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LEGAL OVERVIEW

Understanding the Legal Structure of a Taxable ERISA Medical Travel Benefit

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Overview of EAP Legal Structure

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Following is a very high-level explanation of the legal structure for a medical travel plan designed as a taxable ERISA plan that is an Excepted Benefit EAP[1].

ERISA and Tax Status
These two criteria, ERISA status and tax status, are most often the first questions that need to be clarified in plan design. It is critical to note that *these two classifications are independent and separate from each other*.

With current industry standard plans, almost all ERISA plans are designed to be nontaxable (or "pre-tax") plans. The concept of a taxable ERISA benefit is extremely uncommon. However, a taxable ERISA benefit allows an employer the flexibility to design a much wider scope of coverage that is not restricted by the impractical limits set within I.R.C. § 213(d)[2].

Generalized guidance in considering ERISA and Tax status of an employee benefit plan.

- ERISA status:
  - If a benefit covers medical expenses[3] and is also sponsored[4] by an employer, it is likely going to be an ERISA plan.
- Tax status:
  - If an ERISA plan covers only things that the tax code recognizes as "qualified" medical expenses, then it will likely be a tax advantaged benefit plan.
  - However, if the design of the plan includes *anything* that is *not* recognized as a "qualified" medical expense, then the ERISA plan becomes a taxable benefit plan.

Excepted Benefit Classification
Some ERISA plans are exempt from the pain points often associated with requirements and mandates under the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act (HIPAA), and other healthcare-related legislation. These types of plans have a classification of "Excepted Benefit."

ACA Mandates
Excepted Benefit plans are almost always going to be "excepted" from ACA mandates such as the prohibition on annual dollar limits in coverage.

Common examples of Excepted Benefits are Limited Purpose Flexible Spending Accounts, Excepted Benefit Health Reimbursement Account (which should not be confused with an Integrated Health Reimbursement Account), Dental Benefit Plans, and Vision Benefit Plans.

HIPAA Privacy
Only some Excepted Benefits are "excepted" from HIPAA's administrative simplification rules, including the privacy and security rule. This is because HIPAA regulations use a broader definition of "health plan."

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[1] Detailed legal citations and references are not included in this memo for purposes of efficiency and brevity.
[2] I.R.C. Section 213(d) is the section of the Code that delineates the permissible categories and dollar limits for potential tax exempt medical expenses. This Code Section is a reference point for all medical expenses covered by an employer including FSAs, HRAs, EAPs, Major Medical, Dental, Vision, etc.
[3] Note that current regulations are silent in terms of whether the definition of "medical" only includes those expenses eligible for tax-favored status. A conservative interpretation is to assume that there is not such a limitation on the definition of "medical" expenses.
[4] Whether a plan is one sponsored and administered by an employer is governed by regulations and case law that are not discussed in this document.

A "health plan" as defined under the HIPAA regulations is an individual or group plan that provides, or pays the cost of, medical care[5]. Medical care is defined as amounts paid for: 1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; 2) amounts paid for transportation primarily for and essential to medical care; and 3) amounts paid for insurance covering medical care[6].

While the above definition would include a benefit covering medical travel expenses, it's also important to keep in mind that plan design with a *taxable* plan does not have to follow the strict expense documentation rules required by I.R.C. §213(d). This means that a taxable ERISA plan can be set up in a way that still allows access to HIPAA's Administrative Simplification Rules where the plan does not collect Protected Health Information (PHI). This would *not* be possible if the benefit is designed to be *tax advantaged*.

In other words, HIPAA requirements impact group health plans and their employer sponsors in different ways depending on plan administration and whether the plan is self-funded. Within those rules, there is guidance for a plan that is maintained by an employer with limited access to PHI.[7] Where a plan and an employer do not create or receive PHI, except for limited information, (a so-called "hands-off" plan), the plan and the employer are exempt from most Privacy Rule requirements. The limited information that can be shared between a hands-off plan and the plan sponsor includes summary health information and participation and enrollment data.

While the HIPAA rule's hands-off provision potentially protects the plan sponsor (the employer) from HIPAA rule liability, it is not typically applied in the context of a claims administrator (Espresa). If Espresa is covered by the HIPAA rule as a claims administrator for a "group health plan", it would have to comply with the rule's "business associate" provisions. Business Associate Agreements ("BAA") are relatively straight-forward and operate off a template provided within the HIPAA regulations. However, the burdensome part comes when the claims administrator then has to have all of their third-party vendors enter into BAAs and the time to discuss, negotiate and finalize those agreements. A cleaner approach, that would assist both the employer/plan sponsor as well as Espresa, would be to take the position that the information processed to administer this plan (e.g., car rental, gas, hotel, and airfare receipts) is not "protected health information" (PHI) under the HIPAA rule and therefore the HIPAA rule does not apply to the plan administrator or the sponsor. The test for PHI in the HIPAA rules has two prongs:

- The information must be created or received by a covered entity, and
- It must relate to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.[8]

As an ERISA plan and an excepted benefit EAP, the medical travel plan is a "covered entity" and meets the first prong of the test. But it does not meet the second prong of the test because it does not process information about plan participants' health or the treatment they receive at their travel destinations.

[5] 45 CFR 160.103.
[6] 42 USCS § 300gg-91 (a)(2).
[7] Note that the regulations refer to such a situation as arising in a fully-insured setting, and they are silent on the concept of a self-funded taxable benefit offering where an employer may also only receive limited PHI. Where a plan design is relatively new and unique, it is expected that there will not be direct guidance within existing regulation. In such a case, it is common practice to look to analogous guidance and the intent of the regulations to determine best practice for compliance purposes.
[8] 45 CFR § 160.103. (definitions of "Protected health information", "Individually identifiable health information", and "Health information".)

In other words, while a medical travel EAP is a "group health plan" under HIPAA, the product can be structured to ensure that no information is collected that fits within HIPAA's definition of "individually identifiable health information."

Employee Assistance Program (EAP) Classification
An EAP is a type of benefit plan structure. While it is most common in the industry for an EAP to be set up as a referral program, an EAP can alternatively be set up as an expense reimbursement plan.

An EAP can cover a variety of things such as financial counseling, legal services, referrals for mental health or substance abuse counseling. Where an EAP covers medical care, it can trigger compliance with HIPAA and ACA's group health plan rule. However, this is not necessarily the case where limited-scope rules are met.

The criteria for an EAP to qualify as an Excepted Benefit are:

- The benefit must not provide for significant benefits in the nature of medical care.
    - There are no bright-lines drawn in the regulations.
    - The analysis requires measurement of the amount, scope and duration of medical care covered under the plan.
- The benefits cannot be coordinated with benefits under another group health plan.
    - Employees must not be required to use and exhaust the benefits under the EAP as a prerequisite to benefits under their major medical coverage.
    - Employee eligibility cannot be conditioned on participation in any other group health plan.
- The benefit must be offered at no charge to the employee and the EAP cannot impose any cost-sharing requirements.

Why an Excepted Benefit EAP structure is often preferred over an HRA structure
An EAP is never a Health Reimbursement Account (HRA) and vice versa. Those classifications are mutually exclusive. There are several considerations as to why an EAP benefit plan structure is often preferred by employers over an Integrated HRA[9] benefit plan structure. Following are 2 key considerations.

- Unlike an Integrated HRA, EAP participation does not interfere with an employee's ability to contribute to a Health Savings Account (HSA)[10].
    - Most employers offer a menu of options for major medical benefits which almost always includes a high-deductible health plan/ HSA option. Employers tend to prefer a benefit that they can offer universally to all employees rather than having to implement multiple options designed to fit separate groups within their workforce demographics.
    - While an Integrated HRA can be set up to preserve HSA eligibility if it can be offered on a post-deductible basis, that structure renders the benefit much less meaningful for employees in a high-deductible health plan. It also complicates the administration of the benefit.

[9] This discussion focuses on an Integrated HRA as opposed to an Excepted Benefit HRA. The dollar limit for an EB-HRA for 2025 is $2,150. This dollar limit is adjusted annually for inflation. An Excepted Benefit HRA can potentially solve pain points similar to an EAP. However, the annual dollar limit imposed can often rule out that benefit plan structure as an alternative.
[10] An Integrated HRA is essentially an HRA that is "integrated" with the employer's major medical offerings for purposes of complying with the ACA. As such enrollment in an Integrated HRA can only be permitted for those also enrolled in a group health plan. While the regulations do not explicitly require this to be the group health plan sponsored by the employer, most employers interpret the regulation in that way in practice for administrative convenience.

- An EAP allows for greater employer discretion in designing employee eligibility in comparison to an Integrated HRA.
    - Aside from not being allowed to condition enrollment in the EAP on participation in another group health plan, an employer has freedom to cover employees that are not otherwise eligible to participate in their major medical plans.
    - Some practical examples to illustrate how this can be beneficial for an employer:
        - Employer A has a large portion of its workforce that consists of part-time retail workers. Employer A wants to extend a benefit that will allow them to include those that are not otherwise eligible to participate in the employer's major medical benefit offerings.
        - Employer B has a significant portion of its workforce that is under age 26 and may or may not be still obtaining major medical coverage as dependents on a parent's medical plan. Employer B wants to extend a benefit that its younger workforce will be able to access in spite of not being enrolled in the employer's major medical benefit offering.