

116TH CONGRESS
1ST SESSION

H. R. 692

To amend the Public Health Service Act to prohibit application of pre-existing condition exclusions and to guarantee availability of health insurance coverage in the individual and group market, contingent on the enactment of legislation repealing the Patient Protection and Affordable Care Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 18, 2019

Mr. WALDEN introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act to prohibit application of pre-existing condition exclusions and to guarantee availability of health insurance coverage in the individual and group market, contingent on the enactment of legislation repealing the Patient Protection and Affordable Care Act, and for other purposes.

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Pre-existing Conditions
3 Protection Act of 2019”.

4 **SEC. 2. PROHIBITION OF PRE-EXISTING CONDITION EXCLU-**
5 **SIONS.**

6 (a) GROUP MARKET.—Subject to section 6(a) of this
7 Act, subpart 1 of part A of title XXVII of the Public
8 Health Service Act (42 U.S.C. 300gg et seq.), as restored
9 or revived pursuant to PPACA repeal legislation described
10 in section 6(b) of this Act, is amended by striking section
11 2701 and inserting the following:

12 **“SEC. 2701. PROHIBITION OF PRE-EXISTING CONDITION EX-**
13 **CLUSIONS.**

14 “(a) IN GENERAL.—A group health plan or a health
15 insurance issuer offering group health insurance coverage
16 may not impose any pre-existing condition exclusion with
17 respect to such plan or coverage.

18 “(b) DEFINITIONS.—For purposes of this section:

19 “(1) PRE-EXISTING CONDITION EXCLUSION.—

20 “(A) IN GENERAL.—The term ‘pre-existing
21 condition exclusion’ means, with respect to a
22 group health plan or health insurance coverage,
23 a limitation or exclusion of benefits relating to
24 a condition based on the fact that the condition
25 was present before the date of enrollment in
26 such plan or for such coverage, whether or not

1 any medical advice, diagnosis, care, or treat-
2 ment was recommended or received before such
3 date.

4 “(B) TREATMENT OF GENETIC INFORMA-
5 TION.—Genetic information shall not be treated
6 as a pre-existing condition in the absence of a
7 diagnosis of the condition related to such infor-
8 mation.

9 “(2) DATE OF ENROLLMENT.—The term ‘date
10 of enrollment’ means, with respect to an individual
11 covered under a group health plan or health insur-
12 ance coverage, the date of enrollment of the indi-
13 vidual in the plan or coverage or, if earlier, the first
14 day of the waiting period for such enrollment.

15 “(3) WAITING PERIOD.—The term ‘waiting pe-
16 riod’ means, with respect to a group health plan and
17 an individual who is a potential participant or bene-
18 ficiary in the plan, the period that must pass with
19 respect to the individual before the individual is eli-
20 gible to be covered for benefits under the terms of
21 the plan.”.

22 (b) INDIVIDUAL MARKET.—Subject to section 6(a) of
23 this Act, subpart 1 of part B of title XXVII of the Public
24 Health Service Act (42 U.S.C. 300gg–41 et seq.), as re-
25 stored or revived pursuant to PPACA repeal legislation

1 described in section 6(b) of this Act, is amended by adding
 2 at the end the following:

3 **“SEC. 2746. PROHIBITION OF PRE-EXISTING CONDITION EX-**
 4 **CLUSIONS OR OTHER DISCRIMINATION**
 5 **BASED ON HEALTH STATUS.**

6 “The provisions of section 2701 shall apply to health
 7 insurance coverage offered to individuals by a health in-
 8 surance issuer in the individual market in the same man-
 9 ner as it applies to health insurance coverage offered by
 10 a health insurance issuer in the group market.”.

11 **SEC. 3. GUARANTEED AVAILABILITY OF COVERAGE.**

12 (a) GROUP MARKET.—Subject to section 6(a) of this
 13 Act, subpart 3 of part A of title XXVII of the Public
 14 Health Service Act, as restored or revived pursuant to
 15 PPACA repeal legislation described in section 6(b) of this
 16 Act, is amended by striking section 2711 (42 U.S.C.
 17 300gg–11) and inserting the following:

18 **“SEC. 2711. GUARANTEED AVAILABILITY OF COVERAGE.**

19 “(a) GUARANTEED ISSUANCE OF COVERAGE IN THE
 20 GROUP MARKET.—Subject to subsection (b), each health
 21 insurance issuer that offers health insurance coverage in
 22 the group market in a State shall accept every employer
 23 and every individual in a group in the State that applies
 24 for such coverage.

25 “(b) ENROLLMENT.—

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

5 “(2) ESTABLISHMENT.—A health insurance
6 issuer described in subsection (a) shall establish spe-
7 cial enrollment periods for qualifying events (as such
8 term is defined in section 603 of the Employee Re-
9 tirement Income Security Act of 1974).”.

10 (b) INDIVIDUAL MARKET.—Subject to section 6(a) of
11 this Act, subpart 1 of part B of title XXVII of the Public
12 Health Service Act, as restored or revived pursuant to
13 PPACA repeal legislation described in section 6(b) of this
14 Act, is amended by striking section 2741 of such Act (42
15 U.S.C. 300gg–41) and inserting the following:

16 **“SEC. 2741. GUARANTEED AVAILABILITY OF COVERAGE.**

17 “The provisions of section 2711 shall apply to health
18 insurance coverage offered to individuals by a health in-
19 surance issuer in the individual market in the same man-
20 ner as such provisions apply to health insurance coverage
21 offered to employers by a health insurance issuer in con-
22 nection with health insurance coverage in the group mar-
23 ket. For purposes of this section, the Secretary shall treat
24 any reference of the word ‘employer’ in such section as
25 a reference to the term ‘individual’.”.

1 **SEC. 4. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES**
2
3 **BASED ON HEALTH STATUS.**

4 (a) GROUP MARKET.—Subject to section 6(a) of this
5 Act, section 2702 of the Public Health Service Act, as re-
6 stored or revived pursuant to PPACA repeal legislation
7 described in section 6(b) of this Act, is amended to read
8 as follows:

9 **“SEC. 2702. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES**
10
11 **BASED ON HEALTH STATUS.**

12 “(a) IN GENERAL.—A group health plan and a health
13 insurance issuer offering group health insurance coverage
14 may not establish rules for eligibility (including continued
15 eligibility) of any individual to enroll under the terms of
16 the plan or coverage based on any of the following health
17 status-related factors in relation to the individual or a de-
18 pendent of the individual:

19 “(1) Health status.

20 “(2) Medical condition (including both physical
21 and mental illnesses).

22 “(3) Claims experience.

23 “(4) Receipt of health care.

24 “(5) Medical history.

25 “(6) Genetic information.

1 “(7) Evidence of insurability (including condi-
2 tions arising out of acts of domestic violence).

3 “(8) Disability.

4 “(9) Any other health status-related factor de-
5 termined appropriate by the Secretary.

6 “(b) IN PREMIUM CONTRIBUTIONS.—

7 “(1) IN GENERAL.—A group health plan, and a
8 health insurance issuer offering group health insur-
9 ance coverage, may not require any individual (as a
10 condition of enrollment or continued enrollment
11 under the plan) to pay a premium or contribution
12 which is greater than such premium or contribution
13 for a similarly situated individual enrolled in the
14 plan on the basis of any health status-related factor
15 in relation to the individual or to an individual en-
16 rolled under the plan as a dependent of the indi-
17 vidual.

18 “(2) CONSTRUCTION.—Nothing in paragraph
19 (1) shall be construed—

20 “(A) to restrict the amount that an em-
21 ployer or individual may be charged for cov-
22 erage under a group health plan except as pro-
23 vided in paragraph (3); or

24 “(B) to prevent a group health plan, and
25 a health insurance issuer offering group health

1 insurance coverage, from establishing premium
2 discounts or rebates or modifying otherwise ap-
3 plicable copayments or deductibles in return for
4 adherence to programs of health promotion and
5 disease prevention.

6 “(3) NO GROUP-BASED DISCRIMINATION ON
7 BASIS OF GENETIC INFORMATION.—

8 “(A) IN GENERAL.—For purposes of this
9 section, a group health plan, and health insur-
10 ance issuer offering group health insurance cov-
11 erage, may not adjust premium or contribution
12 amounts for the group covered under such plan
13 on the basis of genetic information.

14 “(B) RULE OF CONSTRUCTION.—Nothing
15 in subparagraph (A) or in paragraphs (1) and
16 (2) of subsection (d) shall be construed to limit
17 the ability of a health insurance issuer offering
18 group health insurance coverage to increase the
19 premium for an employer based on the mani-
20 festation of a disease or disorder of an indi-
21 vidual who is enrolled in the plan. In such case,
22 the manifestation of a disease or disorder in
23 one individual cannot also be used as genetic in-
24 formation about other group members and to
25 further increase the premium for the employer.

1 “(c) GENETIC TESTING.—

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

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

13 “(3) RULE OF CONSTRUCTION REGARDING PAY-
14 MENT.—

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

1 and Accountability Act of 1996, as may be re-
2 vised from time to time) consistent with sub-
3 section (a).

4 “(B) LIMITATION.—For purposes of sub-
5 paragraph (A), a group health plan, or a health
6 insurance issuer offering health insurance cov-
7 erage in connection with a group health plan,
8 may request only the minimum amount of in-
9 formation necessary to accomplish the intended
10 purpose.

11 “(4) RESEARCH EXCEPTION.—Notwithstanding
12 paragraph (1), a group health plan, or a health in-
13 surance issuer offering health insurance coverage in
14 connection with a group health plan, may request,
15 but not require, that a participant or beneficiary un-
16 dergo a genetic test if each of the following condi-
17 tions is met:

18 “(A) The request is made pursuant to re-
19 search that complies with part 46 of title 45,
20 Code of Federal Regulations, or equivalent Fed-
21 eral regulations, and any applicable State or
22 local law or regulations for the protection of
23 human subjects in research.

24 “(B) The plan or issuer clearly indicates to
25 each participant or beneficiary, or in the case of

1 a minor child, to the legal guardian of such
2 beneficiary, to whom the request is made that—

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

5 “(ii) non-compliance will have no ef-
6 fect on enrollment status or premium or
7 contribution amounts.

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

11 “(D) The plan or issuer notifies the Sec-
12 retary in writing that the plan or issuer is con-
13 ducting activities pursuant to the exception pro-
14 vided for under this paragraph, including a de-
15 scription of the activities conducted.

16 “(E) The plan or issuer complies with such
17 other conditions as the Secretary may by regu-
18 lation require for activities conducted under this
19 paragraph.

20 “(d) PROHIBITION ON COLLECTION OF GENETIC IN-
21 FORMATION.—

22 “(1) IN GENERAL.—A group health plan, and a
23 health insurance issuer offering health insurance
24 coverage in connection with a group health plan,
25 shall not request, require, or purchase genetic infor-

1 mation for underwriting purposes (as defined in sec-
2 tion 2791).

3 “(2) PROHIBITION ON COLLECTION OF GE-
4 NETIC INFORMATION PRIOR TO ENROLLMENT.—A
5 group health plan, and a health insurance issuer of-
6 fering health insurance coverage in connection with
7 a group health plan, shall not request, require, or
8 purchase genetic information with respect to any in-
9 dividual prior to such individual’s enrollment under
10 the plan or coverage in connection with such enroll-
11 ment.

12 “(3) INCIDENTAL COLLECTION.—If a group
13 health plan, or a health insurance issuer offering
14 health insurance coverage in connection with a group
15 health plan, obtains genetic information incidental to
16 the requesting, requiring, or purchasing of other in-
17 formation concerning any individual, such request,
18 requirement, or purchase shall not be considered a
19 violation of paragraph (2) if such request, require-
20 ment, or purchase is not in violation of paragraph
21 (1).

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

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

5 “(2) with respect to an individual or family
6 member utilizing an assisted reproductive tech-
7 nology, include genetic information of any embryo le-
8 gally held by the individual or family member.

9 “(f) PROGRAMS OF HEALTH PROMOTION OR DIS-
10 EASE PREVENTION.—

11 “(1) GENERAL PROVISIONS.—

12 “(A) GENERAL RULE.—For purposes of
13 subsection (b)(2)(B), a program of health pro-
14 motion or disease prevention (referred to in this
15 subsection as a ‘wellness program’) shall be a
16 program offered by an employer that is de-
17 signed to promote health or prevent disease
18 that meets the applicable requirements of this
19 subsection.

20 “(B) NO CONDITIONS BASED ON HEALTH
21 STATUS FACTOR.—If none of the conditions for
22 obtaining a premium discount or rebate or
23 other reward for participation in a wellness pro-
24 gram is based on an individual satisfying a
25 standard that is related to a health status fac-

1 tor, such wellness program shall not violate this
2 section if participation in the program is made
3 available to all similarly situated individuals
4 and the requirements of paragraph (2) are com-
5 plied with.

6 “(C) CONDITIONS BASED ON HEALTH STA-
7 TUS FACTOR.—If any of the conditions for ob-
8 taining a premium discount or rebate or other
9 reward for participation in a wellness program
10 is based on an individual satisfying a standard
11 that is related to a health status factor, such
12 wellness program shall not violate this section if
13 the requirements of paragraph (3) are complied
14 with.

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

1 requirements of paragraph (3) if participation in the
2 program is made available to all similarly situated
3 individuals:

4 “(A) A program that reimburses all or
5 part of the cost for memberships in a fitness
6 center.

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

10 “(C) A program that encourages preven-
11 tive care related to a health condition through
12 the waiver of the copayment or deductible re-
13 quirement under group health plan for the costs
14 of certain items or services related to a health
15 condition (such as prenatal care or well-baby
16 visits).

17 “(D) A program that reimburses individ-
18 uals for the costs of smoking cessation pro-
19 grams without regard to whether the individual
20 quits smoking.

21 “(E) A program that provides a reward to
22 individuals for attending a periodic health edu-
23 cation seminar.

24 “(3) WELLNESS PROGRAMS SUBJECT TO RE-
25 QUIREMENTS.—If any of the conditions for obtaining

1 a premium discount, rebate, or reward under a
2 wellness program as described in paragraph (1)(C)
3 is based on an individual satisfying a standard that
4 is related to a health status factor, the wellness pro-
5 gram shall not violate this section if the following re-
6 quirements are complied with:

7 “(A) The reward for the wellness program,
8 together with the reward for other wellness pro-
9 grams with respect to the plan that requires
10 satisfaction of a standard related to a health
11 status factor, shall not exceed 30 percent of the
12 cost of employee-only coverage under the plan.
13 If, in addition to employees or individuals, any
14 class of dependents (such as spouses or spouses
15 and dependent children) may participate fully
16 in the wellness program, such reward shall not
17 exceed 30 percent of the cost of the coverage in
18 which an employee or individual and any de-
19 pendents are enrolled. For purposes of this
20 paragraph, the cost of coverage shall be deter-
21 mined based on the total amount of employer
22 and employee contributions for the benefit
23 package under which the employee is (or the
24 employee and any dependents are) receiving
25 coverage. A reward may be in the form of a dis-

1 count or rebate of a premium or contribution,
2 a waiver of all or part of a cost-sharing mecha-
3 nism (such as deductibles, copayments, or coin-
4 surance), the absence of a surcharge, or the
5 value of a benefit that would otherwise not be
6 provided under the plan. The Secretaries of
7 Labor, Health and Human Services, and the
8 Treasury may increase the reward available
9 under this subparagraph to up to 50 percent of
10 the cost of coverage if the Secretaries determine
11 that such an increase is appropriate.

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

22 “(C) The plan shall give individuals eligible
23 for the program the opportunity to qualify for
24 the reward under the program at least once
25 each year.

1 “(D) The full reward under the wellness
2 program shall be made available to all similarly
3 situated individuals. For such purpose, among
4 other things:

5 “(i) The reward is not available to all
6 similarly situated individuals for a period
7 unless the wellness program allows—

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

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

23 “(ii) If reasonable under the cir-
24 cumstances, the plan or issuer may seek
25 verification, such as a statement from an

1 individual’s physician, that a health status
2 factor makes it unreasonably difficult or
3 medically inadvisable for the individual to
4 satisfy or attempt to satisfy the otherwise
5 applicable standard.

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

16 “(g) EXISTING PROGRAMS.—Nothing in this section
17 shall prohibit a program of health promotion or disease
18 prevention that was established prior to the date of enact-
19 ment of this section and applied with all applicable regula-
20 tions, and that is operating on such date, from continuing
21 to be carried out for as long as such regulations remain
22 in effect.

23 “(h) REGULATIONS.—Nothing in this section shall be
24 construed as prohibiting the Secretaries of Labor, Health

1 and Human Services, or the Treasury from promulgating
2 regulations in connection with this section.”.

3 (b) INDIVIDUAL MARKET.—Subject to section 6(a) of
4 this Act, subpart 1 of part B of title XXVII of the Public
5 Health Service Act, as restored or revived pursuant to
6 PPACA repeal legislation described in section 6(b) of this
7 Act and amended by section 2(b), is further amended by
8 adding at the end the following:

9 **“SEC. 2747. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES**
10 **BASED ON HEALTH STATUS.**
11

12 “The provisions of section 2702 (other than sub-
13 sections (b)(2)(B) and (f) of such section) shall apply to
14 health insurance coverage offered to individuals by a
15 health insurance issuer in the individual market in the
16 same manner as such provisions apply to health insurance
17 coverage offered to employers by a health insurance issuer
18 in connection with health insurance coverage in the group
19 market.”.

20 **SEC. 5. INCORPORATION INTO ERISA AND INTERNAL REVENUE CODE.**
21

22 (a) ERISA.—Subpart B of part 7 of subtitle A of
23 title I of the Employee Retirement Income Security Act
24 of 1974 (29 U.S.C. 1181 et seq.) is amended by adding
25 at the end the following:

1 **“SEC. 715. ADDITIONAL MARKET REFORMS.**

2 “Sections 2701, 2702, and 2711 shall apply to group
3 health plans, and health insurance issuers providing health
4 insurance coverage in connection with group health plans,
5 as if included in this subpart, and to the extent that any
6 provision of this part conflicts with a provision of such
7 a section with respect to group health plans, or health in-
8 surance issuers providing health insurance coverage in
9 connection with group health plans, the provisions of such
10 section shall apply.”.

11 (b) IRC.—Subchapter B of chapter 100 of the Inter-
12 nal Revenue Code of 1986 is amended by adding at the
13 end the following:

14 **“SEC. 9815. ADDITIONAL MARKET REFORMS.**

15 “Sections 2701, 2702, and 2711 shall apply to group
16 health plans, and health insurance issuers providing health
17 insurance coverage in connection with group health plans,
18 as if included in this subchapter, and to the extent that
19 any provision of this subchapter conflicts with a provision
20 of such a section with respect to group health plans, or
21 health insurance issuers providing health insurance cov-
22 erage in connection with group health plans, the provisions
23 of such section shall apply.”.

1 **SEC. 6. EFFECTIVE DATE CONTINGENT ON REPEAL OF**
2 **PPACA.**

3 (a) IN GENERAL.—Sections 2, 3, 4, and 5 and the
4 amendments made by such sections shall take effect upon
5 the enactment of PPACA repeal legislation described in
6 subsection (b) and such sections and amendments shall
7 have no force or effect if such PPACA repeal legislation
8 is not enacted.

9 (b) PPACA REPEAL LEGISLATION DESCRIBED.—
10 For purposes of subsection (a), PPACA repeal legislation
11 described in this subsection is legislation that—

12 (1) repeals Public Law 111–148, and restores
13 or revives the provisions of law amended or repealed,
14 respectively, by such Act as if such Act had not been
15 enacted and without further amendment to such
16 provisions of law; and

17 (2) repeals title I and subtitle B of title II of
18 the Health Care and Education Reconciliation Act of
19 2010 (Public Law 111–152), and restores or revives
20 the provisions of law amended or repealed, respec-
21 tively, by such title or subtitle, respectively, as if
22 such title and subtitle had not been enacted and
23 without further amendment to such provisions of
24 law.

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