PUBLIC HEALTH SERVICE ACT

[As Amended Through P.L. 114–255, Enacted December 13, 2016]

[Currency: This publication is a compilation of the text of title XXII of Chapter 373 of the 78th Congress. It was last amended by the public law listed in the As Amended Through note above and below at the bottom of each page of the pdf version and reflects current law through the date of the enactment of the public law listed at https://www.govinfo.gov/app/collection/comps/]

[Note: While this publication does not represent an official version of any Federal statute, substantial efforts have been made to ensure the accuracy of its contents. The official version of Federal law is found in the United States Statutes at Large and in the United States Code. The legal effect to be given to the Statutes at Large and the United States Code is established by statute (1 U.S.C. 112, 204).]

[References in brackets [] are to title 42, United States Code]

TITLE XXII—REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE AND LOCAL EMPLOYEES

SEC. 2201. [300bb–1] STATE AND LOCAL GOVERNMENTAL GROUP HEALTH PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

(a) IN GENERAL.—In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this Act, by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this title, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

(b) EXCEPTION FOR CERTAIN PLANS.—Subsection (a) shall not apply to—

(1) any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year, or

(2) any group health plan maintained for employees by the government of the District of Columbia or any territory or possession of the United States or any agency or instrumentality.

SEC. 2202. [300bb–2] CONTINUATION COVERAGE.

For purposes of section 2201, the term "continuation coverage" means coverage under the plan which meets the following requirements:

(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to

whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part [1] in connection with such group.

(2) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(A) MAXIMUM REQUIRED PERIOD.—

(i) GENERAL RULE FOR TERMINATIONS AND REDUCED HOURS.—In the case of a qualifying event described in section 2203(2), except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

(ii) SPECIAL RULE FOR MULTIPLE QUALIFYING EVENTS.—If a qualifying event occurs during the 18 months after the date of a qualifying event described in section 2203(2), the date which is 36 months after the date of the qualifying event described in section 2203(2).

(iii) GENERAL RULE FOR OTHER QUALIFYING EVENTS.—In the case of a qualifying event not described in section 2203(2), the date which is 36 months after the date of the qualifying event.

(iv) SPECIAL RULE FOR TAA-ELIGIBLE INDIVIDUALS.—In the case of a qualifying event described in section 2203(2) with respect to a covered employee who is (as of the date that the period of coverage would, but for this clause or clause (v), otherwise terminate under clause (i) or (ii)) a TAA-eligible individual (as defined in section 2205(b)(4)(B)), the period of coverage shall not terminate by reason of clause (i) or (ii), as the case may be, before the later of the date specified in such clause or the date on which such individual ceases to be such a TAA-eligible individual. The preceding sentence shall not require any period of coverage to extend beyond January 1, 2014.

(v) MEDICARE ENTITLEMENT FOLLOWED BY QUALIFYING EVENT.—In the case of a qualifying event described in section 2203(2) that occurs less than 18 months after the date the covered employee became entitled to benefits under title XVIII of the Social Security Act, the period of coverage for qualified beneficiaries other than the covered employee shall not terminate under this subparagraph before the close of the 36-month period beginning on the date the covered employee became so entitled.

(vi) SPECIAL RULE FOR DISABILITY.—In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continuation coverage under this title, any reference in clause

[1] So in law. This title is not divided into parts.

(i) or (ii) to 18 months with respect to such event[2] is deemed a reference to 29 months (with respect to all qualified beneficiaries), but only if the qualified beneficiary has provided notice of such determination under section 2206(3) before the end of such 18 months.

(B) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

(C) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

(D) GROUP HEALTH PLAN COVERAGE OR MEDICARE ENTITLEMEMT.—The date on which the qualified beneficiary first becomes, after the date of the election—

(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of the Internal Revenue Code of 1986, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of this Act), or

(ii) entitled to benefits under title XVIII of the Social Security Act.

(E) TERMINATION OF EXTENDED COVERAGE FOR DISABILITY.—In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this title, the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

(3) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

(A) shall not exceed 102 percent of the applicable premium for such period, and

(B) may, at the election of the payor, be made in monthly installments.

In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to "102 percent" is deemed a reference to "150

[2] Section 421(a)(1)(A)(ii)(III) of Public Law 104–191 (110 Stat. 2087) provides that the last sentence of subparagraph (A) is amended by striking "with respect to such event,". The amendment cannot be executed because the term to be struck does not appear. (Compare "with respect to such event," and "with respect to such event".)

percent" for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).

(4) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(5) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

SEC. 2203. [300bb–3] QUALIFYING EVENT.

For purposes of this title, the term "qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this title, would result in the loss of coverage of a qualified beneficiary:

(1) The death of the covered employee.

(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

(3) The divorce or legal separation of the covered employee from the employee's spouse.

(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

SEC. 2204. [300bb–4] APPLICABLE PREMIUM.

For purposes of this title—

(1) IN GENERAL.—The term "applicable premium" means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

(2) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

(i) is determined on an actuarial basis, and

(ii) takes into account such factors as the Secretary may prescribe in regulations.

(B) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

(3) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

SEC. 2205. [300bb–5] ELECTION.

(a) IN GENERAL.—For purposes of this title—

(1) ELECTION PERIOD.—The term "election period" means the period which—

(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

(B) is of at least 60 days' duration, and

(C) ends not earlier than 60 days after the later of—

(i) the date described in subparagraph (A), or

(ii) in the case of any qualified beneficiary who receives notice under section 2206(4), the date of such notice.

(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 2208(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

(b) TEMPORARY EXTENSION OF COBRA ELECTION PERIOD FOR CERTAIN INDIVIDUALS.—

(1) IN GENERAL.—In the case of a nonelecting TAA-eligible individual and notwithstanding subsection (a), such individual may elect continuation coverage under this title during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual, but only if such election is made not later than 6 months after the date of the TAA-related loss of coverage.

(2) COMMENCEMENT OF COVERAGE; NO REACH-BACK.—Any continuation coverage elected by a TAA-eligible individual under paragraph (1) shall commence at the beginning of the

60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.

(3) PREEXISTING CONDITIONS.—With respect to an individual who elects continuation coverage pursuant to paragraph (1), the period—

(A) beginning on the date of the TAA-related loss of coverage, and

(B) ending on the first day of the 60-day election period described in paragraph (1),

shall be disregarded for purposes of determining the 63-day periods referred to in section 2701(c)(2), section 701(c)(2) of the Employee Retirement Income Security Act of 1974, and section 9801(c)(2) of the Internal Revenue Code of 1986.

(4) DEFINITIONS.—For purposes of this subsection:

(A) NONELECTING TAA-ELIGIBLE INDIVIDUAL.—The term "nonelecting TAA-eligible individual" means a TAA-eligible individual who—

(i) has a TAA-related loss of coverage; and

(ii) did not elect continuation coverage under this part during the TAA-related election period.

(B) TAA-ELIGIBLE INDIVIDUAL.—The term "TAA-eligible individual" means—

(i) an eligible TAA recipient (as defined in paragraph (2) of section 35(c) of the Internal Revenue Code of 1986), and

(ii) an eligible alternative TAA recipient (as defined in paragraph (3) of such section).

(C) TAA-RELATED ELECTION PERIOD.—The term "TAA-related election period" means, with respect to a TAA-related loss of coverage, the 60-day election period under this part which is a direct consequence of such loss.

(D) TAA-RELATED LOSS OF COVERAGE.—The term "TAA-related loss of coverage" means, with respect to an individual whose separation from employment gives rise to being an TAA-eligible individual, the loss of health benefits coverage associated with such separation.

SEC. 2206. [300bb–6] NOTICE REQUIREMENTS.

In accordance with regulations prescribed by the Secretary—

(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection, [3]

(2) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in paragraph (1), (2), or (4) of section 2203 within 30 days of the date of the qualifying event,

(3) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 2203 within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at

[3] So in law. Probably should be "this title".

any time during the first 60 days of continuation coverage under this title is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

(4) the plan administrator shall notify—

(A) in the case of a qualifying event described in paragraph (1), (2), or (4) of section 2203, any qualified beneficiary with respect to such event, and

(B) in the case of a qualifying event described in paragraph (3) or (5) of section 2203 where the covered employee notifies the plan administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection. [4]

For purposes of paragraph (4), any notification shall be made within 14 days of the date on which the plan administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

SEC. 2207. [5] **[300bb–7] ENFORCEMENT.**

Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of this title may bring an action for appropriate equitable relief.

SEC. 2208. [300bb–8] DEFINITIONS.

For purposes of this title—

(1) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given such term in 5000(b) [6] of the Internal Revenue Code of 1986. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code). Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).

(2) COVERED EMPLOYEE.—The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (in-

[4] So in law. Probably should be "this title".

[5] Section 13631(d) of Public Law 103-66 (107 Stat. 643) provides as follows:

(d) CONTINUED COVERAGE OF COSTS OF A PEDIATRIC VACCINE UNDER CERTAIN GROUP HEALTH PLANS.—

(1) REQUIREMENT.—The requirement of this paragraph, with respect to a group health plan for plan years beginning after the date of the enactment of this Act, is that the group health plan not reduce its coverage of the costs of pediatric vaccines (as defined under section 1928(h)(6) of the Social Security Act) below the coverage it provided as of May 1, 1993.

(2) ENFORCEMENT.—For purposes of section 2207 of the Public Health Service Act, the requirement of paragraph (1) is deemed a requirement of title XXII of such Act.

[6] So in law. The word "section" does not appear. See section 102(d) of Public Law 104–191 (110 Stat. 1978).

cluding as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986).

(3) QUALIFIED BENEFICIARY.—

(A) IN GENERAL.—The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

(i) as the spouse of the covered employee, or

(ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this title.[7]

(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 2203(2), the term "qualified beneficiary" includes the covered employee.

(4) PLAN ADMINISTRATOR.—The term "plan administrator" has the meaning given the term "administrator" by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

[7] Indentation is so in law. See section 401(a)(3) of Public Law 104–191 (110 Stat. 2085).