

Introduced by

Representative Brandenburg

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

4 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

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

7 **Health insurance benefits coverage - Fertility health care.**

8 1. As used in this section:

- 9 a. "Diagnosis of infertility" means the services, procedures, testing, or medications  
10 recommended by a licensed physician which are consistent with established,  
11 published, or approved best practices or professional standards or guidelines,  
12 including the American society of reproductive medicine, the American college of  
13 obstetricians and gynecologists, or the American society of clinical oncology for  
14 diagnosing and treating infertility.
- 15 b. "Fertility treatment" means health care services, procedures, testing,  
16 medications, monitoring, treatments, or products, including genetic testing and  
17 assisted reproductive technologies, including oocyte retrievals, in vitro  
18 fertilization, and fresh and frozen embryo transfers, provided with the intent to  
19 achieve a pregnancy that results in a live birth with a healthy outcome.
- 20 c. "Infertility" means a disease or condition characterized by:
- 21 (1) The failure to conceive a pregnancy or to carry a pregnancy to live birth  
22 after unprotected sexual intercourse;
- 23 (2) An individual's inability to cause pregnancy and live birth either as a covered  
24 individual or with the covered individual's partner; or

- 1                   (3) A licensed health care provider's findings and statement based on a  
2                   patient's medical, sexual, and reproductive history, age, physical findings, or  
3                   diagnostic testing.
- 4           d. "Medically necessary" means a health care service or product provided in a  
5           manner:
- 6                   (1) Consistent with the findings and recommendations of a licensed physician,  
7                   based on a patient's medical history, sexual and reproductive history, age,  
8                   partner, physical findings, or diagnostic testing;
- 9                   (2) Consistent with generally accepted standards of medical practice as set  
10                  forth by a professional medical organization with a specialization in any  
11                  aspect of reproductive health, including the American society for  
12                  reproductive medicine or the American college of obstetricians and  
13                  gynecologists; or
- 14                  (3) Clinically appropriate in terms of type, frequency, extent, site, and duration.
- 15           e. "Monitoring" includes ultrasounds, transvaginal ultrasounds, laboratory testing,  
16           and followup appointments.
- 17           f. "Third-party reproductive care for the benefit of the covered individual" means the  
18           use of eggs, sperm, or embryos donated to the covered individual or partner by a  
19           donor, or the use of a gestational carrier, to achieve a live birth with a healthy  
20           outcome.
- 21           2. The board shall provide coverage for the expenses of the diagnosis of infertility and  
22           fertility treatment services if recommended and medically necessary.
- 23           a. Coverage must include:
- 24                   (1) Three completed cycles of intrauterine insemination, in accordance with  
25                   best practices, including the standards and guidelines of the American  
26                   society of reproductive medicine.
- 27                   (2) Fertility treatment services necessary to achieve two live births, or a  
28                   maximum of four completed oocyte retrievals with four fresh and frozen  
29                   embryo transfers, in accordance with best practices, including the guidelines  
30                   of the American society for reproductive medicine, and using no more than  
31                   two embryos per transfer.

- 1           (3) Diagnosis of infertility and fertility treatment services, including third-party  
2           reproductive care for the benefit of the covered individual or partner.
- 3           (4) Fertility treatment, consisting of a method of causing pregnancy other than  
4           sexual intercourse which is provided with the intent to create a legal  
5           parent-child relationship between the covered individual and the resulting  
6           child in accordance with chapter 14-20.
- 7           (5) Medical and laboratory services that reduce excess embryo creation  
8           through egg cryopreservation and thawing in accordance with a covered  
9           individual's religious or ethical beliefs.
- 10          (6) Five years of cryopreservation services.
- 11          b. This section may not be construed to deny the coverage included in this section  
12          to an individual who forgoes a particular fertility treatment service if the  
13          individual's physician determines the fertility treatment service is likely to be  
14          unsuccessful.
- 15          3. To be covered under this section, the diagnosis of infertility and fertility treatment  
16          services must be performed at a facility that conforms to best practices, including the  
17          standards and guidelines developed by the American society for reproductive  
18          medicine, the American college of obstetricians and gynecologists, or the American  
19          society of clinical oncology.
- 20          4. Coverage under this section must be made available to all covered individuals,  
21          including covered individuals who have entered coverage during special enrollment or  
22          open enrollment.
- 23          5. Coverage under this section must be in accordance with best practices, including the  
24          standards or guidelines developed by the American society of reproductive medicine,  
25          the American college of obstetricians and gynecologists, or the American society of  
26          clinical oncology. If a carrier makes, issues, circulates, or causes to be made, issued,  
27          or circulated, clinical guidelines based on data not reasonably current or which do not  
28          cite with specificity, the act constitutes unfair or deceptive acts or practices in the  
29          business of insurance as prohibited by chapter 26.1-04.
- 30          6. Benefits under this section may not be limited based on:

- 1           a. A copayment, deductible, coinsurance, benefit maximum, waiting period, or other  
2           limitation on coverage different from maternity benefits provided under the health  
3           benefits;  
4           b. An exclusion, limitation, or other restriction on coverage of fertility medication  
5           different from restrictions imposed on any other prescription medication;  
6           c. A requirement that provides different benefits to, or imposes different  
7           requirements on, a class protected under chapter 14-02.4 than that provided to or  
8           required of other covered individuals; or  
9           d. A pre-existing condition exclusion, pre-existing condition waiting period on  
10          coverage for required benefits, or a prior diagnosis of infertility, fertility treatment,  
11          or standard fertility preservation services.

12           **SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - FERTILITY HEALTH**

13          **BENEFITS - REPORT TO LEGISLATIVE ASSEMBLY.** Pursuant to section 54-03-28, the public  
14 employees retirement system shall provide a report to the legislative assembly regarding the  
15 effect of the fertility health benefits on the system's health insurance programs, information on  
16 the utilization and costs relating to the benefits, and a recommendation regarding whether the  
17 benefits should be continued for the system's health insurance programs.

18          **SECTION 3. APPLICATION.** This Act applies to health benefits coverage that begins after  
19 June 30, 2027, and which does not extend past June 30, 2029.

20          **SECTION 4. EXPIRATION DATE.** This Act is effective through June 30, 2029, and after that  
21 date is ineffective.