GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 254*

Short Title: Genetic Info/No Discrimination. (Public)

Sponsors: Senators Odom; Ballance, Carpenter, Conder, Dalton, Dannelly, Forrester, Garwood, Hoyle, Jordan, Kerr, Kinnaird, Martin of Pitt, Shaw of Cumberland, Shaw of Guilford, Soles, Warren, Webster, Wellons, and Winner.

Referred to: Pensions & Retirement and Insurance.

February 27, 1997

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT DISCRIMINATION IN HEALTH INSURANCE AND EMPLOYMENT BASED ON GENETIC INFORMATION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-130(a)(1) reads as rewritten:

"(1) Except in the case of a late enrollee, any preexisting-conditions provision may not limit or exclude coverage for a period beyond 12 months following the insured's initial effective date of coverage and must define preexisting conditions as 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage'. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information. As used in this section, the term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 2. G.S. 58-51-15(a)(2) reads as rewritten:

"(2) A provision in the substance of the following language:

TIME LIMIT ON CERTAIN DEFENSES:

a. After two years from the date of issue or reinstatement of this policy no misstatements except fraudulent misstatements made by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provisions may be used in its entirety only in major or catastrophe hospitalization policies and major medical policies each affording benefits of five thousand dollars ($5,000) or more for any one sickness or injury. Disability income policies affording benefits of one hundred dollars ($100.00) or more per month for not less than 12 months and franchise policies. Other policies to which this section applies must delete the words 'except fraudulent misstatements.'

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(b), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

1. Until at least age 50 or,
2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption 'INCONTESTABLE.'

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than one year after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended or that could be medically documented within the one-year period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period

requirements under any previous plan. Credit must be given for that portion of the waiting period that was met under the previous plan. As used in this policy, the term 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an insured person, all health benefit plans must credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information. As used in this section, the term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 3. G.S. 58-51-80(b)(2) reads as rewritten:

"(2) ~~For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50"must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~ An accident and health insurance company shall not establish rules for eligibility (including continued eligibility) for any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status,
b. Medical conditions (including both physical and mental illnesses),
c. Claims experience,
d. Receipt of health care,
e. Medical history,
f. Genetic information,
g. Evidence of insurability (including conditions arising out of acts of domestic violence), and
h. Disability.

An accident and health insurance company shall not require an individual to pay a premium or contribution which is greater than that charged to a similarly situated individual on the basis of any health status-related factor. An accident and health

insurance company shall not raise the premium or contribution rates paid by the group on the basis of genetic information obtained about an individual member of the group."

Section 4. G.S. 58-51-80(b)(3) reads as rewritten:

"(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more persons and for groups under subdivision (1a) of this subsection and under G.S. 58-51-81: In determining whether a preexisting condition provision applies to an eligible employee, association member, student, or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information. As used in this section, the term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 5. G.S. 58-65-60(e)(1) reads as rewritten:

"(1) ~~For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for coverage or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50"must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~ A hospital or medical service corporation shall not establish rules for eligibility (including continued eligibility) for any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status,

b. Medical conditions (including both physical and mental illnesses),
c. Claims experience,
d. Receipt of health care,
e. Medical history,
f. Genetic information,
g. Evidence of insurability (including conditions arising out of acts of domestic violence), and
h. Disability.

A hospital or medical service corporation shall not require an individual to pay a premium or contribution which is greater than that charged to a similarly situated individual on the basis of any health status-related factor. A hospital or medical service corporation shall not raise the premium or contribution rates paid by the group on the basis of genetic information obtained about an individual member of the group."

Section 6. G.S. 58-65-60(e)(2) reads as rewritten:

"(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any prior group plan. Credit must be given for that portion of the waiting period which was met under the prior plan. For employer groups of 50 or more persons: In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous group health benefit plan if the previous coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information. As used in this section, the term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 7. G.S. 58-67-85(b) reads as rewritten:

"(b) ~~For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed~~

~~groups the phrase "groups of 50"must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~ An HMO shall not establish rules for eligibility (including continued eligibility) for any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status,
(2) Medical conditions (including both physical and mental illnesses),
(3) Claims experience,
(4) Receipt of health care,
(5) Medical history,
(6) Genetic information,
(7) Evidence of insurability (including conditions arising out of acts of domestic violence), and
(8) Disability.

An HMO shall not require an individual to pay a premium or contribution which is greater than that charged to a similarly situated individual on the basis of any health status-related factor. An HMO shall not raise the premium or contribution rates paid by the group on the basis of genetic information obtained about an individual member of the group."

Section 8. G.S. 58-67-85(c) reads as rewritten:

"(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subsection, a 'previous plan' includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an eligible employee or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information. As used in this section, the term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 9. Article 51 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-51-45A. Denial of coverage based on genetic information prohibited.**

No entity licensed in this State pursuant to the provisions of Articles 1 through 67 of this Chapter shall refuse to issue or deliver any policy (regardless of whether any of such policies shall be defined as individual, family, group, blanket, franchise, industrial, or otherwise) which is currently being issued for delivery in this State and which affords benefits or coverage for any medical treatment or service authorized or permitted to be furnished by a hospital, clinic, family health plan, neighborhood health plan, health maintenance organization, physician, physician's assistant, nurse practitioner, or any medical service facility or personnel based on genetic information obtained about the person to be insured, nor shall any such policy issued and delivered in this State carry a higher premium rate or charge by reason of the genetic information. The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 10. Article 3 of Chapter 95 of the General Statutes is amended by adding the following new section to read:

"**§ 95-28.2A. Discrimination against persons based on genetic testing or genetic information prohibited.**

(a) No person, firm, corporation, unincorporated association, State agency, unit of local government, or any public or private entity shall deny or refuse employment to any person or discharge any person from employment on account of the person's having requested genetic testing or counseling services, or on the basis of genetic information obtained concerning the person or a member of the person's family. This section shall not be construed to prevent the person from being discharged for cause.

(b) As used in this section, the term 'genetic test' means a test for determining the presence or absence of genetic characteristics in an individual or a member of the individual's family in order to diagnose a genetic condition or characteristic or ascertain susceptibility to a genetic condition. The term 'genetic characteristic' means any scientifically or medically identifiable genes or chromosomes, or alterations or products thereof, which are known individually or in combination with other characteristics to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder, and which are asymptomatic of any disease or disorder. The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member."

Section 11. Nothing in this act applies to specified accident, specified disease, hospital indemnity, disability, or long-term care health insurance policies.

Section 12. This act becomes effective July 1, 1997.