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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

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A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators Urso, Murray, Quezada, Britto, Euer, Bissaillon, Mack, Bell,
and Vargas

Date Introduced: January 30, 2026

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

3 **27-18-30. Health insurance contracts — Infertility.**

4 (a) Any health insurance contract, plan, or policy delivered or issued for delivery or
5 renewed in this state, except contracts providing supplemental coverage to Medicare or other
6 governmental programs, that includes pregnancy-related benefits, shall provide coverage for
7 medically necessary expenses of diagnosis and treatment of infertility for women between the ages
8 of twenty-five (25) and forty-two (42) years, [including preimplantation genetic diagnosis \(PGD\) in](#)
9 [conjunction with in vitro fertilization \(IVF\) subject to the provision of subsection \(i\) of this section.](#)
10 and for standard fertility-preservation services when a medically necessary medical treatment may
11 directly or indirectly cause iatrogenic infertility to a covered person. To the extent that a health
12 insurance contract provides reimbursement for a test or procedure used in the diagnosis or treatment
13 of conditions other than infertility, the tests and procedures shall not be excluded from
14 reimbursement when provided attendant to the diagnosis and treatment of infertility for women
15 between the ages of twenty-five (25) and forty-two (42) years; provided, that a subscriber
16 copayment not to exceed twenty percent (20%) may be required for those programs and/or
17 procedures the sole purpose of which is the treatment of infertility.

18 (b) For purposes of this section, "infertility" means the condition of an otherwise
19 presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of

1 one year.

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

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

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

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

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

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

19 (i) Any health insurance contract, plan, or policy shall only be required to provide coverage,
20 for preimplantation genetic diagnosis (PGD) upon the following conditions:

21 (1) The PGD is recommended or ordered by a healthcare provider acting within the
22 provider's scope of practice;

23 (2) The PGD is recommended or ordered to address, treat, diagnosis a particular risk,
24 specific health danger or specific genetic risk condition;

25 (3) The condition or circumstances of the insured patient fulfill the specific criteria,
26 requirements or stipulations recommended by nationally recognized clinical practice guidelines for
27 preimplantation genetic diagnosis (PGD).

28 (i) For the purpose of this subsection, "nationally recognized clinical practice guidelines"
29 means evidence-based, peer reviewed clinical practice guidelines informed by a systematic review
30 of evidence and an assessment of the benefits, and risks of alternative care options intended to
31 optimize patient care developed by independent organization professional societies utilizing a
32 transparent methodology and reporting structure and with a conflict-of-interest policy.

33 (ii) Nothing in this subsection shall be construed to prevent medical management or
34 utilization review of their services, including preauthorization, to ensure that such services are

1 [consistent with nationally recognized clinical practice guidelines for PGD.](#)

2 **27-18-52. Genetic testing.**

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

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

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

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

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

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

31 (c) For the purposes of this section, “genetic testing” is the analysis of an individual’s DNA,
32 RNA, chromosomes, proteins, and certain metabolites in order to detect heritable disease-related
33 genotypes, mutations, phenotypes, or karyotypes for clinical purposes. Those purposes include
34 predicting risk of disease, identifying carriers, establishing prenatal and clinical diagnosis or

1 prognosis. Prenatal, newborn, and carrier screening, as well as testing in high-risk families, may be
2 included provided there is an approved release by a parent or guardian. Tests for metabolites are
3 covered only when they are undertaken with high probability that an excess of deficiency of the
4 metabolite indicates the presence of heritable mutations in single genes. "Genetic testing" does not
5 mean routine physical measurement, a routine chemical, blood, or urine analysis, or a test for drugs
6 or for HIV infections.

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

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

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

18 (3) Any health insurance contract, plan, or policy that provides coverage, for
19 preimplantation genetic diagnosis (PGD) pursuant to subsection (a) of this section, shall do so only
20 upon the recommendation of a healthcare provider acting within the provider's scope of practice,
21 and as recommended by nationally recognized clinical practice guidelines for preimplantation
22 genetic diagnosis (PGD).

23 (i) For the purpose of this subsection, "nationally recognized clinical practice guidelines"
24 means evidence-based, peer reviewed clinical practice guidelines informed by a systematic review
25 of evidence and an assessment of the benefits, and risks of alternative care options intended to
26 optimize patient care developed by independent organization professional societies utilizing a
27 transparent methodology and reporting structure and with a conflict-of-interest policy.

28 (ii) Nothing in this subsection shall be construed to prevent medical management or
29 utilization review of their services, including preauthorization, to ensure that such services are
30 consistent with nationally recognized clinical practice guidelines for the detection of lung cancer.

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

33 **27-19-23. Coverage for infertility.**

34 (a) Any nonprofit hospital service contract, plan, or insurance policies delivered, issued for

1 delivery, or renewed in this state, except contracts providing supplemental coverage to Medicare
2 or other governmental programs, that includes pregnancy-related benefits, shall provide coverage
3 for medically necessary expenses of diagnosis and treatment of infertility for women between the
4 ages of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis
5 (PGD) in conjunction with in vitro fertilization (IVF) subject to the provision of subsection (h) of
6 this section, and for standard fertility-preservation services when a medically necessary medical
7 treatment may directly or indirectly cause iatrogenic infertility to a covered person. To the extent
8 that a nonprofit hospital service corporation provides reimbursement for a test or procedure used
9 in the diagnosis or treatment of conditions other than infertility, those tests and procedures shall
10 not be excluded from reimbursement when provided attendant to the diagnosis and treatment of
11 infertility for women between the ages of twenty-five (25) and forty-two (42) years; provided, that
12 a subscriber copayment, not to exceed twenty percent (20%), may be required for those programs
13 and/or procedures the sole purpose of which is the treatment of infertility.

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

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

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

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

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

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

32 (h) Any health insurance contract, plan, or policy shall only be required to provide
33 coverage for preimplantation genetic diagnosis (PGD) upon the following conditions:

34 (1) The PGD is recommended or ordered by a healthcare provider acting within the

1 provider's scope of practice:

2 (2) The PGD is recommended or ordered to address, treat, diagnosis a particular risk,
3 specific health danger or specific genetic risk condition:

4 (3) The condition or circumstances of the insured patient fulfill the specific criteria,
5 requirements or stipulations recommended by nationally recognized clinical practice guidelines for
6 preimplantation genetic diagnosis (PGD).

7 (i) For the purpose of this subsection, "nationally recognized clinical practice guidelines"
8 means evidence-based, peer reviewed clinical practice guidelines informed by a systematic review
9 of evidence and an assessment of the benefits, and risks of alternative care options intended to
10 optimize patient care developed by independent organization professional societies utilizing a
11 transparent methodology and reporting structure and with a conflict-of-interest policy.

12 (ii) Nothing in this subsection shall be construed to prevent medical management or
13 utilization review of their services, including preauthorization, to ensure that such services are
14 consistent with nationally recognized clinical practice guidelines for PGD.

15 **27-19-44. Genetic testing.**

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

23 (b) No nonprofit health service corporation subject to the provisions of this chapter shall:

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

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

31 (3) Release the results of a genetic test without the prior written authorization of the
32 individual from whom the test was obtained, except in a format by which individual identifiers are
33 removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient
34 of information pursuant to this section may use or disclose the information solely to carry out the

1 purpose for which the information was disclosed. Authorization shall be required for each
2 redisclosure. An exception shall exist for participation in research settings governed by the federal
3 policy for the protection of human research subjects (also known as “The Common Rule”); or

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

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

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

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

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

27 (3) Any health insurance contract, plan, or policy that provides coverage, for
28 preimplantation genetic diagnosis (PGD) pursuant to subsection (a) of this section, shall do so only
29 upon the recommendation of a healthcare provider acting within the provider's scope of practice,
30 and as recommended by nationally recognized clinical practice guidelines for preimplantation
31 genetic diagnosis (PGD).

32 (i) For the purpose of this subsection, "nationally recognized clinical practice guidelines"
33 means evidence-based, peer reviewed clinical practice guidelines informed by a systematic review
34 of evidence and an assessment of the benefits, and risks of alternative care options intended to

1 [optimize patient care developed by independent organization professional societies utilizing a](#)
2 [transparent methodology and reporting structure and with a conflict-of-interest policy.](#)

3 [\(ii\) Nothing in this subsection shall be construed to prevent medical management or](#)
4 [utilization review of their services, including preauthorization, to ensure that such services are](#)
5 [consistent with nationally recognized clinical practice guidelines for PGD.](#)

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

8 **27-20-20. Coverage for infertility.**

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

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

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

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

33 (e) For purposes of this section, "may directly or indirectly cause" means treatment with a
34 likely side effect of infertility as established by the American Society for Reproductive Medicine,

1 the American Society of Clinical Oncology, or other reputable professional organizations.

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

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

7 (h) Any health insurance contract, plan, or policy that provides coverage, for
8 preimplantation genetic diagnosis (PGD) pursuant to subsection (a) of this section, shall do so only
9 upon the recommendation of a healthcare provider acting within the provider's scope of practice,
10 and as recommended by nationally recognized clinical practice guidelines for preimplantation
11 genetic diagnosis (PGD).

12 (i) Any health insurance contract, plan, or policy shall only be required to provide coverage,
13 for preimplantation genetic diagnosis (PGD) upon the following conditions:

14 (1) The PGD is recommended or ordered by a healthcare provider acting within the
15 provider's scope of practice;

16 (2) The PGD is recommended or ordered to address, treat, diagnosis a particular risk,
17 specific health danger or specific genetic risk condition;

18 (3) The condition or circumstances of the insured patient fulfill the specific criteria,
19 requirements or stipulations recommended by nationally recognized clinical practice guidelines for
20 preimplantation genetic diagnosis (PGD).

21 (i) Nothing in this subsection shall be construed to prevent medical management or
22 utilization review of their services, including preauthorization, to ensure that such services are
23 consistent with nationally recognized clinical practice guidelines for PGD.

24 **27-20-39. Genetic testing.**

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

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

33 (1) Use a genetic test or request for a genetic test or the results of a genetic test to reject,
34 deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or affect

1 a group or individual's health insurance policy, contract, or plan;

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

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

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

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

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

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

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

1 (3) Any health insurance contract, plan, or policy that provides coverage, for
2 preimplantation genetic diagnosis (PGD) pursuant to subsection (a) of this section, shall do so only
3 upon the recommendation of a healthcare provider acting within the provider's scope of practice,
4 and as recommended by nationally recognized clinical practice guidelines for preimplantation
5 genetic diagnosis (PGD).

6 (i) For the purpose of this subsection, "nationally recognized clinical practice guidelines"
7 means evidence-based, peer reviewed clinical practice guidelines informed by a systematic review
8 of evidence and an assessment of the benefits, and risks of alternative care options intended to
9 optimize patient care developed by independent organization professional societies utilizing a
10 transparent methodology and reporting structure and with a conflict-of-interest policy.

11 (ii) Nothing in this subsection shall be construed to prevent medical management or
12 utilization review of their services, including preauthorization, to ensure that such services are
13 consistent with nationally recognized clinical practice guidelines for PGD.

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

16 **27-41-33. Coverage for infertility.**

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

31 (b) For purposes of this section, "infertility" means the condition of an otherwise healthy
32 individual who is unable to conceive or sustain a pregnancy during a period of 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 (h) Any health insurance contract, plan, or policy that provides coverage, for
15 preimplantation genetic diagnosis (PGD) pursuant to subsection (a) of this section, shall do so only
16 upon the recommendation of a healthcare provider acting within the provider's scope of practice,
17 and as recommended by nationally recognized clinical practice guidelines for preimplantation
18 genetic diagnosis (PGD).

19 (i) Any health insurance contract, plan, or policy shall only be required to provide coverage,
20 for preimplantation genetic diagnosis (PGD) upon the following conditions:

21 (1) The PGD is recommended or ordered by a healthcare provider acting within the
22 provider's scope of practice;

23 (2) The PGD is recommended or ordered to address, treat, diagnosis a particular risk,
24 specific health danger or specific genetic risk condition;

25 (3) The condition or circumstances of the insured patient fulfill the specific criteria,
26 requirements or stipulations recommended by nationally recognized clinical practice guidelines for
27 preimplantation genetic diagnosis (PGD).

28 (i) Nothing in this subsection shall be construed to prevent medical management or
29 utilization review of their services, including preauthorization, to ensure that such services are
30 consistent with nationally recognized clinical practice guidelines for PGD.

31 **27-41-53. Genetic testing.**

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

1 the disclosure is being made. An exception shall exist for those participating in research settings
2 governed by the federal policy for the protection of human research subjects (also known as “The
3 Common Rule”). Tests conducted purely for research are excluded from the definition, as are tests
4 for somatic (as opposed to heritable) mutations, and testing for forensic purposes.

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

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

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

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

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

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

31 (d) Any health insurance contract, plan, or policy delivered or issued for delivery or
32 renewed in this state, except contracts providing supplemental coverage to Medicare or other
33 governmental programs, that includes pregnancy-related benefits, shall provide coverage for the
34 expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25)

1 and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with
2 in vitro fertilization (IVF). For purposes of this section:

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

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

8 (3) Any health insurance contract, plan, or policy that provides coverage, for
9 preimplantation genetic diagnosis (PGD) pursuant to subsection (a) of this section, shall do so only
10 upon the recommendation of a healthcare provider acting within the provider's scope of practice,
11 and as recommended by nationally recognized clinical practice guidelines for preimplantation
12 genetic diagnosis (PGD).

13 (i) For the purpose of this subsection, "nationally recognized clinical practice guidelines"
14 means evidence-based, peer reviewed clinical practice guidelines informed by a systematic review
15 of evidence and an assessment of the benefits, and risks of alternative care options intended to
16 optimize patient care developed by independent organization professional societies utilizing a
17 transparent methodology and reporting structure and with a conflict-of-interest policy.

18 (ii) Nothing in this subsection shall be construed to prevent medical management or
19 utilization review of their services, including preauthorization, to ensure that such services are
20 consistent with nationally recognized clinical practice guidelines for PGD.

21 SECTION 5. This act shall take effect on January 1, 2027.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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 (25) and forty-two (42) years including preimplantation genetic diagnosis (PGD) in
4 conjunction with in vitro fertilization (IVF) only on the recommendation of a healthcare provider
5 acting within the scope of their practice.

6 This act would take effect on January 1, 2027.

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