§ 300gg–91

Section applicable with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs, see section 111(b) of Pub. L. 104–191, set out as a note under section 300gg–41 of this title.

PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

§ 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 [29 U.S.C. 1002(1)]) 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(c)(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1144(b)(1)] is provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(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 [29 U.S.C. 1144(b)(2)]). 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 300e(a) of this title),

(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 subchapter, 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.

(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.
(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 subchapter 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 [29 U.S.C. 1002(8)].

(3) Bona fide association
The term “bona fide association” means, with respect to a health insurance 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 title 26, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.
(C) Subchapter XX of this chapter.

(5) Employee
The term “employee” has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(6)].

(6) Employer
The term “employer” has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(5)], 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 [29 U.S.C. 1002(33)].

(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 [29 U.S.C. 1002(32)] 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).

(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 [29 U.S.C. 1002(7)].

(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 adoption 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 [29 U.S.C. 1002(16)(B)].

(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(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.

(20) Qualified health plan
The term "qualified health plan" has the meaning given such term in section 18021(a) of this title.

(21) Exchange
The term "Exchange" means an American Health Benefit Exchange established under section 18031 of this title.

(e) Definitions relating to markets and small employers
For purposes of this subchapter:

(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 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 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 employees on the first day of the plan year.

(5) Small group market
The term "small group market" means the health insurance market under which individ-
uals 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 employees

all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of title 26 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.


REFERENCES IN TEXT

Section 2701, referred to in subsecs. (a)(3) and (d)(15)(A), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg–1 of this title.

AMENDMENTS

2010—Subsec. (d)(20), (21). Pub. L. 111–148, §1563(b), formerly §1562(b), as renumbered by Pub. L. 111–148, §10107(b)(1), added pars. (20) and (21).


Subsec. (e)(4). Pub. L. 111–148, §1563(c)(16)(B), formerly §1562(c)(16)(B), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted “100” for “60” and “at least 1” for “at least 2” in two places.


EFFECTIVE DATE OF 2008 AMENDMENT

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

§ 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 subchapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this subchapter.

(July 1, 1944, ch. 373, title XXXVII, §2792, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1976.)

REFERENCES IN TEXT


ASSURING COORDINATION AMONG DEPARTMENTS OF TREASURY, HEALTH AND HUMAN SERVICES, AND LABOR

Pub. L. 104–191, title I, §104, Aug. 21, 1996, 110 Stat. 1978, provided that: “The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—”

“(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this subtitle [subtitle A (§§101–104) of title I of Pub. L. 104–191, enacting sections 300gg, 300gg–1, 300gg–11 to 300gg–13, 300gg–21 to 300gg–23, and 300gg–91 of this title, and sections 1181 to 1191 and 1191 to 1191c of Title 29, Labor, amending sections 300e and 300bb–8 of this title and sections 1003, 1021, 1022, 1024, 1322, 1132, and 1144 of Title 29, and enacting provisions set out as notes under section 300gg of this title and section 1181 of Title 29] (and the amendments made by this subtitle and section 401 [enacting sections 9801 to 9806 of Title 26, Internal Revenue Code]) are administered so as to have the same effect at all times; and

“(2) coordination of policies relating to enforcing the same requirements through such Secretaries in