§ 1358.24. Adherence to Genetic Information Nondiscrimination Act of 2008

This section applies to all contracts that become effective on or after May 21, 2009.

(a) In addition to the requirements set forth under Sections 1365.5 and 1374.7, an issuer of a Medicare supplement contract shall adhere to the requirements imposed by the federal Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233), as follows:

(1) The issuer shall not deny or condition the issuance or effectiveness of the contract, including the imposition of any exclusion of benefits under the contract based on a preexisting condition, on the basis of the genetic information with respect to that individual or a family member of the individual.

(2) The issuer shall not discriminate in the pricing of the contract, including the adjustment of prepaid or periodic charges, of an individual on the basis of the genetic information with respect to that individual or a family member of the individual.

(b) Nothing in subdivision (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, to do any of the following:

(1) Deny or condition the issuance or effectiveness of the contract or increase the prepaid or periodic charge for a group based on the manifestation of a disease or disorder of an enrollee, subscriber, or applicant.

(2) Increase the prepaid or periodic charge for any contract issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the contract. For purposes of this paragraph, the manifestation of a disease or disorder in one individual shall not also be used as genetic information about other group members and to further increase the prepaid or periodic charge for the group.

(c) An issuer of a Medicare supplement contract shall not request or require an individual or a family member of that individual to undergo a genetic test.

(d) Subdivision (c) shall not be construed to preclude an issuer of a Medicare supplement contract from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time, and consistent with subdivision (a).

(e) For purposes of carrying out subdivision (d), an issuer of a Medicare supplement contract may request only the minimum amount of information necessary to accomplish the intended purpose.

(f) An issuer of a Medicare supplement contract shall not request, require, seek, or purchase genetic information for underwriting purposes.

(g) An issuer of a Medicare supplement contract shall not request, require, seek, or purchase genetic information with respect to any individual or a family member of that individual prior to the individual's enrollment under the contract in connection with that enrollment.

(h) If an issuer of a Medicare supplement contract obtains genetic information incidental to the requesting, requiring, or purchasing of other

information concerning any individual or a family member of that individual, the request, requirement, or purchase shall not be considered a violation of subdivision (g) if the request, requirement, or purchase is not in violation of subdivision (f). However, the issuer shall not use any genetic information obtained under this section for any prohibited purpose described in this section or in Sections 1365.5 and 1374.7.

(i) For the purposes of this section, the following definitions shall apply:

(1) "Issuer of a Medicare supplement contract" includes a third-party administrator, or other person acting for or on behalf of an issuer.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(3) "Genetic information" means, with respect to any individual, information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of the individual. The term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by that pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic education, genetic counseling, including obtaining, interpreting, or assessing genetic information.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" includes all of the following:

(A) Rules for, or determination of, eligibility, including enrollment and continued eligibility, for benefits under the contract.

(B) The computation of prepaid or periodic charges or contribution amounts under the contract.

(C) The application of any preexisting condition exclusion under the contract.

(D) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

HISTORY:

Added Stats 2009 ch 10 § 13 (AB 1543), effective July 2, 2009.

ARTICLE 4

Solicitation and Enrollment

Section
1359. Standards for solicitors and solicitor firms.
1360. Untrue or misleading advertising or solicitations.
1360.1. Representations respecting implications of licensing.
1360.5. Representing, constituting, providing services on behalf of Exchange; Unfair business practice.
1361. New or revised advertisements; Filing.
1361.1. Purchase of health care coverage products; Specified methods prohibited.
1362. Definitions.
1363. Disclosure forms or materials.
1363.01. Notice regarding use of formulary by plan; Information regarding drugs on formulary.
1363.02. Findings; Requirements for service plan.
1363.03. Uniform prescription drug information card; Contents of card.
1363.04. Dental services; Uniform benefits and coverage disclosure matrix.
1363.05. Statement to be included in plan's disclosure form; Modification; Notice to enrollees.
1363.06. Comparative benefit matrices [Inoperative; Operative date contingent].
1363.07. Annual update of comparative benefit matrix by health care service plan; Copies to be mailed to solicitors and employers; Availability of link to matrix on Web site [Inoperative; Operative date contingent].
1363.1. Disclosure on binding arbitration.
1363.2. Use of emergency response system.
1363.3. Standard templates.
1363.5. Disclosure of process used to authorize or deny services; Requirements for criteria used; Notice accompanying disclosure to public.
1364. Supplemental disclosure information.
1364.1. Notice of reduction in emergency service.
1364.5. Filing of procedures to protect confidentiality; Statement for enrollees and subscribers; Notice of availability.
1365. Cancellation and non-renewal of enrollment or subscription.
1365.5. Modification of or refusal to enter contract on discriminatory basis.
1366. Name of plan.
1366.1. Geographic accessibility standard; Applicability; Notice of material modification of plan and public hearing.
1366.2. Availability to group subscribers of termination date of health care contracts in geographic area; Definitions.
1366.3. Plan ceasing to offer individual coverage; Regulations for implementation; Exceptions to applicability.
1366.4. Nonphysician providers.
1366.6. Sale of products by health care service plans; Levels of coverage [Operative term contingent].
1366.6. Sale of products by health care service plans; Levels of coverage [Operative date contingent].

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.