

Health Insurance Portability and Accountability Act of 1996 --  
Benefits Provision

Summary Page

White Paper

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 --  
BENEFITS PROVISIONS**

This White Paper discusses many of the benefit-related provisions of the Health Insurance Portability and Accountability Act of 1996. This legislation represents a slimmed-down version of previous bipartisan health insurance reform proposals and contains provisions that limit preexisting condition exclusions, prohibit discrimination against participants and beneficiaries based on health status, guarantee availability and renewability of coverage for certain employers and individuals, prevent health care fraud and abuse, clarify and expand certain provisions of COBRA, increase the attractiveness of long-term care insurance, and authorize medical spending accounts for small employers and self-employed individuals.

## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 -- BENEFITS PROVISIONS**

September 1996

On August 21, President Clinton signed into law the Health Insurance Portability and Accountability Act of 1996 (the Health Insurance Act). The purpose of the Health Insurance Act, as stated in the Conference Report, is to “improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health care insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.” This legislation represents a slimmed-down version of previous bipartisan health insurance reform proposals and contains provisions that limit preexisting condition exclusions, prohibit discrimination against participants and beneficiaries based on health status, guarantee availability and renewability of coverage for certain employers and individuals, prevent health care fraud and abuse, clarify and expand certain provisions of COBRA, increase the attractiveness of long-term care insurance, and authorize medical spending accounts for small employers and self-employed individuals. Employers will need to review and modify their health care plans and COBRA communications for compliance.

### **Preexisting Condition Exclusions and Health Coverage Portability**

Group health plans and health insurance issuers offering group health insurance coverage will be required to limit preexisting condition exclusions to a maximum of 12 months (18 months for late enrollees). In addition, they will be required to reduce any preexisting condition limitation with respect to an individual by the period during which such individual had prior “creditable coverage,” unless such individual has had a break in coverage that extended beyond 63 days. Any eligibility waiting period would not be counted as part of the 63-day break period. In addition, any preexisting exclusions generally would not apply to pregnancies, newborns, adopted children and children placed for adoption. A plan will not be permitted to exclude a preexisting condition based upon genetic information of the individual unless a diagnosis of a condition related to such information has been made.

“Creditable coverage” includes coverage of the individual under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance), Medicare, Medicaid, military-sponsored health care and certain other government-sponsored medical plans. An individual would establish prior creditable coverage through certification provided by the plan or insurance carrier, or through such other procedure as may be required by regulation. Insurers and health plan sponsors will be required to maintain coverage records and to issue certifications of coverage for periods of coverage occurring after July 1, 1996, and, therefore, will need to develop procedures to meet this new reporting obligation.

The new legislation provides two methods of determining creditable coverage periods, one without regard to specific benefits covered during the period, the other with reference to several classes or categories of benefits provided.

In addition, HMOs or group health plans offering coverage through an HMO may impose a n “affiliation period” of two months (three months for late enrollees) provided the period is applied uniformly without regard to health status and no preexisting condition exclusion exists.

Failure to comply with these provisions may result in a tax equal to \$100 per day until the failure is corrected.

With certain exceptions, these provisions are effective for plan years beginning after June 30, 1997.

### **Availability of Health Coverage**

The Health Insurance Act provides that health plans and health insurance issuers offering group health insurance coverage cannot deny coverage or require greater premiums from an individual based on the individual’s health status, medical condition, medical history, genetic information, evidence of insurability or disability.

In addition, group health plans and health insurance issuers offering group health insurance coverage generally will be required to permit late enrollment for individuals who originally declined coverage due to alternative coverage, if they lose such other coverage and request enrollment within 30 days.

The new legislation also provides that a health insurance issuer offering group health insurance coverage will be required to renew or continue in force coverage at the option of the employer except under limited circumstances (e.g., nonpayment of premiums). Similar provisions also apply to a health insurance issuer that provides individual coverage.

Under the Act, a multiemployer welfare plan may not deny an employer whose employees are covered under such plan continued access to the same or different coverage under the terms of the plan, other than: (1) for nonpayment of contributions; (2) for fraud or other material misrepresentation; (3) for noncompliance with material plan provisions; (4) because the plan is ceasing to offer any coverage in a geographic area; and (5) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining agreement, or to employ employees covered by such agreement.

With certain exceptions, these provisions are effective for plan years beginning after June 30, 1997.

## **Disclosure Requirements**

The Health Insurance Act amends ERISA to provide that in the event there is a material reduction in covered services or benefits provided under a group health plan, a summary description of the modification or change must be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or the change.

These provisions are effective for plan years beginning after June 30, 1997.

## **COBRA Clarifications**

Under current law, the COBRA rules provide that the 18-month maximum coverage continuation period is extended to 29 months if the qualified beneficiary is determined under the Social Security Act to have been disabled at the time of the qualifying event. The new legislation amends COBRA to provide that the extended COBRA coverage period applies if the disability exists at any time during the first 60 days of the COBRA coverage. In addition, the new legislation clarifies that the extended 29-month period also applies to a disabled qualified beneficiary of the covered employee.

The definition of qualified beneficiary is amended to include a child born to or placed for adoption with the covered employee during the period of COBRA coverage. The new legislation also coordinates COBRA rules with the new requirements regarding preexisting condition exclusions. Once the new rules are in effect, a qualified beneficiary's COBRA coverage can be terminated if he or she becomes covered under another group health plan, even if the new coverage contains a preexisting condition limitation or exclusion; provided, however, that the preexisting condition limitation or exclusion under the new coverage does not apply to such individual as a result of the new legislation that limits the application of preexisting conditions.

These changes were effective January 1, 1997, regardless of when the qualifying event has occurred. Group health plans are required to notify each qualified beneficiary who has elected COBRA coverage of these changes by November 1, although any group health plan that has not sent this notice by November 1 should still do so promptly.

## **Medical Spending Accounts**

On an experimental and limited basis, self-employed individuals and small employers (employers with up to 50 employees) can establish or allow employees to establish medical savings accounts (MSAs) in conjunction with high deductible health insurance plans (plans that have an annual deductible of at least \$1,500 and no more than \$2,500 for individual coverage and at least \$3,000 and not more than \$4,500 for family coverage). Contributions to MSAs can be made by either the employer or the employee, but not both (employee contributions are not permitted in any year in which employer contributions are made). In addition, an employer making contributions must make comparable contributions for all employees with comparable health coverage.

Employee contributions to an MSA will be deductible (within limits) by the employee, and employer contributions will be excludable (within the same limits) from the employee's income provided that such contributions are not made through a cafeteria plan. Earnings on amounts held in an MSA will not be currently taxable. In addition, distributions from an MSA for medical expenses generally will be excludable from income provided the individual for whom the expenses were incurred was covered under the high deductible plan. Distributions that are not for medical expenses will be includable in income and will be subject to a 15 percent penalty tax if made prior to age 65, death or disability. Amounts remaining in the individual's MSA upon death will be includable in his or her gross estate, with special rules if the surviving spouse is named as the beneficiary.

These provisions are effective for taxable years beginning after December 31, 1996.

### **Self-Employed Individuals -- Deduction for Health Insurance**

The new legislation provides increases in the deduction for health insurance of self-employed individuals (currently 30 percent) to 40 percent in 1997, 45 percent in 1998 through 2002; 50 percent in 2003; 60 percent in 2004; 70 percent in 2005; and 80 percent in 2006 and thereafter.

### **Long-Term Care Insurance**

Under the Health Insurance Act, employer-provided coverage for long-term care insurance, within modest limits related to age, will be tax-free to covered employees. Long-term care premiums cannot, however, be provided through a cafeteria plan and long-term care expenses cannot be reimbursed under a flexible spending account. COBRA continuation coverage is not required for long-term care insurance.

With certain exceptions, amounts (other than policyholder dividends or premium refunds) received under a long-term care insurance contract generally will be excludable from income, subject to a cap of \$175 per day (indexed), or \$63,875 annually.

Unreimbursed expenses for long-term care services, and long-term care insurance premiums (subject to specified dollar limits), will be deductible as medical expenses (subject to the 7.5 percent floor).

These provisions are effective for taxable years beginning after December 31, 1996.

## **Withdrawals from IRAs for Medical Expenses**

The 10 percent excise tax for early withdrawals from IRAs will not apply to the extent a withdrawal is used for medical expenses that exceed 7.5 percent of the individual's adjusted gross income (the floor for medical expenses). In addition, the 10 percent excise tax will not apply to withdrawals for medical insurance if the individual has received unemployment compensation for at least 12 weeks and the withdrawal is made in the year such unemployment compensation is received or the following year. This exception ceases to apply, however, if the individual has been employed for at least 60 days.

These provisions apply to all withdrawals made after December 31, 1996.

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