H. R. 2803

To require health insurance coverage for the treatment of infertility.

IN THE HOUSE OF REPRESENTATIVES

MAY 16, 2019

Ms. DeLauro (for herself, Ms. Wasserman Schultz, Ms. Wilson of Florida, Mr. Raskin, Ms. Jackson Lee, Mr. Nadler, and Ms. Pingree) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Oversight and Reform, Armed Services, and Veterans’ Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To require health insurance coverage for the treatment of infertility.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,
3 SECTION 1. SHORT TITLE.
4 This Act may be cited as the “Access to Infertility
5 Treatment and Care Act”.
6 SEC. 2. FINDINGS.
7 Congress finds as follows:
(1) Infertility is a medical disease recognized by the World Health Organization, the American Society for Reproductive Medicine, and the American Medical Association that affects men and women equally.

(2) According to the Centers for Disease Control and Prevention, 1 in 8 couples have difficulty getting pregnant or sustaining a pregnancy.

(3) Infertility affects a broad spectrum of prospective parents. No matter what race, religion, sexual orientation, or economic status one is, infertility does not discriminate.

(4) According to the Centers for Disease Control and Prevention, 11 percent of women in the United States between the ages of 15 and 44 have difficulty getting pregnant or staying pregnant. Similarly, 9 percent of men in the United States between the ages of 15 and 44 experience infertility.

(5) Infertility disproportionately affects individuals with particular health complications. For cancer patients and others who must undergo treatments such as chemotherapy, radiation therapy, hormone therapy, or surgery that are likely to harm the reproductive system and organs, fertility preservation becomes necessary.
(6) Leading causes of infertility include chronic conditions and diseases of the endocrine or metabolic systems, such as primary ovarian insufficiency, polycystic ovarian syndrome, endometriosis, thyroid disorders, menstrual cycle defects, autoimmune disorders, hormonal imbalances, testicular disorders, and urological health issues. Other causes include structural problems or blockages within the reproductive system, exposure to infectious diseases, occupational or environmental hazards, or genetic influences.

(7) Recent improvements in therapy and cryopreservation make pregnancy possible for more people than in past years.

(8) Like all other diseases, infertility and its treatments should be covered by health insurance.

(9) A 2017 national survey of employer-sponsored health plans found that 44 percent of employers with at least 500 employees did not cover infertility services, and 25 percent of companies with 20,000 or more employees did not cover infertility services.

(10) Coverage for infertility services under State Medicaid programs is limited. The Medicaid programs of only 5 States provide diagnostic testing
for women and men in all of their program eligibility pathways; the Medicaid program of only one State provides coverage for certain medications for women experiencing infertility; and no State Medicaid programs cover intrauterine insemination or in vitro fertilization.

(11) States that do not require private insurance coverage of assisted reproductive technology have higher rates of multiple births.

(12) The ability to have a family should not be denied to anyone on account of a lack of insurance coverage for medically necessary treatment.

SEC. 3. STANDARDS RELATING TO BENEFITS FOR TREATMENT OF INFERTILITY AND PREVENTION OF IATROGENIC INFERTILITY.

(a) In General.—Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by inserting after section 2728 the following:

“SEC. 2729A. STANDARDS RELATING TO BENEFITS FOR TREATMENT OF INFERTILITY AND PREVENTION OF IATROGENIC INFERTILITY.

“(a) In General.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall ensure that such plan or coverage provides coverage for—
“(1) the treatment of infertility, including non-experimental assisted reproductive technology procedures, if such plan or coverage provides coverage for obstetrical services; and

“(2) standard fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility.

“(b) DEFINITIONS.—In this section:

“(1) the term ‘assisted reproductive technology’ means treatments or procedures that involve the handling of human egg, sperm, and embryo outside of the body with the intent of facilitating a pregnancy, including in vitro fertilization, egg, embryo, or sperm cryopreservation, egg or embryo donation, and gestational surrogacy;

“(2) the term ‘infertility’ means a disease, characterized by the failure to establish a clinical pregnancy—

“(A) after 12 months of regular, unprotected sexual intercourse; or

“(B) due to a person’s incapacity for reproduction either as an individual or with his or her partner, which may be determined after a period of less than 12 months of regular, unprotected sexual intercourse, or based on med-
ical, sexual and reproductive history, age, physical findings, or diagnostic testing; and

“(3) the term ‘iatrogenic infertility’ means an impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment.

“(e) REQUIRED COVERAGE.—

“(1) COVERAGE FOR INFERTILITY.—Subject to paragraph (3), a group health plan and a health insurance issuer offering group or individual health insurance coverage that includes coverage for obstetrical services shall provide coverage for treatment of infertility determined appropriate by the treating physician, including, as appropriate, ovulation induction, egg retrieval, sperm retrieval, artificial insemination, in vitro fertilization, genetic screening, intra cytoplasmic sperm injection, and any other non-experimental treatment, as determined by the Secretary in consultation with appropriate professional and patient organizations such as the American Society for Reproductive Medicine, RESOLVE: The National Infertility Association, and the American College of Obstetricians and Gynecologists.

“(2) COVERAGE FOR IATROGENIC INFERTILITY.—A group health plan and a health insurance issuer offering group or individual health insur-
ance coverage shall provide coverage of fertility pres-
ervation services for individuals who undergo medi-
cally necessary treatment that may cause iatrogenic
infertility, as determined by the treating physician,
including cryopreservation of gametes and other pro-
cedures, as determined by the Secretary, consistent
with established medical practices and professional
guidelines published by professional medical organi-
zations, including the American Society of Clinical
Oncology and the American Society for Reproductive
Medicine.

“(3) LIMITATION ON COVERAGE OF ASSISTED
REPRODUCTIVE TECHNOLOGY.—A group health plan
and a health insurance issuer offering group or indi-
vidual health insurance coverage shall provide cov-
erage for assisted reproductive technology as re-
quired under paragraph (1) if—

“(A) the individual is unable to bring a
pregnancy to a live birth through minimally
invasive infertility treatments, as determined
appropriate by the treating physician, with con-
sideration given to participant’s or beneficiary’s
specific diagnoses or condition for which cov-
erage is available under the plan or coverage; and
“(B) the treatment is performed at a medical facility that—

“(i) conforms to the standards of the American Society for Reproductive Medicine and the Society for Assisted Reproductive Technology; and

“(ii) is in compliance with any standards set by an appropriate Federal agency.

“(d) LIMITATION.—Cost-sharing, including deductibles and coinsurance, or other limitations for infertility and services to prevent iatrogenic infertility may not be imposed with respect to the services required to be covered under subsection (c) to the extent that such cost-sharing exceeds the cost-sharing applied to similar services under the group health plan or health insurance coverage or such other limitations are different from limitations imposed with respect to such similar services.

“(e) PROHIBITIONS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not—

“(1) provide incentives (monetary or otherwise) to a participant or beneficiary to encourage such participant or beneficiary not to be provided infertility treatments or fertility preservation services to which such participant or beneficiary is entitled
under this section or to providers to induce such
providers not to provide such treatments to qualified
participants or beneficiaries;

“(2) prohibit a provider from discussing with a
participant or beneficiary infertility treatments or
fertility preservation technology or medical treat-
ment options relating to this section; or

“(3) penalize or otherwise reduce or limit the
reimbursement of a provider because such provider
provided infertility treatments or fertility preserva-
tion services to a qualified participant or beneficiary
in accordance with this section.

“(f) RULE OF CONSTRUCTION.—Nothing in this sec-
tion shall be construed to require a participant or bene-
ficiary to undergo infertility treatments or fertility preser-
vation services.

“(g) NOTICE.—A group health plan and a health in-
surance issuer offering group or individual health insur-
ance coverage shall provide notice to each participant and
beneficiary under such plan regarding the coverage re-
quired by this section in accordance with regulations pro-
mulgated by the Secretary. Such notice shall be in writing
and prominently positioned in any literature or cor-
respondence made available or distributed by the plan or
issuer and shall be transmitted—
“(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

“(2) as part of any yearly informational packet sent to the participant or beneficiary; or

“(3) not later than January 1, 2020, whichever is earlier.

“(h) Level and Type of Reimbursements.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group or individual health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.”.

(b) Conforming Amendment.—Section 2724(c) of the Public Health Service Act (42 U.S.C. 300gg–23(c)) is amended by striking “section 2704” and inserting “sections 2704 and 2708”.

(c) Effective Dates.—

(1) In general.—The amendments made by subsections (a) and (b) shall apply for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

(2) Collective bargaining exception.—

(A) In general.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between em-
ployee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by subsection (a) shall not apply to plan years beginning before the later of—

(i) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(ii) the date occurring 6 months after the date of the enactment of this Act.

(B) CLARIFICATION.—For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

SEC. 4. FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.

(a) IN GENERAL.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:
“(p) Coverage for Diagnosis and Treatment of Infertility and Prevention of Iatrogenic Infertility.—

“(1) Definitions.—In this subsection, the terms ‘infertility’ and ‘iatrogenic infertility’ have the meanings given those terms in section 2729A of the Public Health Service Act.

“(2) Required Coverage.—A contract under this chapter shall provide, in a manner consistent with section 2729A of the Public Health Service Act—

“(A) coverage for the diagnosis and treatment of infertility, including nonexperimental assisted reproductive technology procedures, if such contract covers obstetrical benefits; and

“(B) coverage for standard fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility.

“(3) Cost.—Coverage for the diagnosis or treatment of infertility and fertility preservation services under a health benefits plan described in section 8903 or 8903a may not be subject to any copayment or deductible greater than the copayment
or deductible, respectively, applicable to obstetrical
benefits under the plan.

“(4) Preemption.—Subsection (m)(1) shall
not, with respect to a contract under this chapter,
prevent the inclusion of any terms that, under para-
graph (2) of this subsection, are required by reason
of section 2729A of the Public Health Service Act.”.

(b) Effective Date.—The amendment made by
subsection (a) shall apply with respect to any contract en-
tered into or renewed for a contract year beginning on
or after the date that is 180 days after the date of enact-
ment of this Act, and any health benefits plan offered
under such a contract.

SEC. 5. BENEFITS FOR TREATMENT OF INFERTILITY AND
PREVENTION OF IATROGENIC INFERTILITY
UNDER THE TRICARE PROGRAM.

(a) In General.—Chapter 55 of title 10, United
States Code, is amended by adding at the end the fol-
lowing new section:

“§ 1110c. Obstetrical and infertility benefits

“(a) In General.—Any health care plan under this
chapter shall provide, in a manner consistent with section
2729A of the Public Health Service Act—

“(1) coverage for the diagnosis and treatment
of infertility, including nonexperimental assisted re-
productive technology procedures, if such plan covers obstetrical benefits; and

“(2) coverage for standard fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility.

“(b) COPAYMENT.—The Secretary of Defense shall establish cost-sharing requirements for the coverage of diagnosis and treatment of infertility and fertility preservation services described in subsection (a) that are consistent with the cost-sharing requirements applicable to health plans and health insurance coverage under section 2729A(d) of the Public Health Service Act.

“(c) REGULATIONS.—The Secretary of Defense shall prescribe any regulations necessary to carry out this section.

“(d) DEFINITIONS.—In this section, the terms ‘infertility’ and ‘iatrogenic infertility’ have the meanings given those terms in section 2729A of the Public Health Service Act.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 55 of such title is amended by adding at the end the following new item:

“1110c. Obstetrical and infertility benefits.”.
SEC. 6. TREATMENT OF INFERTILITY AND PREVENTION OF IATROGENIC INFERTILITY FOR VETERANS AND SPOUSES OR PARTNERS OF VETERANS.

(a) IN GENERAL.—Subchapter II of chapter 17 of title 38, United States Code, is amended by adding at the end the following new section:

“§1720J. Infertility treatment for veterans and spouses or partners of veterans.

“(a) IN GENERAL.—The Secretary shall furnish treatment for infertility and fertility preservation services, including through the use of assisted reproductive technology, to a veteran or a spouse or partner of a veteran if the veteran, and the spouse or partner of the veteran, as applicable, apply jointly for such treatment and counseling through a process prescribed by the Secretary for purposes of this section.

“(b) INFERTILITY DEFINED.—In this section, the terms ‘infertility’ and ‘iatrogenic infertility’ have the meanings given those terms in section 2729A of the Public Health Service Act.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 of such title is amended by inserting after the item relating to section 1720I the following new item:

“1720J. Infertility treatment and counseling for veterans and spouses or partners, of veterans.”.
(c) REGULATIONS.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall prescribe regulations to carry out section 1720J of title 38, United States Code, as added by subsection (a).

SEC. 7. REQUIREMENT FOR STATE MEDICAID PLANS TO PROVIDE MEDICAL ASSISTANCE FOR TREATMENT OF INFERTILITY AND PREVENTION OF IATROGENIC INFERTILITY.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)(4)—

(A) by striking “; and (D)” and inserting “; (D)”;

(B) by inserting before the semicolon at the end the following: “; and (E) services and supplies to treat infertility and prevent iatrogenic infertility (as such terms are defined in section 2729A(b) of the Public Health Service Act) in accordance with subsection (ff)”;

(2) by adding at the end the following new subsection:

“(ff) REQUIREMENTS FOR COVERAGE OF INFERTILITY TREATMENT AND PREVENTION OF IATROGENIC INFERTILITY.—For purposes of subsection (a)(4)(E), a
State shall ensure that the medical assistance provided under the State plan (or waiver of such plan) for treatment of infertility and fertility preservation services complies with the requirements and limitations of section 2729A(c) of the Public Health Service Act in the same manner as such requirements and limitations apply to health insurance coverage offered by a group health plan or health insurance issuer.”.

(b) No Cost Sharing for Infertility Treatment.—

(1) In General.—Subsections (a)(2)(D) and (b)(2)(D) of section 1916 of the Social Security Act (42 U.S.C. 1396o(a)(2)(D)) are amended by inserting “, services and supplies to treat infertility and provide fertility preservation services described in section 1905(a)(4)(E)” before “, or” each place it appears.

(2) Application to Alternative Cost Sharing.—Section 1916A(b)(3)(B)(vii) of the Social Security Act (42 U.S.C. 1396o–1(b)(3)(B)(vii)) is amended by inserting “and services and supplies to treat infertility and provide fertility preservation described in section 1905(a)(4)(E)” before the period.

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(c) Presumptive Eligibility for Infertility Treatment.—Section 1920C of the Social Security Act (42 U.S.C. 1396r–1c) is amended—

(1) in the section heading, by inserting “AND INFERTILITY TREATMENT” after “FAMILY PLANNING SERVICES”;

(2) in subsection (a)—

(A) by striking “State plan” and inserting “A State plan”;

(B) by striking “1905(a)(4)(C)” and inserting “section 1905(a)(4)(C), services and supplies to treat infertility and prevent iatrogenic infertility described in section 1905(a)(4)(E),”; and

(C) by inserting “or in conjunction with an infertility treatment service in an infertility treatment setting” before the period.

(d) Inclusion in Benchmark Coverage.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)) is amended by adding at the end the following new paragraph:

“(8) Coverage of infertility treatment and prevention of iatrogenic infertility.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance
through enrollment of an individual with benchmark
coverage or benchmark-equivalent coverage under
this section unless such coverage includes medical
assistance for services and supplies to treat infer-
tility and provide fertility preservation described in
section 1905(a)(4)(E) in accordance with such sec-
tion.”.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in para-
graph (2), the amendments made by this section
shall take effect on October 1, 2020.

(2) DELAY PERMITTED IF STATE LEGISLATION
REQUIRED.—In the case of a State plan approved
under title XIX of the Social Security Act which the
Secretary of Health and Human Services determines
requires State legislation (other than legislation ap-
propriating funds) in order for the plan to meet the
additional requirement imposed by this section, the
State plan shall not be regarded as failing to comply
with the requirements of such title solely on the
basis of the failure of the plan to meet such addi-
tional requirement before the 1st day of the 1st cal-
endar quarter beginning after the close of the 1st
regular session of the State legislature that ends
after the 1-year period beginning with the date of
the enactment of this section. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature.