WAC 284-66-071 Prohibition against use of genetic information and requests for genetic testing. Effective May 21, 2009, except as provided in subsection (3) of this section:

(1) An issuer of a medicare supplement insurance policy or certificate must not deny or condition the issuance of effectiveness of the policy or certificate and must not discriminate in the pricing of the policy or certificate of an individual on the basis of the genetic information with respect to any individual. This includes the imposition of any exclusion of benefits under the policy based on a preexisting condition or adjustment of premium rates based on genetic information. This subsection shall not be construed to limit the ability of an issuer, to the extent otherwise permitted by law from:

(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium based on the manifestation of a disease or disorder of the insured or applicant; or

(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. The manifestation of a disease or disorder in one individual must not be used as genetic information about other group members or to increase the premium for the group.

(2) An issuer of a medicare supplement insurance policy or certificate must not request or require an individual or a family member of the individual to undergo a genetic test. This subsection shall not be construed to preclude an issuer from obtaining and using the results of a genetic test in making a determination regarding payment consistent with subsection (1) of this section. For purposes of this section, "payment" has the meaning set forth in 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. An issuer may request only the minimum information necessary to accomplish the intended purpose.

(3) An issuer may request, but must not require, that an individual or a family member of the individual undergo a genetic test only if all of the following conditions are met:

(a) The request is made for research that complies with Part 46 of Title 45, Code of Federal Regulations, or its equivalent, or any other applicable state or local law or rule for the protection of human subjects in research;

(b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(i) Compliance with the request is voluntary; and

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

(c) Genetic information collected or acquired under this subsection must not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

(d) The issuer notifies the secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted;

(e) The issuer complies with all other conditions required by regulation by the secretary of the United States Department of Health and Human Services for activities conducted under this subsection;

(4) An issuer must not request, require, or purchase genetic information for underwriting purposes;

(5) An issuer shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment; and

(6) If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase will not be considered a violation of subsection (5) of this section only if the request, requirement, or purchase is not in violation of subsection (4) of this section.

(7) For purposes of this section:

(a) "Issuer" has the meaning set forth in WAC 284-66-030(4) and includes any third-party administrator or other person acting for or on behalf of the issuer.

(b) "Family member" means any individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(c) "Genetic information" means 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. The term includes any requests for or receipt of genetic services or participation in clinical research which includes genetic services by the individual or a family member. Any reference to genetic information concerning an individual or family member who is a pregnant woman includes genetic information of any fetus carried by the 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. Genetic information does not include information about the gender or age of any individual.

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

(e) "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.

(f) "Underwriting purposes" means:

(i) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(ii) The computation of premium or contribution amounts under the policy;

(iii) The application of any preexisting condition exclusion under the policy; and

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

[Statutory Authority: RCW 48.02.060, 48.66.041, and 48.66.165. WSR 19-17-074 (Matter R 2019-01), § 284-66-071, filed 8/20/19, effective 9/20/19.]