HOUSE . . . . . No. 4551

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, September 29, 2025.

The committee on Financial Services, to whom was referred the petition (accompanied by bill, House, No. 1191) of Kevin G. Honan relative to infertility treatment, reports recommending that the accompanying bill (House, No. 4551) ought to pass.

For the committee,

JAMES M. MURPHY.

FILED ON: 9/19/2025

HOUSE . . . . . No. 4551

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

An Act improving access to infertility treatment.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 47H of chapter 175 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the final two sentences and inserting in place thereof the following:-

For purposes of this section, "infertility" means a condition or status characterized by any of the following:

(1) A licensed physician's findings, based on: a patient's medical, sexual, and reproductive history; age; physical findings; diagnostic testing; or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility to establish infertility with or without appropriate exposure to gametes, per the patient's provider.

(2) The need for medical intervention, including, but not limited to, the use of donor gametes, donor embryos, gestational carrier to achieve a live birth either as an individual or with a partner.

(3) The failure to establish a pregnancy or to carry a pregnancy to live birth after unprotected sexual intercourse. For purposes of this section, "unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy that does not result in a live birth will not restart the 12-month or 6-month time period to qualify as having infertility.

(4) An impairment of reproductive ability due to factors, including, but not limited to, medical condition, male factor, female factor, combined or unexplained reproductive challenges, as well as genetic disorders or iatrogenic infertility.

Coverage for medically necessary expenses of diagnosis and treatment of infertility shall include, but shall not be limited to: (i) a minimum of six oocyte retrievals and unlimited fresh and frozen embryo transfers, using single embryo transfer when recommended by patient's physician and medically appropriate; (ii) embryo transfer; (iii) artificial insemination; (iv) surgical sperm extraction procedures; (v) third-party reproduction including in vitro fertilization with donor egg, sperm, or embryo or gestational carrier; (vi) procedures necessary to screen or diagnose a fertilized egg before transfer, including, but not limited to, preimplantation genetic testing for aneuploidy, preimplantation genetic testing for chromosome structural rearrangements, and preimplantation genetic testing for monogenic or single gene disorders.

In administering coverage for medically necessary expenses of diagnosis and treatment of infertility, a carrier or participating provider, as those terms are defined in section 1 of chapter 176O, shall not:

(1) impose conditions for eligibility beyond what is provided in the law;

(2) exclude, limit, or otherwise restrict coverage or processing of benefits for fertility medications that are different from those imposed on other prescription medications;

(3) exclude or deny coverage of any fertility services, including medication, based on an individual's participation in fertility services provided by or to any third party. For purposes of this paragraph, "third party" includes: (i) any fresh or cryopreserved oocyte, sperm, or embryo, regardless of the initial coverage source of the donor or the genetic material; and (ii) a gestational carrier that enables an intended parent, member, and/or partner of a member to become a parent.

(4) exclude services based on the quantity of the patient's existing cryopreserved oocyte, sperm, or embryos; the provider's discretion will determine if cryopreserved oocyte, sperm, or embryo provides a reasonable chance of success and whether additional fertility services are required;

(5) implement any deductible, copayment, coinsurance, benefit maximum, waiting period, or other limitation on coverage that is different from those imposed upon benefits for services not related to infertility;

(6) impose limitations on coverage based solely on arbitrary, non-medically based factors including, but not limited to, number of attempts, dollar amounts, or age; or

(7) provide different benefits to, or impose different requirements for different groups, based on diagnosis.

Limitations on coverage coverage for medically necessary expenses of diagnosis and treatment of infertility shall be based on clinical guidelines and the patient's medical history. Clinical guidelines shall be maintained in written form and available to any enrollee. Standards

or guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology, the Society for Assisted Reproductive Technology, or similar relevant medical societies may serve as a basis for such clinical guidelines. Making, issuing, circulating, or causing to be made, issued or circulated, any clinical guidelines that are based upon data that are not reasonably current or that do not cite with specificity any references relied upon shall constitute an unfair and deceptive act and practice pursuant to section 2 of chapter 93A.

Consistent with Massachusetts anti-discrimination law, coverage for medically necessary expenses of diagnosis and treatment of infertility shall be provided without discrimination based on age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

This section shall not be construed to deny or restrict any existing right or benefit to coverage and treatment of infertility or fertility services under an existing law, plan, or policy. This section shall not be construed to interfere with a medical provider's, physician's, or surgeon's clinical judgment.

SECTION 2. Section 8K of chapter 176A, as so appearing, is hereby amended by striking out the final two sentences and inserting in place thereof the following:-

For purposes of this section, "infertility" means a condition or status characterized by any of the following:

(1) A licensed physician's findings, based on: a patient's medical, sexual, and reproductive history; age; physical findings; diagnostic testing; or any combination of those

factors. This definition shall not prevent testing and diagnosis of infertility to establish infertility with or without appropriate exposure to gametes, per the patient's provider.

(2) The need for medical intervention, including, but not limited to, the use of donor gametes, donor embryos, gestational carrier to achieve a live birth either as an individual or with a partner.

(3) The failure to establish a pregnancy or to carry a pregnancy to live birth after unprotected sexual intercourse. For purposes of this section, "unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy that does not result in a live birth will not restart the 12-month or 6-month time period to qualify as having infertility.

(4) An impairment of reproductive ability due to factors, including, but not limited to, medical condition, male factor, female factor, combined or unexplained reproductive challenges, as well as genetic disorders or iatrogenic infertility.

Coverage for medically necessary expenses of diagnosis and treatment of infertility shall include, but shall not be limited to: (i) a minimum of six oocyte retrievals and unlimited fresh and frozen embryo transfers, using single embryo transfer when recommended by patient's physician and medically appropriate; (ii) embryo transfer; (iii) artificial insemination; (iv) surgical sperm extraction procedures; (v) third-party reproduction including in vitro fertilization with donor egg, sperm, or embryo or gestational carrier; (vi) procedures necessary to screen or diagnose a fertilized egg before transfer, including, but not limited to, preimplantation genetic

testing for aneuploidy, preimplantation genetic testing for chromosome structural rearrangements, and preimplantation genetic testing for monogenic or single gene disorders.

In administering coverage for medically necessary expenses of diagnosis and treatment of infertility, a carrier or participating provider, as those terms are defined in section 1 of chapter 176O, shall not:

(1) impose conditions for eligibility beyond what is provided in the law;

(2) exclude, limit, or otherwise restrict coverage or processing of benefits for fertility medications that are different from those imposed on other prescription medications;

(3) exclude or deny coverage of any fertility services, including medication, based on an individual's participation in fertility services provided by or to any third party. For purposes of this paragraph, "third party" includes: (i) any fresh or cryopreserved oocyte, sperm, or embryo, regardless of the initial coverage source of the donor or the genetic material; and (ii) a gestational carrier that enables an intended parent, member, and/or partner of a member to become a parent.

(4) exclude services based on the quantity of the patient's existing cryopreserved oocyte, sperm, or embryos; the provider's discretion will determine if cryopreserved oocyte, sperm, or embryo provides a reasonable chance of success and whether additional fertility services are required;

(5) implement any deductible, copayment, coinsurance, benefit maximum, waiting period, or other limitation on coverage that is different from those imposed upon benefits for services not related to infertility;

(6) impose limitations on coverage based solely on arbitrary, non-medically based factors including, but not limited to, number of attempts, dollar amounts, or age; or

(7) provide different benefits to, or impose different requirements for different groups, based on diagnosis.

Limitations on coverage coverage for medically necessary expenses of diagnosis and treatment of infertility shall be based on clinical guidelines and the patient's medical history. Clinical guidelines shall be maintained in written form and available to any enrollee. Standards or guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology, the Society for Assisted Reproductive Technology, or similar relevant medical societies may serve as a basis for such clinical guidelines. Making, issuing, circulating, or causing to be made, issued or circulated, any clinical guidelines that are based upon data that are not reasonably current or that do not cite with specificity any references relied upon shall constitute an unfair and deceptive act and practice pursuant to section 2 of chapter 93A.

Consistent with Massachusetts anti-discrimination law, coverage for medically necessary expenses of diagnosis and treatment of infertility shall be provided without discrimination based on age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

This section shall not be construed to deny or restrict any existing right or benefit to coverage and treatment of infertility or fertility services under an existing law, plan, or policy.

This section shall not be construed to interfere with a medical provider's, physician's, or surgeon's clinical judgment.

SECTION 3. Section 4J of chapter 176B of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the final two sentences and inserting in place thereof the following:-

For purposes of this section, "infertility" means a condition or status characterized by any of the following:

(1) A licensed physician's findings, based on: a patient's medical, sexual, and reproductive history; age; physical findings; diagnostic testing; or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility to establish infertility with or without appropriate exposure to gametes, per the patient's provider.

(2) The need for medical intervention, including, but not limited to, the use of donor gametes, donor embryos, gestational carrier to achieve a live birth either as an individual or with a partner.

(3) The failure to establish a pregnancy or to carry a pregnancy to live birth after unprotected sexual intercourse. For purposes of this section, "unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy that does not result in a live birth will not restart the 12-month or 6-month time period to qualify as having infertility.

(4) An impairment of reproductive ability due to factors, including, but not limited to, medical condition, male factor, female factor, combined or unexplained reproductive challenges, as well as genetic disorders or iatrogenic infertility.

Coverage for medically necessary expenses of diagnosis and treatment of infertility shall include, but shall not be limited to: (i) a minimum of six oocyte retrievals and unlimited fresh and frozen embryo transfers, using single embryo transfer when recommended by patient's physician and medically appropriate; (ii) embryo transfer; (iii) artificial insemination; (iv) surgical sperm extraction procedures; (v) third-party reproduction including in vitro fertilization with donor egg, sperm, or embryo or gestational carrier; (vi) procedures necessary to screen or diagnose a fertilized egg before transfer, including, but not limited to, preimplantation genetic testing for aneuploidy, preimplantation genetic testing for chromosome structural rearrangements, and preimplantation genetic testing for monogenic or single gene disorders.

In administering coverage for medically necessary expenses of diagnosis and treatment of infertility, a carrier or participating provider, as those terms are defined in section 1 of chapter 176O, shall not:

(1) impose conditions for eligibility beyond what is provided in the law;

(2) exclude, limit, or otherwise restrict coverage or processing of benefits for fertility medications that are different from those imposed on other prescription medications;

(3) exclude or deny coverage of any fertility services, including medication, based on an individual's participation in fertility services provided by or to any third party. For purposes of this paragraph, "third party" includes: (i) any fresh or cryopreserved oocyte, sperm, or embryo,

regardless of the initial coverage source of the donor or the genetic material; and (ii) a gestational carrier that enables an intended parent, member, and/or partner of a member to become a parent.

(4) exclude services based on the quantity of the patient's existing cryopreserved oocyte, sperm, or embryos; the provider's discretion will determine if cryopreserved oocyte, sperm, or embryo provides a reasonable chance of success and whether additional fertility services are required;

(5) implement any deductible, copayment, coinsurance, benefit maximum, waiting period, or other limitation on coverage that is different from those imposed upon benefits for services not related to infertility;

(6) impose limitations on coverage based solely on arbitrary, non-medically based factors including, but not limited to, number of attempts, dollar amounts, or age; or

(7) provide different benefits to, or impose different requirements for different groups, based on diagnosis.

Limitations on coverage coverage for medically necessary expenses of diagnosis and treatment of infertility shall be based on clinical guidelines and the patient's medical history. Clinical guidelines shall be maintained in written form and available to any enrollee. Standards or guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology, the Society for Assisted Reproductive Technology, or similar relevant medical societies may serve as a basis for such clinical guidelines. Making, issuing, circulating, or causing to be made, issued or circulated, any clinical guidelines that are based upon data that are not reasonably current or that do not cite with specificity any references

relied upon shall constitute an unfair and deceptive act and practice pursuant to section 2 of chapter 93A.

Consistent with Massachusetts anti-discrimination law, coverage for medically necessary expenses of diagnosis and treatment of infertility shall be provided without discrimination based on age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

This section shall not be construed to deny or restrict any existing right or benefit to coverage and treatment of infertility or fertility services under an existing law, plan, or policy. This section shall not be construed to interfere with a medical provider's, physician's, or surgeon's clinical judgment.