

**DESCRIPTION OF THE CHAIRMAN'S AMENDMENT
IN THE NATURE OF A SUBSTITUE
TO THE
REVENUE PROVISIONS OF H.R. 493, THE
"GENETIC INFORMATION NONDISCRIMINATION ACT OF 2007"**

Scheduled for Markup
By the
HOUSE COMMITTEE ON WAYS AND MEANS
on March 21, 2007

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION



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INTRODUCTION

The House Committee on Ways and Means has scheduled a markup on March 21, 2007, relating to H.R. 493, the “Genetic Information Nondiscrimination Act of 2007”. This document,¹ prepared by the staff of the Joint Committee on Taxation, provides a description of the Chairman’s amendment in the nature of a substitute to the revenue provisions of H.R. 493.

¹ This document may be cited as follows: Joint Committee on Taxation, *Description of the Chairman’s Amendment in the Nature of a Substitute to the Revenue Provisions of H.R. 493, the “Genetic Information Nondiscrimination Act of 2007”* (JCX-16-07), March 20, 2007.

A. Prohibition of Discrimination Based on Genetic Testing

Present Law

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) imposes a number of requirements with respect to group health coverage that are designed to provide protections to health plan participants. The requirements are enforced through the Internal Revenue Code of 1986, as amended (the “Code”), the Employee Retirement Income Security Act of 1974 (“ERISA”), and the Public Health Service Act (“PHSA”).

Under present law, HIPAA provides certain protections against genetic discrimination. Among other things, HIPAA provides that a group health plan may not establish rules for eligibility of any individual to enroll under the plan based on genetic information.² Under final regulations issued by the Department of Treasury pursuant to HIPAA, any restriction on benefits provided under a group health plan must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on genetic information of the participants or beneficiaries.³ A group health plan also may not require an individual 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 genetic information of the individual or of a dependent enrolled under the plan.⁴

In addition, HIPAA generally provides that a pre-existing condition exclusion may be imposed with respect to a participant or beneficiary only if: (1) the exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date; (2) the exclusion extends for a period of not more than 12 months after the enrollment date; and (3) the period of any pre-existing condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant as of the enrollment date. The limitation on preexisting condition exclusions applies to exclusions on the basis of genetic information.⁵

Under final regulations issued by the Department of Treasury, genetic information is defined as information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or

² Code sec. 9802(a).

³ Treas. Reg. sec. 54.9802-1(b)(2)(i)(B).

⁴ Code sec. 9802(b).

⁵ Code sec. 9801.

chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.⁶

The requirements do not apply to any governmental plan or any group health plan that has less than two participants who are current employees. A group health plan is defined as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

The Code imposes an excise tax on group health plans which fail to meet these requirements.⁷ The excise tax is equal to \$100 per day during the period of noncompliance and is generally imposed on the employer sponsoring the plan if the plan fails to meet the requirements. The maximum tax that can be imposed during a taxable year cannot exceed the lesser of 10 percent of the employer's group health plan expenses for the prior year or \$500,000. No tax is imposed if the Secretary of the Treasury determines that the employer did not know, and in exercising reasonable diligence would not have known, that the failure existed.

Description of Proposal

The proposal modifies the group health plan requirements under the Code.

Under the proposal, a group health plan may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information. In the case of family members who are covered under the same group health plan, the group health plan is permitted to adjust premium or contribution amounts for the group on the basis of the occurrence of disease or disorders in family members in the group, provided that such information is taken into account only with respect to the individual in which the disease or disorder occurs and not as genetic information with respect to family members in which the disease or disorder has not occurred.

The proposal also requires that a group health plan may not request or require an individual or family member of such individual to undergo a genetic test. The proposal does not 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. The proposal also does not limit the authority of a group health plan to provide information generally about the availability of genetic tests or to provide information about genetic tests to a health care professional with respect to the treatment of an individual to whom such professional is providing health care services.

The proposal contains two rules that prohibit a group health plan from collecting genetic information. First, a group health plan is prohibited from requesting, requiring, or purchasing genetic information for purposes of underwriting. Second, a group health plan is prohibited from

⁶ Treas. Reg. sec. 54.9801-2.

⁷ Code sec. 4980D.

requesting, requiring, or purchasing genetic information with respect to any individual prior to such individual's enrollment under the plan or in connection with such enrollment. The second prohibition is not violated where the collection of genetic information is incidental to the requesting, requiring, or purchasing of other information concerning the individual provided that such request, requirement or purchase is not for purposes of underwriting.

The term underwriting, with respect to any group health plan, means (1) rules for determining eligibility for, or determination of, benefits under the plan; (2) the computation of premium or contribution amounts under the plan; (3) the application of any pre-existing condition exclusion under the plan; and (4) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Under the proposal, the requirement under present law that a group health plan may not establish rules for eligibility based on genetic information is extended to governmental plans and group health plans with less than two participants who are current employees. The provisions requiring (1) that group premiums or contribution amounts may not be adjusted on the basis of genetic information of an individual in the group; (2) that a group health plan may not request or require an individual or family member of such individual undergo a genetic test; and (3) that group health plans not collect genetic information for purposes of underwriting or in connection with enrollment also apply to all group health plans.

Genetic information means, with respect to any individual, information about (1) such individual's genetic tests; (2) the genetic tests of family members of such individual; and (3) the occurrence of a disease or disorder in family members of such individual. The term genetic information also includes, with respect to any individual, any request for genetic services, receipt of genetic services, or participation in any clinical research, or any other program, which includes genetic services, by such individual or any family member of such individual. The term genetic information does not include the occurrence of a disease or disorder in family members of an individual to the extent that such information is taken into account only with respect to the individual in which such disease or disorder occurs and not as genetic information with respect to any other individual.

A genetic test is defined as an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes. The term genetic test does not include (1) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or (2) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

Genetic services are defined as a genetic test, genetic counseling (such as obtaining, interpreting, or assessing genetic information), and genetic education.

A family member means, with respect to an individual, (1) the spouse of the individual; (2) a child of such individual (by birth, adoption, or placement for adoption); and (3) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in (1) or (2).

Under the proposal, the Secretary of the Treasury is directed to issue regulations or other guidance to carry out the proposal no later than one year after date of enactment.

Effective Date

The proposal is effective with respect to group health plans for plan years beginning after the date that is 18 months after the date of enactment.