
Guidance Regarding Reimbursement for Prenatal Care Expenses

Current IRS regulations concerning Medical Flexible Spending Accounts (“Medical FSAs”) create a confusing situation for participants regarding reimbursement for prenatal care and child delivery expenses. This memo attempts to summarize the relevant rules and considerations for participants who seek to be reimbursed from Medical FSAs for prenatal care.

The Situation: The practice of many prenatal care providers to require payment in advance of services (including delivery) is putting participants in a bind. Participants who are required to pay these amounts are doing so before insurance can process the charges and before the charges are eligible for FSA reimbursement.

This puts the Employer and the Plan in a bind, because while the Employer and the Plan seek to assist the participant and provide timely reimbursement, they must adhere to strict IRS rules and regulations that have serious tax consequences for not only the employer, but also the participant.

The Rules: IRS rules are very strict that eligible expenses may only be reimbursed by an FSA plan after the expense has been incurred. As an example: if a participant in a calendar year FSA plan pays \$2,000 in delivery charges on June 1st, but the child is not delivered until July 20th, the delivery charges are not eligible for reimbursement until after July 20th. There are no exceptions.

In addition, there is a plan year limitation. IRS rules only allow reimbursement for services incurred during the active plan year. In the example above, any prenatal care expenses incurred prior to January 1st of this year would not be eligible for reimbursement in this plan year. Only services incurred January 1 – December 31 are eligible.

Documentation: For valid reimbursement, IRS rules require that a participant provide documentation indicating: (1) type of service incurred; (2) date of service incurred; and (3) amount of service incurred. For prenatal care, the appropriate documentation is either a provider invoice or receipt (which must show each of the 3 items listed above) or an Explanation of Benefits (“EOB”) statement from an insurance carrier. For delivery charges, the appropriate documentation is the EOB statement. The EOB statement allows the claims administrator to have all of the necessary information above and be certain of the eligible out-of-pocket amount to be reimbursed.

Proposed Solution: Ideally, when pre-payment is sought by a provider, a participant should make all efforts to convince the provider to wait and require payment only after services are provided (at the time the provider files the charges with the health insurance carrier). If that can be accomplished, then the time of expense and time of reimbursement can be matched in a way to aid the participant. While some providers are obstinate on the issue, many providers understand the participant’s dilemma and realize that the fair solution is requiring payment only after services are rendered and insurance is processed.

In order to assist the participant’s effort to delay payment, ProBenefits provides a Prenatal Provider Letter explaining that there is FSA coverage in place and that the FSA may be available to help the participant fund the amount owed in addition to the health insurance coverage.

Where the provider does not allow the participant to wait until time of service to pay, the participant must be aware that IRS rules do not allow reimbursement until the service date and that the participant will be out-of-pocket for those charges until documentation is provided showing the date of service and expense incurred.

ProBenefits understands that this issue is a difficult issue for participants that comes at a sensitive time, and we want to do everything we can to assist you. If you have any questions or if we may assist you, please contact us. For more information please visit www.ProBenefits.com. For a copy of the Prenatal Provider Letter, please go to www.probenefits.com/Forms/PrenatalProviderLetter.pdf.