State of Wisconsin
1997 - 1998 LEGISLATURE

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1997 ASSEMBLY BILL 286

April 11, 1997 - Introduced by Representatives WASSERMAN, VRAKAS, BALDWIN, BLACK, BOCK, MUSSER, OLSEN, REYNOLDS and WARD, cosponsored by Senator GROBSCHMIDT. Referred to Committee on Health.

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 60.23 (25), 66.184, 120.13 (2) (g), 185.983 (1) (intro.), 185.983 (1m) and 619.14 (3) (q); and ***to create*** 49.45 (20m), 111.91 (2) (n), 185.981 (10), 609.76, 619.14 (4) (n) and 632.893 of the statutes; **relating to:** insurance coverage of the diagnosis and treatment of infertility.

Analysis by the Legislative Reference Bureau

With certain limitations, this bill requires health care plans that provide maternity coverage to provide coverage of any nonexperimental procedure for the diagnosis or treatment of infertility. Infertility is defined in the bill as the inability to conceive or produce conception after at least one year of unprotected intercourse or the inability to carry a pregnancy to live birth. Nonexperimental procedures are defined in the bill as those that are recognized as safe and effective by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. Copayments and deductibles for the infertility coverage may not be greater than any copayments or deductibles for the maternity coverage under the health care plan.

The bill imposes a limitation on the coverage requirement as it applies to 3 specified nonexperimental infertility procedures. These 3 procedures, which are defined in the bill, must be covered only if certain conditions are met.

The coverage requirement applies to individual health insurance policies and group health plans, including health maintenance organizations, preferred provider plans and cooperative sickness care associations; to plans offered by the state to its employes; and to self-insured plans of counties, cities, towns, villages and school

districts. Excluded from the requirement are medicare supplement and replacement policies, long–term care insurance policies, limited service health organization plans, policies issued under the health insurance risk–sharing plan and health care provided to medical assistance recipients.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 40.51 (8) of the statutes, as affected by 1995 Wisconsin Act 289, 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), 632.72 (2), 632.745 (1) to (3) and (5), 632.747, 632.87 (3) to (5), 632.893, 632.895 (5m) and (8) to (10) and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as created by 1995 Wisconsin Act 289, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 632.745 (1) to (3) and (5) ~~and,~~ 632.747 and 632.893.

SECTION 3. 49.45 (20m) of the statutes is created to read:

49.45 **(20m)** EXEMPTION FROM INFERTILITY COVERAGE REQUIREMENTS. Notwithstanding s. 632.755 (1g) (c), an insurer with which the department contracts under sub. (2) (b) 2. for the provision of health care to medical assistance recipients is exempt from the infertility coverage requirements of s. 632.893 with regard to those recipients, their spouses and dependents.

SECTION 4. 60.23 (25) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

60.23 **(25)** SELF–INSURED HEALTH PLANS. Provide health care benefits to its officers and employes on a self–insured basis if the self–insured plan complies with ss. 631.89, 631.90, 631.93 (2), 632.745 (2), (3) and (5) (a) 2. and (b) 2., 632.747 (3), 632.87 (4) and (5), 632.893, 632.895 (9) and 632.896.

SECTION 5. 66.184 of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

66.184 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 employes on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.745 (2), (3) and (5) (a) 2. and (b) 2., 632.747 (3), 632.87 (4) and (5), 632.893, 632.895 (9) and (10), 632.896, 767.25 (4m) (d) and 767.51 (3m) (d).

SECTION 6. 111.91 (2) (n) of the statutes is created to read:

111.91 **(2)** (n) The provision to employes of the health insurance coverage required under s. 632.893.

SECTION 7. 120.13 (2) (g) of the statutes, as affected by 1995 Wisconsin Act 289, 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), 632.745 (2), (3) and (5) (a) 2. and (b) 2., 632.747 (3), 632.87 (4) and (5), 632.893, 632.895 (9) and (10), 632.896, 767.25 (4m) (d) and 767.51 (3m) (d).

SECTION 8. 185.981 (10) of the statutes is created to read:

185.981 **(10)** A sickness care plan that is operated by a cooperative association and that provides maternity coverage is subject to s. 632.893.

SECTION 9. 185.983 (1) (intro.) of the statutes, as affected by 1995 Wisconsin Act 289, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.89, 631.93, 632.72 (2), 632.745, 632.747, 632.749, 632.775, 632.79, 632.795, 632.87 (2m), (3), (4) and (5), 632.893, 632.895 (5), (9) and (10), 632.896 and 632.897 (10), subch. II of ch. 619 and chs. 609, 630, 635, 645 and 646, but the sponsoring association shall:

SECTION 10. 185.983 (1m) of the statutes is amended to read:

185.983 **(1m)** In addition to ss. 601.04, 601.31, 632.79 and 632.895 (5), the commissioner of insurance may by rule subject a medicare supplement policy as defined in s. 600.03 (28r), a medicare replacement policy as defined in s. 600.03 (28p) or a long–term care insurance policy as defined in s. 600.03 (28g) sold by a voluntary nonprofit sickness care plan to other provisions of chs. 600 to 646, except the commissioner may not subject a medicare supplement policy, a medicare replacement policy or a long–term care insurance policy to s. 632.893 or 632.895 (8).

SECTION 11. 609.76 of the statutes is created to read:

609.76 Infertility coverage. Except as provided in s. 49.45 (20m), health maintenance organizations and preferred provider plans are subject to s. 632.893.

SECTION 12. 619.14 (3) (q) of the statutes is amended to read:

619.14 **(3)** (q) Any other health insurance coverage, only to the extent required under subch. VI of ch. 632 and not excluded under sub. (4).

SECTION 13. 619.14 (4) (n) of the statutes is created to read:

619.14 **(4)** (n) Any charge for performing a procedure for the diagnosis or treatment of infertility.

SECTION 14. 632.893 of the statutes is created to read:

632.893 Required coverage of diagnosis and treatment of infertility. **(1)** DEFINITIONS. In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Gamete intrafallopian tube transfer" means a procedure in which a mixture containing both egg and sperm is directly transferred to the fallopian tube, where fertilization occurs.

(c) "Infertility" means the inability to conceive or produce conception after engaging in unprotected sexual intercourse over a period of at least one year, or the inability to carry a pregnancy to live birth.

(d) "In vitro fertilization" means a procedure in which an egg and sperm are combined in a laboratory dish, where fertilization occurs, and the fertilized and dividing egg is transferred to the uterus or cryopreserved for future use.

(e) "Nonexperimental procedure" means a clinical procedure that is recognized as safe and effective by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

(f) "Zygote intrafallopian tube transfer" means a procedure in which an egg and sperm are combined in a laboratory dish, where fertilization occurs, and the fertilized egg is transferred to the fallopian tube at the pronuclear stage before cell division takes place.

(2) REQUIRED COVERAGE. Except as provided in subs. (3) and (5) and s. 49.45 (20m), every disability insurance policy, and every self–insured health plan of the state or a county, city, village, town or school district, that provides maternity coverage shall provide coverage of any nonexperimental procedure for the diagnosis and treatment of infertility.

(3) CONDITIONAL REQUIREMENTS FOR CERTAIN PROCEDURES. The coverage requirement under sub. (2) applies to in vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer only if all of the following apply:

(a) The covered individual has tried other less costly and medically appropriate nonexperimental procedures for the treatment of infertility and has been unable to carry a pregnancy to live birth.

(b) The covered individual has undergone fewer than 4 completed oocyte retrievals at any time in connection with any infertility procedure or procedures.

(c) The covered individual has undergone fewer than 2 completed oocyte retrievals at any time in connection with any infertility procedure or procedures after a live birth following a completed oocyte retrieval.

(d) The procedure is performed at a medical facility that conforms to the standards and guidelines of the American Association of Tissue Banks and of either the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

(4) COPAYMENTS AND DEDUCTIBLES. The coverage required under this section may not be subject to copayments or deductibles that are greater than any copayments or deductibles that apply to maternity coverage under the policy or plan.

(5) EXCLUSION. This section does not apply to any of the following:

(a) A medicare replacement policy, a medicare supplement policy or a long–term care insurance policy.

(b) A limited service health organization, as defined in s. 609.01 (3).

(c) The mandatory health insurance risk–sharing plan under ch. 619 and any alternative plans offered under s. 619.145 to persons eligible for coverage under s. 619.12.

SECTION 15. Initial applicability.

(1) This act first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and self–insured health plans that are established, extended, modified or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employes who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified or renewed.

(c) Self–insured health plans covering employes who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified or renewed.

SECTION 16. Effective date.

(1) This act takes effect on the first day of the 5th month beginning after publication.

(END)