

sistance 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 Title 42, The Public Health and Welfare.

#### EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105-34 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 1531(c) of Pub. L. 105-34, set out as a note under section 4980D of this title.

#### EFFECTIVE DATE

Pub. L. 104-191, title IV, §401(c), Aug. 21, 1996, 110 Stat. 2082, provided that:

“(1) IN GENERAL.—The amendments made by this section [enacting this subtitle] shall apply to plan years beginning after June 30, 1997.

“(2) DETERMINATION OF CREDITABLE COVERAGE.—

“(A) PERIOD OF COVERAGE.—

“(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under chapter 100 of the Internal Revenue Code of 1986 (as added by this section) in determining creditable coverage.

“(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of the Treasury, consistent with section 104 [42 U.S.C. 300gg-92 note], shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

“(B) CERTIFICATIONS, ETC.—

“(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 9801 of the Internal Revenue Code of 1986 (as added by this section) shall apply to events occurring after June 30, 1996.

“(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

“(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

“(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

“(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

“(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

“(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Aug. 21, 1996], the amendments made by this section shall not apply to plan years beginning before the later of—

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

“(B) July 1, 1997.

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

“(4) TIMELY REGULATIONS.—The Secretary of the Treasury, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

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

### § 9802. Prohibiting discrimination against individual participants and beneficiaries based on health status

#### (a) In eligibility to enroll

##### (1) In general

Subject to paragraph (2), a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

##### (2) No application to benefits or exclusions

To the extent consistent with section 9801, paragraph (1) shall not be construed—

(A) to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such plan; or

(B) to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

##### (3) Construction

For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

#### (b) In premium contributions

##### (1) In general

A group health plan may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any factor described in sub-

section (a)(1) in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

**(2) Construction**

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

**(3) No group-based discrimination on basis of genetic information**

**(A) In general**

For purposes of this section, a group health plan may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

**(B) Rule of construction**

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

**(c) Genetic testing**

**(1) Limitation on requesting or requiring genetic testing**

A group health plan may not request or require an individual or a family member of such individual to undergo a genetic test.

**(2) Rule of construction**

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

**(3) Rule of construction regarding payment**

**(A) In general**

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

**(B) Limitation**

For purposes of subparagraph (A), a group health plan may request only the minimum

amount of information necessary to accomplish the intended purpose.

**(4) Research exception**

Notwithstanding paragraph (1), a group health plan may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

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

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

(i) compliance with the request is voluntary; and

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

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

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

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

**(d) Prohibition on collection of genetic information**

**(1) In general**

A group health plan shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 9832).

**(2) Prohibition on collection of genetic information prior to enrollment**

A group health plan shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or in connection with such enrollment.

**(3) Incidental collection**

If a group health plan obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

**(e) Application to all plans**

The provisions of subsections (a)(1)(F), (b)(3), (c), and (d) and subsection (b)(1) and section 9801 with respect to genetic information, shall apply to group health plans without regard to section 9831(a)(2).

**(f) Special rules for church plans**

A church plan (as defined in section 414(e)) shall not be treated as failing to meet the re-

quirements of this section solely because such plan requires evidence of good health for coverage of—

(1) both any employee of an employer with 10 or less employees (determined without regard to section 414(e)(3)(C)) and any self-employed individual, or

(2) any individual who enrolls after the first 90 days of initial eligibility under the plan.

This subsection shall apply to a plan for any year only if the plan included the provisions described in the preceding sentence on July 15, 1997, and at all times thereafter before the beginning of such year.

**(g) Genetic information of a fetus or embryo**

Any reference in this chapter to genetic information concerning an individual or family member of an individual shall—

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

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2078; amended Pub. L. 105-34, title XV, § 1532(a), Aug. 5, 1997, 111 Stat. 1085; Pub. L. 110-233, title I, § 103(a)-(c), May 21, 2008, 122 Stat. 896, 897; Pub. L. 113-295, div. A, title II, § 220(aa), Dec. 19, 2014, 128 Stat. 4037.)

**Editorial Notes**

**REFERENCES IN TEXT**

The Social Security Act, referred to in subsec. (c)(3)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part C of title XI of the Act is classified generally to part C (§ 1320d et seq.) of subchapter XI of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c)(3)(A), is section 264 of Pub. L. 104-191, which is set out as a note under section 1320d-2 of Title 42, The Public Health and Welfare.

**AMENDMENTS**

2014—Subsecs. (f), (g). Pub. L. 113-295 redesignated subsec. (f) relating to genetic information of a fetus or embryo as (g).

2008—Subsec. (b)(2)(A). Pub. L. 110-233, § 103(a)(1), inserted “except as provided in paragraph (3)” before semicolon.

Subsec. (b)(3). Pub. L. 110-233, § 103(a)(2), added par. (3).

Subsecs. (c) to (e). Pub. L. 110-233, § 103(b), added subsecs. (c) to (e). Former subsec. (c) redesignated (f) relating to special rules for church plans.

Subsec. (f). Pub. L. 110-233, § 103(c), added subsec. (f) relating to genetic information of a fetus or embryo.

Pub. L. 110-233, § 103(b), redesignated subsec. (c) as (f) relating to special rules for church plans.

1997—Subsec. (c). Pub. L. 105-34 added subsec. (c).

**Statutory Notes and Related Subsidiaries**

**EFFECTIVE DATE OF 2008 AMENDMENT**

Pub. L. 110-233, title I, § 103(f)(2), May 21, 2008, 122 Stat. 899, provided that: “The amendments made by

this section [enacting section 9834 of this title and amending this section and section 9832 of this title] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of the enactment of this Act [May 21, 2008].”

**EFFECTIVE DATE OF 1997 AMENDMENT**

Pub. L. 105-34, title XV, § 1532(b), Aug. 5, 1997, 111 Stat. 1085, provided that: “The amendments made by subsection (a) [amending this section] shall take effect as if included in the amendments made by section 401(a) of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191].”

**REGULATIONS**

Pub. L. 110-233, title I, § 103(f)(1), May 21, 2008, 122 Stat. 899, provided that: “The Secretary of the Treasury shall issue final regulations or other guidance not later than 12 months after the date of the enactment of this Act [May 21, 2008] to carry out the amendments made by this section [enacting section 9834 of this title and amending this section and section 9832 of this title].”

**EFFECTIVE DATE**

Section applicable to plan years beginning after June 30, 1997, see section 401(c) of Pub. L. 104-191, set out as a note under section 9801 of this title.

**§ 9803. Guaranteed renewability in multi-employer plans and certain multiple employer welfare arrangements**

**(a) In general**

A group health plan which is a multiemployer plan (as defined in section 414(f)) or which is a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under such plan, other than—

(1) for nonpayment of contributions;

(2) for fraud or other intentional misrepresentation of material fact by the employer;

(3) for noncompliance with material plan provisions;

(4) because the plan is ceasing to offer any coverage in a geographic area;

(5) in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or a factor described in section 9802(a)(1) in relation to such individuals or their dependents; or

(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

**(b) Multiple employer welfare arrangement**

For purposes of subsection (a), the term “multiple employer welfare arrangement” has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2079.)