

provision of excepted benefits described in section 1191b(c)(4) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) Treatment of partnerships

For purposes of this part—

(1) Treatment as a group health plan

Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

(2) Employer

In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner.

(3) Participants of group health plans

In the case of a group health plan, the term “participant” also includes—

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is, or may become, eligible to receive a benefit under the plan or such individual’s beneficiaries may be eligible to receive any such benefit.

(Pub. L. 93-406, title I, §732, formerly §705, as added Pub. L. 104-191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1948; renumbered §732 and amended Pub. L. 104-204, title VI, §603(a)(3), (b)(2), (3)(I)–(L), Sept. 26, 1996, 110 Stat. 2935, 2937, 2938.)

Editorial Notes

AMENDMENTS

1996—Subsec. (a). Pub. L. 104-204, §603(b)(2), inserted “(other than section 1185 of this title)” after “part”.

Subsecs. (b), (c)(1) to (3). Pub. L. 104-204, §603(b)(3)(I)–(L), made technical amendment to references in original act which appear in text as references to section 1191b of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104-204 applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104-204, set out as a note under section 1003 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104-191, set out as a note under section 1181 of this title.

§ 1191b. Definitions

(a) Group health plan

For purposes of this part—

(1) In general

The term “group health plan” means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26).

(2) Medical care

The term “medical care” means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) Definitions relating to health insurance

For purposes of this part—

(1) Health insurance coverage

The term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) Health insurance issuer

The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 1144(b)(2) of this title). Such term does not include a group health plan.

(3) Health maintenance organization

The term “health maintenance organization” means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) Group health insurance coverage

The term “group health insurance coverage” means, in connection with a group health

plan, health insurance coverage offered in connection with such plan.

(c) Excepted benefits

For purposes of this part, the term “excepted benefits” means benefits under one or more (or any combination thereof) of the following:

(1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof.
(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers’ compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of title 42), coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan.

(d) Other definitions

For purposes of this part—

(1) COBRA continuation provision

The term “COBRA continuation provision” means any of the following:

(A) Part 6 of this subtitle.

(B) Section 4980B of title 26, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(C) Title XXII of the Public Health Service Act [42 U.S.C. 300bb-1 et seq.].

(2) Health status-related factor

The term “health status-related factor” means any of the factors described in section 1182(a)(1) of this title.

(3) Network plan

The term “network plan” means health insurance coverage offered by a health insurance issuer under which the financing and delivery

of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(4) Placed for adoption

The term “placement”, or being “placed”, for adoption, has the meaning given such term in section 1169(c)(3)(B) of this title.

(5) Family member

The term “family member” means, with respect to an individual—

(A) a dependent (as such term is used for purposes of section 1181(f)(2) of this title) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) Genetic information

(A) In general

The term “genetic information” means, with respect to any individual, information about—

(i) such individual’s genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) Inclusion of genetic services and participation in genetic research

Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) Exclusions

The term “genetic information” shall not include information about the sex or age of any individual.

(7) Genetic test

(A) In general

The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) Exceptions

The term “genetic test” does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(8) Genetic services

The term “genetic services” means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(9) Underwriting purposes

The term “underwriting purposes” means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(Pub. L. 93–406, title I, §733, formerly §706, as added Pub. L. 104–191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1949; renumbered §733, Pub. L. 104–204, title VI, §603(a)(3), Sept. 26, 1996, 110 Stat. 2935; amended Pub. L. 110–233, title I, §101(d), May 21, 2008, 122 Stat. 885; Pub. L. 114–255, div. C, title XVIII, §18001(b)(1), Dec. 13, 2016, 130 Stat. 1343.)

Editorial Notes

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (d)(1)(C), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXII of the Act is classified generally to subchapter XX (§300bb–1 et seq.) of chapter 6A of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

AMENDMENTS

2016—Subsec. (a)(1). Pub. L. 114–255 inserted at end “Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26).”

2008—Subsec. (d)(5) to (9). Pub. L. 110–233 added pars. (5) to (9).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to plan years beginning after Dec. 31, 2016, see section 18001(b)(3) of Pub. L. 114–255, set out as a note under section 1167 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable with respect to group health plans for plan years beginning after the date that is one year after May 21, 2008, see section 101(f)(2) of Pub. L. 110–233, set out as a note under section 1132 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

§ 1191c. Regulations

The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as

may be necessary or appropriate to carry out the provisions of this part. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.

(Pub. L. 93–406, title I, §734, formerly §707, as added Pub. L. 104–191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1951; renumbered §734, Pub. L. 104–204, title VI, §603(a)(3), Sept. 26, 1996, 110 Stat. 2935.)

Editorial Notes

REFERENCES IN TEXT

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in text, probably means section 104 of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, which is set out as a note under section 300gg–92 of Title 42, The Public Health and Welfare.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

§ 1191d. Standardized reporting format

(a) In general

Not later than 1 year after December 27, 2020, the Secretary shall establish (and periodically update) a standardized reporting format for the voluntary reporting, by group health plans to State All Payer Claims Databases, of medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers, and shall provide guidance to States on the process by which States may collect such data from such plans in the standardized reporting format.

(b) Consultation

(1) Advisory Committee

Not later than 90 days after December 27, 2020, the Secretary shall convene an Advisory Committee (referred to in this section as the “Committee”), consisting of 15 members to advise the Secretary regarding the format and guidance described in paragraph (1).¹

(2) Membership

(A) Appointment

In accordance with subparagraph (B), not later than 90 days after December 27, 2020, the Secretary, in coordination with the Secretary of Health and Human Services, shall appoint under subparagraph (B)(iii), and the Comptroller General of the United States shall appoint under subparagraph (B)(iv), members who have distinguished themselves in the fields of health services research, health economics, health informatics, data privacy and security, or the governance of State All Payer Claims Databases, or who represent organizations likely to submit data to or use the database, including patients, employers, or employee organizations

¹ So in original. Probably should be “subsection (a).”