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LC000272  
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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2025

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A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators Urso, Murray, Britto, Gu, Valverde, Pearson, Appollonio,  
Vargas, Lawson, and Acosta  
Date Introduced: January 31, 2025  
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 \(IVF\).](#) and for standard fertility-preservation services when a  
10   medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a  
11   covered person. To the extent that a health insurance contract provides reimbursement for a test or  
12   procedure used in the diagnosis or treatment of conditions other than infertility, the tests and  
13   procedures shall not be excluded from reimbursement when provided attendant to the diagnosis  
14   and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42)  
15   years; provided, that a subscriber co-payment not to exceed twenty percent (20%) may be required  
16   for those programs and/or procedures the sole purpose of which is the treatment of infertility.  
17           (b) For purposes of this section, “infertility” means the condition of an otherwise  
18   presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of  
19   one year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3           **27-19-23. Coverage for infertility.**

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

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

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

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

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

33          (g) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a  
34   technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic

[disorders prior to their transfer to the uterus.](#)

**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 or deficiency of the metabolite indicates the presence of heritable mutations in single genes. “Genetic testing” does not

1 mean routine physical measurement, a routine chemical, blood, or urine analysis, or a test for drugs  
2 or for HIV infection.

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

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

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

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

16 **27-20-20. Coverage for infertility.**

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

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

34 (c) For purposes of this section, "standard fertility-preservation services" means

1 procedures consistent with established medical practices and professional guidelines published by  
2 the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or  
3 other reputable professional medical organizations.

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

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

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

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

15 **27-20-39. 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 insurer 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 to reject,  
25 deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or affect  
26 a group or individual’s health insurance policy, contract, or plan;

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



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

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

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

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

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

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

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

28 **27-41-33. Coverage for infertility.**

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



1 preservation services when a medically necessary medical treatment may directly or indirectly  
2 cause iatrogenic infertility to a covered person. To the extent that a health maintenance organization  
3 provides reimbursement for a test or procedure used in the diagnosis or treatment of conditions  
4 other than infertility, those tests and procedures shall not be excluded from reimbursement when  
5 provided attendant to the diagnosis and treatment of infertility for women between the ages of  
6 twenty-five (25) and forty-two (42) years; provided, that subscriber copayment, not to exceed  
7 twenty percent (20%), may be required for those programs and/or procedures the sole purpose of  
8 which is the treatment of infertility.

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

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

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

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

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

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

26 **27-41-53. Genetic testing.**

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

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

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

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

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

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

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

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

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

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

3           SECTION 5. This act shall take effect on January 1, 2026.

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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 (25) and forty-two (42) years including preimplantation genetic diagnosis (PGD) in  
4 conjunction with in vitro fertilization (IVF).

5           This act would take effect on January 1, 2026.

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