CHAPTER 526

H.B. No. 843

AN ACT

relating to inclusion of benefits for in vitro fertilization procedures under certain accident and sickness insurance policies, health maintenance organizations, and other health benefit plans and arrangements.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Article 3.51–6, Insurance Code, is amended by adding a new Section 3A to read as follows:

Sec. 3A. (a) All insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and all employer, multiple-employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plans, programs, or arrangements that either issue group health insurance policies, enter into health care service contracts or plans, or provide for group health benefits, coverage, or services in this state for hospital, medical, or surgical expenses incurred as a result of accident or sickness shall offer and make available to each group policyholder, contract holder, employer, multiple-employer, union, association, or trustee under a group policy, contract, plan, program, or arrangement that provides hospital, surgical, and medical benefits, coverage for services and benefits on an expense incurred, service, or prepaid basis for out-patient expenses that may arise from in vitro fertilization procedures, if the group insurance policy, contract, plan, program, or arrangement otherwise provides pregnancy-related benefits for the insureds, enrollees, subscribers, employees, members, or other persons covered under the policy contract, plan, program, or arrangement.

(b) An offer made under Subsection (a) of this section is subject to this section.

(c) A rejection of an offer to provide the coverage for services or benefits provided by Subsection (a) of this section must be in writing.

(d) Benefits for in vitro fertilization procedures must be provided to the same extent as the benefits provided for other pregnancy-related procedures under the policy, contract, plan, program, or arrangement.

(e) The offer to make the coverage available is required only under the following conditions:

(1) the patient for the in vitro fertilization procedure is an insured, enrollee, subscriber, member, or otherwise covered employee or person under the policy, contract, plan, program, or arrangement;

(2) the fertilization or attempt at fertilization of the patient's oocytes is made only with the patient's spouse's sperm;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with one or more of the following conditions:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy, contract, plan, program, or arrangement; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

(f) An insurer, health maintenance organization, or self-insuring employer that is owned by or that is part of an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices that in vitro fertilization is contrary to moral principles that the religious denomination considers to be an essential part of its beliefs is exempt from this section's requirement to offer coverage for in vitro fertilization.

SECTION 2. This Act takes effect September 1, 1987, and applies to all policies and other evidences of coverage delivered, issued for delivery, or renewed in this state on and after January 1, 1988. Policies and other evidences of coverage delivered, issued for delivery, or renewed in this state before January 1, 1988, are governed by the law that existed immediately before this Act takes effect, and that law is continued in effect for that purpose.

SECTION 3. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

Passed by the House on May 8, 1987, by a non-record vote; and that the House concurred in Senate amendments to H.B. No. 843 on May 26, 1987, by a non-record vote. Passed by the Senate, with amendments, on May 22, 1987, by a viva-voce vote.

Approved June 17, 1987.

Effective Sept. 1, 1987.