

116TH CONGRESS
1ST SESSION

H. R. 4159

To amend the Health Insurance Portability and Accountability Act to ensure coverage for individuals with preexisting conditions, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 2, 2019

Mr. RIGGLEMAN (for himself, Mrs. WAGNER, Mr. HUIZENGA, Mr. NEWHOUSE, and Ms. HERRERA BEUTLER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and Labor, 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 Health Insurance Portability and Accountability Act to ensure coverage for individuals with preexisting conditions, and for other purposes.

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 “Maintaining Protec-
5 tions for Patients with Preexisting Conditions Act of
6 2019”.

1 **SEC. 2. 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. GUARANTEED AVAILABILITY OF COVERAGE.**

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

14 “(b) ENROLLMENT.—

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

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

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

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

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

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

13 “(B) within the service area of such plan,
14 deny such coverage to such employers and indi-
15 viduals if the issuer has demonstrated, if re-
16 quired, to the applicable State authority that—

17 “(i) it will not have the capacity to de-
18 liver services adequately to enrollees of any
19 additional groups or any additional individ-
20 uals because of its obligations to existing
21 group contract holders and enrollees; and

22 “(ii) it is applying this paragraph uni-
23 formly to all employers and individuals
24 without regard to the claims experience of
25 those individuals, employers and their em-

1 ployees (and their dependents), or any
2 health status-related factor relating to
3 such individuals, employees, and depend-
4 ents.

5 “(2) 180-DAY SUSPENSION UPON DENIAL OF
6 COVERAGE.—An issuer, upon denying health insur-
7 ance coverage in any service area in accordance with
8 paragraph (1)(B), may not offer coverage in the
9 group or individual market within such service area
10 for a period of 180 days after the date such cov-
11 erage is denied.

12 “(d) APPLICATION OF FINANCIAL CAPACITY LIM-
13 ITS.—

14 “(1) IN GENERAL.—A health insurance issuer
15 may deny health insurance coverage in the group or
16 individual market if the issuer has demonstrated, if
17 required, to the applicable State authority that—

18 “(A) it does not have the financial reserves
19 necessary to underwrite additional coverage;
20 and

21 “(B) it is applying this paragraph uni-
22 formly to all employers and individuals in the
23 group or individual market in the State con-
24 sistent with applicable State law and without
25 regard to the claims experience of those individ-

1 uals, employers and their employees (and their
2 dependents) or any health status-related factor
3 relating to such individuals, employees, and de-
4 pendents.

5 “(2) 180-DAY SUSPENSION UPON DENIAL OF
6 COVERAGE.—A health insurance issuer upon denying
7 health insurance coverage in connection with group
8 health plans in accordance with paragraph (1) in a
9 State may not offer coverage in connection with
10 group health plans in the group or individual market
11 in the State for a period of 180 days after the date
12 such coverage is denied or until the issuer has dem-
13 onstrated to the applicable State authority, if re-
14 quired under applicable State law, that the issuer
15 has sufficient financial reserves to underwrite addi-
16 tional coverage, whichever is later. An applicable
17 State authority may provide for the application of
18 this subsection on a service-area-specific basis.

19 “(e) DEFINITIONS.—In this section and in sections
20 197 through 199A:

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

23 “(2) The terms ‘genetic information’, ‘genetic
24 test’, ‘group health plan’, ‘group market’, ‘health in-
25 surance coverage’, ‘health insurance issuer’, ‘group

1 health insurance coverage’, ‘individual health insur-
 2 ance coverage’, ‘individual market’, and ‘under-
 3 writing purpose’ have the meanings given such terms
 4 in section 2791 of the Public Health Service Act.

5 **“SEC. 197. FAIR HEALTH INSURANCE PREMIUMS.**

6 “(a) PROHIBITING DISCRIMINATORY PREMIUM
 7 RATES.—

8 “(1) IN GENERAL.—With respect to the pre-
 9 mium rate charged by a health insurance issuer for
 10 health insurance coverage offered in the individual
 11 or small group market—

12 “(A) such rate shall vary with respect to
 13 the particular plan or coverage involved only
 14 by—

15 “(i) whether such plan or coverage
 16 covers an individual or family;

17 “(ii) rating area, as established in ac-
 18 cordance with paragraph (2);

19 “(iii) age, except that such rate shall
 20 not vary by more than 3 to 1 for adults;
 21 and

22 “(iv) tobacco use, except that such
 23 rate shall not vary by more than 1.5 to 1;
 24 and

1 “(B) such rate shall not vary with respect
2 to the particular plan or coverage involved by
3 any other factor not described in subparagraph
4 (A).

5 “(2) RATING AREA.—

6 “(A) IN GENERAL.—Each State shall es-
7 tablish 1 or more rating areas within that State
8 for purposes of applying the requirements of
9 this title.

10 “(B) SECRETARIAL REVIEW.—The Sec-
11 retary shall review the rating areas established
12 by each State under subparagraph (A) to en-
13 sure the adequacy of such areas for purposes of
14 carrying out the requirements of this title. If
15 the Secretary determines a State’s rating areas
16 are not adequate, or that a State does not es-
17 tablish such areas, the Secretary may establish
18 rating areas for that State.

19 “(3) PERMISSIBLE AGE BANDS.—The Sec-
20 retary, in consultation with the National Association
21 of Insurance Commissioners, shall define the permis-
22 sible age bands for rating purposes under paragraph
23 (1)(A)(iii).

24 “(4) APPLICATION OF VARIATIONS BASED ON
25 AGE OR TOBACCO USE.—With respect to family cov-

7 **“SEC. 198. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES**
8 **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:

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

21 “(4) Receipt of health care.

23 “(6) Genetic information.

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

1 “(8) Disability.

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

4 “(b) IN PREMIUM CONTRIBUTIONS.—

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

16 “(2) CONSTRUCTION.—Nothing in paragraph
17 (1) shall be construed—

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

23 “(B) to prevent a group health plan, and
24 a health insurance issuer offering group health
25 insurance coverage, from establishing premium

1 discounts or rebates or modifying otherwise ap-
2 plicable copayments or deductibles in return for
3 adherence to programs of health promotion and
4 disease prevention.

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

7 “(A) IN GENERAL.—For purposes of this
8 section, a group health plan, and health insur-
9 ance issuer offering group health insurance cov-
10 erage in connection with a group health plan,
11 may not adjust premium or contribution
12 amounts for the group covered under such plan
13 on the basis of genetic information.

14 “(B) RULE OF CONSTRUCTION.—Nothing
15 in subparagraph (A) or in paragraphs (1) and
16 (2) of subsection (d) shall be construed to limit
17 the ability of a health insurance issuer offering
18 group or individual health insurance coverage to
19 increase the premium for an employer based on
20 the manifestation of a disease or disorder of an
21 individual who is enrolled in the plan. In such
22 case, the manifestation of a disease or disorder
23 in one individual cannot also be used as genetic
24 information about other group members and to
25 further increase the premium for the employer.

1 “(c) GENETIC TESTING.—

2 “(1) LIMITATION ON REQUESTING OR REQUIR-
3 ING GENETIC TESTING.—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 or require an individual or a family
7 member of such individual to undergo a genetic test.

8 “(2) RULE OF CONSTRUCTION.—Paragraph (1)
9 shall not be construed to limit the authority of a
10 health care professional who is providing health care
11 services to an individual to request that such indi-
12 vidual undergo a genetic test.

13 “(3) RULE OF CONSTRUCTION REGARDING PAY-
14 MENT.—

15 “(A) IN GENERAL.—Nothing in paragraph
16 (1) shall be construed to preclude a group
17 health plan, or a health insurance issuer offer-
18 ing health insurance coverage in connection
19 with a group health plan, from obtaining and
20 using the results of a genetic test in making a
21 determination regarding payment (as such term
22 is defined for the purposes of applying the regu-
23 lations promulgated by the Secretary under
24 part C of title XI of the Social Security Act and

1 section 264 of this Act, as may be revised from
2 time to time) consistent with subsection (a).

3 “(B) LIMITATION.—For purposes of sub-
4 paragraph (A), a group health plan, or a health
5 insurance issuer offering health insurance cov-
6 erage in connection with a group health plan,
7 may request only the minimum amount of in-
8 formation necessary to accomplish the intended
9 purpose.

10 “(4) RESEARCH EXCEPTION.—Notwithstanding
11 paragraph (1), a group health plan, or a health in-
12 surance issuer offering health insurance coverage in
13 connection with a group health plan, may request,
14 but not require, that a participant or beneficiary un-
15 dergo a genetic test if each of the following condi-
16 tions is met:

17 “(A) The request is made pursuant to re-
18 search that complies with part 46 of title 45,
19 Code of Federal Regulations, or equivalent Fed-
20 eral regulations, and any applicable State or
21 local law or regulations for the protection of
22 human subjects in research.

23 “(B) The plan or issuer clearly indicates to
24 each participant or beneficiary, or in the case of

1 a minor child, to the legal guardian of such
2 beneficiary, to whom the request is made that—

3 “(i) compliance with the request is
4 voluntary; and

5 “(ii) noncompliance will have no effect
6 on enrollment status or premium or con-
7 tribution amounts.

8 “(C) No genetic information collected or
9 acquired under this paragraph shall be used for
10 underwriting purposes.

11 “(D) The plan or issuer notifies the Sec-
12 retary in writing that the plan or issuer is con-
13 ducting activities pursuant to the exception pro-
14 vided for under this paragraph, including a de-
15 scription of the activities conducted.

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

20 “(d) PROHIBITION ON COLLECTION OF GENETIC IN-
21 FORMATION.—

22 “(1) IN GENERAL.—A group health plan, and a
23 health insurance issuer offering health insurance
24 coverage in connection with a group health plan,

1 shall not request, require, or purchase genetic infor-
2 mation for underwriting purposes.

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

12 “(3) INCIDENTAL COLLECTION.—If a group
13 health plan, or a health insurance issuer offering
14 health insurance coverage in connection with a group
15 health plan, obtains genetic information incidental to
16 the requesting, requiring, or purchasing of other in-
17 formation concerning any individual, such request,
18 requirement, or purchase shall not be considered a
19 violation of paragraph (2) if such request, require-
20 ment, or purchase is not in violation of paragraph
21 (1).

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

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

5 “(2) with respect to an individual or family
6 member utilizing an assisted reproductive tech-
7 nology, include genetic information of any embryo le-
8 gally held by the individual or family member.

9 “(f) PROGRAMS OF HEALTH PROMOTION OR DIS-
10 EASE PREVENTION.—

11 “(1) GENERAL PROVISIONS.—

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

20 “(B) NO CONDITIONS BASED ON HEALTH
21 STATUS FACTOR.—If none of the conditions for
22 obtaining a premium discount or rebate or
23 other reward for participation in a wellness pro-
24 gram is based on an individual satisfying a
25 standard that is related to a health status fac-

1 tor, such wellness program shall not violate this
2 section if participation in the program is made
3 available to all similarly situated individuals
4 and the requirements of paragraph (2) are com-
5 plied with.

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

15 “(2) WELLNESS PROGRAMS NOT SUBJECT TO
16 REQUIREMENTS.—If none of the conditions for ob-
17 taining a premium discount or rebate or other re-
18 ward under a wellness program as described in para-
19 graph (1)(B) are based on an individual satisfying
20 a standard that is related to a health status factor
21 (or if such a wellness program does not provide such
22 a reward), the wellness program shall not violate
23 this section if participation in the program is made
24 available to all similarly situated individuals. The
25 following programs shall not have to comply with the

1 requirements of paragraph (3) if participation in the
2 program is made available to all similarly situated
3 individuals:

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

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

10 “(C) A program that encourages preven-
11 tive care related to a health condition through
12 the waiver of the copayment or deductible re-
13 quirement under group health plan for the costs
14 of certain items or services related to a health
15 condition (such as prenatal care or well-baby
16 visits).

17 “(D) A program that reimburses individ-
18 uals for the costs of smoking cessation pro-
19 grams without regard to whether the individual
20 quits smoking.

21 “(E) A program that provides a reward to
22 individuals for attending a periodic health edu-
23 cation seminar.

24 “(3) WELLNESS PROGRAMS SUBJECT TO RE-
25 QUIREMENTS.—If any of the conditions for obtaining

1 a premium discount, rebate, or reward under a
2 wellness program as described in paragraph (1)(C)
3 is based on an individual satisfying a standard that
4 is related to a health status factor, the wellness pro-
5 gram shall not violate this section if the following re-
6 quirements are complied with:

7 “(A) The reward for the wellness program,
8 together with the reward for other wellness pro-
9 grams with respect to the plan that requires
10 satisfaction of a standard related to a health
11 status factor, shall not exceed 30 percent of the
12 cost of employee-only coverage under the plan.
13 If, in addition to employees or individuals, any
14 class of dependents (such as spouses or spouses
15 and dependent children) may participate fully
16 in the wellness program, such reward shall not
17 exceed 30 percent of the cost of the coverage in
18 which an employee or individual and any de-
19 pendents are enrolled. For purposes of this
20 paragraph, the cost of coverage shall be deter-
21 mined based on the total amount of employer
22 and employee contributions for the benefit
23 package under which the employee is (or the
24 employee and any dependents are) receiving
25 coverage. A reward may be in the form of a dis-

1 count or rebate of a premium or contribution,
2 a waiver of all or part of a cost-sharing mecha-
3 nism (such as deductibles, copayments, or coin-
4 surance), the absence of a surcharge, or the
5 value of a benefit that would otherwise not be
6 provided under the plan. The Secretaries of
7 Labor, Health and Human Services, and the
8 Treasury may increase the reward available
9 under this subparagraph to up to 50 percent of
10 the cost of coverage if the Secretaries determine
11 that such an increase is appropriate.

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

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

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

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

8 “(I) for a reasonable alternative
9 standard (or waiver of the otherwise
10 applicable standard) for obtaining the
11 reward for any individual for whom,
12 for that period, it is unreasonably dif-
13 ficult due to a medical condition to
14 satisfy the otherwise applicable stand-
15 ard; and

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

23 “(ii) If reasonable under the cir-
24 cumstances, the plan or issuer may seek
25 verification, such as a statement from an

1 individual’s physician, that a health status
 2 factor makes it unreasonably difficult or
 3 medically inadvisable for the individual to
 4 satisfy or attempt to satisfy the otherwise
 5 applicable standard.

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

16 **“SEC. 199. PROHIBITION OF PREEXISTING CONDITION EX-**
 17 **CLUSIONS OR OTHER DISCRIMINATION**
 18 **BASED ON HEALTH STATUS.**

19 “(a) IN GENERAL.—A group health plan and a health
 20 insurance issuer offering group or individual health insur-
 21 ance coverage may not impose any preexisting condition
 22 exclusion with respect to such plan or coverage.

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

24 “(1) PREEXISTING CONDITION EXCLUSION.—

1 “(A) IN GENERAL.—The term ‘preexisting
2 condition exclusion’ means, with respect to cov-
3 erage, a limitation or exclusion of benefits relat-
4 ing to a condition based on the fact that the
5 condition was present before the date of enroll-
6 ment for such coverage, whether or not any
7 medical advice, diagnosis, care, or treatment
8 was recommended or received before such date.

9 “(B) TREATMENT OF GENETIC INFORMA-
10 TION.—Genetic information shall not be treated
11 as a condition described in subsection (a)(1) in
12 the absence of a diagnosis of the condition re-
13 lated to such information.

14 “(2) ENROLLMENT DATE.—The term ‘enroll-
15 ment date’ means, with respect to an individual cov-
16 ered under a group health plan or health insurance
17 coverage, the date of enrollment of the individual in
18 the plan or coverage or, if earlier, the first day of
19 the waiting period for such enrollment.

20 “(3) LATE ENROLLEE.—The term ‘late en-
21 rollee’ means, with respect to coverage under a
22 group health plan, a participant or beneficiary who
23 enrolls under the plan other than during—

24 “(A) the first period in which the indi-
25 vidual is eligible to enroll under the plan; or

1 “(B) a special enrollment period under
2 subsection (f).

3 “(4) 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 “(c) RULES RELATING TO CREDITING PREVIOUS
11 COVERAGE.—

12 “(1) CREDITABLE COVERAGE DEFINED.—For
13 purposes of this title, the term ‘creditable coverage’
14 means, with respect to an individual, coverage of the
15 individual under any of the following:

16 “(A) A group health plan.

17 “(B) Health insurance coverage.

18 “(C) Part A or part B of title XVIII of the
19 Social Security Act.

20 “(D) Title XIX of the Social Security Act,
21 other than coverage consisting solely of benefits
22 under section 1928.

23 “(E) Chapter 55 of title 10, United States
24 Code.

1 “(F) A medical care program of the Indian
2 Health Service or of a tribal organization.

3 “(G) A State health benefits risk pool.

4 “(H) A health plan offered under chapter
5 89 of title 5, United States Code.

6 “(I) A public health plan (as defined in
7 regulations).

8 “(J) A health benefit plan under section
9 5(e) of the Peace Corps Act (22 U.S.C.
10 2504(e)).

11 Such term does not include coverage consisting sole-
12 ly of coverage of excepted benefits (as defined in sec-
13 tion 2791(c)).

14 “(2) NOT COUNTING PERIODS BEFORE SIGNIFI-
15 CANT BREAKS IN COVERAGE.—

16 “(A) IN GENERAL.—A period of creditable
17 coverage shall not be counted, with respect to
18 enrollment of an individual under a group or in-
19 dividual health plan, if, after such period and
20 before the enrollment date, there was a 63-day
21 period during all of which the individual was
22 not covered under any creditable coverage.

23 “(B) WAITING PERIOD NOT TREATED AS A
24 BREAK IN COVERAGE.—For purposes of sub-
25 paragraph (A) and subsection (d)(4), any pe-

1 riod that an individual is in a waiting period for
2 any coverage under a group or individual health
3 plan (or for group health insurance coverage) or
4 is in an affiliation period (as defined in sub-
5 section (g)(2)) shall not be taken into account
6 in determining the continuous period under
7 subparagraph (A).

8 “(C) TAA-ELIGIBLE INDIVIDUALS.—In the
9 case of plan years beginning before January 1,
10 2014—

11 “(i) TAA PRE-CERTIFICATION PERIOD
12 RULE.—In the case of a TAA-eligible indi-
13 vidual, the period beginning on the date
14 the individual has a TAA-related loss of
15 coverage and ending on the date that is 7
16 days after the date of the issuance by the
17 Secretary (or by any person or entity des-
18 ignated by the Secretary) of a qualified
19 health insurance costs credit eligibility cer-
20 tificate for such individual for purposes of
21 section 7527 of the Internal Revenue Code
22 of 1986 shall not be taken into account in
23 determining the continuous period under
24 subparagraph (A).

1 “(ii) DEFINITIONS.—The terms ‘TAA-
2 eligible individual’ and ‘TAA-related loss of
3 coverage’ have the meanings given such
4 terms in section 2205(b)(4).

5 “(3) METHOD OF CREDITING COVERAGE.—

6 “(A) STANDARD METHOD.—Except as oth-
7 erwise provided under subparagraph (B), for
8 purposes of applying subsection (a)(3), a group
9 health plan, and a health insurance issuer offer-
10 ing group or individual health insurance cov-
11 erage, shall count a period of creditable cov-
12 erage without regard to the specific benefits
13 covered during the period.

14 “(B) ELECTION OF ALTERNATIVE METH-
15 OD.—A group health plan, or a health insur-
16 ance issuer offering group or individual health
17 insurance, may elect to apply subsection (a)(3)
18 based on coverage of benefits within each of
19 several classes or categories of benefits specified
20 in regulations rather than as provided under
21 subparagraph (A). Such election shall be made
22 on a uniform basis for all participants and
23 beneficiaries. Under such election a group or in-
24 dividual health plan or issuer shall count a pe-
25 riod of creditable coverage with respect to any

1 class or category of benefits if any level of bene-
2 fits is covered within such class or category.

3 “(C) PLAN NOTICE.—In the case of an
4 election with respect to a group health plan
5 under subparagraph (B) (whether or not health
6 insurance coverage is provided in connection
7 with such plan), the plan shall—

8 “(i) prominently state in any disclo-
9 sure statements concerning the plan, and
10 state to each enrollee at the time of enroll-
11 ment under the plan, that the plan has
12 made such election; and

13 “(ii) include in such statements a de-
14 scription of the effect of this election.

15 “(D) ISSUER NOTICE.—In the case of an
16 election under subparagraph (B) with respect to
17 health insurance coverage offered by an issuer
18 in the individual or group market, the issuer—

19 “(i) shall prominently state in any dis-
20 closure statements concerning the cov-
21 erage, and to each employer at the time of
22 the offer or sale of the coverage, that the
23 issuer has made such election; and

24 “(ii) shall include in such statements
25 a description of the effect of such election.

1 “(4) ESTABLISHMENT OF PERIOD.—Periods of
2 creditable coverage with respect to an individual
3 shall be established through presentation of certifi-
4 cations described in subsection (e) or in such other
5 manner as may be specified in regulations.

6 “(d) EXCEPTIONS.—

7 “(1) EXCLUSION NOT APPLICABLE TO CERTAIN
8 NEWBORNS.—Subject to paragraph (4), a group
9 health plan, and a health insurance issuer offering
10 group or individual health insurance coverage, may
11 not impose any preexisting condition exclusion in the
12 case of an individual who, as of the last day of the
13 30-day period beginning with the date of birth, is
14 covered under creditable coverage.

15 “(2) EXCLUSION NOT APPLICABLE TO CERTAIN
16 ADOPTED CHILDREN.—Subject to paragraph (4), a
17 group health plan, and a health insurance issuer of-
18 fering group or individual health insurance coverage,
19 may not impose any preexisting condition exclusion
20 in the case of a child who is adopted or placed for
21 adoption before attaining 18 years of age and who,
22 as of the last day of the 30-day period beginning on
23 the date of the adoption or placement for adoption,
24 is covered under creditable coverage. The previous

1 sentence shall not apply to coverage before the date
2 of such adoption or placement for adoption.

3 “(3) EXCLUSION NOT APPLICABLE TO PREG-
4 NANCY.—A group health plan, and health insurance
5 issuer offering group or individual health insurance
6 coverage, may not impose any preexisting condition
7 exclusion relating to pregnancy as a preexisting con-
8 dition.

9 “(4) LOSS IF BREAK IN COVERAGE.—Para-
10 graphs (1) and (2) shall no longer apply to an indi-
11 vidual after the end of the first 63-day period during
12 all of which the individual was not covered under
13 any creditable coverage.

14 “(e) CERTIFICATIONS AND DISCLOSURE OF COV-
15 ERAGE.—

16 “(1) REQUIREMENT FOR CERTIFICATION OF
17 PERIOD OF CREDITABLE COVERAGE.—

18 “(A) IN GENERAL.—A group health plan,
19 and a health insurance issuer offering group or
20 individual health insurance coverage, shall pro-
21 vide the certification described in subparagraph
22 (B)—

23 “(i) at the time an individual ceases
24 to be covered under the plan or otherwise

1 becomes covered under a COBRA continu-
2 ation provision;

3 “(ii) in the case of an individual be-
4 coming covered under such a provision, at
5 the time the individual ceases to be covered
6 under such provision; and

7 “(iii) on the request on behalf of an
8 individual made not later than 24 months
9 after the date of cessation of the coverage
10 described in clause (i) or (ii), whichever is
11 later.

12 The certification under clause (i) may be pro-
13 vided, to the extent practicable, at a time con-
14 sistent with notices required under any applica-
15 ble COBRA continuation provision.

16 “(B) CERTIFICATION.—The certification
17 described in this subparagraph is a written cer-
18 tification of—

19 “(i) the period of creditable coverage
20 of the individual under such plan and the
21 coverage (if any) under such COBRA con-
22 tinuation provision; and

23 “(ii) the waiting period (if any) (and
24 affiliation period, if applicable) imposed

1 with respect to the individual for any cov-
2 erage under such plan.

3 “(C) ISSUER COMPLIANCE.—To the extent
4 that medical care under a group health plan
5 consists of group health insurance coverage, the
6 plan is deemed to have satisfied the certification
7 requirement under this paragraph if the health
8 insurance issuer offering the coverage provides
9 for such certification in accordance with this
10 paragraph.

11 “(2) DISCLOSURE OF INFORMATION ON PRE-
12 VIOUS BENEFITS.—In the case of an election de-
13 scribed in subsection (c)(3)(B) by a group health
14 plan or health insurance issuer, if the plan or issuer
15 enrolls an individual for coverage under the plan and
16 the individual provides a certification of coverage of
17 the individual under paragraph (1)—

18 “(A) upon request of such plan or issuer,
19 the entity which issued the certification pro-
20 vided by the individual shall promptly disclose
21 to such requesting plan or issuer information
22 on coverage of classes and categories of health
23 benefits available under such entity’s plan or
24 coverage; and

1 “(B) such entity may charge the request-
2 ing plan or issuer for the reasonable cost of dis-
3 closing such information.

4 “(3) REGULATIONS.—The Secretary shall es-
5 tablish rules to prevent an entity’s failure to provide
6 information under paragraph (1) or (2) with respect
7 to previous coverage of an individual from adversely
8 affecting any subsequent coverage of the individual
9 under another group health plan or health insurance
10 coverage.

11 “(f) SPECIAL ENROLLMENT PERIODS.—

12 “(1) INDIVIDUALS LOSING OTHER COVERAGE.—
13 A group health plan, and a health insurance issuer
14 offering group health insurance coverage in connec-
15 tion with a group health plan, shall permit an em-
16 ployee who is eligible, but not enrolled, for coverage
17 under the terms of the plan (or a dependent of such
18 an employee if the dependent is eligible, but not en-
19 rolled, for coverage under such terms) to enroll for
20 coverage under the terms of the plan if each of the
21 following conditions is met:

22 “(A) The employee or dependent was cov-
23 ered under a group health plan or had health
24 insurance coverage at the time coverage was
25 previously offered to the employee or dependent.

1 “(B) The employee stated in writing at
2 such time that coverage under a group health
3 plan or health insurance coverage was the rea-
4 son for declining enrollment, but only if the
5 plan sponsor or issuer (if applicable) required
6 such a statement at such time and provided the
7 employee with notice of such requirement (and
8 the consequences of such requirement) at such
9 time.

10 “(C) The employee’s or dependent’s cov-
11 erage described in subparagraph (A)—

12 “(i) was under a COBRA continu-
13 ation provision and the coverage under
14 such provision was exhausted; or

15 “(ii) was not under such a provision
16 and either the coverage was terminated as
17 a result of loss of eligibility for the cov-
18 erage (including as a result of legal separa-
19 tion, divorce, death, termination of employ-
20 ment, or reduction in the number of hours
21 of employment) or employer contributions
22 toward such coverage were terminated.

23 “(D) Under the terms of the plan, the em-
24 ployee requests such enrollment not later than
25 30 days after the date of exhaustion of coverage

described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

“(2) FOR DEPENDENT BENEFICIARIES.—

“(A) IN GENERAL.—If—

“(i) a group health plan makes coverage available with respect to a dependent of an individual;

“(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and

“(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may

1 be enrolled as a dependent of the individual if
2 such spouse is otherwise eligible for coverage.

3 “(B) DEPENDENT SPECIAL ENROLLMENT
4 PERIOD.—A dependent special enrollment pe-
5 riod under this subparagraph shall be a period
6 of not less than 30 days and shall begin on the
7 later of—

8 “(i) the date dependent coverage is
9 made available; or

10 “(ii) the date of the marriage, birth,
11 or adoption or placement for adoption (as
12 the case may be) described in subpara-
13 graph (A)(iii).

14 “(C) NO WAITING PERIOD.—If an indi-
15 vidual seeks to enroll a dependent during the
16 first 30 days of such a dependent special enroll-
17 ment period, the coverage of the dependent
18 shall become effective—

19 “(i) in the case of marriage, not later
20 than the first day of the first month begin-
21 ning after the date the completed request
22 for enrollment is received;

23 “(ii) in the case of a dependent’s
24 birth, as of the date of such birth; or

1 “(iii) in the case of a dependent’s
2 adoption or placement for adoption, the
3 date of such adoption or placement for
4 adoption.

5 “(3) SPECIAL RULES FOR APPLICATION IN CASE
6 OF MEDICAID AND CHIP.—

7 “(A) IN GENERAL.—A group health plan,
8 and a health insurance issuer offering group
9 health insurance coverage in connection with a
10 group health plan, shall permit an employee
11 who is eligible, but not enrolled, for coverage
12 under the terms of the plan (or a dependent of
13 such an employee if the dependent is eligible,
14 but not enrolled, for coverage under such
15 terms) to enroll for coverage under the terms of
16 the plan if either of the following conditions is
17 met:

18 “(i) TERMINATION OF MEDICAID OR
19 CHIP COVERAGE.—The employee or de-
20 pendent is covered under a Medicaid plan
21 under title XIX of the Social Security Act
22 or under a State child health plan under
23 title XXI of such Act and coverage of the
24 employee or dependent under such a plan
25 is terminated as a result of loss of eligi-

1 bility for such coverage and the employee
2 requests coverage under the group health
3 plan (or health insurance coverage) not
4 later than 60 days after the date of termi-
5 nation of such coverage.

6 “(ii) ELIGIBILITY FOR EMPLOYMENT
7 ASSISTANCE UNDER MEDICAID OR CHIP.—

8 The employee or dependent becomes eligi-
9 ble for assistance, with respect to coverage
10 under the group health plan or health in-
11 surance coverage, under such Medicaid
12 plan or State child health plan (including
13 under any waiver or demonstration project
14 conducted under or in relation to such a
15 plan), if the employee requests coverage
16 under the group health plan or health in-
17 surance coverage not later than 60 days
18 after the date the employee or dependent is
19 determined to be eligible for such assist-
20 ance.

21 “(B) COORDINATION WITH MEDICAID AND
22 CHIP.—

23 “(i) OUTREACH TO EMPLOYEES RE-
24 GARDING AVAILABILITY OF MEDICAID AND
25 CHIP COVERAGE.—

1 “(I) IN GENERAL.—Each em-
2 ployer that maintains a group health
3 plan in a State that provides medical
4 assistance under a State Medicaid
5 plan under title XIX of the Social Se-
6 curity Act, or child health assistance
7 under a State child health plan under
8 title XXI of such Act, in the form of
9 premium assistance for the purchase
10 of coverage under a group health
11 plan, shall provide to each employee a
12 written notice informing the employee
13 of potential opportunities then cur-
14 rently available in the State in which
15 the employee resides for premium as-
16 sistance under such plans for health
17 coverage of the employee or the em-
18 ployee’s dependents. For purposes of
19 compliance with this subclause, the
20 employer may use any State-specific
21 model notice developed in accordance
22 with section 701(f)(3)(B)(i)(II) of the
23 Employee Retirement Income Security
24 Act of 1974 (29 U.S.C.
25 1181(f)(3)(B)(i)(II)).

1 “(II) OPTION TO PROVIDE CON-
2 CURRENT WITH PROVISION OF PLAN
3 MATERIALS TO EMPLOYEE.—An em-
4 ployer may provide the model notice
5 applicable to the State in which an
6 employee resides concurrent with the
7 furnishing of materials notifying the
8 employee of health plan eligibility,
9 concurrent with materials provided to
10 the employee in connection with an
11 open season or election process con-
12 ducted under the plan, or concurrent
13 with the furnishing of the summary
14 plan description as provided in section
15 104(b) of the Employee Retirement
16 Income Security Act of 1974.

17 “(ii) DISCLOSURE ABOUT GROUP
18 HEALTH PLAN BENEFITS TO STATES FOR
19 MEDICAID AND CHIP ELIGIBLE INDIVID-
20 UALS.—In the case of an enrollee in a
21 group health plan who is covered under a
22 Medicaid plan of a State under title XIX
23 of the Social Security Act or under a State
24 child health plan under title XXI of such
25 Act, the plan administrator of the group

1 health plan shall disclose to the State,
2 upon request, information about the bene-
3 fits available under the group health plan
4 in sufficient specificity, as determined
5 under regulations of the Secretary of
6 Health and Human Services in consulta-
7 tion with the Secretary that require use of
8 the model coverage coordination disclosure
9 form developed under section 311(b)(1)(C)
10 of the Children’s Health Insurance Reau-
11 thorization Act of 2009, so as to permit
12 the State to make a determination (under
13 paragraph (2)(B), (3), or (10) of section
14 2105(c) of the Social Security Act or oth-
15 erwise) concerning the cost-effectiveness of
16 the State providing medical or child health
17 assistance through premium assistance for
18 the purchase of coverage under such group
19 health plan and in order for the State to
20 provide supplemental benefits required
21 under paragraph (10)(E) of such section
22 or other authority.

23 “(g) USE OF AFFILIATION PERIOD BY HMOs AS AL-
24 TERNATIVE TO PREEXISTING CONDITION EXCLUSION.—

1 “(1) IN GENERAL.—A health maintenance orga-
2 nization which offers health insurance coverage in
3 connection with a group health plan and which does
4 not impose any preexisting condition exclusion al-
5 lowed under subsection (a) with respect to any par-
6 ticular coverage option may impose an affiliation pe-
7 riod for such coverage option, but only if—

8 “(A) such period is applied uniformly with-
9 out regard to any health status-related factors;
10 and

11 “(B) such period does not exceed 2 months
12 (or 3 months in the case of a late enrollee).

13 “(2) AFFILIATION PERIOD.—

14 “(A) DEFINED.—For purposes of this
15 title, the term ‘affiliation period’ means a pe-
16 riod which, under the terms of the health insur-
17 ance coverage offered by the health mainte-
18 nance organization, must expire before the
19 health insurance coverage becomes effective.
20 The organization is not required to provide
21 health care services or benefits during such pe-
22 riod and no premium shall be charged to the
23 participant or beneficiary for any coverage dur-
24 ing the period.

1 “(B) BEGINNING.—Such period shall begin
2 on the enrollment date.

3 “(C) RUNS CONCURRENTLY WITH WAITING
4 PERIODS.—An affiliation period under a plan
5 shall run concurrently with any waiting period
6 under the plan.

7 “(3) ALTERNATIVE METHODS.—A health main-
8 tenance organization described in paragraph (1) may
9 use alternative methods, from those described in
10 such paragraph, to address adverse selection as ap-
11 proved by the State insurance commissioner or offi-
12 cial or officials designated by the State to enforce
13 the requirements of this part for the State involved
14 with respect to such issuer.

15 **“SEC. 199A. ENFORCEMENT OF CERTAIN HEALTH INSUR-**
16 **ANCE REQUIREMENTS.**

17 “(a) STATE ENFORCEMENT.—

18 “(1) STATE AUTHORITY.—Each State may re-
19 quire that health insurance issuers that issue, sell,
20 renew, or offer health insurance coverage in the
21 State in the individual or group market meet the re-
22 quirements of this part with respect to such issuers.

23 “(2) FAILURE TO IMPLEMENT PROVISIONS.—In
24 the case of a determination by the Secretary that a
25 State has failed to substantially enforce a provision

(or provisions) of sections 196 through 199 with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance coverage in such State.

“(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

“(1) LIMITATION.—The provisions of this subsection shall apply to enforcement of a provision (or provisions) described in subsection (a)(2) only—

“(A) as provided under such subsection;

and

“(B) with respect to individual health insurance coverage or group health plans that are non-Federal governmental plans.

“(2) IMPOSITION OF PENALTIES.—In the cases described in paragraph (1)—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any non-Federal governmental plan that is a group health plan and any health insurance issuer that fails to meet a provision of this part appli-

1 cable to such plan or issuer is subject to a civil
2 money penalty under this subsection.

3 “(B) LIABILITY FOR PENALTY.—In the
4 case of a failure by—

5 “(i) a health insurance issuer, the
6 issuer is liable for such penalty; or

7 “(ii) a group health plan that is a
8 non-Federal governmental plan which is—

9 “(I) sponsored by 2 or more em-
10 ployers, the plan is liable for such
11 penalty; or

12 “(II) not so sponsored, the em-
13 ployer is liable for such penalty.

14 “(C) AMOUNT OF PENALTY.—

15 “(i) IN GENERAL.—The maximum
16 amount of penalty imposed under this
17 paragraph is \$100 for each day for each
18 individual with respect to which such a
19 failure occurs.

20 “(ii) CONSIDERATIONS IN IMPOSI-
21 TION.—In determining the amount of any
22 penalty to be assessed under this para-
23 graph, the Secretary shall take into ac-
24 count the previous record of compliance of
25 the entity being assessed with the applica-

1 ble provisions of this part and the gravity
2 of the violation.

3 “(iii) LIMITATIONS.—

4 “(I) PENALTY NOT TO APPLY
5 WHERE FAILURE NOT DISCOVERED
6 EXERCISING REASONABLE DILI-
7 GENCE.—No civil money penalty shall
8 be imposed under this paragraph on
9 any failure during any period for
10 which it is established to the satisfac-
11 tion of the Secretary that none of the
12 entities against whom the penalty
13 would be imposed knew, or exercising
14 reasonable diligence would have
15 known, that such failure existed.

16 “(II) PENALTY NOT TO APPLY
17 TO FAILURES CORRECTED WITHIN 30
18 DAYS.—No civil money penalty shall
19 be imposed under this paragraph on
20 any failure if such failure was due to
21 reasonable cause and not to willful ne-
22 glect, and such failure is corrected
23 during the 30-day period beginning on
24 the first day any of the entities
25 against whom the penalty would be

1 imposed knew, or exercising reason-
2 able diligence would have known, that
3 such failure existed.

4 “(D) ADMINISTRATIVE REVIEW.—

5 “(i) OPPORTUNITY FOR HEARING.—

6 The entity assessed shall be afforded an
7 opportunity for hearing by the Secretary
8 upon request made within 30 days after
9 the date of the issuance of a notice of as-
10 sessment. In such hearing the decision
11 shall be made on the record pursuant to
12 section 554 of title 5, United States Code.
13 If no hearing is requested, the assessment
14 shall constitute a final and unappealable
15 order.

16 “(ii) HEARING PROCEDURE.—If a
17 hearing is requested, the initial agency de-
18 cision shall be made by an administrative
19 law judge, and such decision shall become
20 the final order unless the Secretary modi-
21 fies or vacates the decision. Notice of in-
22 tent to modify or vacate the decision of the
23 administrative law judge shall be issued to
24 the parties within 30 days after the date of
25 the decision of the judge. A final order

1 which takes effect under this paragraph
2 shall be subject to review only as provided
3 under subparagraph (E).

4 “(E) JUDICIAL REVIEW.—

5 “(i) FILING OF ACTION FOR RE-
6 VIEW.—Any entity against whom an order
7 imposing a civil money penalty has been
8 entered after an agency hearing under this
9 paragraph may obtain review by the
10 United States district court for any district
11 in which such entity is located or the
12 United States District Court for the Dis-
13 trict of Columbia by filing a notice of ap-
14 peal in such court within 30 days from the
15 date of such order, and simultaneously
16 sending a copy of such notice by registered
17 mail to the Secretary.

18 “(ii) CERTIFICATION OF ADMINISTRA-
19 TIVE RECORD.—The Secretary shall
20 promptly certify and file in such court the
21 record upon which the penalty was im-
22 posed.

23 “(iii) STANDARD FOR REVIEW.—The
24 findings of the Secretary shall be set aside
25 only if found to be unsupported by sub-

1 stantial evidence as provided by section
2 706(2)(E) of title 5, United States Code.

3 “(iv) APPEAL.—Any final decision,
4 order, or judgment of the district court
5 concerning such review shall be subject to
6 appeal as provided in chapter 83 of title 28
7 of such Code.

8 “(F) FAILURE TO PAY ASSESSMENT; MAIN-
9 TENANCE OF ACTION.—

10 “(i) FAILURE TO PAY ASSESSMENT.—
11 If any entity fails to pay an assessment
12 after it has become a final and
13 unappealable order, or after the court has
14 entered final judgment in favor of the Sec-
15 retary, the Secretary shall refer the matter
16 to the Attorney General who shall recover
17 the amount assessed by action in the ap-
18 propriate United States district court.

19 “(ii) NONREVIEWABILITY.—In such
20 action the validity and appropriateness of
21 the final order imposing the penalty shall
22 not be subject to review.

23 “(G) PAYMENT OF PENALTIES.—Except as
24 otherwise provided, penalties collected under
25 this paragraph shall be paid to the Secretary

(or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

“(3) ENFORCEMENT AUTHORITY RELATING TO GENETIC DISCRIMINATION.—

“(A) GENERAL RULE.—In the cases described in paragraph (1), notwithstanding the provisions of paragraph (2)(C), the succeeding subparagraphs of this paragraph shall apply with respect to an action under this subsection by the Secretary with respect to any failure of a health insurance issuer in connection with a group health plan, to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 196 or section 197 or 196(b)(1) with respect to genetic information in connection with the plan.

“(B) AMOUNT.—

“(i) IN GENERAL.—The amount of the penalty imposed under this paragraph shall be \$100 for each day in the non-compliance period with respect to each par-

1 participant or beneficiary to whom such fail-
 2 ure relates.

3 “(ii) NONCOMPLIANCE PERIOD.—For
 4 purposes of this paragraph, the term ‘non-
 5 compliance period’ means, with respect to
 6 any failure, the period—

7 “(I) beginning on the date such
 8 failure first occurs; and

9 “(II) ending on the date the fail-
 10 ure is corrected.

11 “(C) MINIMUM PENALTIES WHERE FAIL-
 12 URE DISCOVERED.—Notwithstanding clauses (i)
 13 and (ii) of subparagraph (D):

14 “(i) IN GENERAL.—In the case of 1 or
 15 more failures with respect to an indi-
 16 vidual—

17 “(I) which are not corrected be-
 18 fore the date on which the plan re-
 19 ceives a notice from the Secretary of
 20 such violation; and

21 “(II) which occurred or continued
 22 during the period involved;
 23 the amount of penalty imposed by subpara-
 24 graph (A) by reason of such failures with

1 respect to such individual shall not be less
2 than \$2,500.

3 “(ii) HIGHER MINIMUM PENALTY
4 WHERE VIOLATIONS ARE MORE THAN DE
5 MINIMIS.—To the extent violations for
6 which any person is liable under this para-
7 graph for any year are more than de mini-
8 mis, clause (i) shall be applied by sub-
9 stituting ‘\$15,000’ for ‘\$2,500’ with re-
10 spect to such person.

11 “(D) LIMITATIONS.—

12 “(i) PENALTY NOT TO APPLY WHERE
13 FAILURE NOT DISCOVERED EXERCISING
14 REASONABLE DILIGENCE.—No penalty
15 shall be imposed by subparagraph (A) on
16 any failure during any period for which it
17 is established to the satisfaction of the
18 Secretary that the person otherwise liable
19 for such penalty did not know, and exer-
20 cising reasonable diligence would not have
21 known, that such failure existed.

22 “(ii) PENALTY NOT TO APPLY TO
23 FAILURES CORRECTED WITHIN CERTAIN
24 PERIODS.—No penalty shall be imposed by
25 subparagraph (A) on any failure if—

1 “(I) such failure was due to rea-
2 sonable cause and not to willful ne-
3 glect; and

4 “(II) such failure is corrected
5 during the 30-day period beginning on
6 the first date the person otherwise lia-
7 ble for such penalty knew, or exer-
8 cising reasonable diligence would have
9 known, that such failure existed.

10 “(iii) OVERALL LIMITATION FOR UN-
11 INTENTIONAL FAILURES.—In the case of
12 failures which are due to reasonable cause
13 and not to willful neglect, the penalty im-
14 posed by subparagraph (A) for failures
15 shall not exceed the amount equal to the
16 lesser of—

17 “(I) 10 percent of the aggregate
18 amount paid or incurred by the em-
19 ployer (or predecessor employer) dur-
20 ing the preceding taxable year for
21 group health plans; or

22 “(II) \$500,000.

23 “(E) WAIVER BY SECRETARY.—In the case
24 of a failure which is due to reasonable cause
25 and not to willful neglect, the Secretary may

1 waive part or all of the penalty imposed by sub-
 2 paragraph (A) to the extent that the payment
 3 of such penalty would be excessive relative to
 4 the failure involved.

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

6 “(1) GOVERNMENTAL PLAN.—The term ‘gov-
 7 ernmental plan’ has the meaning given such term
 8 under section 3(32) of the Employee Retirement In-
 9 come Security Act of 1974 and any Federal govern-
 10 mental plan.

11 “(2) FEDERAL GOVERNMENTAL PLAN.—The
 12 term “Federal governmental plan” means a govern-
 13 mental plan established or maintained for its em-
 14 ployees by the Government of the United States or
 15 by any agency or instrumentality of such Govern-
 16 ment.

17 “(3) NON-FEDERAL GOVERNMENTAL PLAN.—
 18 The term ‘non-Federal governmental plan’ means a
 19 governmental plan that is not a Federal govern-
 20 mental plan.”.

21 (b) CONFORMING AMENDMENT.—The table of con-
 22 tents under section 1(b) of the Health Insurance Port-
 23 ability and Accountability Act of 1996 (Public Law 104–
 24 191) is amended by inserting after the item relating to
 25 section 195 the following:

“Sec. 196. Guaranteed availability of coverage.

“Sec. 197. Fair health insurance premiums.

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

“Sec. 199. Prohibition of preexisting condition exclusions or other discrimination based on health status.

“Sec. 199A. Enforcement of certain health insurance requirements.”.

1 (c) ERISA AND IRC ENFORCEMENT.—

2 (1) ERISA.—Subpart B of part 7 of title I of
3 the Employee Retirement Income Security Act of
4 1974 (29 U.S.C. 1185 et seq.) is amended by adding
5 at the end the following new section:

6 **“SEC. 716. OTHER MARKET REFORMS.**

7 “Sections 196 and 197 of the Health Insurance Port-
8 ability and Accountability Act of 1996 shall apply to
9 health insurance issuers providing health insurance cov-
10 erage in connection with group health plans, and sections
11 198 through 199 of such Act shall apply to group health
12 plans and health insurance issuers providing health insur-
13 ance coverage in connection with group health plans, as
14 if included in this subpart, and to the extent that any pro-
15 vision of this part conflicts with a provision of such sec-
16 tions 196 or 197 with respect to health insurance issuers
17 providing health insurance coverage in connection with
18 group health plans or of such sections 198 or 199 with
19 respect to group health plans or health insurance issuers
20 providing health insurance coverage in connection with
21 group health plans, the provisions of such sections 196
22 through 199 shall apply.”.

1 (2) IRC.—Subchapter B of chapter 100 of sub-
2 title K of title 26 of the Internal Revenue Code of
3 1986 is amended by adding at the end the following
4 new section:

5 **“SEC. 9816. OTHER MARKET REFORMS.**

6 “Sections 196 and 197 of the Health Insurance Port-
7 ability and Accountability Act of 1996 shall apply to
8 health insurance issuers providing health insurance cov-
9 erage in connection with group health plans, and sections
10 198 through 199 of such Act shall apply to group health
11 plans and health insurance issuers providing health insur-
12 ance coverage in connection with group health plans, as
13 if included in this subchapter, and to the extent that any
14 provision of this chapter conflicts with a provision of such
15 sections 196 or 197 with respect to health insurance
16 issuers providing health insurance coverage in connection
17 with group health plans or of such sections 198 or 199
18 with respect to group health plans or health insurance
19 issuers providing health insurance coverage in connection
20 with group health plans, the provisions of such sections
21 196 through 199 shall apply.”.

○