AMENDMENTS

2011—Subsec. (c)(2)(C). Pub. L. 112–40 substituted ''January 1, 2014'' for ''February 13, 2011'' in introductory provisions. See Codification note above.

2010—Pub. L. 111–148, § 1201(2)(A), substituted ''Prohibition of preexisting condition exclusions or other discrimination based on health status'' for ''Increased portability through limitation on preexisting condition exclusions'' in section catchline, added subsec. (a), and struck out former subsec. (a) which related to limitation on preexisting condition exclusion period.

Subsec. (c)(2)(A), (B). Pub. L. 111–148, § 1563(c)(1)(A)(i), formerly § 1562(c)(1)(A)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health plan'' for ''group health plan''.

Subsec. (c)(2)(C). Pub. L. 111–344 substituted ''February 13, 2011'' for ''January 1, 2011'' in introductory provisions.

Subsec. (c)(3)(A), (B). Pub. L. 111–148, § 1563(c)(1)(A)(ii)(I), formerly § 1562(c)(1)(A)(ii)(I), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance'' for ''group health insurance''.

Subsec. (c)(3)(D). Pub. L. 111–148, § 1563(c)(1)(A)(ii)(II), formerly § 1562(c)(1)(A)(ii)(II), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''individual or group'' for ''small or large'' in introductory provisions.

Subsec. (d)(1) to (3). Pub. L. 111–148, § 1563(c)(1)(B), formerly § 1562(c)(1)(B), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance'' for ''group health insurance''.

Subsec. (e)(1)(A). Pub. L. 111–148, § 1563(c)(1)(C), formerly § 1562(c)(1)(C), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance'' for ''group health insurance'' in introductory provisions.

2009—Subsec. (c)(2)(C). Pub. L. 111–5 added subpar. (C).

Subsec. (f)(3). Pub. L. 111–3 added par. (3).

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to plan years beginning after Feb. 12, 2011, with transitional rules, see section 242(b) of Pub. L. 112–40, set out as a note under section 9801 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–344 applicable to plan years beginning after Dec. 31, 2010, see section 114(d) of Pub. L. 111–344, set out as a note under section 9801 of Title 26, Internal Revenue Code.

Amendment by section 1201(2) of Pub. L. 111–148 effective for plan years beginning on or after Jan. 1, 2014, except that the provisions of this section, as they apply to enrollees who are under 19 years of age, effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1255 of Pub. L. 111–148, set out as an Effective Date note under section 300gg of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Except as otherwise provided and subject to certain applicability provisions, amendment by Pub. L. 111–5 effective upon the expiration of the 90-day period beginning on Feb. 17, 2009, see section 1891 of Pub. L. 111–5, set out as an Effective and Termination Dates of 2009 Amendment note under section 2271 of Title 19, Customs Duties.

Amendment by Pub. L. 111–5 applicable to plan years beginning after Feb. 17, 2009, see section 1899D(d) of Pub. L. 111–5, set out as a note under section 9801 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

§ 300gg–4. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Secretary.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, 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 or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; 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[1] 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

[1] So in original. Probably should be preceded by ''a''.

construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage 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 [42 U.S.C. 1320d et seq.] 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 purchase genetic information for underwriting purposes (as defined in section 300gg–91 of this title).

(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)(6), (b)(3), (c), and (d) and subsection (b)(1) and section 300gg–3 of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 300gg–21(a)[2] of this title.

(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] See References in Text note below.

(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.

(j)[3] Programs of health promotion or disease prevention

(1) General provisions

(A) General rule

For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a ''wellness program'') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

(B) No conditions based on health status factor

If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

(C) Conditions based on health status factor

If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

(2) Wellness programs not subject to requirements

If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

(A) A program that reimburses all or part of the cost for memberships in a fitness center.

(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group[1] health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

(E) A program that provides a reward to individuals for attending a periodic health education seminar.

(3) Wellness programs subject to requirements

If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

[3] So in original. No subsecs. (g) to (i) have been enacted.

(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

(k) Existing programs

Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to March 23, 2010, and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

***(l)* Wellness program demonstration project**

(1) In general

Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

(2) Expansion of demonstration project

If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

(3) Requirements

(A) Maintenance of coverage

The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

(i) will not result in any decrease in coverage; and

(ii) will not increase the cost to the Federal Government in providing credits under section 36B of title 26 or cost-sharing assistance under section 18071 of this title.

(B) Other requirements

States that participate in the demonstration project under this subsection—

(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

(I) do not create undue burdens for individuals insured in the individual market;

(II) do not lead to cost shifting; and

(III) are not a subterfuge for discrimination;

(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and

(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

(m) Report

(1) In general

Not later than 3 years after March 23, 2010, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

(D) the effectiveness of different types of rewards.

(2) Data collection

In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide em-

ployees with access to wellness programs, including State and Federal agencies.

(n) Regulations

Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

(July 1, 1944, ch. 373, title XXVII, § 2705, as added and amended Pub. L. 111–148, title I, § 1201(3), (4), Mar. 23, 2010, 124 Stat. 154, 156.)

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 this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsecs. (c)(3)(A) and (*l*)(3)(B)(iv), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

Section 300gg–21(a) of this title, referred to in subsec. (e), was in the original a reference to section 2735(a) of act July 1, 1944, and was translated as if it referred to section 2722(a) of that act to reflect the probable intent of Congress because of the renumbering of section 2735 as 2722 by Pub. L. 111–148, title I, § 1563(c)(12)(D), formerly § 1562(c)(12)(D), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 269, 911. The act July 1, 1944, does not contain a section 2735.

CODIFICATION

The text of section 300gg–1 of this title, which was amended and transferred to subsecs. (b) to (f) of this section by Pub. L. 111–148, § 1201(3), was based on act July 1, 1944, ch. 373, title XXVII, § 2702, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1961; amended Pub. L. 110–233, title I, § 102(a)(1)–(3), May 21, 2008, 122 Stat. 888, 890.

PRIOR PROVISIONS

A prior section 300gg–4, act July 1, 1944, ch. 373, title XXVII, § 2704, as added Pub. L. 104–204, title VI, § 604(a)(3), Sept. 26, 1996, 110 Stat. 2939, which related to standards relating to benefits for mothers and newborns, was renumbered section 2725 of act July 1, 1944, by Pub. L. 111–148, title I, § 1001(2), Mar. 23, 2010, 124 Stat. 130, and transferred to section 300gg–25 of this title.

A prior section 2705 of act July 1, 1944, was renumbered section 2726 and is classified to section 300gg–26 of this title.

Another prior section 2705 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238d of this title.

AMENDMENTS

2010—Pub. L. 111–148, § 1201(3), transferred section 300gg–1 of this title to subsecs. (b) to (f) of this section after amending it by striking out the section catchline ''Prohibiting discrimination against individual participants and beneficiaries based on health status'', by striking subsec. (a) which prohibited discrimination against individual participants in group health plans based on certain health status-related factors, by amending subsec. (b) by substituting ''health insurance issuer offering group or individual health insurance coverage'' for ''health insurance issuer offering health insurance coverage in connection with a group health plan'' in pars. (1) and (3)(B) and by inserting ''or individual'' after ''employer'' and ''or individual health coverage, as the case may be'' before semicolon in par. (2)(A), and by amending subsec. (e) by substituting ''(a)(6)'' for ''(a)(1)(F)'' and ''300gg–3'' for ''300gg'' and making technical amendment to reference in original act which appears in text as reference to section 300gg–21(a) of this title.

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 300gg–5. Non-discrimination in health care

(a) Providers

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

(b) Individuals

The provisions of section 218c[1] of title 29 (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

(July 1, 1944, ch. 373, title XXVII, § 2706, as added Pub. L. 111–148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 160.)

REFERENCES IN TEXT

Section 218c of title 29, referred to in subsec. (b), was in the original ''section 1558 of the Patient Protection and Affordable Care Act'', meaning section 1558 of Pub. L. 111–148, and was translated as meaning section 18C of act June 25, 1938, ch. 676, which was added by section 1558 of Pub. L. 111–148, to reflect the probable intent of Congress.

PRIOR PROVISIONS

A prior section 300gg–5, act July 1, 1944, ch. 373, title XXVII, § 2705, as added Pub. L. 104–204, title VII, § 703(a), Sept. 26, 1996, 110 Stat. 2947, and amended, which related to parity in mental health and substance use disorder benefits, was renumbered section 2726 of act July 1, 1944, and transferred to section 300gg–26 of this title.

A prior section 2706 of act July 1, 1944, was renumbered section 2727 and is classified to section 300gg–27 of this title.

Another prior section 2706 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238e of this title.

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

[1] See References in Text note below.