State of Wisconsin
2023 - 2024 LEGISLATURE

LRB-4953/1
JPC:amn

2023 ASSEMBLY BILL 766

December 6, 2023 - Introduced by Representatives EMERSON, VINING, BARE, ANDRACA, CLANCY, CONLEY, CONSIDINE, JACOBSON, JOERS, MADISON, MYERS, OHNSTAD, ORTIZ-VELEZ, PALMERI, RATCLIFF, SHELTON, SINICKI and STUBBS, cosponsored by Senators ROYS, AGARD, CARPENTER, HESSELBEIN, L. JOHNSON, LARSON, PFAFF, SPREITZER, TAYLOR, WIRCH and SMITH. Referred to Committee on Insurance.

AN ACT ***to amend*** 40.51 (8), 66.0137 (4) and 120.13 (2) (g); and ***to create*** 632.8965 of the statutes; **relating to:** coverage of infertility services under self-insured governmental health plans and health policies and plans offered to state employees, and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill requires self-insured governmental health plans and health care coverage plans offered by the state to its employees that cover medical or hospital expenses to cover diagnosis of and treatment for infertility and standard fertility preservation services. Coverage required under the bill must include at least four completed egg retrievals with unlimited embryo transfers in accordance with certain guidelines and single embryo transfer is allowed when recommended and medically appropriate. Policies and plans are prohibited from imposing an exclusion, limitation, or other restriction on coverage of medications of which the bill requires coverage that is not imposed on any other prescription medications covered under the policy or plan. Similarly, policies and plans may not impose any exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period or other restriction on diagnosis, treatment, or services for which coverage is required under the bill that is different from any exclusion, limitation, cost-sharing requirement, benefit maximum, waiting period or other restriction imposed on benefits for other services. Also, policies and plans may not impose an exclusion, limitation, or other restriction on diagnosis, treatment, or services for which coverage is required under

the bill on the basis that an insured person participates in fertility services provided by or to a third party.

This proposal may contain a health insurance mandate requiring a social and financial impact report under s. 601.423, stats.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.729, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.861, 632.867, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), ~~and~~ 632.896, and 632.8965.

SECTION 2. 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.861, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, 632.8965, and 767.513 (4).

SECTION 3. 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.729, 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.861, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, 632.8965, and 767.513 (4).

SECTION 4. 632.8965 of the statutes is created to read:

632.8965 Coverage of infertility services. (1) In this section:

(a) "Diagnosis of and treatment for infertility" means any recommended procedure or medication at the direction of a physician that is consistent with established, published, or approved medical practices or professional guidelines from the American College of Obstetricians and Gynecologists, or its successor organization, or the American Society for Reproductive Medicine, or its successor organization.

(b) "Infertility" means a disease, condition, or status characterized by any of the following:

1. 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 these factors.

2. The need for medical intervention, including the use of donor gametes or donor embryos, in order to achieve a successful pregnancy either as an individual or with a partner.

3. The failure to establish a pregnancy or carry a pregnancy to a live birth after regular, unprotected sexual intercourse for, if the woman is under the age of 35, no longer than 12 months or, if the woman is 35 years of age or older, no longer than 6 months including any time during those 12 months or 6 months that the woman has a pregnancy that results in a miscarriage.

(c) "Self–insured health plan" means a self–insured health plan of the state or a county, city, village, town, or school district.

(d) "Standard fertility preservation service" means a procedure that is consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology, or its successor organization, for a

person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

(2) Every self–insured health plan shall cover diagnosis of and treatment for infertility and standard fertility preservation services. Coverage required under this subsection includes at least 4 completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine or its successor organization and single embryo transfer may be used when recommended and medically appropriate.

(3) A self–insured health plan may not do any of the following:

(a) Impose any exclusions, limitations, or other restrictions on coverage required under sub. (2) based on a covered individual's participation in fertility services provided by or to a 3rd party.

(b) Impose any exclusion, limitation, or other restriction on coverage of medications that are required to be covered under sub. (2) that are different from those imposed on any other prescription medications covered under the policy or plan.

(c) Impose any exclusion, limitation, cost–sharing requirement, benefit maximum, waiting period, or other restriction on coverage of the diagnosis of and treatment for infertility and standard fertility preservation services required under sub. (2) that is different from an exclusion, limitation, cost–sharing requirement, benefit maximum, waiting period, or other restriction imposed on benefits for services that are covered by the policy or plan and that are not related to infertility.

(4) Every self–insured health plan shall provide coverage required under sub. (2) to any covered individual under the policy or plan, including any covered spouse

and nonspouse dependent, to the same extent as other pregnancy–related benefits covered under the policy or plan.

(5) The commissioner, after consulting with the department of health services on appropriate treatment for infertility, shall promulgate any rules necessary to implement this section. Before the promulgation of rules, self–insured health plans are considered to comply with the coverage requirements of sub. (2) if the coverage conforms to the standards of the American Society for Reproductive Medicine.

SECTION 5. Initial applicability.

(1) For policies and plans containing provisions inconsistent with this act, the act first applies to policy or plan years beginning on the effective date of this subsection, except as provided in sub. (2).

(2) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with this act, the act first applies to policy or plan years beginning on the effective date of this subsection or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.

(END)