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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.

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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

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# A BILL

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

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Maintaining Protections for Patients with Preexisting Conditions Act of 2019''.

**SEC. 2. GUARANTEED AVAILABILITY OF COVERAGE; PROHIBITING DISCRIMINATION.**

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

**"SEC. 196. GUARANTEED AVAILABILITY OF COVERAGE.**

''(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (d), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

''(b) ENROLLMENT.—

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

''(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

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

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

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

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

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

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

''(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their em-

ployees (and their dependents), or any health status-related factor relating to such individuals, employees, and dependents.

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

''(d) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

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

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

''(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individ-

uals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees, and dependents.

''(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

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

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

''(2) The terms 'genetic information', 'genetic test', 'group health plan', 'group market', 'health insurance coverage', 'health insurance issuer', 'group

health insurance coverage', 'individual health insurance coverage', 'individual market', and 'underwriting purpose' have the meanings given such terms in section 2791 of the Public Health Service Act.

**"SEC. 197. FAIR HEALTH INSURANCE PREMIUMS.**

"(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

"(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

"(A) such rate shall vary with respect to the particular plan or coverage involved only by—

"(i) whether such plan or coverage covers an individual or family;

"(ii) rating area, as established in accordance with paragraph (2);

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

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

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

''(2) RATING AREA.—

''(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

''(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

''(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

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

erage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

**"SEC. 198. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.**

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

''(1) Health status.

''(2) Medical condition (including both physical and mental illnesses).

''(3) Claims experience.

''(4) Receipt of health care.

''(5) Medical history.

''(6) Genetic information.

''(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

''(8) Disability.

''(9) Any other health status-related factor determined appropriate by the Secretary.

''(b) IN PREMIUM CONTRIBUTIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

''(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium

discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

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

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

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

''(c) GENETIC TESTING.—

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

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

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

''(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and

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

''(B) LIMITATION.—For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

''(4) RESEARCH EXCEPTION.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

''(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

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

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

"(i) compliance with the request is voluntary; and

"(ii) noncompliance will have no effect on enrollment status or premium or contribution amounts.

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

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

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

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

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

shall not request, require, or purchase genetic information for underwriting purposes.

''(2) PROHIBITION ON COLLECTION OF GENETIC INFORMATION PRIOR TO ENROLLMENT.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

''(3) INCIDENTAL COLLECTION.—If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

''(e) GENETIC INFORMATION OF A FETUS OR EMBRYO.—Any reference in this part to genetic information concerning an individual or family member of an individual shall—

''(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

''(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

''(f) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

''(1) GENERAL PROVISIONS.—

''(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

''(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status fac-

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

''(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

''(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the

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

"(A) A program that reimburses all or part of the cost for memberships in a fitness center.

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

"(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

"(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

"(E) A program that provides a reward to individuals for attending a periodic health education seminar.

"(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining

a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

''(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a dis-

count or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

''(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

''(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

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

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

''(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

''(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

''(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an

individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

''(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

**"SEC. 199. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION 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 impose any preexisting condition exclusion with respect to such plan or coverage.

''(b) DEFINITIONS.—For purposes of this section—

''(1) PREEXISTING CONDITION EXCLUSION.—

"(A) IN GENERAL.—The term 'preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

"(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

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

"(3) LATE ENROLLEE.—The term 'late enrollee' means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

"(A) the first period in which the individual is eligible to enroll under the plan; or

''(B) a special enrollment period under subsection (f).

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

''(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

''(1) CREDITABLE COVERAGE DEFINED.—For purposes of this title, the term 'creditable coverage' means, with respect to an individual, coverage of the individual under any of the following:

''(A) A group health plan.

''(B) Health insurance coverage.

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

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

''(E) Chapter 55 of title 10, United States Code.

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

"(G) A State health benefits risk pool.

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

"(I) A public health plan (as defined in regulations).

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

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 2791(c)).

"(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

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

"(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any pe-

riod that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

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

''(i) TAA PRE-CERTIFICATION PERIOD RULE.—In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of the Internal Revenue Code of 1986 shall not be taken into account in determining the continuous period under subparagraph (A).

"(ii) DEFINITIONS.—The terms 'TAA-eligible individual' and 'TAA-related loss of coverage' have the meanings given such terms in section 2205(b)(4).

"(3) METHOD OF CREDITING COVERAGE.—

"(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

"(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group or individual health plan or issuer shall count a period of creditable coverage with respect to any

class or category of benefits if any level of benefits is covered within such class or category.

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

''(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election; and

''(ii) include in such statements a description of the effect of this election.

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

''(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election; and

''(ii) shall include in such statements a description of the effect of such election.

''(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

''(d) EXCEPTIONS.—

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

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

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

''(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

''(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

''(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

''(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

''(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)—

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

becomes covered under a COBRA continuation provision;

''(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

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

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

''(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

''(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision; and

''(ii) the waiting period (if any) (and affiliation period, if applicable) imposed

with respect to the individual for any coverage under such plan.

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

''(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

''(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

''(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

''(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

''(f) SPECIAL ENROLLMENT PERIODS.—

''(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

''(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

''(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

''(C) The employee's or dependent's coverage described in subparagraph (A)—

''(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

''(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

''(D) Under the terms of the plan, the employee requests such enrollment not later than 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

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

''(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

''(i) the date dependent coverage is made available; or

''(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

''(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

''(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

''(ii) in the case of a dependent's birth, as of the date of such birth; or

"(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

"(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

"(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

"(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligi-

bility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

''(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

''(B) COORDINATION WITH MEDICAID AND CHIP.—

''(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

"(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

"(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974.

"(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group

health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

''(g) USE OF AFFILIATION PERIOD BY HMOS AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.—

''(1) IN GENERAL.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

''(A) such period is applied uniformly without regard to any health status-related factors; and

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

''(2) AFFILIATION PERIOD.—

''(A) DEFINED.—For purposes of this title, the term 'affiliation period' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

''(B) BEGINNING.—Such period shall begin on the enrollment date.

''(C) RUNS CONCURRENTLY WITH WAITING PERIODS.—An affiliation period under a plan shall run concurrently with any waiting period under the plan.

''(3) ALTERNATIVE METHODS.—A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

**''SEC. 199A. ENFORCEMENT OF CERTAIN HEALTH INSURANCE REQUIREMENTS.**

''(a) STATE ENFORCEMENT.—

''(1) STATE AUTHORITY.—Each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part with respect to such issuers.

''(2) FAILURE TO IMPLEMENT PROVISIONS.—In the case of a determination by the Secretary that a 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-

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

"(B) LIABILITY FOR PENALTY.—In the case of a failure by—

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

"(ii) a group health plan that is a non-Federal governmental plan which is—

"(I) sponsored by 2 or more employers, the plan is liable for such penalty; or

"(II) not so sponsored, the employer is liable for such penalty.

"(C) AMOUNT OF PENALTY.—

"(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

"(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary shall take into account the previous record of compliance of the entity being assessed with the applica-

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

''(iii) LIMITATIONS.—

''(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

''(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be

imposed knew, or exercising reasonable diligence would have known, that such failure existed.

''(D) ADMINISTRATIVE REVIEW.—

''(i) OPPORTUNITY FOR HEARING.—The entity assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

''(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order

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

''(E) JUDICIAL REVIEW.—

''(i) FILING OF ACTION FOR REVIEW.—Any entity against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such entity is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice by registered mail to the Secretary.

''(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

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

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

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

''(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

''(i) FAILURE TO PAY ASSESSMENT.—If any entity fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

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

''(G) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under 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 noncompliance period with respect to each par-

ticipant or beneficiary to whom such failure relates.

"(ii) NONCOMPLIANCE PERIOD.—For purposes of this paragraph, the term 'noncompliance period' means, with respect to any failure, the period—

"(I) beginning on the date such failure first occurs; and

"(II) ending on the date the failure is corrected.

"(C) MINIMUM PENALTIES WHERE FAILURE DISCOVERED.—Notwithstanding clauses (i) and (ii) of subparagraph (D):

"(i) IN GENERAL.—In the case of 1 or more failures with respect to an individual—

"(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

"(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with

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

''(ii) HIGHER MINIMUM PENALTY WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.—To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting '$15,000' for '$2,500' with respect to such person.

''(D) LIMITATIONS.—

''(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

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

''(I) such failure was due to reasonable cause and not to willful neglect; and

''(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

''(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

''(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans; or

''(II) $500,000.

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

waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

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

''(1) GOVERNMENTAL PLAN.—The term 'governmental plan' has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

''(2) FEDERAL GOVERNMENTAL PLAN.—The term ''Federal governmental plan'' means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

''(3) NON-FEDERAL GOVERNMENTAL PLAN.—The term 'non-Federal governmental plan' means a governmental plan that is not a Federal governmental plan.''.

(b) CONFORMING AMENDMENT.—The table of contents under section 1(b) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) is amended by inserting after the item relating to section 195 the following:

''Sec. 196. Guaranteed availability of coverage.

(c) ERISA AND IRC ENFORCEMENT.—

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

**''SEC. 716. OTHER MARKET REFORMS.**

''Sections 196 and 197 of the Health Insurance Portability and Accountability Act of 1996 shall apply to health insurance issuers providing health insurance coverage in connection with group health plans, and sections 198 through 199 of such Act shall apply to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart, and to the extent that any provision of this part conflicts with a provision of such sections 196 or 197 with respect to health insurance issuers providing health insurance coverage in connection with group health plans or of such sections 198 or 199 with respect to group health plans or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such sections 196 through 199 shall apply.''.

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

**"SEC. 9816. OTHER MARKET REFORMS.**

''Sections 196 and 197 of the Health Insurance Portability and Accountability Act of 1996 shall apply to health insurance issuers providing health insurance coverage in connection with group health plans, and sections 198 through 199 of such Act shall apply to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter, and to the extent that any provision of this chapter conflicts with a provision of such sections 196 or 197 with respect to health insurance issuers providing health insurance coverage in connection with group health plans or of such sections 198 or 199 with respect to group health plans or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such sections 196 through 199 shall apply.''.

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