

**AMENDMENT TO  
RULES COMMITTEE PRINT 116-14  
OFFERED BY M . \_\_\_\_\_**

Page 50, after line 2, insert the following:

1 **SEC. 205. PROHIBITION OF PRE-EXISTING CONDITION EX-**  
2 **CLUSIONS, GUARANTEED AVAILABILITY OF**  
3 **COVERAGE, PROHIBITING DISCRIMINATION**  
4 **AGAINST INDIVIDUAL PARTICIPANTS AND**  
5 **BENEFICIARIES BASED ON HEALTH STATUS.**

6 (a) PROHIBITION OF PRE-EXISTING CONDITION EX-  
7 CLUSIONS.—

8 (1) GROUP MARKET.—Subject to subsection (e),  
9 subpart 1 of part A of title XXVII of the Public  
10 Health Service Act (42 U.S.C. 300gg et seq.) is  
11 amended by striking section 2701 and inserting the  
12 following:

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

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

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

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

2 “(A) IN GENERAL.—The term ‘pre-existing  
3 condition exclusion’ means, with respect to a  
4 group health plan or health insurance coverage,  
5 a limitation or exclusion of benefits relating to  
6 a condition based on the fact that the condition  
7 was present before the date of enrollment in  
8 such plan or for such coverage, whether or not  
9 any medical advice, diagnosis, care, or treat-  
10 ment was recommended or received before such  
11 date.

12 “(B) TREATMENT OF GENETIC INFORMA-  
13 TION.—Genetic information shall not be treated  
14 as a pre-existing condition in the absence of a  
15 diagnosis of the condition related to such infor-  
16 mation.

17 “(2) DATE OF ENROLLMENT.—The term ‘date  
18 of enrollment’ means, with respect to an individual  
19 covered under a group health plan or health insur-  
20 ance coverage, the date of enrollment of the indi-  
21 vidual in the plan or coverage or, if earlier, the first  
22 day of the waiting period for such enrollment.

23 “(3) WAITING PERIOD.—The term ‘waiting pe-  
24 riod’ means, with respect to a group health plan and  
25 an individual who is a potential participant or bene-

1       ficiary in the plan, the period that must pass with  
2       respect to the individual before the individual is eli-  
3       gible to be covered for benefits under the terms of  
4       the plan.”.

5           (2) INDIVIDUAL MARKET.—Subject to sub-  
6       section (e), subpart 1 of part B of title XXVII of  
7       the Public Health Service Act (42 U.S.C. 300gg–41  
8       et seq.) is amended by adding at the end the fol-  
9       lowing:

10   **“SEC. 2746. PROHIBITION OF PRE-EXISTING CONDITION EX-**  
11                   **CLUSIONS OR OTHER DISCRIMINATION**  
12                   **BASED ON HEALTH STATUS.**

13       “The provisions of section 2701 shall apply to health  
14       insurance coverage offered to individuals by a health in-  
15       surance issuer in the individual market in the same man-  
16       ner as it applies to health insurance coverage offered by  
17       a health insurance issuer in the group market.”.

18       (b) GUARANTEED AVAILABILITY OF COVERAGE.—

19           (1) GROUP MARKET.—Subject to subsection (e),  
20       subpart 3 of part A of title XXVII of the Public  
21       Health Service Act is amended by striking section  
22       2711 (42 U.S.C. 300gg–11) and inserting the fol-  
23       lowing:

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

2 “(a) GUARANTEED ISSUANCE OF COVERAGE IN THE  
3 GROUP MARKET.—Subject to subsection (b), each health  
4 insurance issuer that offers health insurance coverage in  
5 the group market in a State shall accept every employer  
6 and every individual in a group in the State that applies  
7 for such coverage.

8 “(b) ENROLLMENT.—

9 “(1) RESTRICTION.—A health insurance issuer  
10 described in subsection (a) may restrict enrollment  
11 in coverage described in such subsection to open or  
12 special enrollment periods.

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

18 (2) INDIVIDUAL MARKET.—Subject to sub-  
19 section (e), subpart 1 of part B of title XXVII of  
20 the Public Health Service Act is amended by strik-  
21 ing section 2741 of such Act (42 U.S.C. 300gg–41)  
22 and inserting the following:

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

24 “The provisions of section 2711 shall apply to health  
25 insurance coverage offered to individuals by a health in-  
26 surance issuer in the individual market in the same man-

1 ner as such provisions apply to health insurance coverage  
2 offered to employers by a health insurance issuer in con-  
3 nection with health insurance coverage in the group mar-  
4 ket. For purposes of this section, the Secretary shall treat  
5 any reference of the word ‘employer’ in such section as  
6 a reference to the term ‘individual’.”.

7 (c) PROHIBITING DISCRIMINATION AGAINST INDI-  
8 VIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON  
9 HEALTH STATUS.—

10 (1) GROUP MARKET.—Subject to subsection (e),  
11 section 2702 of the Public Health Service Act is  
12 amended to read as follows:

13 **“SEC. 2702. PROHIBITING DISCRIMINATION AGAINST INDI-  
14 VIDUAL PARTICIPANTS AND BENEFICIARIES  
15 BASED ON HEALTH STATUS.**

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

23 “(1) Health status.

24 “(2) Medical condition (including both physical  
25 and mental illnesses).

1 “(3) Claims experience.

2 “(4) Receipt of health care.

3 “(5) Medical history.

4 “(6) Genetic information.

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

7 “(8) Disability.

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

10 “(b) IN PREMIUM CONTRIBUTIONS.—

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

22 “(2) CONSTRUCTION.—Nothing in paragraph  
23 (1) shall be construed—

24 “(A) to restrict the amount that an em-  
25 ployer or individual may be charged for cov-

1 erage under a group health plan except as pro-  
2 vided in paragraph (3); or

3 “(B) to prevent a group health plan, and  
4 a health insurance issuer offering group health  
5 insurance coverage, from establishing premium  
6 discounts or rebates or modifying otherwise ap-  
7 plicable copayments or deductibles in return for  
8 adherence to programs of health promotion and  
9 disease prevention.

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

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

18 “(B) RULE OF CONSTRUCTION.—Nothing  
19 in subparagraph (A) or in paragraphs (1) and  
20 (2) of subsection (d) shall be construed to limit  
21 the ability of a health insurance issuer offering  
22 group health insurance coverage to increase the  
23 premium for an employer based on the mani-  
24 festation of a disease or disorder of an indi-  
25 vidual who is enrolled in the plan. In such case,

1 the manifestation of a disease or disorder in  
2 one individual cannot also be used as genetic in-  
3 formation about other group members and to  
4 further increase the premium for the employer.

5 “(c) GENETIC TESTING.—

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

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

17 “(3) RULE OF CONSTRUCTION REGARDING PAY-  
18 MENT.—

19 “(A) IN GENERAL.—Nothing in paragraph  
20 (1) shall be construed to preclude a group  
21 health plan, or a health insurance issuer offer-  
22 ing health insurance coverage in connection  
23 with a group health plan, from obtaining and  
24 using the results of a genetic test in making a  
25 determination regarding payment (as such term



1 is defined for the purposes of applying the regu-  
2 lations promulgated by the Secretary under  
3 part C of title XI of the Social Security Act and  
4 section 264 of the Health Insurance Portability  
5 and Accountability Act of 1996, as may be re-  
6 vised from time to time) consistent with sub-  
7 section (a).

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

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

22 “(A) The request is made pursuant to re-  
23 search that complies with part 46 of title 45,  
24 Code of Federal Regulations, or equivalent Fed-  
25 eral regulations, and any applicable State or

1 local law or regulations for the protection of  
2 human subjects in research.

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

7 “(i) compliance with the request is  
8 voluntary; and

9 “(ii) non-compliance will have no ef-  
10 fect on enrollment status or premium or  
11 contribution amounts.

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

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

20 “(E) The plan or issuer complies with such  
21 other conditions as the Secretary may by regu-  
22 lation require for activities conducted under this  
23 paragraph.

24 “(d) PROHIBITION ON COLLECTION OF GENETIC IN-  
25 FORMATION.—

1           “(1) IN GENERAL.—A group health plan, and a  
2 health insurance issuer offering health insurance  
3 coverage in connection with a group health plan,  
4 shall not request, require, or purchase genetic infor-  
5 mation for underwriting purposes (as defined in sec-  
6 tion 2791).

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

16           “(3) INCIDENTAL COLLECTION.—If a group  
17 health plan, or a health insurance issuer offering  
18 health insurance coverage in connection with a group  
19 health plan, obtains genetic information incidental to  
20 the requesting, requiring, or purchasing of other in-  
21 formation concerning any individual, such request,  
22 requirement, or purchase shall not be considered a  
23 violation of paragraph (2) if such request, require-  
24 ment, or purchase is not in violation of paragraph  
25 (1).

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

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

9           “(2) with respect to an individual or family  
10 member utilizing an assisted reproductive tech-  
11 nology, include genetic information of any embryo le-  
12 gally held by the individual or family member.

13       “(f) PROGRAMS OF HEALTH PROMOTION OR DIS-  
14 EASE PREVENTION.—

15           “(1) GENERAL PROVISIONS.—

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

24           “(B) NO CONDITIONS BASED ON HEALTH  
25 STATUS FACTOR.—If none of the conditions for

1           obtaining a premium discount or rebate or  
2           other reward for participation in a wellness pro-  
3           gram is based on an individual satisfying a  
4           standard that is related to a health status fac-  
5           tor, such wellness program shall not violate this  
6           section if participation in the program is made  
7           available to all similarly situated individuals  
8           and the requirements of paragraph (2) are com-  
9           plied with.

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

19                   “(2) WELLNESS PROGRAMS NOT SUBJECT TO  
20           REQUIREMENTS.—If none of the conditions for ob-  
21           taining a premium discount or rebate or other re-  
22           ward under a wellness program as described in para-  
23           graph (1)(B) are based on an individual satisfying  
24           a standard that is related to a health status factor  
25           (or if such a wellness program does not provide such

1 a reward), the wellness program shall not violate  
2 this section if participation in the program is made  
3 available to all similarly situated individuals. The  
4 following programs shall not have to comply with the  
5 requirements of paragraph (3) if participation in the  
6 program is made available to all similarly situated  
7 individuals:

8 “(A) A program that reimburses all or  
9 part of the cost for memberships in a fitness  
10 center.

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

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

21 “(D) A program that reimburses individ-  
22 uals for the costs of smoking cessation pro-  
23 grams without regard to whether the individual  
24 quits smoking.

1           “(E) A program that provides a reward to  
2 individuals for attending a periodic health edu-  
3 cation seminar.

4           “(3) WELLNESS PROGRAMS SUBJECT TO RE-  
5 QUIREMENTS.—If any of the conditions for obtaining  
6 a premium discount, rebate, or reward under a  
7 wellness program as described in paragraph (1)(C)  
8 is based on an individual satisfying a standard that  
9 is related to a health status factor, the wellness pro-  
10 gram shall not violate this section if the following re-  
11 quirements are complied with:

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

1           mined based on the total amount of employer  
2           and employee contributions for the benefit  
3           package under which the employee is (or the  
4           employee and any dependents are) receiving  
5           coverage. A reward may be in the form of a dis-  
6           count or rebate of a premium or contribution,  
7           a waiver of all or part of a cost-sharing mecha-  
8           nism (such as deductibles, copayments, or coin-  
9           surance), the absence of a surcharge, or the  
10          value of a benefit that would otherwise not be  
11          provided under the plan. The Secretaries of  
12          Labor, Health and Human Services, and the  
13          Treasury may increase the reward available  
14          under this subparagraph to up to 50 percent of  
15          the cost of coverage if the Secretaries determine  
16          that such an increase is appropriate.

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



1 and is not highly suspect in the method chosen  
2 to promote health or prevent disease.

3 “(C) The plan shall give individuals eligible  
4 for the program the opportunity to qualify for  
5 the reward under the program at least once  
6 each year.

7 “(D) The full reward under the wellness  
8 program shall be made available to all similarly  
9 situated individuals. For such purpose, among  
10 other things:

11 “(i) The reward is not available to all  
12 similarly situated individuals for a period  
13 unless the wellness program allows—

14 “(I) for a reasonable alternative  
15 standard (or waiver of the otherwise  
16 applicable standard) for obtaining the  
17 reward for any individual for whom,  
18 for that period, it is unreasonably dif-  
19 ficult due to a medical condition to  
20 satisfy the otherwise applicable stand-  
21 ard; and

22 “(II) for a reasonable alternative  
23 standard (or waiver of the otherwise  
24 applicable standard) for obtaining the  
25 reward for any individual for whom,

1 for that period, it is medically inadvis-  
2 able to attempt to satisfy the other-  
3 wise applicable standard.

4 “(ii) If reasonable under the cir-  
5 cumstances, the plan or issuer may seek  
6 verification, such as a statement from an  
7 individual’s physician, that a health status  
8 factor makes it unreasonably difficult or  
9 medically inadvisable for the individual to  
10 satisfy or attempt to satisfy the otherwise  
11 applicable standard.

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

22 “(g) EXISTING PROGRAMS.—Nothing in this section  
23 shall prohibit a program of health promotion or disease  
24 prevention that was established prior to the date of enact-  
25 ment of this section and applied with all applicable regula-

1 tions, and that is operating on such date, from continuing  
2 to be carried out for as long as such regulations remain  
3 in effect.

4 “(h) REGULATIONS.—Nothing in this section shall be  
5 construed as prohibiting the Secretaries of Labor, Health  
6 and Human Services, or the Treasury from promulgating  
7 regulations in connection with this section.”.

8 (2) INDIVIDUAL MARKET.—Subject to sub-  
9 section (e), subpart 1 of part B of title XXVII of  
10 the Public Health Service Act, as previously amend-  
11 ed, is further amended by adding at the end the fol-  
12 lowing:

13 **“SEC. 2747. PROHIBITING DISCRIMINATION AGAINST INDI-**  
14 **VIDUAL PARTICIPANTS AND BENEFICIARIES**  
15 **BASED ON HEALTH STATUS.**

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

24 (d) INCORPORATION INTO ERISA AND INTERNAL  
25 REVENUE CODE.—

1           (1) ERISA.—Subject to subsection (e), subpart  
2           B of part 7 of subtitle A of title I of the Employee  
3           Retirement Income Security Act of 1974 (29 U.S.C.  
4           1181 et seq.) is amended by adding at the end the  
5           following:

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

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

16          (2) IRC.—Subject to subsection (e), subchapter  
17          B of chapter 100 of the Internal Revenue Code of  
18          1986 is amended by adding at the end the following:

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

20          “Sections 2701, 2702, and 2711 shall apply to group  
21          health plans, and health insurance issuers providing health  
22          insurance coverage in connection with group health plans,  
23          as if included in this subchapter, and to the extent that  
24          any provision of this subchapter conflicts with a provision  
25          of such a section with respect to group health plans, or

1 health insurance issuers providing health insurance cov-  
2 erage in connection with group health plans, the provisions  
3 of such section shall apply.”.

4 (e) EFFECTIVE DATE CONTINGENT ON PPACA  
5 COURT DECISION.—The amendments made by this sec-  
6 tion shall take effect upon the issuance of a decision of  
7 the Supreme Court resulting in the provisions of the Pa-  
8 tient Protection and Affordable Care Act (Public Law  
9 111–148), including the amendments made by such Act,  
10 having no force or effect and the provisions of law amend-  
11 ed by such Act being restored or revived as if such Act  
12 had never been enacted.

