

115TH CONGRESS
2D SESSION

S. 3388

To amend the Health Insurance Portability and Accountability Act.

IN THE SENATE OF THE UNITED STATES

AUGUST 23, 2018

Mr. TILLIS (for himself, Mr. ALEXANDER, Mr. GRASSLEY, Mrs. ERNST, Ms. MURKOWSKI, Mr. CASSIDY, Mr. WICKER, Mr. GRAHAM, Mr. HELLER, and Mr. BARRASSO) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Health Insurance Portability and
Accountability Act.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Ensuring Coverage for
5 Patients with Pre-Existing Conditions Act”.

6 **SEC. 2. GUARANTEED AVAILABILITY OF COVERAGE; PRO-**
7 **HIBITING DISCRIMINATION.**

8 (a) IN GENERAL.—Subtitle C of title I of the Health
9 Insurance Portability and Accountability Act of 1996

1 (Public Law 104–191) is amended by adding at the end
 2 the following:

3 **“SEC. 196. GUARANTEED AVAILABILITY OF COVERAGE.**

4 “(a) **GUARANTEED ISSUANCE OF COVERAGE IN THE**
 5 **INDIVIDUAL AND GROUP MARKET.**—Subject to sub-
 6 sections (b) through (d), each health insurance issuer that
 7 offers health insurance coverage in the individual or group
 8 market in a State must accept every employer and indi-
 9 vidual in the State that applies for such coverage.

10 “(b) **ENROLLMENT.**—

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

15 “(2) **ESTABLISHMENT.**—A health insurance
 16 issuer described in subsection (a) shall, in accord-
 17 ance with the regulations promulgated under para-
 18 graph (3), establish special enrollment periods for
 19 qualifying events (under section 603 of the Em-
 20 ployee Retirement Income Security Act of 1974).

21 “(3) **REGULATIONS.**—The Secretary shall pro-
 22 mulgate regulations with respect to enrollment peri-
 23 ods under paragraphs (1) and (2).

24 “(c) **SPECIAL RULES FOR NETWORK PLANS.**—

1 “(1) IN GENERAL.—In the case of a health in-
2 surance issuer that offers health insurance coverage
3 in the group and individual market through a net-
4 work plan, the issuer may—

5 “(A) limit the employers that may apply
6 for such coverage to those with eligible individ-
7 uals who live, work, or reside in the service area
8 for such network plan; and

9 “(B) within the service area of such plan,
10 deny such coverage to such employers and indi-
11 viduals if the issuer has demonstrated, if re-
12 quired, to the applicable State authority that—

13 “(i) it will not have the capacity to de-
14 liver services adequately to enrollees of any
15 additional groups or any additional individ-
16 uals because of its obligations to existing
17 group contract holders and enrollees; and

18 “(ii) it is applying this paragraph uni-
19 formly to all employers and individuals
20 without regard to the claims experience of
21 those individuals, employers and their em-
22 ployees (and their dependents), or any
23 health status-related factor relating to
24 such individuals, employees, and depend-
25 ents.

1 “(2) 180-DAY SUSPENSION UPON DENIAL OF
 2 COVERAGE.—An issuer, upon denying health insur-
 3 ance coverage in any service area in accordance with
 4 paragraph (1)(B), may not offer coverage in the
 5 group or individual market within such service area
 6 for a period of 180 days after the date such cov-
 7 erage is denied.

8 “(d) APPLICATION OF FINANCIAL CAPACITY LIM-
 9 ITS.—

10 “(1) IN GENERAL.—A health insurance issuer
 11 may deny health insurance coverage in the group or
 12 individual market if the issuer has demonstrated, if
 13 required, to the applicable State authority that—

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

17 “(B) it is applying this paragraph uni-
 18 formly to all employers and individuals in the
 19 group or individual market in the State con-
 20 sistent with applicable State law and without
 21 regard to the claims experience of those individ-
 22 uals, employers and their employees (and their
 23 dependents) or any health status-related factor
 24 relating to such individuals, employees, and de-
 25 pendents.

1 “(2) 180-DAY SUSPENSION UPON DENIAL OF
 2 COVERAGE.—A health insurance issuer upon denying
 3 health insurance coverage in connection with group
 4 health plans in accordance with paragraph (1) in a
 5 State may not offer coverage in connection with
 6 group health plans in the group or individual market
 7 in the State for a period of 180 days after the date
 8 such coverage is denied or until the issuer has dem-
 9 onstrated to the applicable State authority, if re-
 10 quired under applicable State law, that the issuer
 11 has sufficient financial reserves to underwrite addi-
 12 tional coverage, whichever is later. An applicable
 13 State authority may provide for the application of
 14 this subsection on a service-area-specific basis.

15 “(e) DEFINITIONS.—In this section and in section
 16 197:

17 “(1) The term ‘Secretary’ means the Secretary
 18 of Health and Human Services.

19 “(2) The terms ‘genetic information’, ‘genetic
 20 test’, ‘group health plan’, ‘group market’, ‘health in-
 21 surance coverage’, ‘health insurance issuer’, ‘group
 22 health insurance coverage’, ‘individual health insur-
 23 ance coverage’, ‘individual market’, and ‘under-
 24 writing purpose’ have the meanings given such terms
 25 in section 2791 of the Public Health Service Act.

1 **“SEC. 197. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES**
 2 **BASED ON HEALTH STATUS.**

4 “(a) IN GENERAL.—A group health plan and a health
 5 insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll
 6 under the terms of the plan or coverage based on any of
 7 the following health status-related factors in relation to
 8 the individual or a dependent of the individual:
 9

11 “(1) Health status.

12 “(2) Medical condition (including both physical
 13 and mental illnesses).

14 “(3) Claims experience.

15 “(4) Receipt of health care.

16 “(5) Medical history.

17 “(6) Genetic information.

18 “(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

20 “(8) Disability.

21 “(9) Any other health status-related factor determined appropriate by the Secretary.

23 “(b) IN PREMIUM CONTRIBUTIONS.—

24 “(1) IN GENERAL.—A group health plan, and a
 25 health insurance issuer offering group or individual
 26 health insurance coverage, may not require any indi-

vidual (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.—

1 “(A) IN GENERAL.—For purposes of this
2 section, a group health plan, and health insur-
3 ance issuer offering group health insurance cov-
4 erage in connection with a group health plan,
5 may not adjust premium or contribution
6 amounts for the group covered under such plan
7 on the basis of genetic information.

8 “(B) RULE OF CONSTRUCTION.—Nothing
9 in subparagraph (A) or in paragraphs (1) and
10 (2) of subsection (d) shall be construed to limit
11 the ability of a health insurance issuer offering
12 group or individual health insurance coverage to
13 increase the premium for an employer based on
14 the manifestation of a disease or disorder of an
15 individual who is enrolled in the plan. In such
16 case, the manifestation of a disease or disorder
17 in one individual cannot also be used as genetic
18 information about other group members and to
19 further increase the premium for the employer.

20 “(c) GENETIC TESTING.—

21 “(1) LIMITATION ON REQUESTING OR REQUIR-
22 ING GENETIC TESTING.—A group health plan, and a
23 health insurance issuer offering health insurance
24 coverage in connection with a group health plan,

1 shall not request or require an individual or a family
2 member of such individual to undergo a genetic test.

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

8 “(3) RULE OF CONSTRUCTION REGARDING PAY-
9 MENT.—

10 “(A) IN GENERAL.—Nothing in paragraph
11 (1) shall be construed to preclude a group
12 health plan, or a health insurance issuer offer-
13 ing health insurance coverage in connection
14 with a group health plan, from obtaining and
15 using the results of a genetic test in making a
16 determination regarding payment (as such term
17 is defined for the purposes of applying the regu-
18 lations promulgated by the Secretary under
19 part C of title XI of the Social Security Act and
20 section 264 of this Act, as may be revised from
21 time to time) consistent with subsection (a).

22 “(B) LIMITATION.—For purposes of sub-
23 paragraph (A), a group health plan, or a health
24 insurance issuer offering health insurance cov-
25 erage in connection with a group health plan,

1 may request only the minimum amount of in-
2 formation necessary to accomplish the intended
3 purpose.

4 “(4) RESEARCH EXCEPTION.—Notwithstanding
5 paragraph (1), a group health plan, or a health in-
6 surance issuer offering health insurance coverage in
7 connection with a group health plan, may request,
8 but not require, that a participant or beneficiary un-
9 dergo a genetic test if each of the following condi-
10 tions is met:

11 “(A) The request is made pursuant to re-
12 search that complies with part 46 of title 45,
13 Code of Federal Regulations, or equivalent Fed-
14 eral regulations, and any applicable State or
15 local law or regulations for the protection of
16 human subjects in research.

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

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

23 “(ii) noncompliance will have no effect
24 on enrollment status or premium or con-
25 tribution amounts.

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

4 “(D) The plan or issuer notifies the Sec-
5 retary in writing that the plan or issuer is con-
6 ducting activities pursuant to the exception pro-
7 vided for under this paragraph, including a de-
8 scription of the activities conducted.

9 “(E) The plan or issuer complies with such
10 other conditions as the Secretary may by regu-
11 lation require for activities conducted under this
12 paragraph.

13 “(d) PROHIBITION ON COLLECTION OF GENETIC IN-
14 FORMATION.—

15 “(1) IN GENERAL.—A group health plan, and a
16 health insurance issuer offering health insurance
17 coverage in connection with a group health plan,
18 shall not request, require, or purchase genetic infor-
19 mation for underwriting purposes.

20 “(2) PROHIBITION ON COLLECTION OF GE-
21 NETIC INFORMATION PRIOR TO ENROLLMENT.—A
22 group health plan, and a health insurance issuer of-
23 fering health insurance coverage in connection with
24 a group health plan, shall not request, require, or
25 purchase genetic information with respect to any in-

1 dividual prior to such individual's enrollment under
2 the plan or coverage in connection with such enroll-
3 ment.

4 “(3) INCIDENTAL COLLECTION.—If a group
5 health plan, or a health insurance issuer offering
6 health insurance coverage in connection with a group
7 health plan, obtains genetic information incidental to
8 the requesting, requiring, or purchasing of other in-
9 formation concerning any individual, such request,
10 requirement, or purchase shall not be considered a
11 violation of paragraph (2) if such request, require-
12 ment, or purchase is not in violation of paragraph
13 (1).

14 “(e) GENETIC INFORMATION OF A FETUS OR EM-
15 BRYO.—Any reference in this part to genetic information
16 concerning an individual or family member of an indi-
17 vidual shall—

18 “(1) with respect to such an individual or fam-
19 ily member of an individual who is a pregnant
20 woman, include genetic information of any fetus car-
21 ried by such pregnant woman; and

22 “(2) with respect to an individual or family
23 member utilizing an assisted reproductive tech-
24 nology, include genetic information of any embryo le-
25 gally held by the individual or family member.

1 “(f) PROGRAMS OF HEALTH PROMOTION OR DIS-
2 EASE PREVENTION.—

3 “(1) GENERAL PROVISIONS.—

4 “(A) GENERAL RULE.—For purposes of
5 subsection (b)(2)(B), a program of health pro-
6 motion or disease prevention (referred to in this
7 subsection as a ‘wellness program’) shall be a
8 program offered by an employer that is de-
9 signed to promote health or prevent disease
10 that meets the applicable requirements of this
11 subsection.

12 “(B) NO CONDITIONS BASED ON HEALTH
13 STATUS FACTOR.—If none of the conditions for
14 obtaining a premium discount or rebate or
15 other reward for participation in a wellness pro-
16 gram is based on an individual satisfying a
17 standard that is related to a health status fac-
18 tor, such wellness program shall not violate this
19 section if participation in the program is made
20 available to all similarly situated individuals
21 and the requirements of paragraph (2) are com-
22 plied with.

23 “(C) CONDITIONS BASED ON HEALTH STA-
24 TUS FACTOR.—If any of the conditions for ob-
25 taining a premium discount or rebate or other

1 reward for participation in a wellness program
2 is based on an individual satisfying a standard
3 that is related to a health status factor, such
4 wellness program shall not violate this section if
5 the requirements of paragraph (3) are complied
6 with.

7 “(2) WELLNESS PROGRAMS NOT SUBJECT TO
8 REQUIREMENTS.—If none of the conditions for ob-
9 taining a premium discount or rebate or other re-
10 ward under a wellness program as described in para-
11 graph (1)(B) are based on an individual satisfying
12 a standard that is related to a health status factor
13 (or if such a wellness program does not provide such
14 a reward), the wellness program shall not violate
15 this section if participation in the program is made
16 available to all similarly situated individuals. The
17 following programs shall not have to comply with the
18 requirements of paragraph (3) if participation in the
19 program is made available to all similarly situated
20 individuals:

21 “(A) A program that reimburses all or
22 part of the cost for memberships in a fitness
23 center.

1 “(B) A diagnostic testing program that
2 provides a reward for participation and does
3 not base any part of the reward on outcomes.

4 “(C) A program that encourages preven-
5 tive care related to a health condition through
6 the waiver of the copayment or deductible re-
7 quirement under group health plan for the costs
8 of certain items or services related to a health
9 condition (such as prenatal care or well-baby
10 visits).

11 “(D) A program that reimburses individ-
12 uals for the costs of smoking cessation pro-
13 grams without regard to whether the individual
14 quits smoking.

15 “(E) A program that provides a reward to
16 individuals for attending a periodic health edu-
17 cation seminar.

18 “(3) WELLNESS PROGRAMS SUBJECT TO RE-
19 QUIREMENTS.—If any of the conditions for obtaining
20 a premium discount, rebate, or reward under a
21 wellness program as described in paragraph (1)(C)
22 is based on an individual satisfying a standard that
23 is related to a health status factor, the wellness pro-
24 gram shall not violate this section if the following re-
25 quirements are complied with:

1 “(A) The reward for the wellness program,
2 together with the reward for other wellness pro-
3 grams with respect to the plan that requires
4 satisfaction of a standard related to a health
5 status factor, shall not exceed 30 percent of the
6 cost of employee-only coverage under the plan.
7 If, in addition to employees or individuals, any
8 class of dependents (such as spouses or spouses
9 and dependent children) may participate fully
10 in the wellness program, such reward shall not
11 exceed 30 percent of the cost of the coverage in
12 which an employee or individual and any de-
13 pendents are enrolled. For purposes of this
14 paragraph, the cost of coverage shall be deter-
15 mined based on the total amount of employer
16 and employee contributions for the benefit
17 package under which the employee is (or the
18 employee and any dependents are) receiving
19 coverage. A reward may be in the form of a dis-
20 count or rebate of a premium or contribution,
21 a waiver of all or part of a cost-sharing mecha-
22 nism (such as deductibles, copayments, or coin-
23 surance), the absence of a surcharge, or the
24 value of a benefit that would otherwise not be
25 provided under the plan. The Secretaries of

1 Labor, Health and Human Services, and the
2 Treasury may increase the reward available
3 under this subparagraph to up to 50 percent of
4 the cost of coverage if the Secretaries determine
5 that such an increase is appropriate.

6 “(B) The wellness program shall be rea-
7 sonably designed to promote health or prevent
8 disease. A program complies with the preceding
9 sentence if the program has a reasonable
10 chance of improving the health of, or preventing
11 disease in, participating individuals and it is
12 not overly burdensome, is not a subterfuge for
13 discriminating based on a health status factor,
14 and is not highly suspect in the method chosen
15 to promote health or prevent disease.

16 “(C) The plan shall give individuals eligible
17 for the program the opportunity to qualify for
18 the reward under the program at least once
19 each year.

20 “(D) The full reward under the wellness
21 program shall be made available to all similarly
22 situated individuals. For such purpose, among
23 other things:

1 “(i) The reward is not available to all
2 similarly situated individuals for a period
3 unless the wellness program allows—

4 “(I) for a reasonable alternative
5 standard (or waiver of the otherwise
6 applicable standard) for obtaining the
7 reward for any individual for whom,
8 for that period, it is unreasonably dif-
9 ficult due to a medical condition to
10 satisfy the otherwise applicable stand-
11 ard; and

12 “(II) for a reasonable alternative
13 standard (or waiver of the otherwise
14 applicable standard) for obtaining the
15 reward for any individual for whom,
16 for that period, it is medically inadvis-
17 able to attempt to satisfy the other-
18 wise applicable standard.

19 “(ii) If reasonable under the cir-
20 cumstances, the plan or issuer may seek
21 verification, such as a statement from an
22 individual’s physician, that a health status
23 factor makes it unreasonably difficult or
24 medically inadvisable for the individual to

1 satisfy or attempt to satisfy the otherwise
2 applicable standard.

3 “(E) The plan or issuer involved shall dis-
4 close in all plan materials describing the terms
5 of the wellness program the availability of a
6 reasonable alternative standard (or the possi-
7 bility of waiver of the otherwise applicable
8 standard) required under subparagraph (D). If
9 plan materials disclose that such a program is
10 available, without describing its terms, the dis-
11 closure under this subparagraph shall not be re-
12 quired.”.

13 (b) CONFORMING AMENDMENT.—The table of con-
14 tents under section 1(b) of the Health Insurance Port-
15 ability and Accountability Act of 1996 (Public Law 104–
16 191) is amended by inserting after the item relating to
17 section 195 the following:

“Sec. 196. Guaranteed Availability of Coverage.

“Sec. 197. Prohibiting Discrimination against individual participants and bene-
 ficiaries based on health status.”.

18 (c) ENFORCEMENT.—

19 (1) PHSA.—Section 2723 of the Public Health
20 Service Act (42 U.S.C. 300gg–22) is amended—

21 (A) in subsection (a)—

22 (i) in paragraph (1), by inserting

23 “and sections 196 and 197 of the Health

1 Insurance Portability and Accountability
2 Act of 1996” after “this part”; and

3 (ii) in paragraph (2), by inserting “or
4 section 196 or 197 of the Health Insur-
5 ance Portability and Accountability Act of
6 1996” after “this part”; and

7 (B) in subsection (b), by inserting “or sec-
8 tion 196 or 197 of the Health Insurance Port-
9 ability and Accountability Act of 1996” after
10 “this part” each place such term appears.

11 (2) ERISA.—Section 715 of the Employee Re-
12 tirement Income Security Act of 1974 (29 U.S.C.
13 1185d) is amended by adding at the end the fol-
14 lowing:

15 “(c) ADDITIONAL PROVISIONS.—Section 196 of the
16 Health Insurance Portability and Accountability Act of
17 1996 shall apply to health insurance issuers providing
18 health insurance coverage in connection with group health
19 plans, and section 197 of such Act shall apply to group
20 health plans and health insurance issuers providing health
21 insurance coverage in connection with group health plans,
22 as if included in this subpart, and to the extent that any
23 provision of this part conflicts with a provision of such
24 section 196 with respect to health insurance issuers pro-
25 viding health insurance coverage in connection with group

1 health plans or of such section 197 with respect to group
 2 health plans or health insurance issuers providing health
 3 insurance coverage in connection with group health plans,
 4 the provisions of such sections 196 and 197 shall apply.”.

5 (3) IRC.—Section 9815 of the Internal Rev-
 6 enue Code of 1986 is amended by adding at the end
 7 the following:

8 “(c) ADDITIONAL PROVISIONS.—Section 196 of the
 9 Health Insurance Portability and Accountability Act of
 10 1996 shall apply to health insurance issuers providing
 11 health insurance coverage in connection with group health
 12 plans, and section 197 of such Act shall apply to group
 13 health plans and health insurance issuers providing health
 14 insurance coverage in connection with group health plans,
 15 as if included in this subchapter, and to the extent that
 16 any provision of this chapter conflicts with a provision of
 17 such section 196 with respect to health insurance issuers
 18 providing health insurance coverage in connection with
 19 group health plans or of such section 197 with respect
 20 to group health plans or health insurance issuers providing
 21 health insurance coverage in connection with group health
 22 plans, the provisions of such sections 196 and 197 shall
 23 apply.”.

