I

103D CONGRESS
1ST SESSION

H. R. 1526

To limit discrimination in health insurance coverage based on health status or past claims experience and to reform the provision of health coverage to small employer groups.

IN THE HOUSE OF REPRESENTATIVES

Mr. DURBIN (for himself, Mr. REYNOLDS, Mr. SMITH of New Jersey, Mrs. BYRNE, Mr. HASTINGS, and Mr. PASTOR) introduced the following bill; which was referred jointly to the Committees on Ways and Means, and Energy and Commerce

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A BILL

To limit discrimination in health insurance coverage based on health status or past claims experience and to reform the provision of health coverage to small employer groups.

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 ''Health Insurance Fairness Act of 1993''.

SEC. 2. HEALTH PLAN STANDARDS.

The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—HEALTH PLAN STANDARDS

''PART A—INDIVIDUAL HEALTH PLANS

"SEC. 2101. PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS FOR COVERAGE, BENEFITS, AND PREMIUMS.

''(a) IN GENERAL.—Except as provided under subsection (b), an individual health plan, and any person which issues such a plan, may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to health services, or vary the premiums charged for such coverage, based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

''(b) EXCEPTION FOR CERTAIN PRE-EXISTING CONDITIONS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, individual health plans may exclude coverage of services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 24 months. The exclusion of coverage shall not apply to services furnished to newborns who are covered at the time of birth.

''(2) CREDITING OF PREVIOUS COVERAGE.—

''(A) IN GENERAL.—An individual health plan shall provide that if an individual under such plan is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of application for coverage under such plan (determined without regard to any waiting period under such plan), any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

''(B) DEFINITIONS.—As used in this subsection:

''(i) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under an individual or group health plan or under title XVIII or XIX of the Social Security Act which provides substantially the same or similar benefits with respect to such services and ends on the date the individual is

not so enrolled for a continuous period of more than 3 months.

''(ii) PREEXISTING CONDITION.—The term 'preexisting condition' means a condition which has been diagnosed or treated during the 1-year period ending on the day before the first date of such coverage.

''(3) EXCEPTION.—

''(A) IN GENERAL.—Subsection (a) shall not affect an individual health plan's variation of premiums based only on the age, sex, or geographic area of residence of an individual.

''(B) WAITING PERIOD.—An individual health plan may offer to an individual to waive an exclusion of coverage with respect to a preexisting condition for which an exclusion could otherwise be applied under this subsection in exchange for an increase in the premium during the period in which the exclusion could otherwise be applied. If the individual rejects this offer, the limitations on premiums and exclusions that would apply in the absence of such offer shall continue to apply.

''PART B—GROUP HEALTH PLANS

''Subpart 1—Prohibition of Discrimination Based on Health Status

"SEC. 2111. PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS FOR COVERAGE, BENEFITS, AND PREMIUMS.

''(a) IN GENERAL.—Except as provided under subsection (b), a group health plan, and any person which issues such a plan, may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to health services, or vary the premiums charged for such coverage, based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

''(b) EXCEPTION FOR CERTAIN PRE-EXISTING CONDITIONS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, group health plans may exclude coverage of services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns who are covered at the time of birth.

''(2) CREDITING OF PREVIOUS COVERAGE.—

''(A) IN GENERAL.—A group health plan shall provide that if an individual under such plan is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of coverage under such plan (determined without regard to any waiting period under such plan), any period of exclusion of coverage with respect to a pre-existing condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

''(B) DEFINITIONS.—As used in this subsection:

''(i) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under an individual or group health plan or title XVIII or XIX of the Social Security Act which provides substantially the same or similar benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

''(ii) PREEXISTING CONDITION.—The term 'preexisting condition' means a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage.

"SEC. 2112. PROHIBITION OF RATE VARIATION IN GROUP HEALTH PLANS BASED ON HEALTH STATUS.

''A person that issues a group health plan with respect to a group may not vary premiums charged for coverage with respect to health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of a member of the group.

''Subpart 2—Requirements for Health Plans Issued to Small Employers

"SEC. 2121. GENERAL REQUIREMENTS FOR HEALTH PLANS ISSUED TO SMALL EMPLOYERS.

''(a) REGISTRATION.—Each insurer (as defined in section 2133(b)(1)) shall register with the Secretary and with any applicable regulatory authority for each State in which it issues or offers a health plan to small employers.

''(b) GUARANTEED ELIGIBILITY.—

''(1) IN GENERAL.—No insurer may exclude from coverage under a health plan any eligible employee, the spouse or any dependent child of the eli-

gible employee to whom coverage is made available by a small employer.

''(2) WAITING PERIODS.—Paragraph (1) shall not apply to any period an eligible employee is excluded from coverage under the health plan solely by reason of a requirement applicable to all employees that a minimum period of service with the small employer is required before the employee is eligible for such coverage.

''(c) GUARANTEED ISSUE.—

''(1) IN GENERAL.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, an insurer that offers a health plan to small employers in a geographic area in a community must offer the same plan to any other small employer located in the area. Such requirement shall apply on a continuous, year-round basis.

''(B) STATE ALTERNATIVE.—Subparagraph (A) shall not apply to a community in a State if the Secretary certifies that the State has implemented an alternative approach for assuring the availability for all small employers in the community of health insurance that provides the same benefits at the same premium as

would have applied if subparagraph (A) had continued to apply.

''(2) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—

''(A) GEOGRAPHIC LIMITATIONS.—A health maintenance organization may deny enrollment to employees (and family members) of a small employer if the employees are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.

''(B) SIZE LIMITS.—A health maintenance organization may apply to the Secretary to cease enrolling new small employer groups in its health plan (or in a geographic area served by the plan) if—

''(i) it ceases to enroll any new employer groups, and

''(ii) it can demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be im-

paired if it is required to enroll new employer groups.

''(3) GROUNDS FOR REFUSAL TO RENEW.—

''(A) IN GENERAL.—An insurer may refuse to renew, or may terminate, a health plan under this subpart only for—

''(i) nonpayment of premiums,

''(ii) fraud or misrepresentation,

''(iii) failure to maintain minimum participation rates (consistent with subparagraph (B)), or

''(iv) in the case of a managed care plan, the employer leaves the geographic service area of the plan.

''(B) MINIMUM PARTICIPATION RATES.—An insurer may require, with respect to a health plan issued to a small employer, that a minimum percentage of eligible employees who do not otherwise have health insurance are enrolled in such plan, so long as such percentage is enforced uniformly for all plans offered to employers of comparable size.

''(d) MINIMUM PLAN PERIOD.—An insurer may not offer to, or issue with respect to, a small employer a health plan with a term of less than 12 months.

''(e) NOTICES AND RENEWAL PERIODS.—

''(1) NOTICE ON EXPIRATION.—An insurer providing health plans to small employers shall provide for notice, at least 60 days before the date of expiration of the health plan, of the terms for renewal of the plan. Except with respect to rates and administrative changes, the terms of renewal (including benefits) shall be the same as the terms of issuance.

''(2) PERIOD OF RENEWAL.—The period of renewal of each small employer health plan shall be for a period of not less than 12 months.

''(f) GUARANTEED RENEWABILITY.—

''(1) IN GENERAL.—

''(A) GENERAL RULE.—Subject to the succeeding provisions of this subsection, an insurer shall ensure that a health plan issued to a small employer be renewed, at the option of the small employer, unless the plan is terminated for a reason specified in subparagraph (B) or in subsection (c)(3)(A).

''(B) TERMINATION OF SMALL EMPLOYER BUSINESS.—An insurer need not renew a health plan with respect to a small employer if the insurer—

''(i) elects not to renew all of its health plans issued to small employers in a State; and

''(ii) provides notice to the Secretary, any applicable regulatory authority in the State, and to each small employer covered under the plan of such termination at least 180 days before the date of expiration of the plan.

In the case of such a termination, the insurer may not provide for issuance of any health plan to a small employer in the State during the 5-year period beginning on the date of termination of the last plan not so renewed.

"SEC. 2122. REQUIREMENTS RELATED TO RESTRICTIONS ON RATING PRACTICES.

''(a) LIMIT ON VARIATION OF REFERENCE PREMIUM RATES BETWEEN BLOCKS OF BUSINESS.—

''(1) IN GENERAL.—The index rate for any block of business of an insurer may not exceed the index rate for any other block of business by more than 20 percent.

''(2) EXCEPTIONS.—Paragraph (1) shall not apply to a block of business if—

''(A) the block is one for which the insurer does not reject, and never has rejected, small employers included within the definition of employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claims experience, health status, industry, or occupation,

''(B) the insurer does not transfer, and never has transferred, a health plan involuntarily into or out of the block of business, and

''(C) the block of business is currently available for purchase at the time an exception to paragraph (1) is sought by the insurer.

''(b) USE OF COMMUNITY RATING IN PREMIUM RATES WITHIN A BLOCK OF BUSINESS.—

''(1) LIMITING VARIATIONS ON PREMIUM TO AGE AND SEX.—Subject to paragraph (5), the reference premium rate charged for a health plan offered to small employers within a community (as defined under the plan consistent with paragraph (3)) with similar benefits for a type of family enrollment (described in paragraph (4)) shall be the same for all small employers in the same block of business in the community.

''(2) AGE AND SEX ADJUSTMENT TO COMMUNITY-RATING.—

''(A) IN GENERAL.—Subject to subparagraph (B), a health plan offered to a small employer may provide for an adjustment to the reference premium rate based on age and gender of covered individuals. Any such adjustment shall be applied consistently to all small employers.

''(B) LIMITATION ON ADJUSTMENT.—The adjustment under subparagraph (A) may not result, with respect to health plans with similar benefits in a community in a block of business, in premium rates that vary from the index rate by more than 25 percent of the index rate.

''(3) SPECIFICATION OF COMMUNITY.—For purposes of paragraph (1), no insurer may use a geographic area that is smaller than a metropolitan statistical area as a community.

''(4) TYPES OF FAMILY ENROLLMENT.—Each health plan offered to a small employer shall permit enrollment of (and shall compute premiums separately for) individuals based on each of the following beneficiary classes:

''(A) 1 adult.

''(B) A married couple without children.

''(C) A married couple with 1 or more children, or 1 adult with 1 or more children.

''(5) ADDITIONAL VARIATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), a health plan offered to a small employer may provide for an adjustment to premium rates based on features of the plan that involve the use of managed care, the pursuit of healthy lifestyles, and other factors within the control of plan beneficiaries that cut costs by reducing the need for health care services and not by reducing the benefits associated with such services. Any such adjustment shall be applied consistently to all small employers.

''(B) LIMITATION ON ADJUSTMENT.—The adjustment under subparagraph (A) may not result, with respect to health plans with similar benefits in a community in a block of business with respect to an age and gender class of covered individuals, in premium rates that vary from the rate described in subparagraph (C) by more than 25 percent of such rate.

''(C) RATE.—For purposes of subparagraph (B), the rate described in this paragraph,

for an age and gender class of covered individuals within a block of business for each rating period in a community, is 133⅓ percent of the lowest premium rate charged or which could have been charged for individuals in such class by the insurer under a rating system for that block of business to small employers in the community for health plans with the same or similar coverage.

''(c) LIMIT ON TRANSFER OF EMPLOYERS AMONG BLOCKS OF BUSINESS.—

''(1) An insurer may not transfer a small employer from one block of business to another without the consent of the employer.

''(2) An insurer may not offer to transfer a small employer from one block of business to another unless—

''(A) the offer is made without regard to age, sex, geography, claims experience, health status, industry, occupation or the date on which the policy was issued, and

''(B) the same offer is made to all other small employers in the same block of business.

''(d) LIMITS ON VARIATION IN PREMIUM INCREASES.—The percentage increase in the premium rate

charged to a small employer for a new rating period (determined on an annual basis) may not exceed the sum of the percentage change in the base premium rate plus 5 percentage points.

''(e) DEFINITIONS.—In this section:

''(1) BLOCK OF BUSINESS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'block of business' means, with respect to an insurer, all of the small employers with a health plan issued by the insurer (as shown on the records of the insurer).

''(B) DISTINCT GROUPS.—A distinct group of small employers with health plans issued by an insurer may be treated as a block of business by such insurer if all of the plans in such group—

''(i) are marketed primarily by direct mail or are not marketed primarily by direct mail,

''(ii) have been acquired from another insurer as a distinct group, or

''(iii) are provided through an association with membership of not less than 25 small employers that has been formed for

purposes other than obtaining health insurance.

''(2) INDEX RATE.—The term 'index rate' means, with respect to a block of business, 133⅓ percent of the reference premium rate for the block of business.

''(3) REFERENCE PREMIUM RATE.—The term 'reference premium rate' means, for each block of business for each rating period in a community, the lowest premium rate charged or which could have been charged, for the most favorable actuarial class, by the insurer under a rating system for that block of business to small employers in the community for health plans with the same or similar coverage. Such a rate shall be determined without regard to an adjustment under subsection (b)(5).

''(f) FULL DISCLOSURE OF RATING PRACTICES.—

''(1) IN GENERAL.—At the time an insurer offers a health plan to a small employer, the insurer shall fully disclose to the employer all of the following:

''(A) Rating practices for small employer health plans, including rating practices for different populations and benefit designs.

''(B) The extent to which premium rates for the small employer are established or adjusted based upon the actual or expected variation in claims costs or health condition of the employees and of such small employer and their dependents.

''(C) The provisions concerning the insurer's right to change premium rates, the extent to which premiums can be modified, and the factors which affect changes in premium rates.

''(2) NOTICE ON EXPIRATION.—An insurer providing health plans to small employers shall provide for notice, at least 60 days before the date of expiration of the health plan, of the terms for renewal of the plan.

''(g) ACTUARIAL CERTIFICATION.—Each insurer shall file annually with the Secretary and any applicable regulatory authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such authority) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for small employer health plans—

''(1) the insurer is in compliance with the applicable provisions of this section, and

''(2) the rating methods are actuarially sound.

Each insurer shall retain a copy of such statement for examination at its principal place of business.

''PART C—ESTABLISHMENT OF STANDARDS; DEFINITIONS

"SEC. 2131. STANDARDS AND REQUIREMENTS.

''(a) APPROVAL REQUIRED.—

''(1) IN GENERAL.—No individual or group policy may be issued under a health plan (as defined in section 2133(a)) on or after the effective date specified in subsection (d) (and no new contract may be offered under such plan with respect to any small employer beginning on or after such effective date) unless the plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) or approved by a State regulatory program (approved under subsection (b)) as meeting the applicable standards established under section 2132 by such effective date.

''(2) PLAN DISAPPROVED.—If the Secretary determines that a health plan does not meet such applicable standards on or after such effective date, no coverage may be provided under the plan to individ-

uals not enrolled as of the date of the determination and the plan may not be continued for plan years beginning after the date of such determination until the Secretary determines that such plan is in compliance with such standards.

''(b) CERTIFIED BY STATE APPROVED PROGRAMS.—

''(1) IN GENERAL.—If the Secretary determines that a State has in effect an effective regulatory program for the application of the standards established under section 2132 to health plans, the Secretary may approve such program for purposes of certification of health plans under this part.

''(2) ANNUAL REPORTS.—As a condition for the continued approval of such a regulatory program, the State shall report to the Secretary annually such information as the Secretary may require with respect to the performance of the program. Such information shall include the health plans certified under the program, the compliance of such plans with the standards established under section 2132, and enforcement actions taken to ensure such compliance.

''(3) PERIODIC SECRETARIAL REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary annually shall review State regulatory programs approved under paragraph (1) to determine if they continue to

meet and enforce the standards for approval. If the Secretary initially determines that a State regulatory program no longer meets such standards, the Secretary shall provide the State an opportunity to adopt such a plan of correction that would bring such program into compliance with such standards. If the Secretary makes a final determination that the State regulatory program fails to meet and enforce such standards after such an opportunity, the Secretary shall disapprove such program and reassume responsibility for certification of all health plans in that State.

''(4) GAO AUDITS.—The Comptroller General shall conduct periodic reviews on a sample of State regulatory programs approved under paragraph (1) to determine their compliance with the requirements of such paragraph. The Comptroller General shall report to the Secretary and Congress on the findings of such reviews.

''(c) EXCISE TAX SANCTIONS.—For application of excise tax in the case of a nonconforming plan, see section 5000A of the Internal Revenue Code of 1986.

''(d) EFFECTIVE DATE.—The effective date specified in this subsection is—

''(1) January 1, 1994, with respect to the standards established to carry out section 2111,

''(2) January 1, 1995, with respect to the standards established to carry out part A, section 2112, and section 2121, and

''(3) January 1, 1996, with respect to the standards established to carry out section 2122, applicable to premiums for months beginning with January 1996.

''SEC. 2132. ESTABLISHMENT OF STANDARDS.

''(a) ESTABLISHMENT OF STANDARDS.—The Secretary shall develop, establish, and publish, by not later than 3 months before the respective effective date specified under section 2131(d), specific standards to implement the requirements of parts A and B and to be applied under section 5000A of the Internal Revenue Code of 1986.

''(b) MORE STRINGENT STATE STANDARDS PERMITTED.—A State may implement standards that are more stringent than the standards established under this section to meet the requirements under parts A and B.

''(c) TELEPHONE INFORMATION SYSTEM.—The Secretary shall provide for the establishment of a toll-free telephone information and complaint system which provides for—

''(1) a system for the receipt and disposition of consumer complaints or inquiries regarding compliance of health plans with the standards, and

''(2) information to small employers about insurers in the area of the employers that offer health plans that meet the standards.

"SEC. 2133. DEFINITIONS.

''(a) HEALTH PLAN; GROUP HEALTH PLAN; INDIVIDUAL HEALTH PLAN.—As used in this title:

''(1) HEALTH PLAN.—The term 'health plan' means any hospital or medical service policy or certificate, hospital or medical service plan contract, health maintenance organization group contract, or a multiple employer welfare arrangement, but—

''(A) does not include any of the following offered by an insurer—

''(i) accident only, vision only, dental only, disability only, or long-term care only insurance,

''(ii) coverage issued as a supplement to liability insurance,

''(iii) workmen's compensation or similar insurance,

''(iv) automobile medical-payment insurance, or

''(v) a medicare supplemental policy; and

''(B) for purposes of subpart 2 of part B only, does not include a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

''(2) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1) of the Internal Revenue Code of 1986.

''(3) INDIVIDUAL HEALTH PLAN.—The term 'individual health plan' means a health plan which is not a group health plan.

''(b) INSURER AND HEALTH MAINTENANCE ORGANIZATION.—As used in this title:

''(1) INSURER.—The term 'insurer' means any person that offers to provide coverage under a health plan to a small employer.

''(2) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' has the meaning given the term 'eligible organization' in section 1876(b).

''(c) GENERAL DEFINITIONS.—As used in this title:

''(1) APPLICABLE REGULATORY AUTHORITY.—The term 'applicable regulatory authority' means,

with respect to a health plan in a State with a regulatory program approved under section 2131(b), the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance.

''(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 51 eligible employees on a typical business day. For the purposes of this paragraph, the term 'employee' includes a self-employed individual. Section 5000A(b)(3) of the Internal Revenue Code of 1986 shall apply for purposes of the preceding sentence.

''(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 17½ hours of service per week for that employer.''.

SEC. 3. EXCISE TAX ON PREMIUMS RECEIVED ON HEALTH PLANS WHICH DO NOT MEET CERTAIN REQUIREMENTS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to taxes on group health plans)

is amended by adding at the end thereof the following new section:

"SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH PLANS.

''(a) GENERAL RULE.—

''(1) TITLE XXI STANDARDS.—

''(A) TAX.—In the case of any health plan, there is hereby imposed a tax on the failure of the plan (or the person issuing the plan) to meet at any time during any taxable year the applicable standards established under section 2131 of title XXI of the Social Security Act.

''(B) DETERMINATION OF VIOLATIONS.—The Secretary of Health and Human Services shall determine whether a plan or person meets the standards requirements of such title.

''(2) SMALL EMPLOYER SELF-INSURING FOR HEALTH BENEFITS.—In the case of a small employer, there is hereby imposed a tax on expenditures for a health plan that is not an insured health plan.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—

''(A) TITLE XXI STANDARDS.—The amount of tax imposed by subsection (a)(1) by

reason of 1 or more failures during a taxable year shall be equal to 25 percent of the gross premiums received during such taxable year with respect to all health plans issued by the person on whom such tax is imposed (or in the case of a violation of a standard established with respect to a requirement of subpart 2 of part B of title XXI of the Social Security Act issued by the person to small employers).

''(B) SMALL EMPLOYER SELF-INSURANCE.—The amount of tax imposed by subsection (a)(2) by reason of 1 or more failures during a taxable year shall be equal to 25 percent of the expenditures under any uninsured health plan during such taxable year.

''(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any health plan.

''(3) CONTROLLED GROUPS.—For purposes of paragraph (1)—

''(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 person. For purposes of the preceding sentence, the term 'controlled group of

corporations' has the meaning given to such term by section 1563(a), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

''(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of section 1563.

''(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or business (whether or not incorporated) which are under common control shall be treated as 1 person. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, and exer-

cising reasonable diligence would not have known, that such failure existed.

''(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

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

''(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

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

''(1) HEALTH PLAN.—The term 'health plan' has the meaning given such term in section 2133(a)(1) of the Social Security Act.

''(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an

employer that normally employs more than 1 but less than 51 eligible employees on a typical business day. For the purposes of this paragraph, the term 'employee' includes a self-employed individual. Subsection (b)(3) shall also apply for purposes of the preceding sentence.

''(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 17½ hours of service per week for that employer.''

(b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of section 275(a) of such Code (relating to nondeductibility of certain taxes) is amended by inserting ''47,'' after ''46,''.

(c) CLERICAL AMENDMENTS.—The table of sections for such chapter 47 is amended by adding at the end thereof the following new item:

''Sec. 5000A. Failure to satisfy certain standards for health insurance.''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a) and (c) shall take effect on the date of the enactment of this Act.

(2) NONDEDUCTIBILITY OF TAX.—The amendment made by subsection (b) shall apply to taxable years beginning after December 31, 1992.

SEC. 4. GAO STUDY AND REPORT ON RATING REQUIREMENTS FOR SMALL GROUP HEALTH INSURANCE.

The Comptroller General of the United States shall study and report to the Congress by no later than January 1, 1996, on the impact of the standards for rating practices for small group health insurance established under section 2122 of the Social Security Act on the availability and price of insurance offered to small employers. The study shall also include the Comptroller General's recommendations for adjusting the rating standards to eliminate variation in premiums associated with demographic factors.

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