

104TH CONGRESS
1ST SESSION

H. R. 1604

To amend the Internal Revenue Code of 1986 to promote the continuity and portability of health insurance coverage by restricting discrimination based on health status, limiting use of preexisting condition exclusions, and making COBRA continuation coverage more affordable and available.

IN THE HOUSE OF REPRESENTATIVES

MAY 10, 1995

Mrs. JOHNSON of Connecticut (for herself and Mr. THOMAS of California) introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To amend the Internal Revenue Code of 1986 to promote the continuity and portability of health insurance coverage by restricting discrimination based on health status, limiting use of preexisting condition exclusions, and making COBRA continuation coverage more affordable and available.

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 “Working Families
5 Health Access Act of 1995”.

1 **SEC. 2. PROMOTING THE CONTINUITY AND PORTABILITY**
 2 **OF HEALTH COVERAGE.**

3 (a) IN GENERAL.—Subtitle D of the Internal Reve-
 4 nue Code of 1986 is amended by inserting after chapter
 5 44 the following new chapter:

6 **“CHAPTER 45—CONTINUITY AND**
 7 **PORTABILITY OF HEALTH COVERAGE**

“Sec. 4986. Imposition of tax.

“Sec. 4987. Nondiscrimination based on health status.

“Sec. 4988. Limited use of preexisting condition exclusions.

“Sec. 4989. Guaranteed renewability of health insurance coverage.

“Sec. 4990. Relation to State standards.

“Sec. 4991. Definitions.

8 **“SEC. 4986. IMPOSITION OF TAX FOR FAILURE TO MEET**
 9 **CONTINUITY AND PORTABILITY STANDARDS.**

10 “(a) INSURED HEALTH PLANS.—

11 “(1) IN GENERAL.—In the case of any health
 12 insurance policy which fails to meet the applicable
 13 standards specified in this chapter at any time dur-
 14 ing a calendar year, there is hereby imposed a tax
 15 equal to 25 percent of the premiums received under
 16 such policy during the calendar year.

17 “(2) LIABILITY FOR TAX.—The tax imposed by
 18 paragraph (1) shall be paid by the issuer of the pol-
 19 icy.

20 “(3) TREATMENT OF PREPAID HEALTH COV-
 21 ERAGE.—For purposes of this subsection:

1 “(A) IN GENERAL.—In the case of any
2 prepaid health arrangement—

3 “(i) such arrangement shall be treated
4 as a health insurance policy,

5 “(ii) the payments or premiums re-
6 ferred to in subparagraph (B)(i) shall be
7 treated as premiums received for a health
8 insurance policy, and

9 “(iii) the person referred to in sub-
10 subparagraph (B)(i) shall be treated as the is-
11 suer.

12 “(B) PREPAID HEALTH ARRANGEMENT.—
13 For purposes of subparagraph (A), the term
14 ‘prepaid health arrangement’ means an ar-
15 rangement under which—

16 “(i) fixed payments or premiums are
17 received as consideration for any person’s
18 agreement to provide or arrange for the
19 provision of accident or health coverage re-
20 gardless of how such coverage is provided
21 or arranged to be provided, and

22 “(ii) substantially all of the risks of
23 the rates of utilization of services is as-
24 sumed by such person or the provider of
25 such services.

1 “(4) INSURANCE POLICY.—For purposes of this
2 subsection, the term ‘insurance policy’ means any
3 policy or other instrument whereby a contract of in-
4 surance is issued, renewed, or extended.

5 “(5) PREMIUM.—For purposes of this sub-
6 section, the term ‘premium’ means the gross amount
7 of premiums and other consideration (including ad-
8 vance premiums, deposits, fees, and assessments)
9 arising from policies issued by a person acting as the
10 primary insurer, adjusted for any return or addi-
11 tional premiums paid as a result of endorsements,
12 cancellations, audits, or retrospective rating.

13 “(b) SELF-INSURED HEALTH PLANS.—

14 “(1) IN GENERAL.—In the case of a self-in-
15 sured health plan which fails to meet the applicable
16 standards specified in this chapter at any time dur-
17 ing a calendar year, there is hereby imposed a tax
18 equal to 25 percent of the health coverage expendi-
19 tures for such calendar year under such plan.

20 “(2) LIABILITY FOR TAX.—The tax imposed by
21 paragraph (1) shall be paid by the plan sponsor.

22 “(3) SELF-INSURED HEALTH PLAN.—For pur-
23 poses of this subsection, the term ‘self-insured
24 health plan’ means any plan for providing accident

1 or health coverage if any portion of such coverage is
2 provided other than through an insurance policy.

3 “(4) HEALTH COVERAGE EXPENDITURES.—For
4 purposes of this subsection, the health coverage ex-
5 penditures of any self-insured health plan for any
6 calendar year are the aggregate expenditures for
7 such year for health coverage provided under such
8 plan.

9 “(c) LIMITATIONS ON IMPOSITION.—

10 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
11 DISCOVERED EXERCISING REASONABLE DILI-
12 GENCE.—No tax shall be imposed under this section
13 on any failure for which it is established to the satis-
14 faction of the Secretary that none of the persons lia-
15 ble for the tax knew, or exercising reasonable dili-
16 gence would have known, that such failure existed.

17 “(2) TAX NOT TO APPLY TO CERTAIN FAILURES
18 CORRECTED WITHIN 30 DAYS.—No tax shall be im-
19 posed by subsection (a) or (b) on any failure if—

20 “(A) such failure was due to reasonable
21 cause and not to willful neglect, and

22 “(B) such failure is corrected during the
23 30-day period beginning on the 1st date any
24 person liable for the tax knew, or exercising

1 reasonable diligence would have known, that
2 such failure existed.

3 “(3) WAIVER BY SECRETARY.—In the case of a
4 failure which is due to reasonable cause and not to
5 willful neglect, the Secretary may waive part or all
6 of the tax imposed by this section to the extent that
7 the payment of such tax would be excessive relative
8 to the failure involved.

9 **“SEC. 4987. NONDISCRIMINATION BASED ON HEALTH STA-**
10 **TUS.**

11 “(a) COVERAGE UNDER GROUP HEALTH PLANS.—
12 A group health plan and a carrier offering health insur-
13 ance coverage in connection with such a plan may not es-
14 tablish or impose eligibility, continuation, enrollment, or
15 contribution requirements for an individual based on fac-
16 tors directly related to the health status, medical condi-
17 tion, claims experience, receipt of health care, medical his-
18 tory, disability, or evidence of insurability of the individ-
19 ual.

20 “(b) INDIVIDUAL COVERAGE.—

21 “(1) IN GENERAL.—A carrier offering health
22 insurance coverage (other than in connection with a
23 group health plan) may not establish or impose eligi-
24 bility, continuation, or enrollment requirements for a
25 qualifying individual (as defined in paragraph (2))

1 based on factors directly related to the health status,
2 medical condition, claims experience, receipt of
3 health care, medical history, disability, or evidence of
4 insurability of the individual.

5 “(2) QUALIFYING INDIVIDUAL DEFINED.—For
6 purposes of paragraph (1), the term ‘qualifying indi-
7 vidual’ means an individual who meets all of the fol-
8 lowing requirements:

9 “(A) The individual is in a period of quali-
10 fying previous coverage (as defined in para-
11 graph (3)) which is at least 6 months long.

12 “(B) The individual is not eligible for cov-
13 erage under any group health plan (including
14 continuation coverage under section 4980B)
15 and has not lost such coverage but for a failure
16 to make required premium payments or con-
17 tributions or due to fraud or misrepresentation
18 of material fact.

19 “(C) If the individual’s most recent cov-
20 erage during the period of qualifying previous
21 coverage under subparagraph (A) was health
22 insurance coverage not in connection with a
23 group health plan, such coverage was discon-
24 tinued or terminated by the carrier only on the
25 basis of—

1 “(i) a change in residence of the indi-
2 vidual so that the individual no longer re-
3 sided within a service area of the carrier
4 with respect to such coverage, or

5 “(ii) a change in the individual’s sta-
6 tus so that the individual was no longer el-
7 igible for dependent coverage, if the indi-
8 vidual previously was only eligible for such
9 coverage as a dependent.

10 Nothing in subparagraph (C) shall be construed as
11 preventing a carrier from waiving the application of
12 such subparagraph during an annual open enroll-
13 ment period or otherwise.

14 “(3) PERIOD OF QUALIFYING PREVIOUS COV-
15 ERAGE DEFINED.—For purposes of this chapter, the
16 term ‘period of qualifying previous coverage’ means
17 the period—

18 “(A) beginning on the date an individual is
19 enrolled under a group health plan or is pro-
20 vided health insurance coverage, and

21 “(B) ending on the date the individual is
22 neither covered under a group health plan or
23 covered under health insurance coverage (in-
24 cluding coverage described in section

1 4991(2)(D)) for a continuous period of more
2 than 2 months.

3 **“SEC. 4988. LIMITED USE OF PREEXISTING CONDITION EX-**
4 **CLUSIONS.**

5 “(a) IN GENERAL.—A carrier offering health insur-
6 ance coverage and a group health plan may impose a limi-
7 tation or exclusion of benefits relating to treatment of a
8 condition based on the fact that the condition is a preexist-
9 ing condition (as defined in subsection (c)) only if the fol-
10 lowing requirements are met:

11 “(1) LIMITATION TO 3-MONTH LOOK-BACK.—
12 The condition was diagnosed or treated during the
13 period not more than 3 months before the date of
14 enrollment for such coverage or under such plan.

15 “(2) LIMITATION ON EXCLUSION PERIOD.—

16 “(A) GENERAL RULE OF MAXIMUM OF 6-
17 MONTH EXCLUSION.—Subject to paragraph (3),
18 the limitation or exclusion extends for a period
19 not more than 6 months (or 12 months in the
20 case of a late enrollee described in subpara-
21 graph (B)) after such date of enrollment.

22 “(B) LATE ENROLLEE DESCRIBED.—

23 “(i) IN GENERAL.—Except as pro-
24 vided in clause (ii), a late enrollee de-
25 scribed in this subparagraph with respect

1 to a group health plan is an individual who
2 becomes covered under the plan but who,
3 at the time the individual first was eligible
4 to elect such coverage, had elected not to
5 be covered under the plan.

6 “(ii) EXCEPTION FOR INDIVIDUALS
7 WITH CONTINUOUS COVERAGE.—An indi-
8 vidual shall not be considered to be a late
9 enrollee with respect to a plan if the indi-
10 vidual establishes that, with respect to the
11 period beginning on the date the individual
12 first could have obtained coverage under
13 the plan and until the date the individual
14 was so covered, there was no period of
15 more than 2 months during all of which
16 the individual neither had health insurance
17 coverage (including coverage described in
18 subparagraph (C) or (D) of section
19 4991(2)) or was covered under any group
20 health plan.

21 “(3) CREDIT FOR PREVIOUS QUALIFYING COV-
22 ERAGE.—In the case of an individual who is in a pe-
23 riod of qualifying previous coverage (as defined in
24 section 4987(b)(3)) as of the date of enrollment for
25 health insurance coverage or under the group health

1 plan, the limitation or exclusion period under para-
2 graph (2)(A) shall be reduced by the length of such
3 period of qualifying previous coverage.

4 “(4) EXCEPTION FOR TREATMENT OF PREG-
5 NANCY.—The limitation or exclusion does not apply
6 to treatment relating to pregnancy.

7 “(5) EXCEPTION FOR CERTAIN DEPENDENT
8 COVERAGE.—

9 “(A) NEWBORNS.—The limitation or exclu-
10 sion does not apply to a child who has health
11 insurance coverage (or is covered under a group
12 health plan) as a dependent within 1 month of
13 the birthdate until such time as the child does
14 not have such coverage (or is not so covered)
15 for a continuous period of more than 2 months.

16 “(B) ADOPTED CHILDREN.—The limita-
17 tion or exclusion does not apply (beginning on
18 the date of adoption) to an adopted child who
19 has health insurance coverage (or is covered
20 under a group health plan) within 1 month of
21 such date until such time as the child does not
22 have such coverage (or is not so covered) for a
23 continuous period of more than 2 months.

24 “(b) LIMITATION ON USE OF DELAYED COVERAGE
25 IN LIEU OF PREEXISTING EXCLUSION LIMITATIONS.—

1 “(1) IN GENERAL.—A carrier offering health
2 insurance coverage and a group health plan provid-
3 ing coverage, with respect to an individual, may
4 delay the effective date of coverage of the individual
5 beyond the first date of the month beginning after
6 the date of election of the coverage only if the fol-
7 lowing requirements are met:

8 “(A) LIMITATION ON DELAY PERIOD.—
9 Subject to paragraph (2), such additional delay
10 does not extend over a period of longer than 2
11 months (or 3 months in the case of a late en-
12 rollee described in subsection (a)(2)(B)).

13 “(B) NO SUBSEQUENT APPLICATION OF
14 ANY PREEXISTING EXCLUSION.—After the pe-
15 riod of such additional delay, no limitation or
16 exclusion described in subsection (a) may be ap-
17 plied.

18 “(C) NO PREMIUMS.—No premium or re-
19 quired contribution may be charged for the pe-
20 riod before the effective date of coverage.

21 Nothing in this paragraph shall waive the applicable
22 requirements of subsection (a).

23 “(2) VOLUNTARY WAIVER.—The additional
24 delay may extend over a period longer than the pe-
25 riod specified under paragraph (1)(A) if the individ-

1 ual involved waives the protection provided under
2 such paragraph.

3 “(c) **PREEXISTING CONDITION DEFINED.**—For pur-
4 poses of this section, the term ‘preexisting condition’
5 means, with respect to coverage under health insurance
6 coverage or under a group health plan, a condition which
7 was diagnosed or treated for a condition, or for which a
8 reasonably prudent person would have sought medical care
9 diagnosis or treatment, within the 3-month period ending
10 on the day before the date of enrollment (without regard
11 to any delayed coverage period).

12 **“SEC. 4989. GUARANTEED RENEWABILITY OF HEALTH IN-**
13 **SURANCE COVERAGE.**

14 “(a) **IN GENERAL.**—Except as provided in subsection
15 (b), a carrier offering health insurance coverage shall
16 guarantee that such coverage may be renewed or contin-
17 ued in force at the option of the policyholder or contract-
18 holder.

19 “(b) **GROUND FOR REFUSAL TO RENEW.**—

20 “(1) **IN GENERAL.**—Subject to paragraphs (3)
21 and (4), a carrier offering health insurance coverage
22 may cancel or refuse to renew such coverage—

23 “(A) for nonpayment of premium or con-
24 tribution in accordance with the terms of the
25 coverage;

1 “(B) for fraud or misrepresentation of ma-
2 terial fact;

3 “(C) because of a general discontinuation
4 or termination of coverage, but only if the car-
5 rier provides prior notice of such discontinu-
6 ation or termination and if the conditions de-
7 scribed in clause (i) or (ii) of paragraph (2)(A)
8 are met;

9 “(D) in the case of coverage offered in
10 connection with a group health plan, for failure
11 of the plan to maintain participation rules con-
12 sistent with paragraph (4); or

13 “(E) in the case of coverage that is con-
14 tinuation coverage under section 4980B, for
15 loss of eligibility to continue such coverage.

16 “(2) CONDITIONS FOR DISCONTINUATION.—

17 “(A) IN GENERAL.—

18 “(i) NONDISCRIMINATORY SUBSTI-
19 TUTION OF ALTERNATIVE COVERAGE.—
20 The conditions described in this clause are
21 the following:

22 “(I) The carrier is no longer of-
23 fering health insurance coverage to
24 new policyholders or contractholders.

1 “(II) The carrier is offering to
2 the previously covered policyholder or
3 contractholder the option to purchase
4 any other health insurance coverage
5 currently being offered to new policy-
6 holders or contractholders.

7 “(III) The discontinuation or ter-
8 mination of coverage and option to re-
9 place with other coverage is made uni-
10 formly without regard to the health
11 status or insurability of any person
12 provided health insurance coverage.

13 “(ii) GENERAL DISCONTINUATION OF
14 COVERAGE IN A STATE.—The conditions
15 described in this clause are that the carrier
16 is discontinuing and not renewing all
17 health insurance coverage within a class of
18 coverage (as defined in subparagraph (B))
19 in a State.

20 “(B) CLASSES OF COVERAGE.—For pur-
21 poses of subparagraph (A)(ii), each of the fol-
22 lowing is considered a separate class of health
23 insurance coverage:

1 “(i) INDIVIDUAL COVERAGE.—Health
2 insurance coverage not offered in connec-
3 tion with any group health plan.

4 “(ii) SMALL EMPLOYER GROUP COV-
5 ERAGE.—Health insurance coverage of-
6 fered to small employers (as defined by
7 State law) in connection with any group
8 health plan for covered employees and
9 their dependents.

10 “(iii) OTHER GROUP COVERAGE.—
11 Health insurance coverage offered in con-
12 nection with a group health plan and not
13 described in clause (ii).

14 “(3) APPLICATION OF GEOGRAPHIC LIMITA-
15 TIONS TO COVERAGE PROVIDED THROUGH A NET-
16 WORK ARRANGEMENT.—

17 “(A) IN GENERAL.—Coverage under health
18 insurance or under a group health plan that
19 consists primarily of coverage through a net-
20 work arrangement (as defined in subparagraph
21 (B)) may be denied to individuals who neither
22 live nor reside in the service area of the ar-
23 rangement, but only if such denial is applied
24 uniformly, without regard to the health status
25 or the insurability of particular individuals.

1 “(B) NETWORK ARRANGEMENTS.—For
2 purposes of subparagraph (A), the term ‘net-
3 work arrangement’ means, with respect to a
4 group health plan or under health insurance
5 coverage, an arrangement under such plan or
6 coverage whereby providers agree to provide
7 items and services covered under the arrange-
8 ment to individuals covered under the plan or
9 who have such coverage.

10 “(4) MINIMUM PARTICIPATION REQUIRE-
11 MENTS.—A carrier that offers health insurance cov-
12 erage in connection with a group health plan that
13 covers the employees of one or more employers may
14 require that a minimum percentage of eligible em-
15 ployees of such an employer obtain such coverage if
16 such percentage is applied uniformly to all such cov-
17 erage offered to employers of comparable size.

18 **“SEC. 4990. RELATION TO STATE STANDARDS.**

19 “Nothing in this chapter shall prevent a State from
20 establishing, implementing, or continuing in effect stand-
21 ards related to health insurance coverage (including the
22 issuance, renewal, or rating of such coverage) if such
23 standards are at least as stringent as the standards estab-
24 lished under this chapter with respect to such coverage.

1 **“SEC. 4991. DEFINITIONS.**

2 “For purposes of this chapter—

3 “(1) CARRIER.—The term ‘carrier’ means—

4 “(A) a licensed insurance company;

5 “(B) an entity offering prepaid hospital or
6 medical service plan;

7 “(C) a health maintenance organization;

8 and

9 “(D) any similar entity which (i) is en-
10 gaged in the business of providing a plan of
11 health insurance or health benefits or services
12 and (ii) is regulated under State law for sol-
13 vency.

14 “(2) HEALTH INSURANCE COVERAGE.—

15 “(A) IN GENERAL.—Except as provided in
16 subparagraph (B), the term ‘health insurance
17 coverage’ means any hospital or medical service
18 policy or certificate, hospital or medical service
19 plan contract, or health maintenance organiza-
20 tion group contract offered by a carrier.

21 “(B) EXCEPTION.—Such term does not in-
22 clude any of the following (or any combination
23 of the following):

24 “(i) Coverage only for accident, den-
25 tal, vision, or disability income, or any
26 combination thereof.

1 “(ii) Medicare supplemental health in-
2 surance.

3 “(iii) Coverage issued as a supplement
4 to liability insurance.

5 “(iv) Liability insurance, including
6 general liability insurance and automobile
7 liability insurance.

8 “(v) Workers’ compensation or similar
9 insurance.

10 “(vi) Automobile medical-payment in-
11 surance.

12 “(vii) Coverage providing wages or
13 payments in lieu of wages for any period
14 during which an employee is absent from
15 work on account of sickness or injury.

16 “(viii) A long-term care insurance cov-
17 erage, including a nursing home fixed in-
18 demnity policy (unless the Secretary of
19 Health and Human Services, in consulta-
20 tion with the Secretaries of Labor and of
21 the Treasury, determines that such cov-
22 erage is sufficiently comprehensive so that
23 it should be treated as health insurance
24 coverage.)

1 “(ix) Any coverage not described in
2 any preceding clause which consists of ben-
3 efit payments, on a periodic basis, for a
4 specified disease or illness or period of hos-
5 pitalization without regard to the costs in-
6 curred or services rendered during the pe-
7 riod to which the payments relate.

8 “(x) Such other coverage as the Sec-
9 retary of Health and Human Services, in
10 consultation with the Secretaries of Labor
11 and of the Treasury, determines is not
12 health insurance coverage.

13 “(C) TREATMENT OF STATE RISK
14 POOLS.—Except for purposes of sections
15 4987(b)(3), 4988(a)(2)(B)(ii), and 4988(a)(3),
16 such term does not include coverage provided
17 through a State risk pool, uncompensated care
18 pool or similar subsidized program.

19 “(D) PUBLIC PLANS COUNTED FOR PUR-
20 POSES OF QUALIFYING PREVIOUS COVERAGE.—
21 For purposes of sections 4987(b)(3),
22 4988(a)(2)(B)(ii), and 4988(a)(3), such term
23 also includes coverage under any of the follow-
24 ing:

1 “(i) The medicare program under title
2 XVIII of the Social Security Act.

3 “(ii) A State plan under title XIX of
4 such Act.

5 “(iii) A program of the Indian Health
6 Service.

7 “(iv) The Civilian Health and Medical
8 Program of the Uniformed Services
9 (CHAMPUS) under title 10, United States
10 Code.

11 “(v) Any other similar governmental
12 health insurance program (including a pro-
13 gram described in subparagraph (C)).

14 “(3) GROUP HEALTH PLAN.—The term ‘group
15 health plan’ has the meaning given such term in sec-
16 tion 5000(b)(1), but does not include any type of
17 coverage excluded from the definition of health in-
18 surance coverage under paragraph (2)(B) or (C) and
19 does not include any plan unless at least one of the
20 following requirements is met:

21 “(A) Any portion of the premium or bene-
22 fits under the plan is paid by or on behalf of
23 the employer.

24 “(B) An eligible employee or dependent is
25 reimbursed, whether through wage adjustments

1 or otherwise, by or on behalf of the employer
2 for any portion of the premium.

3 “(C) The health benefit plan is treated by
4 the employer, or any of the eligible employees
5 or dependents, as part of a plan or program for
6 the purposes of section 162, section 25, or sec-
7 tion 106 of the Internal Revenue Code of 1986.

8 “(4) STATE.—The term ‘State’ includes the
9 District of Columbia, Puerto Rico, the Virgin Is-
10 lands, Guam, American Samoa, and the Northern
11 Mariana Islands.”

12 (b) EFFECTIVE DATE.—

13 (1) IN GENERAL.—The amendments made by
14 subsection (a) shall apply to individuals who com-
15 mence health insurance coverage or coverage under
16 a group health plan after the first day of the first
17 month beginning more than 6 months after the date
18 of the enactment of this Act.

19 (2) PLAN YEAR EXCEPTION.—Such amend-
20 ments shall not apply to plan years ending before
21 the first day referred to in paragraph (1).

22 (c) CLERICAL AMENDMENT.—The table of chapters
23 for subtitle D is amended by inserting after the item relat-
24 ing to chapter 44 the following new item:

“CHAPTER 45. Continuity and portability of health coverage.”

1 **SEC. 3. CHANGES IN COBRA CONTINUATION REQUIRE-**
2 **MENTS.**

3 (a) MORE AFFORDABLE COVERAGE THROUGH RE-
4 QUIREMENT OF LOWER-COST HEALTH PLAN CHOICES.—

5 (1) IN GENERAL.—Section 4980B(f) of the In-
6 ternal Revenue Code of 1986 is amended—

7 (A) in paragraph (1), by striking “, con-
8 tinuation coverage under the plan” and insert-
9 ing “and as selected by the qualified beneficiary
10 under this subsection, continuation coverage of
11 the type described in subparagraph (A), (F)(i),
12 or (F)(ii) of paragraph (2)”;

13 (B) in paragraph (2)(A), by striking “The
14 coverage” and inserting “Unless the coverage is
15 the type of coverage described in clause (i) or
16 (ii) of subparagraph (F), the coverage”;

17 (C) in paragraph (2)(C)—

18 (i) in clause (i), by inserting “(or in
19 the case of alternative continuation cov-
20 erage described in clause (i) or (ii) of sub-
21 paragraph (F), 69 percent or 52 percent,
22 respectively, of such applicable premium)”
23 after “for such period”, and

24 (ii) in the last sentence by inserting “,
25 ‘69 percent’, or ‘52 percent’ ” after “ ‘102

1 percent' ” and by inserting “, ‘100 per-
2 cent’, or ‘75 percent’, respectively,”;

3 (D) by adding at the end of paragraph (2)
4 the following new subparagraph:

5 “(F) TYPES OF ALTERNATIVE CONTINU-
6 ATION COVERAGE REQUIRED.—

7 “(i) COVERAGE WITH TWO-THIRDS AC-
8 TUARIAL VALUE.—The type of coverage
9 described in this clause is coverage
10 which—

11 “(I) has an actuarial value (de-
12 termined with respect to the similarly
13 situated beneficiaries referred to in
14 subparagraph (A)) of not less than $\frac{2}{3}$
15 of the actuarial value (determined
16 with respect to such beneficiaries) of
17 the reference coverage, and

18 “(II) meets the requirements of
19 clause (iii).

20 “(ii) COVERAGE WITH ONE-HALF AC-
21 TUARIAL VALUE.—The type of coverage
22 described in this clause is coverage
23 which—

24 “(I) has an actuarial value (de-
25 termined with respect to the similarly

1 situated beneficiaries referred to in
2 subparagraph (A)) of not less than $\frac{1}{2}$
3 of the actuarial value (determined
4 with respect to such beneficiaries) of
5 the reference coverage, and

6 “(II) meets the requirements of
7 clause (iii).

8 “(iii) REQUIREMENTS RELATING TO
9 GENERAL AVAILABILITY AND PREEXISTING
10 CONDITIONS.—Coverage meets the require-
11 ments of this clause if the coverage—

12 “(I) is made available to all
13 qualified beneficiaries who become eli-
14 gible for coverage under this sub-
15 section after the effective date of this
16 subparagraph, and

17 “(II) does not impose any restric-
18 tion or limitation on coverage based
19 on a preexisting condition unless such
20 restriction or limitation could be im-
21 posed under the coverage described in
22 subparagraph (A).

23 “(iv) REFERENCE COVERAGE DE-
24 FINED.—For purposes of this subpara-
25 graph, the term ‘reference coverage’

1 means, with respect to a group health
2 plan, the costliest continuation coverage
3 available under subparagraph (A) under
4 the plan, excluding coverage in which an
5 insignificant proportion of the eligible indi-
6 viduals is enrolled.”; and

7 (E) by adding at the end of paragraph (4)
8 the following new subparagraph:

9 “(D) COMPUTATION BASED ON FULL COV-
10 ERAGE.—For purposes of this section, the ap-
11 plicable premium shall be computed based on
12 the type of coverage described in paragraph
13 (2)(A).”

14 (2) EFFECTIVE DATE.—The amendments made
15 by this subsection shall apply to plan years begin-
16 ning on or after the first day of the first month be-
17 ginning at least 6 months after the date of the en-
18 actment of this Act.

19 (b) CONTINUATION COVERAGE FOR CERTAIN FOR-
20 MERLY COVERED DEPENDENT SPOUSES AND CHIL-
21 DREN.—

22 (1) IN GENERAL.—Section 4980B(f) of such
23 Code is amended by adding at the end the following
24 new paragraph:

1 “(9) CAPTURE OF DELAYED DIVORCE OR SEPA-
2 RATION.—

3 “(A) IN GENERAL.—For purposes of this
4 section, if a covered employee disenrolls from
5 coverage (or fails to renew coverage of) a quali-
6 fied beneficiary within the 12-month period pre-
7 ceding the date of the divorce or legal separa-
8 tion of the employee from the employee’s
9 spouse, the divorce or separation shall be treat-
10 ed as a qualifying event described in paragraph
11 (3)(C) and the loss of coverage shall be consid-
12 ered to be a result (and by reason) of such
13 event.

14 “(B) EXCEPTION.—Subparagraph (A)
15 shall not apply to a qualified beneficiary if—

16 “(i) the beneficiary waives the rights
17 under such subparagraph, or

18 “(ii) the qualified beneficiary at the
19 time of the qualifying event or at the time
20 of the disenrollment or failure to renew
21 coverage has coverage under a group
22 health plan (other than by reason of this
23 paragraph) if the plan does not contain
24 any exclusion or limitation with respect to

1 any preexisting condition of such bene-
2 ficiary.”.

3 (2) TREATMENT OF PERIOD BEFORE DELAYED
4 DIVORCE OR SEPARATION.—Subparagraph (D) of
5 section 4980B(f)(2) of such Act is amended by add-
6 ing at the end the following new sentence: “For pur-
7 poses of applying any preexisting condition limita-
8 tion or restriction, any period beginning on the date
9 of the disenrollment or failure to renew coverage re-
10 ferred to in paragraph (9)(A) and ending on the
11 date of the divorce or separation referred to in such
12 paragraph shall not be treated as a break in cov-
13 erage if such paragraph applies to the qualified ben-
14 eficiary.”.

15 (3) TREATMENT OF ANNULMENTS.—Section
16 4980B(g) of such Code is amended by adding at the
17 end the following new paragraph:

18 “(5) TREATMENT OF ANNULMENT AS DI-
19 VORCE.—The term ‘divorce’ includes an annul-
20 ment.”.

21 (4) EFFECTIVE DATE.—The amendments made
22 by this section shall apply to divorces, legal separa-
23 tions, and annulments occurring more than 60 days
24 after the date of the enactment of this Act.

1 (c) ELIMINATION OF TERMINATION OF CONTINU-
2 ATION COVERAGE BY REASON OF MEDICARE ELIGIBILITY
3 THROUGH END STAGE RENAL DISEASE.—

4 (1) IN GENERAL.—Subclause (II) of section
5 4980B(f)(2)(B)(iv) of such Code is amended by in-
6 sserting “other than by reason of section 226A of
7 such Act” after “the Social Security Act”.

8 (2) EFFECTIVE DATE.—The amendment made
9 by this subsection shall apply to covered employees
10 and qualified beneficiaries who become entitled to
11 benefits under title XVIII of the Social Security Act
12 pursuant to section 226A of such Act on or after the
13 first day of the first month that begins after the
14 date of the enactment of this Act.

○

HR 1604 IH—2