new mandate on any party regarding health insurance coverage, see section 203(f) of Pub. L. 107–210, set out as a Construction note under section 35 of this title.

NOTIFICATION OF CHANGES IN CONTINUATION COVERAGE

Pub. L. 104–191, title IV, §421(e), Aug. 21, 1996, 110 Stat. 2089, provided that: ''Not later than November 1, 1996, each group health plan (covered under title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.], part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1161 et seq.], and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section [amending this section, sections 1162, 1166, and 1167 of Title 29, Labor, and sections 300bb–2, 300bb–6, and 300bb–8 of Title 42, The Public Health and Welfare].''

### § 4980C. Requirements for issuers of qualified long-term care insurance contracts

**(a) General rule**

There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

**(b) Amount**

**(1) In general**

The amount of the tax imposed by subsection (a) shall be $100 per insured for each day any requirement of subsection (c) or (d) is not met with respect to each qualified long-term care insurance contract.

**(2) Waiver**

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 payment of the tax would be excessive relative to the failure involved.

**(c) Responsibilities**

The requirements of this subsection are as follows:

**(1) Requirements of model provisions**

**(A) Model regulation**

The following requirements of the model regulation must be met:

(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.)

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,