

111TH CONGRESS }  
2d Session

LEGISLATIVE COUNSEL

{ PRINT 111-2

COMPILATION OF TITLE XXVII OF THE PUBLIC HEALTH SERVICE ACT (AND RELATED PROVISIONS)

---

[As Amended Through May 1, 2010]

REFLECTING AMENDMENTS MADE BY

PATIENT PROTECTION AND AFFORDABLE CARE ACT  
HEALTH CARE AND EDUCATION RECONCILIATION ACT OF  
2010

---

PREPARED BY THE  
Office of the Legislative Counsel  
FOR THE USE OF THE  
U.S. HOUSE OF REPRESENTATIVES



MAY 2010

OFFICE OF THE LEGISLATIVE COUNSEL

SANDRA L. STROKOFF, Legislative Counsel  
EDWARD G. GROSSMAN, Deputy Legislative Counsel

---

*Prepared by*

LAWRENCE A. JOHNSTON, *Senior Counsel*  
EDWARD G. GROSSMAN, *Deputy Legislative Counsel*  
with the assistance of  
CRAIG A. STERKX, *Publications Coordinator*

This document shows title XXVII of the Public Health Service Act (“PHSA”) as it will appear as of January 1, 2014, as amended by the Patient Protection and Affordable Care Act (“PPACA”) (Public Law 111–148; March 23, 2010; 124 Stat. 119) and by the Health Care and Education Reconciliation Act of 2010 (“HCERA”) (Public Law 111–152; March 30, 2010; 124 Stat. 1029), and certain related provisions in the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and title I of the Patient Protection and Affordable Care Act. *Note that many of the provisions shown will not be in effect until January 1, 2014.*

**Special section references.**—Because certain sections in title I of PPACA were later redesignated (or renumbered) by title X of PPACA, to help the reader in the explanatory notations in this document, these redesignated sections are referred to as follows:

- References to “section 1563[2\*]” of PPACA are to the original section 1562 (conforming amendments) redesignated as a section 1563 by section 10107(b)(1) of PPACA; and
- References to “section 1255[3\*]” of PPACA are to the original section 1253 (effective dates) redesignated as section 1255 by section 10103(f)(1) of PPACA.

**Preparation of document.**—This document was prepared by the attorneys and staff of the House Office of the Legislative Counsel (HOLC) for the use of its attorneys and clients. It is not an official document of the House of Representatives or its committees and may not be cited as “the law”. At the request of the Leadership, it is being made available to the public through Congressional websites and may be downloaded at <http://docs.house.gov/energycommerce/phsa027.pdf>. Errors in this document are solely the responsibility of HOLC. Please email any corrections to “[hlcomments@mail.house.gov](mailto:hlcomments@mail.house.gov)”. This document (originally dated May 24, 2010) may be updated to reflect corrections of errors.

**Typography indicating changes.**—The following typographic devices are used in showing changes made to title XXVII of the PHSA by PPACA and HCERA:

- Original text not changed or moved shown in Century roman.
- Original text that has been moved but otherwise unchanged is shown in Gothic roman.

- Text added by PPACA shown in *italics*.
- Additions to italic text (made by title X of PPACA or by HCERA) shown in ***italic boldface***.
- Deletions in text (including roman and italic text) shown in **[bold brackets]**.
- Notations indicating sources or changes being made are contained in liteface bracketed notes, viz., [*note* ].

**Cross-reference notation.**—PPACA effected a major reorganization of previous sections in part A of title XXVII of the Public Health Service Act, as well as the addition of new sections. However, cross-references to current sections that have been redesignated have often not been corrected to reflect that reorganization. For the aid of the reader, where it is fairly clear that a pre-PPACA reference to a section should have been conformed to refer to a new section reference, the new section reference is indicated in braces, viz., {}.

**United States Code citations.**—United States Code section numbers assigned to sections in the PHSA are specified in brackets after the PHSA section numbers in the heading of each section, viz., 2711 [42 U.S.C. 300gg–11]. In addition, there is an outline of disposition of sections in part A (and new sections in part C) of title XXVII of the PHSA, including US Code section numbers, appended at the end of the document.

May 24, 2010

# CONTENTS

---

	Page
TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE	
PART A—INDIVIDUAL AND GROUP MARKET REFORMS	
Subpart I—General Reform	
Sec. 2701. Fair health insurance premiums .....	1
Sec. 2702. Guaranteed availability of coverage .....	2
Sec. 2703. Guaranteed renewability of coverage .....	5
Sec. 2704. Prohibition of preexisting condition exclusions or other dis- crimination based on health status .....	8
Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status .....	15
Sec. 2706. Non-discrimination in health care .....	22
Sec. 2707. Comprehensive health insurance coverage .....	23
Sec. 2708. Prohibition on excessive waiting periods .....	23
Sec. 2709. Coverage for individuals participating in approved clinical trials .....	23
Sec. 2709. Disclosure of information .....	26
Subpart II—Improving Coverage	
Sec. 2711. No lifetime or annual limits .....	26
Sec. 2712. Prohibition on rescissions .....	27
Sec. 2713. Coverage of preventive health services .....	27
Sec. 2714. Extension of dependent coverage .....	28
Sec. 2715. Development and utilization of uniform explanation of cov- erage documents and standardized definitions .....	29
Sec. 2715A. Provision of additional information .....	31
Sec. 2716. Prohibition on discrimination in favor of highly compensated individuals .....	32
Sec. 2717. Ensuring the quality of care .....	32
Sec. 2718. Bringing down the cost of health care coverage .....	34
Sec. 2719. Appeals process .....	36
Sec. 2719A. Patient protections .....	38
Sec. 2725. Standards relating to benefits for mothers and newborns. ....	40
Sec. 2726. Parity in mental health and substance use disorder benefits ...	42
Sec. 2727. Required coverage for reconstructive surgery following mastectomies .....	48
Sec. 2728. Coverage of dependent students on medically necessary leave of absence .....	48
Subpart 2—Exclusion of Plans; Enforcement; Preemption .....	50
Sec. 2722. Exclusion of certain plans .....	50
Sec. 2723. Enforcement .....	53
Sec. 2724. Preemption; State flexibility; construction .....	57

## PART B—INDIVIDUAL MARKET RULES

## Subpart 1—Portability, Access, and Renewability Requirements

Sec. 2741. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage .....	58
Sec. 2742. Guaranteed renewability of individual health insurance coverage .....	61
Sec. 2743. Certification of coverage .....	63
Sec. 2744. State flexibility in individual market reforms .....	63
Sec. 2745. Relief for high risk pools .....	66

## Subpart 2—Other Requirements

Sec. 2751. Standards relating to benefits for mothers and newborns .....	69
Sec. 2752. Required coverage for reconstructive surgery following mastectomies .....	70
Sec. 2753. Prohibition of health discrimination on the basis of genetic information .....	70

## Subpart 3—General Provisions

Sec. 2761. Enforcement .....	72
Sec. 2762. Preemption and application .....	73
Sec. 2763. General exceptions .....	73
Sec. 2753. Coverage of dependent students on medically necessary leave of absence .....	74

## PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

Sec. 2791. Definitions .....	74
Sec. 2792. Regulations .....	80
Sec. 2793. Health insurance consumer information .....	80
Sec. 2794. Ensuring that consumers get value for their dollars .....	81
Sec. 2794. Uniform fraud and abuse referral format .....	83

## ADDITIONAL PROVISIONS

Employee Retirement Income Security Act of 1974	
Sec. 715. Additional market reforms .....	84
Internal Revenue Code of 1986	
Sec. 9815. Additional market reforms .....	85
Selected Additional Provisions of PPACA	
Sec. 1004. Effective dates .....	86
Sec. 1101. Immediate access to insurance for uninsured individuals with a preexisting condition .....	86
Sec. 1103. Immediate information that allows consumers to identify affordable coverage options .....	89
Sec. 1251. Preservation of right to maintain existing coverage .....	90
Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans .....	92
Sec. 1253. Annual report on self-insured plans .....	92
Sec. 1254. Study of large group market .....	97
Sec. 1255. Effective dates .....	93
Sec. 1304. Related definitions .....	94
Sec. 1312. Consumer choice .....	95
Sec. 1560. Rules of construction .....	96

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH  
INSURANCE COVERAGE

[Part A designation amended by section 1001(1) of PPACA. Table of contents not  
included in law.]

**[Part A—Group Market Reforms]**

***PART A—INDIVIDUAL AND GROUP MARKET  
REFORMS***

[Subpart I designation amended by section 1201(1) of PPACA.]

**[Subpart 1—Portability, Access, and Renewability  
Requirements]**

***Subpart I—General Reform***

[Section 2701 added by section 1201(4) of PPACA, effective for plan years beginning  
on or after 1/1/14 under section 1255[3\*] of PPACA. Previous section 2701 now  
appears as section 2704 (see amendment made by section 1201(2) of PPACA).]

**SEC. 2701. [42 U.S.C. 300gg] FAIR HEALTH INSURANCE PREMIUMS.**

*(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—*

*(1) IN GENERAL.—With respect to the premium rate charged  
by a health insurance issuer for health insurance coverage of-  
fered in the individual or small group market—*

*(A) such rate shall vary with respect to the particular  
plan or coverage involved only by—*

*(i) whether such plan or coverage covers an indi-  
vidual or family;*

*(ii) rating area, as established in accordance with  
paragraph (2);*

*(iii) age, except that such rate shall not vary by  
more than 3 to 1 for adults (consistent with section  
2707(c)); and*

*(iv) tobacco use, except that such rate shall not  
vary by more than 1.5 to 1; and*

*(B) such rate shall not vary with respect to the par-  
ticular plan or coverage involved by any other factor not de-  
scribed in subparagraph (A).*

*(2) RATING AREA.—*

*(A) IN GENERAL.—Each State shall establish 1 or more  
rating areas within that State for purposes of applying the  
requirements of this title.*

*(B) SECRETARIAL REVIEW.—The Secretary shall review  
the rating areas established by each State under subpara-*

graph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

(3) *PERMISSIBLE AGE BANDS.*—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) *APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.*—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) *SPECIAL RULE FOR LARGE GROUP MARKET.*—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

[There are no subsections in section 2701 following subsection (a).]

[Section 2702 added by section 1201(4) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

**SEC. 2702. [42 U.S.C. 300gg-1] GUARANTEED AVAILABILITY OF COVERAGE.**

(a) *GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.*—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

(b) *ENROLLMENT.*—

(1) *RESTRICTION.*—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

(2) *ESTABLISHMENT.*—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

(3) *REGULATIONS.*—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

[Section heading and subsections (a) and (b) below originally in section 2711, redesignated as section 2731 by section 1001(3) of PPACA, stricken by section 1563[2\*](c)(8) of PPACA before section, as amended, was transferred here; shown for information purposes only.]

**[SEC. 2711. GUARANTEED AVAILABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.**

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



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

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

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

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

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

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

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

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

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

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

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

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

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

[Subsection (c), originally in section 2711, redesignated as section 2731 by section 1001(3), amended and transferred to the end of section 2702 by section 1563[2\*](c)(8) of PPACA.]

(c) SPECIAL RULES FOR NETWORK PLANS.—

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

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

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

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

(ii) it is applying this paragraph uniformly to all employers [without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such] *and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals* [sic; lacking punctuation] employees and dependents.

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

[Subsection (d), originally in section 2711, redesignated as section 2731 by section 1001(3), amended and transferred to the end of section 2702 by section 1563[2\*](c)(8) of PPACA.]

(d) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

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

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

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

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

applicable State authority may provide for the application of this subsection on a service-area-specific basis.

[Subsections (e) and (f), originally in section 2711, redesignated as section 2731 by section 1001(3) of PPACA, amended and stricken by section 1563[2\*](c)(8) of PPACA before section, as amended, was transferred here; shown for information purposes only.]

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

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

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

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

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

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

[Section 2703 added by section 1201(4) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

**SEC. 2703. [42 U.S.C. 300gg-2] GUARANTEED RENEWABILITY OF COVERAGE.**

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

[Section heading and subsection (a) of section 2712, redesignated as section 2732 by section 1001(3), stricken by section 1563[2\*](c)(9) of PPACA; shown for information purposes only.]

**[SEC. 2712. GUARANTEED RENEWABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.**

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

[Subsection (b), originally in section 2712, redesignated as section 2732 by section 1001(3), amended and transferred to the end of section 2703 by section 1563[2\*](c)(9) of PPACA.]

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

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

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

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

(3) **VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.**—*In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.*

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

(5) **MOVEMENT OUTSIDE SERVICE AREA.**—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711{2702}(c)(1)(A).

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

[Subsection (c), originally in section 2712, redesignated as section 2732 by section 1001(3), amended and transferred to the end of section 2703 by section 1563[2\*](c)(9) of PPACA.]

(c) **REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.**—

(1) **PARTICULAR TYPE OF COVERAGE NOT OFFERED.**—In any case in which an issuer decides to discontinue offering a particular type of [group health insurance coverage offered in the small or large group market] *group or individual health insurance coverage*, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if—

(A) the issuer provides notice to each plan sponsor *or individual, as applicable*, provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such dis-

continuation at least 90 days prior to the date of the discontinuation of such coverage;

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

[Insertion of language reflects probable intent of section 1563[2\*](c)(9)(C)(I)(iii)(bb) of PPACA; no placement for insertion specified.]

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

(2) DISCONTINUANCE OF ALL COVERAGE.—

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

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

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

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

[Subsection (d), originally in section 2712, redesignated as section 2732 by section 1001(3), amended and transferred to the end of section 2703 by section 1563[2\*](c)(9) of PPACA.]

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

(1) in the large group market; or

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

[Subsection (e), originally in section 2712, redesignated as section 2732 by section 1001(3), amended and transferred to the end of section 2703 by section 1563[2\*](c)(9) of PPACA.]

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

[Section heading and subsection (a) of section 2701, as redesignated as section 2704 and amended by section 1201(2)(A) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA, except that under section 1255[3\*](2) of PPACA the provisions of this section as they apply to enrollees who are under 19 years of age shall become effective for plan years beginning on or after September 23, 2010.]

**[SEC. 2701. INCREASED PORTABILITY THROUGH LIMITATION OF PRE-EXISTING CONDITION EXCLUSIONS.**

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

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

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

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

**SEC. 2704. [42 U.S.C. 300gg-3] PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION 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 impose any preexisting condition exclusion with respect to such plan or coverage.

[Subsection (b), originally in section 2701, transferred by section 1201(2)(B) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA, except that under section 1255[3\*](2) of PPACA the provisions of this section as they apply to enrollees who are under 19 years of age shall become effective for plan years beginning on or after September 23, 2010.]

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

(1) PREEXISTING CONDITION EXCLUSION.—

(A) IN GENERAL.—The term “preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before

the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

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

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

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

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

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

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

[Subsection (c), originally in section 2701, transferred by section 1201(2)(B) of PPACA, and amended by section 1563(2\*)(c)(1) of PPACA.]

(c) **RULES RELATING TO CREDITING PREVIOUS COVERAGE.**—

(1) **CREDITABLE COVERAGE DEFINED.**—For purposes of this title, the term “creditable coverage” means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act.

(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

(E) Chapter 55 of title 10, United States Code.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5, United States Code.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

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

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

(A) **IN GENERAL.**—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group *or individual* 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 *or individual* health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

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

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

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

(3) METHOD OF CREDITING COVERAGE.—

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

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

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

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

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

(D) ISSUER NOTICE.—In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the [small or large] *individual or group* group [sic; duplicate “group” in law] market, the issuer—

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

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

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



[Subsection (d), originally in section 2701, transferred by section 1201(2)(B) of PPACA, and amended by section 1563[2\*](c)(1) of PPACA.]

(d) EXCEPTIONS.—

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

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

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

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

[Subsection (e), originally in section 2701, transferred by section 1201(2)(B) of PPACA, and amended by section 1563[2\*](c)(1) of PPACA.]

(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Subsection (f), originally in section 2701, transferred by section 1201(2)(B) of PPACA.]

(f) **SPECIAL ENROLLMENT PERIODS.**—

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

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

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

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

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

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

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

## (2) FOR DEPENDENT BENEFICIARIES.—

## (A) IN GENERAL.—If—

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

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

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

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

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

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

(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a 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 FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

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

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

(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or dem-

onstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) COORDINATION WITH MEDICAID AND CHIP.—

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

(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

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

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

[Section 2705 added by section 1201(4) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

**SEC. 2705. [42 U.S.C. 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.*

[Section heading and subsection (a) of section 2702; stricken by section 1201(3)(A) of PPACA before section was transferred by section 1201(3)(B) of PPACA to end of new section 2705.]

**[SEC. 2702. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.**

**[(a) IN ELIGIBILITY TO ENROLL.—**

**[(1) IN GENERAL.—**Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- [(A) Health status.**
- [(B) Medical condition (including both physical and mental illnesses).**
- [(C) Claims experience.**
- [(D) Receipt of health care.**
- [(E) Medical history.**
- [(F) Genetic information.**
- [(G) Evidence of insurability (including conditions arising out of acts of domestic violence).**
- [(H) Disability.**

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

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

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

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

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

[Subsection (b), originally in section 2702, amended and transferred to the end of section 2705 (as added) by section 1201(3) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

(b) IN PREMIUM CONTRIBUTIONS.—

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

(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a [health insurance issuer offering health insurance coverage in connection with a group health plan] *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.

[Subsection (c), originally in section 2702, transferred to the end of section 2705 (as added) by section 1201(3) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

(c) GENETIC TESTING.—

(1) **LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.**—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

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

(3) **RULE OF CONSTRUCTION REGARDING PAYMENT.**—

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

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

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

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

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

(i) compliance with the request is voluntary; and

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

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

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

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

[Subsection (d), originally in section 2702, transferred to the end of section 2705 (as added) by section 1201(3)(B) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

(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 2791).

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

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

[Subsection (e), originally in section 2702, amended and transferred to the end of section 2705 (as added) by section 1201(3) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

(e) APPLICATION TO ALL PLANS.—The provisions of subsections [(a)(1)(F)] (a)(6), (b)(3), (c), and (d) and subsection (b)(1) and section [2701] 2704 with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section [2721(a)] 2735(a) {2722(a)}.

[Subsection (f), originally in section 2702, transferred to the end of section 2705 (as added) by section 1201(3)(B) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

(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.

[There are no subsections (g) through (i).]

[Subsections (j) through (n) inserted (together with new section heading for section 2705 and new subsection (a)) by section 1201(4) of PPACA.]

(j) 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 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) receiv-

ing 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—

(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 estab-

lished prior to the date of enactment of this section 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.

(1) *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 the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

(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 the date of enactment of the Patient Protection and Affordable Care Act, 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 employees 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.

[Section 2706 added by section 1201(4) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

**SEC. 2706. [42 U.S.C. 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 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

[Section 2707 added by section 1201(4) of PPACA, effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA.]

**SEC. 2707. [42 U.S.C. 300gg-6] COMPREHENSIVE HEALTH INSURANCE COVERAGE.**

(a) *COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.*—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

(b) *COST-SHARING UNDER GROUP HEALTH PLANS.*—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c) [sic; presumably referring to that section in PPACA].

(c) *CHILD-ONLY PLANS.*—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

(d) *DENTAL ONLY.*—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I) [sic; presumably referring to section 1302(d)(2)(B)(ii) in PPACA].

[Section 2708 added by section 1201(4) of PPACA (effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA) and amended by section 10103(b) of PPACA.]

**SEC. 2708. [42 U.S.C. 300gg-7] PROHIBITION ON EXCESSIVE WAITING PERIODS.**

A group health plan and a health insurance issuer offering group [or individual] health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.

[There are 2 sections numbered 2709. The following section 2709 was “inserted after section 2708” (so it appears as the first section 2709) by section 10103(c) of PPACA, and may be effective for plan years beginning on or after 1/1/14 under section 1255[3\*] of PPACA (even though not part of an “amendment made by this subtitle”). See amendments made by section 1563[2\*](c)(10)(C) and section 10103(c).]

**SEC. 2709. [42 U.S.C. 300gg-8] COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.**

(a) *COVERAGE.*—

(1) *IN GENERAL.*—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the individual’s participation in such trial.

(2) *ROUTINE PATIENT COSTS.*—

(A) *INCLUSION.*—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

(B) *EXCLUSION.*—For purposes of paragraph (1)(B), routine patient costs does not include—

(i) the investigational item, device, or service, itself;

(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(3) *USE OF IN-NETWORK PROVIDERS.*—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(4) *USE OF OUT-OF-NETWORK.*—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

(b) *QUALIFIED INDIVIDUAL DEFINED.*—For purposes of subsection (a), the term “qualified individual” means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

(2) Either—

(A) the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant or beneficiary provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) *LIMITATIONS ON COVERAGE.*—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan’s (or coverage’s) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

(d) *APPROVED CLINICAL TRIAL DEFINED.*—

(1) *IN GENERAL.*—In this section, the term “approved clinical trial” means a phase I, phase II, phase III, or phase IV

*clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:*

(A) *FEDERALLY FUNDED TRIALS.*—*The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:*

(i) *The National Institutes of Health.*

(ii) *The Centers for Disease Control and Prevention.*

(iii) *The Agency for Health Care Research and Quality.*

(iv) *The Centers for Medicare & Medicaid Services.*

(v) *cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.*

(vi) *A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.*

(vii) *Any of the following if the conditions described in paragraph (2) are met:*

(I) *The Department of Veterans Affairs.*

(II) *The Department of Defense.*

(III) *The Department of Energy.*

(B) *The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.*

(C) *The study or investigation is a drug trial that is exempt from having such an investigational new drug application.*

(2) *CONDITIONS FOR DEPARTMENTS.*—*The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—*

(A) *to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and*

(B) *assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.*

(e) *LIFE-THREATENING CONDITION DEFINED.*—*In this section, the term “life-threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.*

(f) *CONSTRUCTION.*—*Nothing in this section shall be construed to limit a plan’s or issuer’s coverage with respect to clinical trials.*

(g) *APPLICATION TO FEHBP.*—*Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.*

(h) *PREEMPTION.*—*Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a*

*clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.*

[Section 2713 redesignated as section 2733 by section 1001(3), amended and transferred and redesignated as section 2709 by section 1563[2\*](c)(10)(C) of PPACA.]

**SEC. [2713] 2709. [42 U.S.C. 300gg-9] DISCLOSURE OF INFORMATION.**

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

(1) shall make a reasonable disclosure to such employer, *or individual, as applicable*, [sic; double commas in law] as part of its solicitation and sales materials, of the availability of information described in subsection (b), and

(2) upon request of such a [small employer] *employer, or individual, as applicable*, [sic; double commas in law] provide such information.

(b) **INFORMATION DESCRIBED.**—

(1) **IN GENERAL.**—Subject to paragraph (3), with respect to a health insurance issuer offering health insurance coverage to a [small employer] *employer, or individual, as applicable*, [sic; double commas in law] information described in this subsection is information concerning—

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

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

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

[(D)] (B) the benefits and premiums available under all health insurance coverage for which the employer, *or individual, as applicable*, is qualified.

(2) **FORM OF INFORMATION.**—Information under this subsection shall be provided to [small employers] *employers, or individuals, as applicable*, in a manner determined to be understandable by the average [small employer] *employer, or individual, as applicable*, [sic; double commas in law] and shall be sufficient to reasonably inform [small employers] *employers, or individuals, as applicable*, of their rights and obligations under the health insurance coverage.

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

[Subpart II added by section 1001(5) of PPACA.]

### ***Subpart II—Improving Coverage***

[Section 2711 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA, and amended to read as follows in section 10101(d) of PPACA. Text of original section 2711 is omitted.]

**SEC. 2711. [42 U.S.C. 300gg-11] NO LIFETIME OR ANNUAL LIMITS.**

(a) **PROHIBITION.**—



(1) *IN GENERAL.*—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.

(2) *ANNUAL LIMITS PRIOR TO 2014.*—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term “restricted annual limit” for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

(b) *PER BENEFICIARY LIMITS.*—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.

[Section 2712 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA.]

**SEC. 2712. [42 U.S.C. 300gg-12] PROHIBITION ON RESCISSIONS.**

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c){probably 2703(b)} or 2742(b).

[Section 2713 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA.]

**SEC. 2713. [42 U.S.C. 300gg-13] COVERAGE OF PREVENTIVE HEALTH SERVICES.**

(a) *IN GENERAL.*—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

(1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

(5) for the purposes of this Act, and for the purposes of any other provisions of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

(b) *INTERVAL.*—

(1) *IN GENERAL.*—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

(2) *MINIMUM.*—The interval described in paragraph (1) shall not be less than 1 year.

(c) *VALUE-BASED INSURANCE DESIGN.*—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

[Section 2714 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA, and amended by section 2301(b) of Health Care and Education Reconciliation Act of 2010 (P.L. 111–152). See boldface brackets in subsection (a) for text stricken by section 2301(b) of Public Law 111–152.]

**SEC. 2714. [42 U.S.C. 300gg–14] EXTENSION OF DEPENDENT COVERAGE.**

(a) *IN GENERAL.*—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child **[(who is not married)]** until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

(b) *REGULATIONS.*—The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

(c) *RULE OF CONSTRUCTION.*—Nothing in this section shall be construed to modify the definition of “dependent” as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

[Section 2715 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA, and amended by section 10101(b) of PPACA.]

**SEC. 2715. [42 U.S.C. 300gg–15] DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.**

(a) *IN GENERAL.*—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling **[and providing to enrollees] and providing to applicants, enrollees, and policyholders or certificate holders** a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the “NAIC”), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

(b) *REQUIREMENTS.*—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

(1) *APPEARANCE.*—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

(2) *LANGUAGE.*—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(3) *CONTENTS.*—The standards shall ensure that the summary of benefits and coverage includes—

(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

(B) a description of the coverage, including cost sharing for—

(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

(ii) other benefits, as identified by the Secretary;

(C) the exceptions, reductions, and limitations on coverage;

(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

- (E) the renewability and continuation of coverage provisions;
- (F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;
- (G) a statement of whether the plan or coverage—
- (i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and
- (ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;
- (H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and
- (I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.
- (c) **PERIODIC REVIEW AND UPDATING.**—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.
- (d) **REQUIREMENT TO PROVIDE.**—
- (1) **IN GENERAL.**—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—
- (A) an applicant at the time of application;
- (B) an enrollee prior to the time of enrollment or re-enrollment, as applicable; and
- (C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.
- (2) **COMPLIANCE.**—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.
- (3) **ENTITIES IN GENERAL.**—An entity described in this paragraph is—
- (A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or
- (B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).
- (4) **NOTICE OF MODIFICATIONS.**—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security

Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

(e) *PREEMPTION.*—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

(f) *FAILURE TO PROVIDE.*—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

(g) *DEVELOPMENT OF STANDARD DEFINITIONS.*—

(1) *IN GENERAL.*—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

(2) *INSURANCE-RELATED TERMS.*—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(3) *MEDICAL TERMS.*—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

[Section 2715A added by section 10101(c) of PPACA.]

**SEC. 2715A. [42 U.S.C. 300gg-15a] PROVISION OF ADDITIONAL INFORMATION.**

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.

[Section 2716 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA, and amended to read as follows in section 10101(d) of PPACA. Text of original section 2716 is omitted]

**SEC. 2716. [42 U.S.C. 300gg-16] PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS.**

(a) *IN GENERAL.*—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

(b) *RULES AND DEFINITIONS.*—For purposes of this section—

(1) *CERTAIN RULES TO APPLY.*—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

(2) *HIGHLY COMPENSATED INDIVIDUAL.*—The term “highly compensated individual” has the meaning given such term by section 105(h)(5) of such Code.

[Section 2717 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA, and amended by section 10101(e) of PPACA.]

**SEC. 2717. [42 U.S.C. 300gg-17] ENSURING THE QUALITY OF CARE.**

(a) *QUALITY REPORTING.*—

(1) *IN GENERAL.*—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) implement wellness and health promotion activities.

(2) *REPORTING REQUIREMENTS.*—

(A) *IN GENERAL.*—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and

to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

(B) *TIMING OF REPORTS.*—A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

(C) *AVAILABILITY OF REPORTS.*—The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website

(D) *PENALTIES.*—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

(E) *EXCEPTIONS.*—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

(b) *WELLNESS AND PREVENTION PROGRAMS.*—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

- (1) Smoking cessation.
- (2) Weight management.
- (3) Stress management.
- (4) Physical fitness.
- (5) Nutrition.
- (6) Heart disease prevention.
- (7) Healthy lifestyle support.
- (8) Diabetes prevention.

[Subsection (c) added by section 10101(e) of PPACA.]

**(c) PROTECTION OF SECOND AMENDMENT GUN RIGHTS.**—

**(1) WELLNESS AND PREVENTION PROGRAMS.**—A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

**(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or**

**(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.**

**(2) LIMITATION ON DATA COLLECTION.**—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

(A) *the lawful ownership or possession of a firearm or ammunition;*

(B) *the lawful use of a firearm or ammunition; or*

(C) *the lawful storage of a firearm or ammunition.*

(3) **LIMITATION ON DATABASES OR DATA BANKS.**—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

(4) **LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.**—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

(A) *the lawful ownership or possession of a firearm or ammunition; or*

(B) *the lawful use or storage of a firearm or ammunition.*

(5) **LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.**—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

(A) *the lawful ownership or possession of a firearm or ammunition; or*

(B) *the lawful use, possession, or storage of a firearm or ammunition.*

**([c] d) REGULATIONS.**—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

**([d] e) STUDY AND REPORT.**—Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.



[Section 2718 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA, and amended to read as follows by section 10101(f) of PPACA. Text of original section 2718 is omitted.]

**SEC. 2718. [42 U.S.C. 300gg-18] BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.**

(a) *CLEAR ACCOUNTING FOR COSTS.*—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

- (1) on reimbursement for clinical services provided to enrollees under such coverage;
- (2) for activities that improve health care quality; and
- (3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

(b) *ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.*—

(1) *REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.*—

(A) *REQUIREMENT.*—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

- (i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or
- (ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

(B) *REBATE AMOUNT.*—

(i) *CALCULATION OF AMOUNT.*—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

(ii) *CALCULATION BASED ON AVERAGE RATIO.*—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

(2) *CONSIDERATION IN SETTING PERCENTAGES.*—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

(3) *ENFORCEMENT.*—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

(c) *DEFINITIONS.*—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

(d) *ADJUSTMENTS.*—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

(e) *STANDARD HOSPITAL CHARGES.*—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

[Section 2719 added by section 1001(5) of PPACA, effective for plan years beginning on or after September 23, 2010, under section 1004(a) of PPACA, and amended to read as follows by section 10101(h) of PPACA. Text of original section 2719 is omitted.]

**SEC. 2719. [42 U.S.C. 300gg-19] APPEALS PROCESS.**

**(a) INTERNAL CLAIMS APPEALS.—**

**(1) IN GENERAL.—**A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

**(A)** have in effect an internal claims appeal process;

**(B)** provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

**(C)** allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

**(2) ESTABLISHED PROCESSES.—**To comply with paragraph (1)—

**(A)** a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503-1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

**(B)** a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

**(b) EXTERNAL REVIEW.—**A group health plan and a health insurance issuer offering group or individual health insurance coverage—

**(1)** shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

**(2)** shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

(c) **SECRETARY AUTHORITY.**—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.

[Section 2719A added by section 10101(h) of PPACA.]

**SEC. 2719A. [42 U.S.C. 300gg-19a] PATIENT PROTECTIONS.**

(a) **CHOICE OF HEALTH CARE PROFESSIONAL.**—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) **COVERAGE OF EMERGENCY SERVICES.**—

(1) **IN GENERAL.**—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network; [sic; missing “and”]

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of bene-

*fits, or an affiliation or waiting period, permitted under section 2701(2704) of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).*

(2) *DEFINITIONS.—In this subsection:*

(A) *EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.*

(B) *EMERGENCY SERVICES.—The term “emergency services” means, with respect to an emergency medical condition—*

*(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and*

*(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.*

(C) *STABILIZE.—The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

(c) *ACCESS TO PEDIATRIC CARE.—*

(1) *PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.*

(2) *CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.*

(d) *PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—*

(1) *GENERAL RIGHTS.—*

(A) *DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph*

(2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) **OBSTETRICAL AND GYNECOLOGICAL CARE.**—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) **APPLICATION OF PARAGRAPH.**—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

(A) provides coverage for obstetric or gynecologic care;

and

(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(3) **CONSTRUCTION.**—Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

[Heading for subpart 2 stricken in section 1563[2\*](c)(2) of PPACA.]

### **【Subpart 2—Other Requirements】**

[The following section (originally section 2704) remained in place and was redesignated as section 2725 by section 1001(2) and amended by section 1563[2\*](c)(3) of PPACA.]

[There are no sections in the law between section 2719A and 2725; however, sections 2722-2724 appear now following section 2728.]

### **SEC. [2704] 2725. [42 U.S.C. 300gg-25] STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.**

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

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

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

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

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours, or

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

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

(b) PROHIBITIONS.—A group health plan, and a [health insurance issuer offering group health insurance coverage in connection with a group health plan] *health insurance issuer offering group or individual health insurance coverage*, 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] *plan or coverage*, solely for the purpose of avoiding the requirements of this section;

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

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

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

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

(c) RULES OF CONSTRUCTION.—

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

(A) to give birth in a hospital; or

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

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

(3) Nothing in this section shall be construed as preventing a group health plan or [issuer] *health insurance issuer* from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

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

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

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

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723{2724}(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

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

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

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

(2) CONSTRUCTION.—Section 2723{2724}(a)(1) shall not be construed as superseding a State law described in paragraph (1).

[The following section (originally section 2705) remained in place and was redesignated as section 2726 by section 1001(2) and amended by section 1563{2\*}(c)(4) of PPACA.]

**SEC. [2705] 2726. [42 U.S.C. 300gg-26] PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.**

(a) IN GENERAL.—

(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan [(or health insurance coverage offered in connec-



tion with such a plan)] or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

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

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

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

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

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

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

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

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

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

limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

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

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

(3) **FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.**—

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

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

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

(B) **DEFINITIONS.**—In this paragraph:

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

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

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

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

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

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

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

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

(c) EXEMPTIONS.—

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

(2) COST EXEMPTION.—

(A) IN GENERAL.—With respect to a group health plan [(or health insurance coverage offered in connection with such a plan)] or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs

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

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

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

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

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

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

[Section 1563(c)(4)(B)(ii) of PPACA amended this paragraph by striking “(or health insurance coverage offered in connection with such a plan)” and inserted “(or a health insurance issuer offering group or individual health insurance coverage”. Likely intention was to substitute language in (D) above and (E)(i) below in the manner similar to the amendment shown in subparagraph (A) above.]

(E) **NOTIFICATION.**—

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

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

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

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

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

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

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

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

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

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

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

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

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

month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

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

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

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

[The following section (originally section 2706) remained in place and was redesignated as section 2727 by section 1001(2) and amended by section 1563[2\*](c)(5) of PPACA.]

**SEC. [2706] 2727. [42 U.S.C. 300gg-27] REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.**

The provisions of section 713 of the Employee Retirement Income Security Act of 1974 shall apply to group health plans, and [health insurance issuers providing health insurance coverage in connection with group health plans] *and* [sic; double “and” in law] *health insurance issuers offering group or individual health insurance coverage*, as if included in this subpart.

[The following section (originally section 2707) remained in place and was redesignated as section 2728 by section 1001(2) and amended by section 1563[2\*](c)(6) of PPACA.]

**SEC. [2707] 2728. [42 U.S.C. 300gg-28] COVERAGE OF DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE.**

(a) **MEDICALLY NECESSARY LEAVE OF ABSENCE.**—In this section, the term “medically necessary leave of absence” means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan or [health insurance coverage offered in connection with such plan] *individual health insurance coverage*, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that—

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

(2) is medically necessary; and

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

(b) **REQUIREMENT TO CONTINUE COVERAGE.**—

(1) **IN GENERAL.**—In the case of a dependent child described in paragraph (2), a group health plan, [or a health insurance issuer that provides health insurance coverage in connection with a group health plan] *or a health insurance issuer that offers group or individual health insurance coverage*, shall

not terminate coverage of such child under such plan or health insurance coverage due to a medically necessary leave of absence before the date that is the earlier of—

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

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

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

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

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

(3) CERTIFICATION BY PHYSICIAN.—Paragraph (1) shall apply to a group health plan or [health insurance coverage offered by an issuer in connection with such plan] *individual health insurance coverage* only if the plan or issuer of the coverage has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

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

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

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

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

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change

between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children, this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

[Heading for subpart 3 stricken in section 1563[2\*](c)(7) of PPACA.]

**【Subpart 3—Provisions Applicable Only to Health Insurance Issuers】**

[Section 2711 now appears as section 2702; see amendments made by sections 1001(3) and 1563[2\*](c)(8) of PPACA.]

[Section 2712 now appears as section 2703; see amendments made by sections 1001(3) and 1563[2\*](c)(9) of PPACA.]

[Section 2713 now appears as the second section 2709; see amendments made by section 1001(3) and section 1563[2\*](c)(10) of PPACA.]

[Subpart 4 redesignated as subpart 2 in section 1563[2\*](c)(11) of PPACA. Note that there is an earlier subpart “II” as well as this subpart “2”. Sections 2722 through 2724 are shown below and are not in sequence with other provisions.]

**Subpart 【4】 2—Exclusion of Plans; Enforcement; Preemption**

[The following section (originally section 2721) remained in place but was redesignated as section 2735 by section 1001(4) and amended and redesignated as section 2722 by section 1563[2\*](c)(12) of PPACA. Old subsection (a) shown for information purposes.]

**SEC. 【2721】 2722. 【42 U.S.C. 300gg-21】 EXCLUSION OF CERTAIN PLANS.**

**【(a) EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.—**The requirements of subparts 1 and 3 shall not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.**】**

[References in this section to subparts “1” and “2” appear in law and may be intended to refer to subparts “I” and “II”.]

[Note: Section 1563[2\*](a) of PPACA amended subsections (b)(1), (b)(2), (c), (d)(1), and (d)(2) of this section by striking subparts “1 through 3” and inserting “subparts ‘1 and 2’”. Section 1565[3\*](c)(12)(B) of PPACA subsequently struck “subparts 1 through 3” and inserted “subpart 1” each place it appeared in this section; this later amendment could not be executed because of the previous amendment, but the probable intent was to reflect subpart 1 as this provision is in subpart 2 and the reference to subpart 2 would be circular.]

**【(b)】 (a) LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.—**

(1) IN GENERAL.—The requirements of [subparts 1 through 3] *subparts 1 and 2* [alternative: *subpart 1*] shall apply with respect to group health plans only—

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



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

(2) TREATMENT OF NONFEDERAL GOVERNMENTAL PLANS.—

(A) ELECTION TO BE EXCLUDED.—Except as provided in **[subparagraph (D)] subparagraph (D) or (E)**, if the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of **[subparts 1 through 3] subparts 1 and 2 [alternative: subpart 1]** otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts **[sic; if just applicable to subpart 1]** insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

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

(i) for a single specified plan year, or

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

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

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

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

(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701{2704}(e).

(D) ELECTION NOT APPLICABLE TO REQUIREMENTS CONCERNING GENETIC INFORMATION.—The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (a)(1)(F){(a)(6)}, (b)(3), (c), and (d) of section 2702{2705} and the provisions of sections 2701{2704} and 2702{2705}(b) to the extent that such provisions apply to genetic information.

[Subparagraph (E), added by section 1563{2\*}(a)(2)(B)(iii) of PPACA, and amended by section 10107(a) of PPACA.]

*(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of [subpart 1] subparts I and II.*

**[(c)] (b) EXCEPTION FOR CERTAIN BENEFITS.**—The requirements of **[subparts 1 through 3] subparts 1 and 2 [alternative: subpart 1]** shall not apply to any *individual coverage or any* group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(1).

**[(d)] (c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.**—

(1) LIMITED, EXCEPTED BENEFITS.—The requirements of [subparts 1 through 3] *subparts 1 and 2* [alternative: *subpart 1*] shall not apply to any *individual coverage or any group health plan* (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(2) if the benefits—

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

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

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

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

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

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

[Insertion above reflects probable intent; placement of inserted language not specified in section 1563[2\*](a)(4)(B)(ii) of PPACA.]

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part shall not apply to any *individual coverage or any group health plan* (and group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

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

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

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

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

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

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual, if such individual is, or may become, eligible to receive a benefit under the plan or such individual’s beneficiaries may be eligible to receive any such benefit.

[The following section (originally section 2722) remained in place and was redesignated as section 2736 by section 1001(4) and amended and redesignated as section 2723 by section 1563[2\*](c)(13) of PPACA.]

**SEC. [2722] 2723. [42 U.S.C. 300gg-22] ENFORCEMENT.**

(a) STATE ENFORCEMENT.—

(1) STATE AUTHORITY.—Subject to section 2723{2724}, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the [small or large group markets] *individual or group market* meet the requirements of this part with respect to such issuers.

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

(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

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

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

(B) with respect to *individual health insurance coverage* or group health plans that are non-Federal governmental plans.

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

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

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

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

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

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

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

(C) AMOUNT OF PENALTY.—

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

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

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

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

(D) ADMINISTRATIVE REVIEW.—

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

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

(E) JUDICIAL REVIEW.—

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

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

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

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

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

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

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

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

(3) ENFORCEMENT AUTHORITY RELATING TO GENETIC DISCRIMINATION.—

(A) GENERAL RULE.—In the cases described in paragraph (1), notwithstanding the provisions of paragraph (2)(C), the succeeding subparagraphs of this paragraph shall apply with respect to an action under this subsection by the Secretary with respect to any failure of a health insurance issuer in connection with a group health plan, to meet the requirements of subsection (a)(1)(F){(a)(6)}, (b)(3), (c), or (d) of section 2702{2705} or section 2701{2704} or 2702{2705}(b)(1) with respect to genetic information in connection with the plan.

(B) AMOUNT.—

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

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

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

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

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

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

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

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

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

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

(D) LIMITATIONS.—

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

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

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

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

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

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

(II) \$500,000.

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

[The following section (originally section 2723) remained in place and was redesignated as section 2737 by section 1001(4) and amended and redesignated as section 2724 by section 1563[2\*](c)(14) of PPACA. Reflects presumed intent of section 1563[2\*](c)(14)(B) of PPACA to redesignate entire section, rather than redesignating just subsection (a)(1).]

**SEC. [2723] 2724. [42 U.S.C. 300gg-23] PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.**

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

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

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

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

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

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

(i) substitutes for the reference to “6-month period” in section 2701(a)(1){reference no longer there} a reference to any shorter period of time;

(ii) substitutes for the reference to “12 months” and “18 months” in section 2701(a)(2){reference no longer there} a reference to any shorter period of time;

(iii) substitutes for the references to “63” days in sections 2701{2704}(c)(2)(A) and 2701(d)(4)(A){2704(d)(4)} a reference to any greater number of days;

(iv) substitutes for the reference to “30-day period” in sections 2701(b)(2){2704(d)(2)} and 2701{2704}(d)(1) a reference to any greater period;

(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701{2704}(d) or expands the exceptions described in such section;

(vi) requires special enrollment periods in addition to those required under section 2701{2704}(f); or

(vii) reduces the maximum period permitted in an affiliation period under section 2701{2704}(g)(1)(B).

(c) RULES OF CONSTRUCTION.—Nothing in this part (other than section 2704{2725}) shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

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

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

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

[Note: Sections 2725-2728 appear immediately before section 2722.]

## PART B—INDIVIDUAL MARKET RULES

### Subpart 1—Portability, Access, and Renewability Requirements

#### SEC. 2741. [42 U.S.C. 300gg–41] GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE.

(a) GUARANTEED AVAILABILITY.—

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

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

(B) impose any preexisting condition exclusion (as defined in section 2701{2704}(b)(1)(A)) with respect to such coverage.

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



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

(1)(A) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage (as defined in section 2701{2704}(c)) is 18 or more months and (B) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

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

(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) was not terminated based on a factor described in paragraph (1) or (2) of section 2712{2703}(b) (relating to nonpayment of premiums or fraud);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) SPECIAL RULES FOR NETWORK PLANS.—

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

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

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

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

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

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

(e) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

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

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

(B) it is applying this paragraph uniformly to all individuals in the individual market in the State consistent with applicable State law and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

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

(e) MARKET REQUIREMENTS.—

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

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

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

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

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

**SEC. 2742. [42 U.S.C. 300gg-42] GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.**

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

(b) **GENERAL EXCEPTIONS.**—A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

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

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

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

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

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

(c) **REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.**—

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

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

(B) the issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage

currently being offered by the issuer for individuals in such market; and

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

(2) DISCONTINUANCE OF ALL COVERAGE.—

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

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

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

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

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

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

**SEC. 2743. [42 U.S.C. 300gg-43] CERTIFICATION OF COVERAGE.**

The provisions of section 2701{2704}(e) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

**SEC. 2744. [42 U.S.C. 300gg-44] STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.**

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

(1) IN GENERAL.—The requirements of section 2741 shall not apply with respect to health insurance coverage offered in the individual market in the State so long as a State is found

to be implementing, in accordance with this section and consistent with section 2762(b), an alternative mechanism (in this section referred to as an “acceptable alternative mechanism”)—

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

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

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

(D) in a State which is implementing—

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

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

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

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

(b) APPLICATION OF ACCEPTABLE ALTERNATIVE MECHANISMS.—

(1) PRESUMPTION.—

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

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

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

(B) DELAY PERMITTED FOR CERTAIN STATES.—

(i) EFFECT OF DELAY.—In the case of a State described in clause (ii) that provides notice under subparagraph (A)(i), for the presumption to continue on

and after July 1, 1998, the chief executive officer of the State by April 1, 1998—

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

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

(ii) STATES DESCRIBED.—A State described in this clause is a State that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act.

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

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

(A) shall notify the State of—

(i) such preliminary determination, and

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

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

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

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

(5) FUTURE ADOPTION OF MECHANISMS.—If a State, after January 1, 1997, submits the notice and information described in paragraph (1), unless the Secretary makes a finding described in paragraph (3) within the 90-day period beginning on

the date of submission of the notice and information, the mechanism shall be considered to be an acceptable alternative mechanism for purposes of this section, effective 90 days after the end of such period, subject to the second sentence of paragraph (1).

(c) PROVISION RELATED TO RISK.—

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

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

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

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

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

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

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

[Note that section 1101 of PPACA, shown on p. 90, provided for the establishment of a temporary high risk health insurance pool program.]

**SEC. 2745. [42 U.S.C. 300gg–45] RELIEF FOR HIGH RISK POOLS.**

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

(b) GRANTS FOR OPERATIONAL LOSSES.—

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

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

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



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

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

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

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

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

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

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

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

(c) BONUS GRANTS FOR SUPPLEMENTAL CONSUMER BENEFITS.—

(1) IN GENERAL.—In the case of a State that is one of the 50 States or the District of Columbia, that has established a qualified high risk pool, and that is receiving a grant under subsection (b)(1), the Secretary shall provide, from the funds appropriated under paragraphs (1)(B)(ii) and (2)(B) of sub-

section (d) and allotted to the State under paragraph (3), a grant to be used to provide supplemental consumer benefits to enrollees or potential enrollees (or defined subsets of such enrollees or potential enrollees) in qualified high risk pools.

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

(A) Low-income premium subsidies.

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

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

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

(E) Increased benefits.

(F) The establishment of disease management programs.

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

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

(d) FUNDING.—

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

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

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

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

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

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

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

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

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

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

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

(e) APPLICATIONS.—To be eligible for a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

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

(g) DEFINITIONS.—In this section:

(1) QUALIFIED HIGH RISK POOL.—

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

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

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

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

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

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

#### Subpart 2—Other Requirements

#### SEC. 2751. [42 U.S.C. 300gg–51] STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.

(a) IN GENERAL.—The provisions of section 2704{2725} (other than subsections (d) and (f)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market

in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

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

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

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723{2724}(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

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

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

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

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

**SEC. 2752. [42 U.S.C. 300gg-52] REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.**

The provisions of section 2706{2727} 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.

[Note: There is a section 2753, relating to coverage of dependent students on medically necessary leave of absence, in subpart 3 following section 2763.]

**SEC. 2753. [42 U.S.C. 300gg-53] PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION.**

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

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market may not establish rules for the eligibility (including continued eligibility) of any individual to enroll in individual health insurance coverage based on genetic information.

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

for eligibility for an individual to enroll in individual health insurance coverage based on the manifestation of a disease or disorder in that individual, or in a family member of such individual where such family member is covered under the policy that covers such individual.

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

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

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or in paragraphs (1) and (2) of subsection (e) shall be construed to preclude a health insurance issuer from adjusting premium or contribution amounts for an individual on the basis of a manifestation of a disease or disorder in that individual, or in a family member of such individual where such family member is covered under the policy that covers such individual. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other individuals covered under the policy issued to such individual and to further increase premiums or contribution amounts.

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

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market may not, on the basis of genetic information, impose any preexisting condition exclusion (as defined in section 2701{2704}(b)(1)(A)) with respect to such coverage.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or in paragraphs (1) and (2) of subsection (e) shall be construed to preclude a health insurance issuer from imposing any preexisting condition exclusion for an individual with respect to health insurance coverage on the basis of a manifestation of a disease or disorder in that individual.

(d) GENETIC TESTING.—

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

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

(3) RULE OF CONSTRUCTION REGARDING PAYMENT.—

(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to preclude a health insurance issuer offering health insurance coverage in the individual market from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the So-

cial Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a) and (c).

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

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

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any 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 2791).

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

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

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

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

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

### Subpart 3—General Provisions

#### SEC. 2761. [42 U.S.C. 300gg-61] ENFORCEMENT.

(a) STATE ENFORCEMENT.—

(1) STATE AUTHORITY.—Subject to section 2762, 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 this part with respect to health insurance issuers in the State, the Secretary shall enforce the requirements of this part under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in the individual market in such State.

(b) SECRETARIAL ENFORCEMENT AUTHORITY.—The Secretary shall have the same authority in relation to enforcement of the provisions of this part with respect to issuers of health insurance coverage in the individual market in a State as the Secretary has under section 2722{2723}(b)(2), and section 2722{2723}(b)(3) with respect to violations of genetic nondiscrimination provisions, in relation to the enforcement of the provisions of part A with respect to issuers of health insurance coverage in the small group market in the State.

[Heading to section 2762 amended by section 1563[2\*](e)(15) of PPACA.]

#### SEC. 2762. [42 U.S.C. 300gg-62] PREEMPTION AND APPLICATION.

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

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

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

[Subsection (c) added by section 1563[2\*](c)(15) of PPACA.]

*(c) APPLICATION OF PART A PROVISIONS.—*

*(1) IN GENERAL.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.*

*(2) CLARIFICATION.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply.*

**SEC. 2763. [42 U.S.C. 300gg-63] GENERAL EXCEPTIONS.**

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

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

[The placement of section 2753 at the end of subpart 3 is so in law. See amendment made by section 2(b)(2) of Public Law 110-381 122 Stat. 4084). Section 102(b)(1)(A) of Public 110-233 redesignated subpart 3 of part B as subpart 2. Also, another section designated as section 2753 was added by section 102(b)(1)(B) of such Public Law (122 Stat. 893). Probable intent was to make this a section 2754 after that section 2753.]

**SEC. 2753. [42 U.S.C. 300gg-54] COVERAGE OF DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE.**

The provisions of section 2707{2728} 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.

PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

**SEC. 2791. [42 U.S.C. 300gg-91] DEFINITIONS.**

(a) GROUP HEALTH PLAN.—

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

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

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



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

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

(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701{2704}(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701{2704}(e).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

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

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

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

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

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

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

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

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

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

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

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

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

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

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

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

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

(A) Limited scope dental or vision benefits.

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

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

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

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

(B) Hospital indemnity or other fixed indemnity insurance.

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

(d) OTHER DEFINITIONS.—

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

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

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

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

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

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

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

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

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

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

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

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

(C) Title XXII of this Act.

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

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

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

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

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

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

(9) HEALTH STATUS-RELATED FACTOR.—The term “health status-related factor” means any of the factors described in section 2702(a)(1){2705(a)}.

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

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

(12) PLACED FOR ADOPTION DEFINED.—The term “placement”, or being “placed”, for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adop-

tion of such child. The child's placement with such person terminates upon the termination of such legal obligation.

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

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

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

(A) a dependent (as such term is used for purposes of section 2701{2704}(f)(2)) of such individual; and

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

(16) GENETIC INFORMATION.—

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

(i) such individual's genetic tests,

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

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

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

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

(17) GENETIC TEST.—

(A) IN GENERAL.—The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

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

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

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

(A) a genetic test;

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

(C) genetic education.

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

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

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

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

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

[Paragraphs (20) and (21) added by section 1563[2\*](b) of PPACA.]

(20) QUALIFIED HEALTH PLAN.—The term “qualified health plan” has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

(21) EXCHANGE.—The term “Exchange” means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

[Subsection (e) amended by section 1563[2\*](c)(16) of PPACA.]

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

(1) INDIVIDUAL MARKET.—

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

(B) TREATMENT OF VERY SMALL GROUPS.—

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

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

(2) LARGE EMPLOYER.—The term “large employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least ~~51~~ 101 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

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

(4) SMALL EMPLOYER.—The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an av-

erage of [at least 2] *at least 1* but not more than [50] 100 employees on business days during the preceding calendar year and who employs [at least 2] *at least 1* employees [*sic*] on the first day of the plan year.

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

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

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

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

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

**SEC. 2792. [42 U.S.C. 300gg-92] REGULATIONS.**

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

[Section 2793 added by section 1002 of PPACA, effective under section 1004 of PPACA either on date of enactment (under subsection (b)) or for fiscal year 2010 (under subsection (a)).]

**SEC. 2793. [42 U.S.C. 300gg-93] HEALTH INSURANCE CONSUMER INFORMATION.**

(a) *IN GENERAL.*—*The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—*

*(1) offices of health insurance consumer assistance; or*

*(2) health insurance ombudsman programs.*

(b) *ELIGIBILITY.*—

*(1) IN GENERAL.*—*To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.*

*(2) CRITERIA.*—*A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.*

(c) *DUTIES.*—The office of health insurance consumer assistance or health insurance ombudsman shall—

(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

(2) collect, track, and quantify problems and inquiries encountered by consumers;

(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

(d) *DATA COLLECTION.*—As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

(e) *FUNDING.*—

(1) *INITIAL FUNDING.*—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, \$30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.

(2) *AUTHORIZATION FOR SUBSEQUENT YEARS.*—There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.

[Section 2794 added by section 1003 of PPACA, effective under section 1004 of PPACA either on date of enactment (under subsection (b)) or for fiscal year 2010 (under subsection (a)), and amended by section 10101(i) of PPACA.]

**SEC. 2794. [42 U.S.C. 300gg-94] ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.**

(a) *INITIAL PREMIUM REVIEW PROCESS.*—

(1) *IN GENERAL.*—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

(2) *JUSTIFICATION AND DISCLOSURE.*—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

(b) CONTINUING PREMIUM REVIEW PROCESS.—

(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

(B) CONSIDERATION IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

(c) GRANTS IN SUPPORT OF PROCESS.—

(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage;

(B) in providing information and recommendations to the Secretary under subsection (b)(1); **[and]**

[Subparagraph (C) added by section 10101(i)(1)(C) of PPACA.]

**(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.**

(2) FUNDING.—

(A) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary \$250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014,



any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

(C) *ALLOCATION.*—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

(ii) no State qualifying for a grant under paragraph (1) shall receive less than \$1,000,000, or more than \$5,000,000 for a grant year.

[Subsection (d) added by section 10101(i)(2) of PPACA.]

(d) *MEDICAL REIMBURSEMENT DATA CENTERS.*—

(1) *FUNCTIONS.*—A center established under subsection (c)(1)(C) shall—

(A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;

(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

(2) *CONFLICTS OF INTEREST.*—A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center's analysis of health care costs.

(3) *RULE OF CONSTRUCTION.*—Nothing in this subsection shall be construed to permit a center established under subsection (c)(1)(C) to compel health insurance issuers to provide data to the center.

[Note that there are 2 sections numbered 2794. The following section 2794 added by section 6603 of PPACA.]

**SEC. 2794. [42 U.S.C. 300gg-95] UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.**

The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for pri-

---

*vate health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.*

---

**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF  
1974**

\* \* \* \* \*

**TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS**

\* \* \* \* \*

**SUBTITLE B—REGULATORY PROVISIONS**

\* \* \* \* \*

**PART 7—GROUP HEALTH PLAN REQUIREMENTS**

\* \* \* \* \*

**SUBPART B—OTHER REQUIREMENTS**

\* \* \* \* \*

[Section 715 was added by section 1563[2\*](e) of PPACA.]

**SEC. 715. [29 U.S.C. 1185d] ADDITIONAL MARKET REFORMS.**

(a) *GENERAL RULE.*—Except as provided in subsection (b)—

(1) *the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and*

(2) *to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.*

(b) *EXCEPTION.*—Notwithstanding subsection (a), *the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.*

\* \* \* \* \*

**INTERNAL REVENUE CODE OF 1986**

\* \* \* \* \*

**SUBTITLE K—GROUP HEALTH PLAN REQUIREMENTS**

\* \* \* \* \*

**CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS**

\* \* \* \* \*

**SUBCHAPTER B—OTHER REQUIREMENTS**

\* \* \* \* \*

[Section 9815 was added by section 1563[2\*](f) of PPACA.]

**SEC. 9815. ADDITIONAL MARKET REFORMS.**

(a) *GENERAL RULE.*—Except as provided in subsection (b)—

(1) *the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and*

(2) *to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.*

(b) *EXCEPTION.*—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

SELECTED ADDITIONAL PROVISIONS OF PPACA

\* \* \* \* \*

**TITLE I—QUALITY, AFFORDABLE  
HEALTH CARE FOR ALL AMERICANS**

**Subtitle A—Immediate Improvements in  
Health Care Coverage for All Americans**

\* \* \* \* \*

**SEC. 1004. [42 U.S.C. 300gg-11 note] EFFECTIVE DATES.**

(a) **IN GENERAL.**—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) [*Note: “this subtitle” added new sections 2711-2719A, 2793, and the section 2794 that relates to ensuring that consumers get value for their dollars.*] shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010.

(b) **SPECIAL RULE.**—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act.

\* \* \* \* \*

**Subtitle C—Quality Health Insurance  
Coverage for All Americans**

**PART 1—HEALTH INSURANCE MARKET  
REFORMS**

\* \* \* \* \*

**Subtitle B—Immediate Actions to Preserve  
and Expand Coverage**

**SEC. 1101. [42 U.S.C. 18001] IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION.**

(a) **IN GENERAL.**—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) **ADMINISTRATION.**—

(1) **IN GENERAL.**—The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) ELIGIBLE ENTITIES.—To be eligible for a contract under paragraph (1), an entity shall—

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) MAINTENANCE OF EFFORT.—To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) QUALIFIED HIGH RISK POOL.—

(1) IN GENERAL.—Amounts made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

(2) REQUIREMENTS.—A qualified high risk pool meets the requirements of this paragraph if such pool—

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;

(B) provides health insurance coverage—

(i) in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit not greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall—

(i) except as provided in clause (ii), vary only as provided for under section 2701 of the Public Health Service Act (as amended by this Act and notwithstanding the date on which such amendments take effect);

(ii) vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) ELIGIBLE INDIVIDUAL.—An individual shall be deemed to be an eligible individual for purposes of this section if such individual—

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 1411);

(2) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and

(3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) PROTECTION AGAINST DUMPING RISK BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

(2) SANCTIONS.—An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.

(B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan—

(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or

(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)—

(I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or

(II) the prior coverage is a policy for which duration of coverage from issue or health status are factors that can be considered in determining premiums at renewal.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(f) OVERSIGHT.—The Secretary shall establish—

(1) an appeals process to enable individuals to appeal a determination under this section; and

(2) procedures to protect against waste, fraud, and abuse.

(g) FUNDING; TERMINATION OF AUTHORITY.—

(1) IN GENERAL.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$5,000,000,000 to pay claims against (and the administrative

costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.

(2) **INSUFFICIENT FUNDS.**—If the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit.

(3) **TERMINATION OF AUTHORITY.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.

(B) **TRANSITION TO EXCHANGE.**—The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool established under this section into qualified health plans offered through an Exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

(4) **LIMITATIONS.**—The Secretary has the authority to stop taking applications for participation in the program under this section to comply with the funding limitation provided for in paragraph (1).

(5) **RELATION TO STATE LAWS.**—The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

\* \* \* \* \*

**SEC. 1103. [42 U.S.C. 18003] IMMEDIATE INFORMATION THAT ALLOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.**

(a) **INTERNET PORTAL TO AFFORDABLE COVERAGE OPTIONS.**—

[Subsection (a) was amended by section 10102(b) of PPACA.]

(1) **IMMEDIATE ESTABLISHMENT.**—Not later than July 1, 2010, the Secretary, in consultation with the States, shall establish a mechanism, including an Internet website, through which a resident of any, or small business in, State may identify affordable health insurance coverage options in that State.

(2) **CONNECTING TO AFFORDABLE COVERAGE.**—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of, and small businesses in, any State to receive information on at least the following coverage options:

(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

(i) a single disease or condition; or



(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary).

(B) Medicaid coverage under title XIX of the Social Security Act.

(C) Coverage under title XXI of the Social Security Act.

(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

(E) Coverage under a high risk pool under section 1101.

(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 45R of the Internal Revenue Code of 1986 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.

(b) ENHANCING COMPARATIVE PURCHASING OPTIONS.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall develop a standardized format to be used for the presentation of information relating to the coverage options described in subsection (a)(2). Such format shall, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 2715 of the Public Health Service Act.

(2) USE OF FORMAT.—The Secretary shall utilize the format developed under paragraph (1) in compiling information concerning coverage options on the Internet website established under subsection (a).

(c) AUTHORITY TO CONTRACT.—The Secretary may carry out this section through contracts entered into with qualified entities.

\* \* \* \* \*

**Subtitle C—Quality Health Insurance Coverage for All Americans**

\* \* \* \* \*

**PART 2—OTHER PROVISIONS**

**SEC. 1251. [42 U.S.C. 18011] PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.**

(a) NO CHANGES TO EXISTING COVERAGE.—

(1) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health

insurance coverage in which such individual was enrolled on the date of enactment of this Act.

[Paragraph (2) was amended by section 10103(d)(1) of PPACA.]

(2) CONTINUATION OF COVERAGE.—Except as provided in paragraph (3), with respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

[Paragraph (3) added by section 10103(d)(1) of PPACA.]

(3) APPLICATION OF CERTAIN PROVISIONS.—The provisions of sections 2715 and 2718 of the Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.

[Paragraph (4) added by section 2301(a) of Public Law 111–152.]

(4) APPLICATION OF CERTAIN PROVISIONS.—

(A) IN GENERAL.—The following provisions of the Public Health Service Act (as added by this title) shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:

(i) Section 2708 (relating to excessive waiting periods).

(ii) Those provisions of section 2711 relating to lifetime limits.

(iii) Section 2712 (relating to rescissions).

(iv) Section 2714 (relating to extension of dependent coverage).

(B) PROVISIONS APPLICABLE ONLY TO GROUP HEALTH PLANS.—

(i) PROVISIONS DESCRIBED.—Those provisions of section 2711 relating to annual limits and the provisions of section 2704 (relating to pre-existing condition exclusions) of the Public Health Service Act (as added by this subtitle) shall apply to grandfathered health plans that are group health plans for plan years beginning with the first plan year to which such provisions otherwise apply.

(ii) ADULT CHILD COVERAGE.—For plan years beginning before January 1, 2014, the provisions of section 2714 of the Public Health Service Act (as added by this subtitle) shall apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if such adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code of 1986) other than such grandfathered health plan.

(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) DEFINITION.—In this title, the term “grandfathered health plan” means any group health plan or health insurance coverage to which this section applies.

**SEC. 1252. [42 U.S.C. 18012] RATING REFORMS MUST APPLY UNIFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.**

Any standard or requirement adopted by a State pursuant to this title, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 1321(d).

[Section 1253 added by section 10103(f)(2) of PPACA.]

**SEC. 1253. [42 U.S.C. 300gg note] ANNUAL REPORT ON SELF-INSURED PLANS.**

Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Labor shall prepare an aggregate annual report, using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500), that shall include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments,

and expenses). The Secretary shall submit such reports to the appropriate committees of Congress.

[Section 1254 added by section 10103(f)(2) of PPACA.]

**SEC. 1254. [42 U.S.C. 18013] STUDY OF LARGE GROUP MARKET.**

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall conduct a study of the fully-insured and self-insured group health plan markets to—

(1) compare the characteristics of employers (including industry, size, and other characteristics as determined appropriate by the Secretary), health plan benefits, financial solvency, capital reserve levels, and the risks of becoming insolvent; and

(2) determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.

(b) **COLLECTION OF INFORMATION.**—In conducting the study under subsection (a), the Secretary, in coordination with the Secretary of Labor, shall collect information and analyze—

(1) the extent to which self-insured group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead or to the denial of claims and the offering very limited benefit packages;

(2) claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns), and the impact of the limited recourse options on consumers; and

(3) any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer's financial contribution or profit margin, and the impact of such conflict on administration of the health plan.

(c) **REPORT.**—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a).

[Section 1255 was originally section 1253 but was revised by section 10103(e), and redesignated by section 10103(f)(1), of PPACA.]

**SEC. 1255. [42 U.S.C. 300gg note] EFFECTIVE DATES.**

This subtitle (and the amendments made by this subtitle) **[Note: “this subtitle” added (and amended) sections 2701-2708 and added the section 2794 relating to disclosure of information.]** shall become effective for plan years beginning on or after January 1, 2014, except that—

(1) section 1251 shall take effect on the date of enactment of this Act; and

(2) the provisions of section 2704 of the Public Health Service Act (as amended by section 1201), as they apply to enrollees who are under 19 years of age, shall become effective

for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

\* \* \* \* \*

## Subtitle D—Available Coverage Choices for All Americans

### PART 1—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

\* \* \* \* \*

[Definitions in this section apply to “this title” which includes PPACA amendments to PHSA, so these definitions may apply to PHSA-related provisions.]

#### SEC. 1304. [42 U.S.C. 18024] RELATED DEFINITIONS.

(a) DEFINITIONS RELATING TO MARKETS.—In this title:

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

(2) INDIVIDUAL MARKET.—The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) LARGE AND SMALL GROUP MARKETS.—The terms “large group market” and “small group market” mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(b) EMPLOYERS.—In this title:

(1) LARGE EMPLOYER.—The term “large employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) SMALL EMPLOYER.—The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting “51 employees” for “101 employees” in paragraph (1) and by substituting “50 employees” for “100 employees” in paragraph (2).

(4) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this subsection—

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

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

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

(D) CONTINUATION OF PARTICIPATION FOR GROWING SMALL EMPLOYERS.—If—

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subtitle for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) SECRETARY.—In this title, the term “Secretary” means the Secretary of Health and Human Services.

(d) STATE.—In this title, the term “State” means each of the 50 States and the District of Columbia.

[Subsection (e) was added by section 10104(d) of PPACA.]

(e) EDUCATED HEALTH CARE CONSUMERS.—The term “educated health care consumer” means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.

\* \* \* \* \*

[This section referred to in section 2701(a)(5) of PHSA.]

**SEC. 1312. [42 U.S.C. 18032] CONSUMER CHOICE.**

\* \* \*

(f) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—

(1) \* \* \*

(2) QUALIFIED EMPLOYER.—In this title:

(A) IN GENERAL.—The term “qualified employer” means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) EXTENSION TO LARGE GROUPS.—

(i) IN GENERAL.—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

\* \* \* \* \*

**Subtitle F—Shared Responsibility for Health Care**

\* \* \* \* \*

**Subtitle G—Miscellaneous Provisions**

\* \* \* \* \*

**SEC. 1560. [42 U.S.C. 18118 note] RULES OF CONSTRUCTION.**

(a) \* \* \*

\* \* \* \* \*

(c) STUDENT HEALTH INSURANCE PLANS.—Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

**Table showing reorganization of provisions in part A of title XXVII of the Public Health Service Act ("PHSA") made by the Patient Protection and Affordable Care Act ("PPACA"; Public Law 111-148)**

(source: Ed Grossman, House Office of the Legislative Counsel; May 4, 2010)

Note: Temporary section designation in PHSA used (but later overridden) by PPACA shown in {braces}

<u>pre-PPACA provision in title XXVII of PHSA [current 42 USC section # in italics]</u>	<u>subject/heading</u>	<u>section/provision in PHSA post-PPACA {temporary PPACA sec. designation, if any, in braces} [42 USC section # in italics]</u>
part A	group market reforms=>Individual and Group Market Reforms	
subpart "1"=>subpart "1"	portability, access, & renewability=>General Reforms	[change in designation to subpart "1"]
2701 [300gg]	Increased portability through limitation on pre-existing condition exclusions	2704 [300gg-3]
2702 [300gg-1]	prohibiting discrimination against individual participants and beneficiaries based on health status	2705 end [300gg-4]
subpart 2		[subpart heading dropped]
2704 [300gg-4]	standards relating to benefits for mothers and newborns	2725 [300gg-25]
2705 [300gg-5]	parity in mental health and substance use disorder benefits	2726 [300gg-26]
2706 [300gg-6]	required coverage for reconstructive surgery following mastectomies	2727 [300gg-27]
2707 [300gg-7]	coverage of dependent students on medically necessary leave of absence	2728 [300gg-28]
subpart 3		[subpart heading dropped]
2711 [300gg-11]	health insurance issuers only guaranteed availability of coverage for employers in the group market	end of 2702 {2731} [300gg-1]
2712 [300gg-12]	guaranteed renewability of coverage for employers in the group market	end of 2703 {2732} [300gg-2]
2713 [300gg-13]	disclosure of information	2709 [300gg-9] (2nd) [this duplicates number of section added by PPACA] {2733}
subpart 4		redesignated as subpart "2"
2721 [300gg-21]	Exclusion of plans; enforcement; preemption	2722 {2735} [300gg-21]
2722 [300gg-22]	exclusion of certain plans	2723 {2736} [300gg-22]
2723 [300gg-23]	enforcement	2724 {2737} [300gg-23]
	preemption; State flexibility; construction	



**New provisions  
added by PPACA**  
[in subpart "I"]

fair health insurance premiums	2701 [300gg]
guaranteed availability of coverage	2702 [300gg-1]
guaranteed renewability of coverage	2703 [300gg-2]
prohibition of preexisting condition exclusions or other discrimination based on health status	2704 [300gg-3]
prohibiting discrimination against individual participants and beneficiaries based on health status	2705 [300gg-4]
nondiscrimination in health care	2706 [300gg-5]
comprehen health insurance coverage	2707 [300gg-6]
prohibition on excessive waiting periods	2708 [300gg-7]
	2709 [300gg-8] (1st)
	[duplicates number of section redesignated by PPACA]
coverage for individuals participating in approved clinical trials	

[New subpart "II"]

Improving Coverage	New subpart "II"
no lifetime or annual limits	2711 [300gg-11]
prohibition on rescissions	2712 [300gg-12]
coverage of preventive health services	2713 [300gg-13]
extension of dependent coverage	2714 [300gg-14]
development and utilization of uniform explanation of coverage documents and standardized definitions	2715 [300gg-15]
provision of additional information	2715A [300gg-15a]
prohibition on discrimination in favor of highly compensated individuals	2716 [300gg-16]
ensuring the quality of care	2717 [300gg-17]
bringing down the cost of health insurance coverage	2718 [300gg-18]
appeals process	2719 [300gg-19]
patient protections	2719A [300gg-19a]

in part C (for info.  
Purposes)

health insurance consumer information	2793 [300gg-93]
ensuring that consumers get value for their dollars	2794 [300gg-94]
uniform fraud and abuse referral referral format	2794 [300gg-95]

