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The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Guidance on Frequently Asked Questions

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ABSTRACT

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191), guarantees the availability and renewability of health insurance coverage for certain individuals. It permits a limited number of small businesses and self-employed individuals to establish tax-favored medical savings accounts (MSAs), increases the tax deduction for health insurance for the self-employed, and amends the Internal Revenue Code to treat private long-term care policies the way health insurance policies and health care expenses are currently treated. This report provides guidance on the most frequently asked questions about the insurance provisions of HIPAA in a question and answer format. It is updated periodically to reflect regulations and other information. For further information, see *Health Insurance: Reforming the Private Market*, CRS Report 95-877; *Medical Savings Accounts: Legislation in the 105th Congress*, CRS Report 97-643; and *Long Term Care for the Elderly*, CRS Issue Brief 95039.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Guidance on Frequently Asked Questions

Summary

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191), provides for changes in the health insurance market. It guarantees the availability and renewability of health insurance coverage for certain employees and individuals, and limits the use of preexisting condition restrictions. The Act creates federal standards for insurers, health maintenance organizations (HMOs), and employer plans, including those who self-insure. It permits, however, substantial state flexibility for compliance with the requirements on insurers.

The Act also includes other provisions relating to health insurance. Changes are made to the Internal Revenue Code (IRC) to permit a limited number of small businesses and self-employed individuals to establish and contribute to medical savings accounts (MSAs) if they are used in conjunction with qualified high-deductible health insurance plans. It also increases the tax deduction for health insurance for self-employed individuals. Finally, it amends the IRC to treat private long-term care policies the way health insurance policies and health care expenses are currently treated.

The Act has generated numerous questions about how it will work. What kinds of policies does it cover? What are its requirements? When do they go into effect? How does it help people who are currently uninsured? How does it help people with preexisting medical conditions? How do the new Act's requirements interact with the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage? How does it affect premiums charged for health insurance coverage? How do the MSA and long-term care tax provisions work? And many more.

This document is designed to provide guidance on the most frequently asked questions about the insurance provisions of the Act. Some questions cannot be answered definitively. The answers will depend on the rules implementing the Act that will be issued by the various entities charged with administering the law. (Interim rules covering the portability provisions were published April 8, 1997. Proposed rules related to the long-term care insurance provisions were issued January 2, 1998.) Also, the answer to many questions about the requirements on the individual health insurance market depend upon how a person's particular state has responded to the Act. Some states have implemented the federal minimum requirements ("the federal fallback"); many more have or are in the process of establishing an acceptable alternative mechanism, such as a high-risk pool. As of May 5, 1998, five states had failed to do either and are or expected to be regulated directly by the federal government.

The Act has been amended to require group health plans and insurers to cover minimum hospital stays for maternity care and to require group health plans and group coverage to provide for parity in certain mental health limits. Moreover, the deduction for the self-employed for health insurance has been increased to 100% by 2007, with a faster transition to full deductibility.

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The Health Insurance Portability and Accountability Act of 1996: Guidance on Frequently Asked Questions

Overview of Law

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA) provides for changes in the health insurance market and imposes certain requirements on health insurance plans offered by public and private employers. It guarantees the availability and renewability of health insurance coverage for certain employees and individuals, and limits the use of preexisting condition restrictions. The Act creates federal standards for insurers, health maintenance organizations (HMOs), and employer plans, including those who self-insure. However, it permits substantial state flexibility for compliance with the federal requirements on insurers.¹

The Act also includes other provisions relating to health insurance. Changes are made to the Internal Revenue Code (IRC) to permit a limited number of small businesses and self-employed individuals to establish and contribute to medical savings accounts (MSAs) if they are used in conjunction with qualified high-deductible health insurance plans. It also increases the tax deduction for health insurance for self-employed individuals. Finally, it amends the IRC to treat private long-term care policies the way health insurance policies and health care expenses are currently treated.

Not long after HIPAA was enacted, it was amended by P.L. 104-294.² This law prohibits, with exceptions, group health plans and issuers of insurance plans in the group and individual markets from restricting benefits for any hospital length-of-stay for mothers and their newborns following a vaginal delivery to less than 48 hours and following a caesarean to less than 96 hours or from requiring that a provider obtain authority from the plan or the issuer for prescribing longer length-of-stays. It also provides, with exceptions, for limited parity for mental health coverage under group

¹ For a legislative history of and additional information on the Health Insurance Availability and Accountability Act of 1996 see *Health Insurance: Reforming the Private Market*. CRS Report 95-877, by Beth C. Fuchs; *Medical Savings Accounts in the 105th Congress* CRS Report 97-643, by Bob Lyke; *Income Tax Treatment of Accelerated Death Benefits and “Viatical” Settlement Payments* CRS Report 95-971, by Jack Taylor. (Hereafter cited as Taylor, *Income Tax Treatment of Accelerated Death Benefits*); *Long Term Care for the Elderly*. CRS Issue Brief 95039, by Richard Price (regularly updated). (Hereafter cited as Price, *Long Term Care for the Elderly*)

² These provisions were part of the FY1997 appropriations act for the Departments of Veterans Affairs and Housing and Urban Development.

health plans with 50 or more employees by requiring annual and aggregate lifetime limits for mental health coverage to be the same as for physical health coverage.

The HIPAA amends the Employee Retirement Income Security Act (ERISA), the Public Health Service (PHS) Act, and IRC. In general, requirements on employer plans are found in the ERISA and IRC amendments; requirements on health insurance issuers, such as insurance carriers and health maintenance organizations (HMOs) are found in the PHS Act and ERISA amendments. The increase in the self-employed deduction, establishment of tax-favored MSAs, and long-term care provisions are amendments to the IRC.³

Guidance on frequently asked questions about the health insurance provisions of the Act follows. As with any general guide, readers should also consult the statutory language and the regulations. Interim rules on the portability provisions of the Act were published April 8, 1997.⁴ The Internal Revenue Service published a notice providing interim guidance on May 6, 1997 and proposed rules on January 2, 1998 on the tax treatment of long-term care insurance under HIPAA. Additional guidance is expected on various aspects of HIPAA and its amendments.

To ensure clarity, a few definitions may be helpful. The term “participant” generally refers to an active or former employee who is covered under a group health plan. “Beneficiary” is typically the spouse or dependents of the participant. “Issuer” is a health insurer or carrier such as a commercial insurance company, an HMO, or other entity in the business of providing health insurance.

Part I. The Act in General

What Is the Basic Intent of the Act?

The Act is designed to ensure that people who are moving from one job to another or from employment to unemployment are not denied health insurance because they have a preexisting medical condition. The Act also restricts the waiting time before a plan covers any preexisting medical condition for participants and beneficiaries in group health plans. Other provisions seek to make health insurance more affordable. The tax deduction for health insurance premiums paid by the self-employed is gradually increased from the current level of 40% to 100% by the year 2007.⁵ MSAs coupled with qualified high deductible health insurance plans are available on a trial basis to a limited number of individuals. And new tax incentives

³ P.L. 104-204 only included the mental health and maternity stay provisions in the PHS Act and ERISA. In P.L. 105-34 (the Taxpayer Relief Act of 1997), they were added to the IRC. P.L. 105-34 also sped up the increase in the self-employed health insurance deduction and increased the deduction to 100% effective 2007 and thereafter.

⁴ *Federal Register*, v. 62, no. 67, April 8, 1997. p. 16893-17005. (Hereafter cited as *Federal Register*, April 8, 1997)

⁵ HIPAA (P.L. 104-191) provided for a slower phase-in to 80% by 2006. This was changed by P.L. 105-34, signed into law on August 5, 1997.

are available to encourage individuals and employers to purchase long-term care insurance.

What Does the Term “Portability” Mean in the Context of this Act?

The term “portability” does not mean that you can take your specific health insurance policy from one job to another. It means that once you obtain health insurance, you will be able to use evidence of that insurance to reduce or eliminate any preexisting medical condition exclusion period that might otherwise have been imposed on your coverage when you move to another group health plan or, in certain circumstances, to an individual policy. The concept of portability is really one of being able to maintain coverage and being given *credit* for having been insured when changing health plans.

What Is Creditable Coverage?

The concept of creditable coverage is that individuals should be given credit for previous insurance when applying for a new plan. It has been suggested that creditable coverage works much like carrying course credits from one school to another. You have changed schools and possibly changed courses but successful completion of courses in your previous school is applicable towards satisfaction of the requirements for graduation from your new school.

Under the Act, creditable coverage is coverage under any of the following: (a) a group health plan; (b) health insurance coverage (which is defined as benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer) and includes individual health insurance coverage; (c) Medicare; (d) Medicaid; (e) military health care;⁶ (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) the Federal Employee Health Benefits Program; (i) a public health plan (as defined in regulations); or (j) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

How Can I Make Sure That I Am Able to Take Full Advantage of the Portability Provisions of the Act?

As described below, most of the requirements of the Act began taking effect as early as July 1997. Most health plans sponsored by employers and almost all health insurance issuers should now be complying with the Act’s requirements. In the event that you are in a plan that is not yet covered by the Act (for example, your plan is under a collective bargaining agreement whose new contract period has not yet begun), your coverage may still be creditable toward the satisfaction of a preexisting condition exclusion period imposed by some new plan that covers you. (The

⁶ Military health care is care described under Chapter 55 of Title 10 of the United States Code.

schedule of effective dates is described below.) Therefore, to benefit from the Act, you should maintain coverage under a health insurance plan. Do not allow your insurance coverage to lapse for 63 or more days.

Will the Act Help Me If I Am Currently Uninsured?

The Act was designed to help Americans who have been unable to get coverage for a preexisting medical condition, or who have stayed in a job because they feared that they would lose coverage for such a condition if they changed to a new employer or moved to an individual policy. But the Act may be limited in reducing the number of uninsured Americans, about 42 million people in 1996.

It is also the case, however, that HIPAA largely addressed the availability of insurance and not for the most part the cost of health insurance. Some uninsured persons who are self-employed may be encouraged to buy insurance because they will be able to deduct more of the premium than they can today. (The deduction will increase from today's 40% to 100% by 2007.) The establishment of high deductible policies being sold in conjunction with tax-favored MSAs may encourage some employers that currently do not sponsor a health plan to do so. Also, MSAs may be attractive to some currently uninsured self-employed individuals. But HIPAA does not regulate the price of health insurance coverage.⁷ Early evidence indicates that the cost of health insurance in the individual market for individuals taking advantage of HIPAA's group-to-individual portability provisions is significantly higher than the cost for individuals who could otherwise obtain insurance. This may be discouraging many "HIPAA eligibles" from buying insurance.⁸ Whether this experience continues over the long run remains to be seen.

Part II. Changes to the Health Insurance Market

Group Health Plans and Group Health Insurance

Does My Employer Have to Cover Me? No, the Act does not require employers to offer or pay for health insurance for their employees. Also, the Act does not require employers to offer or pay for family coverage (spouses and dependents). Finally, the Act does not require employers to cover part time, seasonal, or temporary employees. However, an employer who elects to sponsor a group health plan has to comply with certain requirements of the Act. These requirements: (a) restrict the use of preexisting condition limitation periods; (b) prohibit an employer plan from discriminating on the basis of health status in the determination of the eligibility of an employee to enroll in a group health plan (and the employee's spouse and dependents if the plan provides family coverage); (c) prohibit an employer plan from requiring an individual to pay premiums or

⁷ Insurance that is regulated by state law may be subject to state premium limits. There are no premium limits on self-insured employer plans.

⁸ U.S. General Accounting Office. Health Insurance Standards. *New Federal Law Creates Challenges for Consumers, Insurers, Regulators*. GAO/HEHS-98-67, February 1998.

contributions which are greater than those charged to a similarly situated individual on the basis of health status; and (d) mandate documentation of creditable coverage.

What Does the Act Mean for Me If I Am Already Covered Under a Group Health Insurance Plan? When the group health plan in which you are enrolled is covered by the Act (which may be July 1, 1997 or later),⁹ the plan has to meet new federal requirements:

- When you first enroll, the plan cannot impose a limitation period on a preexisting condition that is longer than 12 months (18 months for late enrollees as defined below), and has to credit towards that limitation period any *creditable coverage* that you may have. The plan cannot apply any preexisting condition waiting period on pregnancy, a covered newborn, or on any covered child under 18 that you may adopt (even if the adoption is not finalized). However, the employer may still require you to work a while before you can participate in the health plan. This is called a “waiting period” and should not be confused with a “preexisting condition limitation period.”¹⁰
- If you leave your job, the employer has to give you a certificate that states the amount of creditable coverage you have accumulated and whether you were subject to any waiting period under the employer’s plan. You will use this certificate to demonstrate prior creditable coverage when moving to a new group or individual health insurance plan. The Act does not require an employer to continue offering you coverage after you leave your current job, except under COBRA continuation provisions as described below.

What Is a Preexisting Medical Condition? Under the Act, a preexisting medical condition is a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date. The enrollment date is the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.¹¹ Pregnancy is not considered a preexisting medical condition. Also a preexisting medical condition limit or exclusion may not be imposed on covered benefits for newborns who are covered under creditable coverage within 30 days of birth. Finally, a preexisting medical condition limit or exclusion may not be imposed on covered benefits for newly adopted children or children newly placed for adoption, if the child becomes covered under creditable coverage within 30 days of the adoption or placement.

The Act also prohibits the use of genetic information as a preexisting condition unless there is a diagnosis of a preexisting medical condition related to the information. For example, evidence of a positive test for the gene that predisposes a woman to inheritable breast cancer cannot be treated as a preexisting condition,

⁹ The effective dates for group health plans are described below.

¹⁰ See below for more information on limitation and waiting periods.

¹¹ See below for more information on limitation and waiting periods.

unless a diagnosis of breast cancer is made within the 6-month period described above.

What Is a Preexisting Medical Condition Limitation Period? During this period, a plan may exclude or restrict coverage of a participant's or beneficiary's preexisting medical condition. Under the Act, a plan is prohibited from imposing more than a 12-month preexisting condition limitation period (18 months for late enrollees) on a participant or beneficiary. As described below, that period is reduced by the amount of the individual's creditable coverage.

How Long Can a Group Health Plan Restrict Coverage for a Preexisting Medical Condition? Coverage of a preexisting medical condition may be limited or excluded for up to 12 months if you enroll in the health plan when you are first eligible to enroll. If you delay enrollment (i.e., are a late enrollee), the maximum permitted limitation is 18 months.

If you move from one group plan to another group plan, or from individual to group coverage, the new group plan must reduce any preexisting condition limitations by 1 month for every month that you had creditable coverage under a previous plan, provided that you enroll when first eligible and have no break in previous coverage of 63 or more continuous days. For example, if you have 6 months of prior creditable coverage, you could face a maximum preexisting condition limitation period of 6 months. If you have 11 months of prior creditable coverage, you could face a maximum limitation period of 1 month. Once a 12-month limitation period is met, no new limitation may ever be imposed on you *as long as you maintain continuous coverage* (that is, you experience no break in coverage lasting longer than 62 days), even if you change jobs or health plans. If you experience a period of 63 consecutive days during all of which you do not have any creditable coverage, you have experienced a significant break in coverage. (Significant breaks in coverage do not include waiting periods or affiliation periods.) In this case, you will not have creditable coverage and you may be subject to as much as a 12-month preexisting condition exclusion period (or an 18 month exclusion if you are a late enrollee).¹²

You establish eligibility for waiver of preexisting condition limitations by presenting certifications that document prior creditable coverage. Health plans and health insurance issuers must supply these written certifications of: your period of creditable coverage under the plan; coverage (if any) under COBRA continuation provisions; and any waiting or affiliation periods imposed on you. The certification must be provided: (1) when you are no longer covered under the plan or otherwise become covered under a COBRA continuation provision; (2) after termination of COBRA coverage, if applicable; and (3) upon a request which is made not later than 24 months after your coverage ends.¹³ The interim rules issued by the three agencies

¹² See "What is Late Enrollment?" below.

¹³ Certifications apply to events occurring after June 30, 1996. For events occurring after June 30, 1996 and before October 1, 1996, individuals must request certification in writing but the plan or issuer does not have to provide the document before June 1, 1997. However, (continued...)

administering the Act provide guidance and model certification forms to streamline this process.¹⁴ In general, the certification must be provided in writing.

How Is Prior Coverage Credited? The plan or issuer may choose one of two alternatives when determining creditable coverage: 1) it can disregard specific benefits covered and include all periods of coverage from qualified sources; or 2) it can examine prior coverage on a benefit-specific basis, and exclude from creditable coverage any categories or classes of benefits not covered under the most recent prior plan. The April 8, 1997 interim rules defines the categories of benefits to be: (a) mental health; (b) substance abuse treatment; (c) prescription drugs; (d) dental care; or (e) vision care.¹⁵ Thus, for example, if your prior plan did not cover prescription drugs, and the new plan includes this benefit, the new plan may exclude coverage of prescription drugs for you for up to 12 months under this second method. If the second method is chosen, plans or issuers must disclose its use at the time of enrollment or sale of the plan, and apply it uniformly.

What Is a Special Enrollment Period ? The Act provides for two different special enrollment periods:

(1) Individual Losing Other Coverage. A group health plan or an issuer offering coverage in connection with a group health plan must allow an employee who is eligible, but not enrolled, to become covered under the plan. (The employee's dependent would also be allowed to enroll, if family coverage is provided under the terms of the plan.) For this special enrollment period to apply, each of the following conditions would have to be met:

- 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. For example, the employee may have been covered by a spouse's employer and declined coverage under his own employer's plan.
- The employee stated in writing at the time of declining enrollment that the reason for declining was that he or she was covered under another health insurance plan. This condition applies only if the plan sponsor or issuer requires such a written statement.
- The employee's or dependent's previous coverage was under a COBRA continuation provision that had become exhausted or was under some other coverage that had been terminated as a result of a loss of eligibility for the

¹³ (...continued)

in order to ease administration of this requirement, plans and issuers may have begun issuing certifications before June 1, 1997. In the case of an individual who seeks to establish creditable coverage for events occurring before June 30, 1996, the individual may present other credible evidence of such coverage. Plans and issuers will not be subject to any penalty or enforcement action with respect to crediting or not crediting coverage during this transition period if the plan or issuer makes a good faith effort to comply.

¹⁴ *Federal Register*, April 8, 1997.

¹⁵ *Ibid.*, p. 16932, 16945-6, 16961-2.

coverage (for reasons such as: legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), or because the employer contribution towards such coverage was terminated.

To take advantage of this special enrollment period, the employee would have to request enrollment no later than 30 days after the date in which his or her prior coverage was exhausted or terminated.

(2) *Dependent Beneficiaries.* Generally, this provision applies if a group health plan makes dependent coverage available, and the dependent's spouse or parent 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 but has not enrolled). Then, if the person becomes a dependent through marriage, birth, adoption, or placement of adoption, the person must be allowed to enroll as a beneficiary under the plan. (If not already enrolled, the employee and spouse also may enroll at this time.) Enrollment has to be sought within 30 days of the qualifying event (e.g., the marriage). Coverage is effective on the date of the birth, adoption, or placement for adoption. In the case of marriage, coverage is effective no later than the first of the month beginning after the date the request for enrollment is received.

What Is Late Enrollment? Late enrollment occurs when an individual enrolls in a group health 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. As described above, a group health plan may require a late enrollee to wait 18 months before a preexisting condition is covered.

What Is a Waiting Period? How Does it Differ from a Preexisting Medical Condition Limitation Period? A waiting period is one which must pass before an individual is eligible to enroll in a health plan and is referred to throughout this document as a "waiting period." For example, an employer may require an employee to work for 6 months before he or she is eligible to enroll in the employer's health insurance plan. The Act does not limit this type of waiting period — employers and health insurance issuers are free to determine the length of this type of waiting period. However, the Act requires that any waiting periods be applied uniformly without regard to the health status of potential plan participants or beneficiaries. Also, days in a waiting period are not taken into account when determining whether an individual has experienced a break in coverage of 63 or more days.

The second type of waiting period applies to any preexisting medical conditions and is referred to in the Act as a preexisting condition exclusion limitation period. The Act limits the length of time that a group health plan may deny or limit coverage for a preexisting medical condition to a maximum of 12 months (18 months for late enrollees). This limitation period may be reduced as a result of previous creditable coverage. *Also, any waiting period required before an employee or his or family member can become a plan participant or beneficiary must run concurrently with any preexisting condition limitation period.* For example, if an employer required an employee without any creditable coverage to work for 5 months before he or she could enroll in the firm's health plan, then the preexisting condition limitation period imposed on the coverage of that individual could not exceed 7 months from the date of actual enrollment in the plan. If that individual had 7 or more months of creditable

coverage, then no preexisting condition limitation period could be imposed on the coverage under the new plan.

Can a Group Health Plan Fail to Enroll Me If I Have a History of Illness or Disability or High Medical Expenses? Can it Drop Me from Coverage If I Become Sick or Start Using a Lot of Medical Care? No, the Act prohibits a group health plan and an issuer offering group health coverage from establishing rules for eligibility for any individual to enroll under the plan based on health status-related factors. These include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence) and disability. Group health plans are also prohibited from failing to reenroll a participant or beneficiary on the basis of health status-related factors.

Do These Protections Apply to an Individual's Spouse and Children? Under a group health plan, an employer is not required to offer coverage to an individual's spouse or children. If the employer does offer family coverage, the same protections as described above apply to a spouse and dependents. Coverage may not be denied because a family member is sick, and preexisting condition restrictions are limited as described above.

Does a Group Health Plan Have to Provide Any Specific Benefits? No, the Act does not require an employer or issuer of group health insurance to offer any specific benefits. But the Act also does not preempt (i.e., override) state insurance laws that mandate insurers to provide specific benefits or reimbursement of specific providers. Accordingly, fully insured plans issued to employers by insurers still have to comply with any state-mandated benefit laws that may exist. As is currently the case, plans that are not fully insured (that is, they self-insure (i.e., self-fund) part or all of the risk for paying claims for covered services) do not have to comply with state-mandated benefit laws because of a provision of ERISA.

Do the Requirements of the Act Apply to the Plans of Employers That Provide for Dental-only Coverage or Vision-only Coverage? No, such specific benefit plans do not have to comply with the requirements of the Act if they meet certain conditions spelled out in the Act. To be exempt, for example, the dental-only policy would have to be provided under a separate policy, certificate, or contract of insurance or not otherwise be an integral part of the plan.

Can an Employer Exclude Coverage for Specific Types of Illnesses, Such as Cancer, Acquired Immune Deficiency Syndrome (AIDS) or Heart Disease? An employer plan can exclude coverage for specific types of services (e.g., mental health services) if the exclusion applies to all similarly situated individuals in the plan. However, according to the staff of the committees of Congress that wrote the Act, it was not the intent of Congress to permit employer plans and issuers of group health policies to carve out coverage for specific illnesses, such as cancer or AIDS, and provide for such coverage under separate policies that are not subject to the portability requirements of the Act. To illustrate, a single plan sponsor provides two separate group health plans. One provides cancer coverage and the other plan provides comprehensive coverage but excludes or reduces coverage for cancer. Both

plans would be subject to the Act's requirements since the coverage would be considered to be coordinated.

Can an Employer Condition Coverage under its Health Plan on Passing a Physical Examination? No, the Act prohibits employer plans and issuers of group health coverage from establishing rules of eligibility to enroll under the terms of the plan that discriminate based on one or more health-status related factors.

Does the Act Restrict the Amount of Premium That an Employer Can Charge Me for Health Insurance? No, the Act does not restrict the amount of premium that an employer or insurer can charge. It also expressly permits an employer or group health insurer to offer premium discounts or rebates, or modify otherwise applicable copayments or deductibles, for participation in health promotion and disease prevention programs. However, the Act does prohibit a health plan from charging an individual a higher premium than the premium charged for another similarly situated individual enrolled in the plan on the basis of any health-related factor, such as a preexisting medical condition.

Does the Act Help Individuals with a History of Mental Illness or a Need for Mental Health Services? Yes, the Act prohibits employers who offer health coverage and group health issuers from establishing rules for eligibility (including continued eligibility) based on a medical condition (including both physical and mental illnesses). However, the Act does not require the health plan to cover services for mental health care on par with services for physical illness. An amendment to require such mental health "parity" was not included in the final version of the legislation but has been included in modified form in a subsequent law. Under P.L. 104-204, a group health plan (or health insurance coverage offered in connection with the group health plan) must provide for parity in the imposition of aggregate lifetime limits and annual limits on mental health services with such limits on physical services. This requirement applies to group health plan years beginning on or after January 1, 1998. The requirement does not apply to plans of employers with 50 employees or less. It also does not apply with respect to a group health plan (or coverage offered in connection with a group health plan) if the requirement results in an increase in the cost of at least 1%.

Does the Act Require Insurance Companies and HMOs to Accept Any Employer Group That Applies for Insurance? No, the Act only requires insurers, HMOs, and other issuers of health insurance selling in the *small group market* to accept any small employer that applies for coverage, regardless of the health status or claims history of the employer's group.¹⁶ This requirement is often referred to as "guaranteed issue." The Act defines a small employer as one with 2 to 50 employees. (If, on the first day of the plan year, the plan has fewer than two participants who are current employees, it is not considered a small group and would not be covered by this "guaranteed issue" requirement.) Under guaranteed issue, the issuer must accept for enrollment under the policy not just the employer's group but also every eligible

¹⁶ This is consistent with most state health insurance reforms which primarily apply to the small group market, typically defined as 2 to 25, 2 to 35 or 2 to 50 employees. However, some state laws provide for guarantee issue of groups down to one employee.

individual who applies for timely enrollment.¹⁷ Exceptions to guaranteed issue are provided in the Act for network plans that might otherwise exceed capacity limits or in the event that the employer's employees do not live, work, or reside in the network plan's area.

Employer groups with more than 50 employees are not protected under this requirement unless otherwise required under state law. In the past, health insurance issuers usually did not examine the health status or medical history of larger employer groups when deciding whether to accept such groups for coverage. The Act requires the Secretary of Health and Human Services (HHS) and the General Accounting Office to report on access to health insurance in the large group market.

Can Health Insurance Issuers Drop or Cancel Coverage for Groups Because of High Medical Costs? No, the Act requires all health insurance issuers to continue coverage for any group, regardless of health status or use of services, if the group requests renewal. This requirement is known as guaranteed renewability. An issuer may drop coverage in cases of non-payment of premium, fraud, or similar reasons not related to health status, such as violation of participation or contribution rules.¹⁸ But, there are no limits on amounts insurers may charge.

Do the Requirements of the Act Apply to Association-Sponsored Group Health Plans? If you are covered under a group health plan sponsored by an association of which your employer is a member, then the association plan covering employees (and dependents) of a member employer must comply with the various requirements of the Act relating to group health coverage. For example, the sponsor of an association plan cannot drop a group from coverage because of the use of medical services by the group's members. Moreover, the association plan must comply with the restrictions on the use of preexisting medical condition limitation periods, provide for creditable coverage, and renew coverage except in limited cases. However, nothing under the Act requires that an association plan accept for coverage individuals who are *not* members of the association.

Can States Impose Requirements on Insurers Selling to Group Health Plans That Are Different from Those in the Act? Yes, with limited exceptions designed to ensure that state laws do not prevent the application of the consumer protections of the Act. For example, state laws regulating rating will continue to apply because the Act generally does not address rating practices. On the other hand, the Act's provisions relating to portability, such as restrictions on the use of preexisting medical condition limitation periods, will override state laws. Exceptions

¹⁷ The interim rules interpret the guaranteed issue requirement to apply to all products actively marketed by an issuer in the small group market. *Federal Register*, April 8, 1997, p. 16971.

¹⁸ An example of a participation rule is a requirement set by the issuer that 80% of all full time employees participate in the employer's group health plan. An example of a contribution requirement is that all participants in the health plan must pay 20% of the plan premium. These requirements are used to protect the issuer from a selection bias (also known as "adverse selection") in which only sick members of an employer's group sign up for insurance coverage.

include specific types of state laws that provide for *greater portability* such as state laws that:

- define a preexisting medical condition to be one that existed for less than 6 months prior to becoming covered (instead of the 6 months required under the Act);
- provide for preexisting medical condition limitation periods shorter than 12 (and 18) months (instead of 12 (and 18) months in the Act); and
- provide for breaks in continuous coverage longer than the 62-day period specified under the Act.¹⁹

Thus, for example, a state may prohibit issuers selling to group health plans from imposing more than a 6-month preexisting medical condition limitation period on enrollees, instead of the 12-month limit in the Act. However, state laws that allowed such limitation periods in excess of 12 months would be overridden by the requirement of the Act.

It is important to note that the Act does not affect ERISA's preemption of state regulation of employer-sponsored group health plans.²⁰

Individual Insurance Market

Who Is Eligible for Group to Individual Market Portability Under the Act?

An *eligible individual* must have:

- creditable health insurance coverage for 18 months or longer;
- most recent coverage under a group plan;
- exhausted any COBRA (or other continuation) coverage;²¹
- no eligibility for coverage under any employment-based plan, Medicare or Medicaid; and
- no breaks in coverage of 63 or more days.²²

¹⁹ Other possible types of state laws providing for greater consumer protections are also specified in the Act.

²⁰ Nothing in the Act “shall be construed to affect or modify the provisions of Section 514 [of ERISA] with respect to group health plans (new Section 704 of ERISA as added by Section 101 of P.L. 104-191).” This means that states cannot impose requirements different from those of the Act on group health plans that are not fully insured (i.e., are self-insured).

²¹ Individuals may have continuation coverage that is not COBRA coverage under FEHBP or under state continuation of coverage laws.

²² Under the interim final rule, an eligible individual is one with 18 months or more of (continued...)

How Does Group to Individual Market Portability Work Under the Act?

The Act gives states an opportunity to implement their own access mechanisms for *eligible individuals* moving from group to individual coverage instead of having to comply with federal requirements (also known as the “*federal fallback*” requirements). In general, a state was presumed to be implementing an acceptable mechanism as of July 1, 1997 if by April 1, 1997, the state notified the Secretary of HHS that the state had enacted or intended to enact any necessary legislation to provide for its implementation. States with legislatures meeting within 12 months after enactment of the Act had until January 1, 1998 to enact legislation providing for implementation of the alternative mechanism. All remaining states have until July 1, 1998. The requirements for an alternative state mechanism are addressed below. In those states not adopting alternative mechanisms (or in states for which the Secretary of HHS has determined the mechanism is not adequate), federal group-to-individual portability requirements apply in the individual market. (See Table 1.)

What Are the Federal Requirements for Group to Individual Portability?

Once the provisions take effect, each health insurance issuer operating in the individual health insurance market is required to offer coverage to *eligible individuals*. No limits can be placed on coverage of any preexisting medical condition.

Issuers can comply with the Act’s requirements in three ways:

- (1) they must offer eligible individuals access to coverage to every individual insurance policy they sell in the state; or
- (2) they must offer eligible individuals access to coverage to their two most popular insurance policies (based on premium volume); or
- (3) they must offer eligible individuals access to a lower-level and higher-level coverage. These two policies must include benefits that are substantially similar to other coverage offered by the issuer in the state, and must include risk adjustment, risk spreading, or financial subsidization.

Issuers can refuse to cover individuals seeking portability from the group market if financial or provider capacity would be impaired. This means, for example, that if a network-based plan like an HMO can demonstrate that it is filled to capacity, then

²² (...continued)

aggregate creditable group coverage and not (as some have concluded) 18 months of group health coverage plus exhaustion of any continuation coverage for which the individual is eligible. Accordingly, an eligible individual need only show 18 months of creditable health insurance coverage, at least the last day of which was under a group health plan. A child is deemed to be an eligible individual if the child was covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption, and the child has not had a break in coverage of 63 or more days. (Issuers are not required, however, to offer family coverage.) *Federal Register*, April 8, 1997, p. 16996.

it would not have to accept eligible individuals. It would have to apply this exception uniformly, without regard to the health status of applicants.²³

What Are the Requirements for an Acceptable Alternative State Mechanism? An acceptable alternative state mechanism for coverage of eligible individuals must:

- provide a choice of health insurance coverage to all eligible individuals;
- not impose any preexisting condition restrictions; and
- include at least one policy form of coverage that is comparable to either comprehensive health insurance coverage offered in the individual market in the state, or a standard option of coverage available under the group or individual health insurance laws in the state.

In addition to these requirements, a state may implement one of the following mechanisms:

- certain National Association of Insurance Commissioners Model Acts;
- a qualified high risk pool that meets certain specified requirements; or
- other mechanisms that provide for risk adjustment, risk spreading, or a risk spreading mechanism, otherwise provide some financial subsidies for participating insurers or eligible individuals, or a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

Examples of potential alternative state mechanisms include health insurance coverage pools or programs, mandatory group conversion policies, guaranteed issue of one or more plans of individual health insurance coverage, open enrollment by one or more health insurance issuers, or a combination of such mechanisms.

How Do I Know What Is Going to Apply in My State? Table 1 provides information on how each state is implementing the Act's group-to-individual portability provisions. As of May 1998, 5 states have failed to implement either an alternative mechanism or the federal fallback mechanism. In these states, HHS is implementing and or will be enforcing the federal fallback requirements. Many states have elected to provide for group-to-individual portability through high-risk pools. To obtain more information on a state's health insurance regulation of the

²³ Many people ask whether college plans are covered under the group-to-individual requirements. The interim rule indicates they do not. If an issuer offers student coverage through a 'bona fide' association that meets specific requirements of the Act, the issuer does not have to make the coverage available in the individual market to eligible individuals and does not have to renew coverage for a student who leaves the association. If the college plan is not a bona fide association, it does have to guarantee coverage to all eligible individuals in the individual market and must renew the coverage indefinitely at the option of former students. *Federal Register*, April 8, 1997, p. 16919, 16992.

individual market, individuals may wish to contact that state's department of insurance.²⁴

Table 1. State Group-to Individual Insurance Portability Mechanisms

State	Mechanism
Alabama	Alternative mechanism: high-risk pool.
Alaska	Alternative mechanism: high-risk pool.
Arizona	Federal fallback.
Arkansas	Alternative mechanism: high-risk pool.
California	Federal fallback with HCFA enforcement.
Colorado	Federal fallback.
Connecticut	Alternative mechanism: high-risk pool.
Delaware	Federal fallback.
District of Columbia	Federal fallback.
Florida	Alternative mechanism: guaranteed issue to HIPAA-eligible persons; health plans required to offer a choice of conversion plans, one of which must be the state approved "standard policy" currently offered in the small group market.
Georgia	Alternative mechanism: assigned risk pool. HIPAA-eligible persons may apply for coverage to the insurance commissioner who then "assigns" eligible individuals to health plans based on a health plan's pro rata volume of individual health insurance business done in the state.
Hawaii	Federal fallback.
Idaho	Alternative mechanism: existing state insurance reform laws. Includes guaranteed issue of 3 products; guaranteed renewal; restrictions on use of pre-existing condition limitations; limits on rating.
Illinois	Alternative mechanism: high-risk pool.
Indiana	Alternative mechanism: high-risk pool.
Iowa	Alternative mechanism: high-risk pool.
Kansas	Alternative mechanism: high-risk pool.
Kentucky	Exempted from implementing group-to-individual portability until July 1, 1998 because state legislature did not meet in regular session in 1997.
Louisiana	Alternative mechanism: high-risk pool.

²⁴ According to the Department of Health and Human Services, as of May, 1998, two of the five states had not officially indicated that they are out of compliance with HIPAA but have, in effect, failed to enact conforming legislation.

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Maine	Alternative mechanism: existing state insurance reform laws. These include: guarantee issue of all products, guarantee renewal, no pre-existing condition applied to HIPAA-eligibles; community rating with adjustments limited to a specified range of variation for age, smoking status, industry, and geography.
Maryland	Federal fall-back.
Massachusetts	Federal fallback with HCFA enforcement.*
Michigan	Federal fall-back with HCFA enforcement.*
Minnesota	Alternative mechanism: high-risk pool.
Mississippi	Alternative mechanism: high-risk pool.
Missouri	Federal fall-back with HCFA enforcement.
Montana	Alternative mechanism: high-risk pool.
Nebraska	Alternative mechanism: high-risk pool.
Nevada	Federal fall-back.
New Hampshire	Alternative mechanism: existing state insurance laws. Includes guarantee issue of all products, guarantee renewal, restrictions on use of preexisting condition limitations, community rating with adjustments, and limits on annual premium increases.
New Jersey	Alternative mechanism: existing state insurance laws. Includes guarantee issue of 5 standardized products, guarantee renewal, no preexisting condition waiting period applied to HIPAA eligibles, community rating with adjustments for geography and family composition.
New Mexico	Alternative mechanism: HIPAA-eligibles can choose to obtain coverage through either the high-risk pool or the purchasing alliance.
New York	Alternative mechanism: existing state insurance reform laws. Includes guarantee issue of all products, guarantee renewal, no preexisting condition waiting period applicable to HIPAA-eligibles, community rating with adjustments for family composition and geography.
North Carolina	Federal fall-back.
North Dakota	Alternative mechanism: high-risk pool.
Ohio	Alternative mechanism: separate open enrollment period for HIPAA eligibles until health plans meet their enrollment caps.
Oklahoma	Alternative mechanism: high-risk pool.
Oregon	Alternative mechanism: high-risk pool.
Pennsylvania	Alternative mechanism: Blue Cross and Blue Shield Plans serve as the guaranteed issue carrier.
Rhode Island	Federal fall-back with HCFA enforcement.
South Carolina	Alternative mechanism: high-risk pool.
South Dakota	Alternative mechanism: existing state insurance reform laws.

Tennessee	Federal fall-back
Texas	Alternative mechanism: high-risk pool.
Utah	Alternative mechanism: combines existing insurance market guaranteed issue requirement with a high-risk pool for those whose risk is judged by objective guidelines to be over a specified threshold of risk. Otherwise, carrier to which individual applied would have to provide the insurance.
Vermont	Alternative mechanism: existing state insurance reform laws. Includes guarantee issue of all products, guarantee renewal, no preexisting condition waiting period for HIPAA-eligibles, community rating with adjustment limited to specified range of variation.
Virginia	Alternative mechanism: guarantee issue all currently offered non-group products to HIPAA eligibles.
Washington	Alternative mechanism: existing state insurance reform laws. Includes guarantee issue of all products; guarantee renewal, coverage of preexisting conditions for HIPAA-eligibles without a waiting period, rating limits.
West Virginia	Federal fall-back
Wisconsin	Alternative mechanism: high-risk pool.
Wyoming	Alternative mechanism: high-risk pool.

Source: Adapted from: Blue Cross and Blue Shield Association, *State Legislature Health Care and Insurance Issues. 1997 Survey of Plans*. Washington, December 1997. According to HCFA, as of May, 1998, Massachusetts and Michigan had not yet formally indicated to HCFA that they are out of compliance with HIPAA.

Does the Act Regulate the Premium That an Issuer Can Charge an Eligible Individual? No, the Act does not place any restrictions on the premiums that issuers can charge. However, some states limit insurance premiums in the individual market and more may decide to do so in the future. Such limits would then apply because the Act does not preempt or override future state laws regulating the cost of insurance.

Implementation, Enforcement, and Timing

Which Federal Agencies Are Required to Oversee the Implementation of the Act? The Secretaries of HHS, Labor, and Treasury are required to enforce the provisions of the Act. The Secretary of Labor enforces the requirements on employer plans under Title I of ERISA. The Secretary of Labor is also generally given authority to promulgate regulations necessary to carry out the provisions of the Act relating to group health plans and health insurance issuers in connection with any group health plans. The Secretary of Treasury will enforce requirements on group health plans under the IRC. Requirements on issuers will be enforced by the Secretary of HHS to the extent that such requirements are not enforced by the states. The Secretaries are required to coordinate their activities to avoid duplication of effort.

The Departments of Treasury, Labor, and HHS issued interim final rules implementing the portability provisions of the Act for the group and individual

insurance markets in the *Federal Register* on April 8, 1997. The same agencies issued a clarification of the interim regulations on the portability nondiscrimination provisions of the Act in the *Federal Register* on December 29, 1997.

How Are the Insurance Requirements of the Act Enforced? Noncomplying group health plans covered under ERISA may be subject to civil money penalties, and both plans and issuers can be sued by participants and beneficiaries to recover any benefits due under the plan. The Secretary of Labor has the investigative authority to determine whether any person is out of compliance with the law's requirements. For group health plans, generally the IRS can fine a noncomplying employer \$100 per day per violation.

Requirements on issuers, such as insurance carriers and HMOs, will be enforced by the states. If the Secretary of HHS determines that a state is not substantially enforcing the provisions of the Act, the Secretary will enforce the provisions. The Secretary may impose a fine of \$100 for each day the entity (the issuer or a nonfederal governmental plan)²⁵ is out of compliance. The Act gives the Secretary of HHS the authority to promulgate regulations needed to carry out the provisions of the Act relating to requirements on issuers of coverage.

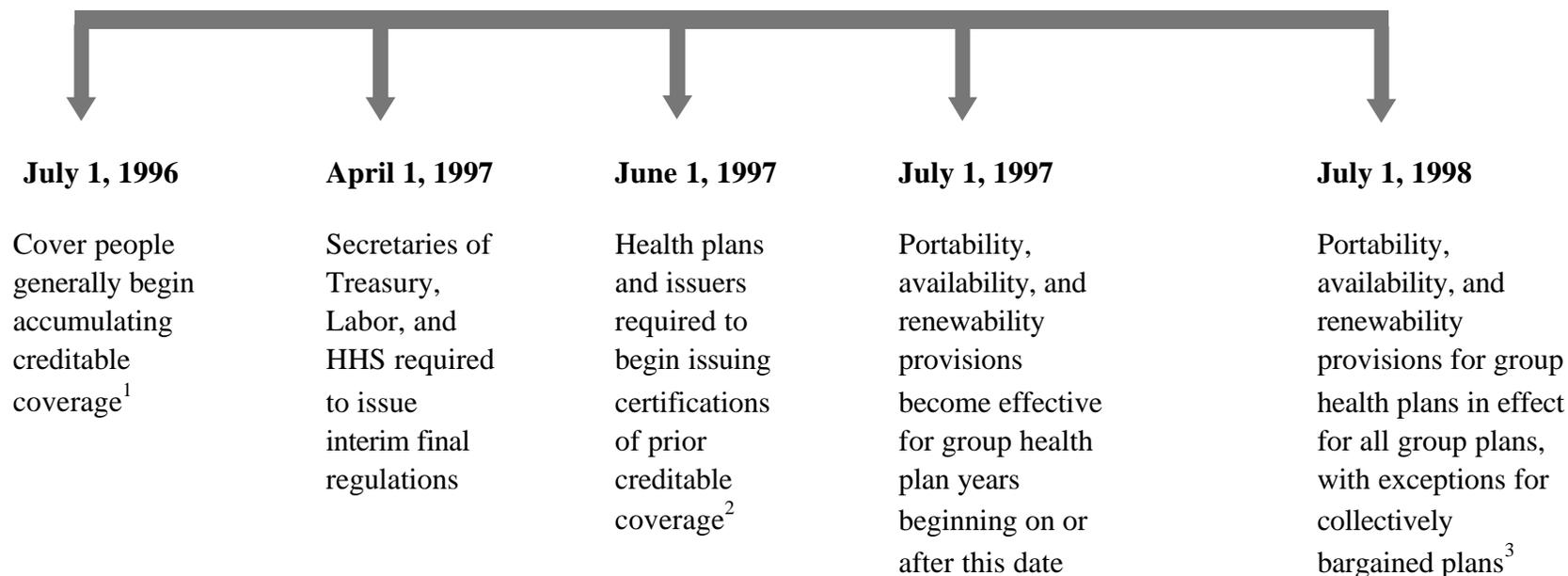
When Do the Insurance Provisions of the Act Go into Effect? The group health insurance reforms are effective for group health plan years beginning after June 30, 1997 (**Figure 1**). The individual market reforms are not effective before July 1, 1997; the effective date depends on state action (**Figure 2**).

Health insurance plans and health insurance issuers must provide certification of creditable coverage to former plan participants beginning on June 1, 1997. These certifications must include any health insurance coverage received after June 30, 1996. The Act provides for transition processes. Individuals who need to establish creditable coverage for a period before July 1, 1996 may be given credit through presentation of documents or other means as established by the Secretaries of Labor, HHS, and Treasury.

Note that the provision establishing tax-favored MSAs became effective January 1, 1997.

²⁵ "A nonfederal governmental plan" is a plan sponsored by a state or local governmental entity.

Figure 1. Effective Dates for Health Insurance Provisions in the Group Market Under H.R. 3103



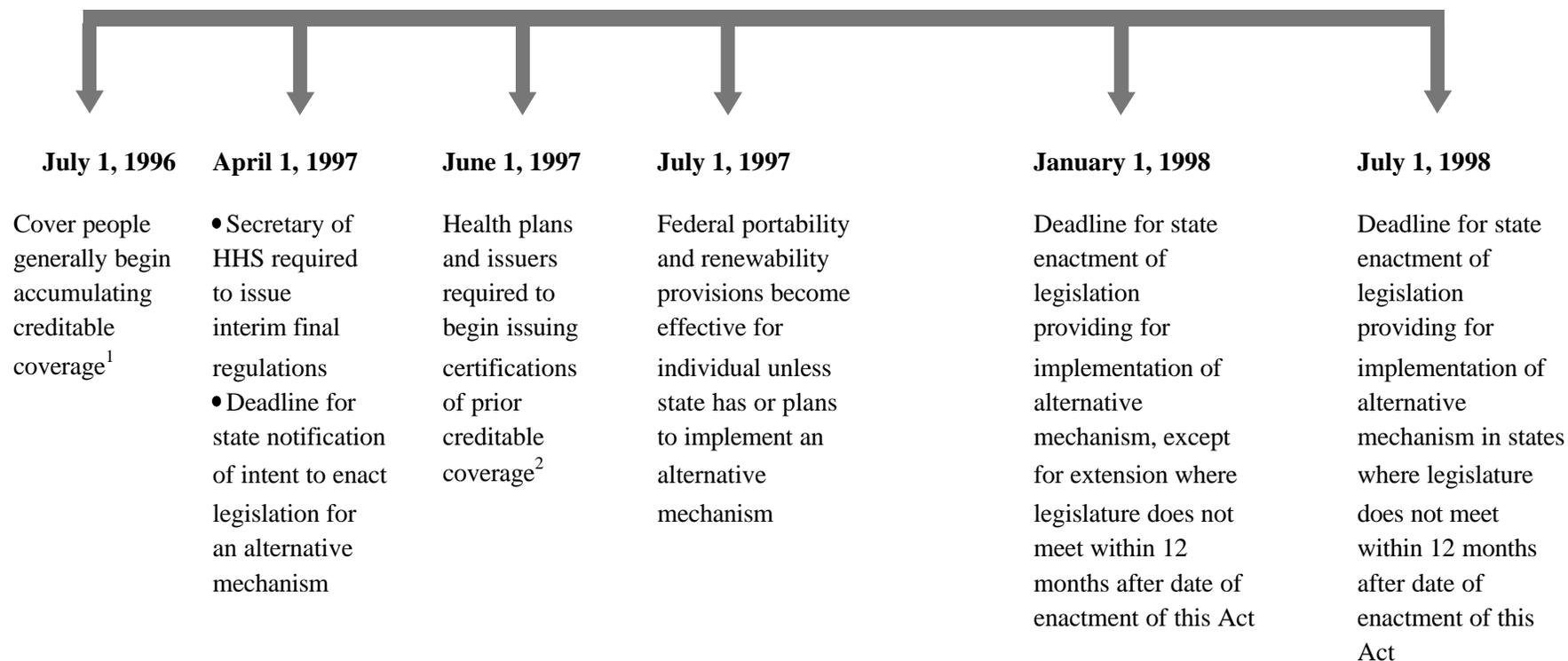
Source: Congressional Research Service.

¹Former enrollees who need to document creditable coverage prior to July 1, 1996 may follow procedures established by the Secretaries of Labor, Health and Human Services, and Treasury.

²Former enrollees must make written requests for certification of creditable coverage which ended between July 1, and October 1, 1996.

³Effective date for collective bargaining agreements is later of July 1, 1997 or the date on which the last of the collectively bargained agreements relating to the plan terminates (determined without regard to any extensions agreed to after the date of enactment of this Act).

Figure 2. Effective Dates for Health Insurance Provisions in the Individual Market Under H.R. 3103



Source: Congressional Research Service.

¹Former enrollees who need to document creditable coverage prior to July 1, 1996 may follow procedures established by the Secretaries of Labor, Health and Human Services, and Treasury.

²Former enrollees must make written requests for certification of creditable coverage which ended between July 1, and October 1, 1996.

COBRA Continuation Coverage

If Someone Is on COBRA Continuation Coverage²⁶ Today, How Will That Person Be Affected by the Act? That depends on several factors. A person's COBRA continuation coverage is considered *creditable coverage* in the case of an individual who moves from one group policy to another group policy or from a group policy to an individual policy. This may enable an individual to move from COBRA to a new health plan without having to wait for coverage of any preexisting medical condition under the new plan. However, for this to work, an individual cannot have a lapse in coverage of 63 or more days.

Also, the effective date of this Act varies among employer-sponsored health plans. Individuals seeking to use COBRA as creditable coverage need to determine whether the new group plan is regulated under the Act. While some group health plans had to comply by July 1, 1997, most plans did not have to comply until January 1, 1998. Some collectively bargained plans do not have to comply until after July 1, 1998. (See **Figure 1** above.)

In the case of an individual moving from COBRA to an individual policy, the situation is more complicated. As described above, the Act provides that persons who are "eligible individuals" be able to move from group to individual coverage without experiencing waiting periods for their preexisting conditions to be covered. An eligible individual is one who was covered under a group health plan and has elected and exhausted any COBRA or state continuation coverage and is not covered by Medicare or Medicaid. In "federal fall-back" states, this means that insurers in the individual market must accept eligible individuals without restrictions on their preexisting conditions. In other states, it means that they should be able to obtain coverage without preexisting condition restrictions from the risk pool or other alternative mechanism established by the state to comply with the law. It is important to note that the insurer accepting the eligible individual for coverage can charge whatever rate is allowed under state law. (The Act does not limit the premiums that insurers can charge.)

Until the Act becomes applicable to all health plans, individuals with preexisting medical conditions who exhaust their COBRA coverage may be able to obtain health insurance through the following: conversion policies,²⁷ state high-risk

²⁶ The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) requires employers with 20 or more employees to offer continued group health insurance coverage to employees and their dependents after certain events. See *Health Insurance Continuation Coverage under COBRA*, CRS Issue Brief 87182, by Beth C. Fuchs (regularly updated).

²⁷ Some group health plans include a conversion option. This enables an individual to keep the same plan as that available under COBRA. However, the premium would be changed from one based on the group rate to an individual (and therefore higher) rate. The interim final rule cautions that electing a conversion option jeopardizes one's right to be an "eligible individual" under the group-to-individual portability protections of the Act. "An individual who accepts a conversion policy, however, maintains eligibility only for the group market (continued...)"

pools for medically uninsurables, and open enrollment policies offered by some Blue Cross and Blue Shield plans.

Does the Act Provide for Changes in COBRA Continuation of Coverage Requirements? Yes, the Act makes several changes to the laws providing for COBRA continuation of coverage: It provides:

- (1) a clarification that a disabled qualified beneficiary is also eligible for the additional 11 months of COBRA;
- (2) that the qualifying event of disability applies in the case of a qualified beneficiary who is determined under the Social Security Act to be disabled during the first 60 days of COBRA coverage;²⁸
- (3) that a qualified beneficiary for COBRA coverage includes a child who is born to, or placed for adoption with, the covered employee during the period of COBRA coverage; and
- (4) that COBRA can be terminated if a qualified beneficiary becomes covered under a group health plan which does not contain any exclusion or limitation affecting a participant or his or her beneficiaries because of the requirements of the Act.²⁹

These changes to COBRA became effective on January 1, 1997, regardless of whether the qualifying event occurred before, on, or after such date. Plans were required to notify qualified beneficiaries of these changes by November 1, 1996.

It should also be noted that under the Medical Savings Account (MSA) provisions of the Act (see below), individuals may withdraw funds from their MSAs without penalty to pay their COBRA premiums.

²⁷ (...continued)

and forfeits the right to be an 'eligible individual' for the individual market. This is so because the statute provides no portability from one individual policy to another. A conversion policy is an individual policy, not a group policy, even though prior group coverage is a prerequisite to qualifying for the conversion policy." *Federal Register*, April 8, 1997, p. 16987.

²⁸ Under current law, an individual qualifies for an additional 11 months of COBRA continuation coverage only if the onset of the disability is determined to have occurred prior to or on the date of the qualifying event, such as a job termination.

²⁹ Prior to this change, individuals may keep their COBRA continuation coverage when they become covered under another group health plan if the new plan imposes a preexisting condition restriction or exclusion with respect to the individual. Then the new plan coordinates with COBRA coverage. Under the Health Insurance Portability and Accountability Act, the need for this protection is eliminated if the new group health plan has to waive the application of any preexisting condition restriction to an individual's coverage because that individual has 12 or more months of creditable coverage.

Part III. Medical Savings Accounts (MSAs)

What is an MSA?

An MSA is a personal savings account for unreimbursed medical expenses. It is used to pay for health care not covered by insurance, including deductibles and copayments. Coverage may be limited to an individual or include a spouse and dependents.

The Health Insurance Portability and Accountability Act of 1996 allows a limited number of tax-advantaged MSAs beginning in the years 1997-2000. Requirements for these MSAs are described below.³⁰ MSAs *without* tax advantages, which some employers have recently been offering, are not covered by the Act.

The Internal Revenue Service (IRS) has published basic information about MSAs in the form of 29 questions and answers. The guidance does not attempt to summarize all rules that might apply.³¹

The Balanced Budget Act of 1997 (P.L. 105-33) authorized a limited number of Medicare MSAs (called Medicare+Choice MSAs) under a demonstration beginning in 1999. The MSA provisions discussed in this report do not apply to Medicare MSAs.³²

Who Is Eligible for a Tax-Advantaged MSA?

The Act authorizes a limited number of tax-advantaged MSAs for individuals who are covered by high deductible health insurance and no other insurance, with some exceptions (see the insurance requirements, below), and who are either self-employed or employees covered by small employer plans.³³ Self-employed is defined by reference under the Act as individuals with net earnings from self-employment; the term includes general partners (as well as limited partners receiving guaranteed payments) and individuals who receive wages from an S-corporation in which they are more than 2% shareholders.³⁴ Small employers are defined as having an average

³⁰ The MSA provisions were in Section 301 of the Health Insurance Portability and Accountability Act, which created new section 220 of the Internal Revenue Code.) Other Code sections were amended as well. The provisions were subsequently modified by technical amendments included in the Balanced Budget Act of 1997 (Section 4006(b)(2)) and the Taxpayer Relief Act of 1997 (Sections 1602(a)(2) and (3)).

³¹ Notice 96-53. The notice is included in the *Internal Revenue Bulletin* for December 16, 1996.

³² For an overview of Medicare MSAs, see CRS Report 97-643, *Medical Savings Accounts: Legislation in the 105th Congress*, by Bob Lyke.

³³ The spouse of an eligible individual is also considered an eligible individual.

³⁴ Self-employed individuals may have tax-advantaged MSAs even if they are eligible to participate in subsidized health plans maintained by their employer (when they also have income as an employee) or their spouse's employer, but choose not to participate. However, (continued...)

of 50 or fewer employees during either of the 2 preceding calendar years,³⁵ though once having met this test and made tax-advantaged MSA contributions, they can continue to be treated as small employers provided they do not employ on average more than 200 persons a year.

Eligibility to begin a tax-advantaged MSA will be restricted after the *earlier* of (1) December 31, 2000, or (2) specified dates in the years 1997-1999 following a determination that the number of taxpayers who are active MSA participants (had tax-advantaged contributions to their accounts) exceeds certain thresholds.³⁶ Once eligibility is restricted, tax-advantaged MSAs generally will be limited to individuals who either were active MSA participants prior to the cut-off date or become active participants through a participating employer.³⁷

What Insurance Requirements Apply?

To have a tax-advantaged MSA, individuals generally must be covered by high deductible insurance (or, more broadly, high deductible health plans.)³⁸ Under the

³⁴ (...continued)

in this case they would not be able to deduct any of the cost of their health insurance.

³⁵ For a new employer, the determination is based on the average number of employees it is reasonably expected to employ in the current calendar year.

³⁶ The Act has a schedule of “cut-off dates” which are designed to enable the Department of the Treasury to limit the total number of tax-advantaged MSAs established. Cut-off dates apply if a threshold is exceeded earlier in the year. The general cut-off date for 1997 is September 1, 1997, while for 1998 and 1999 it is the October 1 of those years. (For self-employed individuals, the dates are October 1 for 1997 and November 1 for 1998 and 1999. For all 3 years, the date is December 31 for individuals whose employers have regularly-scheduled enrollment periods during the last 3 months of the year.) For 1997, the thresholds are (1) 375,000, based on accounts established as of April 30 and (2) 525,000, based on accounts established as of June 30. (The IRS determined that 7,383 countable MSAs were established by the former date and 17,145 by the latter. See IRS announcements 97-79 and 97-96.) For 1998, the thresholds are (1) 600,000, based on accounts shown on returns (filed on or before April 15) for the 1997 tax year and estimates of 1997 accounts started since then, or (2) 750,000, based on 90% of the sum in (1) plus 2.5 times the estimated number of accounts started in January through June. For 1999, the thresholds are (1) 750,000, based on accounts shown on returns (filed on or before April 15) for the 1998 tax year and estimates of 1998 accounts started since then, or (2) 750,000, based on 90% of the sum in (1) plus 2.5 times the estimated number of accounts started in January through June. Individuals who were uninsured for 6 months prior to beginning coverage under a high deductible plan are not counted toward these caps, nor are people whose spouse also established an MSA.

³⁷ A participating employer is one that previously made an MSA contribution that is excludable from gross income or, in a cut-off year, had at least 20% of its employees make contributions of \$100 or more of their own which are deductible.

³⁸ The high deductible insurance requirement applies only to periods when contributions (aside from account earnings) are made to an MSA. Individuals are allowed to retain their MSAs if they change to low-deductible or other non-qualifying plans, in which case contributions must cease (though subsequent account earnings would remain untaxed). For

(continued...)

Act, high deductible insurance has an annual deductible of at least \$1,500 (but not more than \$2,250) for one person and at least \$3,000 (but not more than \$4,500) for more than one (i.e., for a family policy).³⁹ Maximum annual out-of-pocket expenses with respect to covered benefits cannot exceed \$3,000 for one person and \$5,500 for more than one. These figures are adjusted for inflation after 1998.

Insurance or health plans will still be considered high deductible if state law precludes deductibles for preventive care.

Individuals may not be covered under any health plan that is not a high deductible plan and that provides coverage for any benefit covered under the high deductible plan. Exceptions are allowed for coverage (through insurance or otherwise) for accidents, disability, dental care, vision care, long-term care, and certain “permitted insurance.”⁴⁰

What Are Annual Limits and Other Restrictions on MSA Contributions?

MSA contributions are subject to two annual limits. First, they are limited to a percentage of the annual deductible for the high deductible insurance: 65% if the MSA covers one person and 75% if it covers more than one. Second, in the case of eligible employees, they are limited to compensation from the employer sponsoring the high deductible plan; in the case of the self-employed, they are limited to net earnings from the trade or business with respect to which the high deductible health plan is established.⁴¹ No after-tax contributions may be made, and excess contributions (those that exceed the limits just described) are subject to an excise tax.

³⁸ (...continued)

an eligible employee (and for the spouse), the high deductible plan must be established and maintained by the employer; for an eligible self-employed individual (and for the spouse), the plan cannot be established or maintained by any employer.

³⁹ The IRS has ruled that the deductible for insurance covering more than one person applies to all covered expenditures for those individuals (i.e., the insurance must not provide reimbursement until covered expenditures total at least \$3,000). A temporary exception applies to family policies that provide reimbursement when covered expenditures for *one* individual total at least \$1,500. Rev. Rul. 97-20.

⁴⁰ Permitted insurance includes (1) insurance if substantially all the coverage relates to workers’ compensation laws or other liabilities, (2) insurance for a specified disease or illness, and (3) insurance paying a fixed amount per day or other period of hospitalization.

⁴¹ The deduction that self-employed individuals may take for a portion of their health insurance premiums (45% in 1998, rising to 100% in 2007 and thereafter) is also limited to net earnings from self-employment. The two limits apparently are not coordinated: thus the sum of the deduction for the premium and the deduction for the MSA contribution could exceed net earnings.

Employers must make comparable MSA contributions for all participating employees who have comparable coverage.⁴² Either the same amount must be contributed for each employee or the same percentage of the deductible must be. Employers are subject to an excise tax for failure to comply with this rule. Employer contributions may not be made through a cafeteria plan.

Individuals may not contribute to their MSA if their employer does. They also may not contribute if their spouse is covered by the same high deductible insurance plan and the spouse's employer contributes to an MSA of the spouse. Individuals who may be claimed as dependents by another taxpayer may not make contributions of their own. Beginning in 1999, no contributions are allowed for individuals who are entitled to Medicare benefits. Contributions for a year may be made until the due date (without regard to extensions) for the taxpayer's return.

What Is the Tax Treatment of MSA Contributions and Earnings?

With respect to federal income taxes, individuals' MSA contributions are deductible (subject to annual limits described above) in determining adjusted gross income. Thus, they are "above the line" deductions that are not restricted to taxpayers who itemize deductions. Employers' contributions are excludable from gross income, subject to the same limits. Employer contributions are also excluded from employment taxes of both the employer and the employee.

Account earnings are excluded from gross income. Thus interest earned on account balances is tax-exempt.

Some states have enacted legislation with respect to their own income taxes that authorizes deductions and exclusions similar to those just described.⁴³ Other states might automatically allow the same treatment by virtue of the way their taxes are calculated (that is, the calculations are based upon federal income tax returns unless otherwise provided).

What Is the Tax Treatment of MSA Distributions?

Distributions for MSAs are exempt from federal income taxes if used to pay for unreimbursed medical expenses deductible for income tax purposes.⁴⁴ MSA disbursements are not tax exempt if used to purchase insurance, with three exceptions: qualified long-term care insurance as defined by the Health Insurance Portability and Accountability Act of 1996, continuation coverage required by federal law (such as COBRA), and health plan insurance when the individual receives unemployment compensation.

⁴² This rule is applied separately to part-time employees (those who customarily are employed fewer than 30 hours a week).

⁴³ State tax allowances typically apply to MSAs generally, not just those that qualify for federal tax advantages.

⁴⁴ For guidance on what expenses are deductible, see Internal Revenue Service publication 17 (*Your Federal Income Tax*) or 502 (*Medical and Dental Expenses*).

As a general rule, other distributions are included in gross income in calculating federal income taxes and an additional 15% penalty is applied. The 15% penalty is waived in cases of disability, death, or attaining age 65.

Some states have enacted legislation that exempts distributions used to pay unreimbursed medical expenses from their own income taxes.⁴⁵ However, state legislation regarding payments for insurance and the additional penalty for non-qualified distributions is likely to differ from federal law.

Upon death, an MSA may be passed on to a surviving spouse without federal tax liability; otherwise, it is included in the gross income of the beneficiary or of the decedent on the latter's final return. MSA balances are taken into account for determining the federal estate tax.

How Can One Start an MSA?

Employees who work for qualifying small employers should refer questions about starting MSAs to their employers or benefit managers. If their employer chooses not to offer high deductible insurance as defined by the Act, employees will not be eligible to have a tax-advantaged MSA.

Self-employed individuals should inquire about obtaining high deductible insurance from insurance agents or companies licensed to sell insurance in their state. Information about which companies offer policies often is available from the state insurance commissioner. Individuals might approach banks or other financial institutions about administering their MSA. Some insurance companies administer MSAs in conjunction with the high deductible insurance they offer.

Part IV. Other Provisions

When Does the Increase in the Health Insurance Deduction for the Self-employed Go into Effect?

In 1996, the self-employed could deduct 30% of the cost of health insurance for themselves and their families. This deduction increased to 40% in 1997. For 1998 and 1999, the deduction will be 45%. As a result of a further change in law (P.L. 105-35), the phased increase of the deduction will be 50% for 2000 and 2001, 60% for 2002, 80% for 2003 through 2005, 90% for 2006, and 100% for 2007 and thereafter.

How Do the Long-Term Care Tax Incentives Work?

Effective January 1, 1997, the Act amends the tax code to treat private long-term care policies and long-term care expenses the way health insurance policies and

⁴⁵ If states do not authorize tax-advantaged MSAs with respect to their own income taxes, distributions would not be subject to state taxes in the first place.

health care expenses are currently treated under the code. These changes have several different dimensions:

(1) Amounts received under a “qualified” long-term care insurance plan will be considered medical expenses and excluded from gross income. (Per diem policies that pay benefits on the basis of disability and not actual services used, however, would be subject to a cap. The amount of the dollar cap is \$175 per day per person, indexed for inflation. In the event that a person has both a per diem disability policy and another policy that reimburses for services used, then this cap amount is reduced by the amount of reimbursements and payments received by anyone for the cost of qualified long-term care services for the insured person. If more than one person receives payments for services needed by the insured person, then all such persons are treated as one person for purposes of the dollar cap. If payments under long-term care insurance plans exceed the dollar cap, then the excess is excluded from income subject to taxation only to the extent the individual has incurred actual costs for long-term care services in excess of the dollar cap. Amounts in excess of the dollar cap, with respect to which no actual costs were incurred for long-term care services, are fully includable in income and subject to taxation.)

(2) Contributions of an employer to the cost of qualified long-term care insurance premiums will be excluded from the gross income of the employee, and will, therefore, be exempt from tax to the employee (so long as they do not exceed certain annual dollar limits that vary with the insured person’s age). This favorable tax treatment, however, is not extended to employer-sponsored cafeteria plans or flexible spending arrangements. (Long-term care insurance premiums paid by an employer would continue to be tax deductible as a business expense for the employer, as they are under current law.)

(3) Out-of-pocket (i.e., unreimbursed) long-term care expenses (including premium costs within age-adjusted limits) will be allowed as itemized deductions, to the extent they and other unreimbursed medical expenses exceed 7.5% of adjusted gross income.

(4) Self-employed individuals will be allowed to include the premium costs of long-term care insurance in determining their allowable deduction for health insurance expenses. Only amounts not exceeding age adjusted limits can be included. The deduction for health insurance expenses rises from 40% of the amount paid in 1997 to 80% in 2006 and years thereafter.

What Is a “Qualified” Long-Term Care Insurance Policy?

A qualified long-term care insurance plan is defined as a contract that covers only long-term care services; does not pay or reimburse expenses covered under Medicare; is guaranteed renewable; does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policy holder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Policies issued before January 1, 1997, and

meeting a state's long-term care insurance requirements at the time the policy was issued, would be considered a qualified plan for purposes of favorable tax treatment.

Have Regulations Been Issued to Implement the Long-Term Care Insurance Provisions of the Act

On May 6, 1997 (Notice 97-31), and December 31, 1997 (Proposed Regulations), the Internal Revenue Service issued interim standards for taxpayers to use in interpreting these new long-term care provisions.⁴⁶ Among other things, the interim standards provide safe harbor definitions for certain terms, such as “substantial assistance,” “severe cognitive impairment,” and “substantial supervision” that will apply to post-1996 contracts until regulations are published on these issues. The guidance also establishes a safe harbor for continuation of pre-1997 insurance standards to post-1996 contracts for purposes of determining whether an individual is unable to perform an ADL due to a loss of functional capacity or requires substantial supervision due to cognitive impairment. This means that if an insurance company makes determinations regarding an individual's functional or cognitive impairment under a post-1996 contract using its pre-1997 standards, the contract will be deemed to satisfy the law's requirement for eligibility, until regulations are issued. In addition, the interim guidance outlines the procedure for determining whether a policy meets the consumer protection requirements of the law. Finally the guidance specifies practices that will not be treated as material changes of policies issued before January 1, 1997, that would compromise their “grandfathered” status as described above. This interim guidance, together with the law, sets forth requirements that “qualified” long-term care insurance and expenses must meet in order to be eligible for favorable tax treatment under the law.

What Are “Qualified” Long-Term Care Services?

Qualified long-term care services are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are required by a chronically ill individual, and are provided according to a plan of care prescribed by a licensed health care practitioner. However, amounts paid for services provided by the spouse of a chronically ill person or by a relative (directly or through a partnership, corporation, or other entity) will not be considered a medical expense eligible for favorable tax treatment, unless the service is provided by a licensed professional.

How Are Chronically Ill Persons Defined?

Chronically ill persons are those individuals unable to perform, without substantial assistance from another individual, at least two of six specified activities of daily living (ADLs) for a period of at least 90 days due to a loss of functional capacity. The six specified ADLs include bathing, dressing, transferring, toileting, eating, and continence. Furthermore, the number of ADLs that are taken into account under a plan may not be less than five of those specified above. In other words, a

⁴⁶ The December 31, 1997 proposed regulations were published in the *Federal Register* of January 2, 1998.

plan does not meet the definition if it requires that an individual be unable to perform two out of any four of the activities listed in the bill. The Act also defines chronically ill persons as including those having a level of disability similar (as determined by the Secretary of the Treasury in consultation with the Secretary of HHS) to the level of disability specified for functional impairments, as well as those requiring substantial supervision to protect them from threats to health and safety due to severe cognitive impairment. Persons are required to be certified by a licensed health practitioner within the preceding 12-month period in order to meet these definitional requirements.

Does the Act Extend Favorable Tax Treatment to Accelerated Life Insurance Benefits Used by Persons Requiring Long-Term Care?

Yes. The Act amends the tax code to extend favorable tax treatment to “accelerated death benefits” received by chronically ill persons (as defined above) and terminally ill persons under life insurance policies. Many life insurance policies now contain clauses or riders allowing part of the value of death benefits to be paid because of impending death instead of waiting until actual death. These accelerated death benefits are calculated based on the benefits that would be paid at death, discounted to the time of actual payment based on the projected time of death and an agreed discount rate. Under current tax law (i.e., before January 1, 1997), benefits paid because of the death of the insured are generally not taxable, but the proceeds from cashing in or selling a life insurance policy are taxable if they exceed the cost of the policy, just as for the sale of any asset.

For the chronically and terminally ill, the Act excludes from gross income (1) amounts received as accelerated death benefits and (2) amounts received for the sale or assignment of a life insurance policy to a qualified viatical settlement provider, i.e., companies which are regularly engaged in the trade or business of purchasing or taking assignment of life insurance policies on the lives of insured persons who are chronically or terminally ill and which meet certain specified requirements.⁴⁷ The exclusion is limited to payments for long-term care services not compensated for by insurance or otherwise.

⁴⁷ For more information on accelerated death benefits under P.L. 104-191, see: Taylor, *Income Tax Treatment of Accelerated Death Benefits*.

