(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 that sponsor group health plans, health care providers, health insurance issuers, or third-party administrators of group health plans. Such members shall serve 3-year terms on a staggered basis. Vacancies on the Committee shall be filled by appointment consistent with this paragraph not later than 3 months after the vacancy arises.

(B) Composition

The Committee shall be comprised of—

(i) the Assistant Secretary of Employee Benefits and Security Administration of the Department of Labor, or a designee of such Assistant Secretary;

(ii) the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, or a designee of such Assistant Secretary;

(iii) members appointed by the Secretary, in coordination with the Secretary of Health and Human Services, including—

(I) 1 member to serve as the chair of the Committee;

(II) 1 representative of the Centers for Medicare & Medicaid Services;

(III) 1 representative of the Agency for Healthcare Research and Quality;

(IV) 1 representative of the Office for Civil Rights of the Department of Health and Human Services with expertise in data privacy and security;

(V) 1 representative of the National Center for Health Statistics;

(VI) 1 representative of the Office of the National Coordinator for Health Information Technology; and

(VII) 1 representative of a State All-Payer[2] Claims Database;

(iv) members appointed by the Comptroller General of the United States, including—

(I) 1 representative of an employer that sponsors a group health plan;

(II) 1 representative of an employee organization that sponsors a group health plan;

(III) 1 academic researcher with expertise in health economics or health services research;

(IV) 1 consumer advocate; and

(V) 2 additional members.

(3) Report

Not later than 180 days after December 27, 2020, the Committee shall report to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce and the Committee on Education and Labor of the House of Representatives. Such report shall include recommendations on the establishment of the format and guidance described in subsection (a).

(c) State All Payer Claims Database

In this section, the term ''State All Payer Claims Database'' means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

(d) Authorization of appropriations

To carry out this section, there are authorized to be appropriated $5,000,000 for fiscal year 2021, to remain available until expended or, if sooner, until the date described in subsection (e).

(e) Sunset

Beginning on the date on which the report is submitted under subsection (b)(3), subsection (b) shall have no force or effect.

(Pub. L. 93–406, title I, § 735, as added Pub. L. 116–260, div. BB, title I, § 115(b), Dec. 27, 2020, 134 Stat. 2877.)

[1] So in original. Probably should be ''subsection (a).''

[2] So in original. Definition in subsec. (c) does not contain hyphen in ''All Payer''.