

“(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2)(B), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Aug. 21, 1996], part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (other than section 2701(e) [now 2704(e)] thereof [42 U.S.C. 300gg-3(e)]) shall not apply to plan years beginning before the later of—

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

“(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of such part shall not be treated as a termination of such collective bargaining agreement.

“(4) TIMELY REGULATIONS.—The Secretary of Health and Human Services, consistent with section 104 [set out as a note under section 300gg-92 of this title], shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section [enacting this section and sections 300gg-1, 300gg-11 to 300gg-13, 300gg-21 to 300gg-23, 300gg-91, and 300gg-92 of this title and amending sections 300e and 300bb-8 of this title] and section 111 [enacting sections 300gg-41 to 300gg-44 and 300gg-61 to 300gg-63 of this title].

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

CONGRESSIONAL FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY; SEVERABILITY

Pub. L. 104-191, title I, §195, Aug. 21, 1996, 110 Stat. 1991, provided that:

“(a) FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY.—Congress finds the following in relation to the provisions of this title [enacting this subchapter and sections 1181 to 1183 and 1191 to 1191c of Title 29, Labor, amending sections 233, 300e, and 300bb-8 of this title and sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of Title 29, and enacting provisions set out as notes under this section, section 300gg-92 of this title, and section 1181 of Title 29]:

“(1) Provisions in group health plans and health insurance coverage that impose certain preexisting condition exclusions impact the ability of employees to seek employment in interstate commerce, thereby impeding such commerce.

“(2) Health insurance coverage is commercial in nature and is in and affects interstate commerce.

“(3) It is a necessary and proper exercise of Congressional authority to impose requirements under this title on group health plans and health insurance coverage (including coverage offered to individuals previously covered under group health plans) in order to promote commerce among the States.

“(4) Congress, however, intends to defer to States, to the maximum extent practicable, in carrying out such requirements with respect to insurers and health maintenance organizations that are subject to State regulation, consistent with the provisions of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

“(b) SEVERABILITY.—If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of

such to any person or circumstance shall not be affected thereby.”

HEALTH COVERAGE AVAILABILITY STUDIES

Pub. L. 104-191, title I, §191, Aug. 21, 1996, 110 Stat. 1987, directed the Secretary of Health and Human Services to provide for a study on the effectiveness of the provisions of title I of Pub. L. 104-191 and the various State laws, in ensuring the availability of reasonably priced health coverage to employers and individuals and a study on access to, and choice of, health care providers and the cost and cost-effectiveness to health insurance issuers of providing access to out-of-network providers, and the potential impact of providing such access on the cost and quality of health insurance coverage, and to report to the appropriate committees of Congress on each of such studies not later than Jan. 1, 2000.

§ 300gg-1. Guaranteed availability of coverage

(a) Guaranteed issuance of coverage in the individual and group market

Subject to subsections (b) through (e),¹ 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 1163 of title 29).

(3) Regulations

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

(c) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the 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 and individuals

¹ So in original.

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 individuals¹ 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 group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the 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 and individuals in the group or individual market in the State consistent with applicable State law and 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, 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 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.

(July 1, 1944, ch. 373, title XXVII, §2702, as added and amended Pub. L. 111-148, title I, §§1201(4), 1563(c)(8), formerly §1562(c)(8), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 266, 911.)

ENACTMENT OF SECTION

For delayed effective date of section, see Effective Date note below.

CODIFICATION

The text of section 300gg-11 of this title, which was amended and transferred to subsecs. (c) and (d) of this section by Pub. L. 111-148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111-148, §10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, §2731, formerly §2711, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1962; renumbered §2731, Pub. L. 111-148, title I, §1001(3), Mar. 23, 2010, 124 Stat. 130. For text of section 300gg-11 prior to amendment and transfer, see Prior Provisions note under section 300gg-11 of this title.

PRIOR PROVISIONS

A prior section 300gg-1, act July 1, 1944, ch. 373, title XXVII, §2702, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1961; Pub. L. 110-233, title I, §102(a)(1)-(3), May 21, 2008, 122 Stat. 888, 890, was amended by Pub. L. 111-148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, effective for plan years beginning on or after Jan. 1, 2014, and was transferred to subsecs. (d) to (f) of section 300gg-4 of this title. Prior to amendment and transfer by Pub. L. 111-148, text of section 300gg-1 read as follows:

“(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 300gg of this title, 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.

“(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, 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 may be charged for coverage under a group health plan except as provided in paragraph (3); 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 to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

“(c) GENETIC TESTING.—

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

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

“(3) RULE OF CONSTRUCTION REGARDING PAYMENT.—

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

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

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

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

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

“(i) compliance with the request is voluntary; and

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

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

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

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

“(d) PROHIBITION ON COLLECTION OF GENETIC INFORMATION.—

“(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not re-

quest, require, or purchase genetic information for underwriting purposes (as defined in section 300gg-91 of this title).

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

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

“(e) APPLICATION TO ALL PLANS.—The provisions of subsections (a)(1)(F), (b)(3), (c), and (d) and subsection (b)(1) and section 300gg of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 300gg-21(a) of this title.

“(f) GENETIC INFORMATION OF A FETUS OR EMBRYO.—Any reference in this part to genetic information concerning an individual or family member of an individual shall—

“(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

“(2) 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.”

Another prior section 2702 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238a of this title.

AMENDMENTS

2010—Pub. L. 111-148, § 1563(c)(8), formerly § 1562(c)(8), as renumbered by Pub. L. 111-148, § 10107(b)(1), transferred section 300gg-11 of this title to the end of this section after amending it by striking out the section catchline “Guaranteed availability of coverage for employers in group market”, by striking out subsec. (a) which related to issuance of coverage in small group market, subsec. (b) which related to assurance of access in large group market, subsec. (e) which related to exception to requirement for failure to meet certain minimum participation or contribution rules, and subsec. (f) which related to exception for coverage offered only to bona fide association members, by amending subsec. (c) by substituting “group and individual” for “small group” in introductory provisions of par. (1), inserting “and individuals” after “employers” in introductory provisions of par. (1)(B), inserting “or any additional individuals” after “additional groups” in par. (1)(B)(i), substituting “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” for “without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such” in par. (1)(B)(ii), and substituting “group or individual” for “small group” in par. (2), and by amending subsec. (d) by substituting “group or individual” for “small group” wherever appearing and substituting “all employers and individuals” for “all employers”, “those individuals, employers” for “those employers”, and “such individuals, employees” for “such employees” in par. (1)(B).

EFFECTIVE DATE

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

§ 300gg-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.

(b) General exceptions

A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a 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 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) of this section 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(c)(1)(A).¹

(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.

(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 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 discontinuation 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

(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 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,² (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.

(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

¹ See References in Text note below.

² So in original.