To amend the Public Health Service Act to prohibit application of pre-existing condition exclusions and to guarantee availability of health insurance coverage in the individual and group market, contingent on the enactment of legislation repealing the Patient Protection and Affordable Care Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 16, 2017

Mr. WALDEN (for himself, Mr. LATTA, Mr. WALBERG, Mr. GUTHRIE, Mr. LANCE, Mr. McKINLEY, Mr. BILIRAKIS, Mrs. MIMI WALTERS of California, Mr. MITCHELL, Mr. BISHOP of Michigan, Mrs. WAGNER, Mrs. BROOKS of Indiana, Mr. KNIGHT, Mr. BUCSHON, Mr. CRAMER, Mr. RODNEY DAVIS of Illinois, Mr. POLIQUIN, Ms. HERRERA BEUTLER, Mr. REICHERT, Mr. HARPER, Mr. UPTON, Mr. ROYCE of California, Mr. ALLEN, Mr. ABRAHAM, Mr. TIPTON, Mr. SMUCKER, Mr. KELLY of Pennsylvania, Mr. DENHAM, Mr. DONOVAN, Mr. FORTENBERRY, Ms. JENKINS of Kansas, Mr. COLLINS of New York, Mr. STIVERS, Mrs. McMORRIS RODGERS, Mr. COSTELLO of Pennsylvania, Mr. FLORES, Mr. ROSKAM, Mr. KINZINGER, Mr. SHUSTER, Mr. THIBERI, Mr. WILSON of South Carolina, Mr. SIMPSON, and Mr. MURPHY of Pennsylvania) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act to prohibit application of pre-existing condition exclusions and to guarantee availability of health insurance coverage in the individual and group market, contingent on the enactment of legis-
lation repealing the Patient Protection and Affordable Care Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Pre-existing Conditions Protection Act of 2017”.

SEC. 2. PROHIBITION OF PRE-EXISTING CONDITION EXCLUSIONS.

(a) GROUP MARKET.—Subject to section 6(a) of this Act, subpart 1 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as restored or revived pursuant to PPACA repeal legislation described in section 6(b) of this Act, is amended by striking section 2701 and inserting the following:

“SEC. 2701. PROHIBITION OF PRE-EXISTING CONDITION EXCLUSIONS.

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

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

“(1) PRE-EXISTING CONDITION EXCLUSION.—

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

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

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

“(3) WAITING PERIOD.—The term ‘waiting pe-
riod’ means, with respect to a group health plan and
an individual who is a potential participant or bene-
fiary in the plan, the period that must pass with
respect to the individual before the individual is eli-
gible to be covered for benefits under the terms of
the plan.”.
(b) INDIVIDUAL MARKET.—Subject to section 6(a) of this Act, subpart 1 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–41 et seq.), as restored or revived pursuant to PPACA repeal legislation described in section 6(b) of this Act, is amended by adding at the end the following:

“SEC. 2746. PROHIBITION OF PRE-EXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

“The provisions of section 2701 shall apply to health insurance coverage offered to individuals by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in the group market.”.

SEC. 3. GUARANTEED AVAILABILITY OF COVERAGE.

(a) GROUP MARKET.—Subject to section 6(a) of this Act, subpart 3 of part A of title XXVII of the Public Health Service Act, as restored or revived pursuant to PPACA repeal legislation described in section 6(b) of this Act, is amended by striking section 2711 (42 U.S.C. 300gg–11) and inserting the following:

“SEC. 2711. GUARANTEED AVAILABILITY OF COVERAGE.

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

“(b) ENROLLMENT.—

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

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

(b) INDIVIDUAL MARKET.—Subject to section 6(a) of
this Act, subpart 1 of part B of title XXVII of the Public
Health Service Act, as restored or revived pursuant to
PPACA repeal legislation described in section 6(b) of this
Act, is amended by striking section 2741 of such Act (42
U.S.C. 300gg–41) and inserting the following:

“SEC. 2741. GUARANTEED AVAILABILITY OF COVERAGE.

“The provisions of section 2711 shall apply to health
insurance coverage offered to individuals by a health in-
surance issuer in the individual market in the same man-
ner as such provisions apply to health insurance coverage
offered to employers by a health insurance issuer in con-
connection with health insurance coverage in the group market. For purposes of this section, the Secretary shall treat any reference of the word ‘employer’ in such section as a reference to the term ‘individual’.”.

SEC. 4. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

(a) GROUP MARKET.—Subject to section 6(a) of this Act, section 2702 of the Public Health Service Act, as restored or revived pursuant to PPACA repeal legislation described in section 6(b) of this Act, is amended to read as follows:

“SEC. 2702. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

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

“(1) Health status.

“(2) Medical condition (including both physical and mental illnesses).
“(3) Claims experience.
“(4) Receipt of health care.
“(5) Medical history.
“(6) Genetic information.
“(7) Evidence of insurability (including conditions arising out of acts of domestic violence).
“(8) Disability.
“(9) Any other health status-related factor determined appropriate by the Secretary.
“(b) In Premium Contributions.—
“(1) In General.—A group health plan, and a health insurance issuer offering group health insurance coverage, 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 or individual may be charged for cov-
verage under a group health plan except as pro-
vided 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 ap-
licable 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 health insur-
ance issuer offering group health insurance cov-
erage, 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
group health insurance coverage to increase the
premium for an employer based on the mani-
festation of a disease or disorder of an indi-
vidual 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 in-
formation 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 indi-
vidual 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 offer-
ing 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 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, 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 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 ef-
fact 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 Sec-
retary in writing that the plan or issuer is con-
ducting activities pursuant to the exception pro-
vided for under this paragraph, including a de-
scription of the activities conducted.

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

“(d) Prohibition on Collection of Genetic In-
formation.—
‘‘(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 2791).

‘‘(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) 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.

“(f) Programs of Health Promotion or Disease Prevention.—

“(1) General provisions.—

“(A) General rule.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a ‘wellness program’) shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

“(B) No conditions based on health status factor.—If none of the conditions for
obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

“(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

“(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such
a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

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

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

“(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

“(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.
“(E) A program that provides a reward to individuals for attending a periodic health education seminar.

“(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

“(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be deter-
mined based on the total amount of employer
and employee contributions for the benefit
package under which the employee is (or the
employee and any dependents are) receiving
coverage. A reward may be in the form of a dis-
count or rebate of a premium or contribution,
a waiver of all or part of a cost-sharing mecha-
nism (such as deductibles, copayments, or coin-
surance), the absence of a surcharge, or the
value of a benefit that would otherwise not be
provided under the plan. The Secretaries of
Labor, Health and Human Services, and the
Treasury may increase the reward available
under this subparagraph to up to 50 percent of
the cost of coverage if the Secretaries determine
that such an increase is appropriate.

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

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

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

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

“(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

“(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom,
for that period, it is medically inadvis-
able to attempt to satisfy the other-
wise applicable standard.

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

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

“(g) EXISTING PROGRAMS.—Nothing in this section
shall prohibit a program of health promotion or disease
prevention that was established prior to the date of enact-
ment of this section and applied with all applicable regula-
...
SEC. 5. INCORPORATION INTO ERISA AND INTERNAL REVENUE CODE.

(a) ERISA.—Subpart B of part 7 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended by adding at the end the following:

“SEC. 715. ADDITIONAL MARKET REFORMS.

“Sections 2701, 2702, and 2711 shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart, and to the extent that any provision of this part conflicts with a provision of such a section with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such section shall apply.”

(b) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“SEC. 9815. ADDITIONAL MARKET REFORMS.

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

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health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such section shall apply.”.

SEC. 6. EFFECTIVE DATE CONTINGENT ON REPEAL OF PPACA.

(a) IN GENERAL.—Sections 2, 3, 4, and 5 and the amendments made by such sections shall take effect upon the enactment of PPACA repeal legislation described in subsection (b) and such sections and amendments shall have no force or effect if such PPACA repeal legislation is not enacted.

(b) PPACA REPEAL LEGISLATION DESCRIBED.—For purposes of subsection (a), PPACA repeal legislation described in this subsection is legislation that—

(1) repeals Public Law 111–148, and restores or revives the provisions of law amended or repealed, respectively, by such Act as if such Act had not been enacted and without further amendment to such provisions of law; and

(2) repeals title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), and restores or revives the provisions of law amended or repealed, respectively, by such title or subtitle, respectively, as if such title and subtitle had not been enacted and
without further amendment to such provisions of law.