

Calendar No. 554

116TH CONGRESS
2D SESSION**S. 4675**

To amend the Health Insurance Portability and Accountability Act.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 23, 2020

Mr. TILLIS introduced the following bill; which was read the first time

SEPTEMBER 24, 2020

Read the second time and placed on the calendar

A BILL

To amend the Health Insurance Portability and
Accountability Act.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Protect Act”.

5 **SEC. 2. FINDINGS.**

6 Congress finds as follows:

7 (1) In President Obama’s last year in office,
8 Obamacare’s high costs exposed working Americans

1 to potential health insurance coverage loss, the most
2 extreme form of lacking pre-existing conditions pro-
3 tection. That year, there was a 20 percent decrease
4 in enrollment in plans offered on the Exchange
5 among working Americans who earned too much to
6 receive a premium tax credit subsidy, but not
7 enough to cover the over 105 percent increases in
8 premiums under Obamacare.

9 (2) In 2015, nearly 80 percent of the house-
10 holds who paid the individual mandate tax earned
11 less than \$50,000 per year.

12 (3) Recognizing this unfair burden, in Decem-
13 ber 2017, Congress acted to restore freedom and lib-
14 erty to Americans by eliminating the penalty for
15 noncompliance with such individual mandate.

16 (4) Obamacare is not the only way to protect
17 Americans with pre-existing conditions.

18 (5) Obamacare's one-size-fits-all approach un-
19 dermines States' ability to care for their populations
20 and left many Americans unable to afford any health
21 insurance in the individual market.

22 (6) Congress will protect individuals with pre-
23 existing conditions if the Supreme Court ultimately
24 determines in *Texas v. California* that Obamacare is
25 unconstitutional.

1 **SEC. 3. GUARANTEED AVAILABILITY OF COVERAGE; PRO-**
 2 **HIBITING DISCRIMINATION.**

3 (a) IN GENERAL.—Subtitle C of title I of the Health
 4 Insurance Portability and Accountability Act of 1996
 5 (Public Law 104–191) is amended by adding at the end
 6 the following:

7 **“SEC. 196. PROHIBITION OF PRE-EXISTING CONDITION EX-**
 8 **CLUSIONS.**

9 “(a) IN GENERAL.—A group health plan and a health
 10 insurance issuer offering group or individual health insur-
 11 ance coverage may not impose any pre-existing condition
 12 exclusion with respect to such plan or coverage.

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

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

15 “(A) IN GENERAL.—The term ‘pre-existing
 16 condition exclusion’ means, with respect to cov-
 17 erage, a limitation or exclusion of benefits relat-
 18 ing to a condition based on the fact that the
 19 condition was present before the enrollment
 20 date for such coverage, whether or not any
 21 medical advice, diagnosis, care, or treatment
 22 was recommended or received before such date.

23 “(B) TREATMENT OF GENETIC INFORMA-
 24 TION.—Genetic information shall not be treated
 25 as a condition described in subparagraph (A) in

1 the absence of a diagnosis of the condition re-
2 lated to such information.

3 “(2) ENROLLMENT DATE.—The term ‘enroll-
4 ment date’ means, with respect to an individual cov-
5 ered under a group health plan or health insurance
6 coverage, the date of enrollment of the individual in
7 the plan or coverage or, if earlier, the first day of
8 the waiting period for such enrollment.

9 “(3) WAITING PERIOD.—The term ‘waiting pe-
10 riod’ means, with respect to a group health plan and
11 an individual who is a potential participant or bene-
12 ficiary in the plan, the period that must pass with
13 respect to the individual before the individual is eli-
14 gible to be covered for benefits under the terms of
15 the plan.

16 **“SEC. 197. GUARANTEED AVAILABILITY OF COVERAGE.**

17 “(a) GUARANTEED ISSUANCE OF COVERAGE IN THE
18 INDIVIDUAL AND GROUP MARKET.—Subject to sub-
19 sections (b) through (d), each health insurance issuer that
20 offers health insurance coverage in the individual or group
21 market in a State must accept every employer and indi-
22 vidual in the State that applies for such coverage.

23 “(b) ENROLLMENT.—

24 “(1) RESTRICTION.—A health insurance issuer
25 described in subsection (a) may restrict enrollment

1 in coverage described in such subsection to open or
2 special enrollment periods.

3 “(2) ESTABLISHMENT.—A health insurance
4 issuer described in subsection (a) shall, in accord-
5 ance with the regulations promulgated under para-
6 graph (3), establish special enrollment periods for
7 qualifying events (under section 603 of the Em-
8 ployee Retirement Income Security Act of 1974).

9 “(3) REGULATIONS.—The Secretary shall pro-
10 mulgate regulations with respect to enrollment peri-
11 ods under paragraphs (1) and (2).

12 “(c) SPECIAL RULES FOR NETWORK PLANS.—

13 “(1) IN GENERAL.—In the case of a health in-
14 surance issuer that offers health insurance coverage
15 in the group and individual market through a net-
16 work plan, the issuer may—

17 “(A) limit the employers that may apply
18 for such coverage to those with eligible individ-
19 uals who live, work, or reside in the service area
20 for such network plan; and

21 “(B) within the service area of such plan,
22 deny such coverage to such employers and indi-
23 viduals if the issuer has demonstrated, if re-
24 quired, to the applicable State authority that—

1 “(i) it will not have the capacity to de-
2 liver services adequately to enrollees of any
3 additional groups or any additional individ-
4 uals because of its obligations to existing
5 group contract holders and enrollees; and

6 “(ii) it is applying this paragraph uni-
7 formly to all employers and individuals
8 without regard to the claims experience of
9 those individuals, employers and their em-
10 ployees (and their dependents), or any
11 health status-related factor relating to
12 such individuals, employees, and depend-
13 ents.

14 “(2) 180-DAY SUSPENSION UPON DENIAL OF
15 COVERAGE.—An issuer, upon denying health insur-
16 ance coverage in any service area in accordance with
17 paragraph (1)(B), may not offer coverage in the
18 group or individual market within such service area
19 for a period of 180 days after the date such cov-
20 erage is denied.

21 “(d) APPLICATION OF FINANCIAL CAPACITY LIM-
22 ITS.—

23 “(1) IN GENERAL.—A health insurance issuer
24 may deny health insurance coverage in the group or

1 individual market if the issuer has demonstrated, if
2 required, to the applicable State authority that—

3 “(A) it does not have the financial reserves
4 necessary to underwrite additional coverage;
5 and

6 “(B) it is applying this paragraph uni-
7 formly to all employers and individuals in the
8 group or individual market in the State con-
9 sistent with applicable State law and without
10 regard to the claims experience of those individ-
11 uals, employers and their employees (and their
12 dependents) or any health status-related factor
13 relating to such individuals, employees, and de-
14 pendents.

15 “(2) 180-DAY SUSPENSION UPON DENIAL OF
16 COVERAGE.—A health insurance issuer upon denying
17 health insurance coverage in connection with group
18 health plans in accordance with paragraph (1) in a
19 State may not offer coverage in connection with
20 group health plans in the group or individual market
21 in the State for a period of 180 days after the date
22 such coverage is denied or until the issuer has dem-
23 onstrated to the applicable State authority, if re-
24 quired under applicable State law, that the issuer
25 has sufficient financial reserves to underwrite addi-

1 tional coverage, whichever is later. An applicable
 2 State authority may provide for the application of
 3 this subsection on a service-area-specific basis

4 “(e) DEFINITIONS.—In this section and in sections
 5 196 and 198:

6 “(1) The term ‘Secretary’ means the Secretary
 7 of Health and Human Services.

8 “(2) The terms ‘genetic information’, ‘genetic
 9 test’, ‘group health plan’, ‘group market’, ‘health in-
 10 surance coverage’, ‘health insurance issuer’, ‘group
 11 health insurance coverage’, ‘individual health insur-
 12 ance coverage’, ‘individual market’, and ‘under-
 13 writing purpose’ have the meanings given such terms
 14 in section 2791 of the Public Health Service Act.”.

15 **“SEC. 198. PROHIBITING DISCRIMINATION AGAINST INDI-
 16 VIDUAL PARTICIPANTS AND BENEFICIARIES
 17 BASED ON HEALTH STATUS.**

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

25 “(1) Health status.

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

3 “(3) Claims experience.

4 “(4) Receipt of health care.

5 “(5) Medical history.

6 “(6) Genetic information.

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

9 “(8) Disability.

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

12 “(b) IN PREMIUM CONTRIBUTIONS.—

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

24 “(2) CONSTRUCTION.—Nothing in paragraph
25 (1) shall be construed—

1 “(A) to restrict the amount that an em-
2 ployer or individual may be charged for cov-
3 erage under a group health plan except as pro-
4 vided in paragraph (3) or individual health cov-
5 erage, as the case may be; or

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

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

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

22 “(B) RULE OF CONSTRUCTION.—Nothing
23 in subparagraph (A) or in paragraphs (1) and
24 (2) of subsection (d) shall be construed to limit
25 the ability of a health insurance issuer offering

1 group or individual health insurance coverage to
2 increase the premium for an employer based on
3 the manifestation of a disease or disorder of an
4 individual who is enrolled in the plan. In such
5 case, the manifestation of a disease or disorder
6 in one individual cannot also be used as genetic
7 information about other group members and to
8 further increase the premium for the employer.

9 “(c) GENETIC TESTING.—

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

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

21 “(3) RULE OF CONSTRUCTION REGARDING PAY-
22 MENT.—

23 “(A) IN GENERAL.—Nothing in paragraph
24 (1) shall be construed to preclude a group
25 health plan, or a health insurance issuer offer-

1 ing health insurance coverage in connection
2 with a group health plan, from obtaining and
3 using the results of a genetic test in making a
4 determination regarding payment (as such term
5 is defined for the purposes of applying the regu-
6 lations promulgated by the Secretary under
7 part C of title XI of the Social Security Act and
8 section 264 of this Act, as may be revised from
9 time to time) consistent with subsection (a).

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

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

24 “(A) The request is made pursuant to re-
25 search that complies with part 46 of title 45,

1 Code of Federal Regulations, or equivalent Fed-
2 eral regulations, and any applicable State or
3 local law or regulations for the protection of
4 human subjects in research.

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

9 “(i) compliance with the request is
10 voluntary; and

11 “(ii) noncompliance will have no effect
12 on enrollment status or premium or con-
13 tribution amounts.

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

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

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

1 “(d) PROHIBITION ON COLLECTION OF GENETIC IN-
2 FORMATION.—

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

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

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

1 ment, or purchase is not in violation of paragraph
2 (1).

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

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

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

15 “(f) PROGRAMS OF HEALTH PROMOTION OR DIS-
16 EASE PREVENTION.—

17 “(1) GENERAL PROVISIONS.—

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

1 “(B) NO CONDITIONS BASED ON HEALTH
2 STATUS FACTOR.—If none of the conditions for
3 obtaining a premium discount or rebate or
4 other reward for participation in a wellness pro-
5 gram is based on an individual satisfying a
6 standard that is related to a health status fac-
7 tor, such wellness program shall not violate this
8 section if participation in the program is made
9 available to all similarly situated individuals
10 and the requirements of paragraph (2) are com-
11 plied with.

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

21 “(2) WELLNESS PROGRAMS NOT SUBJECT TO
22 REQUIREMENTS.—If none of the conditions for ob-
23 taining a premium discount or rebate or other re-
24 ward under a wellness program as described in para-
25 graph (1)(B) are based on an individual satisfying

1 a standard that is related to a health status factor
2 (or if such a wellness program does not provide such
3 a reward), the wellness program shall not violate
4 this section if participation in the program is made
5 available to all similarly situated individuals. The
6 following programs shall not have to comply with the
7 requirements of paragraph (3) if participation in the
8 program is made available to all similarly situated
9 individuals:

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

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

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

23 “(D) A program that reimburses individ-
24 uals for the costs of smoking cessation pro-

1 grams without regard to whether the individual
2 quits smoking.

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

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

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

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

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

1 discriminating based on a health status factor,
2 and is not highly suspect in the method chosen
3 to promote health or prevent disease.

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

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

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

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

23 “(II) for a reasonable alternative
24 standard (or waiver of the otherwise
25 applicable standard) for obtaining the

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

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

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

23 (b) CONFORMING AMENDMENT.—The table of con-
24 tents under section 1(b) of the Health Insurance Port-
25 ability and Accountability Act of 1996 (Public Law 104–

1 191) is amended by inserting after the item relating to
 2 section 195 the following:

“Sec. 196. Prohibition of pre-existing condition exclusions.

“Sec. 197. Guaranteed Availability of Coverage.

“Sec. 198. Prohibiting Discrimination against individual participants and beneficiaries based on health status.”.

3 (c) ENFORCEMENT.—

4 (1) PHSA.—Section 2723 of the Public Health
 5 Service Act (42 U.S.C. 300gg-22) is amended—

6 (A) in subsection (a)—

7 (i) in paragraph (1), by inserting
 8 “and sections 196 ,197, and 198 of the
 9 Health Insurance Portability and Account-
 10 ability Act of 1996” after “this part”; and

11 (ii) in paragraph (2), by inserting “or
 12 section 196, 197, or 198 of the Health In-
 13 surance Portability and Accountability Act
 14 of 1996” after “this part”; and

15 (B) in subsection (b), by inserting “or sec-
 16 tion 196, 197, or 198 of the Health Insurance
 17 Portability and Accountability Act of 1996”
 18 after “this part” each place such term appears.

19 (2) ERISA.—Section 715 of the Employee Re-
 20 tirement Income Security Act of 1974 (29 U.S.C.
 21 1185d) is amended by adding at the end the fol-
 22 lowing:

1 “(c) ADDITIONAL PROVISIONS.—Section 197 of the
2 Health Insurance Portability and Accountability Act of
3 1996 shall apply to health insurance issuers providing
4 health insurance coverage in connection with group health
5 plans, and sections 196 and 198 of such Act shall apply
6 to group health plans and health insurance issuers pro-
7 viding health insurance coverage in connection with group
8 health plans, as if included in this subpart, and to the
9 extent that any provision of this part conflicts with a pro-
10 vision of such section 197 with respect to health insurance
11 issuers providing health insurance coverage in connection
12 with group health plans or of such section 196 or 198
13 with respect to group health plans or health insurance
14 issuers providing health insurance coverage in connection
15 with group health plans, the provisions of such sections
16 196, 197, and 198, as applicable, shall apply.”.

17 (3) IRC.—Section 9815 of the Internal Rev-
18 enue Code of 1986 is amended by adding at the end
19 the following:

20 “(c) ADDITIONAL PROVISIONS.—Section 197 of the
21 Health Insurance Portability and Accountability Act of
22 1996 shall apply to health insurance issuers providing
23 health insurance coverage in connection with group health
24 plans, and section 196 and 198 of such Act shall apply
25 to group health plans and health insurance issuers pro-

1 viding health insurance coverage in connection with group
2 health plans, as if included in this subchapter, and to the
3 extent that any provision of this chapter conflicts with a
4 provision of such section 197 with respect to health insur-
5 ance issuers providing health insurance coverage in con-
6 nection with group health plans or of such section 196
7 or 198 with respect to group health plans or health insur-
8 ance issuers providing health insurance coverage in con-
9 nection with group health plans, the provisions of such
10 sections 196, 197, and 198, as applicable, shall apply.”.

11 (d) EFFECTIVE DATE.—This amendments made by
12 this section shall take effect one day after the date of en-
13 actment of this Act.

Calendar No. 554

116TH CONGRESS
2^D SESSION

S. 4675

A BILL

To amend the Health Insurance Portability and
Accountability Act.

SEPTEMBER 24, 2020

Read the second time and placed on the calendar