

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Part 54****DEPARTMENT OF LABOR****Pension and Welfare Benefits Administration****29 CFR Part 2590****DEPARTMENT OF HEALTH AND HUMAN SERVICES****Health Care Financing Administration****45 CFR Subtitle A, Parts 144 and 146****Application of HIPAA Group Market Portability Rules to Health Flexible Spending Arrangements**

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Clarification of regulations.

SUMMARY: This document clarifies that it is appropriate to treat benefits under certain health flexible spending arrangements as excepted benefits for purposes of the group market portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

FOR FURTHER INFORMATION CONTACT: Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-4695; Amy Scheingold, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-4377; or Joan Kral, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-9539.

Customer service information. Individuals interested in obtaining a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law," may call the following toll-free number: 1-800-998-7542. This information is also available on the Department's website at: <http://www.dol.gov/dol/pwba>

SUPPLEMENTARY INFORMATION:**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 54.9801-1T 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

¹ See Q&A-7, prop. Treas. Reg., proposed 26 CFR 1.125-2 (54 FR 9460, 9502, March 7, 1989).

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.

Dated: December 18, 1997.

Michael P. Dolan,

Deputy Commissioner of Internal Revenue.

Signed at Washington, DC, this 19th day of December, 1997.

Olena Berg,

Assistant Secretary, Pension and Welfare Benefits Administration, U.S. Department of Labor.

Dated: December 18, 1997.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

[FR Doc. 97-33602 Filed 12-24-97; 8:45 am]

BILLING CODE 4830-01-P; 4510-29-P; 4120-01-P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

45 CFR Subtitle A, Parts 144 and 146

Application of HIPAA Group Market Rules to Individuals Who Were Denied Coverage Due to a Health Status-Related Factor

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Clarification of regulations.

SUMMARY: This document addresses certain issues arising under the group market portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with respect to employees (or their dependents) who, until the effective date of the HIPAA nondiscrimination provisions, were denied coverage under a group health plan, including group health insurance coverage, because of a health status-related factor.

FOR FURTHER INFORMATION CONTACT: Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-4695; Amy Scheingold, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-4377; or Joan Kral, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-9539.

Customer service information.

Individuals interested in obtaining a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law," which includes information on the nondiscrimination provisions of HIPAA, may call the following toll-free number: 1-800-998-7542. This information is also available on the Department's website at: <http://www.dol.gov/dol/pwba>.

SUPPLEMENTARY INFORMATION:

I. Purpose

This document addresses certain issues arising under the group market portability provisions added by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), with respect to employees (or their dependents) who, until the effective date of the HIPAA nondiscrimination provisions, were denied coverage under a group health plan, including health insurance coverage offered in connection with a group health plan, because of a health status-related factor. Under those provisions and the implementing regulations, neither a group health plan nor group health insurance coverage can continue to exclude such individuals from enrolling in the plan or coverage. This document clarifies certain rights of these individuals.

II. Background

HIPAA contains provisions designed 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 interim final regulations implementing these group market provisions at 26 CFR 54.9801-1T 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 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