

104TH CONGRESS
2D SESSION

H. R. 3043

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.

IN THE HOUSE OF REPRESENTATIVES

MARCH 7, 1996

Mrs. JOHNSON of Connecticut 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.

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 1996”.

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 to
20 regardless of how such coverage is pro-
21 vided 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, genetic pre-
17 disposition, medical condition, claims experience, receipt
18 of health care, medical history, disability, or evidence of
19 insurability of the individual.

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 genetic predisposition, medical condition, claims ex-
3 perience, receipt of health care, medical history, dis-
4 ability, or evidence of 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 12 months long.

12 “(B) The individual is not eligible for cov-
13 erage under any group health plan and has not
14 lost such coverage due to a failure to make re-
15 quired premium payments or contributions or
16 due to fraud or misrepresentation of material
17 fact. For purposes of this subparagraph, con-
18 tinuation coverage under section 4980B shall
19 not be considered to be coverage under a group
20 health plan.

21 “(C) If the individual’s most recent cov-
22 erage during the period of qualifying previous
23 coverage under subparagraph (A) was health
24 insurance coverage not in connection with a

1 group health plan, such coverage was discon-
2 tinued or terminated—

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

8 “(ii) by the carrier on the basis of a
9 change in the individual’s status so that
10 the individual was no longer eligible for de-
11 pendent coverage, if the individual pre-
12 viously was only eligible for such coverage
13 as a dependent,

14 “(iii) by the carrier on the basis of the
15 discontinuation of such coverage by the
16 carrier in accordance with the require-
17 ments of section 4989(b)(2), or

18 “(iv) by the individual at a time that
19 the individual obtained less expensive or
20 less extensive coverage (as defined by the
21 Secretary of Health and Human Services).

22 Nothing in subparagraph (C) shall be construed as
23 preventing a carrier from waiving the application of
24 clauses (i) through (iv) of such subparagraph during
25 an annual open enrollment period or otherwise.

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

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

8 “(B) ending on the date the individual is
9 neither covered under a group health plan or
10 covered under health insurance coverage (in-
11 cluding coverage described in section
12 4991(2)(D)) for a continuous period of more
13 than 2 months.

14 **“SEC. 4988. LIMITED USE OF PREEXISTING CONDITION EX-**
15 **CLUSIONS.**

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

22 “(1) LIMITATION TO 3-MONTH LOOK-BACK.—
23 The condition was diagnosed or treated (or is a con-
24 dition which a reasonably prudent person would have
25 sought medical care diagnosis or treatment) during

1 the period not more than 3 months before the date
2 of enrollment for such coverage or under such plan.

3 “(2) LIMITATION ON EXCLUSION PERIOD.—

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

10 “(B) LATE ENROLLEE DESCRIBED.—

11 “(i) IN GENERAL.—Except as pro-
12 vided in clause (ii), a late enrollee de-
13 scribed in this subparagraph with respect
14 to a group health plan is an individual who
15 becomes covered under the plan but who,
16 at the time the individual first was eligible
17 to elect such coverage, had elected not to
18 be covered under the plan.

19 “(ii) EXCEPTION FOR INDIVIDUALS
20 WITH CONTINUOUS COVERAGE.—An indi-
21 vidual shall not be considered to be a late
22 enrollee with respect to a plan if the indi-
23 vidual establishes that, with respect to the
24 period beginning on the date the individual
25 first could have obtained coverage under

1 the plan and until the date the individual
2 was so covered, there was no period of
3 more than 2 months during all of which
4 the individual neither had health insurance
5 coverage (including coverage described in
6 subparagraph (C) or (D) of section
7 4991(2)) or was covered under any group
8 health plan.

9 “(3) CREDIT FOR PREVIOUS QUALIFYING COV-
10 ERAGE.—In the case of an individual who is in a pe-
11 riod of qualifying previous coverage (as defined in
12 section 4987(b)(3)) as of the date of enrollment for
13 health insurance coverage or under the group health
14 plan, the limitation or exclusion period under para-
15 graph (2)(A) shall be reduced by the length of such
16 period of qualifying previous coverage.

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

20 “(5) EXCEPTION FOR CERTAIN DEPENDENT
21 COVERAGE.—

22 “(A) NEWBORNS.—The limitation or exclu-
23 sion does not apply to a child who has health
24 insurance coverage (or is covered under a group
25 health plan) as a dependent within 1 month of

1 the birthdate until such time as the child does
2 not have such coverage (or is not so covered)
3 for a continuous period of more than 2 months.

4 “(B) ADOPTED CHILDREN.—The limita-
5 tion or exclusion does not apply (beginning on
6 the date of adoption) to an adopted child who
7 has health insurance coverage (or is covered
8 under a group health plan) within 1 month of
9 such date until such time as the child does not
10 have such coverage (or is not so covered) for a
11 continuous period of more than 2 months.

12 “(6) VOLUNTARY WAIVER.—The look-back pe-
13 riod described in paragraph (1) and the maximum
14 period of exclusion under paragraph (2)(A) may ex-
15 tend over a longer period than the period specified
16 in the respective subsection if the individual involved
17 waives the protection provided under such para-
18 graph.

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

21 “(1) IN GENERAL.—A carrier offering health
22 insurance coverage and a group health plan provid-
23 ing coverage, with respect to an individual, may
24 delay the effective date of coverage of the individual
25 beyond the first date of the month beginning after

1 the date of election of the coverage only if the fol-
2 lowing requirements are met:

3 “(A) LIMITATION ON DELAY PERIOD.—

4 Subject to paragraph (2), such additional delay
5 does not extend over a period of longer than 2
6 months (or 3 months in the case of a late en-
7 rollee described in subsection (a)(2)(B)).

8 “(B) NO SUBSEQUENT APPLICATION OF

9 ANY PREEXISTING EXCLUSION.—After the pe-
10 riod of such additional delay, no limitation or
11 exclusion described in subsection (a) may be ap-
12 plied.

13 “(C) NO PREMIUMS.—No premium or re-

14 quired contribution may be charged for the pe-
15 riod before the effective date of coverage.

16 Nothing in this paragraph shall waive the applicable
17 requirements of subsection (a).

18 “(2) VOLUNTARY WAIVER.—The additional

19 delay may extend over a period longer than the pe-
20 riod specified under paragraph (1)(A) if the individ-
21 ual involved waives the protection provided under
22 such paragraph.

23 “(c) PREEXISTING CONDITION DEFINED.—

24 “(1) IN GENERAL.—For purposes of this sec-

25 tion, the term ‘preexisting condition’ means, with re-

1 spect to coverage under health insurance coverage or
2 under a group health plan, a condition which was di-
3 agnosed or treated, or a condition for which a rea-
4 sonably prudent person would have sought medical
5 care diagnosis or treatment, within the 3-month pe-
6 riod ending on the day before the date of enrollment
7 (without regard to any delayed coverage period).

8 “(2) TREATMENT OF INFORMATION RELATING
9 TO GENETIC PREDISPOSITION.—For purposes of this
10 section, information relating to one’s genetic pre-
11 disposition alone shall not be considered to be a pre-
12 existing condition, so long as treatment of the condi-
13 tion to which the predisposition is applicable has not
14 been (or should not have been) sought during the 3-
15 month period described in paragraph (1).

16 **“SEC. 4989. GUARANTEED RENEWABILITY OF HEALTH IN-**
17 **SURANCE COVERAGE.**

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

23 “(b) GROUNDS FOR REFUSAL TO RENEW.—

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

4 “(A) for nonpayment of premium or con-
5 tribution in accordance with the terms of the
6 coverage;

7 “(B) for fraud or misrepresentation of ma-
8 terial fact;

9 “(C) because of a general discontinuation
10 or termination of that type of coverage, but
11 only if the conditions described in clause (i) or
12 (ii) of paragraph (2)(A) are met;

13 “(D) in the case of coverage offered in
14 connection with a group health plan, for failure
15 of the plan to maintain participation rules con-
16 sistent with paragraph (4); or

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

20 “(2) CONDITIONS FOR DISCONTINUATION.—

21 “(A) IN GENERAL.—

22 “(i) NONDISCRIMINATORY SUBSTI-
23 TUTION OF ALTERNATIVE COVERAGE.—

24 The conditions described in this clause are
25 the following:

1 “(I) The carrier provides notice
2 to each group purchaser covered
3 under the type of health insurance
4 coverage involved (and participants
5 and beneficiaries covered under such
6 coverage offered in connection with a
7 group health plan) of the discontinu-
8 ation of coverage at least 90 days
9 prior to the date of such discontinu-
10 ation.

11 “(II) The carrier is no longer of-
12 fering health insurance coverage of
13 the type involved to new policyholders
14 or contractholders.

15 “(III) The carrier is offering to
16 the previously covered policyholder or
17 contractholder the option to purchase
18 any other type of health insurance
19 coverage currently being offered to
20 new policyholders or contractholders.

21 “(IV) The discontinuation or ter-
22 mination of coverage and option to re-
23 place with other coverage is made uni-
24 formly without regard to the health

1 status or insurability of any person
2 provided health insurance coverage.

3 “(ii) GENERAL DISCONTINUATION OF
4 COVERAGE IN A STATE.—The conditions
5 described in this clause are as follows:

6 “(I) The carrier is discontinuing
7 and not renewing all types of health
8 insurance coverage within a class of
9 coverage (as defined in subparagraph
10 (B)) in a State.

11 “(II) The carrier provides notice
12 to each purchaser within the class of
13 coverage involved (and participants
14 and beneficiaries covered under such
15 coverage offered in connection with a
16 group health plan) of the discontinu-
17 ation of coverage at least 180 days
18 prior to the date of such discontinu-
19 ation.

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 “(C) PROHIBITION ON MARKET RE-
15 ENTRY.—In the case of a discontinuation of a
16 type or class coverage in a State under this
17 paragraph, the carrier may not provide for the
18 issuance of any health insurance coverage with-
19 in the type or class of coverage discontinued in
20 the State involved during the 5-year period be-
21 ginning on the date of the discontinuation of
22 the last coverage not so renewed.

23 “(3) APPLICATION OF GEOGRAPHIC LIMITA-
24 TIONS TO COVERAGE PROVIDED THROUGH A NET-
25 WORK ARRANGEMENT.—

1 “(A) IN GENERAL.—Coverage under health
2 insurance coverage or under a group health
3 plan that consists primarily of coverage through
4 a network arrangement (as defined in subpara-
5 graph (B)) may be denied to individuals who
6 neither live nor reside in the service area of the
7 arrangement, but only if such denial is applied
8 uniformly, without regard to the health status
9 or the insurability of particular individuals.

10 “(B) NETWORK ARRANGEMENTS.—For
11 purposes of subparagraph (A), the term ‘net-
12 work arrangement’ means, with respect to a
13 group health plan or under health insurance
14 coverage, an arrangement under such plan or
15 coverage whereby providers agree to provide
16 items and services covered under the arrange-
17 ment to individuals covered under the plan or
18 who have such coverage.

19 “(4) MINIMUM PARTICIPATION REQUIRE-
20 MENTS.—A carrier that offers health insurance cov-
21 erage in connection with a group health plan that
22 covers the employees of one or more employers may
23 require to provide that a minimum percentage of eli-
24 gible employees of such an employer obtain such cov-
25 erage if such percentage is applied uniformly to all

1 such coverage offered to employers of comparable
2 size.

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

4 “(a) IN GENERAL.—Nothing in this chapter shall
5 prevent a State from establishing, implementing, or con-
6 tinuing in effect standards related to health insurance cov-
7 erage (including the issuance, renewal, or rating of such
8 coverage) if such standards are at least as stringent as
9 the standards established under this chapter with respect
10 to such coverage.

11 “(b) CONSTRUCTION.—Nothing in this chapter shall
12 be construed to preempt State laws that—

13 “(1) require carriers to impose a shorter look-
14 back period than that specified in section
15 4988(a)(1),

16 “(2) require carriers to impose a limitation or
17 exclusion of benefits relating to the treatment of a
18 preexisting condition for periods that are shorter
19 than those provided for under section 4988(a)(2)(A),
20 or

21 “(3) allow individuals to be considered to be in
22 a period of qualifying previous coverage if such indi-
23 vidual experiences a lapse in coverage that is greater
24 than the period specified in section
25 4988(a)(2)(B)(ii);

1 unless such laws are preempted by section 514 of the Em-
2 ployee Retirement Income Security Act of 1974 (29
3 U.S.C. 1144).

4 **“SEC. 4991. DEFINITIONS.**

5 “For purposes of this chapter—

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

7 “(A) a licensed insurance company;

8 “(B) an entity offering prepaid hospital or
9 medical service plan;

10 “(C) a health maintenance organization;

11 and

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

17 “(2) HEALTH INSURANCE COVERAGE.—

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

1 “(B) EXCEPTION.—Such term does not in-
2 clude any of the following (or any combination
3 of the following):

4 “(i) Coverage only for accident, den-
5 tal, vision, or disability income, or any
6 combination thereof.

7 “(ii) Medicare supplemental health in-
8 surance.

9 “(iii) Coverage issued as a supplement
10 to liability insurance.

11 “(iv) Liability insurance, including
12 general liability insurance and automobile
13 liability insurance.

14 “(v) Workers’ compensation or similar
15 insurance.

16 “(vi) Automobile medical-payment in-
17 surance.

18 “(vii) Coverage providing wages or
19 payments in lieu of wages for any period
20 during which an employee is absent from
21 work on account of sickness or injury.

22 “(viii) A long-term care insurance cov-
23 erage, including a nursing home fixed in-
24 demnity policy (unless the Secretary of
25 Health and Human Services, in consulta-

1 tion with the Secretaries of Labor and of
2 the Treasury, determines that such cov-
3 erage is sufficiently comprehensive so that
4 it should be treated as health insurance
5 coverage.

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

13 “(x) Such other coverage as the Sec-
14 retary of Health and Human Services, in
15 consultation with the Secretaries of Labor
16 and of the Treasury, determines is not
17 health insurance coverage.

18 “(C) TREATMENT OF STATE RISK
19 POOLS.—Except for purposes of sections
20 4987(b)(3), 4988(a)(2)(B)(ii), and 4988(a)(3),
21 such term does not include coverage provided
22 through a State risk pool, uncompensated care
23 pool or similar subsidized program.

24 “(D) PUBLIC PLANS COUNTED FOR PUR-
25 POSES OF QUALIFYING PREVIOUS COVERAGE.—

1 For purposes of sections 4987(b)(3),
2 4988(a)(2)(B)(ii), and 4988(a)(3), such term
3 also includes coverage under any of the follow-
4 ing:

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

7 “(ii) A State plan under title XIX of
8 such Act.

9 “(iii) A program of the Indian Health
10 Service.

11 “(iv) The Civilian Health and Medical
12 Program of the Uniformed Services
13 (CHAMPUS) under title 10, United States
14 Code.

15 “(v) Any other similar governmental
16 health insurance program (including a pro-
17 gram described in subparagraph (C)).

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

1 “(A) Any portion of the premium or bene-
2 fits under the plan is paid by or on behalf of
3 the employer.

4 “(B) An eligible employee or dependent is
5 reimbursed, whether through wage adjustments
6 or otherwise, by or on behalf of the employer
7 for any portion of the premium.

8 “(C) The health benefit plan is treated by
9 the employer, or any of the eligible employees
10 or dependents, as part of a plan or program for
11 the purposes of section 162, section 25, or sec-
12 tion 106 of the Internal Revenue Code of 1986.

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

17 (b) EFFECTIVE DATE.—

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

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

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

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

7 **SEC. 3. CHANGES IN COBRA CONTINUATION REQUIRE-**
8 **MENTS RELATING TO DIVORCES, LEGAL SEP-**
9 **ARATIONS, AND ANNULMENTS.**

10 (a) CONTINUATION COVERAGE FOR CERTAIN FOR-
11 MERLY COVERED DEPENDENT SPOUSES AND CHIL-
12 DREN.—Section 4980B(f) of the Internal Revenue Code
13 of 1986 is amended by adding at the end the following
14 new paragraph:

15 “(9) CAPTURE OF DELAYED DIVORCE OR SEPA-
16 RATION.—

17 “(A) IN GENERAL.—For purposes of this
18 section, if a covered employee disenrolls from
19 coverage (or fails to renew coverage of) a quali-
20 fied beneficiary within the 12-month period pre-
21 ceding the date of the divorce or legal separa-
22 tion of the employee from the employee’s
23 spouse, the divorce or separation shall be treat-
24 ed as a qualifying event described in paragraph
25 (3)(C) and the loss of coverage shall be consid-

1 ered to be a result (and by reason) of such
2 event.

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

5 “(i) the beneficiary waives the rights
6 under such subparagraph, or

7 “(ii) the qualified beneficiary at the
8 time of the qualifying event or at the time
9 of the disenrollment or failure to renew
10 coverage has coverage under a group
11 health plan (other than by reason of this
12 paragraph) if the plan does not contain
13 any exclusion or limitation with respect to
14 any preexisting condition of such bene-
15 ficiary.”

16 (b) TREATMENT OF PERIOD BEFORE DELAYED DI-
17 VORCE OR SEPARATION.—Subparagraph (D) of section
18 4980B(f)(2) of such Code is amended by adding at the
19 end the following new sentence: “For purposes of applying
20 any preexisting condition limitation or restriction, any pe-
21 riod beginning on the date of the disenrollment or failure
22 to renew coverage referred to in paragraph (9)(A) and
23 ending on the date of the divorce or separation referred
24 to in such paragraph shall not be treated as a break in

1 coverage if such paragraph applies to the qualified bene-
2 ficiary.”.

3 (c) TREATMENT OF ANNULMENTS.—Section
4 4980B(g) of such Code is amended by adding at the end
5 the following new paragraph:

6 “(5) TREATMENT OF ANNULMENT AS DI-
7 VORCE.—The term ‘divorce’ includes an annul-
8 ment.”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to divorces, legal separations, and
11 annulments occurring more than 60 days after the date
12 of the enactment of this Act.

13 **SEC. 4. TERMINATION OF COBRA CONTINUATION IN CASE**
14 **OF ELIGIBILITY FOR GROUP HEALTH COV-**
15 **ERAGE WITHOUT IMPOSITION OF PREEXIST-**
16 **ING CONDITION EXCLUSION.**

17 (a) IN GENERAL.—Section 4980B(f)(2)(B)(iv)(I) of
18 the Internal Revenue Code of 1986 is amended—

19 (1) insert “, or eligible for coverage in the case
20 of an employee,” after “otherwise”), and

21 (2) by inserting “or for which the period in
22 which such an exclusion or limitation may be applied
23 has ended under section 4988(a)(2)” after “of such
24 beneficiary”.

25 (b) EFFECTIVE DATE.—

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

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

○

HR 3043 IH—2