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S T A T E   O F   R H O D E   I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

A N   A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators Cano, and Mack

Date Introduced: April 02, 2024

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Sections 27-18-30 and 27-18-52 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" are hereby amended to read as follows:

27-18-30. ~~Health insurance contracts — Infertility.~~ Health insurance contracts -- Fertility healthcare.

(a) Any health insurance contract, plan, or policy delivered or issued for delivery or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, that includes pregnancy-related benefits, shall provide coverage for ~~medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years and for standard fertility-preservation services when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.~~ :

(1) Fertility diagnostic care;

(2) Fertility treatment if the enrollee is a fertility patient;

(3) Standard fertility preservation services; and

(4) In vitro laboratory services required in the course of fertility diagnostic care, fertility treatment, and/or fertility preservation regardless of whether donor gametes or embryos are used or if embryo(s) will be transferred to a surrogate and including preimplantation genetic diagnosis (PGD).

(b) A policy that provides coverage for the services required under this section, shall not:

(1) Impose any limitations on coverage for a fertility patient solely on the basis of such patient's age;

(2) Require that a pregnancy loss, including, but not limited to, a miscarriage or stillbirth, suffered during the periods referenced in subsections (f)(2) and (f)(3) of this section shall result in the commencement of a new twelve (12) month or six (6) month period in which to determine whether an individual is experiencing infertility;

(3) Use any prior diagnosis or fertility treatment as a basis for excluding, limiting, or otherwise restricting the availability of coverage required under this section;

(4) Impose any limitations on coverage required under this section based on an individual's use of donor gametes, donor embryos, or surrogacy;

(5) Impose any copayments, deductibles, coinsurances, benefit maximums, waiting periods, or other limitations on coverage that are different than any maternity benefits provided by the health insurance policy;

(6) Impose any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on any other prescription medications;

(7) Impose different limitations on coverage for, provide different benefits to, or impose different requirements on a fertility patient who is a part of any of a class of persons whose rights are protected pursuant to § 23-17-19.1; and

(8) Base any limitations imposed by the policy on anything other than the medical assessment of an individual's licensed physician and clinical guidelines adopted by the policy.

(c) Any clinical guidelines used for a policy subject to the requirements of this section shall:

(1) Be based on current guidelines developed by the American Society for Reproductive Medicine, its successor organization, or a comparable organization;

(2) Cite with specificity any data or scientific reference relied upon;

(3) Be maintained in written form; and

(4) Be made available to an individual in writing upon request.

(d) A policy that provides coverage for the services required under this section may:

(1) Limit such coverage to four (4) completed oocyte retrievals, with unlimited embryo transfers;

(2) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of six (6) cycles;

(3) Limit coverage for in vitro fertilization to those individuals who have been unable to achieve or sustain a pregnancy to live birth through less expensive and medically viable fertility

treatment or procedures covered under such policy; and

(4) Require that treatment or procedures that must be covered as provided in this section be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society for Reproductive Endocrinology and Infertility.

(e) Any health insurance policy issued pursuant to subsection (a) of this section shall not be required to provide coverage for:

(1) Any experimental fertility procedure; or

(2) Any non-medical fees related to procuring gametes, embryos, or surrogacy services.

To the extent that a health insurance contract provides reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than infertility, the tests and procedures shall not be excluded from reimbursement when provided attendant to the diagnosis and treatment of infertility ~~for women between the ages of twenty-five (25) and forty-two (42) years~~; provided, that a subscriber co-payment not to exceed twenty percent (20%) may be required for those programs and/or procedures the sole purpose of which is the treatment of infertility.

~~(b)~~(f) For purposes of this section, “infertility” ~~means the condition of an otherwise presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of one year.~~ Means: (1) The presence of a condition recognized by a licensed physician as a cause of loss or impairment of fertility, based on an individual's medical, sexual and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors; (2) An individual's inability to achieve pregnancy after twelve (12) months of unprotected sexual intercourse when the individual and their partner have the necessary gametes to achieve pregnancy; (3) An individual's inability to achieve pregnancy after six (6) months of unprotected sexual intercourse due to such individual's age; or (4) As defined by the American Society of Reproductive Medicine, its successor organization, or comparable organization.

~~(c)~~(g) For purposes of this section, “standard fertility-preservation services” means procedures (1) Procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional medical organizations~~.~~, their successor organizations, or a comparable organization, for an individual who has a medical or genetic condition or who is expected to undergo treatment that may directly or indirectly cause a risk of impairment of fertility, and (2) includes, but is not limited to, the procurement and cryopreservation of gametes, embryos, and reproductive material, and storage from the date of cryopreservation until the individual reaches the age of thirty (30), or for a period of not less than five (5) years, whichever is later.

(h) For the purposes of this section, "fertility patient" means: (1) An individual diagnosed

with infertility; (2) An individual who is, independently or with their partner, at increased risk of transmitting a serious inheritable genetic or chromosomal abnormality to a child; (3) An individual unable to achieve a pregnancy as an individual or with a partner because the individual or individual and their partner does not have the necessary gametes to achieve a pregnancy; or (4) An individual for whom fertility preservation services are medically necessary.

(i) For the purposes of this section, "fertility treatment" means procedures, products, genetic testing, medications, and services intended to achieve pregnancy that result in a live birth and that are provided in a manner consistent with established medical practice and professional guidelines published by the American Society for Reproductive Medicine, its successor organization, or a comparable organization.

(j) For the purposes of this section, "experimental fertility procedure" means a procedure for which the published medical evidence is not sufficient for the American Society for Reproductive Medicine, its successor organization, or a comparable organization to regard the procedure as established medical practice.

(k) For the purposes of this section, "fertility diagnostic care" means procedures, products, medications, and services intended to provide information and counseling about an individual's fertility, including laboratory assessments and imaging studies.

~~(d) For purposes of this section, “iatrogenic infertility” means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.~~

~~(e) For purposes of this section, “may directly or indirectly cause” means treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional organizations.~~

~~(f)~~(l) Notwithstanding the provisions of § 27-18-19 or any other provision to the contrary, this section shall apply to blanket or group policies of insurance.

~~(g)~~(m) The health insurance contract may limit coverage to a lifetime cap of one hundred thousand dollars ($100,000).

(n) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer to the uterus.

27-18-52. Genetic testing.

(a) Except as provided in chapter 37.3 of title 5, insurance administrators, health plans and providers shall be prohibited from releasing genetic information without prior written authorization of the individual. Written authorization shall be required for each disclosure and include to whom

the disclosure is being made. An exception shall exist for those participating in research settings governed by the Federal Policy for the Protection of Human Research Subjects (also known as "The Common Rule"). Tests conducted purely for research are excluded from the definition, as are tests for somatic (as opposed to heritable) mutations, and testing for forensic purposes.

(b) No individual or group health insurance contract, plan, or policy delivered, issued for delivery, or renewed in this state which provides health insurance medical coverage that includes coverage for physician services in a physician's office, and every policy which provides major medical or similar comprehensive-type coverage excluding disability income, long term care and insurance supplemental policies which only provide coverage for specified diseases or other supplemental policies, shall:

(1) Use a genetic test or request for genetic tests or the results of a genetic test to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or affect a group or an individual health insurance policy, contract, or plan;

(2) Request or require a genetic test for the purpose of determining whether or not to issue or renew an individual's health benefits coverage, to set reimbursement/co-pay levels or determine covered benefits and services;

(3) Release the results of a genetic test without the prior written authorization of the individual from whom the test was obtained, except in a format whereby individual identifiers are removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient of information pursuant to this section may use or disclose this information solely to carry out the purpose for which the information was disclosed. Authorization shall be required for each redisclosure; an exception shall exist for participating in research settings governed by the Federal Policy for the Protection of Human Research Subjects (also known as "The Common Rule").

(4) Request or require information as to whether an individual has ever had a genetic test, or participated in genetic testing of any kind, whether for clinical or research purposes.

(c) For the purposes of this section, "genetic testing" is the analysis of an individual's DNA, RNA, chromosomes, proteins and certain metabolites in order to detect heritable disease-related genotypes, mutations, phenotypes or karyotypes for clinical purposes. Those purposes include predicting risk of disease, identifying carriers, establishing prenatal and clinical diagnosis or prognosis. Prenatal, newborn and carrier screening, as well as testing in high risk families may be included provided there is an approved release by a parent or guardian. Tests for metabolites are covered only when they are undertaken with high probability that an excess of deficiency of the metabolite indicates the presence of heritable mutations in single genes. "Genetic testing" does not mean routine physical measurement, a routine chemical, blood, or urine analysis or a test for drugs

1 or for HIV infections.

2 (d) Any health insurance contract, plan, or policy delivered or issued for delivery or
3 renewed in this state, except contracts providing supplemental coverage to Medicare or other
4 governmental programs, that includes pregnancy-related benefits, shall provide coverage for the
5 expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25)
6 and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with
7 in vitro fertilization (IVF). For purposes of this section:

8 (1) "Preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction
9 with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer
10 to the uterus;

11 (2) "Infertility" means the condition of an otherwise presumably healthy individual who is
12 unable to conceive or sustain a pregnancy during a period of one year.

13 SECTION 2. Sections 27-19-23 and 27-19-44 of the General Laws in Chapter 27-19
14 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

15 **27-19-23. Coverage for infertility.**

16 (a) Any nonprofit hospital service contract, plan, or insurance policies delivered, issued for
17 delivery, or renewed in this state, except contracts providing supplemental coverage to Medicare
18 or other governmental programs, that includes pregnancy-related benefits, shall provide coverage
19 for medically necessary expenses of diagnosis and treatment of infertility for women between the
20 ages of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis
21 (PGD) in conjunction with in vitro fertilization (IVF), and for standard fertility-preservation
22 services when a medically necessary medical treatment may directly or indirectly cause iatrogenic
23 infertility to a covered person. To the extent that a nonprofit hospital service corporation provides
24 reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than
25 infertility, those tests and procedures shall not be excluded from reimbursement when provided
26 attendant to the diagnosis and treatment of infertility for women between the ages of twenty-five
27 (25) and forty-two (42) years; provided, that a subscriber copayment, not to exceed twenty percent
28 (20%), may be required for those programs and/or procedures the sole purpose of which is the
29 treatment of infertility.

30 (b) For purposes of this section, “infertility” means the condition of an otherwise
31 presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of
32 one year.

33 (c) For purposes of this section, “standard fertility-preservation services” means
34 procedures consistent with established medical practices and professional guidelines published by

1 the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or
2 other reputable professional medical organizations.
3 (d) For purposes of this section, “iatrogenic infertility” means an impairment of fertility by
4 surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or
5 processes.
6 (e) For purposes of this section, “may directly or indirectly cause” means treatment with a
7 likely side effect of infertility as established by the American Society for Reproductive Medicine,
8 the American Society of Clinical Oncology, or other reputable professional organizations.
9 (f) The health insurance contract may limit coverage to a lifetime cap of one hundred
10 thousand dollars ($100,000).
11 (g) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a
12 technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic
13 disorders prior to their transfer to the uterus.
14 **27-19-44. Genetic testing.**
15 (a) Except as provided in chapter 37.3 of title 5, insurance administrators, health plans, and
16 providers shall be prohibited from releasing genetic information without prior written authorization
17 of the individual. Written authorization shall be required for each disclosure and include to whom
18 the disclosure is being made. An exception shall exist for those participating in research settings
19 governed by the federal policy for the protection of human research subjects (also known as “The
20 Common Rule”). Tests conducted purely for research are excluded from the definition, as are tests
21 for somatic (as opposed to heritable) mutations, and testing for forensic purposes.
22 (b) No nonprofit health service corporation subject to the provisions of this chapter shall:
23 (1) Use a genetic test or request for a genetic test or the results of a genetic test or other
24 genetic information to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the
25 terms or conditions of, or affect a group or an individual’s health insurance policy, contract, or
26 plan;
27 (2) Request or require a genetic test for the purpose of determining whether or not to issue
28 or renew a group, individual health benefits coverage, to set reimbursement/copay levels, or
29 determine covered benefits and services;
30 (3) Release the results of a genetic test without the prior written authorization of the
31 individual from whom the test was obtained, except in a format by which individual identifiers are
32 removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient
33 of information pursuant to this section may use or disclose the information solely to carry out the
34 purpose for which the information was disclosed. Authorization shall be required for each

redisclosure. An exception shall exist for participation in research settings governed by the federal policy for the protection of human research subjects (also known as “The Common Rule”); or

(4) Request or require information as to whether an individual has ever had a genetic test, or participated in genetic testing of any kind, whether for clinical or research purposes.

(c) For the purposes of this section, “genetic testing” is the analysis of an individual’s DNA, RNA, chromosomes, proteins, and certain metabolites in order to detect heritable disease-related genotypes, mutations, phenotypes, or karyotypes for clinical purposes. These purposes include predicting risk of disease, identifying carriers, establishing prenatal and clinical diagnosis or prognosis. Prenatal, newborn, and carrier screening, as well as testing in high-risk families, may be included provided there is an approved release by a parent or guardian. Tests for metabolites are covered only when they are undertaken with high probability that an excess of deficiency of the metabolite indicates the presence of heritable mutations in single genes. “Genetic testing” does not mean routine physical measurement, a routine chemical, blood, or urine analysis, or a test for drugs or for HIV infection.

(d) Any health insurance contract, plan, or policy delivered or issued for delivery or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, that includes pregnancy-related benefits, shall provide coverage for the expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with in vitro fertilization (IVF). For purposes of this section:

(1) "Preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer to the uterus;

(2) "Infertility" means the condition of an otherwise presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of one year.

SECTION 3. Sections 27-20-20 and 27-20-39 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

27-20-20. Coverage for infertility.

(a) Any nonprofit medical service contract, plan, or insurance policies delivered, issued for delivery, or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, that includes pregnancy-related benefits, shall provide coverage for the medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with in vitro fertilization (IVF), and for standard fertility-preservation

1 services when a medically necessary medical treatment may directly or indirectly cause iatrogenic
2 infertility to a covered person. To the extent that a nonprofit medical service corporation provides
3 reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than
4 infertility, those tests and procedures shall not be excluded from reimbursement when provided
5 attendant to the diagnosis and treatment of infertility for women between the ages of twenty-five
6 (25) and forty-two (42) years; provided, that subscriber copayment, not to exceed twenty percent
7 (20%), may be required for those programs and/or procedures the sole purpose of which is the
8 treatment of infertility.
9 (b) For purposes of this section, "infertility" means the condition of an otherwise
10 presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of
11 one year.
12 (c) For purposes of this section, "standard fertility-preservation services" means
13 procedures consistent with established medical practices and professional guidelines published by
14 the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or
15 other reputable professional medical organizations.
16 (d) For purposes of this section, "iatrogenic infertility" means an impairment of fertility by
17 surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or
18 processes.
19 (e) For purposes of this section, "may directly or indirectly cause" means treatment with a
20 likely side effect of infertility as established by the American Society for Reproductive Medicine,
21 the American Society of Clinical Oncology, or other reputable professional organizations.
22 (f) The health insurance contract may limit coverage to a lifetime cap of one hundred
23 thousand dollars ($100,000).
24 (g) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a
25 technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic
26 disorders prior to their transfer to the uterus.
27 **27-20-39. Genetic testing.**
28 (a) Except as provided in chapter 37.3 of title 5, insurance administrators, health plans, and
29 providers shall be prohibited from releasing genetic information without prior written authorization
30 of the individual. Written authorization shall be required for each disclosure and include to whom
31 the disclosure is being made. An exception shall exist for those participating in research settings
32 governed by the federal policy for the protection of human research subjects (also known as "The
33 Common Rule"). Tests conducted purely for research are excluded from the definition, as are tests
34 for somatic (as opposed to heritable) mutations, and testing for forensic purposes.

(b) No nonprofit health insurer subject to the provisions of this chapter shall:

(1) Use a genetic test or request for a genetic test or the results of a genetic test to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or affect a group or individual's health insurance policy, contract, or plan;

(2) Request or require a genetic test for the purpose of determining whether or not to issue or renew health benefits coverage, to set reimbursement/copay levels, or determine covered benefits and services;

(3) Release the results of a genetic test without the prior written authorization of the individual from whom the test was obtained, except in a format by which individual identifiers are removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient of information pursuant to this section may use or disclose the information solely to carry out the purpose for which the information was disclosed. Authorization shall be required for each redisclosure. An exception shall exist for participation in research settings governed by the federal policy for the protection of human research subjects (also known as "The Common Rule"); or

(4) Request or require information as to whether an individual has ever had a genetic test, or participated in genetic testing of any kind, whether for clinical or research purposes.

(c) For the purposes of this section, "genetic testing" is the analysis of an individual's DNA, RNA, chromosomes, proteins, and certain metabolites in order to detect heritable disease-related genotypes, mutations, phenotypes, or karyotypes for clinical purposes. Those purposes include predicting risk of disease, identifying carriers, establishing prenatal and clinical diagnosis or prognosis. Prenatal, newborn, and carrier screening, as well as testing in high-risk families, may be included provided there is an approved release by a parent or guardian. Tests for metabolites are covered only when they are undertaken with high probability that an excess of deficiency of the metabolite indicates the presence of heritable mutations in single genes. "Genetic testing" does not mean routine physical measurement, a routine chemical, blood, or urine analysis, or a test for drugs or for HIV infections.

(d) Any health insurance contract, plan, or policy delivered or issued for delivery or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, that includes pregnancy-related benefits, shall provide coverage for the expenses of diagnosis and treatment of infertility for individuals between the ages of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with in vitro fertilization (IVF). For purposes of this section:

(1) "Preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer

to the uterus;

(2) "Infertility" means the condition of an otherwise presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of one year.

SECTION 4. Sections 27-41-33 and 27-41-53 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

27-41-33. Coverage for infertility.

(a) Any health maintenance organization service contract plan or policy delivered, issued for delivery, or renewed in this state, except a contract providing supplemental coverage to Medicare or other governmental programs, that includes pregnancy-related benefits, shall provide coverage for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42), including preimplantation genetic diagnosis (PGD) in conjunction with in vitro fertilization (IVF), years and for standard fertility-preservation services when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person. To the extent that a health maintenance organization provides reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than infertility, those tests and procedures shall not be excluded from reimbursement when provided attendant to the diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years; provided, that subscriber copayment, not to exceed twenty percent (20%), may be required for those programs and/or procedures the sole purpose of which is the treatment of infertility.

(b) For purposes of this section, “infertility” means the condition of an otherwise healthy individual who is unable to conceive or sustain a pregnancy during a period of one year.

(c) For purposes of this section, “standard fertility-preservation services” means procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional medical organizations.

(d) For purposes of this section, “iatrogenic infertility” means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

(e) For purposes of this section, “may directly or indirectly cause” means treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional organizations.

(f) The health insurance contract may limit coverage to a lifetime cap of one hundred thousand dollars ($100,000).

(g) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer to the uterus.

27-41-53. Genetic testing.

(a) Except as provided in chapter 37.3 of title 5, insurance administrators, health plans, and providers shall be prohibited from releasing genetic information without prior written authorization of the individual. Written authorization shall be required for each disclosure and include to whom the disclosure is being made. An exception shall exist for those participating in research settings governed by the federal policy for the protection of human research subjects (also known as “The Common Rule”). Tests conducted purely for research are excluded from the definition, as are tests for somatic (as opposed to heritable) mutations, and testing for forensic purposes.

(b) No health maintenance organization subject to the provisions of this chapter shall:

(1) Use a genetic test or request for genetic test or the results of a genetic test to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or affect a group or an individual’s health insurance policy contract, or plan;

(2) Request or require a genetic test for the purpose of determining whether or not to issue or renew an individual’s health benefits coverage, to set reimbursement/copay levels, or determine covered benefits and services;

(3) Release the results of a genetic test without the prior written authorization of the individual from whom the test was obtained, except in a format where individual identifiers are removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient of information pursuant to this section may use or disclose the information solely to carry out the purpose for which the information was disclosed. Authorization shall be required for each re-disclosure. An exception shall exist for participation in research settings governed by the federal policy for the protection of human research subjects (also known as “The Common Rule”); or

(4) Request or require information as to whether an individual has ever had a genetic test, or participated in genetic testing of any kind, whether for clinical or research purposes.

(c) For the purposes of this section, “genetic testing” is the analysis of an individual’s DNA, RNA, chromosomes, protein, and certain metabolites in order to detect heritable inheritable disease-related genotypes, mutations, phenotypes, or karyotypes for clinical purposes. Those purposes include predicting risk of disease, identifying carriers, establishing prenatal and clinical diagnosis or prognosis. Prenatal, newborn, and carrier screening, and testing in high-risk families may be included provided there is an approved release by a parent or guardian. Tests for metabolites are covered only when they are undertaken with high probability that an excess or deficiency of the

metabolite indicates the presence of heritable mutations in single genes. “Genetic testing” does not mean routine physical measurement, a routine chemical, blood, or urine analysis or a test for drugs or for HIV infections.

(d) Any health insurance contract, plan, or policy delivered or issued for delivery or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, that includes pregnancy-related benefits, shall provide coverage for the expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with in vitro fertilization (IVF). For purposes of this section:

(1) "Preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer to the uterus;

(2) "Infertility" means the condition of an otherwise presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of one year.

SECTION 5. This act shall take effect on January 1, 2025.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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1 This act would mandate all insurance contracts, plans or policies provide insurance
2 coverage for the expense of diagnosing and treating infertility for women between the ages of
3 twenty-five and forty-two years including preimplantation genetic diagnosis (PGD) in conjunction
4 with in vitro fertilization (IVF).
5 This act would take effect on January 1, 2025.

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