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**HISTORY OF LEGISLATIVE ACTIONS**

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**VERSIONS OF THIS BILL**

[1/13/2010](file:///p:\pprever\2009-10\4298_20100113.docx)

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, SO AS TO ENACT MICHELLE’S LAW BY ADDING SECTIONS 38‑71‑355 AND 38‑71‑785 SO AS TO REQUIRE HEALTH INSURANCE ISSUERS TO PERMIT A DEPENDENT CHILD ON A MEDICALLY NECESSARY LEAVE OF ABSENCE FROM A POSTSECONDARY EDUCATIONAL INSTITUTION TO CONTINUE DEPENDENT COVERAGE AND TO PROVIDE FOR THE REQUIREMENTS RELATED TO THAT COVERAGE; TO AMEND SECTION 38‑71‑850, RELATING TO THE DEFINITION OF “CREDITABLE COVERAGE” FOR GROUP HEALTH INSURANCE COVERAGE AND SPECIAL ENROLLMENT IN GROUP HEALTH INSURANCE COVERAGE, BOTH UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, SO AS TO ADD COVERAGE OF AN INDIVIDUAL UNDER THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM AND TO ENACT FEDERAL REQUIREMENTS SET FORTH IN THE CHILDREN’S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 TO PROVIDE FOR SPECIAL ENROLLMENT OF AN EMPLOYEE OR AN EMPLOYEE’S DEPENDENT IN THE CASE OF TERMINATION OF MEDICAID COVERAGE OR COVERAGE UNDER A STATE CHILDREN’S HEALTH INSURANCE PROGRAM OR THE INDIVIDUAL BECOMING ELIGIBLE FOR ASSISTANCE IN THE PURCHASE OF EMPLOYMENT‑BASED COVERAGE; TO AMEND SECTION 38‑74‑10, AS AMENDED, RELATING TO THE DEFINITION OF “CREDITABLE COVERAGE” FOR THE SOUTH CAROLINA HEALTH INSURANCE POOL, SO AS TO ADD COVERAGE OF AN INDIVIDUAL UNDER THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM; TO AMEND SECTIONS 38‑90‑40, AS AMENDED, 38‑90‑45, AND 38‑90‑50, AS AMENDED, RELATING TO CAPITALIZATION REQUIREMENTS FOR CAPTIVE INSURANCE COMPANIES, SO AS TO PROVIDE THAT THE DIRECTOR OF INSURANCE MAY CONSIDER THE NET AMOUNT OF RISK RETAINED FOR AN INDIVIDUAL RISK WHEN ARRIVING AT A FINDING RELATING TO ADDITIONAL CAPITAL OR NET ASSETS REQUIREMENTS; TO AMEND SECTION 38‑90‑70, AS AMENDED, RELATING TO REPORTS REQUIRED TO BE SUBMITTED BY A CAPTIVE INSURANCE COMPANY TO THE DIRECTOR, SO AS TO REQUIRE AN ASSOCIATION CAPTIVE INSURANCE COMPANY AND INDUSTRIAL INSURED GROUP TO SUBMIT ITS REPORT IN THE MANNER REQUIRED BY SECTION 38‑13‑80; TO AMEND SECTION 38‑90‑80, AS AMENDED, RELATING TO INSPECTIONS AND EXAMINATIONS OF A CAPTIVE INSURANCE COMPANY, SO AS TO PERMIT THE DIRECTOR TO GRANT ACCESS TO, USE, AND MAKE PUBLIC CERTAIN INFORMATION DISCOVERED OR DEVELOPED DURING THE COURSE OF AN EXAMINATION; TO AMEND SECTION 38‑90‑160, AS AMENDED, RELATING TO THE APPLICATION OF THE PROVISIONS OF TITLE 38 TO CAPTIVE INSURANCE COMPANIES, SO AS TO SPECIFY THAT REGULATIONS PROMULGATED PURSUANT TO APPLICABLE STATUTES ALSO APPLY TO CAPTIVE INSURANCE COMPANIES AND TO PROVIDE A LISTING OF THOSE PROVISIONS OF TITLE 38 THAT APPLY TO CERTAIN CAPTIVE INSURANCE COMPANIES; TO AMEND SECTION 38‑90‑430, AS AMENDED, RELATING TO THE APPLICATION OF THE PROVISIONS OF TITLE 38 TO SPECIAL PURPOSE FINANCIAL CAPTIVES, SO AS TO SPECIFY THAT REGULATIONS PROMULGATED PURSUANT TO APPLICABLE STATUTES ALSO APPLY TO SPECIAL PURPOSE FINANCIAL CAPTIVES; AND TO AMEND CHAPTER 93, TITLE 38, RELATING TO THE PRIVACY OF GENETIC INFORMATION, SO AS TO ENACT FEDERAL REQUIREMENTS SET FORTH IN THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 TO PROHIBIT DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION, PROVIDE FOR THE REQUIREMENTS RELATING TO THE COLLECTION OF GENETIC INFORMATION, AND TO PROVIDE FOR THE SCOPE OF THE CHAPTER.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Sections 2 and 3 of this act may be cited as “Michelle’s Law”.

SECTION 2. Subarticle 1, Article 3, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑355. (A) As used in this section:

(1) ‘Dependent child’ means a covered person under a policy who:

(a) is a dependent child, under the terms of the coverage, of an individual under the coverage; and

(b) was enrolled in the coverage, on the basis of being a student at a postsecondary educational institution immediately before the first date of the medically necessary leave of absence involved.

(2) ‘Health insurance coverage’ means as defined in Section 38‑71‑670(6).

(3) ‘Health insurance issuer’ or ‘issuer’ means an entity that provides health insurance coverage in this State as defined in Section 38‑71‑670(7).

(4) ‘Medically necessary leave of absence’ means a leave of absence of a dependent child from a postsecondary educational institution, including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965, or any other change in enrollment of the child at such an institution, that:

(a) commences while the child is suffering from a serious illness or injury;

(b) is medically necessary; and

(c) causes the child to lose student status for purposes of coverage under the terms of the policy.

(B) This section applies to health insurance coverage offered by a health insurance issuer, that is delivered, issued for delivery, or renewed in this State and which provides health insurance coverage in the individual market.

(C)(1) In the case of a dependent child, a health insurance issuer may not terminate health insurance coverage of the child due to a medically necessary leave of absence before the date that is the earlier of:

(a) one year after the first day of the medically necessary leave of absence; or

(b) the date on which the coverage would otherwise terminate under the terms of the policy.

(2) The provisions of this subsection apply to health insurance coverage offered by a health insurance issuer only if the issuer has received written certification by a treating physician of the dependent child that states the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.

(D) Each health insurance issuer shall include with a notice regarding a requirement for certification of student status for coverage under the policy or coverage a plain‑language description of the terms of this section for continued coverage during medically necessary leaves of absence.

(E) A dependent child whose benefits are continued under this section is entitled to the same benefits during the medically necessary leave of absence as if the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(F) Coverage of the dependent child shall continue for the remainder of the period of the medically necessary leave of absence under the changed coverage in the same manner as it would have under the previous coverage in the case where:

(1) a dependent child is in a period of health insurance coverage pursuant to a medically necessary leave of absence;

(2) the manner in which the insured or dependent child is covered under the policy changes, whether through a change in health insurance coverage or health insurance issuer, or otherwise;

and

(3) the coverage as changed continues to provide coverage of dependent children.”

SECTION 3. Subarticle 1, Article 5, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑785. (A) As used in this section:

(1) ‘Dependent child’ means a beneficiary under a policy or certificate of coverage who:

(a) is a dependent child, under the terms of the coverage, of a participant or beneficiary under the coverage; and

(b) was enrolled in the coverage, on the basis of being a student at a postsecondary educational institution immediately before the first date of the medically necessary leave of absence involved.

(2) ‘Health insurance coverage’ means as defined in Section 38‑71‑840(14).

(3) ‘Health insurance issuer’ or ‘issuer’ means an entity that provides health insurance coverage in this State as defined in Section 38‑71‑840(16).

(4) ‘Medically necessary leave of absence’ means a leave of absence of a dependent child from a postsecondary educational institution, including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965, or any other change in enrollment of the child at such an institution, that:

(a) commences while the child is suffering from a serious illness or injury;

(b) is medically necessary; and

(c) causes the child to lose student status for purposes of coverage under the terms of the policy or certificate of coverage.

(5) ‘State health plan’ means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.

(B) This section applies to health insurance coverage offered by a health insurance issuer, including the state health plan, that is delivered, issued for delivery, or renewed in this State and which provides health insurance coverage in the group market.

(C)(1) In the case of a dependent child, a health insurance issuer may not terminate health insurance coverage of the child due to a medically necessary leave of absence before the date that is the earlier of:

(a) one year after the first day of the medically necessary leave of absence; or

(b) the date on which the coverage would otherwise terminate under the terms of the policy or certificate of coverage.

(2) The provisions of this subsection apply to health insurance coverage offered by a health insurance issuer only if the issuer has received written certification by a treating physician of the dependent child that states the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.

(D) Each health insurance issuer shall include with a notice regarding a requirement for certification of student status for coverage under the policy or coverage a plain‑language description of the terms of this section for continued coverage during medically necessary leaves of absence.

(E) A dependent child whose benefits are continued under this section is entitled to the same benefits during the medically necessary leave of absence as if the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(F) Coverage of the dependent child shall continue for the remainder of the period of the medically necessary leave of absence under the changed coverage in the same manner as it would have under the previous coverage in the case where:

(1) a dependent child is in a period of health insurance coverage pursuant to a medically necessary leave of absence;

(2) the manner in which the participant or beneficiary is covered under the policy or certificate of coverage changes, whether through a change in health insurance coverage or health insurance issuer, a change from self‑insured coverage to health insurance coverage, or otherwise; and

(3) the coverage as changed continues to provide coverage of dependent children.”

SECTION 4. Section 38‑71‑850(B)(1) of the 1976 Code is amended to read:

“(1) For purposes of this subarticle, ‘creditable coverage’ means, with respect to an individual, coverage of the individual under ~~any of the following~~:

(a) a group health plan;

(b) health insurance coverage;

(c) Part A or Part B, Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55, Title 10 of the United States Code;

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool, including the South Carolina Health Insurance Pool;

(h) a health plan offered under Chapter 89 of Title 5, United States Code;

(i) a public health plan as defined in regulations;

(j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or

(k) Title XXI of the Social Security Act (State Children’s Health Insurance Program).

The term does not include coverage consisting ~~solely~~ only of those benefits excepted from the definition of health insurance coverage.”

SECTION 5. Section 38‑71‑850(E) of the 1976 Code is amended by adding a new item to read:

“(4) A health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee who is eligible, but not enrolled for coverage, or a dependent of the employee if the dependent is eligible, but not enrolled for coverage, to enroll for coverage under the terms of the plan if one of the following conditions is met:

(a) the employee or dependent was covered under a Medicaid plan pursuant to Title XIX of the Social Security Act or under a State Children’s Health Insurance Program pursuant to Title XXI of the Social Security Act and coverage of the employee or dependent under the plan or program is terminated as a result of loss of eligibility for the coverage and the employee requests enrollment not later than sixty days after the date of termination of the coverage; or

(b) the employee or dependent becomes eligible for assistance with respect to coverage under the group health plan under a Medicaid plan or State Children’s Health Insurance Program, including under any waiver or demonstration project conducted under or in relation to the plan or program, if the employee requests enrollment not later than sixty days after the date the employee or dependent is determined to be eligible for assistance.

An individual who requests enrollment as specified in this item must be enrolled, even if there is otherwise no open enrollment period, without any penalties for late enrollment.”

SECTION 6. Section 38‑74‑10(20) of the 1976 Code is amended to read:

“(20) ‘Creditable coverage’ means, with respect to an individual, coverage of the individual under ~~any of the following~~:

(a) a group health plan;

(b) health insurance;

(c) Part A or B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55, Title 10 of the United States Code;

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool, including the South Carolina Health Insurance Pool;

(h) a health plan offered under Chapter 89, Title 5 of the United States Code;

(i) a public health plan, as defined in regulations;

(j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U. S.C. 2504(e)); or

(k) Title XXI of the Social Security Act (State Children’s Health Insurance Program).

The term does not include coverage consisting ~~solely~~ only of those benefits excepted from the definition of health insurance.

A period of creditable coverage ~~shall~~ is not ~~be~~ counted if, after such period and before the enrollment date, there was a sixty‑three day period during all of which the individual was not covered under any creditable coverage. However, in determining whether there has been continuous coverage, no period ~~shall~~ must be taken into account during which the individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period.

Periods of creditable coverage with respect to an individual ~~shall~~ must be established through presentation of certifications as described in Section 38‑71‑850(D) or in a manner specified in regulations.”

SECTION 7. Section 38‑90‑40(D) of the 1976 Code, as last amended by Act 332 of 2006, is further amended to read:

“(D) The director may prescribe additional capital or net assets based upon the type, volume, and nature of insurance business transacted including, but not limited to, the net amount of risk retained for an individual risk. Contributions in connection with these prescribed additional net assets or capital must be in the form of:

(1) cash;

(2) cash equivalent;

(3) an irrevocable letter of credit issued by a bank chartered by this State or a member bank of the Federal Reserve System with a branch office in this State or as approved by the director; or

(4) securities invested as provided in Section 38‑90‑100.”

SECTION 8. Section 38‑90‑45(B) of the 1976 Code, as added by Act 58 of 2001, is amended to read:

“(B) The director may prescribe additional capital or surplus based upon the type, volume, and nature of the insurance business transacted including, but not limited to, the net amount of risk retained for an individual risk.”

SECTION 9. Section 38‑90‑50(D) of the 1976 Code, as last amended by Act 332 of 2006, is further amended to read:

“(D) The director may prescribe additional surplus based upon the type, volume, and nature of insurance business transacted including, but not limited to, the net amount of risk retained for an individual risk. This additional surplus must be in the form of:

(1) cash;

(2) cash equivalent;

(3) an irrevocable letter of credit issued by a bank chartered by this State, or a member bank of the Federal Reserve System with a branch in this State or as approved by the director; or

(4) securities invested as provided in Section 38‑90‑100.”

SECTION 10. Section 38‑90‑70(B) of the 1976 Code, as last amended by Act 291 of 2004, is further amended to read:

“(B) Before March first of each year, a captive insurance company or a captive reinsurance company shall submit to the director a report of its financial condition, verified by oath of two of its executive officers. Except as provided in Sections 38‑90‑40 and 38‑90‑50, a captive insurance company or a captive reinsurance company shall report using generally accepted accounting principles, unless the director approves the use of statutory accounting principles, with useful or necessary modifications or adaptations required or approved or accepted by the director for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the director. Except as otherwise provided, an association captive insurance company and an industrial insured group shall file its report in the form and manner required by Section 38‑13‑80, and each industrial insured group shall comply with the requirements ~~set forth~~ provided for in Section 38‑13‑85. The director by regulation shall prescribe the forms in which pure captive insurance companies and industrial insured captive insurance companies shall report. Information submitted pursuant to this section is confidential as provided in Section 38‑90‑35, except for reports submitted by a captive insurance company formed as a Risk Retention Group under the Product Liability Risk Retention Act of 1986, 15 U.S.C. Section 3901, et seq., as amended.”

SECTION 11. Section 38‑90‑80(B)(2) and (3) of the 1976 Code, as last amended by Act 291 of 2004, is further amended to read:

“(2) The director may grant access to this information to public officers having jurisdiction over the regulation of insurance in any other state or country, or to law enforcement officers of this State or any other state or country or agency of the federal government at any time, so long as the officers receiving the information agree in writing to hold it in a manner consistent with this section.

(3) The confidentiality provisions of this subsection do not extend to final reports produced by the director in inspecting or examining a captive insurance company formed as a Risk Retention Group under the Product Liability Risk Retention Act of 1986, 15 U.S.C. Section 3901, et seq., as amended. In addition, nothing contained in this subsection limits the authority of the director or his designee to use and, if appropriate, make public a preliminary examination report, examiner or insurer work papers or other documents, or other information discovered or developed during the course of an examination in the furtherance of a legal or regulatory action which the director or his designee, in his sole discretion, considers appropriate.”

SECTION 12. Section 38‑90‑160 of the 1976 Code, as last amended by Act 188 of 2002, is further amended to read:

“Section 38‑90‑160. (A) No provisions of this title, other than those contained in this chapter or contained in specific references contained in this chapter and regulations applicable to them, apply to captive insurance companies.

(B) The director may exempt, by rule, regulation, or order, ~~exempt~~ special purpose captive insurance companies, on a case by case basis, from provisions of this chapter that he determines to be inappropriate given the nature of the risks to be insured.

(C) The provisions of Sections 38‑5‑120(A)(3), 38‑5‑120(C), 38‑5‑120(D), 38‑9‑225, 38‑9‑230, 38‑9‑320, 38‑21‑10, 38‑21‑30, 38‑21‑60, 38‑21‑70, 38‑21‑90, 38‑21‑95, 38‑21‑120, 38‑21‑130, 38‑21‑140, 38‑21‑150, 38‑21‑160, 38‑21‑170, 38‑21‑250, 38‑21‑270, 38‑21‑280, 38‑21‑310, 38‑21‑320, 38‑21‑330, 38‑21‑360, 38‑55‑75 and Chapters 44 and 46, Title 38 apply in full to a risk retention group licensed as an industrial insured captive insurance company and, if a conflict occurs between those code sections and chapters referenced in this subsection and this chapter (Chapter 90, Title 38), then the code sections and chapters referenced in this subsection control.

(D) Except as provided elsewhere in this chapter, the provisions of Chapter 87, Title 38 apply to a risk retention group licensed as an industrial insured captive insurance company.”

SECTION 13. Section 38‑90‑430(A) of the 1976 Code, as added by Act 291 of 2004, is amended to read:

“(A) No provisions of Title 38, other than those specifically referenced in this article and regulations applicable to them, apply to a SPFC, and those provisions apply only as modified by this article. If a conflict occurs between a provision of Title 38 and a provision of this article, the latter controls.”

SECTION 14. Chapter 93, Title 38 of the 1976 Code is amended to read:

“CHAPTER 93

Privacy of Genetic Information

~~Section 38‑93‑10.~~  ~~As used in this chapter:~~

~~(1)~~ ~~‘Genetic characteristic’ means any scientifically or medically identifiable gene or chromosome, or alteration thereof, which is known to be a cause of disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder and which is asymptomatic of any disease or disorder.~~

~~(2)~~ ~~‘Genetic information’ means information about genes, gene products, or genetic characteristics derived from an individual or a family member of the individual. ‘Gene product’ is a scientific term that means messenger RNA and translated protein. For purposes of this chapter, genetic information shall not include routine physical measurements; chemical, blood, and urine analysis, unless conducted purposely to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of the human immunodeficiency virus.~~

~~(3)~~ ~~‘Genetic test’ means a laboratory test or other scientifically or medically accepted procedure for determining the presence or absence of genetic characteristics in an individual.~~

~~Section 38‑93‑20.~~ ~~(A)~~ ~~No person when issuing, renewing, or reissuing a policy, contract, or plan of accident and health insurance providing hospital, medical and surgical, or major medical coverage on an expense incurred basis, providing a corporate health services plan, or providing a health care plan for health care services by a health maintenance organization, on the basis of any genetic information obtained concerning an individual or on the individual’s request for genetic services, with respect to such policy, contract, or plan shall:~~

~~(1)~~ ~~terminate, restrict, limit, or otherwise apply conditions to coverage of an individual or restrict the sale to an individual;~~

~~(2)~~ ~~cancel or refuse to renew the coverage of an individual;~~

~~(3)~~ ~~exclude an individual from coverage;~~

~~(4)~~ ~~impose a waiting period prior to commencement of coverage of an individual;~~

~~(5)~~ ~~require inclusion of a rider that excludes coverage for certain benefits and services; or~~

~~(6)~~ ~~establish differential in premium rates for coverage.~~

~~(B)~~ ~~In addition, no discrimination must be made in the fees or commissions of an agent or agency for an enrollment, a subscription, or the renewal of an enrollment or subscription of a person on the basis of a person’s genetic characteristics which under some circumstances may be associated with disability in that person or that person’s offspring.~~

~~(C)~~ ~~Accident and health insurance as used in this chapter does not include accident‑only, blanket accident and sickness, specified disease, credit, dental, vision, Medicare supplement, long‑term care, or disability‑income insurance; coverage issued as a supplement to liability or other insurance; coverage designed solely to provide payments on a per diem, fixed indemnity or nonexpense incurred basis, coverage for Medicare or Medicaid services pursuant to a contract with state or federal government, workers’ compensation or similar insurance; or automobile medical payment insurance.~~

~~Section 38‑93‑30.~~  ~~All genetic information obtained before or after the effective date of this chapter must be confidential and must not be disclosed to a third party in a manner that allows identification of the individual tested without first obtaining the written informed consent of that individual or a person legally authorized to consent on behalf of the individual, except that genetic information may be disclosed without consent:~~

~~(1)~~ ~~as necessary for the purpose of a criminal or death investigation, a criminal or judicial proceeding, an inquest, or a child fatality review, or for purposes of the State DNA Database established by Section 23‑3‑610;~~

~~(2)~~ ~~to determine the paternity of a person pursuant to Section 63‑17‑30;~~

~~(3)~~ ~~pursuant to an order of a court of competent jurisdiction specifically ordering disclosure of the genetic information;~~

~~(4)~~ ~~where genetic information concerning a deceased individual will assist in medical diagnosis of blood relatives of the decedent;~~

~~(5)~~ ~~to a law enforcement or other authorized agency for the purpose of identifying a person or a dead body; or~~

~~(6)~~ ~~as specifically authorized or required by a state or federal statute.~~

~~A provider of accident and health insurance may not require a person to consent to the disclosure of genetic information to the insurer as a condition for obtaining accident and health insurance.~~

~~Section 38‑93‑40.~~ ~~It is unlawful to perform a genetic test on tissue, blood, urine, or other biological sample taken from an individual without first obtaining specific informed consent to the test from the individual, or a person legally authorized to consent on behalf of the individual, unless the test is performed:~~

~~(1)~~ ~~by or for a law enforcement agency in a criminal investigation or for the State DNA Database as provided in Sections 23‑3‑620 through 23‑3‑640;~~

~~(2)~~ ~~for purposes of identifying a person or a dead body;~~

~~(3)~~ ~~to establish paternity as provided by Section 63‑17‑30;~~

~~(4)~~ ~~for use in a study in which the identities of the persons from whom the genetic information is obtained are not disclosed to the person conducting the study; or~~

~~(5)~~ ~~pursuant to a statute or court order specifically requiring that the test be performed.~~

~~Section 38‑93‑50.~~  ~~Agents and insurance support organizations are subject to the provisions of this chapter to the extent of their participation in the issue, reissue, or renewal of a policy, contract, or plan of accident and health insurance.~~

~~Section 38‑93‑60.~~  ~~(A)~~ ~~Any violation of this chapter is an unfair trade practice as defined in Section 39‑5‑20 and is subject to the provisions of Sections 39‑5‑110 to 39‑5‑160.~~

~~(B)~~ ~~Any individual who is injured by a person’s violation of this chapter may recover in a court of competent jurisdiction the following remedies:~~

~~(1)~~ ~~equitable relief, which may include a retroactive order, directing the person to provide health insurance appropriate to the injured individual under the same terms and conditions as would have applied had the violation not occurred; and~~

~~(2)~~ ~~an amount equal to any actual damages suffered by the individual as a result of the violation.~~

~~(C)~~ ~~The prevailing party in an action under this section may recover costs and reasonable attorney’s fees.~~

Section 38‑93‑10. As used in this chapter:

(1) ‘Family member’ means, with respect to an individual:

(a) a dependent of the individual; and

(b) any other individual who is a first‑degree, second‑degree, third‑degree, or fourth‑degree relative of the individual or his dependent.

(2)(a) ‘Genetic information’ means, with respect to an individual, the:

(i) individual’s genetic tests;

(ii) genetic tests of the individual’s family members; and

(iii) manifestation of a disease or disorder in family members of the individual.

(b) The term includes, with respect to an individual, a request for, or receipt of, genetic services or participation in clinical research which includes genetic services by the individual or a family member of the individual.

(c) A reference to genetic information concerning an individual or family member of an individual includes:

(i) with respect to an individual or family member of an individual who is a pregnant woman, genetic information on any fetus carried by the pregnant woman; or

(ii) with respect to an individual or family member of an individual utilizing an assisted reproductive technology, genetic information of an embryo legally held by the individual or family member.

(d) The term does not include information about the sex or age of an individual.

(3) ‘Genetic services’ means:

(a) a genetic test;

(b) genetic counseling, including obtaining, interpreting, or assessing genetic information; or

(c) genetic education.

(4)(a) ‘Genetic test’ means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations or chromosomal changes.

(b) The term does not include:

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that reasonably could be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(5) ‘Health insurance coverage’ or ‘coverage’ means as defined in Sections 38‑71‑670(6) and 38‑71‑840(14).

(6) ‘Health insurance issuer’ or ‘issuer’ means an entity that provides health insurance coverage in this State as defined in Sections 38‑71‑670(7) and 38‑71‑840(16).

(7) ‘Individual’ means an insured, individual enrollee, covered dependent, participant, covered person, beneficiary, eligible employee, dependent of an eligible employee, or applicant for coverage.

(8) ‘Secretary’ means the Secretary of the United States Department of Health and Human Services.

(9) ‘Underwriting purposes’ means:

(a) rules for, or determination of, eligibility including enrollment and continued eligibility for benefits under the policy or coverage;

(b) the computation of premium or contribution amounts under the policy or coverage;

(c) the application of any pre‑existing condition exclusion under the policy or coverage; and

(d) other activities related to the creation, renewal, or replacement of a policy or contract of health insurance coverage.

Section 38‑93‑20. This chapter applies to health insurance coverage offered in connection with an individual health plan, a group health plan, or a health benefit plan that is delivered, issued for delivery, or renewed in this State. Producers, agencies, and insurance support organizations are subject to the provisions of this chapter to the extent of their participation in the issue, reissue, or renewal of a policy or contract of health insurance coverage.

Section 38‑93‑30. (A) A health insurance issuer when issuing, renewing, or reissuing a policy or contract of health insurance coverage, on the basis of any genetic information obtained concerning an individual or a family member of the individual or on the individual’s request for genetic services, with respect to the policy or contract, may not:

(1) terminate, restrict, limit, or otherwise apply conditions to coverage of an individual or restrict the sale to an individual;

(2) cancel or refuse to renew the coverage of an individual;

(3) exclude an individual from coverage or establish rules for eligibility, including continued eligibility, of an individual to enroll for coverage;

(4) impose a waiting period before commencement of coverage of an individual;

(5) impose a pre‑existing condition exclusion;

(6) require inclusion of a rider that excludes coverage for certain benefits or services; or

(7) adjust premium or contribution amounts or establish a differential in premium rates for coverage.

(B)(1) In the case of group health insurance coverage, a health insurance issuer is prohibited from adjusting premium or contribution amounts for the group covered under a policy or contract of group health insurance coverage on the basis of genetic information.

(2) Nothing in item (1) may be construed to limit the ability of an issuer offering group health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder in an individual who is enrolled in the policy or contract of coverage. In this case, the manifestation of a disease or disorder in one individual may not be used as genetic information about other group members and to further increase the premium for the employer.

(C) In addition, discrimination must not be made in the fees or commissions of a producer or agency for an enrollment, application, or the renewal of coverage of an individual or group on the basis of an individual’s genetic information.

Section 38‑93‑40. (A) All genetic information obtained before or after the effective date of this chapter must be confidential and must not be disclosed to a third party in a manner that allows identification of the individual tested without first obtaining the written informed consent of that individual or a person legally authorized to consent on behalf of the individual, except that genetic information may be disclosed without consent:

(1) as necessary for the purpose of a criminal or death investigation, a criminal or judicial proceeding, an inquest, or a child fatality review, or for purposes of the State DNA Database established by Section 23‑3‑610;

(2) to determine the paternity of a person pursuant to Section 63‑17‑30;

(3) pursuant to an order of a court of competent jurisdiction specifically ordering disclosure of the genetic information;

(4) where genetic information concerning a deceased individual will assist in medical diagnosis of blood relatives of the decedent;

(5) to a law enforcement or other authorized agency for the purpose of identifying a person or a dead body; or

(6) as specifically authorized or required by a state or federal statute.

(B) A health insurance issuer may not require an individual to consent to the disclosure of genetic information to the issuer as a condition for obtaining health insurance coverage.

Section 38‑93‑50. It is unlawful to perform a genetic test on an individual without first obtaining specific informed consent to the test from the individual, or a person legally authorized to consent on behalf of the individual, unless the test is performed:

(1) by or for a law enforcement agency in a criminal investigation or for the State DNA Database as provided in Sections 23‑3‑620 through 23‑3‑640;

(2) for purposes of identifying a person or a dead body;

(3) to establish paternity as provided by Section 63‑17‑30;

(4) pursuant to a statute or court order specifically requiring that the test be performed.

Section 38‑93‑60. (A) A health insurance issuer may not request or require an individual or a family member of an individual to undergo a genetic test. However, nothing in this subsection may be construed so as to limit the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test.

(B) Notwithstanding subsection (A), a health insurance issuer may request, but not require, that an individual or a family member of the individual undergo a genetic test if each of the following conditions is met:

(1) the request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations and any applicable state law or regulations for the protection of human subjects in research;

(2) the issuer clearly indicates to each individual, or a person legally authorized to consent on behalf of the individual, to whom the request is made that:

(i) compliance with the request is voluntary; and

(ii) noncompliance will have no effect on enrollment or coverage status or premium or contribution amounts;

(3) no genetic information collected or acquired under this chapter may be used for underwriting purposes;

(4) the issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided in this subsection, including a description of the activities conducted; and

(5) the issuer complies with other conditions as the Secretary may require by regulation for activities conducted under this subsection.

Section 38‑93‑70. (A)(1) A health insurance issuer may not request, require, or purchase genetic information for underwriting purposes.

(2) An issuer may not request, require, or purchase genetic information with respect to an individual before the individual’s enrollment under the policy or contract of health insurance coverage.

(B) If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning an individual, the request, requirement, or purchase may not be considered a violation of item (2) of subsection (A) if the request, requirement, or purchase is not a violation of item (1) of subsection (A).

Section 38‑93‑80. Nothing in this chapter may be construed so as to preclude a health insurance issuer from:

(1) establishing rules for eligibility for an individual to purchase or enroll for individual coverage based on the manifestation of a disease or disorder in that individual or in a family member of the individual where the family member is covered under the policy or contract of individual health insurance coverage that covers the individual;

(2) adjusting premium or contribution amounts for an individual on the basis of a manifestation of a disease or disorder in that individual or in a family member of the individual where the family member is covered under the policy or contract of health insurance coverage that covers the individual. In this case, the manifestation of a disease or disorder in one individual must not be used as genetic information about other individuals covered under the policy or contract of health insurance coverage issued to the individual and to further increase premiums or contribution amounts;

(3) imposing a pre‑existing condition exclusion as otherwise permitted by law for an individual with respect to coverage under the policy or contract of health insurance coverage on the basis of a manifestation of a disease or disorder in that individual; or

(4) obtaining and using the results of a genetic test in making a determination regarding payment (as that term is defined for purposes of applying the regulations promulgated by the Secretary under Part C of Title XI of the Social Security Act and Section 264 of HIPAA, as may be revised) consistent with the provisions of this chapter. However, the issuer may request only the minimum amount of information necessary to make a determination.

Section 38‑93‑90. (A) A violation of this chapter, including a single instance of a prohibited practice, is an unfair trade practice pursuant to Chapter 57, Title 38 and is subject to the penalties as provided for in Chapter 57 and in Section 38‑2‑10. The director or his designee at any time may examine an issuer, producer, agency, or insurance support organization to enforce this chapter. The expense of examination must be paid by the issuer, producer, agency, or insurance support organization. If an issuer, producer, agency, or insurance support organization determines that the fees assessed are unreasonable in relation to the examination performed, the issuer, producer, agency, or insurance support organization may appeal the assessments to the Administrative Law Court. Examination fees must be retained by the department and are considered ‘other’ funds.

(B) In addition, a violation of this chapter is an unfair trade practice as defined in Section 39‑5‑20 and is subject to the provisions of Sections 39‑5‑110 to 39‑5‑160.

(C) The penalties and enforcement provisions of subsections (A) and (B) are in addition to penalties and enforcement provisions of federal law, including those set forth in the Genetic Information Nondiscrimination Act of 2008, Public Law 110‑233.

(D) An individual who is injured by a person’s violation of this chapter may recover in a court of competent jurisdiction the following remedies:

(1) equitable relief, which may include a retroactive order, directing the person to provide health insurance appropriate to the injured individual under the same terms and conditions as would have applied had the violation not occurred; and

(2) an amount equal to any actual damages suffered by the individual as a result of the violation.

(E) The prevailing party in an action under this section may recover costs and reasonable attorney’s fees.”

SECTION 15. The Department of Insurance may promulgate regulations necessary for implementation of this act.

SECTION 16. If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

SECTION 17. This act takes effect upon approval by the Governor.

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