

1                                   A bill to be entitled  
2           An act relating to health insurance coverage  
3           for infertility; creating ss. 627.64062 and  
4           627.65742, F.S., and amending s. 641.31, F.S.;  
5           requiring coverage by health insurance  
6           policies, group, franchise, and blanket health  
7           insurance policies, and health maintenance  
8           contracts for diagnosis and treatment of  
9           infertility under certain circumstances;  
10          providing requirements and criteria; providing  
11          limitations; providing definitions; providing  
12          an exception for certain religious  
13          organizations; providing application; excluding  
14          payments for donor eggs or certain medical  
15          services; amending ss. 627.651, 627.6515, and  
16          627.6699, F.S.; providing for application to  
17          group contracts and plans of self insurance,  
18          out-of-state groups, and standard, basic, and  
19          limited health benefit plans; providing an  
20          effective date.

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22 Be It Enacted by the Legislature of the State of Florida:

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24           Section 1. Section 627.64062, Florida Statutes, is  
25           created to read:

26           627.64062 Coverage of diagnosis and treatment of  
27           infertility.--

28           (1) Any health insurance policy that provides coverage  
29           for pregnancy-related benefits shall also provide coverage for  
30           the diagnosis and treatment of infertility, including all  
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1 nonexperimental assisted reproductive technology procedures  
2 and artificial insemination with partner or donor sperm.  
3 (2) The coverage required under this section is  
4 subject to the following conditions:  
5 (a) Coverage shall be subject to any deductible and  
6 coinsurance conditions and all other terms and conditions  
7 applicable to other benefits.  
8 (b) Coverage for procedures for in vitro  
9 fertilization, gamete intrafallopian transfer, or zygote  
10 intrafallopian transfer shall be required only if:  
11 1. The covered individual has been unable to carry a  
12 pregnancy to live birth.  
13 2. The covered individual has been unable to carry a  
14 pregnancy to live birth through less costly medically  
15 appropriate infertility treatments for which coverage is  
16 available under the policy, plan, or contract.  
17 3. The covered individual has not undergone 4 complete  
18 oocyte retrievals.  
19 4. The procedures are performed at medical facilities  
20 that conform to the standards of the American Society for  
21 Reproductive Medicine, the Society for Assisted Reproductive  
22 Technology, and the American College of Obstetricians and  
23 Gynecologists.  
24 5. The laboratory or facility has received  
25 accreditation from the Reproductive Laboratory Accreditation  
26 Program of the College of American Pathologists or another  
27 accreditation organization approved by the Society for  
28 Assisted Reproductive Medicine.  
29 (c) In order to undergo in vitro fertilization, gamete  
30 intrafallopian transfer, or zygote intrafallopian transfer, a  
31 second opinion is required by a certified reproductive

1 endocrinologist who is actively experienced in assisted  
2 reproductive technologies but is not in the same group as the  
3 treating physician.

4 (d) The provider must include at least one certified  
5 reproductive endocrinologist or a physician with fellowship  
6 training and subspecialty board eligibility in reproductive  
7 endocrinology and infertility.

8 (3) As used in this section:

9 (a) "Pregnancy-related benefits" means benefits that  
10 cover any related medical condition that may be associated  
11 with pregnancy, including complications of pregnancy.

12 (b) "Infertility" means a disease or condition  
13 affecting the reproductive system that interferes with the  
14 ability of a man or woman to achieve a pregnancy or of a woman  
15 to carry a pregnancy to live birth. The duration of the  
16 failure to conceive should be 12 or more months before an  
17 investigation is undertaken unless medical history and  
18 physical findings dictate earlier evaluation and treatment.

19 (c) "Nonexperimental procedure" means any clinical  
20 treatment or procedure the safety and efficacy of which is  
21 recognized as such by the American Society for Reproductive  
22 Medicine or the American College of Obstetricians and  
23 Gynecologists.

24 (4) Nothing in this section applies to any health  
25 insurance policy which is purchased by an entity, group, or  
26 order that is directly affiliated with a bona fide religious  
27 denomination that includes as an integral part of its beliefs  
28 and practices the tenet that drug therapy for infertility or  
29 in vitro fertilization services are contrary to the moral  
30 principles that the religious denomination considers to be an  
31 essential part of its beliefs.

1       (5) This section applies to benefits for the state  
2 group insurance program under s. 110.123.

3       (6) This section does not apply to payment for donor  
4 eggs or medical services rendered to a surrogate for purposes  
5 of child birth.

6           Section 2. Subsection (4) of section 627.651, Florida  
7 Statutes, is amended to read:

8           627.651 Group contracts and plans of self-insurance  
9 must meet group requirements.--

10          (4) This section does not apply to any plan which is  
11 established or maintained by an individual employer in  
12 accordance with the Employee Retirement Income Security Act of  
13 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
14 arrangement as defined in s. 624.437(1), except that a  
15 multiple-employer welfare arrangement shall comply with ss.  
16 627.419, 627.657, 627.65742, 627.6575, 627.6576, 627.6578,  
17 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616,  
18 and 627.662(6). This subsection does not allow an authorized  
19 insurer to issue a group health insurance policy or  
20 certificate which does not comply with this part.

21           Section 3. Paragraph (c) of subsection (2) of section  
22 627.6515, Florida Statutes, 1998 Supplement, is amended to  
23 read:

24           627.6515 Out-of-state groups.--

25          (2) This part does not apply to a group health  
26 insurance policy issued or delivered outside this state under  
27 which a resident of this state is provided coverage if:

28          (c) The policy provides the benefits specified in ss.  
29 627.419, 627.6574, 627.65742, 627.6575, 627.6579, 627.6612,  
30 627.66121, 627.66122, 627.6613, 627.667, 627.6675, 627.6691,  
31 and 627.66911.

1           Section 4. Section 627.65742, Florida Statutes, is  
2 created to read:

3           627.65742 Coverage of diagnosis and treatment of  
4 infertility.--

5           (1) Any group, franchise, or blanket health insurance  
6 policy that provides coverage for pregnancy-related benefits  
7 shall also provide coverage for the diagnosis and treatment of  
8 infertility, including all nonexperimental assisted  
9 reproductive technology procedures and artificial insemination  
10 with partner or donor sperm.

11           (2) The coverage required under this section is  
12 subject to the following conditions:

13           (a) Coverage may not be subject to copayments or  
14 deductible requirements which are greater than those applied  
15 to pregnancy-related benefits under the insured's policy,  
16 plan, or contract.

17           (b) Coverage for procedures for in vitro  
18 fertilization, gamete intrafallopian transfer, or zygote  
19 intrafallopian transfer shall be required only if:

20           1. The covered individual has been unable to carry a  
21 pregnancy to live birth.

22           2. The covered individual has been unable to carry a  
23 pregnancy to live birth through less costly medically  
24 appropriate infertility treatments for which coverage is  
25 available under the policy, plan, or contract.

26           3. The covered individual has not undergone 4 complete  
27 oocyte retrievals.

28           4. The procedures are performed at medical facilities  
29 that conform to the standards of the American Society for  
30 Reproductive Medicine, the Society for Assisted Reproductive  
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1 Technology, and the American College of Obstetricians and  
2 Gynecologists.

3 5. The laboratory or facility has received  
4 accreditation from the Reproductive Laboratory Accreditation  
5 Program of the College of American Pathologists or another  
6 accreditation organization approved by the Society for  
7 Assisted Reproductive Medicine.

8 (c) In order to undergo in vitro fertilization, gamete  
9 intrafallopian transfer, or zygote intrafallopian transfer, a  
10 second opinion is required by a certified reproductive  
11 endocrinologist who is actively experienced in assisted  
12 reproductive technologies but is not in the same group as the  
13 treating physician.

14 (d) The provider must include at least one certified  
15 reproductive endocrinologist or a physician with fellowship  
16 training and subspecialty board eligibility in reproductive  
17 endocrinology and infertility.

18 (3) As used in this section:

19 (a) "Pregnancy-related benefits" means benefits that  
20 cover any related medical condition that may be associated  
21 with pregnancy, including complications of pregnancy.

22 (b) "Infertility" means a disease or condition  
23 affecting the reproductive system that interferes with the  
24 ability of a man or woman to achieve a pregnancy or of a woman  
25 to carry a pregnancy to live birth. The duration of the  
26 failure to conceive should be 12 or more months before an  
27 investigation is undertaken unless medical history and  
28 physical findings dictate earlier evaluation and treatment.

29 (c) "Nonexperimental procedure" means any clinical  
30 treatment or procedure the safety and efficacy of which is  
31 recognized as such by the American Society for Reproductive

1 Medicine or the American College of Obstetricians and  
2 Gynecologists.

3 (4) Nothing in this section applies to any group,  
4 franchise, or blanket health insurance policy that is  
5 purchased by an entity, group, or order that is directly  
6 affiliated with a bona fide religious denomination that  
7 includes as an integral part of its beliefs and practices the  
8 tenet that drug therapy for infertility or in vitro  
9 fertilization services are contrary to the moral principles  
10 that the religious denomination considers to be an essential  
11 part of its beliefs.

12 (5) This section does not apply to payment for donor  
13 eggs or medical services rendered to a surrogate for purposes  
14 of child birth.

15 Section 5. Paragraph (b) of subsection (12) of section  
16 627.6699, Florida Statutes, 1998 Supplement, is amended to  
17 read:

18 627.6699 Employee Health Care Access Act.--

19 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT  
20 PLANS.--

21 (b)1. Each small employer carrier issuing new health  
22 benefit plans shall offer to any small employer, upon request,  
23 a standard health benefit plan and a basic health benefit plan  
24 that meets the criteria set forth in this section.

25 2. For purposes of this subsection, the terms  
26 "standard health benefit plan" and "basic health benefit plan"  
27 mean policies or contracts that a small employer carrier  
28 offers to eligible small employers that contain:

29 a. An exclusion for services that are not medically  
30 necessary or that are not covered preventive health services;  
31 and

1           b. A procedure for preauthorization by the small  
2 employer carrier, or its designees.

3           3. A small employer carrier may include the following  
4 managed care provisions in the policy or contract to control  
5 costs:

6           a. A preferred provider arrangement or exclusive  
7 provider organization or any combination thereof, in which a  
8 small employer carrier enters into a written agreement with  
9 the provider to provide services at specified levels of  
10 reimbursement or to provide reimbursement to specified  
11 providers. Any such written agreement between a provider and a  
12 small employer carrier must contain a provision under which  
13 the parties agree that the insured individual or covered  
14 member has no obligation to make payment for any medical  
15 service rendered by the provider which is determined not to be  
16 medically necessary. A carrier may use preferred provider  
17 arrangements or exclusive provider arrangements to the same  
18 extent as allowed in group products that are not issued to  
19 small employers.

20           b. A procedure for utilization review by the small  
21 employer carrier or its designees.

22  
23 This subparagraph does not prohibit a small employer carrier  
24 from including in its policy or contract additional managed  
25 care and cost containment provisions, subject to the approval  
26 of the department, which have potential for controlling costs  
27 in a manner that does not result in inequitable treatment of  
28 insureds or subscribers. The carrier may use such provisions  
29 to the same extent as authorized for group products that are  
30 not issued to small employers.

31           4. The standard health benefit plan shall include:



- 1           a. Coverage for inpatient hospitalization;  
2           b. Coverage for outpatient services;  
3           c. Coverage for newborn children pursuant to s.  
4 627.6575;  
5           d. Coverage for child care supervision services  
6 pursuant to s. 627.6579;  
7           e. Coverage for adopted children upon placement in the  
8 residence pursuant to s. 627.6578;  
9           f. Coverage for mammograms pursuant to s. 627.6613;  
10          g. Coverage for handicapped children pursuant to s.  
11 627.6615;  
12          h. Emergency or urgent care out of the geographic  
13 service area; and  
14          i. Coverage for services provided by a hospice  
15 licensed under s. 400.602 in cases where such coverage would  
16 be the most appropriate and the most cost-effective method for  
17 treating a covered illness.
- 18          5. The standard health benefit plan and the basic  
19 health benefit plan may include a schedule of benefit  
20 limitations for specified services and procedures. If the  
21 committee develops such a schedule of benefits limitation for  
22 the standard health benefit plan or the basic health benefit  
23 plan, a small employer carrier offering the plan must offer  
24 the employer an option for increasing the benefit schedule  
25 amounts by 4 percent annually.
- 26          6. The basic health benefit plan shall include all of  
27 the benefits specified in subparagraph 4.; however, the basic  
28 health benefit plan shall place additional restrictions on the  
29 benefits and utilization and may also impose additional cost  
30 containment measures.  
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1           7. Sections 627.419(2), (3), and (4), 627.6574,  
2 627.65742, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618,  
3 627.668, and 627.66911 apply to the standard health benefit  
4 plan and to the basic health benefit plan. However,  
5 notwithstanding said provisions, the plans may specify limits  
6 on the number of authorized treatments, if such limits are  
7 reasonable and do not discriminate against any type of  
8 provider.

9           8. Each small employer carrier that provides for  
10 inpatient and outpatient services by allopathic hospitals may  
11 provide as an option of the insured similar inpatient and  
12 outpatient services by hospitals accredited by the American  
13 Osteopathic Association when such services are available and  
14 the osteopathic hospital agrees to provide the service.

15           Section 6. Subsection (36) is added to section 641.31,  
16 Florida Statutes, 1998 Supplement, is amended to read:

17           641.31 Health maintenance contracts.--

18           (36)(a) Any health maintenance contract that provides  
19 coverage for pregnancy-related benefits shall also provide  
20 coverage for the diagnosis and treatment of infertility,  
21 including all nonexperimental assisted reproductive technology  
22 procedures and artificial insemination with partner or donor  
23 sperm.

24           (b) The coverage required under this subsection is  
25 subject to the following conditions:

26           1. Coverage shall be subject to any deductible and  
27 coinsurance conditions and all other terms and conditions  
28 applicable to other benefits.

29           2. Coverage for procedures for in vitro fertilization,  
30 gamete intrafallopian transfer, or zygote intrafallopian  
31 transfer shall be required only if:

1           a. The covered individual has been unable to carry a  
2 pregnancy to live birth.

3           b. The covered individual has been unable to carry a  
4 pregnancy to live birth through less costly medically  
5 appropriate infertility treatments for which coverage is  
6 available under the policy, plan, or contract.

7           c. The covered individual has not undergone 4 complete  
8 oocyte retrievals.

9           d. The procedures are performed at medical facilities  
10 that conform to the standards of the American Society for  
11 Reproductive Medicine, the Society for Assisted Reproductive  
12 Technology, and the American College of Obstetricians and  
13 Gynecologists.

14           e. The laboratory or facility has received  
15 accreditation from the Reproductive Laboratory Accreditation  
16 Program of the College of American Pathologists or another  
17 accreditation organization approved by the Society for  
18 Assisted Reproductive Medicine.

19           3. In order to undergo in vitro fertilization, gamete  
20 intrafallopian transfer, or zygote intrafallopian transfer, a  
21 second opinion is required by a certified reproductive  
22 endocrinologist who is actively experienced in assisted  
23 reproductive technologies but is not in the same group as the  
24 treating physician.

25           4. The provider must include at least one certified  
26 reproductive endocrinologist or a physician with fellowship  
27 training and subspecialty board eligibility in reproductive  
28 endocrinology and infertility.

29           (c) As used in this subsection:  
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1           1. "Pregnancy-related benefits" means benefits that  
2 cover any related medical condition that may be associated  
3 with pregnancy, including complications of pregnancy.

4           2. "Infertility" means a disease or condition  
5 affecting the reproductive system that interferes with the  
6 ability of a man or woman to achieve a pregnancy or of a woman  
7 to carry a pregnancy to live birth. The duration of the  
8 failure to conceive should be 12 or more months before an  
9 investigation is undertaken unless medical history and  
10 physical findings dictate earlier evaluation and treatment.

11           3. "Nonexperimental procedure" means any clinical  
12 treatment or procedure whose safety and efficacy is recognized  
13 as such by the American Society for Reproductive Medicine or  
14 the American College of Obstetricians and Gynecologists.

15           (d) Nothing in this subsection applies to any health  
16 maintenance contract that is purchased by an entity, group, or  
17 order that is directly affiliated with a bona fide religious  
18 denomination that includes as an integral part of its beliefs  
19 and practices the tenet that drug therapy for infertility or  
20 in vitro fertilization services are contrary to the moral  
21 principles that the religious denomination considers to be an  
22 essential part of its beliefs.

23           (e) This subsection applies to benefits for the state  
24 group insurance program under s. 110.123.

25           (f) This subsection does not apply to payment for  
26 donor eggs or medical services rendered to a surrogate for  
27 purposes of child birth.

28           Section 7. This act shall take effect October 1, 1999.  
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HOUSE SUMMARY

Requires coverage by health insurance policies, group, franchise, and blanket health insurance policies, and health maintenance contracts for diagnosis and treatment of infertility. Provides an exception for religious organizations. Applies the requirement to group contracts and plans of self insurance, out-of-state groups, and standard, basic, and limited health benefit plans. See bill for details.