This file contains a version of title XXVII of the Public Health Service Act, as in effect before the enactment of the Patient Protection and Affordable Care Act (Public Law 111-148).

PUBLIC HEALTH SERVICE ACT

[As Amended Through P.L. 111–87, Enacted October 30, 2009]

[References in brackets [] are to title 42, United States Code]

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

PART A—GROUP MARKET REFORMS [1]

Subpart 1—Portability, Access, and Renewability Requirements

SEC. 2701. [300gg] INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD; CREDITING FOR PERIODS OF PREVIOUS COVERAGE.—Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.

(b) DEFINITIONS.—For purposes of this part—

(1) PREEXISTING CONDITION EXCLUSION.—

(A) IN GENERAL.—The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

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[1] Section 102(c) of Public Law 104–191 (110 Stat. 1976) provides in part as follows:

"(c) Effective Date.—

"(1) In general.—Except as provided in this subsection, part A of title XXVII of the Public Health Service Act (as added by subsection (a)) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997.".

Paragraph (2) of such section 102(c) relates to the determination of creditable coverage, including provisions regarding certifications.

(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

(2) ENROLLMENT DATE.—The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) LATE ENROLLEE.—The term "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

(4) WAITING PERIOD.—The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

(1) CREDITABLE COVERAGE DEFINED.—For purposes of this title, the term "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 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 of title 10, 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.

(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)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 2791(c)).

(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an 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 (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-ELIGIBLE INDIVIDUALS.—In the case of plan years beginning before January 1, 2011—

(i) TAA PRE-CERTIFICATION PERIOD RULE.—In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of the Internal Revenue Code of 1986 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) DEFINITIONS.—The terms "TAA-eligible individual" and "TAA-related loss of coverage" have the meanings given such terms in section 2205(b)(4).

(3) METHOD OF CREDITING COVERAGE.—

(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan, or a health insurance issuer offering group health insurance, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) ISSUER NOTICE.—In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer—

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

(d) EXCEPTIONS.—

(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) SPECIAL ENROLLMENT PERIODS.—

(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan, and 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 under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance

coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) FOR DEPENDENT BENEFICIARIES.—

(A) IN GENERAL.—If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a depend-

ent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

(A) IN GENERAL.—A group health plan, and 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 under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) COORDINATION WITH MEDICAID AND CHIP.—

(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each

employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974.

(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) USE OF AFFILIATION PERIOD BY HMOS AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.—

(1) IN GENERAL.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect

to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) AFFILIATION PERIOD.—

(A) DEFINED.—For purposes of this title, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) BEGINNING.—Such period shall begin on the enrollment date.

(C) RUNS CONCURRENTLY WITH WAITING PERIODS.—An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) ALTERNATIVE METHODS.—A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

SEC. 2702. [300gg–1] PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

(a) IN ELIGIBILITY TO ENROLL.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of 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 condition (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).

(H) Disability.

(2) NO APPLICATION TO BENEFITS OR EXCLUSIONS.—To the extent consistent with section 701, paragraph (1) shall not be construed—

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than

those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) CONSTRUCTION.—For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) IN PREMIUM CONTRIBUTIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) NO GROUP-BASED DISCRIMINATION ON BASIS OF GENETIC INFORMATION.—

(A) IN GENERAL.—For purposes of this section, a group health plan, and health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering health insurance coverage in connection with a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) GENETIC TESTING.—

(1) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group

health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) RULE OF CONSTRUCTION REGARDING PAYMENT.—

(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

(B) LIMITATION.—For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) RESEARCH EXCEPTION.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) 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 or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) PROHIBITION ON COLLECTION OF GENETIC INFORMATION.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or pur-

chase genetic information for underwriting purposes (as defined in section 2791).

(2) PROHIBITION ON COLLECTION OF GENETIC INFORMATION PRIOR TO ENROLLMENT.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) INCIDENTAL COLLECTION.—If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) APPLICATION TO ALL PLANS.—The provisions of subsections (a)(1)(F), (b)(3), (c), and (d) and subsection (b)(1) and section 2701 with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 2721(a).

(f) GENETIC INFORMATION OF A FETUS OR EMBRYO.—Any reference in this part to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

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

Subpart 2—Other Requirements [1]

SEC. 2704. [300gg–4] STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.

(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING BIRTH.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or new-

[1] Section 604(a)(3) of Public Law 104–204 (110 Stat. 2939) adds this subpart to part A. Subsection (c) of section 604 provides as follows:

(c) Effective Date.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

born child, following a cesarean section, to less than 96 hours, or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) RULES OF CONSTRUCTION.—

(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

(A) to give birth in a hospital; or

(B) to stay in the hospital for a fixed period of time following the birth of her child.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under

subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.

(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(f) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) CONSTRUCTION.—Section 2723(a)(1) shall not be construed as superseding a State law described in paragraph (1).

SEC. 2705. [300gg–5] PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.[1]

(a) IN GENERAL.—

(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the

[1] Section 703(a) of Public Law 104–204 (110 Stat. 2947) adds this section to subpart 2. Subsection (b) of such section provides as follows:

(b) Effective Date.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

"applicable lifetime limit"), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) ANNUAL LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual

limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.—

(A) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) DEFINITIONS.—In this paragraph:

(i) FINANCIAL REQUIREMENT.—The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) PREDOMINANT.—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) TREATMENT LIMITATION.—The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) OUT-OF-NETWORK PROVIDERS.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(b) CONSTRUCTION.—Nothing in this section shall be construed—

(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) EXEMPTIONS.—

(1) SMALL EMPLOYER EXEMPTION.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer (as defined in section 2791(e)(4), except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) COST EXEMPTION.—

(A) IN GENERAL.—With respect to a group health plan (or health insurance coverage offered in connection with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) NOTIFICATION.—

(i) IN GENERAL.—A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) REQUIREMENT.—A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) CONFIDENTIALITY.—A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) AUDITS BY APPROPRIATE AGENCIES.—To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) DEFINITIONS.—For purposes of this section—

(1) AGGREGATE LIFETIME LIMIT.—The term "aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) ANNUAL LIMIT.—The term "annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) MEDICAL OR SURGICAL BENEFITS.—The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) MENTAL HEALTH BENEFITS.—The term "mental health benefits" means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) SUBSTANCE USE DISORDER BENEFITS.—The term "substance use disorder benefits" means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

SEC. 2706. [300gg–6] REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.[1]

The provisions of section 713 of the Employee Retirement Income Security Act of 1974 shall apply to group health plans, and

[1] Section 2706 was added by subsection (a) of section 903 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1999 (as contained in section 101(f) of division A of Public Law 105–277; 112 Stat. 2681–438). Subsection (c) of such section 903 concerns effective dates, and paragraph (1) of the subsection provides as follows:

"(1) Group plans.—

"(A) In general.—The amendment made by subsection (a) shall apply to group health plans for plan years beginning on or after the date of enactment of this Act.

Continued

health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart.

SEC. 2707. [300gg–7] COVERAGE OF DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE.

(a) MEDICALLY NECESSARY LEAVE OF ABSENCE.—In this section, the term "medically necessary leave of absence" means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan or health insurance coverage offered in connection with such plan, a leave of absence of such 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 such child at such an institution, that—

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

(2) is medically necessary; and

(3) causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

(b) REQUIREMENT TO CONTINUE COVERAGE.—

(1) IN GENERAL.—In the case of a dependent child described in paragraph (2), a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, shall not terminate coverage of such child under such plan or health insurance coverage due to a medically necessary leave of absence before the date that is the earlier of—

(A) the date that is 1 year after the first day of the medically necessary leave of absence; or

(B) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(2) DEPENDENT CHILD DESCRIBED.—A dependent child described in this paragraph is, with respect to a group health plan or health insurance coverage offered in connection with the plan, a beneficiary under the plan who—

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

(B) was enrolled in the plan or coverage, on the basis of being a student at a postsecondary educational institution (as described in subsection (a)), immediately before the first day of the medically necessary leave of absence involved.

(3) CERTIFICATION BY PHYSICIAN.—Paragraph (1) shall apply to a group health plan or health insurance coverage offered by an issuer in connection with such plan only if the plan or issuer of the coverage has received written certification by

"(B) Special rule for collective bargaining agreements.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by the amendment made by subsection (a) shall not be treated as a termination of such collective bargaining agreement.".

The Public Law was enacted October 21, 1998.

a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall include, with any notice regarding a requirement for certification of student status for coverage under the plan or coverage, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

(d) NO CHANGE IN BENEFITS.—A dependent child whose benefits are continued under this section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(e) CONTINUED APPLICATION IN CASE OF CHANGED COVERAGE.—If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan or health insurance coverage offered in connection with such a plan, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

Subpart 3—Provisions Applicable Only to Health Insurance Issuers

SEC. 2711. [300gg–11] GUARANTEED AVAILABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.

(a) ISSUANCE OF COVERAGE IN THE SMALL GROUP MARKET.—

(1) IN GENERAL.—Subject to subsections (c) through (f), each health insurance issuer that offers health insurance coverage in the small group market in a State—

(A) must accept every small employer (as defined in section 2791(e)(4)) in the State that applies for such coverage; and

(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (2)) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any restriction which is inconsistent with section 2702 on an eligible individual being a participant or beneficiary.

(2) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term "eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined—

(A) in accordance with the terms of such plan,

(B) as provided by the issuer under rules of the issuer which are uniformly applicable in a State to small employers in the small group market, and

(C) in accordance with all applicable State laws governing such issuer and such market.

(b) ASSURING ACCESS IN THE LARGE GROUP MARKET.—

(1) REPORTS TO HHS.—The Secretary shall request that the chief executive officer of each State submit to the Secretary, by not later December 31, 2000, and every 3 years thereafter a report on—

(A) the access of large employers to health insurance coverage in the State, and

(B) the circumstances for lack of access (if any) of large employers (or one or more classes of such employers) in the State to such coverage.

(2) TRIENNIAL REPORTS TO CONGRESS.—The Secretary, based on the reports submitted under paragraph (1) and such other information as the Secretary may use, shall prepare and submit to Congress, every 3 years, a report describing the extent to which large employers (and classes of such employers) that seek health insurance coverage in the different States are able to obtain access to such coverage. Such report shall include such recommendations as the Secretary determines to be appropriate.

(3) GAO REPORT ON LARGE EMPLOYER ACCESS TO HEALTH INSURANCE COVERAGE.—The Comptroller General shall provide for a study of the extent to which classes of large employers in the different States are able to obtain access to health insurance coverage and the circumstances for lack of access (if any) to such coverage. The Comptroller General shall submit to Congress a report on such study not later than 18 months after the date of the enactment of this title.

(c) SPECIAL RULES FOR NETWORK PLANS.—

(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the small group market through a network plan, the issuer may—

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

(d) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers in the small group market in the State consistent with applicable State law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the small group market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

(e) EXCEPTION TO REQUIREMENT FOR FAILURE TO MEET CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES.—

(1) IN GENERAL.—Subsection (a) shall not be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market, as allowed under applicable State law.

(2) RULES DEFINED.—For purposes of paragraph (1)—

(A) the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

(B) the term "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(f) EXCEPTION FOR COVERAGE OFFERED ONLY TO BONA FIDE ASSOCIATION MEMBERS.—Subsection (a) shall not apply to health insurance coverage offered by a health insurance issuer if such coverage is made available in the small group market only through one or more bona fide associations (as defined in section 2791(d)(3)).

SEC. 2712. [300gg–12] GUARANTEED RENEWABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.

(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan.

(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

(1) NONPAYMENT OF PREMIUMS.—The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) FRAUD.—The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RULES.—The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 2711(e) in the case of the small group market or pursuant to applicable State law in the case of the large group market.

(4) TERMINATION OF COVERAGE.—The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

(5) MOVEMENT OUTSIDE SERVICE AREA.—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711(c)(1)(A).

(6) ASSOCIATION MEMBERSHIP CEASES.—In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.—

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the

small or large group market, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if—

(A) the issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) DISCONTINUANCE OF ALL COVERAGE.—

(A) IN GENERAL.—In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in a State, health insurance coverage may be discontinued by the issuer only in accordance with applicable State law and if—

(i) the issuer provides notice to the applicable State authority and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan—

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

SEC. 2713. [300gg–13] DISCLOSURE OF INFORMATION.

(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.—In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer—

(1) shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b), and

(2) upon request of such a small employer, provide such information.

(b) INFORMATION DESCRIBED.—

(1) IN GENERAL.—Subject to paragraph (3), with respect to a health insurance issuer offering health insurance coverage to a small employer, information described in this subsection is information concerning—

(A) the provisions of such coverage concerning issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) the provisions of such coverage relating to renewability of coverage;

(C) the provisions of such coverage relating to any preexisting condition exclusion; and

(D) the benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) FORM OF INFORMATION.—Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

(3) EXCEPTION.—An issuer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

Subpart 4—Exclusion of Plans; Enforcement; Preemption

SEC. 2721. [300gg–21] EXCLUSION OF CERTAIN PLANS.[1]

(a) EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.—The requirements of subparts 1 and 3[1] shall not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first

[1] Section 604(b) of Public Law 104–204 (110 Stat. 2940) provided that various provisions of section 2721 are amended by striking "subparts 1 and 2" and inserting "subparts 1 and 3". Subsection (c) of such section provides as follows:

(c) Effective Date.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

[1] Clauses (i) through (vii) probably should be redesignated as subparagraphs (A) through (G). See section 102(a) of Public Law 104–191 (110 Stat. 1971).

day of such plan year, such plan has less than 2 participants who are current employees.

(b) LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.—

(1) IN GENERAL.—The requirements of subparts 1 through 3 shall apply with respect to group health plans only—

(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

(2) TREATMENT OF NONFEDERAL GOVERNMENTAL PLANS.—

(A) ELECTION TO BE EXCLUDED.—Except as provided in subparagraph (D), if the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 through 3 otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

(B) PERIOD OF ELECTION.—An election under subparagraph (A) shall apply—

(i) for a single specified plan year, or

(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

An election under clause (i) may be extended through subsequent elections under this paragraph.

(C) NOTICE TO ENROLLEES.—Under such an election, the plan shall provide for—

(i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and

(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701(e).

(D) ELECTION NOT APPLICABLE TO REQUIREMENTS CONCERNING GENETIC INFORMATION.—The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (a)(1)(F), (b)(3), (c), and (d) of section 2702 and the provisions of sections 2701 and 2702(b) to the extent that such provisions apply to genetic information.

(c) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of subparts 1 through 3 shall not apply to any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(1).

(d) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

(1) LIMITED, EXCEPTED BENEFITS.—The requirements of subparts 1 through 3 shall not apply to any group health plan

(and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(2) if the benefits—

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of subparts 1 through 3 shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(3) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 27971(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(e) TREATMENT OF PARTNERSHIPS.—For purposes of this part—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

(2) EMPLOYER.—In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner.

(3) PARTICIPANTS OF GROUP HEALTH PLANS.—In the case of a group health plan, the term "participant" also includes—

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

SEC. 2722. [300gg–22] ENFORCEMENT.

(a) STATE ENFORCEMENT.—

(1) STATE AUTHORITY.—Subject to section 2723, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the small or large group markets meet the requirements of this part with respect to such issuers.

(2) FAILURE TO IMPLEMENT PROVISIONS.—In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) in this part with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans in such State.

(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

(1) LIMITATION.—The provisions of this subsection shall apply to enforcement of a provision (or provisions) of this part only—

(A) as provided under subsection (a)(2); and

(B) with respect to group health plans that are non-Federal governmental plans.

(2) IMPOSITION OF PENALTIES.—In the cases described in paragraph (1)—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any non-Federal governmental plan that is a group health plan and any health insurance issuer that fails to meet a provision of this part applicable to such plan or issuer is subject to a civil money penalty under this subsection.

(B) LIABILITY FOR PENALTY.—In the case of a failure by—

(i) a health insurance issuer, the issuer is liable for such penalty, or

(ii) a group health plan that is a non-Federal governmental plan which is—

(I) sponsored by 2 or more employers, the plan is liable for such penalty, or

(II) not so sponsored, the employer is liable for such penalty.

(C) AMOUNT OF PENALTY.—

(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary shall take into account the previous record of compliance of the entity being assessed with the applicable provisions of this part and the gravity of the violation.

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILI-

GENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(D) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The entity assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subparagraph (E).

(E) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any entity against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such entity is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice by registered mail to the Secretary.

(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(iv) APPEAL.—Any final decision, order, or judgment of the district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(i) FAILURE TO PAY ASSESSMENT.—If any entity fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(ii) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(G) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(3) ENFORCEMENT AUTHORITY RELATING TO GENETIC DISCRIMINATION.—

(A) GENERAL RULE.—In the cases described in paragraph (1), notwithstanding the provisions of paragraph (2)(C), the succeeding subparagraphs of this paragraph shall apply with respect to an action under this subsection by the Secretary with respect to any failure of a health insurance issuer in connection with a group health plan, to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 2702 or section 2701 or 2702(b)(1) with respect to genetic information in connection with the plan.

(B) AMOUNT.—

(i) IN GENERAL.—The amount of the penalty imposed under this paragraph shall be $100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) NONCOMPLIANCE PERIOD.—For purposes of this paragraph, the term "noncompliance period" means, with respect to any failure, the period—

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) MINIMUM PENALTIES WHERE FAILURE DISCOVERED.—Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) IN GENERAL.—In the case of 1 or more failures with respect to an individual—

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such individual shall not be less than $2,500.

(ii) HIGHER MINIMUM PENALTY WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.—To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting "$15,000" for "$2,500" with respect to such person.

(D) LIMITATIONS.—

(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN CERTAIN PERIODS.—No penalty shall be imposed by subparagraph (A) on any failure if—

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans; or

(II) $500,000.

(E) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

SEC. 2723. [300gg–23] PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2) and except as provided in subsection (b), this part and part C insofar as it relates to this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insur-

ance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) EXCEPTIONS.—Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i)[1] substitutes for the reference to "6-month period" in section 2701(a)(1) a reference to any shorter period of time;

(ii)[1] substitutes for the reference to "12 months" and "18 months" in section 2701(a)(2) a reference to any shorter period of time;

(iii)[1] substitutes for the references to "63" days in sections 2701(c)(2)(A) and 2701(d)(4)(A) a reference to any greater number of days;

(iv)[1] substitutes for the reference to "30-day period" in sections 2701(b)(2) and 2701(d)(1) a reference to any greater period;

(v)[1] prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) or expands the exceptions described in such section;

(vi)[1] requires special enrollment periods in addition to those required under section 2701(f); or

(vii)[1] reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B).

(c) RULES OF CONSTRUCTION.—Nothing in this part (other than section 2704)[2] shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(d) DEFINITIONS.—For purposes of this section—

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[2] Section 604(b)(2) of Public Law 104–204 (110 Stat. 2941) inserted "(other than section 2704)" after "part". Subsection (c) of such section provides as follows:

(c) Effective Date.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

[1] Section 111(b) of Public Law 104–191 (110 Stat. 1987) provides as follows:

"(b) Effective Date.—

"(1) In general.—Except as provided in this subsection, part B of title XXVII of the Public Health Service Act (as inserted by subsection (a)) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market

(1) STATE LAW.—The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term "State" includes a State (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

PART B—INDIVIDUAL MARKET RULES [1]

Subpart 1—Portability, Access, and Renewability Requirements

SEC. 2741. [300gg–41] GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE.

(a) GUARANTEED AVAILABILITY.—

(1) IN GENERAL.—Subject to the succeeding subsections of this section and section 2744, each health insurance issuer that offers health insurance coverage (as defined in section 2791(b)(1)) in the individual market in a State may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in individual health insurance coverage—

(A) decline to offer such coverage to, or deny enrollment of, such individual; or

(B) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A)) with respect to such coverage.

(2) SUBSTITUTION BY STATE OF ACCEPTABLE ALTERNATIVE MECHANISM.—The requirement of paragraph (1) shall not apply to health insurance coverage offered in the individual market in a State in which the State is implementing an acceptable alternative mechanism under section 2744.

(b) ELIGIBLE INDIVIDUAL DEFINED.—In this part, the term "eligible individual" means an individual—

(1)(A) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage (as defined in section 2701(c)) is 18 or more months and (B) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) who is not eligible for coverage under (A) a group health plan, (B) part A or part B of title XVIII of the Social Security Act, or (C) a State plan under title XIX of such Act (or any successor program), and does not have other health insurance coverage;

(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) was not terminated based on a factor described in paragraph (1) or (2) of section 2712(b) (relating to nonpayment of premiums or fraud);

(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(c) ALTERNATIVE COVERAGE PERMITTED WHERE NO STATE MECHANISM.—

(1) IN GENERAL.—In the case of health insurance coverage offered in the individual market in a State in which the State is not implementing an acceptable alternative mechanism under section 2744, the health insurance issuer may elect to limit the coverage offered under subsection (a) so long as it offers at least two different policy forms of health insurance coverage both of which—

(A) are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer; and

(B) meet the requirement of paragraph (2) or (3), as elected by the issuer.

For purposes of this subsection, policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) CHOICE OF MOST POPULAR POLICY FORMS.—The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in the State or applicable marketing or service area (as may be prescribed in regulation) by the issuer in the individual market in the period involved.

(3) CHOICE OF 2 POLICY FORMS WITH REPRESENTATIVE COVERAGE.—

(A) IN GENERAL.—The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers a lower-level coverage policy form (as defined in subparagraph (B)) and a higher-level coverage policy form (as defined in subparagraph (C)) each of which includes benefits substantially similar to other individual health insurance coverage offered by the issuer in that State and each of which is covered under a method described in section 2744(c)(3)(A) (relating to risk adjustment, risk spreading, or financial subsidization).

(B) LOWER-LEVEL OF COVERAGE DESCRIBED.—A policy form is described in this subparagraph if the actuarial value of the benefits under the coverage is at least 85 percent but not greater than 100 percent of a weighted average (described in subparagraph (D)).

(C) HIGHER-LEVEL OF COVERAGE DESCRIBED.—A policy form is described in this subparagraph if—

(i) the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the coverage described in subparagraph (B) offered by the issuer in the area involved; and

(ii) the actuarial value of the benefits under the coverage is at least 100 percent but not greater than 120 percent of a weighted average (described in subparagraph (D)).

(D) WEIGHTED AVERAGE.—For purposes of this paragraph, the weighted average described in this subparagraph is the average actuarial value of the benefits provided by all the health insurance coverage issued (as elected by the issuer) either by that issuer or by all issuers in the State in the individual market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

(4) ELECTION.—The issuer elections under this subsection shall apply uniformly to all eligible individuals in the State for that issuer. Such an election shall be effective for policies offered during a period of not shorter than 2 years.

(5) ASSUMPTIONS.—For purposes of paragraph (3), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(d) SPECIAL RULES FOR NETWORK PLANS.—

(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the issuer may—

(A) limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and

(ii) it is applying this paragraph uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

(e) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all individuals in the individual market in the State consistent

with applicable State law and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer upon denying individual health insurance coverage in any service area in accordance with paragraph (1) may not offer such coverage in the individual market within such service area for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated, if required under applicable State law, to the applicable State authority that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. A State may provide for the application of this paragraph on a service-area-specific basis.

(e)[1] MARKET REQUIREMENTS.—

(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

(2) CONVERSION POLICIES.—A health insurance issuer offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

(f)[1] CONSTRUCTION.—Nothing in this section shall be construed—

(1) to restrict the amount of the premium rates that an issuer may charge an individual for health insurance coverage provided in the individual market under applicable State law; or

(2) to prevent a health insurance issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

SEC. 2742. [300gg–42] GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual

[1] So in law. Probably should redesignate the second subsection (e) and subsection (f) as subsections (f) and (g), respectively. See section 111(a) of Pub. L. 104–191 (110 Stat. 1978).

[1] Section 2752 was added by subsection (b) of section 903 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1999 (as contained in section 101(f) of division A of Public Law 105–277 (112 Stat. 2681–438)). Subsection (c) of such section 903 concerns effective dates, and paragraph (2) of the subsection provides as follows:

"(2) Individual plans.—The amendment made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.".

The Public Law was enacted October 21, 1998.

in the individual market based only on one or more of the following:

(1) NONPAYMENT OF PREMIUMS.—The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) FRAUD.—The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) TERMINATION OF PLAN.—The issuer is ceasing to offer coverage in the individual market in accordance with subsection (c) and applicable State law.

(4) MOVEMENT OUTSIDE SERVICE AREA.—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(5) ASSOCIATION MEMBERSHIP CEASES.—In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.—

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if—

(A) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(2) DISCONTINUANCE OF ALL COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (C), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in a State, health insurance coverage may be discontinued by the issuer only if—

(i) the issuer provides notice to the applicable State authority and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market are discontinued and coverage under such health insurance coverage in such market is not renewed.

(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association (of which the individual is a member).

SEC. 2743. [300gg–43] CERTIFICATION OF COVERAGE.

The provisions of section 2701(e) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

SEC. 2744. [300gg–44] STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

(a) WAIVER OF REQUIREMENTS WHERE IMPLEMENTATION OF ACCEPTABLE ALTERNATIVE MECHANISM.—

(1) IN GENERAL.—The requirements of section 2741 shall not apply with respect to health insurance coverage offered in the individual market in the State so long as a State is found to be implementing, in accordance with this section and consistent with section 2762(b), an alternative mechanism (in this section referred to as an "acceptable alternative mechanism")—

(A) under which all eligible individuals are provided a choice of health insurance coverage;

(B) under which such coverage does not impose any preexisting condition exclusion with respect to such coverage;

(C) under which such choice of coverage includes at least one policy form of coverage that is comparable to comprehensive health insurance coverage offered in the individual market in such State or that is comparable to a

standard option of coverage available under the group or individual health insurance laws of such State; and

(D) in a State which is implementing—

(i) a model act described in subsection (c)(1),

(ii) a qualified high risk pool described in subsection (c)(2), or

(iii) a mechanism described in subsection (c)(3).

(2) PERMISSIBLE FORMS OF MECHANISMS.—A private or public individual health insurance mechanism (such as a health insurance coverage pool or programs, mandatory group conversion policies, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers), or combination of such mechanisms, that is designed to provide access to health benefits for individuals in the individual market in the State in accordance with this section may constitute an acceptable alternative mechanism.

(b) APPLICATION OF ACCEPTABLE ALTERNATIVE MECHANISMS.—

(1) PRESUMPTION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State is presumed to be implementing an acceptable alternative mechanism in accordance with this section as of July 1, 1997, if, by not later than April 1, 1997, the chief executive officer of a State—

(i) notifies the Secretary that the State has enacted or intends to enact (by not later than January 1, 1998, or July 1, 1998, in the case of a State described in subparagraph (B)(ii)) any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998, (or, in the case of a State described in subparagraph (B)(ii), July 1, 1998); and

(ii) provides the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

(B) DELAY PERMITTED FOR CERTAIN STATES.—

(i) EFFECT OF DELAY.—In the case of a State described in clause (ii) that provides notice under subparagraph (A)(i), for the presumption to continue on and after July 1, 1998, the chief executive officer of the State by April 1, 1998—

(I) must notify the Secretary that the State has enacted any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of July 1, 1998; and

(II) must provide the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

(ii) STATES DESCRIBED.—A State described in this clause is a State that has a legislature that does not

meet within the 12-month period beginning on the date of enactment of this Act.

(C) CONTINUED APPLICATION.—In order for a mechanism to continue to be presumed to be an acceptable alternative mechanism, the State shall provide the Secretary every 3 years with information described in subparagraph (A)(ii) or (B)(i)(II) (as the case may be).

(2) NOTICE.—If the Secretary finds, after review of information provided under paragraph (1) and in consultation with the chief executive officer of the State and the insurance commissioner or chief insurance regulatory official of the State, that such a mechanism is not an acceptable alternative mechanism or is not (or no longer) being implemented, the Secretary—

(A) shall notify the State of—

(i) such preliminary determination, and

(ii) the consequences under paragraph (3) of a failure to implement such a mechanism; and

(B) shall permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) in a manner so that may be an acceptable alternative mechanism or to provide for implementation of such a mechanism.

(3) FINAL DETERMINATION.—If, after providing notice and opportunity under paragraph (2), the Secretary finds that the mechanism is not an acceptable alternative mechanism or the State is not implementing such a mechanism, the Secretary shall notify the State that the State is no longer considered to be implementing an acceptable alternative mechanism and that the requirements of section 2741 shall apply to health insurance coverage offered in the individual market in the State, effective as of a date specified in the notice.

(4) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not make a determination under paragraph (2) or (3) on any basis other than the basis that a mechanism is not an acceptable alternative mechanism or is not being implemented.

(5) FUTURE ADOPTION OF MECHANISMS.—If a State, after January 1, 1997, submits the notice and information described in paragraph (1), unless the Secretary makes a finding described in paragraph (3) within the 90-day period beginning on the date of submission of the notice and information, the mechanism shall be considered to be an acceptable alternative mechanism for purposes of this section, effective 90 days after the end of such period, subject to the second sentence of paragraph (1).

(c) PROVISION RELATED TO RISK.—

(1) ADOPTION OF NAIC MODELS.—The model act referred to in subsection (a)(1)(D)(i) is the Small Employer and Individual Health Insurance Availability Model Act (adopted by the National Association of Insurance Commissioners on June 3, 1996) insofar as it applies to individual health insurance coverage or the Individual Health Insurance Portability Model Act (also adopted by such Association on such date).

(2) QUALIFIED HIGH RISK POOL.—For purposes of subsection (a)(1)(D)(ii), a "qualified high risk pool" described in this paragraph is a high risk pool that—

(A) provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion with respect to such coverage for all eligible individuals, and

(B) provides for premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect as of the date of the enactment of this title).

(3) OTHER MECHANISMS.—For purposes of subsection (a)(1)(D)(iii), a mechanism described in this paragraph—

(A) provides for risk adjustment, risk spreading, or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers; or

(B) is a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

SEC. 2745. [300gg–45] RELIEF FOR HIGH RISK POOLS.

(a) SEED GRANTS TO STATES.—The Secretary shall provide from the funds appropriated under subsection (d)(1)(A) a grant of up to $1,000,000 to each State that has not created a qualified high risk pool as of the date of enactment of the State High Risk Pool Funding Extension Act of 2006 for the State's costs of creation and initial operation of such a pool.

(b) GRANTS FOR OPERATIONAL LOSSES.—

(1) IN GENERAL.—In the case of a State that has established a qualified high risk pool that—

(A) restricts premiums charged under the pool to no more than 200 percent of the premium for applicable standard risk rates;

(B) offers a choice of two or more coverage options through the pool; and

(C) has in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the State in connection with operation of the pool after the end of the last fiscal year for which a grant is provided under this paragraph;

the Secretary shall provide, from the funds appropriated under paragraphs (1)(B)(i) and (2)(A) of subsection (d) and allotted to the State under paragraph (2), a grant for the losses incurred by the State in connection with the operation of the pool.

(2) ALLOTMENT.—Subject to paragraph (4), the amounts appropriated under paragraphs (1)(B)(i) and (2)(A) of subsection (d) for a fiscal year shall be allotted and made available to the States (or the entities that operate the high risk pool under applicable State law) that qualify for a grant under paragraph (1) as follows:

(A) An amount equal to 40 percent of such appropriated amount for the fiscal year shall be allotted in equal amounts to each qualifying State that is one of the 50 States or the District of Columbia and that applies for a grant under this subsection.

(B) An amount equal to 30 percent of such appropriated amount for the fiscal year shall be allotted among qualifying States that apply for such a grant so that the amount allotted to such a State bears the same ratio to such appropriated amount as the number of uninsured individuals in the State bears to the total number of uninsured individuals (as determined by the Secretary) in all qualifying States that so apply.

(C) An amount equal to 30 percent of such appropriated amount for the fiscal year shall be allotted among qualifying States that apply for such a grant so that the amount allotted to a State bears the same ratio to such appropriated amount as the number of individuals enrolled in health care coverage through the qualified high risk pool of the State bears to the total number of individuals so enrolled through qualified high risk pools (as determined by the Secretary) in all qualifying States that so apply.

(3) SPECIAL RULE FOR POOLS CHARGING HIGHER PREMIUMS.—In the case of a qualified high risk pool of a State which charges premiums that exceed 150 percent of the premium for applicable standard risks, the State shall use at least 50 percent of the amount of the grant provided to the State to carry out this subsection to reduce premiums for enrollees.

(4) LIMITATION FOR TERRITORIES.—In no case shall the aggregate amount allotted and made available under paragraph (2) for a fiscal year to States that are not the 50 States or the District of Columbia exceed $1,000,000.

(c) BONUS GRANTS FOR SUPPLEMENTAL CONSUMER BENEFITS.—

(1) IN GENERAL.—In the case of a State that is one of the 50 States or the District of Columbia, that has established a qualified high risk pool, and that is receiving a grant under subsection (b)(1), the Secretary shall provide, from the funds appropriated under paragraphs (1)(B)(ii) and (2)(B) of subsection (d) and allotted to the State under paragraph (3), a grant to be used to provide supplemental consumer benefits to enrollees or potential enrollees (or defined subsets of such enrollees or potential enrollees) in qualified high risk pools.

(2) BENEFITS.—A State shall use amounts received under a grant under this subsection to provide one or more of the following benefits:

(A) Low-income premium subsidies.

(B) A reduction in premium trends, actual premiums, or other cost-sharing requirements.

(C) An expansion or broadening of the pool of individuals eligible for coverage, such as through eliminating waiting lists, increasing enrollment caps, or providing flexibility in enrollment rules.

(D) Less stringent rules, or additional waiver authority, with respect to coverage of pre-existing conditions.

(E) Increased benefits.

(F) The establishment of disease management programs.

(3) ALLOTMENT; LIMITATION.—The Secretary shall allot funds appropriated under paragraphs (1)(B)(ii) and (2)(B) of subsection (d) among States qualifying for a grant under paragraph (1) in a manner specified by the Secretary, but in no case shall the amount so allotted to a State for a fiscal year exceed 10 percent of the funds so appropriated for the fiscal year.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit a State that, on the date of the enactment of the State High Risk Pool Funding Extension Act of 2006, is in the process of implementing a program to provide benefits of the type described in paragraph (2), from being eligible for a grant under this subsection.

(d) FUNDING.—

(1) APPROPRIATION FOR FISCAL YEAR 2006.—There are authorized to be appropriated for fiscal year 2006—

(A) $15,000,000 to carry out subsection (a); and

(B) $75,000,000, of which, subject to paragraph (4)—

(i) two-thirds of the amount appropriated shall be made available for allotments under subsection (b)(2); and

(ii) one-third of the amount appropriated shall be made available for allotments under subsection (c)(3).

(2) AUTHORIZATION OF APPROPRIATIONS FOR FISCAL YEARS 2007 THROUGH 2010.—There are authorized to be appropriated $75,000,000 for each of fiscal years 2007 through 2010, of which, subject to paragraph (4)—

(A) two-thirds of the amount appropriated for a fiscal year shall be made available for allotments under subsection (b)(2); and

(B) one-third of the amount appropriated for a fiscal year shall be made available for allotments under subsection (c)(3).

(3) AVAILABILITY.—Funds appropriated for purposes of carrying out this section for a fiscal year shall remain available for obligation through the end of the following fiscal year.

(4) REALLOTMENT.—If, on June 30 of each fiscal year for which funds are appropriated under paragraph (1)(B) or (2), the Secretary determines that all the amounts so appropriated are not allotted or otherwise made available to States, such remaining amounts shall be allotted and made available under subsection (b) among States receiving grants under subsection (b) for the fiscal year based upon the allotment formula specified in such subsection.

(5) NO ENTITLEMENT.—Nothing in this section shall be construed as providing a State with an entitlement to a grant under this section.

(e) APPLICATIONS.—To be eligible for a grant under this section, a State shall submit to the Secretary an application at such

time, in such manner, and containing such information as the Secretary may require.

(f) ANNUAL REPORT.—The Secretary shall submit to Congress an annual report on grants provided under this section. Each such report shall include information on the distribution of such grants among States and the use of grant funds by States.

(g) DEFINITIONS.—In this section:

(1) QUALIFIED HIGH RISK POOL.—

(A) IN GENERAL.—The term "qualified high risk pool" has the meaning given such term in section 2744(c)(2), except that a State may elect to meet the requirement of subparagraph (A) of such section (insofar as it requires the provision of coverage to all eligible individuals) through providing for the enrollment of eligible individuals through an acceptable alternative mechanism (as defined for purposes of section 2744) that includes a high risk pool as a component.

(2) STANDARD RISK RATE.—The term "standard risk rate" means a rate—

(A) determined under the State high risk pool by considering the premium rates charged by other health insurers offering health insurance coverage to individuals in the insurance market served;

(B) that is established using reasonable actuarial techniques; and

(C) that reflects anticipated claims experience and expenses for the coverage involved.

(3) STATE.—The term "State" means any of the 50 States and the District of Columbia and includes Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Subpart 2—Other Requirements

SEC. 2751. [300gg–51] STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.

(a) IN GENERAL.—The provisions of section 2704 (other than subsections (d) and (f)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(b) NOTICE REQUIREMENT.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.

(c) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) CONSTRUCTION.—Section 2762(a) shall not be construed as superseding a State law described in paragraph (1).

SEC. 2752. [300gg–52] REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.[1]

The provisions of section 2706 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

SEC. 2753. [300gg–53] PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION.

(a) PROHIBITION ON GENETIC INFORMATION AS A CONDITION OF ELIGIBILITY.—

(1) IN GENERAL.—A health insurance 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 (1) or in paragraphs (1) and (2) of subsection (e) shall be construed to preclude a health insurance 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 such individual where such family member is covered under the policy that covers such individual.

(b) PROHIBITION ON GENETIC INFORMATION IN SETTING PREMIUM RATES.—

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market shall not adjust premium or contribution amounts for an individual on the basis of genetic information concerning the individual or a family member of the individual.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or in paragraphs (1) and (2) of subsection (e) shall be construed to preclude a health insurance issuer from 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 such individual where such family member

is covered under the policy that covers such individual. In such case, 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 such individual and to further increase premiums or contribution amounts.

(c) PROHIBITION ON GENETIC INFORMATION AS PREEXISTING CONDITION.—

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market may not, on the basis of genetic information, impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A)) with respect to such coverage.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or in paragraphs (1) and (2) of subsection (e) shall be construed to preclude a health insurance 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) GENETIC TESTING.—

(1) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A health insurance issuer offering health insurance coverage in the individual market shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) RULE OF CONSTRUCTION REGARDING PAYMENT.—

(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to preclude a health insurance issuer offering health insurance coverage in the individual market from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a) and (c).

(B) LIMITATION.—For purposes of subparagraph (A), a health insurance issuer offering health insurance coverage in the individual market may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) RESEARCH EXCEPTION.—Notwithstanding paragraph (1), a health insurance issuer offering health insurance coverage in the individual market may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(A) 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 applica-

ble State or local law or regulations 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 such child, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(e) PROHIBITION ON COLLECTION OF GENETIC INFORMATION.—

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 2791).

(2) PROHIBITION ON COLLECTION OF GENETIC INFORMATION PRIOR TO ENROLLMENT.—A health insurance issuer offering health insurance coverage in the individual market shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan in connection with such enrollment.

(3) INCIDENTAL COLLECTION.—If a health insurance issuer offering health insurance coverage in the individual market obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(f) GENETIC INFORMATION OF A FETUS OR EMBRYO.—Any reference in this part to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

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

Subpart 3—General Provisions [2]

SEC. 2761. [300gg–61] ENFORCEMENT.

(a) STATE ENFORCEMENT.—

(1) STATE AUTHORITY.—Subject to section 2762, each State may require that health insurance issuers that issue, sell,

[2] Section 605(a)(3) of Public Law 104–204 (110 Stat. 2941) adds this subpart designation and heading to part B.

renew, or offer health insurance coverage in the State in the individual market meet the requirements established under this part with respect to such issuers.

(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a State that fails to substantially enforce the requirements set forth in this part with respect to health insurance issuers in the State, the Secretary shall enforce the requirements of this part under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in the individual market in such State.

(b) SECRETARIAL ENFORCEMENT AUTHORITY.—The Secretary shall have the same authority in relation to enforcement of the provisions of this part with respect to issuers of health insurance coverage in the individual market in a State as the Secretary has under section 2722(b)(2), and section 2722(b)(3) with respect to violations of genetic nondiscrimination provisions, in relation to the enforcement of the provisions of part A with respect to issuers of health insurance coverage in the small group market in the State.

SEC. 2762. [300gg–62] PREEMPTION.

(a) IN GENERAL.—Subject to subsection (b), nothing in this part (or part C insofar as it applies to this part) shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of this part.

(b) RULES OF CONSTRUCTION.—(1) Nothing in this part (or part C insofar as it applies to this part) shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(2) Nothing in this part (other than section 2751) shall be construed as requiring health insurance coverage offered in the individual market to provide specific benefits under the terms of such coverage.

SEC. 2763. [300gg–63] GENERAL EXCEPTIONS.

(a) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in section 2791(c)(1).

(b) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 2791(c) if the benefits are provided under a separate policy, certificate, or contract of insurance.

SEC. 2753. [300gg–54] COVERAGE OF DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE.[1]

The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance cov-

[1] The placement of section 2753 at the end of subpart 3 is so in law. See amendment made by section 2(b)(2) of Public Law 110–381 122 Stat. 4084). Section 102(b)(1)(A) of Public Law 110–233 redesignated subpart 3 of part B as subpart 2. Also, another section designated as section 2753 was added by section 102(b)(1)(B) of such Public Law (122 Stat. 893).

erage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 2791. [300gg–91] DEFINITIONS.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) MEDICAL CARE.—The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

(1) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(5) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) EXCEPTED BENEFITS.—For purposes of this title, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

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

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

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—

(1) APPLICABLE STATE AUTHORITY.—The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such issuer.

(2) BENEFICIARY.—The term "beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974.

(3) BONA FIDE ASSOCIATION.—The term "bona fide association" means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of such Act.

(C) Title XXII of this Act.

(5) EMPLOYEE.—The term "employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(6) EMPLOYER.—The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.

(7) CHURCH PLAN.—The term "church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(8) GOVERNMENTAL PLAN.—(A) The term "governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

(B) FEDERAL GOVERNMENTAL PLAN.—The term "Federal governmental plan" means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(C) NON-FEDERAL GOVERNMENTAL PLAN.—The term "non-Federal governmental plan" means a governmental plan that is not a Federal governmental plan.

(9) HEALTH STATUS-RELATED FACTOR.—The term "health status-related factor" means any of the factors described in section 2702(a)(1).

(10) NETWORK PLAN.—The term "network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(11) PARTICIPANT.—The term "participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(12) PLACED FOR ADOPTION DEFINED.—The term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(13) PLAN SPONSOR.—The term "plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(14) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(15) FAMILY MEMBER.—The term "family member" means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 2701(f)(2)) of such individual; and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(16) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

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

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such 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 such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(17) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or

metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(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 could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(18) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

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

(C) genetic education.

(19) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

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

(B) the computation of premium or contribution amounts under the plan or coverage;

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

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

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—For purposes of this title:

(1) INDIVIDUAL MARKET.—

(A) IN GENERAL.—The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) TREATMENT OF VERY SMALL GROUPS.—

(i) IN GENERAL.—Subject to clause (ii), such terms includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) LARGE EMPLOYER.—The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) LARGE GROUP MARKET.—The term "large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(5) SMALL GROUP MARKET.—The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

SEC. 2792. [300gg–92] REGULATIONS.

The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this title. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this title.