

“(i) MEDICAID, CHIP, AND EMPLOYER-SPONSORED COVERAGE COORDINATION WORKING GROUP.—

“(I) IN GENERAL.—Not later than 60 days after the date of enactment of this Act [Feb. 4, 2009], the Secretary of Health and Human Services and the Secretary of Labor shall jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group (in this subparagraph referred to as the ‘Working Group’). The purpose of the Working Group shall be to develop the model coverage coordination disclosure form described in subclause (II) and to identify the impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health plans and members who are eligible for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or child health assistance or other health benefits coverage under title XXI of such Act [42 U.S.C. 1397aa et seq.].

“(II) MODEL COVERAGE COORDINATION DISCLOSURE FORM DESCRIBED.—The model form described in this subclause is a form for plan administrators of group health plans to complete for purposes of permitting a State to determine the availability and cost-effectiveness of the coverage available under such plans to employees who have family members who are eligible for premium assistance offered under a State plan under title XIX or XXI of such Act and to allow for coordination of coverage for enrollees of such plans. Such form shall provide the following information in addition to such other information as the Working Group determines appropriate:

“(aa) A determination of whether the employee is eligible for coverage under the group health plan.

“(bb) The name and contract information of the plan administrator of the group health plan.

“(cc) The benefits offered under the plan.

“(dd) The premiums and cost-sharing required under the plan.

“(ee) Any other information relevant to coverage under the plan.

“(ii) MEMBERSHIP.—The Working Group shall consist of not more than 30 members and shall be composed of representatives of—

“(I) the Department of Labor;

“(II) the Department of Health and Human Services;

“(III) State directors of the Medicaid program under title XIX of the Social Security Act;

“(IV) State directors of the State Children’s Health Insurance Program under title XXI of the Social Security Act;

“(V) employers, including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals;

“(VI) plan administrators and plan sponsors of group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]);

“(VII) health insurance issuers; and

“(VIII) children and other beneficiaries of medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

“(iii) COMPENSATION.—The members of the Working Group shall serve without compensation.

“(iv) ADMINISTRATIVE SUPPORT.—The Department of Health and Human Services and the Department of Labor shall jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group may use the services and facilities of either such Department, with or without reimbursement, as jointly determined by such Departments.

“(v) REPORT.—

“(I) REPORT BY WORKING GROUP TO THE SECRETARIES.—Not later than 18 months after the date of the enactment of this Act, the Working Group shall submit to the Secretary of Labor and the Secretary

of Health and Human Services the model form described in clause (i)(II) along with a report containing recommendations for appropriate measures to address the impediments to the effective coordination of coverage between group health plans and the State plans under titles XIX and XXI of the Social Security Act.

“(II) REPORT BY SECRETARIES TO THE CONGRESS.—Not later than 2 months after receipt of the report pursuant to subclause (I), the Secretaries shall jointly submit a report to each House of the Congress regarding the recommendations contained in the report under such subclause.

“(vi) TERMINATION.—The Working Group shall terminate 30 days after the date of the issuance of its report under clause (v).”

[For definitions of “CHIP” and “Medicaid” as used in section 311(b)(1)(C) of Pub. L. 111-3, set out above, see section 1(c)(1), (2) of Pub. L. 111-3, set out as a Definitions note under section 1396 of Title 42, The Public Health and Welfare.]

#### IMPLEMENTATION OF 2009 AMENDMENT

Pub. L. 111-3, title III, §311(b)(1)(D), Feb. 4, 2009, 123 Stat. 69, provided that: “The Secretary of Labor and the Secretary of Health and Human Services shall develop the initial model notices under section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181(f)(3)(B)(i)(II)], and the Secretary of Labor shall provide such notices to employers, not later than the date that is 1 year after the date of enactment of this Act [Feb. 4, 2009], and each employer shall provide the initial annual notices to such employer’s employees beginning with the first plan year that begins after the date on which such initial model notices are first issued. The model coverage coordination disclosure form developed under subparagraph (C) [set out above] shall apply with respect to requests made by States beginning with the first plan year that begins after the date on which such model coverage coordination disclosure form is first issued.”

### § 1182. 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, and a health insurance issuer offering group health insurance coverage in connection with 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 health status-related 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 1181 of this title, paragraph (1) shall not be construed—

(A) to require a group health plan, or group health insurance coverage, to provide

particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage 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, and a health insurance issuer offering health insurance coverage in connection with 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 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 may be charged for coverage under a group health plan except as provided in paragraph (3); 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**

**(A) In general**

For purposes of this section, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with 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 health insurance issuer offering health insurance coverage in connection with 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, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall 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, or a health insurance issuer offering health insurance coverage in connection with 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 [42 U.S.C. 1320d et seq.] 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, or a health insurance issuer offering health insurance coverage in connection with 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, or a health insurance issuer offering health insurance coverage in connection with 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, in writing, 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 or issuer 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 or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer 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, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 1191b of this title).

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

A group health plan, and a health insurance issuer offering health insurance coverage in connection with 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 coverage in connection with such enrollment.

**(3) Incidental collection**

If a group health plan, or a health insurance issuer offering health insurance coverage in connection with 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 1181 of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 1191a(a) of this title.

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

Any reference in this part 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.

(Pub. L. 93-406, title I, §702, as added Pub. L. 104-191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1945; amended Pub. L. 110-233, title I, §101(a)-(c), May 21, 2008, 122 Stat. 883, 885.)

**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

2008—Subsec. (b)(2)(A). Pub. L. 110-233, §101(a)(1), inserted “except as provided in paragraph (3)” before semicolon.

Subsec. (b)(3). Pub. L. 110-233, §101(a)(2), added par. (3).

Subsecs. (c) to (e). Pub. L. 110-233, §101(b), added subsecs. (c) to (e).

Subsec. (f). Pub. L. 110-233, §101(c), added subsec. (f).

**Statutory Notes and Related Subsidiaries**

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.

**§ 1183. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements**

A group health plan which is a multiemployer plan or which is a multiple employer welfare arrangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a 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, 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 any health status-related factor in relation to such individuals or their dependents; and

(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.

(Pub. L. 93-406, title I, §703, as added Pub. L. 104-191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1946.)

Subpart B—Other Requirements

**§ 1185. Standards relating to benefits for mothers and newborns**

**(a) Requirements for minimum hospital stay following birth**

**(1) In general**

A group health plan, and a health insurance issuer offering group health insurance coverage, may not—