

Health Insurance Reform Legislation

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The Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996 (Public Law 104-19), provides for improved access and renewability with respect to employment-related group health plans, to health insurance coverage sold in connection with group plans, and to the individual market (by amending the Public Health Service Act). The Act's provisions include improvements in portability and continuity of health insurance coverage; combatting waste, fraud, and abuse in health insurance and health care delivery; promoting the use of medical savings accounts; improving access to long-term care services and insurance coverage; administrative simplification; and addressing duplication and coordination of Medicare benefits.

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Provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996 (Public Law 104-19), fall under five titles:

Title I enacts reforms in both the group and individual health insurance markets to help workers maintain insurance coverage if they lose or leave their jobs.

Title II makes changes to the Social Security Act concerning health care fraud and abuse, administrative simplification, and duplication and coordination of Medicare benefits.

Title III contains major health-related tax provisions.

Title IV provides, through the Code, for the application and enforcement of group health plan requirements that parallel those of Title I.

Title V discusses revenue offsets. Major changes under this provision are explained in more detail later in the article.

Title I of HIPAA amends the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS), and Title IV amends the Internal Revenue Code of 1986 (the Code). Group health plans are generally regulated by the Department of Labor under ERISA, and by the Internal Revenue Service under the Code.

Health insurance coverage sold to plans in the group market, and to individuals, is regulated by the States under State law. The individual health insurance market provisions of HIPAA recognize their primary role and afford the States great flexibility in implementing the required reforms. While the statute gives the Department of Health and Human Services (HHS) enforcement authority if a State fails to substantially enforce Federal requirements, the primary authority rests with the States.

Title I: Health Care Portability, Access, and Renewability

Under group market rules, new provisions are added to ERISA, the PHS Act, and the Code to include portability, accessibility, and renewability requirements of group health plans.

Increased Portability

The new law provides increased portability by limiting the use of "preexisting condition" exclusions in group health plans. Group health plans and issuers of health insurance offering coverage under

group health plans may impose a preexisting condition exclusion with respect to a participant or beneficiary only if:

- the exclusion relates to a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;
- the exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and
- the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of “creditable coverage” applicable to the participant or beneficiary as of the enrollment date.

For purposes of the last provision, creditable coverage means coverage of the individual under any of the following:

- (1) a group health plan (including a government or church plan);
- (2) health insurance coverage (group or individual);
- (3) Medicare;
- (4) Medicaid;
- (5) military-sponsored health programs;
- (6) Indian Health Service or tribal health programs;
- (7) a State health benefits risk pool;
- (8) Federal Employees’ health benefit plans;
- (9) a public health plan; or
- (10) a health benefit plan under the Peace Corps Act.

However, a period of creditable coverage is not counted with respect to an individual if, *after* such a period of coverage and *before* the enrollment date, there is a 63-day period during all of which the individual does not have any creditable coverage. Any waiting period imposed is not taken into account when determining whether there has been a 63-day break, and a waiting period is not counted as creditable coverage. There are two methods for counting creditable coverage:

The standard method.—The plan or issuer imposing a preexisting condition exclusion counts creditable coverage without regard to the specific benefits included in the coverage; and

The alternative method.—The plan or issuer counts creditable coverage based on coverage within classes or categories of benefits specified in the interim regulations, published on April 8, 1997, in the *Federal Register* (with corrections published in the *Federal Register* on June 10, 1997). Creditable coverage is then counted with respect to any class or category if any level of benefits is covered within the class or

category. The plan or issuer must use this alternative method on a uniform basis for, and must prominently disclose this fact to, all participants and employers.

No preexisting pregnancy exclusion may be imposed, and no preexisting condition exclusion may be applied to newborns who have creditable coverage as of the 30th day after birth. No exclusion may be imposed for coverage of children adopted (or placed for adoption) before attaining 18 years of age if creditable coverage is provided as of the 30th day after adoption. However, a preexisting condition exclusion may be imposed on newborns and adopted children if they incur a break in coverage of at least 63 days.

A “certificate of creditable coverage” is the principal means for demonstrating an individual’s creditable coverage. It is a written document that must include information specified in the interim regulations published on April 8, 1997, in the *Federal Register*. With respect to certificates, coverage providers fall into two groups. Those in the first group include plans; issuers of group or individual insurance (including association plans and college health plans); Medicare; Medicaid; CHAMPUS; and the Indian Health Service and are required to issue certificates.

Those in the second group include the Federal Employees’ Health Benefit Program; State high-risk pools; public health plans; and Peace Corps plans are not specifically required to issue certificates by the Act. However, in the latter case, any issuer from the first group used to provide this coverage may be required to furnish certificates unless the “underlying” program decides to issue them voluntarily.

In the absence of a certificate, creditable coverage may be demonstrated by presenting other documentation. Any plan or issuer seeking to impose a preexisting condition exclusion period must accept the attestation unless it can prove that the individual did not have the claimed creditable coverage.

Both the Act and interim regulations provide special rules with regard to certification for dependent coverage.

Special Enrollment Periods for Individuals Losing Other Coverage

Group health plans and insurers offering group health insurance coverage must permit an employee who is not enrolled but is eligible for coverage under the terms of the plan (or a dependent if the dependent is so eligible) to enroll under the terms of the plan if each of the following conditions is met.

- The employee or dependent must have been covered under a group health plan or had health insurance at the time coverage was previously offered.
- The employee must have stated in writing when coverage was offered (if the plan sponsor required such a statement) that the reason for declining it was that he or she had other coverage.
- If the employee or dependent had COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation

coverage at the time the coverage under the plan was offered, that continuation coverage must be exhausted. If the other coverage was not COBRA, it must have terminated as a result of loss of eligibility (including, specifically, as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), or employer contributions toward such coverage must be terminated.

- The employee must request coverage under the plan no later than 30 days after the date of exhaustion of the COBRA continuation coverage, or the termination of the other coverage or employer contributions toward it.

Special Enrollment Rules for Dependents.—A special enrollment period for dependents is available when the following three conditions are met:

- (1) A group health plan or issuer of group health insurance coverage makes coverage available to the dependent;
- (2) The individual on whom dependency rests is a participant under the plan (or would be an eligible enrollee but for failure to enroll during a previous enrollment period); and
- (3) The dependent special enrollment period must last at least 30 days beginning on the later of the date dependent coverage is made available, or the date of the marriage, birth, adoption, or placement of adoption.

Use of Affiliation Periods.—As an alternative to the preexisting condition provisions outlined above, group plans offering medical care through a health maintenance organization (HMO) may provide for an *affiliation period* that must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during the affiliation period and no premium may be charged for any coverage during the period. There can be an affiliation period only if: no preexisting condition exclusion is imposed; the period is imposed uniformly without regard to any health status-related factors; and the period does not exceed 2 months, or 3 months in the case of late enrollment.

Prohibiting Discrimination Based on Health Status.—Group health plans must not establish rules for enrollment eligibility (including continued eligibility) based on any of the following factors relating to the health of any person or dependent: health status; medical condition (including both physical or mental illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

Guaranteed Renewability in Multi-employer Plans or Multiple Employer Welfare Arrangements.—A multi-employer group health plan or multiple employer welfare arrangement may not deny an employer continued employee access to the same or different coverage under the terms of the plan except

under the following conditions: nonpayment of contributions; fraud or other intentional misrepresentation of material fact by the employer; noncompliance with material plan provisions; the plan ceases to offer any coverage in a geographic area; or, when the plan offers benefits through a network and there is no longer any enrolled employee living or working in the area served by the network.

These plans may deny renewal based on failure to meet the terms of any applicable collective bargaining agreement. Plans offered through an association of which the employer is a member may also deny renewal if the employer no longer is a member of the sponsoring association.

Preemption and Enforcement.

Nothing in the Act may be construed as preempting State laws that establish, implement, or continue in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage, with two exceptions: (1) to the extent that such standard or requirement prevents application of any requirement of the Act, and (2) with regard to preexisting conditions. However, States may implement preexisting-condition limitations that are more favorable to individuals than those in the Act. Preemption under ERISA with respect to group health plans is not modified by the Act. The provisions do not apply to group health plans with fewer than two participants who are current employees unless a State regulates this as a group health plan. In addition, State and Federal enforcement provisions are provided for failure to meet certain requirements in the small or large group health insurance markets.

A *small* employer is one with an average during the calendar year of at least 2 but not more than 50 employees; a *large* employer averages more. States may opt to regulate “groups of one” in the group market or raise the small group threshold higher than 50.

Each health issuer offering health insurance coverage in the small-group market in a State must accept every small employer that applies for such coverage, must enroll every eligible individual who applies during the period when first eligible, and may not place any restriction inconsistent with the Act’s prohibition against discrimination based on health status.

Non-Federal (State and local) Governmental Plans

In addition to having oversight of State enforcement, HHS has direct regulatory authority over non-Federal government plans. If self-funded, such plans may annually elect to be exempt from any or all HIPAA requirements, except for those dealing with certificates of creditable coverage. Procedures to opt out of HIPAA requirements are specified in interim regulations published in the *Federal Register* on April 8, 1997.

The Secretary of HHS may request that the chief executive officer of each State provide information concerning access and lack of access by large employers to health insurance. The Comptroller General must conduct a study of the extent to

which large employers in different States are able to obtain access to health insurance coverage and the circumstances surrounding lack of access.

Insurers offering health insurance in the small group market through network plans, may limit the employers that they accept to those with eligible individuals who live, work, or reside in the network service area. Such plans may also deny coverage *within* the service area to employers if the issuer can demonstrate to the applicable State authority (if required) an incapacity to deliver adequate services to enrollees of any additional groups because of obligations to existing group contract holders and enrollees, and, that it is applying this exception uniformly to all employers without regard to the claims experience of those employers and their employees, dependents, or any health status-related factor. An issuer who denies coverage in an area on these grounds may not then offer coverage in that area for at least 180 days.

An issuer may deny insurance coverage in the small group market, having demonstrated (if required) that it does not have the financial reserves needed to underwrite additional coverage, and that it is applying this policy uniformly. An issuer denying coverage on this basis may not then issue coverage to group health plans in the State for 180 days, or until it has sufficient financial reserves to underwrite additional coverage, whichever is later.

These restrictions must not be construed as prohibiting insurers from establishing minimum levels of employer contributions toward the premium for enrollment of beneficiaries, or from establishing a minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees.

Guaranteed Renewability

Health insurance offered to employers in both the small and large group markets must be renewable, with limited exceptions. Permitted reasons for termination are: nonpayment of premiums; fraud; violation of participation or contribution rules; termination of coverage; movement outside service area; and ending of association membership.

When an issuer decides to discontinue offering *a particular type* of large or small group market group health insurance coverage in compliance with applicable State law, the issuer must provide at least 90 days notice to each plan sponsor that is provided such coverage, and to all participants and beneficiaries. The issuer also must offer to each plan sponsor the option to purchase any health insurance coverage currently being offered by the issuer to a group health plan in the market. In exercising this option, the issuer must act uniformly without regard to claims experience of sponsors and any health status-related factor.

A plan may also discontinue offering *all* group health insurance in a market, giving 180 days notice and assuring that all health insurance offered by the issuer in the market is discontinued and not renewed. In such cases, the issuer may not reenter the State market in question for at least 5 years.

Modifications can be made to health insurance offered to large-employer group plans if the modifications are made in accordance with State law and are effective on a uniform basis among all plans with that product.

Disclosure of Information.—Health insurance issuers must make reasonable disclosure to small employers concerning the plans offered, the issuer's right to change premium rates and the factors that may affect changes, renewability, preexisting condition exclusions, and the benefits and premiums available under all health insurance coverage for which the employer qualifies.

Individual Market Rules.—The *individual* market offers health insurance coverage to individuals other than in connection with group plans. Insurers offering individual coverage cannot deny enrollment of an "eligible individual" (as defined in HIPAA and interim regulations published in the *Federal Register* on April 8, 1997). Also, no preexisting condition exclusion may be applied.

An issuer providing coverage to anyone in the individual market is required to renew or continue coverage at the individual's option, barring premium nonpayment, fraud or other specified factors. Individual market issuers are responsible for certifying periods of creditable coverage in the same manner as issuers in the group market. A State may implement the Federal fallback rules for implementing the guaranteed eligible individual availability provisions of HIPAA identified in the Act or interim regulations published on April 8, 1997, in the *Federal Register*; alternatively, it may implement a mechanism permitting the State to determine how a choice of individual market coverage will be made available to eligible individuals. HIPAA also provides for Federal enforcement of the fallback rules if a State does not act.

General and Miscellaneous Provisions.—Studies and reports to appropriate Congressional committees are mandated on: (1) the effectiveness of the provisions of this title and State laws in ensuring the group and individual health coverage availability; and (2) patient access to and choice of providers inside and outside of networks, the cost and cost-effectiveness to issuers of out-of-network access, and the impact providing that access on cost and quality. The Health Care Financing Administration (HCFA) is required to complete its study of Medicare reimbursement of all telemedicine services and report to Congress.

An HMO is allowed to offer a high-deductible health plan. A free clinic health professional is deemed to be a Public Health Service employee for purposes of provisions relating to proceedings against commissioned officers or employees for damages resulting from the provision of health services.

Title II: Preventing Health Care Fraud and Abuse; Administrative Simplification; and Medical Liability Reform

Unless noted otherwise, changes under this title shall be considered to be made to the Social Security Act.

Fraud and Abuse Control Program

Title XI of the Social Security Act was amended to require the Secretary of Health and Human Services (HHS), acting through HHS' Office of Inspector General (IG), and the Justice Department's Attorney General to establish a program to:

- coordinate Federal, State, and local law enforcement programs to control health care fraud and abuse;
- conduct investigations, audits, and inspections relating to the delivery of and payment for health care;
- facilitate enforcement of certain provisions to Title XI and other Acts applicable to health care fraud and abuse;
- provide for the modification and establishment of safe harbors, and issue advisory opinions and special fraud alerts; and
- provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the establishment of the data collection system.

The Health Care Fraud and Abuse Control Account (Account)

This Account is established in Medicare's Federal Hospital Insurance Trust Fund to hold the criminal fines, civil monetary penalties and assessments obtained from all health-care cases, property forfeiture proceeds resulting from such cases, and other specified amounts for financing the program above, and for the Medicare Integrity Program established by this title. Appropriations are made to the trust fund and Account, earmarking amounts for activities of HHS' Inspector General with respect to the Medicare and Medicaid programs under SSA Titles XVIII and XIX. The Secretary and the Attorney General are required to jointly submit a report to Congress with regard to trust fund appropriations. The Comptroller General is directed to submit a similar report to Congress analyzing trust fund operations.

Health Care Fraud and Abuse Data Collection

The Secretary is directed to establish a national health care fraud and abuse data collection program for reporting final adverse actions against health care providers, suppliers, or practitioners and maintain a database of such information. Each Government agency and health plan is required to report to the Secretary any such adverse action. The Secretary is allowed to establish reasonable fees for disclosure of information in the database.

The Medicare Integrity Program

Under this Program, the Secretary shall promote the integrity of the Medicare program by entering into contracts with certain eligible entities to:

- review the activities of Medicare providers and others furnishing services, audit cost reports, and determine whether payment should not have been made as a result of the Medicare Secondary Payer provision;
- educate service providers, beneficiaries, and other persons with respect to payment and benefit issues; and
- develop and periodically update a list of items of durable medical equipment subject to prior authorization.

The process for entering into contracts is detailed, and certain limitations on contractor liability are set.

Fiscal intermediaries under Medicare Part A and carriers under Medicare Part B carrying out certain activities under contract to this Program are prohibited from carrying out such activity under a Medicare intermediary or carrier contract.

The Beneficiary Incentive Program

The Secretary is directed to explain Medicare benefits for which payment may be made to an individual with respect to each furnished item or service, whether or not a deductible or coinsurance may be imposed.

The Secretary is also directed to establish a program for encouraging individuals to report fraud and abuse under Federal or State health care programs, and to suggest methods to improve Medicare's efficiency. Individuals will be paid a portion of amounts collected due to any such reports, or the savings resulting from any suggestions which are adopted.

Expansion of Authority under Section 1128B

SSA Title XI is amended to require applying criminal penalties specified for acts involving the Medicare program to similar violations of any plan or program providing health benefits—whether directly, through insurance, or otherwise—which are directly funded, in whole or in part, by the Federal Government, except the Federal Employees' Health Benefits Program.

Application of Fraud and Abuse Sanctions

The Secretary is directed to periodically publish a notice in the *Federal Register* soliciting proposals for:

- (1) modifications to existing safe harbors issued under the Medicare and Medicaid Patient and Program Protection Act of 1987;
- (2) additional safe harbors specifying payment practices that shall not be treated as a criminal offense or serve as the basis for an exclusion;
- (3) advisory opinions by the HHS Inspector General with regard to prohibited remuneration constituting grounds for the imposition of a sanction; and

- (4) special fraud alerts by the Inspector General with regard to suspect practices under the Medicare program or a State health care program.

The Secretary is required to issue appropriate implementing regulations.

Revisions to Current Sanctions for Fraud and Abuse

The Secretary must exclude from participation in Medicare and State health care programs any individual or entity convicted of a felony related to a controlled substance other than possession, or to fraud or other financial misconduct in connection with the delivery of a health-care item or service, or with respect to an act or omission in a health care program funded in whole or in part by Federal, State or local government. Other changes include:

- Revising specified current sanctions involving exclusion for fraud and abuse under Medicare and State health care programs to establish minimum exclusion periods for:
 - (1) individuals and entities subject to permissive exclusion from Medicare and State health care programs; and
 - (2) practitioners and persons failing to meet certain statutory obligations with regard to services or items.
- Authorizing the permissive exclusion of individuals with a direct or indirect ownership or controlling interest in certain sanctioned entities.
- Repealing the prerequisite that a practitioner or person be determined “unwilling or unable” to comply with Medicare provider obligations before imposing sanctions (thus increasing the Secretary’s ability to exclude providers of poor quality care).
- Permitting intermediate sanctions on Medicare health maintenance organizations in addition to the current termination option, and providing additional intermediate sanctions for miscellaneous violations.
- Providing an additional specified exception to anti-kickback penalties for risk-sharing arrangements, and a process for negotiated rulemaking.
- Creating a criminal penalty under SSATitle XIX for any person who knowingly and willfully disposes of assets, including any transfer to a trust, in order for an individual to become eligible for Medicaid long-term care benefits.

Civil Monetary Penalties

Civil monetary penalties are revised, providing for:

- (1) exclusion from participation in Federal and State health care programs of persons subject to penalties and assessments for applicable program violations;

- (2) modifications in the amounts of various specified penalties and assessments, including sanctions against health care practitioners who violate their statutory obligations with regard to the services or items ordered or provided to a covered beneficiary or recipient;
- (3) a prohibition against offering inducements to individuals enrolled under Medicare or a State health care program;
- (4) civil money penalties for excluded individuals retaining an ownership or controlling interest in a participating entity if they knew or should have known of the action constituting the basis for exclusion at the time of violation;
- (5) a specific definition of remuneration, for penalty purposes, which includes waiver of coinsurance and deductible amounts and transfers of items or services for free or for other than fair market value; and
- (6) a penalty for false certification for home-health services.

Revisions to Criminal Law

The Federal criminal code is amended to set penalties for committing health-care fraud, theft, or embezzlement in connection with health-care, false statements relating to health-care matters, obstruction of criminal investigations of Federal health care offenses, and laundering of monetary instruments in connection with such an offense. Injunctive relief for covered Federal health care offenses is provided, as well as property forfeitures. Investigative demand procedures are specified, including limits on the disclosure of health information about an individual in any administrative, civil, or criminal action or investigation.

Administrative Simplification

Title XI of the Social Security Act is amended to add a new Part C—*Administrative Simplification*. This new Part requires the Secretary to adopt the following specified standards and requirements for the electronic transmission of certain health information which will apply to the entire health care industry:

- Health claims or equivalent encounter information.
- Enrollment and disenrollment in a health plan.
- Eligibility for a health plan.
- Health care payment and remittance advice.
- Health plan premium payments.
- First report of injury.
- Health claims status.
- Referral certification and authorization.

- Coordination of benefits.
- Attachments.
- Code sets for the data elements of the above transactions.
- Unique identifiers for individuals, employers, health plans, and health care providers.
- Security standards and safeguards for electronic information systems involved in the above transactions and electronic signatures.

In adopting these standards, the Secretary is required to rely on recommendations of the National Committee on Vital and Health Statistics, and to consult with appropriate Federal and State agencies and private organizations. Additional Administrative Simplification provisions include:

- Penalties for violations of this subtitle, including wrongful disclosure of individually identifiable health information.
- Amending the Public Health Service Act to change the membership and duties of the National Committee on Vital and Health Statistics, including responsibility for advising the Secretary and the Congress on implementation of the Administrative Simplification requirements of this subtitle.
- Directing the Secretary to submit detailed recommendations to specified Congressional committees on the privacy standards for individually identifiable health information.

Duplication and Coordination of Medicare-Related Plans

Certain health insurance policies (other than supplemental Medicare policies) are not considered to duplicate benefits under Medicare, Medicaid, or other health insurance policies, if they fit into one of two categories. The first includes policies that do not coordinate benefits with any other coverage, such as hospital indemnity and specified disease policies. The second category of policies provides health care benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof; coordinates against or excludes items and services available or paid for under Medicare or another health insurance policy; and discloses such coordination or exclusion, in policies sold or issued on or after a specified date, in the policy's outline of coverage. The disclosure statements that must be borne by these categories of policies are also revised.

Patent Extension

Beginning February 28, 1997, the active agent patent (and prohibition of infringement) for any owner of the right to market a nonsteroidal anti-inflammatory drug that: (1) contains

a patented active agent; (2) has been reviewed by the Food and Drug Administration (FDA) for more than 96 months as a new drug application; and (3) was approved as safe and effective by the FDA on January 31, 1991, is extended for 2 years. An owner, as a condition of eligibility for entitlement, is required to (1) pay \$10 million per year to the HHS Secretary in fiscal years 1997 and 1998; and (2) enter into a legally binding agreement with the Secretary to provide a means for ensuring that entitlement shall not create any net costs to the States under Medicaid.

Title III. Tax-Related Health Provisions

The provisions under this title described below mostly relate to one of two major topics: *Medical Savings Accounts* (MSA's), or *long-term care* (LTC). Additional provisions relate to the treatment of life insurance and to miscellaneous subjects.

Medical Savings Accounts

Medical Savings Accounts are an innovation created by this Act. To provide incentives for most cost conscious purchases of medical services and offer alternatives to low-deductible insurance, the Internal Revenue Code (IRC) is amended to allow a deduction for limited amounts paid to a high-deductible MSA for a 4-year pilot period (1997-2000). However, the opportunity to establish an MSA generally will end earlier if the number of taxpayers contributing (or receiving employer contributions) to an Account exceeds limits set for 1997, 1998, or 1999.

*Nature of Medical Savings Accounts*¹.—A MSA is defined as a trust or custodial account created exclusively for paying the account holder's medical expenses, and is subject to rules similar to those applying to individual retirement accounts. The trustee of a MSA can be a bank, insurance company, or other person who demonstrates to the satisfaction of the Secretary of Treasury that the manner in which the trust will be administered is consistent with applicable requirements.

MSA-Eligible Individuals.—Beginning in 1997, MSAs are available to employees covered by a small employer-sponsored high deductible plan and to self-employed individuals regardless of the size of the entity for which the individual performs services. An employer is "small" if, on average, no more than 50 persons are employed on business days during either the preceding or second preceding year.

In order for a small-employer employee to be eligible to make MSA contributions (or to have employer contributions made on his or her behalf), the individual must be covered under an employer-sponsored high deductible health plan and not covered under any other health plan other than a plan that provides certain permitted coverage, discussed below.

Contributions can be made to an MSA either by the individual or the employer. However, an individual is not eligible to make contributions in a given year if any employer contributions are made. Similarly, if a spouse is covered under the

high deductible plan and the spouse's employer makes an MSA contribution, the individual may not make MSA contributions for the year. Likewise, in order to be eligible to make contributions, a self-employed individual must be covered under a high deductible health plan and no other health plan (unless it provides certain permitted coverage).

Anyone with coverage in addition to a high deductible plan is still eligible for an MSA if the other coverage is permitted insurance, or covers (through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. Permitted insurance comprises:

- Medicare supplemental insurance;
- Insurance which is substantially all related to liabilities incurred under worker's compensation law; tort liabilities; property ownership or use-related liabilities (for example, auto insurance); or other similar liabilities the Secretary may prescribe by regulation;
- Insurance for a specified disease or illness; and
- Insurance that provides a fixed payment for hospitalization.

Individuals covered by Medicare are not eligible for an MSA. Medicare is not a high deductible plan and is not permitted coverage. For example, if covered under a high deductible plan and also under Medicare (for example, still employed with Medicare as secondary payer), the individual is not eligible because of coverage that is not permitted in addition to the high deductible plan.

Tax treatment of and limits on MSA contributions.—Individual contributions to an MSA are deductible (within limits) in determining adjusted gross income (for example, "above the line"). In addition, employer contributions are excludable from gross income and wages for employment tax purposes (within the same limits), except that this exclusion does not apply to contributions made through a cafeteria plan (defined under Long-Term Care Services and Contracts). No deduction for MSA contributions is allowed to anyone who is a dependent on another taxpayer's tax return. The deduction cannot exceed a self-employed individual's earnings from the trade or business with respect to which the high deductible plan is established, or an employee's compensation attributable to the employer sponsoring the high deductible plan.

The maximum annual contribution that can be made to an MSA is 65 percent of the high deductible under the plan for individual coverage, and 75 percent of the deductible for family coverage. No other dollar limits apply. A *high-deductible* plan is one with a deductible of at least \$1,500 but no more than \$2,250 for individual coverage, and at least \$3,000 but no more than \$4,500 for family coverage. Maximum out-of-pocket expenditures must be no more than \$3,000 for individuals and \$5,500 for families. After 1998, these dollar amounts are indexed for inflation (using the consumer price index) in \$50 increments.²

Comparability rule for employer contributions.—If an

employer provides high deductible coverage coupled with an MSA to employees and makes contributions to the Accounts during a calendar year, the employer must offer comparable contributions on behalf of all eligible employees with comparable coverage during the same coverage period in the calendar year. Contributions are considered comparable if they are either the same dollar amount or the same percentage of the deductible. If someone is employed for only part of the calendar year, an MSA contribution is treated as comparable if it bears the same ratio to the otherwise "comparable" amount as the time employed bears to the calendar year. The comparability rule is applied separately to part-time employees (customarily employed for fewer than 30 hours per week). No restrictions are placed on the employer's offering different plans to different groups of employees.

When employer contributions do not comply with the rule during a calendar year, the employer must pay an excise tax equal to 35 percent of the aggregate amount contributed to employee MSAs for the year. This tax is designed as a proxy for the denial of employer contributions. When failure to comply with the comparability rule is due to reasonable cause rather than willful neglect, the Secretary may waive part or all of the tax if the payment would be excessive relative to the failure involved.

State insurance commissions will continue to have oversight over the issuance of high deductible plans issued in conjunction with MSAs and can impose additional consumer protections. It is intended that the National Association of Insurance Commissioners (NAIC) will develop model standards for high deductible plans.

General tax treatment of MSAs.—Earnings on amounts in an MSA are not included in current income. Distributions from an MSA for the medical expenses of the individual and his or her spouse or dependents are generally excludable from income. However, in any year when a contribution is made into an MSA, withdrawals are excludable from income only if the individual was covered under a high deductible plan for the month in which the expenses are incurred. This rule is designed to ensure that MSAs are in fact used in conjunction with a high deductible plan.

Medical expenses are expenditures as defined in Section 213 of the Internal Revenue Code, except that they exclude expenses for insurance other than a qualified long-term care insurance contract, premiums for health care continuation coverage, or premiums for health care coverage while receiving unemployment compensation under Federal or State law.

Non-medical distributions are included in income, and also subject to an additional 15 percent tax unless made after age 65, death, or disability. The MSA trustee or custodian is responsible for reporting annual distributions, but the account holder is responsible for properly reporting them as taxable or nontaxable on his or her tax return, and whether the 15-percent tax applies.

Estate tax treatment of MSAs.—Any balance remaining in a decedent's MSA is part of his or her gross estate. If the account holder's surviving spouse is the named beneficiary,

the MSA becomes the property of the surviving spouse and the MSA balance may be deducted when computing the taxable estate, pursuant to the estate tax marital deduction provided in the tax code. The MSA qualifies for the marital deduction because the account holder has sole control over disposition of these assets. The surviving spouse is not required to include any amount in income as a result of the death; the general rules applicable to MSAs apply to the surviving spouse's MSA (for example, the surviving spouse is subject to income tax only on distributions from the MSA for nonmedical purposes). The surviving spouse can exclude from income amounts withdrawn from the MSA for expenses incurred by the decedent prior to death that are qualified medical expenses.

If the MSA passes to a named beneficiary other than a surviving spouse, the account ceases to be an MSA as of the date of death, and the beneficiary is required to include the fair market value of MSA assets as of that date in gross income for that taxable year. The amount is reduced by the portion of the MSA used, within one year of the death, to pay the decedent's prior qualified medical expenses. As with other distributions, whether the expenses are qualified medical expenses is determined as of the time they were incurred.

If there is no named beneficiary for the decedent's MSA, the account ceases to be an MSA as of the date of death, and the fair market value of the assets at that date are included in the decedent's gross income for the year of the death. This rule applies even if a surviving spouse ultimately obtains the right to MSA assets.

Measuring the effects.—During 1997-2000, the Department of the Treasury will evaluate MSA participation and the resulting reduction in Federal revenues, and report these evaluations to Congress as the Secretary deems appropriate. The General Accounting Office is directed to contract with an organization with expertise in health economics, health insurance markets and actuarial science to conduct a study regarding the effects of MSAs in the small group market on:

- selection (including adverse selection);
- health costs, including the impact on premiums of persons with comprehensive coverage;
- use of preventive care;
- consumer choice;
- the scope of coverage of high deductible plans purchased in conjunction with an MSA; and
- other relevant issues, to be submitted to Congress by January 1, 1999.

It is intended that the study be broad in scope, gather enough data to fully evaluate the relevant issues, and be adequately funded. It is expected that the study will use appropriate techniques to measure the impact of MSAs on the broader health care market, including an in-depth analysis of local markets with high penetration, and an evaluation of the impact of MSAs on individuals and families who experience

high health care costs, especially low- and middle-income families.

Increase in Deduction for Health Insurance Costs of Self-Employed Individuals.—The deduction for medical insurance premiums by self-employed individuals was increased from 30 percent to 80 percent by the year 2006 in order to reduce the disparity of treatment of such expenses and employer-provided health insurance, and to help make health insurance more affordable for the self-employed. The deduction will be 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

LTC provisions in HIPAA provide an incentive for individuals to take financial responsibility for their long-term care needs by providing favorable tax treatment to LTC insurance contracts and services meeting requirements. First, qualified long-term care insurance is treated as accident and health insurance, thereby making premiums (within indexed limits) medical expenses eligible for deduction to the extent total medical expenses exceed 7-1/2 percent of adjusted gross income. Second, proceeds from such policies will generally not be included in income. Employer provided qualified long-term care insurance costs are also not included in the covered employee's taxable income.

Definition of qualified LTC insurance.—The only insurance coverage permitted under qualified LTC insurance contracts is of qualified LTC services. Such policies must be guaranteed renewable; provide no cash surrender value or other money that can be paid, assigned, pledged, or borrowed; must apply refunds or dividends only to reduce future premiums or increase future benefits; and cannot reimburse for services covered under Medicare or services that would be covered by Medicare but for a deductible or co-pay (except where Medicare is a secondary payer).

A contract does not fail to be qualified LTC insurance solely because it provides for payments on a per diem or other periodic basis without regard to expenses incurred during the period.

Definition of qualified LTC services.—Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services required by a chronically ill individual that are provided pursuant to a plan of care prescribed by a licensed health care practitioner. It is anticipated that the scope of maintenance and personal care services will be defined in Treasury regulations.

A chronically ill individual is one who has been certified within the previous 12 months by a licensed health care practitioner as:

- being unable to perform (without substantial assistance from another individual) at least two activities of daily living for at least 90 days³ due to a loss of functional capacity;

- having a similar level of disability as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of HHS; or
- requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.⁴ The Congressional Conference Report states the intent that a physically able person who has a cognitive impairment such as Alzheimer's disease or any other irreversible loss of mental capacity is to be treated similarly to an individual who is unable to perform (without substantial assistance) at least two activities of daily living. Reflecting a concern that eligibility for the medical expense deduction not be diagnosis driven, the provision requires cognitive impairment to be severe. The Report indicates the intent that severe cognitive impairment mean a deterioration or loss in intellectual capacity as measured by clinical evidence and standardized tests which reliably measure impairment in:

- short- or long-term memory;
- orientation to people, places, or time; and
- deductive or abstract reasoning.

Employer-provided LTC coverage.—An employer plan providing qualified LTC coverage generally is treated as an accident and health plan. Thus, employer contributions for employees, spouses, and dependents (as defined for tax purposes) are excludable from income and wages for employment tax purposes. However, such coverage is not excludable from tax if provided through a cafeteria plan, under which employees can elect among cash and certain employer-provided qualified benefits. Similarly, gross employee income includes employer-provided coverage for qualified long-term care services under a flexible spending arrangement (FSA), where an employee is reimbursed for medical expenses or other nontaxable employer-provided benefits, such as dependent care, and under which the maximum reimbursement that is reasonably available to a participant for a coverage period is not substantially in excess of the total premium. Employer contributions for qualified LTC insurance are generally deductible by the employer. Amounts received from qualified LTC insurance purchased by the employer are excludable from income in accordance with the rules relating to proceeds of accident or health insurance.

State-maintained LTC plans.—An arrangement is treated as qualified insurance if the individual receives coverage for qualified services under a State LTC plan, and the terms of the arrangement would satisfy requirements if the arrangement were an insurance contract. For this purpose, a State LTC plan is any plan established and maintained by a State (or State instrumentality) under which only employees (and former employees, including retirees) of the State or a political subdivision or instrumentality, and their spouses, relatives, and

spouses' relatives, may receive coverage only for qualified LTC services.

Medicare LTC duplication rules.—No provision of law is to be construed or applied so as to prohibit the offering of a qualified LTC insurance contract on the basis that the contract coordinates its benefits with those under Medicare. (See other provisions in Title II relating to Medicare duplication and coordination.)

LTC expenses treated as medical expenses.—Unreimbursed expenses for qualified LTC services provided to the taxpayer, or the taxpayer's spouse or dependent, are treated as expenditures for medical care for purposes of the itemized deduction for medical expenses (subject to the present-law floor of 7.5 percent of adjusted gross income).

When making deductions, qualified services do not include services provided by a relative or spouse (directly, or through a partnership, corporation, or other entity), unless the relative is a licensed professional with respect to such services, or those provided by a related corporation (within the meaning of IRC section 267(b) or 707(b)).⁵

LTC premiums treated as medical expenses.—Qualified long-term care insurance premiums that do not exceed specified age-based dollar limits are treated as medical expenses for purposes of itemized medical deductions. The deductible limit for an individual 40 years of age would be \$200 in 1997; \$375 for ages 41-50; \$750 for ages 51-60; \$2,000 for ages 61-70; and \$2,500 if older.

These dollar limits are now indexed to increases in the medical care component of the consumer price index, but the Secretary of Treasury, in consultation with the Secretary of HHS, is to develop a more appropriate index. Such an alternative might, for example, be based on increases in skilled-nursing facility and home-health care costs.

Long-term care riders on life insurance contracts.—When LTC insurance coverage is provided by a rider on or as part of a life insurance contract, the requirements apply as if the portion providing such coverage were a separate contract. The term "portion" means only the terms and benefits that are in addition to the terms and benefits under the life insurance contract without regard to long-term care. If the applicable requirements are met by the long-term care portion, amounts received as provided by the rider are treated in the same manner as qualified LTC insurance benefits, whether or not the payment of such amounts causes a reduction in the contract's death benefit or cash surrender value.⁶

LTC continuation rules.—COBRA health care continuation rules do not apply to coverage under a qualified LTC contract or under a plan, substantially all of whose coverage is for qualified LTC services.

Interim LTC guidance: Internal Revenue Service Notice 97-31.—On May 6, 1997, the IRS and the Treasury Department issued Notice 97-31. This notice provides interim guidance relating to qualified LTC services and insurance contracts under Sections 213, 7702B, and 4980C of the Internal Revenue Code, effective pending the publication of proposed regulations or other guidance. It deals with the definition of a

“chronically ill individual,” including safe-harbor definitions of the terms “substantial assistance,” “hands on assistance,” “standby assistance,” “severe cognitive impairment,” and “substantial supervision.” The notice also includes an interim safe harbor that allows key provisions in qualified LTC contracts to be interpreted by an insurance company using the same standards as before 1997 to determine whether an individual is unable to perform activities of daily living or is cognitively impaired. In addition, the notice provides interim guidance on the scope of the statutory grandfather provisions that apply to individual and group contracts issued before 1997. The safe harbors are designed to provide standards for taxpayers to use in interpreting the new LTC provisions, and to provide interim guidance to facilitate operation of the insurance market without the need for interim amendment of contracts.

LTC Reporting Requirements.—A payer of long-term care benefits is required to report to the Internal Revenue Service:

- the aggregate benefits paid to any person during any calendar year;
- the name, address, and taxpayer identification number of the recipient;
- the name, address, and taxpayer identification number of the chronically ill individual on account of whose condition such amounts were paid; and
- whether the amount was paid under a per diem-type contract.

A copy of the report must be provided to the payee by January 31 following the year of payment. Failure to file the report or provide the copy is subject to generally applicable penalties.

LTC consumer protection provisions.—Qualified LTC insurance contracts and issuers of contracts are required to satisfy certain provisions of the Long-Term Care Insurance Model Act and Model Regulations adopted by the National Association of Insurance Commissioners (NAIC), as of January 1993. The requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post-claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization. HIPAA also provides disclosure and nonforfeiture requirements. The nonforfeiture provision gives a policyholder who is unable to continue to pay premiums the option of selecting reduced paid-up insurance, extended term insurance, or a shortened benefit period.⁷ The consumer protection provisions apply only for purposes of determining whether a contract is a HIPAA-qualified LTC insurance contract.

The requirements for insurance issuers relate to application forms, reporting requirements, marketing, appropriateness of purchase, format, shopper’s guide, right to return, outline of

coverage, group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. A \$100-per-insured-per-day tax is imposed for failure to satisfy these requirements. The consumer protection requirements for issuers apply with respect to HIPAA-qualified LTC insurance contracts.

For purposes of both required contract terms and requirements relating to issuers, the determination of whether any requirement of an NAIC Model Regulation or Model Act has been met is made by the Secretary of Treasury. It was not intended that the Secretary create a Federal standard but rather look to applicable or appropriate State standards, or to those provided specifically in the NAIC Model Regulation or Model Act.

An otherwise qualified LTC contract will not fail to be qualified, and will not be treated as failing to meet the analogous requirement under HIPAA, solely because it satisfies a consumer-protection standard imposed under applicable State law more stringent than the analogous HIPAA standard, nor does HIPAA preclude States from enacting more stringent consumer protection provisions.

It is intended that a contract be treated as meeting State LTC insurance requirements if it meets requirements for contracts covering certain types of qualified LTC services (such as nursing home care only, or home health care only), even when such State requirements are separate from long-term care insurance requirements, or prohibit it from being labeled a “long-term care” contract. Similarly, a State waiver of an LTC insurance contract (such as a loss ratio requirement) in the case of a rider or provision under a life insurance contract is not intended to cause the contract to be treated as not meeting the LTC insurance requirements of that State.

Effective date of LTC-related provisions.—Provisions defining qualified insurance contracts and qualified services apply to contracts issued after December 31, 1996.

Grandfathering.—Any contract issued earlier that met State long-term care insurance requirements where the contract was situated when issued is treated as qualified, and services provided under or reimbursed by it are treated as qualified services. Solely for purposes of this grandfather rule, it is intended that a group contract that was issued before 1997 will continue to be qualified LTC insurance even if new individuals are added after December 31, 1996.

Exchanges.—A contract providing for LTC insurance may be exchanged for another qualified contract (or the former canceled and the proceeds reinvested in the latter within 60 days) tax free between the date of enactment (August 21, 1996) and January 1, 1998. Taxable gain would be recognized to the extent money or other property is received in the exchange. The issuance or conformance of a rider providing qualified LTC coverage to a life insurance contract is not treated as a modification or a material change for purposes of IRC Sections 101(f), 7702 and 7702A.

Treatment as medical expenses.—The provisions relating to treatment of eligible premiums and qualified services as

medical expenses generally are effective for taxable years beginning after December 31, 1996, as are provisions relating to the maximum exclusion for certain LTC benefits and reporting. Thus, the first year when reports will be filed with the IRS and copies provided to the payee will be 1998, with respect to long-term care benefits paid in 1997.

Reserves: The provision relating to life insurance company reserves is effective for contracts issued after 1997.

Treatment of Certain Life Insurance-Derived Benefits

Two provisions liberalize the manner in which income derived from qualified life insurance contracts is taxed. To qualify as life insurance for Federal income tax purposes, a contract must qualify as life insurance under applicable State or foreign law and must satisfy either a *cash value accumulation test* (cash surrender value may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits), or both a *guideline premium requirement* (premiums paid never exceed the greater of the guideline single premium or the sum of guideline-level premiums) and a *cash value corridor requirement* (the death benefit is not less than a varying statutory percentage of cash surrender value).

Favorable tax treatment of amounts received under a life insurance contract.—Under prior law, amounts received under a life insurance contract (other than a modified endowment) prior to the death of the insured were included in the recipient's gross income, to the extent that the amount received constituted cash value in excess of the *taxpayer's investment* in the contract. Generally, that investment is the aggregate premiums paid less amounts previously received and excluded from gross income.

Under HIPAA, gross income no longer includes proceeds that are paid pursuant to the contract due to death of the insured. In addition, undistributed investment income ("inside buildup") earned on premiums credited under the contract is not subject to current taxation for the contract owner. This exclusion applies regardless of whether the death benefits are paid as a lump sum or otherwise. If a contract is not treated as life insurance, inside buildup is generally subject to tax.

Treatment of accelerated death benefits and viatical settlements.—Congress wished to extend the present law rule permitting an exclusion from income for amounts paid under a life insurance contract to exclude *accelerated death benefits* paid with respect to chronically ill or terminally ill insured individuals (who have been certified by a physician as having an illness or physical condition that reasonably can be expected to result in death within 24 months of certification). In addition, Congress believed that this exclusion from income should be extended to certain *sales or assignments* of all, or a portion of, a life insurance contract to a viatical settlement provider (defined as any person regularly engaged in the trade or business of purchasing or taking assignments of life insurance contracts on the lives of insured individuals who are terminally or chronically ill, so long as the provider meets

certain requirements). To provide parity in treatment to the extent possible, the same definition of "chronically ill" applies for the rule under this provision and the rules governing qualified long-term care insurance contracts.

Miscellaneous Health-related Changes in the Tax Code Organ and Tissue Donation Information.—The Secretary Treasury is directed, to the extent practicable, to include certain organ and tissue donation information with income tax refund payments.

State insurance pools.—Certain State-established membership organizations established exclusively to provide: (1) nonprofit medical care coverage to high risk individuals; or (2) to reimburse members for losses arising under workmen's compensation acts are exempt from taxation.

Organizations subject to Section 833.—Special rules under IRS section 833 allow (for affording a special deduction) an organization that is not a Blue Cross or Blue Shield (BCBS) organization to be treated as if it were a BCBS organization if it is not for profit and meets other requirements.

IRA distributions to the unemployed.—Penalty-free distributions from IRA accounts to pay health insurance premiums for certain unemployed individuals are permitted.

Title IV. Application and Enforcement of Group Health Plan Requirements

The Internal Revenue Code of 1986 is amended by adding at the end a new subtitle, *Subtitle K—Group Health Plan Portability, Access, and Renewability Requirements* (Sections 9801 through 9806). These provisions parallel amendments made to ERISA and the PHS Act (see Title I discussion).

Application and Enforcement of Health Plans.—A group health plan is permitted to impose a preexisting condition exclusion only under circumstances set out in Title I. Provisions are set forth concerning: (1) exceptions for certain plans (including government plans within the exceptions) and benefits; (2) definitions; (3) promulgation of regulations; and (4) penalties for failure to meet certain group health plan requirements. Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements is provided, subject to certain exceptions, as set out in Title I.

Failure to Meet Requirements.—The Internal Revenue Code was amended to impose a \$100 per person per day excise tax on group health plan issuers for failure to comply with the portability, nondiscrimination and guaranteed renewability provisions of HIPAA, comparable to that provided in Title III with respect to LTC insurance. In general, a tax will not be imposed if the violation were due to reasonable cause and not to willful neglect, and is corrected within 30 days. The maximum tax for such violations that can be imposed is the lesser of (1) 10 percent of the employer's payments during the taxable year preceding the year in which the failure occurred under group health plans (or 10 percent of the amount paid by the multiemployer plan or multiple employer welfare arrangement during the plan year in which the failure occurred for medical care, if applicable), or (2) \$500,000. The Secretary of

the Treasury may waive all or part of the tax for failures to comply that are due to reasonable cause and not to willful neglect, to the extent that payment of the tax would be excessive relative to the failure involved.

COBRA Modifications.—Under the Consolidated Omnibus Budget Reconciliation Act of 1985, health care continuation rules generally required that group health plans of employers with 20 or more employees must offer certain employees and their dependents (“qualified beneficiaries”) the option of purchasing continued health coverage in case of certain qualifying events, which include:

- termination or reduction in hours of employment;
- death, divorce, or legal separation;
- entitlement to Medicare;
- bankruptcy of the employer; or
- the end of a child’s dependency under a parent’s health plan.

The maximum period of COBRA coverage is 18 months if the qualifying event is a termination of employment or reduction in hours of employment. That maximum period is extended to 29 months, however, if the qualified beneficiary is determined to have been disabled under the terms of the Social Security Act at the time of the qualifying event.

HIPAA modified COBRA to minimize gaps in health coverage for newborns, adopted children, individuals with disabilities, and to avoid unnecessary duplicative coverage in the case of persons eligible for coverage under the portability provisions of HIPAA. To this end, the COBRA rules were modified by:

- clarifying that the extended maximum coverage of 29 months in cases of disability also applies to nondisabled qualified beneficiaries *in the same family* as the disabled qualified beneficiary. Coverage is extended if the disability exists at any time during the first 60 days of COBRA coverage, as opposed to requiring disability at the time of the qualifying event. As under prior law, the disability determination still has to be made, and the notice of the disability still has to be given, before the end of the initial 18-month coverage period.
- modifying the definition of qualified beneficiary to include a child born to or placed for adoption with the covered employee during the period of COBRA coverage.
- coordinating COBRA rules with the new requirements regarding preexisting condition exclusions so that extended coverage terminates if a qualified beneficiary becomes covered under another group health plan, even if it has a preexisting condition limitation or exclusion, provided that preexisting-condition restriction does not apply to the qualified beneficiary by reason of the new HIPAA requirements.

Title V. Revenue Offsets

Several other provisions intended to increase revenues were added to compensate for anticipated revenue losses under other provisions of the Act.

Company-Owned Life Insurance

Deductions are prohibited for interest on loans with respect to company-owned life insurance, including company-owned endowment or annuity contracts.

Treatment of Individuals Who Lose U.S. Citizenship

Provisions were revised concerning expatriation to avoid taxes, including the following changes: (1) applying the provisions to certain long-term residents; (2) permitting the Treasury Secretary to expand the 10-year taxation period to 15 years; (3) increasing the categories of income treated as U.S. source income; (4) crediting foreign taxes imposed on U.S. source income; and (5) requiring the filing of certain information by expatriates. The comparable estate and gift tax provisions were revised.

Repeal of Financial Institution Transition Rule to Interest Allocation

The Tax Reform Act of 1986 is amended to repeal a provision concerning the allocation and apportionment of interest expense by financial institutions that are members of an affiliated group between U.S. and foreign source income.

Notes

¹ The Internal Revenue Service published Notice 96-53 providing basic information on Medical Savings Accounts on December 16, 1996, in Internal Revenue Bulletin No. 96-51.

² The Internal Revenue Service published Revenue Ruling 97-20 on May 12, 1997, in Internal Revenue Bulletin 97-19 on page 4, which provides guidance concerning the definition of the term “high deductible plan”.

³ The 90-day period is not a waiting period. Thus, for example, an individual can be certified as chronically ill if the licensed health care practitioner certifies that the individual will be unable to perform at least 2 activities of daily living for at least 90 days.

⁴ HIPAA provides that, for purposes of determining whether an individual is chronically ill, the number of activities of daily living that are taken into account under a qualified long-term care insurance contract may not be less than five. For example, a contract could require that an individual be unable to perform (without substantial assistance) two out of any five of the activities listed in HIPAA. By contrast, a contract does not meet this requirement if it required that an individual be unable to perform two out of any four of the activities listed in HIPAA. This requirement does not apply to the determination of whether an individual is a chronically ill individual by reason of severe cognitive impairment.

⁵ The rule limiting such services provided by a relative or a related corporation does not apply for purposes of the exclusion for

amounts received under a qualified long-term care insurance contract, whether the contract is employer-provided or purchased by an individual. The Conference Report indicates that the limitation is unnecessary in such cases because it is anticipated that the insurer will monitor reimbursements to limit opportunities for fraud in connection with the performance of services by the taxpayer's relative or a related corporation.

⁶ Similarly, charges against the life insurance contract's cash surrender value that are includable in income are treated within certain limits as medical expenses (provided the rider constitutes a qualified LTC insurance contract).

⁷ The nonforfeiture provision shall provide for a benefit in the event of a default in the payment of any premiums; the amount of this benefit may be adjusted after being initially granted only as needed to reflect changes in claims, persistency, and interest, as reflected in changes in rates for premium paying policies approved by the appropriate State regulatory authority for the same contract form.