117TH CONGRESS
1ST SESSION

S. ______

To amend the Health Insurance Portability and Accountability Act.

IN THE SENATE OF THE UNITED STATES

Mr. TILLIS (for himself, Ms. ERNST, Mr. PORTMAN, Mr. CORNYN, Mrs. HYDE-SMITH, Mrs. CAPITO, Mr. JOHNSON, Mr. MARSHALL, Mr. BURR, and Mr. YOUNG) introduced the following bill; which was read twice and referred to the Committee on ______

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. GUARANTEED AVAILABILITY OF COVERAGE; PRO-**
6 **HIBITING DISCRIMINATION.**

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

1 **"SEC. 196. PROHIBITION OF PRE-EXISTING CONDITION EX-**
2 **CLUSIONS.**

3 "(a) IN GENERAL.—A group health plan and a health
4 insurance issuer offering group or individual health insur-
5 ance coverage may not impose any pre-existing condition
6 exclusion with respect to such plan or coverage.

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

8 "(1) PRE-EXISTING CONDITION EXCLUSION.—

9 "(A) IN GENERAL.—The term 'pre-existing
10 condition exclusion' means, with respect to cov-
11 erage, a limitation or exclusion of benefits relat-
12 ing to a condition based on the fact that the
13 condition was present before the enrollment
14 date for such coverage, whether or not any
15 medical advice, diagnosis, care, or treatment
16 was recommended or received before such date.

17 "(B) TREATMENT OF GENETIC INFORMA-
18 TION.—Genetic information shall not be treated
19 as a condition described in subparagraph (A) in
20 the absence of a diagnosis of the condition re-
21 lated to such information.

22 "(2) ENROLLMENT DATE.—The term 'enroll-
23 ment date' means, with respect to an individual cov-
24 ered under a group health plan or health insurance
25 coverage, the date of enrollment of the individual in

1 the plan or coverage or, if earlier, the first day of
2 the waiting period for such enrollment.
3 ‘‘(3) WAITING PERIOD.—The term ‘waiting pe-
4 riod’ means, with respect to a group health plan and
5 an individual who is a potential participant or bene-
6 ficiary in the plan, the period that must pass with
7 respect to the individual before the individual is eli-
8 gible to be covered for benefits under the terms of
9 the plan.

10 **‘‘SEC. 197. GUARANTEED AVAILABILITY OF COVERAGE.**

11 ‘‘(a) GUARANTEED ISSUANCE OF COVERAGE IN THE
12 INDIVIDUAL AND GROUP MARKET.—Subject to sub-
13 sections (b) through (d), each health insurance issuer that
14 offers health insurance coverage in the individual or group
15 market in a State must accept every employer and indi-
16 vidual in the State that applies for such coverage.
17 ‘‘(b) ENROLLMENT.—
18 ‘‘(1) RESTRICTION.—A health insurance issuer
19 described in subsection (a) may restrict enrollment
20 in coverage described in such subsection to open or
21 special enrollment periods.
22 ‘‘(2) ESTABLISHMENT.—A health insurance
23 issuer described in subsection (a) shall, in accord-
24 ance with the regulations promulgated under para-
25 graph (3), establish special enrollment periods for

1 qualifying events (under section 603 of the Em-
2 ployee Retirement Income Security Act of 1974).
3 ''(3) REGULATIONS.—The Secretary shall pro-
4 mulgate regulations with respect to enrollment peri-
5 ods under paragraphs (1) and (2).
6 ''(c) SPECIAL RULES FOR NETWORK PLANS.—
7 ''(1) IN GENERAL.—In the case of a health in-
8 surance issuer that offers health insurance coverage
9 in the group and individual market through a net-
10 work plan, the issuer may—
11 ''(A) limit the employers that may apply
12 for such coverage to those with eligible individ-
13 uals who live, work, or reside in the service area
14 for such network plan; and
15 ''(B) within the service area of such plan,
16 deny such coverage to such employers and indi-
17 viduals if the issuer has demonstrated, if re-
18 quired, to the applicable State authority that—
19 ''(i) it will not have the capacity to de-
20 liver services adequately to enrollees of any
21 additional groups or any additional individ-
22 uals because of its obligations to existing
23 group contract holders and enrollees; and
24 ''(ii) it is applying this paragraph uni-
25 formly to all employers and individuals

1 without regard to the claims experience of
2 those individuals, employers and their em-
3 ployees (and their dependents), or any
4 health status-related factor relating to
5 such individuals, employees, and depend-
6 ents.
7 ''(2) 180-DAY SUSPENSION UPON DENIAL OF
8 COVERAGE.—An issuer, upon denying health insur-
9 ance coverage in any service area in accordance with
10 paragraph (1)(B), may not offer coverage in the
11 group or individual market within such service area
12 for a period of 180 days after the date such cov-
13 erage is denied.
14 ''(d) APPLICATION OF FINANCIAL CAPACITY LIM-
15 ITS.—
16 ''(1) IN GENERAL.—A health insurance issuer
17 may deny health insurance coverage in the group or
18 individual market if the issuer has demonstrated, if
19 required, to the applicable State authority that—
20 ''(A) it does not have the financial reserves
21 necessary to underwrite additional coverage;
22 and
23 ''(B) it is applying this paragraph uni-
24 formly to all employers and individuals in the
25 group or individual market in the State con-

1 sistent with applicable State law and without
2 regard to the claims experience of those individ-
3 uals, employers and their employees (and their
4 dependents) or any health status-related factor
5 relating to such individuals, employees, and de-
6 pendents.

7 ''(2) 180-DAY SUSPENSION UPON DENIAL OF
8 COVERAGE.—A health insurance issuer upon denying
9 health insurance coverage in connection with group
10 health plans in accordance with paragraph (1) in a
11 State may not offer coverage in connection with
12 group health plans in the group or individual market
13 in the State for a period of 180 days after the date
14 such coverage is denied or until the issuer has dem-
15 onstrated to the applicable State authority, if re-
16 quired under applicable State law, that the issuer
17 has sufficient financial reserves to underwrite addi-
18 tional coverage, whichever is later. An applicable
19 State authority may provide for the application of
20 this subsection on a service-area-specific basis.

21 ''(e) DEFINITIONS.—In this section and in sections
22 196 and 198:

23 ''(1) The term 'Secretary' means the Secretary
24 of Health and Human Services.

1 ''(2) The terms 'genetic information', 'genetic
2 test', 'group health plan', 'group market', 'health in-
3 surance coverage', 'health insurance issuer', 'group
4 health insurance coverage', 'individual health insur-
5 ance coverage', 'individual market', and 'under-
6 writing purpose' have the meanings given such terms
7 in section 2791 of the Public Health Service Act.''.

8 **''SEC. 198. PROHIBITING DISCRIMINATION AGAINST INDI-**
9 **VIDUAL PARTICIPANTS AND BENEFICIARIES**
10 **BASED ON HEALTH STATUS.**

11 ''(a) IN GENERAL.—A group health plan and a health
12 insurance issuer offering group or individual health insur-
13 ance coverage may not establish rules for eligibility (in-
14 cluding continued eligibility) of any individual to enroll
15 under the terms of the plan or coverage based on any of
16 the following health status-related factors in relation to
17 the individual or a dependent of the individual:

18 ''(1) Health status.
19 ''(2) Medical condition (including both physical
20 and mental illnesses).
21 ''(3) Claims experience.
22 ''(4) Receipt of health care.
23 ''(5) Medical history.
24 ''(6) Genetic information.

1 "(7) Evidence of insurability (including condi-
2 tions arising out of acts of domestic violence).
3 "(8) Disability.
4 "(9) Any other health status-related factor de-
5 termined appropriate by the Secretary.
6 "(b) IN PREMIUM CONTRIBUTIONS.—
7 "(1) IN GENERAL.—A group health plan, and a
8 health insurance issuer offering group or individual
9 health insurance coverage, may not require any indi-
10 vidual (as a condition of enrollment or continued en-
11 rollment under the plan) to pay a premium or con-
12 tribution which is greater than such premium or
13 contribution for a similarly situated individual en-
14 rolled in the plan on the basis of any health status-
15 related factor in relation to the individual or to an
16 individual enrolled under the plan as a dependent of
17 the individual.
18 "(2) CONSTRUCTION.—Nothing in paragraph
19 (1) shall be construed—
20 "(A) to restrict the amount that an em-
21 ployer or individual may be charged for cov-
22 erage under a group health plan except as pro-
23 vided in paragraph (3) or individual health cov-
24 erage, as the case may be; or

1 ‘‘(B) to prevent a group health plan, and
2 a health insurance issuer offering group health
3 insurance coverage, from establishing premium
4 discounts or rebates or modifying otherwise ap-
5 plicable copayments or deductibles in return for
6 adherence to programs of health promotion and
7 disease prevention.
8 ‘‘(3) NO GROUP-BASED DISCRIMINATION ON
9 BASIS OF GENETIC INFORMATION.—
10 ‘‘(A) IN GENERAL.—For purposes of this
11 section, a group health plan, and health insur-
12 ance issuer offering group health insurance cov-
13 erage in connection with a group health plan,
14 may not adjust premium or contribution
15 amounts for the group covered under such plan
16 on the basis of genetic information.
17 ‘‘(B) RULE OF CONSTRUCTION.—Nothing
18 in subparagraph (A) or in paragraphs (1) and
19 (2) of subsection (d) shall be construed to limit
20 the ability of a health insurance issuer offering
21 group or individual health insurance coverage to
22 increase the premium for an employer based on
23 the manifestation of a disease or disorder of an
24 individual who is enrolled in the plan. In such
25 case, the manifestation of a disease or disorder

1 in one individual cannot also be used as genetic
2 information about other group members and to
3 further increase the premium for the employer.
4 ''(c) GENETIC TESTING.—
5 ''(1) LIMITATION ON REQUESTING OR REQUIR-
6 ING GENETIC TESTING.—A group health plan, and a
7 health insurance issuer offering health insurance
8 coverage in connection with a group health plan,
9 shall not request or require an individual or a family
10 member of such individual to undergo a genetic test.
11 ''(2) RULE OF CONSTRUCTION.—Paragraph (1)
12 shall not be construed to limit the authority of a
13 health care professional who is providing health care
14 services to an individual to request that such indi-
15 vidual undergo a genetic test.
16 ''(3) RULE OF CONSTRUCTION REGARDING PAY-
17 MENT.—
18 ''(A) IN GENERAL.—Nothing in paragraph
19 (1) shall be construed to preclude a group
20 health plan, or a health insurance issuer offer-
21 ing health insurance coverage in connection
22 with a group health plan, from obtaining and
23 using the results of a genetic test in making a
24 determination regarding payment (as such term
25 is defined for the purposes of applying the regu-

1 lations promulgated by the Secretary under
2 part C of title XI of the Social Security Act and
3 section 264 of this Act, as may be revised from
4 time to time) consistent with subsection (a).
5 ''(B) LIMITATION.—For purposes of sub-
6 paragraph (A), a group health plan, or a health
7 insurance issuer offering health insurance cov-
8 erage in connection with a group health plan,
9 may request only the minimum amount of in-
10 formation necessary to accomplish the intended
11 purpose.
12 ''(4) RESEARCH EXCEPTION.—Notwithstanding
13 paragraph (1), a group health plan, or a health in-
14 surance issuer offering health insurance coverage in
15 connection with a group health plan, may request,
16 but not require, that a participant or beneficiary un-
17 dergo a genetic test if each of the following condi-
18 tions is met:
19 ''(A) The request is made pursuant to re-
20 search that complies with part 46 of title 45,
21 Code of Federal Regulations, or equivalent Fed-
22 eral regulations, and any applicable State or
23 local law or regulations for the protection of
24 human subjects in research.

1 "(B) The plan or issuer clearly indicates to
2 each participant or beneficiary, or in the case of
3 a minor child, to the legal guardian of such
4 beneficiary, to whom the request is made that—
5 "(i) compliance with the request is
6 voluntary; and
7 "(ii) noncompliance will have no effect
8 on enrollment status or premium or con-
9 tribution amounts.
10 "(C) No genetic information collected or
11 acquired under this paragraph shall be used for
12 underwriting purposes.
13 "(D) The plan or issuer notifies the Sec-
14 retary in writing that the plan or issuer is con-
15 ducting activities pursuant to the exception pro-
16 vided for under this paragraph, including a de-
17 scription of the activities conducted.
18 "(E) The plan or issuer complies with such
19 other conditions as the Secretary may by regu-
20 lation require for activities conducted under this
21 paragraph.
22 "(d) PROHIBITION ON COLLECTION OF GENETIC IN-
23 FORMATION.—
24 "(1) IN GENERAL.—A group health plan, and a
25 health insurance issuer offering health insurance

1 coverage in connection with a group health plan,
2 shall not request, require, or purchase genetic infor-
3 mation for underwriting purposes.
4 “(2) PROHIBITION ON COLLECTION OF GE-
5 NETIC INFORMATION PRIOR TO ENROLLMENT.—A
6 group health plan, and a health insurance issuer of-
7 fering health insurance coverage in connection with
8 a group health plan, shall not request, require, or
9 purchase genetic information with respect to any in-
10 dividual prior to such individual’s enrollment under
11 the plan or coverage in connection with such enroll-
12 ment.
13 “(3) INCIDENTAL COLLECTION.—If a group
14 health plan, or a health insurance issuer offering
15 health insurance coverage in connection with a group
16 health plan, obtains genetic information incidental to
17 the requesting, requiring, or purchasing of other in-
18 formation concerning any individual, such request,
19 requirement, or purchase shall not be considered a
20 violation of paragraph (2) if such request, require-
21 ment, or purchase is not in violation of paragraph
22 (1).
23 “(e) GENETIC INFORMATION OF A FETUS OR EM-
24 BRYO.—Any reference in this part to genetic information

1 concerning an individual or family member of an indi-
2 vidual shall—
3 ‘‘(1) with respect to such an individual or fam-
4 ily member of an individual who is a pregnant
5 woman, include genetic information of any fetus car-
6 ried by such pregnant woman; and
7 ‘‘(2) with respect to an individual or family
8 member utilizing an assisted reproductive tech-
9 nology, include genetic information of any embryo le-
10 gally held by the individual or family member.
11 ‘‘(f) PROGRAMS OF HEALTH PROMOTION OR DIS-
12 EASE PREVENTION.—
13 ‘‘(1) GENERAL PROVISIONS.—
14 ‘‘(A) GENERAL RULE.—For purposes of
15 subsection (b)(2)(B), a program of health pro-
16 motion or disease prevention (referred to in this
17 subsection as a ‘wellness program’) shall be a
18 program offered by an employer that is de-
19 signed to promote health or prevent disease
20 that meets the applicable requirements of this
21 subsection.
22 ‘‘(B) NO CONDITIONS BASED ON HEALTH
23 STATUS FACTOR.—If none of the conditions for
24 obtaining a premium discount or rebate or
25 other reward for participation in a wellness pro-

1 gram is based on an individual satisfying a
2 standard that is related to a health status fac-
3 tor, such wellness program shall not violate this
4 section if participation in the program is made
5 available to all similarly situated individuals
6 and the requirements of paragraph (2) are com-
7 plied with.
8 "(C) CONDITIONS BASED ON HEALTH STA-
9 TUS FACTOR.—If any of the conditions for ob-
10 taining a premium discount or rebate or other
11 reward for participation in a wellness program
12 is based on an individual satisfying a standard
13 that is related to a health status factor, such
14 wellness program shall not violate this section if
15 the requirements of paragraph (3) are complied
16 with.
17 "(2) WELLNESS PROGRAMS NOT SUBJECT TO
18 REQUIREMENTS.—If none of the conditions for ob-
19 taining a premium discount or rebate or other re-
20 ward under a wellness program as described in para-
21 graph (1)(B) are based on an individual satisfying
22 a standard that is related to a health status factor
23 (or if such a wellness program does not provide such
24 a reward), the wellness program shall not violate
25 this section if participation in the program is made

1 available to all similarly situated individuals. The
2 following programs shall not have to comply with the
3 requirements of paragraph (3) if participation in the
4 program is made available to all similarly situated
5 individuals:
6 ‘‘(A) A program that reimburses all or
7 part of the cost for memberships in a fitness
8 center.
9 ‘‘(B) A diagnostic testing program that
10 provides a reward for participation and does
11 not base any part of the reward on outcomes.
12 ‘‘(C) A program that encourages preven-
13 tive care related to a health condition through
14 the waiver of the copayment or deductible re-
15 quirement under group health plan for the costs
16 of certain items or services related to a health
17 condition (such as prenatal care or well-baby
18 visits).
19 ‘‘(D) A program that reimburses individ-
20 uals for the costs of smoking cessation pro-
21 grams without regard to whether the individual
22 quits smoking.
23 ‘‘(E) A program that provides a reward to
24 individuals for attending a periodic health edu-
25 cation seminar.

1 "(3) WELLNESS PROGRAMS SUBJECT TO RE-
2 QUIREMENTS.—If any of the conditions for obtaining
3 a premium discount, rebate, or reward under a
4 wellness program as described in paragraph (1)(C)
5 is based on an individual satisfying a standard that
6 is related to a health status factor, the wellness pro-
7 gram shall not violate this section if the following re-
8 quirements are complied with:
9 "(A) The reward for the wellness program,
10 together with the reward for other wellness pro-
11 grams with respect to the plan that requires
12 satisfaction of a standard related to a health
13 status factor, shall not exceed 30 percent of the
14 cost of employee-only coverage under the plan.
15 If, in addition to employees or individuals, any
16 class of dependents (such as spouses or spouses
17 and dependent children) may participate fully
18 in the wellness program, such reward shall not
19 exceed 30 percent of the cost of the coverage in
20 which an employee or individual and any de-
21 pendents are enrolled. For purposes of this
22 paragraph, the cost of coverage shall be deter-
23 mined based on the total amount of employer
24 and employee contributions for the benefit
25 package under which the employee is (or the

1 employee and any dependents are) receiving
2 coverage. A reward may be in the form of a dis-
3 count or rebate of a premium or contribution,
4 a waiver of all or part of a cost-sharing mecha-
5 nism (such as deductibles, copayments, or coin-
6 surance), the absence of a surcharge, or the
7 value of a benefit that would otherwise not be
8 provided under the plan. The Secretaries of
9 Labor, Health and Human Services, and the
10 Treasury may increase the reward available
11 under this subparagraph to up to 50 percent of
12 the cost of coverage if the Secretaries determine
13 that such an increase is appropriate.
14 ''(B) The wellness program shall be rea-
15 sonably designed to promote health or prevent
16 disease. A program complies with the preceding
17 sentence if the program has a reasonable
18 chance of improving the health of, or preventing
19 disease in, participating individuals and it is
20 not overly burdensome, is not a subterfuge for
21 discriminating based on a health status factor,
22 and is not highly suspect in the method chosen
23 to promote health or prevent disease.
24 ''(C) The plan shall give individuals eligible
25 for the program the opportunity to qualify for

1 the reward under the program at least once
2 each year.
3 "(D) The full reward under the wellness
4 program shall be made available to all similarly
5 situated individuals. For such purpose, among
6 other things:
7 "(i) The reward is not available to all
8 similarly situated individuals for a period
9 unless the wellness program allows—
10 "(I) for a reasonable alternative
11 standard (or waiver of the otherwise
12 applicable standard) for obtaining the
13 reward for any individual for whom,
14 for that period, it is unreasonably dif-
15 ficult due to a medical condition to
16 satisfy the otherwise applicable stand-
17 ard; and
18 "(II) for a reasonable alternative
19 standard (or waiver of the otherwise
20 applicable standard) for obtaining the
21 reward for any individual for whom,
22 for that period, it is medically inadvis-
23 able to attempt to satisfy the other-
24 wise applicable standard.

1 "(ii) If reasonable under the cir-
2 cumstances, the plan or issuer may seek
3 verification, such as a statement from an
4 individual's physician, that a health status
5 factor makes it unreasonably difficult or
6 medically inadvisable for the individual to
7 satisfy or attempt to satisfy the otherwise
8 applicable standard.
9 "(E) The plan or issuer involved shall dis-
10 close in all plan materials describing the terms
11 of the wellness program the availability of a
12 reasonable alternative standard (or the possi-
13 bility of waiver of the otherwise applicable
14 standard) required under subparagraph (D). If
15 plan materials disclose that such a program is
16 available, without describing its terms, the dis-
17 closure under this subparagraph shall not be re-
18 quired.".
19 (b) CONFORMING AMENDMENT.—The table of con-
20 tents under section 1(b) of the Health Insurance Port-
21 ability and Accountability Act of 1996 (Public Law 104–
22 191) is amended by inserting after the item relating to
23 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.".

1 (c) ENFORCEMENT.—
2 (1) PHSA.—Section 2723 of the Public Health
3 Service Act (42 U.S.C. 300gg–22) is amended—
4 (A) in subsection (a)—
5 (i) in paragraph (1), by inserting
6 ‘‘and sections 196, 197, and 198 of the
7 Health Insurance Portability and Account-
8 ability Act of 1996’’ after ‘‘this part’’; and
9 (ii) in paragraph (2), by inserting ‘‘or
10 section 196, 197, or 198 of the Health In-
11 surance Portability and Accountability Act
12 of 1996’’ after ‘‘this part’’; and
13 (B) in subsection (b), by inserting ‘‘or sec-
14 tion 196, 197, or 198 of the Health Insurance
15 Portability and Accountability Act of 1996’’
16 after ‘‘this part’’ each place such term appears.
17 (2) ERISA.—Section 715 of the Employee Re-
18 tirement Income Security Act of 1974 (29 U.S.C.
19 1185d) is amended by adding at the end the fol-
20 lowing:
21 ‘‘(c) ADDITIONAL PROVISIONS.—Section 197 of the
22 Health Insurance Portability and Accountability Act of
23 1996 shall apply to health insurance issuers providing
24 health insurance coverage in connection with group health
25 plans, and sections 196 and 198 of such Act shall apply

1 to group health plans and health insurance issuers pro-
2 viding health insurance coverage in connection with group
3 health plans, as if included in this subpart, and to the
4 extent that any provision of this part conflicts with a pro-
5 vision of such section 197 with respect to health insurance
6 issuers providing health insurance coverage in connection
7 with group health plans or of such section 196 or 198
8 with respect to group health plans or health insurance
9 issuers providing health insurance coverage in connection
10 with group health plans, the provisions of such sections
11 196, 197, and 198, as applicable, shall apply.''.
12 (3) IRC.—Section 9815 of the Internal Rev-
13 enue Code of 1986 is amended by adding at the end
14 the following:
15 ''(c) ADDITIONAL PROVISIONS.—Section 197 of the
16 Health Insurance Portability and Accountability Act of
17 1996 shall apply to health insurance issuers providing
18 health insurance coverage in connection with group health
19 plans, and section 196 and 198 of such Act shall apply
20 to group health plans and health insurance issuers pro-
21 viding health insurance coverage in connection with group
22 health plans, as if included in this subchapter, and to the
23 extent that any provision of this chapter conflicts with a
24 provision of such section 197 with respect to health insur-
25 ance issuers providing health insurance coverage in con-

1 nection with group health plans or of such section 196
2 or 198 with respect to group health plans or health insur-
3 ance issuers providing health insurance coverage in con-
4 nection with group health plans, the provisions of such
5 sections 196, 197, and 198, as applicable, shall apply.''.