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

(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.

(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.

(July 1, 1944, ch. 373, title XXVII, §2703, as added and amended Pub. L. 111–148, title I, §§1201(4), 1563(c)(9), formerly §1562(c)(9), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 267, 911.)

Editorial Notes

REFERENCES IN TEXT

Section 2711, referred to in subsec. (b)(5), is a reference to section 2711 of act July 1, 1944. Section 2711, which was classified to section 300gg–11 of this title, was renumbered section 2731 and amended and transferred by Pub. L. 111–148, title I, §§1001(3), 1563(c)(8), formerly §1562(c)(8), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911, to the end of section 2702 of act July 1, 1944, as added by Pub. L. 111–148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, and classified to section 300gg–1 of this title. A new section 2711 of act July 1, 1944, related to no lifetime or annual limits, was added by Pub. L. 111–148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 131, effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, and is classified to section 300gg–11 of this title.

CODIFICATION

The text of section 300gg–12 of this title, which was amended and transferred to subsecs. (b) to (e) of this section by Pub. L. 111–148, §1563(c)(9), formerly §1562(c)(9), as renumbered by Pub. L. 111–148, §10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, §2732, formerly §2712, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1964; renumbered §2732, Pub. L. 111–148, title I, §1001(3), Mar. 23, 2010, 124 Stat. 130.

PRIOR PROVISIONS

A prior section 2703 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238b of this title.

AMENDMENTS

2010—Pub. L. 111–148, §1563(c)(9), formerly §1562(c)(9), as renumbered by Pub. L. 111–148, §10107(b)(1), transferred section 300gg–12 of this title to the end of this section after amending it by striking out the section catchline ''Guaranteed renewability of coverage for employers in group market'', by striking subsec. (a) which required a health insurance issuer offering coverage in connection with a group health plan to renew such coverage at the option of the plan sponsor, by amending subsec. (b) by substituting ''health insurance coverage offered in the group or individual market'' for ''group health plan in the small or large group market'' in introductory provisions, inserting '', or individual, as applicable,'' after ''plan sponsor'' in pars. (1) and (2), adding par. (3), and striking out former par. (3) which related to violation of participation or contribution rules, and by amending subsec. (c) by substituting ''group or individual health insurance coverage'' for ''group health insurance coverage offered in the small or large group market'' in introductory provisions of par. (1), inserting ''or individual, as applicable,'' after ''plan sponsor'' in par. (1)(A) and (B), inserting ''or individual health insurance coverage'' in par. (1)(B), inserting ''or individuals, as applicable,'' after ''those sponsors'' in par. (1)(C), substituting ''individual or group market, or all markets,'' for ''small group market or the large group market, or both markets,'' in introductory provisions of par. (2)(A), and inserting ''or individual, as applicable,'' after ''plan sponsor'' in par. (2)(A)(i). Amendment inserting ''or individual health insurance coverage'' in subsec. (c)(1)(B) was executed by making the insertion after ''group health plan'' as the probable intent of Congress, notwithstanding that the directory language did not specify where in subsec. (c)(1)(B) to make the insertion.

Statutory Notes and Related Subsidiaries

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–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.

(b) Definitions

For purposes of this part—

[2] So in original.

(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)[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.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this subchapter, 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 [42 U.S.C. 1395c et seq., 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].

(E) Chapter 55 of title 10.

(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.

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

(J) A health benefit plan under section 2504(e) of title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg–91(c) of this title).

(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, 2014—

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date 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 title 26 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 300bb–5(b)(4) of this title.

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3),[1] 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)[1] 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

[1] See References in Text note below.

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 individual or group group[2] 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.

(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.

(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

[2] So in original.

(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.

(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 [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] 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 demonstration 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 [42 U.S.C. 1396 et seq.], or child health assistance under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], 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 1181(f)(3)(B)(i)(II) of title 29.

(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 1024(b) of title 29.

(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 [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], 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[3] 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 [42 U.S.C. 1397ee(c)(2)(B), (3), (10)] 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.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion

(1) In general

A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) "Affiliation period" defined

For purposes of this subchapter, the term ''affiliation period'' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

[3] So in original. Probably should be followed by the word ''Program''.

(July 1, 1944, ch. 373, title XXVII, § 2704, formerly § 2701, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1955; amended Pub. L. 111–3, title III, § 311(b)(2), Feb. 4, 2009, 123 Stat. 70; Pub. L. 111–5, div. B, title I, § 1899D(c), Feb. 17, 2009, 123 Stat. 426; renumbered § 2704 and amended Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911; Pub. L. 111–344, title I, § 114(c), Dec. 29, 2010, 124 Stat. 3615; Pub. L. 112–40, title II, § 242(a)(3), (4), Oct. 21, 2011, 125 Stat. 419.)

Editorial Notes

REFERENCES IN TEXT

Subsection (a), referred to in subsecs. (b)(1)(B) and (c)(3)(A), (B), was struck out, and a new subsec. (a) was added, by Pub. L. 111–148, title I, § 1201(2)(A), Mar. 23, 2010, 124 Stat. 154, and as so amended, subsec. (a) no longer contains paragraphs.

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

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

CODIFICATION

Section was classified to section 300gg of this title prior to amendment and renumbering by Pub. L. 111–148.

Section 242(a)(3) of Pub. L. 112–40 amended section 2701 of act July 1, 1944, ''as in effect for plan years beginning before January 1, 2014'', which was classified to section 300gg of this title prior to amendment and renumbering by Pub. L. 111–148. Section 242(a)(4) of Pub. L. 112–40 made identical amendment to section 2704 of act July 1, 1944, ''as in effect for plan years beginning on or after January 1, 2014'', which is set out as this section. See 2011 Amendment note below. For effective date of renumbering by section 1201(2) of Pub. L. 111–148, see Effective Date of 2010 Amendment note below.

PRIOR PROVISIONS

A prior section 2704 of act July 1, 1944, was renumbered section 2725 and is classified to section 300gg–25 of this title.

Another prior section 2704 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238c of this title.

AMENDMENTS

2011—Subsec. (c)(2)(C). Pub. L. 112–40 substituted ''January 1, 2014'' for ''February 13, 2011'' in introductory provisions. See Codification note above.

2010—Pub. L. 111–148, § 1201(2)(A), substituted ''Prohibition of preexisting condition exclusions or other discrimination based on health status'' for ''Increased portability through limitation on preexisting condition exclusions'' in section catchline, added subsec. (a), and struck out former subsec. (a) which related to limitation on preexisting condition exclusion period.

Subsec. (c)(2)(A), (B). Pub. L. 111–148, § 1563(c)(1)(A)(i), formerly § 1562(c)(1)(A)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health plan'' for ''group health plan''.

Subsec. (c)(2)(C). Pub. L. 111–344 substituted ''February 13, 2011'' for ''January 1, 2011'' in introductory provisions.

Subsec. (c)(3)(A), (B). Pub. L. 111–148, § 1563(c)(1)(A)(ii)(I), formerly § 1562(c)(1)(A)(ii)(I), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance'' for ''group health insurance''.

Subsec. (c)(3)(D). Pub. L. 111–148, § 1563(c)(1)(A)(ii)(II), formerly § 1562(c)(1)(A)(ii)(II), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''individual or group'' for ''small or large'' in introductory provisions.

Subsec. (d)(1) to (3). Pub. L. 111–148, § 1563(c)(1)(B), formerly § 1562(c)(1)(B), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance'' for ''group health insurance''.

Subsec. (e)(1)(A). Pub. L. 111–148, § 1563(c)(1)(C), formerly § 1562(c)(1)(C), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance'' for ''group health insurance'' in introductory provisions.

2009—Subsec. (c)(2)(C). Pub. L. 111–5 added subpar. (C).

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

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to plan years beginning after Feb. 12, 2011, with transitional rules, see section 242(b) of Pub. L. 112–40, set out as a note under section 9801 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–344 applicable to plan years beginning after Dec. 31, 2010, see section 114(d) of Pub. L. 111–344, set out as a note under section 9801 of Title 26, Internal Revenue Code.

Amendment by section 1201(2) of Pub. L. 111–148 effective for plan years beginning on or after Jan. 1, 2014, except that the provisions of this section, as they apply to enrollees who are under 19 years of age, effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1255 of Pub. L. 111–148, set out as an Effective Date note under section 300gg of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Except as otherwise provided and subject to certain applicability provisions, amendment by Pub. L. 111–5 effective upon the expiration of the 90-day period beginning on Feb. 17, 2009, see section 1891 of Pub. L. 111–5, set out as an Effective and Termination Dates of 2009 Amendment note under section 2271 of Title 19, Customs Duties.

Amendment by Pub. L. 111–5 applicable to plan years beginning after Feb. 17, 2009, see section 1899D(d) of Pub. L. 111–5, set out as a note under section 9801 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

§ 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: