

**2026 -- S 2382**

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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**

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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, Bissailon, 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 rediscovery; 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 of 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 of 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.

(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

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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LC004261  
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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) 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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