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the individual market if there is a state law regulating the coverage that meets any of the following criteria:

(i) The state law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) The state law requires the coverage to provide for maternity and pediatric care in accordance with guidelines that relate to care following childbirth established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The state law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) Relation to section 2762(a) of the PHS Act. The preemption provisions contained in section 2762(a) of the PHS Act and §148.210(b) do not supersede a state law described in paragraph (e)(1) of this section.

(a) Definitions. For purposes of this section, the following definitions as set forth in §146.122 of this subchapter pertain to health insurance issuers in the individual market to the extent that those definitions are not inconsistent with respect to health insurance coverage offered, sold, issued, renewed, in effect or operated in the individual market:

Collect has the meaning set forth at §146.122(a).

Family member has the meaning set forth at §146.122(a).

Genetic information has the meaning set forth at §146.122(a).

Genetic services has the meaning set forth at §146.122(a).

Generictest has the meaning set forth at §146.122(a).

Preexisting condition exclusion has the meaning set forth at §144.103.

Underwriting purposes has the meaning set forth at §148.180(f)(1).

(b) Prohibition on genetic information as a condition of eligibility.

(1) In general. An issuer offering health insurance coverage in the individual market may not establish rules for the eligibility (including continued eligibility) of any individual to enroll in individual health insurance coverage based on genetic information.

(2) Rule of construction. Nothing in paragraph (b)(1) of this section precludes an issuer from establishing rules for eligibility for an individual to enroll in individual health insurance coverage based on the manifestation of a disease or disorder in that individual, or in a family member of that individual when the family member is covered under the policy that covers the individual.

(3) Examples. The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) Facts. A State implements the HIPAA guaranteed availability requirement in the individual health insurance market in accordance with §148.120. Individual A and his spouse S are not "eligible individuals" as that term is defined at §148.103 and, therefore, they are not entitled to obtain individual health insurance coverage on a guaranteed available basis. They apply for individual coverage with Issuer M. As part of the application for coverage, M receives health information about A and S. Although A has no known medical conditions, S has high blood pressure. M declines to offer coverage to S.

(ii) Conclusion. In this Example 1, M permissible may decline to offer coverage to S because S has a manifested disorder (high blood pressure) that makes her ineligible for coverage under the policy’s rules for eligibility.

Example 2. (i) Facts. Same facts as Example 1, except that S does not have high blood pressure.

(ii) Conclusion. In this Example 2, M may not decline to offer coverage to S because S is not otherwise ineligible for coverage under the policy’s rules for eligibility.
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An issuer offering health insurance coverage in the individual market must not adjust premium amounts for an individual on the basis of genetic information regarding the individual or a family member of the individual.

(a) Rule of construction. (1) Nothing in paragraph (c)(1) of this section precludes an issuer from adjusting premium amounts for an individual on the basis of a manifestation of a disease or disorder in that individual, or on the basis of a manifestation of a disease or disorder in a family member of that individual when the family member is covered under the policy that covers the individual.

(ii) The manifestation of a disease or disorder in one individual cannot also be used as genetic information about other individuals covered under the policy issued to that individual and to further increase premium amounts.

(b) Prohibition on genetic information in setting premium rates.

(i) In general. An issuer offering health insurance coverage in the individual market may not, on the basis of genetic information regarding the individual or a family member of the individual.

(ii) Rule of construction. Nothing in paragraph (c)(1) of this section precludes an issuer from imposing any preexisting condition exclusion for an individual with respect to health insurance coverage on the basis of a manifestation of a disease or disorder in that individual.

(c) Prohibition on genetic information as preexisting condition.

(i) In general. An issuer offering health insurance coverage in the individual market may not, on the basis of genetic information, impose any preexisting condition exclusion with respect to that coverage.

(ii) Rule of construction. Nothing in paragraph (d)(1) of this section precludes an issuer from imposing any preexisting condition exclusion for an individual with respect to health insurance coverage on the basis of a manifestation of a disease or disorder in that individual.

(d) Prohibition on genetic information as preexisting condition.

(i) In general. An issuer offering health insurance coverage in the individual market may not, on the basis of genetic information, impose any preexisting condition exclusion with respect to that coverage.

(ii) Rule of construction. Nothing in paragraph (d)(1) of this section precludes an issuer from imposing any preexisting condition exclusion for an individual with respect to health insurance coverage on the basis of a manifestation of a disease or disorder in that individual.

Example 1. (i) Facts. Individual B is covered under an individual health insurance policy through Issuer N. Every other policy year, before renewal, N requires policyholders to submit updated health information before the policy renewal date for purposes of determining an appropriate premium, in excess of any increases due to inflation, based on the policyholders' health status. B complies with that requirement. During the past year, B's blood glucose levels have increased significantly. N increases B's premium for renewing B's policy to account for N's increased risk associated with B's elevated blood glucose levels.

(ii) Conclusion. In this Example 1, N is permitted to increase the premium for B's policy on the basis of a manifested disorder (elevated blood glucose) in B.

Example 2. (i) Facts. Same facts as Example 1, except that B's blood glucose levels have increased and are well within the normal range. In providing updated health information to N, B indicates that both his mother and sister are being treated for adult onset diabetes mellitus (Type 2 diabetes). B provides this information voluntarily and not in response to a specific request for family medical history or other genetic information. N increases B's premium to account for B's genetic predisposition to develop Type 2 diabetes in the future.

(ii) Conclusion. In this Example 2, N cannot increase B's premium on the basis of B's family medical history of Type 2 diabetes, which is genetic information with respect to B. Since there is no manifestation of the disease in B at this point in time, N cannot increase B's premium.

Example 3. The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) Facts. Individual C has encountered delays in receiving payment from the issuer of his individual health insurance policy for covered services. He decides to switch carriers and applies for an individual health insurance policy through Issuer O. O is generally in good health, but has arthritis for which he has received medical treatment. O offers C an individual policy that excludes coverage for a 12-month period for any services related to C's arthritis.

(ii) Conclusion. In this Example 1, O is permitted to impose a preexisting condition exclusion with respect to C because C has a manifested disease (arthritis).

Example 2. (i) Facts. Individual D applies for individual health insurance coverage through Issuer P. D has no known medical conditions. However, in response to P's request for medical information about D, P receives information from D's physician that indicates that both of D's parents have adult
onset diabetes mellitus (Type 2 diabetes). 

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medical history of Type 2 diabetes).

E. Huntington’s Disease. The physician advises that

ical history, and

tion. The physician reviews

physician for a routine physical examina-

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tion, based on the fact that both of D’s parents have the
disease.

(ii) Conclusion. In this Example 2, the rider
violates this paragraph (d) because the pre-
existing condition exclusion is based on ge-
netic information with respect to D (family
medical history of Type 2 diabetes).

(e) Limitation on requesting or requir-
ging genetic testing.

(1) General rule. Except as otherwise
provided in this paragraph (e), an
issuer offering health insurance cov-
verage in the individual market must
not request or require an individual or
a family member of the individual to
undergo a genetic test.

(ii) Conclusion. In this Example 2, the
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've provided health care services to

E.

Therefore, the physician’s
test does not violate this paragraph (e).

(ii) Conclusion. In this Example 2,
Even though the physician is employed by the
HMO, the physician is nonetheless a health care professional who is providing health care services to F.

There number of paragraphs and sections in the text, as well as the complexity of the language used, indicates that the content is detailed and informative, likely focusing on the legal and medical aspects of genetic testing and health care. The text appears to be discussing the conditions under which an individual or family member of an individual may be required to undergo a genetic test, and the implications of such a request on insurance coverage and payment. The regulations and privacy considerations are also highlighted, with references to other sections of the Health Insurance Portability and Accountability Act (HIPAA) and the rules of paragraphs (e)(4) of this section. The text also provides examples to illustrate the application of these rules, including specific scenarios involving a child with leukemia and a family member with Huntington’s Disease.
regulations for the protection of human subjects in research.

(ii) Written request for participation in research. The issuer makes the request in writing, and the request clearly indicates to each individual (or, in the case of a minor child, to the child’s legal guardian) that—

(A) Compliance with the request is voluntary; and

(B) Noncompliance will have no effect on eligibility for benefits (as described in paragraph (b) of this section) or premium amounts (as described in paragraph (c) of this section).

(iii) Prohibition on underwriting. No genetic information collected or acquired under this paragraph (e)(5) can be used for underwriting purposes (as described in paragraph (f)(1) of this section).

(iv) Notice to Federal agencies. The issuer completes a copy of the “Notice of Research Exception under the Genetic Information Nondiscrimination Act” authorized by the Secretary and provides the notice to the address specified in the instructions thereto.

(f) Prohibitions on collection of genetic information.

(1) For underwriting purposes.

(i) General rule. An issuer offering health insurance coverage in the individual market must not collect (as defined in paragraph (a) of this section) genetic information for underwriting purposes. See paragraph (g) of this section for examples illustrating the rules of this paragraph (f)(1), as well as other provisions of this section.

(ii) Underwriting purposes defined. Subject to paragraph (f)(1)(iii) of this section, underwriting purposes means, with respect to any issuer offering health insurance coverage in the individual market—

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

(B) The computation of premium amounts under the coverage;

(C) The application of any pre-existing condition exclusion under the coverage; and

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

(iii) Medical appropriateness. An issuer in the individual market may limit or exclude a benefit based on whether the benefit is medically appropriate, and the determination of whether the benefit is medically appropriate is not within the meaning of underwriting purposes. Accordingly, if an issuer conditions a benefit based on its medical appropriateness and the medical appropriateness of the benefit depends on a covered individual’s genetic information, the issuer is permitted to condition the benefit on the genetic information. An issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness, and may deny the benefit if the covered individual does not provide the genetic information required to determine medical appropriateness. See paragraph (g) of this section for examples illustrating the applicability of this paragraph (f)(1)(iii), as well as other provisions of this section.

(2) Prior to or in connection with enrollment.

(i) In general. An issuer offering health insurance coverage in the individual market must not collect genetic information with respect to any individual prior to that individual’s enrollment under the coverage or in connection with that individual’s enrollment. Whether or not an individual’s information is collected prior to that individual’s enrollment is determined at the time of collection.

(ii) Incidental collection exception.

(A) In general. If an issuer offering health insurance coverage in the individual market obtains genetic information incidental to the collection of other information concerning any individual, the collection is not a violation of this paragraph (f)(2), as long as the collection is not for underwriting purposes in violation of paragraph (f)(1) of this section.

(B) Limitation. The incidental collection exception of this paragraph (f)(2)(ii) does not apply in connection with any collection where it is reasonable to anticipate that health information will be received, unless the collection explicitly provides that genetic information should not be provided.
(iii) Examples. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) Facts. Individual G applies for a health insurance policy through Issuer Q. Q’s application materials ask for the applicant’s medical history, but not for family medical history. The application’s instructions state that no genetic information, including family medical history, should be provided. G answers the questions in the application completely and truthfully, but volunteers certain health information about diseases his parents had, believing that Q also needs this information.

(ii) Conclusion. In this Example 1, G’s family medical history is genetic information with respect to G. However, since Q did not request this genetic information, and Q’s instructions stated that no genetic information should be provided, Q’s collection is an incidental collection under paragraph (e)(2)(ii). However, Q may not use the genetic information it obtained incidentally for underwriting purposes.

Example 2. (i) Facts. Individual H applies for a health insurance policy through Issuer R. R’s application materials request that an applicant provide information on his or her individual medical history, including the names and contact information of physicians from whom the applicant sought treatment. The application includes a release which authorizes the physicians to furnish information to R. R forwards a request for health information about H, including the signed release, to his primary care physician. Although the request for information does not ask for genetic information, including family medical history, it does not state that no genetic information should be provided. The physician’s office administrator includes part of H’s family medical history in the package to R.

(ii) Conclusion. In this Example 2, R’s request was for health information solely about its applicant, H, which is not genetic information with respect to H. However, R’s materials did not state that genetic information should not be provided. Therefore, R’s collection of H’s family medical history (which is genetic information with respect to H) violates the rule against collection of genetic information and does not qualify for the incidental collection exception under paragraph (e)(2)(ii).

Example 3. (i) Facts. Issuer S acquires Issuer T. S requests T’s records, stating that S should not provide genetic information and should review the records to excise any genetic information. T assembles the data requested by S and, although T reviews it to delete genetic information, the data from a specific region included some individuals’ family medical history. Consequently, S receives genetic information about some of T’s covered individuals.

(ii) Conclusion. In this Example 3, S’s request for health information explicitly stated that genetic information should not be provided. Therefore, its collection of genetic information was within the incidental collection exception. However, S may not use the genetic information it obtained incidentally for underwriting purposes.

(g) Examples regarding determinations of medical appropriateness. The application of the rules of paragraphs (e) and (f) of this section to issuer determinations of medical appropriateness is illustrated by the following examples:

Example 1. (i) Facts. Individual J has an individual health insurance policy through Issuer U that covers genetic testing for celiac disease for individuals who have family members with this condition. J’s policy includes dependent coverage. After J’s son is diagnosed with celiac disease, J undergoes a genetic test and promptly submits a claim, before the claim is paid.

(ii) Conclusion. In this Example 1, under the rules of paragraph (e)(4) of this section, U is permitted to request only the minimum amount of information necessary to make a decision regarding payment. Because the results of the test are not necessary for U to make a decision regarding the payment of J’s claim, U’s request for the results of the genetic test before the claim is paid.

Example 2. (i) Facts. Individual J has an individual health insurance policy through Issuer V that covers a yearly mammogram for participants starting at age 40, or at age 30 for those with increased risk for breast cancer, including individuals with BRCA1 or BRCA2 gene mutations. J is 33 years old and has the BRCA2 mutation. J undergoes a mammogram and promptly submits a claim to V for reimbursement. V asks J for evidence of increased risk of breast cancer, such as the results of a genetic test, before the claim for the mammogram is paid.

(ii) Conclusion. In this Example 2, V does not violate paragraphs (e) or (f) of this section. Under paragraph (e), an issuer is permitted to request and use the results of a genetic test to make a determination regarding payment, provided the issuer requests only the minimum amount of information necessary. Because the medical appropriateness of the mammogram depends on the covered individual’s genetic makeup, the minimum amount of information necessary includes the results of the genetic test. Similarly, V does not violate paragraph (f) of this
§ 148.210 Preemption; Excepted Benefits

(a) Scope. (1) This section describes the effect of sections 2741 through 2763 and 2791 of the PHS Act on a State’s authority to regulate health insurance issuers in the individual market. This section makes clear that States remain subject to section 514 of ERISA, which generally preempts State law that relates to ERISA-covered plans.

(2) Sections 2741 through 2763 and 2791 of the PHS Act cannot be construed to affect or modify the provisions of section 514 of ERISA.

(b) Regulation of insurance issuers. The individual market rules of this part do not prevent a State law from establishing, implementing, or continuing in effect standards or requirements unless the standards or requirements prevent the application of a requirement of this part.

§ 148.220 Excepted benefits.

The requirements of this part and part 147 of this subchapter do not apply to any individual coverage in relation to its provision of the benefits described in paragraphs (a) and (b) of this section (or any combination of the benefits).

(a) Benefits excepted in all circumstances. The following benefits are excepted in all circumstances:

(1) Coverage only for accident (including accidental death and dismemberment).

(2) Disability income insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Coverage issued as a supplement to liability insurance.

(5) Workers’ compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Credit-only insurance (for example, mortgage insurance).

(8) Coverage for on-site medical clinics.

(b) Other excepted benefits. The requirements of this part do not apply to individual health insurance coverage described in paragraphs (b)(1) through (b)(6) of this section if the benefits are provided under a separate policy, certificate, or contract of insurance.

(1) Limited scope dental or vision benefits. These benefits are dental or vision benefits that are limited in scope to a narrow range or type of benefits that are generally excluded from benefit packages that combine hospital, medical, and surgical benefits.

(2) Long-term care benefits. These benefits are benefits that are either—

(i) Subject to State long-term care insurance laws;

(ii) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided...