116TH CONGRESS
1ST SESSION

S. _____

To amend the Health Insurance Portability and Accountability Act.

IN THE SENATE OF THE UNITED STATES

Mr. TILLIS (for himself, Mr. ALEXANDER, Mr. GRASSLEY, Mr. CASSIDY, Mr. PORTMAN, Mr. PERDUE, Ms. ERNST, Mr. CORNYN, Mr. CRAMER, Mr. ISAKSON, Mr. WICKER, Mrs. CAPITO, Mr. KENNEDY, Mr. BARRASSO, Mr. SCOTT of Florida, Mr. BURR, Mr. YOUNG, and Mr. COTTON) 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.

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 ''Protect Act''.

SEC. 2. FINDINGS.

Congress finds as follows:

(1) In President Obama's last year in office, Obamacare's high costs exposed working Americans to potential health insurance coverage loss, the most

extreme form of lacking pre-existing conditions protection. That year, there was a 20 percent decrease in enrollment in plans offered on the Exchange among working Americans who earned too much to receive a premium tax credit subsidy, but not enough to cover the over 105 percent increases in premiums under Obamacare.

(2) In 2015, nearly 80 percent of the households who paid the individual mandate tax earned less than $50,000 per year.

(3) Recognizing this unfair burden, in December 2017, Congress acted to restore freedom and liberty to Americans by eliminating the penalty for noncompliance with such individual mandate.

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

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

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

SEC. 3. GUARANTEED AVAILABILITY OF COVERAGE; PROHIBITING DISCRIMINATION.

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

"SEC. 196. PROHIBITION OF PRE-EXISTING CONDITION EXCLUSIONS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual 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 coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

''(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a condition described in subparagraph (A) in

the absence of a diagnosis of the condition related to such information.

''(2) ENROLLMENT DATE.—The term 'enrollment date' means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

''(3) WAITING PERIOD.—The term 'waiting period' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

"SEC. 197. GUARANTEED AVAILABILITY OF COVERAGE.

''(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (d), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual 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, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

''(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

''(c) SPECIAL RULES FOR NETWORK PLANS.—

''(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—

''(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

''(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—

"(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees; and

"(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents), or any health status-related factor relating to such individuals, employees, and dependents.

"(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

"(d) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

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

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

"(A) it does not have the financial reserves necessary to underwrite additional coverage; and

"(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees, and dependents.

"(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite addi-

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

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

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

''(2) The terms 'genetic information', 'genetic test', 'group health plan', 'group market', 'health insurance coverage', 'health insurance issuer', 'group health insurance coverage', 'individual health insurance coverage', 'individual market', and 'underwriting purpose' have the meanings given such terms in section 2791 of the Public Health Service Act.''.

''SEC. 198. 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 or individual 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 or individual 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 coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

"(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

"(3) NO GROUP-BASED DISCRIMINATION ON BASIS OF GENETIC INFORMATION.—

"(A) IN GENERAL.—For purposes of this section, a group health plan, and health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

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

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

''(c) GENETIC TESTING.—

''(1) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

''(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

''(3) RULE OF CONSTRUCTION REGARDING PAYMENT.—

''(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer 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 this Act, 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) noncompliance will have no effect on enrollment status or premium or contribution amounts.

''(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

''(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

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

"(d) PROHIBITION ON COLLECTION OF GENETIC INFORMATION.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes.

"(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, require-

ment, 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 pro-

grams 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 de-

pendents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined 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 discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), 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 reasonably 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 inadvisable to attempt to satisfy the otherwise applicable standard.

''(ii) If reasonable under the circumstances, 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 disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility 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 disclosure under this subparagraph shall not be required.''.

(b) CONFORMING AMENDMENT.—The table of contents under section 1(b) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–

191) is amended by inserting after the item relating to 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.".

(c) ENFORCEMENT.—

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

(A) in subsection (a)—

(i) in paragraph (1), by inserting "and sections 196 ,197, and 198 of the Health Insurance Portability and Accountability Act of 1996" after "this part"; and

(ii) in paragraph (2), by inserting "or section 196, 197, or 198 of the Health Insurance Portability and Accountability Act of 1996" after "this part"; and

(B) in subsection (b), by inserting "or section 196, 197, or 198 of the Health Insurance Portability and Accountability Act of 1996" after "this part" each place such term appears.

(2) ERISA.—Section 715 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185d) is amended by adding at the end the following:

''(c) ADDITIONAL PROVISIONS.—Section 197 of the Health Insurance Portability and Accountability Act of 1996 shall apply to health insurance issuers providing health insurance coverage in connection with group health plans, and sections 196 and 198 of such Act 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 section 197 with respect to health insurance issuers providing health insurance coverage in connection with group health plans or of such section 196 or 198 with respect to group health plans or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such sections 196, 197, and 198, as applicable, shall apply.''.

(3) IRC.—Section 9815 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

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

viding health insurance coverage in connection with group health plans, as if included in this subchapter, and to the extent that any provision of this chapter conflicts with a provision of such section 197 with respect to health insurance issuers providing health insurance coverage in connection with group health plans or of such section 196 or 198 with respect to group health plans or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such sections 196, 197, and 198, as applicable, shall apply.''.