25.0069.03000

Sixty-ninth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1282

Introduced by

Representatives Brandenburg, Hanson, Mitskog, Satrom, Schauer

Senators Axtman, Hogan

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee fertility health benefits; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Fertility health care.

1. As used in this section:
   a. "Diagnosis of infertility" means the services, procedures, testing, or medications recommended by a licensed physician which are consistent with established, published, or approved best practices or professional standards or guidelines, including the American society of reproductive medicine, the American college of obstetricians and gynecologists, or the American society of clinical oncology for diagnosing and treating infertility.
   b. "Fertility treatment" means health care services, procedures, testing, medications, monitoring, treatments, or products, including genetic testing and assisted reproductive technologies, including oocyte retrievals, in vitro fertilization, and fresh and frozen embryo transfers, provided with the intent to achieve a pregnancy that results in a live birth with a healthy outcome.
   c. "Infertility" means a disease or condition characterized by:
      (1) The failure to conceive a pregnancy or to carry a pregnancy to live birth after unprotected sexual intercourse;

(2) An individual's inability to cause pregnancy and live birth either as a covered individual or with the covered individual's partner; or

(3) A licensed health care provider's findings and statement based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

d. "Medically necessary" means a health care service or product provided in a manner:

(1) Consistent with the findings and recommendations of a licensed physician, based on a patient's medical history, sexual and reproductive history, age, partner, physical findings, or diagnostic testing;

(2) Consistent with generally accepted standards of medical practice as set forth by a professional medical organization with a specialization in any aspect of reproductive health, including the American society for reproductive medicine or the American college of obstetricians and gynecologists; or

(3) Clinically appropriate in terms of type, frequency, extent, site, and duration.

e. "Monitoring" includes, ultrasounds, transvaginal ultrasounds, laboratory testing, and followup appointments.

f. "Third-party reproductive care for the benefit of the covered individual" means the use of eggs, sperm, or embryos donated to the covered individual or partner by a donor, or the use of a gestational carrier, to achieve a live birth with a healthy outcome.

2. The board shall provide coverage for the expenses of the diagnosis of infertility and fertility treatment services if recommended and medically necessary.

a. Coverage must include:

(1) Three completed cycles of intrauterine insemination, in accordance with best practices, including the standards and guidelines of the American society of reproductive medicine.

(2) Fertility treatment services necessary to achieve two live births, or a maximum of four completed oocyte retrievals with four fresh and frozen embryo transfers, in accordance with best practices, including the guidelines

of the American society for reproductive medicine, and using no more than two embryos per transfer.

(3) Diagnosis of infertility and fertility treatment services, including third-party reproductive care for the benefit of the covered individual or partner.

(4) Fertility treatment, consisting of a method of causing pregnancy other than sexual intercourse which is provided with the intent to create a legal parent-child relationship between the covered individual and the resulting child in accordance with chapter 14-20.

(5) Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with a covered individual's religious or ethical beliefs.

(6) Five years of cryopreservation services.

b. This section may not be construed to deny the included coverage in this section to an individual who forgoes a particular fertility treatment service if the individual's physician determines the fertility treatment service is likely to be unsuccessful.

3. To be covered under this section, the diagnosis of infertility and fertility treatment services must be performed at a facility that conforms to best practices, including the standards and guidelines developed by the American society for reproductive medicine, the American college of obstetricians and gynecologists, or the American society of clinical oncology.

4. Coverage under this section must be made available to all covered individuals, including covered individuals who have entered coverage during special enrollment or open enrollment.

5. Coverage under this section must be in accordance with best practices, including the standards or guidelines developed by the American society of reproductive medicine, the American college of obstetricians and gynecologists, or the American society of clinical oncology. If a carrier makes, issues, circulates, or causes to be made, issued, or circulated, clinical guidelines based on data not reasonably current or which do not cite with specificity, the act constitutes unfair or deceptive acts or practices in the business of insurance as prohibited by chapter 26.1-04.

6. Benefits under this section may not be limited based on:

a. A copayment, deductible, coinsurance, benefit maximum, waiting period, or other limitation on coverage different from maternity benefits provided under the health benefits;

b. An exclusion, limitation, or other restriction on coverage of fertility medication different from restrictions imposed on any other prescription medication;

c. A requirement that provides different benefits to, or imposes different requirements on, a class protected under chapter 14-02.4 than that provided to or required of other covered individuals; or

d. A pre-existing condition exclusion, pre-existing condition waiting period on coverage for required benefits, or a prior diagnosis of infertility, fertility treatment, or standard fertility preservation services.

7. This section does not apply to the Medicare part D prescription drug coverage plan.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - FERTILITY HEALTH BENEFITS - REPORT TO LEGISLATIVE ASSEMBLY. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the seventieth legislative assembly to repeal the expiration date for this Act and to extend the coverage of fertility health benefits to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the fertility health benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

SECTION 3. APPLICATION. This Act applies to health benefits coverage that begins after June 30, 2025, and which does not extend past June 30, 2027.

SECTION 4. EXPIRATION DATE. This Act is effective through June 30, 2027, and after that date is ineffective.