

individual participants and beneficiaries based on health status”, 9803 “Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements”, 9804 “General exceptions”, 9805 “Definitions”, and 9806 “Regulations”.

§ 9801. 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 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 length of the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions

For purposes of this section—

(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.

(B) Treatment of genetic information

For purposes of this section, 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, the date of enrollment of the individual in the plan 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 part, 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 9832(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 is in an affiliation period shall not be taken into account in determining the continuous period under subparagraph (A).

(C) Affiliation period

(i) In general

For purposes of this section, 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. During such an affiliation period, the organization is not required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(ii) Beginning

Such period shall begin on the enrollment date.

(iii) Runs concurrently with waiting periods

Any such affiliation period shall run concurrently with any waiting period under the plan.

(D) TAA-eligible individuals

In the case of plan years beginning before January 1, 2014—

(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 which 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 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 4980B(f)(5)(C)(iv).

(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 shall count a period of creditable coverage without regard to the specific benefits for which coverage is offered during the period.

(B) Election of alternative method

A group health plan may elect to apply subsection (a)(3) based on coverage of any 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 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), 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.

(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 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 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

For purposes of this section, a group health plan 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 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 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 health insurance coverage offered in connection with the plan, the plan is deemed to have satisfied the certification requirement under this paragraph if the issuer provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits**(A) In general**

In the case of an election described in subsection (c)(3)(B) by a group health plan, if the plan enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

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

(ii) 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 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 individual.

(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 the health insurance issuer offering health insurance coverage in connection with the plan) 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

The 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 coverage of a dependent during the first 30 days of such a dependent 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 relating to Medicaid and CHIP**(A) In general**

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 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 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 not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Employee outreach and disclosure

(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 clause, 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 (29 U.S.C. 1024).

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of a participant or beneficiary of 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 Program 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.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2073; amended Pub. L. 105-34, title XV, § 1531(b)(1)(A), Aug. 5, 1997, 111 Stat. 1084; Pub. L. 111-3, title III, § 311(a), Feb. 4, 2009, 123 Stat. 64; Pub. L. 111-5, div. B, title I, § 1899D(a), Feb. 17, 2009, 123 Stat. 425; Pub. L. 111-344, title I, § 114(a), Dec. 29, 2010, 124 Stat. 3615; Pub. L. 112-40, title II, § 242(a)(1), Oct. 21, 2011, 125 Stat. 419.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (c)(1)(C), (D), (f)(3)(A)(i), (B)(i)(I), (ii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Parts A and B of title XVIII of the Act are classified generally to parts A (§ 1395c et seq.) and B (§ 1395j et seq.) of subchapter XVIII of chapter 7 of Title 42, The Public Health and Welfare. Titles XIX and XXI of the Act are classified generally to subchapters XIX (§ 1396 et seq.) and XXI (§ 1397aa et seq.), respectively, of chapter 7 of Title 42. Sections 1928 and 2105 of the Act are classified to sections 1396s and 1397ee, respectively, of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, referred to in subsec. (f)(3)(B)(ii), is section 311(b)(1)(C) of Pub. L. 111-3, which is set out as a note under section 1181 of Title 29, Labor.

AMENDMENTS

2011—Subsec. (c)(2)(D). Pub. L. 112-40 substituted “January 1, 2014” for “February 13, 2011” in introductory provisions.

2010—Subsec. (c)(2)(D). Pub. L. 111-344 substituted “February 13, 2011” for “January 1, 2011” in introductory provisions.

2009—Subsec. (c)(2)(D). Pub. L. 111-5 added subpar. (D).

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

1997—Subsec. (c)(1). Pub. L. 105-34 substituted “section 9832(c)” for “section 9805(c)” in concluding provisions.

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112-40, title II, §242(b), Oct. 21, 2011, 125 Stat. 419, provided that:

“(1) IN GENERAL.—The amendments made by this section [amending this section, section 1181 of Title 29, Labor, and sections 300gg and 300gg-3 of Title 42, The Public Health and Welfare] shall apply to plan years beginning after February 12, 2011.

“(2) TRANSITIONAL RULES.—

“(A) BENEFIT DETERMINATIONS.—Notwithstanding the amendments made by this section (and the provisions of law amended thereby), a plan shall not be required to modify benefit determinations for the period beginning on February 13, 2011, and ending 30 days after the date of the enactment of this Act [Oct. 21, 2011], but a plan shall not fail to be qualified health insurance within the meaning of section 35(e) of the Internal Revenue Code of 1986 during this period merely due to such failure to modify benefit determinations.

“(B) GUIDANCE CONCERNING PERIODS BEFORE 30 DAYS AFTER ENACTMENT.—Except as provided in subparagraph (A), the Secretary of the Treasury (or his designee), in consultation with the Secretary of Health and Human Services and the Secretary of Labor, may issue regulations or other guidance regarding the scope of the application of the amendments made by this section to periods before the date which is 30 days after the date of the enactment of this Act.

“(C) SPECIAL RULE RELATING TO CERTAIN LOSS OF COVERAGE.—In the case of a TAA-related loss of coverage (as defined in section 4980B(f)(5)(C)(iv) of the Internal Revenue Code of 1986) that occurs during the period beginning on February 13, 2011, and ending 30 days after the date of the enactment of this Act, the 7-day period described in section 9801(c)(2)(D) of the Internal Revenue Code of 1986, section 701(c)(2)(C) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181(c)(2)(C)], and section 2701(c)(2)(C) of the Public Health Service Act [renumbered section 2704(c)(2)(C), see 42 U.S.C. 300gg-3(c)(2)(C)] shall be extended until 30 days after such date of enactment.”

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-344, title I, §114(d), Dec. 29, 2010, 124 Stat. 3615, provided that: “The amendments made by this section [amending this section, section 1181 of Title 29, Labor, and section 300gg of Title 42, The Public Health and Welfare] shall apply to plan years beginning after December 31, 2010.”

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.

Pub. L. 111-5, div. B, title I, §1899D(d), Feb. 17, 2009, 123 Stat. 426, provided that: “The amendments made by this section [amending this section, section 1181 of Title 29, Labor, and section 300gg of Title 42, The Public Health and Welfare] shall apply to plan years beginning after the date of the enactment of this Act [Feb. 17, 2009].”

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 Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105-34 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 1531(c) of Pub. L. 105-34, set out as a note under section 4980D of this title.

EFFECTIVE DATE

Pub. L. 104-191, title IV, §401(c), Aug. 21, 1996, 110 Stat. 2082, provided that:

“(1) IN GENERAL.—The amendments made by this section [enacting this subtitle] shall apply to plan years beginning after June 30, 1997.

“(2) DETERMINATION OF CREDITABLE COVERAGE.—

“(A) PERIOD OF COVERAGE.—

“(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under chapter 100 of the Internal Revenue Code of 1986 (as added by this section) in determining creditable coverage.

“(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of the Treasury, consistent with section 104 [42 U.S.C. 300gg-92 note], shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

“(B) CERTIFICATIONS, ETC.—

“(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 9801 of the Internal Revenue Code of 1986 (as added by this section) shall apply to events occurring after June 30, 1996.

“(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

“(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

“(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

“(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

“(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan’s or issuer’s crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

“(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Aug. 21, 1996], the amendments made by this section shall not apply to plan years beginning before the later of—

“(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

“(B) July 1, 1997.

For purposes of subparagraph (A), 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 this section shall not be treated as a termination of such collective bargaining agreement.

“(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