

Application of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to Health Flexible Spending Arrangements

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Contents

Part A - Overview

Part B - ERISA Technical Release 97-1, 12/18/97 - Final Rule First published 4/1/97 as Proposed Technical Release

Part A - Overview

Certain health-related benefits—called “excepted benefits”—are excepted from the access and renewability requirements under HIPAA. These benefits include benefits under one or more (or any combination) of the forms of coverage described below.

Benefits excepted from the HIPAA requirements.

The following benefits are categorically excepted from the HIPAA portability requirements:

- coverage only for accident or disability income insurance, or any combination of these coverages;
- coverage issued as a supplement to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance;
- coverage for on-site medical clinics; and
- other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. 1
- health flexible spending accounts (FSAs) offered to employees through a cafeteria plan, to the extent that (i) the maximum benefit payable for

the employee under the health FSA for a plan year does not exceed two times the employee's salary reduction election under the health FSA for the year (or, if greater, the amount of the employee's salary reduction election under the health FSA for the year, plus \$500); (ii) the employee has other coverage available under a group health plan *of the employer* for the year; and (iii) the other coverage is not limited to benefits that are excepted benefits. 2

TAI observation: The rule expressed in ERISA Technical Release No. 97-01 is also adopted by IRS and HHS with regard to the portions of HIPAA under the agencies' respective jurisdictions (see 62 Fed. Reg. 67687, 12/29/1997).

1

ERISA § 733(c)(1)(A) - (H); Code Sec. 9832(c)(1)(A) - (H); 42 USCS 300gg-91(c)(1) ; Labor Reg. § 2570.732 .

2

ERISA Technical Release 97-01 .

Benefits not subject to requirements if offered separately.

The following benefits—while facially in the nature of health care—are nonetheless excepted from HIPAA if provided on a separate policy or contract basis:

- limited scope dental or vision benefits;
- benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- such other similar limited benefits as are specified in regulations. 3

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ERISA § 733(c)(2)(A) - (C); Code Sec. 9832(c)(2)(A) - (C); 42 USCS 300gg-91(c)(2); Labor Reg. § 2590.732.

Benefits not subject to requirements if offered as independent noncoordinated benefits.

The HIPAA requirements do not apply to:

- coverage only for a specified disease or illness, and
- hospital indemnity or other fixed indemnity insurance. 4

4

ERISA § 733(c)(3)(A) -(B); Code Sec. 9832(c)(3)(A) -(B); 42 USCS 300gg-91(c)(3) ; Labor Reg. § 2590.732.

Benefits not subject to requirements if offered as a separate insurance policy.

The HIPAA requirements do not apply to Medicare supplemental health insurance as defined in 42 USCS §1395ss(g) (1), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar coverage provided to supplement coverage under a group health plan. 5

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ERISA § 733(c)(4); Code Sec. 9832(c)(4); 42 USCS 300gg-91(c)(4) ; Labor Reg. § 2590.732.

Part B. ERISA Technical Release 97-1, 12/18/1997 - Final Rule

Application of HIPAA Group Market Portability Rules to Health Flexible Spending Arrangements; DOL Rulings & Releases

I. Purpose

This document addresses the application of certain portability provisions added by the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191 (HIPAA), to flexible spending arrangements (FSAs). The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have concluded that it is appropriate to treat benefits under certain health FSAs as excepted benefits under sections 9831 and 9832(c) of the Internal Revenue Code of 1986 (Code), sections 732 and 733(c) of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 2721 and 2791(c) of the Public Health Service Act (PHS Act).

II. Background

HIPAA Group Market Portability Provisions

HIPAA provides measures to improve portability and continuity with respect to group health plan coverage provided in connection with employment. These provisions include limitations on preexisting condition exclusions, rules prohibiting discrimination on the basis of any health status-related factor, and rules requiring special enrollment. These provisions are generally effective for group health plans and group health insurance coverage for plan years beginning on or after July 1, 1997. The Departments of the Treasury, Labor, and Health and Human Services (the Departments) issued regulations implementing these group market provisions at 26 CFR 54.9801-1 T through 54.9801-6T, 54.9802-1T, 54.9831-1T (formerly 54.9804-1T), 54.9833-1T (formerly 54.9806-1T); 29 CFR part 2590 ; and 45 CFR parts 144 and 146 (made available to the public on April 1, 1997 and published in the Federal Register on April 8, 1997, 62 FR 16893).

The HIPAA portability provisions in section 9801 of the Internal Revenue Code of 1986 (Code), section 701 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 2701 of the Public Health Service Act (PHS Act), and the implementing regulations impose limits on the maximum preexisting condition exclusion period that may be imposed by a group health plan or a group health insurance issuer. In general, neither a group health plan nor a group health insurance issuer may impose more than a 12-month preexisting condition exclusion for individuals enrolling in the plan or coverage, although a plan or issuer can impose an 18-month preexisting condition exclusion for late enrollees. In either case, the exclusion period must be reduced by the amount of an individual's prior "creditable coverage." Plans and issuers subject to the HIPAA requirements generally must also issue certificates of creditable coverage for an individual to use as proof of creditable coverage for subsequent coverage.

In general, these group market portability provisions apply to group health plans (generally plans sponsored by employers or employee organizations, or both) and health insurance issuers providing coverage under a group health plan, effective for plan years beginning after June 30, 1997, except that the obligation to provide certain information relating to creditable coverage became effective as early as June 1, 1997.

However, the group market portability provisions do not apply to certain excepted benefits. For example, the group market portability provisions do not apply to certain types of supplemental coverage provided under a separate policy, certificate, or contract of insurance. In general, if benefits under a plan or coverage are excepted benefits, then plans and issuers do not have to provide certificates for the coverage, and the coverage may not qualify as creditable coverage.

Health Flexible Spending Arrangements

Under proposed Treasury Regulations, a health FSA generally is a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for the participant's coverage. Coverage and reimbursements provided to an individual under a group health plan that is a health FSA and that conforms to the generally applicable rules for accident or health plans qualify for the same tax-favored treatment that generally is extended to coverage and reimbursements under employer-provided accident or health plans. ¹ Health FSA reimbursements typically provide coverage for medical care expenses not otherwise covered by the employer's primary group health plan. A health FSA is permitted to operate under a cafeteria plan described in section 125 of the Code. Pursuant to the rules of section 125, an employee can elect to reduce the employee's salary in order to pay for health FSA coverage without the employee having to include that portion of the salary in gross income. Commonly, the maximum benefit payable under a health FSA for any year is equal to the amount of the employee's salary reduction election for the year, plus any additional employer contribution for the year.

III. Clarification

This document clarifies the conditions under which it is appropriate to treat benefits under a health FSA as excepted benefits. Specifically, benefits under a health FSA are excepted benefits if the maximum benefit payable for the employee under the health FSA for the year does not exceed two times the employee's salary reduction election under the

health FSA for the year (or, if greater, the amount of the employee's salary reduction election under the health FSA for the year, plus \$500), the employee has other coverage available under a group health plan of the employer for the year, and the other coverage is not limited to benefits that are excepted benefits.

The effect of treating benefits under a health FSA as excepted benefits is that the health FSA is not subject to the group market portability provisions. Accordingly, there would be no requirement under section 9801 of the Code , section 701 of ERISA , or section 2701 of the PHS Act and the implementing regulations to issue a certificate of creditable coverage for such a health FSA. In addition, coverage that consists solely of coverage under such a health FSA does not constitute creditable coverage.

Group health plans, issuers, and other entities subject to the group market portability provisions of HIPAA may rely on this document in treating benefits under health FSAs described in the first paragraph of this section III as excepted benefits.

1

See Q&A-7, prop. Treas. Reg., proposed 26 CFR 1.125-2 (54 FR 9460, 9502, March 7, 1989).