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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. 2026

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:

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.

(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, including preimplantation genetic diagnosis (PGD) in conjunction with in vitro fertilization (IVF) subject to the provision of subsection (i) of this section, 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 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 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 presumably 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) 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) The health insurance contract may limit coverage to a lifetime cap of one hundred thousand dollars ($100,000).

(h) 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.

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

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

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

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

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

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

consistent with nationally recognized clinical practice guidelines for PGD.

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 that provides health insurance medical coverage that includes coverage for physician services in a physician's office, and every policy that provides major medical or similar comprehensive-type coverage excluding disability income, long-term care, and insurance supplemental policies that 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/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 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 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.

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

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

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

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

27-19-23. Coverage for infertility.

(a) Any nonprofit hospital 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 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) subject to the provision of subsection (h) of this section, 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 nonprofit hospital service corporation 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 a 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 presumably 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.

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

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

provider's scope of practice;

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

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

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

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

27-19-44. 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 nonprofit health service corporation 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 or other genetic information 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 a group, individual 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. 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.

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

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

optimize patient care developed by independent organization professional societies utilizing a transparent methodology and reporting structure and with a conflict-of-interest policy.

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

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) subject to the provision of subsection (i) of this section, 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 nonprofit medical service corporation 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 presumably 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.

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

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

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

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

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

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

27-20-39. 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 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 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.

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

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

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

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) years, including preimplantation genetic diagnosis (PGD) in conjunction with in vitro fertilization (IVF) subject to the provision of subsection (i) of this section, 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.

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

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

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

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

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

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

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.

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

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

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

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

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This act would mandate all insurance contracts, plans or policies provide insurance coverage for the expense of diagnosing and treating 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) only on the recommendation of a healthcare provider acting within the scope of their practice.

This act would take effect on January 1, 2027.

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