GROOM LAW GROUP

December 14, 2007

MEMORANDUM TO CLIENTS

RE: December Health Plan Update

The Department of Labor and the Internal Revenue Service recently issued two pieces of guidance affecting health plans-- supplemental health plan guidance and qualified medical expense guidance. Both of these guidance items are described in detail below.

I. DOL Issues HIPAA Guidance on Supplemental Plans

The Department of Labor (DOL) issued a Field Assistance Bulletin (FAB) on Friday, December 7th that addresses when an arrangement is a "supplemental" plan under HIPAA's excepted benefits provisions. *See* Field Assistance Bulletin No. 2007-04 (Dec. 7, 2007) (http://www.dol.gov/ebsa/regs/fab2007-4.html). A background of HIPAA's supplemental benefit exception and a summary of the new FAB guidance is set out below.

Background

HIPAA provides an exception from its nondiscrimination, portability, and special enrollment requirements for certain "supplemental" benefits that are issued under a separate policy of insurance. Specifically, the statute says that the exception applies to Medicare Supplement insurance, coverage supplemental to TRICARE, and "similar supplemental coverage provided to coverage under a group health plan." ERISA §733(c)(4).

The HIPAA regulations further state that, in order to be supplemental coverage, the coverage must be specifically deigned to fill gaps in primary coverage, such as coinsurance or deductibles. Supplemental coverage would not include coverage that is supplemental or secondary only under a coordination of benefits provision. 29 C.F.R. § 2590.732(c)(5)(i)(C) (DOL regulation). Other than the statute and regulations, there has been very little guidance on the meaning of a "supplemental" plan for HIPAA purposes.

DOL Field Assistance Bulletin

Generally, the DOL FAB establishes a safe harbor under which supplemental health insurance will be considered an "excepted benefit" for HIPAA purposes. The FAB says coverage that does not meet this safe harbor "may be subject to enforcement actions by the Department." The FAB also states that each of the agencies responsible for enforcing HIPAA (DOL, HHS, and IRS) is issuing similar guidance, which has been developed on a coordinated basis. The FAB says that HHS also will be issuing guidance on similar supplemental coverage for the individual market.

The DOL FAB says that coverage must meet the 4 prongs below to meet the safe harbor:

1. Issued by Separate Entity - The supplemental coverage must be issued by a different entity than the entity providing primary coverage. Entities within the same controlled group would be considered a single entity.

2. Designed to Fill Gaps - The supplemental coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles (and not merely coordinate with the underlying policy).

3. Cost of Coverage - The cost of the supplemental coverage may not exceed 15% of the cost of primary coverage. "Cost" is to be determined using the applicable COBRA premium.

4. Nondiscrimination - The supplemental coverage may not differentiate among individuals in eligibility, benefits, or premiums based on a health factor.

The first three prongs are fairly straightforward, but the 4th raises some questions. One is whether the nondiscrimination provision would preclude an insurer or plan from making an initial eligibility determination based on a health factor (i.e., refusing to offer supplemental coverage to certain individuals based on a health factor) , or whether the requirement simply precludes an insurer or plan from differentiating based on a health factor once an individual is enrolled (i.e., providing lower levels of benefits for certain individuals based on health factors). Also, the nondiscrimination requirement, on its face, appears to be more stringent than HIPAA's general nondiscrimination rule. The HIPAA rule includes a specific exception for coverage that meets the HIPAA wellness program requirements. In contrast, the 4th prong of the safe harbor sets out a flat prohibition against discrimination, with no reference to the wellness program exception. This would mean that a supplemental plan could not differentiate at all based on a health factor, even under a HIPAA-compliant wellness program.

Note that the FAB says that these 4 prongs are a safe harbor. The FAB does not say that an arrangement must meet these 4 prongs in order to be a supplemental plan under HIPAA. Thus, a plan could qualify as a supplemental plan without clearly meeting the 4 prongs.

II. IRS Provides New Deductible Medical Expenses under Code § 213

Revenue Ruling 2007-72, published by the Internal Revenue Service ("IRS") on December 10, 2007, rules that amounts paid for annual physical exams, full body electronic scans and pregnancy test kits are deductible "medical care" expenses under section 213 of the Internal Revenue Code ("Code"). Rev. Rul. 2007-72, 2007-50 I.R.B. 1154 (December 10, 2007).

Code § 213(a) provides that medical care expenses, not reimbursed through another source, are deductible from income if a taxpayer's medical expenses exceed 7.5% of the taxpayer's adjusted gross income. Code § 213 also defines what medical care expenses are eligible for tax-free reimbursement through Health Flexible Spending Arrangements ("FSA"),

Health Savings Accounts ("HSA"), and Health Reimbursement Arrangements ("HRA"). "Medical care" for this purpose includes "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of any disease or for the purpose of affecting any structure of function of the body." Code § 213(d).

Revenue Ruling 2007-72 explains why three situations qualify as deductible medical care.

1. Physical Exam - In Situation 1, Taxpayer A undergoes and pays for an annual physical exam which is performed by a physician. Situation 1 qualifies as a medical care expense because a diagnosis is "medical care," even where no illness is present.

2. Full-Body Electronic Scan - In Situation 2, Taxpayer B pays for a clinic to perform a costly full-body electronic scan for the purpose of examining the condition of B's internal organs before B consults with a physician. Situation 2 qualifies as a medical care expense even without a physician's recommendation or symptoms because the test serves no non-medical purpose and the cost of treatment does not affect whether it is "medical care."

3. Pregnancy Test Kit - In Situation 3, Taxpayer C buys and uses a test kit to determine whether she is pregnant. Situation 3 qualifies as a medical care expenses because medical care includes tests to detect healthy functioning of the body, as well as to detect disease.

It is helpful to have new guidance in this area because very little formal guidance exists concerning whether particular items would qualify as medical expenses under Code § 213(d). Currently, entities seeking to comply with Code § 213 medical care guidelines frequently rely on IRS Publication 502. Unlike a revenue ruling, IRS publications are not binding on the IRS, however, and may not be relied upon by taxpayers in a legal controversy with the IRS.

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