(i) Section 13 (relating to application forms and replacement coverage).

(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

(iii) Section 20 (relating to filing requirements for marketing).

(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance contract, misrepresent a material fact; and

(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

(v) Section 22 (relating to appropriateness of recommended purchase).

(vi) Section 24 (relating to standard format outline of coverage).

(vii) Section 25 (relating to requirement to deliver shopper's guide).

(B) Model Act

The following requirements of the model Act must be met:

(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

(ii) Section 6G (relating to outline of coverage).

(iii) Section 6H (relating to requirements for certificates under group plans).

(iv) Section 6I (relating to policy summary).

(v) Section 6J (relating to monthly reports on accelerated death benefits).

(vi) Section 7 (relating to incontestability period).

(C) Definitions

For purposes of this paragraph, the terms ''model regulation'' and ''model Act'' have the meanings given such terms by section 7702B(g)(2)(B).

(2) Delivery of policy

If an application for a qualified long-term care insurance contract (or for a certificate under such a contract for a group) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the contract (or certificate) of insurance not later than 30 days after the date of the approval.

(3) Information on denials of claims

If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

(A) provide a written explanation of the reasons for the denial, and

(B) make available all information directly relating to such denial.

(d) Disclosure

The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

(e) Qualified long-term care insurance contract defined

For purposes of this section, the term ''qualified long-term care insurance contract'' has the meaning given such term by section 7702B.

(f) Coordination with State requirements

If a State imposes any requirement which is more stringent than the analogous requirement imposed by this section or section 7702B(g), the requirement imposed by this section or section 7702B(g) shall be treated as met if the more stringent State requirement is met.

(Added Pub. L. 104–191, title III, §326(a), Aug. 21, 1996, 110 Stat. 2065.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 104–191, title III, §327, Aug. 21, 1996, 110 Stat. 2066, provided that:

''(a) IN GENERAL.—The provisions of, and amendments made by, this part [part II (§§325–327) of subtitle C of title III of Pub. L. 104–191, enacting this section and amending section 7702B of this title] shall apply to contracts issued after December 31, 1996. The provisions of section 321(f) [set out as an Effective Date note under section 7702B of this title] (relating to transition rule) shall apply to such contracts.

''(b) ISSUERS.—The amendments made by section 326 [enacting this section] shall apply to actions taken after December 31, 1996.''

§4980D. Failure to meet certain group health plan requirements

(a) General rule

There is hereby imposed a tax on any failure of a group health plan to meet the requirements of chapter 100 (relating to group health plan requirements).

(b) Amount of tax

(1) In general

The amount of the tax imposed by subsection (a) on any failure shall be $100 for each day in the noncompliance period with respect to each individual to whom such failure relates.

(2) Noncompliance period

For purposes of this section, the term ''noncompliance period'' means, with respect to any failure, the period—

(A) beginning on the date such failure first occurs, and

(B) ending on the date such failure is corrected.

(3) Minimum tax for noncompliance period where failure discovered after notice of examination

Notwithstanding paragraphs (1) and (2) of subsection (c)—

(A) In general

In the case of 1 or more failures with respect to an individual—

(i) which are not corrected before the date a notice of examination of income tax liability is sent to the employer, and

(ii) which occurred or continued during the period under examination,

the amount of tax imposed by subsection (a) by reason of such failures with respect to such individual shall not be less than the lesser of $2,500 or the amount of tax which would be imposed by subsection (a) without regard to such paragraphs.

(B) Higher minimum tax where violations are more than de minimis

To the extent violations for which any person is liable under subsection (e) for any year are more than de minimis, subparagraph (A) shall be applied by substituting ''$15,000'' for ''$2,500'' with respect to such person.

(C) Exception for church plans

This paragraph shall not apply to any failure under a church plan (as defined in section 414(e)).

(c) Limitations on amount of tax

(1) Tax not to apply where failure not discovered exercising reasonable diligence

No tax shall be imposed by subsection (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 tax did not know, and exercising reasonable diligence would not have known, that such failure existed.

(2) Tax not to apply to failures corrected within certain periods

No tax shall be imposed by subsection (a) on any failure if—

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

(B)(i) in the case of a plan other than a church plan (as defined in section 414(e)), such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such tax knew, or exercising reasonable diligence would have known, that such failure existed, and

(ii) in the case of a church plan (as so defined), such failure is corrected before the close of the correction period (determined under the rules of section 414(e)(4)(C)).

(3) Overall limitation for unintentional failures

In the case of failures which are due to reasonable cause and not to willful neglect—

(A) Single employer plans

(i) In general

In the case of failures with respect to plans other than specified multiple employer health plans, the tax imposed by subsection (a) for failures during the taxable year of the employer 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.

(ii) Taxable years in the case of certain controlled groups

For purposes of this subparagraph, if not all persons who are treated as a single employer for purposes of this section have the same taxable year, the taxable years taken into account shall be determined under principles similar to the principles of section 1561.

(B) Specified multiple employer health plans

(i) In general

In the case of failures with respect to a specified multiple employer health plan, the tax imposed by subsection (a) for failures during the taxable year of the trust forming part of such plan shall not exceed the amount equal to the lesser of—

(I) 10 percent of the amount paid or incurred by such trust during such taxable year to provide medical care (as defined in section 9832(d)(3)) directly or through insurance, reimbursement, or otherwise, or

(II) $500,000.

For purposes of the preceding sentence, all plans of which the same trust forms a part shall be treated as one plan.

(ii) Special rule for employers required to pay tax

If an employer is assessed a tax imposed by subsection (a) by reason of a failure with respect to a specified multiple employer health plan, the limit shall be determined under subparagraph (A) (and not under this subparagraph) and as if such plan were not a specified multiple employer health plan.

(4) 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 tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

(d) Tax not to apply to certain insured small employer plans

(1) In general

In the case of a group health plan of a small employer which provides health insurance coverage solely through a contract with a health insurance issuer, no tax shall be imposed by this section on the employer on any failure (other than a failure attributable to section 9811) which is solely because of the health insurance coverage offered by such issuer.

(2) Small employer

(A) In general

For purposes of paragraph (1), the term ''small employer'' means, with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (*o*) of section 414 shall be treated as one employer.

(B) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) Predecessors

Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(3) Health insurance coverage; health insurance issuer

For purposes of paragraph (1), the terms ''health insurance coverage'' and ''health insurance issuer'' have the respective meanings given such terms by section 9832.

(e) Liability for tax

The following shall be liable for the tax imposed by subsection (a) on a failure:

(1) Except as otherwise provided in this subsection, the employer.

(2) In the case of a multiemployer plan, the plan.

(3) In the case of a failure under section 9803 (relating to guaranteed renewability) with respect to a plan described in subsection (f)(2)(B), the plan.

(f) Definitions

For purposes of this section—

(1) Group health plan

The term ''group health plan'' has the meaning given such term by section 9832(a).

(2) Specified multiple employer health plan

The term ''specified multiple employer health plan'' means a group health plan which is—

(A) any multiemployer plan, or

(B) any multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section).

(3) Correction

A failure of a group health plan shall be treated as corrected if—

(A) such failure is retroactively undone to the extent possible, and

(B) the person to whom the failure relates is placed in a financial position which is as good as such person would have been in had such failure not occurred.

(Added Pub. L. 104–191, title IV, §402(a), Aug. 21, 1996, 110 Stat. 2084; amended Pub. L. 105–34, title XV, §1531(b)(2), Aug. 5, 1997, 111 Stat. 1085; Pub. L. 109–135, title IV, §412(ww), Dec. 21, 2005, 119 Stat. 2640.)

Editorial Notes

REFERENCES IN TEXT

Section 3(40) of the Employee Retirement Income Security Act of 1974, referred to in subsec. (f)(2)(B), is classified to section 1002(40) of Title 29, Labor.

The date of the enactment of this section, referred to in subsec. (f)(2)(B), is the date of enactment of Pub. L. 104–191, which was approved Aug. 21, 1996.

AMENDMENTS

2005—Subsec. (a). Pub. L. 109–135 substituted ''plan requirements'' for ''plans requirements''.

1997—Subsec. (a). Pub. L. 105–34, §1531(b)(2)(A), substituted ''plans'' for ''plan portability, access, and renewability''.

Subsec. (c)(3)(B)(i)(I). Pub. L. 105–34, §1531(b)(2)(B), substituted ''9832(d)(3)'' for ''9805(d)(3)''.

Subsec. (d)(1). Pub. L. 105–34, §1531(b)(2)(C), inserted ''(other than a failure attributable to section 9811)'' after ''on any failure''.

Subsec. (d)(3). Pub. L. 105–34, §1531(b)(2)(D), substituted ''section 9832'' for ''section 9805''.

Subsec. (f)(1). Pub. L. 105–34, §1531(b)(2)(E), substituted ''section 9832(a)'' for ''section 9805(a)''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–34, title XV, §1531(c), Aug. 5, 1997, 111 Stat. 1085, provided that: ''The amendments made by this section [enacting sections 9811 and 9812 of this title, amending this section and sections 9801 and 9831 of this title, and renumbering sections 9804 to 9806 of this title as sections 9831 to 9833 of this title] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.''

EFFECTIVE DATE

Pub. L. 104–191, title IV, §402(c), Aug. 21, 1996, 110 Stat. 2087, provided that: ''The amendments made by this section [enacting this section] shall apply to failures under chapter 100 of the Internal Revenue Code of 1986 (as added by section 401 of this Act).''

§4980E. Failure of employer to make comparable Archer MSA contributions

(a) General rule

In the case of an employer who makes a contribution to the Archer MSA of any employee with respect to coverage under a high deductible health plan of the employer during a calendar year, there is hereby imposed a tax on the failure of such employer to meet the requirements of subsection (d) for such calendar year.

(b) Amount of tax

The amount of the tax imposed by subsection (a) on any failure for any calendar year is the amount equal to 35 percent of the aggregate amount contributed by the employer to Archer MSAs of employees for taxable years of such employees ending with or within such calendar year.