''(4) TIMELY REGULATIONS.—The Secretary of the Treasury, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

''(5) LIMITATION ON ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.''

§ 9802. 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 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 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 9801, paragraph (1) shall not be construed—

(A) to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such plan; or

(B) to prevent such a plan 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 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 factor described in subsection (a)(1) 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 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 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 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 may 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 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 of Health and Human Services 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 may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception

Notwithstanding paragraph (1), 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 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 notifies the Secretary in writing that the plan is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan 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 shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 9832).

(2) Prohibition on collection of genetic information prior to enrollment

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 in connection with such enrollment.

(3) Incidental collection

If 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 9801 with respect to genetic information, shall apply to group health plans without regard to section 9831(a)(2).

(f) [1] Special rules for church plans

A church plan (as defined in section 414(e)) shall not be treated as failing to meet the requirements of this section solely because such plan requires evidence of good health for coverage of—

(1) both any employee of an employer with 10 or less employees (determined without regard to section 414(e)(3)(C)) and any self-employed individual, or

(2) any individual who enrolls after the first 90 days of initial eligibility under the plan.

This subsection shall apply to a plan for any year only if the plan included the provisions described in the preceding sentence on July 15, 1997, and at all times thereafter before the beginning of such year.

(f) [1] Genetic information of a fetus or embryo

Any reference in this chapter 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.

(Added Pub. L. 104–191, title IV, §401(a), Aug. 21, 1996, 110 Stat. 2078; amended Pub. L. 105–34, title XV, §1532(a), Aug. 5, 1997, 111 Stat. 1085; Pub. L. 110–233, title I, §103(a)–(c), May 21, 2008, 122 Stat. 896, 897.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(3)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part C of title XI of the Act is classified generally to part C (§1320d et seq.) of subchapter XI of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c)(3)(A), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of Title 42, The Public Health and Welfare.

AMENDMENTS

2008—Subsec. (b)(2)(A). Pub. L. 110–233, §103(a)(1), inserted ''except as provided in paragraph (3)'' before semicolon.

Subsec. (b)(3). Pub. L. 110–233, §103(a)(2), added par. (3).

Subsecs. (c) to (e). Pub. L. 110–233, §103(b), added subsecs. (c) to (e). Former subsec. (c) redesignated (f) relating to special rules for church plans.

Subsec. (f). Pub. L. 110–233, §103(c), added subsec. (f) relating to genetic information of a fetus or embryo.

Pub. L. 110–233, §103(b), redesignated subsec. (c) as (f) relating to special rules for church plans.

1997—Subsec. (c). Pub. L. 105–34 added subsec. (c).

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–233, title I, §103(f)(2), May 21, 2008, 122 Stat. 899, provided that: ''The amendments made by this section [enacting section 9834 of this title and amending this section and section 9832 of this title] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of the enactment of this Act [May 21, 2008].''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–34, title XV, §1532(b), Aug. 5, 1997, 111 Stat. 1085, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect as if included in the amendments made by section 401(a) of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104–191].''

REGULATIONS

Pub. L. 110–233, title I, §103(f)(1), May 21, 2008, 122 Stat. 899, provided that: ''The Secretary of the Treas-

[1] So in original. Two subsecs. (f) have been enacted.

ury shall issue final regulations or other guidance not later than 12 months after the date of the enactment of this Act [May 21, 2008] to carry out the amendments made by this section [enacting section 9834 of this title and amending this section and section 9832 of this title].''

§ 9803. Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements

(a) In general

A group health plan which is a multiemployer plan (as defined in section 414(f)) or which is a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under such plan, other than—

(1) for nonpayment of contributions;

(2) for fraud or other intentional misrepresentation of material fact by the employer;

(3) for noncompliance with material plan provisions;

(4) because the plan is ceasing to offer any coverage in a geographic area;

(5) in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or a factor described in section 9802(a)(1) in relation to such individuals or their dependents; or

(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

(b) Multiple employer welfare arrangement

For purposes of subsection (a), the term ''multiple employer welfare arrangement'' has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section.

(Added Pub. L. 104–191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2079.)

REFERENCES IN TEXT

Section 3(40) of the Employee Retirement Income Security Act of 1974, referred to in subsec. (b), is classified to section 1002(40) of Title 29, Labor.

The date of the enactment of this section, referred to in subsec. (b), is the date of enactment of Pub. L. 104–191, which was approved Aug. 21, 1996.

[§ 9804. Renumbered § 9831]

[§ 9805. Renumbered § 9832]

[§ 9806. Renumbered § 9833]

Subchapter B—Other Requirements

AMENDMENTS

2008—Pub. L. 110–381, § 2(c)(2), Oct. 9, 2008, 122 Stat. 4086, added item 9813.

Pub. L. 110–343, div. C, title V, § 512(g)(3)(B), Oct. 3, 2008, 122 Stat. 3892, added item 9812 and struck out former item 9812 ''Parity in the application of certain limits to mental health benefits''.

1997—Pub. L. 105–34, title XV, § 1531(a)(4), Aug. 5, 1997, 111 Stat. 1081, added subchapter heading and analysis.

§ 9811. Standards relating to benefits for mothers and newborns

(a) Requirements for minimum hospital stay following birth

(1) In general

A group health plan 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 newborn child, following a caesarean 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 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 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 hos-

[1] Editorially supplied. Section 9815 added by Pub. L. 111–148 without corresponding amendment of analysis. No section 9814 has been enacted.