancy or to carry a pregnancy to live birth after 12 months of unprotected sexual intercourse when the individual and the individual's partner have the necessary gametes to establish a pregnancy. Pregnancy loss does not restart the 12-month period; or

4. An individual's inability to establish a pregnancy or to carry a pregnancy to live birth after six months of unprotected sexual intercourse due to the individual's age when the individual and the individual's partner have the necessary gametes to establish a pregnancy. Pregnancy loss does not restart the six-month period.

That chapter 700c of the general statutes be amended to require individual and group health insurance policies to expand coverage for fertility treatment and to provide for a new section "(c)" as follows:

Such policy may not impose any limitations on coverage for any treatment for infertility based on an individual's use of donor gametes, donor embryos, or a surrogate.

RECOMMENDED LANGUAGE FOR ENSURING COVERAGE FOR MEDICALLY NECESSARY HORMONE PRESCRIPTIONS

A new section is added to chapter 700C to read as follows:

(a) As used in this section, "prescription hormone therapy" means all drugs approved by the United States Food and Drug Administration that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels, as determined by the prescribing provider. Prescription hormone therapy does not include glucagon-like peptide-1 and glucagon-like peptide-1 receptor agonists.

(b) Each individual and group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2027, that includes coverage for prescription hormone therapy must provide reimbursement for a twelve-month supply of covered prescription hormone therapy and any necessary supplies for administration dispensed at one time, unless the enrollee requests a smaller supply, the prescribing provider instructs that the enrollee must receive a smaller supply, or the prescription hormone therapy is a controlled substance. If the prescription hormone therapy is a controlled substance, the health plan must provide reimbursement for the maximum refill allowed under state and federal law to be obtained at one time by the enrollee.

(c) Nothing in this section prohibits a health plan from limiting refills that may be obtained in the last quarter of the plan year if a twelve-month supply of the prescription hormone therapy has already been dispensed during the plan year.

(d) To the extent not otherwise prohibited under this section or state or federal law, health plans may apply drug utilization management strategies to prescription drugs covered under subsection (a) of this section.