

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.

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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

coverage, although the 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." Most, but not all, types of health coverage are creditable coverage.

The nondiscrimination provisions in section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act and the implementing regulations provide that neither a group health plan nor a health insurance issuer offering group health insurance coverage may establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any health status-related factor. Health status-related factors include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

Under these nondiscrimination provisions, an employee (and any dependent of the employee) cannot be denied coverage under a group health plan or group health insurance coverage based on a health status-related factor on or after the effective date of HIPAA. The interim final regulations clarify that an employee or dependent cannot be required to pass a physical examination as a condition of enrollment, even if the individual is a late enrollee.¹

III. Clarification

Although the interim final regulations make clear that group health plans and group health insurance issuers cannot continue to exclude employees (and

their dependents) from coverage based on a health status-related factor, questions have arisen concerning the application of the HIPAA group market portability rules to individuals who previously were denied coverage based on a health status-related factor. This document clarifies the circumstances under which these individuals cannot be treated as late enrollees for purposes of applying a preexisting condition exclusion period.

Any individual to whom coverage has not been made available before the effective date of HIPAA because of a health status-related factor, and who enrolls when first eligible on or after the effective date of the HIPAA nondiscrimination provisions (which are generally effective on the first day of the first plan year beginning on or after July 1, 1997), may not be treated as a late enrollee for purposes of section 9801(a) of the Code, section 701(a) of ERISA, or section 2701(a) of the PHS Act or the implementing regulations.² This includes any individual who failed to apply for coverage before the effective date of the HIPAA nondiscrimination provisions because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated on the basis of a health status-related factor. These rules apply whether or not the plan offers late enrollment.³ These rules do not change the special enrollment rules that prohibit treating a special enrollee as a late enrollee.

These rules are illustrated by the following example:

Example: (i) Employee A is an active employee of Employer X. A was hired on May 3, 1992. X maintains a group health plan

with a plan year beginning on January 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired and on each January 1, but only if they can pass a physical examination. A's application to enroll in May of 1992 was denied because A had diabetes and could not pass a physical examination. A has not applied since then because A has reasonably believed that the application would be denied because A has diabetes.

(ii) In this *Example*, effective January 1, 1998, X's plan cannot deny coverage to A based on a health status-related factor. If A enrolls effective January 1, 1998, A may not be treated as a late enrollee for the purpose of determining the maximum period of any preexisting condition exclusion that may be imposed by the plan with respect to A (or for the purpose of determining A's enrollment date).

HIPAA provides that no enforcement action can be taken against a plan or issuer with respect to a violation of the group market rules before January 1, 1998 if the plan or issuer has sought to comply in good faith with such rules. The preamble to the interim final regulations extended this good faith period with respect to the nondiscrimination provisions until further regulations are issued by the Departments. Compliance with the terms of this document is considered good faith for this purpose.

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.

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¹ Note, however, that under section 1532 of the Taxpayer Relief Act of 1997, Pub. L. 105-34 (enacted after interim final regulations were published), certain church plans may require evidence of good health of certain individuals without violating the nondiscrimination requirements of HIPAA. This document does not apply to those church plans under those circumstances.

² For related rules to determine the individual's enrollment date, see the interim final regulations at 26 CFR 54.9806-1T(a)(3), 29 CFR 2590.736(a)(3), and 45 CFR 146.125(a)(3).

³ For a definition of late enrollment, see the interim final regulations at 26 CFR 54.9801-3(a)(2)(iv), 29 CFR 2590.701-3(a)(2)(iv), 45 CFR 146.111(a)(2)(iv).