Frequently Asked Questions about Fertility Preservation Services

Chapter 140 of the Acts of 2024 includes mandates for coverage for standard fertility preservation services for fully insured products by adding M.G.L. chs. 175, §47VV; 176A, §8WW; 176B, §4WW and 176G, §4OO.

The Division of Insurance ("DOI") developed the following Q&A to help consumers and providers understand this mandated benefit, which applies to fully insured health plans issued under Massachusetts law by insurance companies, Blue Cross and Blue Shield of Massachusetts, and Health Maintenance Organizations (collectively referred to as "Insurance Carriers").

DIFFERENT TYPES OF HEALTH PLANS

If someone has insurance coverage, how can they know if their health plan is subject to this mandate to include coverage for fertility preservation services and subject to the jurisdiction of the DOI?[1]

This mandate applies to all fully insured health benefit plans delivered, issued or renewed to individuals in the Commonwealth, and to fully insured group health benefit plans delivered, issued or renewed in the Commonwealth and certain out-of-state fully insured group health benefit plans that insure residents of the Commonwealth. This includes health plans purchased through the Massachusetts Health Connector (e.g., all ConnectorCare Health Plans).

This mandate also applies to plans offered by the Group Insurance Commission; however, these programs are not subject to DOI jurisdiction. This mandate does not apply to public insurance, such as MassHealth (Medicaid).

How can someone know if their health plan includes fertility preservation benefits?

Individuals should review their plan documents or contact their employer's human resources representative or their health plan's Member Services to understand whether their health plan includes coverage for fertility preservation services.

Many large employers self-fund employee health benefits, meaning that they pay the benefits from their own resources rather than buying a fully-insured health plan from an Insurance Carrier. Self-funded health plans are exempt from state mandated benefits, including the fertility preservation law, and the DOI does not have jurisdiction over these plans. However, in some instances self-funded plans may include these benefits, check with your employer or health plan for specific details of your plan's benefits.

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[1] Consider going to https://www.mass.gov/health-care for more information about health plans.

FERTILITY PRESERVATION SERVICES

What fertility preservation services are available to me/my patient under this law?

The law states that covered fertility preservation services include "procedures or treatments to preserve fertility as recommended by a board-certified obstetrician gynecologist, reproductive endocrinologist or other physician; provided, however, that the recommendation shall be made in accordance with current medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology or other reputable professional organizations." It is further noted that these services include, but are not limited to "coverage for procurement, cryopreservation and storage of gametes, embryos or other reproductive tissue", when the enrollee has a diagnosed medical or genetic condition that may directly or indirectly cause impairment of fertility by affecting reproductive organs or processes. Coverage shall be provided to the same extent that coverage is provided for other pregnancy-related procedures. An individual can contact the Member Services department in their health plan for a copy of their health plan benefits to understand the details of fertility preservation services provided by their plan.

When are persons in fully insured plans eligible for fertility preservation services under this law?

The services are to be available when "the enrollee has a diagnosed medical or genetic condition that may directly or indirectly cause impairment of fertility by affecting reproductive organs or processes." The law states that an individual has a condition that "directly or indirectly cause[s] impairment of fertility" if there are "circumstances where a disease or the necessary treatment for a disease has a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology or other reputable professional organizations." Such medical treatment can include individuals receiving or about to receive gender-affirming hormone treatment.

Are there instances where a fully insured health plan might not cover certain fertility preservation services?

Yes, your fully insured health plan may not cover fertility preservation services received from a health care provider that is not in your plan's network, if your plan requires you to use an in-network provider. If your plan provides some benefits when out-of-network providers are used, you may receive reduced coverage.

Insurance Carriers are expected to clearly disclose how individuals can access fertility preservation services. You should always check with your plan's network requirements, including any out-of-network benefits available and their associated costs, before receiving services.

How may fertility preservation services be impacted if I change health plans?

If an individual is receiving fertility preservation benefits from a fully insured health plan, that plan is required to present information that explains how coverage for fertility preservation services may change if the individual changes health insurance plans. When switching health plans,

- If an individual switches to another fully insured health plan, the individual may be subject to different health plan cost-sharing (deductibles, coinsurance or copayments) and may be required to pay more out-of-pocket than was required in the former health plan before switching coverage.
- If an individual switches coverage to a fully insured plan that requires the use of in-network providers, the individual may be required to switch to a provider that is available in the network of the new plan.
- If an individual switches coverage to a health plan that is not subject to the fertility preservation mandate, such as a self-insured plan, the individual may not have any fertility preservation services covered under the new health plan.

May health plans deny any services?

For fully insured health plans, Insurance Carriers are required to follow managed care practices that review requests for services according to medical necessity criteria established by a health plan's medical director. Insurance Carriers are required to review all requests and either approve or deny a completed request within 2 business days. If a request is denied, the Insurance Carrier is to issue an adverse determination letter that explains the medical necessity reasons for a denial and the patient's right to appeal the decision. If there are any questions about the appeal process, including about requests for expedited appeals, the Office of Patient Protection can be reached by e-mail at HPCOPP@mass.gov.

If there are additional questions, please contact Niels Puetthoff, Director, Bureau of Managed Care, at niels.puetthoff@mass.gov. If you have any complaints, please visit Filing An Insurance Complaint | Mass.gov .