§ 300gg–51. Standards relating to benefits for mothers and newborns

(a) In general

The provisions of section 2704[1] (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 1185(d) of title 29 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 300gg–23(d)(1)[1] of this title) 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 300gg–62(a) of this title shall not be construed as superseding a State law described in paragraph (1).

(July 1, 1944, ch. 373, title XXVII, § 2751, as added Pub. L. 104–204, title VI, § 605(a)(4), Sept. 26, 1996, 110 Stat. 2941.)

REFERENCES IN TEXT

Section 2704, referred to in subsec. (a), is a reference to section 2704 of act July 1, 1944. Section 2704, which was classified to section 300gg–4 of this title, was renumbered section 2725, and amended by Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(3), formerly § 1562(c)(3), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911, and was transferred to section 300gg–25 of this title. A new section 2704 of act July 1, 1944, related to prohibition of preexisting condition exclusions or other discrimination based on health status, was added, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and is classified to section 300gg–3 of this title.

Section 300gg–23(d)(1) of this title, referred to in subsec. (c)(1), was in the original ''section 2723(d)(1)'', and was translated as meaning section 2724(d)(1) of act July 1, 1944, to reflect the probable intent of Congress and the renumbering of section 2723 as 2724 by Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(14)(B), formerly § 1562(c)(14)(B), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

EFFECTIVE DATE

Section applicable to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after Jan. 1, 1998, see section 605(c) of Pub. L. 104–204, set out as an Effective Date of 1996 Amendment note under section 300gg–44 of this title.

[1] See References in Text note below.

§ 300gg–52. Required coverage for reconstructive surgery following mastectomies

The provisions of section 2706[1] 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.

(July 1, 1944, ch. 373, title XXVII, § 2752, as added Pub. L. 105–277, div. A, § 101(f) [title IX, § 903(b)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438.)

REFERENCES IN TEXT

Section 2706, referred to in text, is a reference to section 2706 of act July 1, 1944. Section 2706, which was classified to section 300gg–6 of this title, was renumbered section 2727 and amended by Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(5), formerly § 1562(c)(5), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911, and was transferred to section 300gg–27 of this title. A new section 2706 of act July 1, 1944, related to non-discrimination in health care, was added, effective for plan years beginning on or after Jan. 1, 2014, by Pub. L. 111–148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 160, and is classified to section 300gg–5 of this title.

EFFECTIVE DATE

Pub. L. 105–277, div. A, § 101(f) [title IX, § 903(c)(2)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438, provided that: ''The amendment made by subsection (b) [enacting this section] 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 [Oct. 21, 1998].''

§ 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 estab-

[1] See References in Text note below.

lishing 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)) [1] 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 [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 [2] (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 applicable 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 300gg–91 of this title).

[1] See References in Text note below.

[2] So in original. Probably should be "subsections".

(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.

(July 1, 1944, ch. 373, title XXVII, § 2753, as added Pub. L. 110–233, title I, § 102(b)(1)(B), May 21, 2008, 122 Stat. 893.)

REFERENCES IN TEXT

Section 2701, referred to in subsec. (c)(1), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

The Social Security Act, referred to in subsec. (d)(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 subsec. (d)(3)(A), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

CODIFICATION

Another section 2753 of act July 1, 1944, is classified to section 300gg–54 of this title.

EFFECTIVE DATE

Section applicable, with respect to group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning after the date that is one year after May 21, 2008, and, with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market, after the date that is one year after May 21, 2008, see section 102(d)(2) of Pub. L. 110–233, set out as an Effective Date of 2008 Amendment note under section 300gg–21 of this title.

§ 300gg–54. Coverage of dependent students on medically necessary leave of absence

The provisions of section 2707[1] 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.

(July 1, 1944, ch. 373, title XXVII, § 2753, as added Pub. L. 110–381, § 2(b)(2), Oct. 9, 2008, 122 Stat. 4084.)

REFERENCES IN TEXT

Section 2707, referred to in text, is a reference to section 2707 of act July 1, 1944. Section 2707, which was classified to section 300gg–7 of this title, was renumbered section 2728 and amended by Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(6), formerly § 1562(c)(6), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911, and was transferred to section 300gg–28 of this title. A new section 2707 of act July 1, 1944, related to comprehensive health insurance coverage, was added, effective for plan years beginning on or after Jan. 1, 2014, by Pub. L. 111–148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 161, and is classified to section 300gg–6 of this title.

CODIFICATION

Section 2(b)(2) of Pub. L. 110–381, which directed amendment of subpart 3 of part B of title XXVII of act July 1, 1944, by adding this section at the end, was executed in this subpart, which is subpart 2 of part B of title XXVII of act July 1, 1944, to reflect the probable intent of Congress and the redesignation of subpart 3 as subpart 2 by Pub. L. 110–233, title I, § 102(b)(1)(A), May 21, 2008, 122 Stat. 893.

Another section 2753 of act July 1, 1944, is classified to section 300gg–53 of this title.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110–381, set out as a note under section 9813 of Title 26, Internal Revenue Code.

SUBPART 3—GENERAL PROVISIONS

CODIFICATION

Another subpart 3 of part B of title XXVII of act July 1, 1944, was redesignated subpart 2 by Pub. L. 110–233, title I, § 102(b)(1)(A), May 21, 2008, 122 Stat. 892, and is classified to subpart 2 (§ 300gg–51 et seq.) of this part.

§ 300gg–61. Enforcement

(a) State enforcement

(1) State authority

Subject to section 300gg–62 of this title, each State may require that health insurance issuers that issue, sell, 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

[1] See References in Text note below.