



## Excepted Benefits

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## **Excepted Benefits**

### **Overview**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires special processes and procedures be implemented for group health plans. Under the HIPAA portability rules, a category of health benefits were excused from having to comply. These benefits are called “Excepted Benefits<sup>1</sup>.”

Excepted benefits are generally dental, vision, most Health Care FSAs and other group health coverage offered as an ancillary benefit such as coverage for accidents only, automobile medical payment insurance and on-site medical clinics. Disability, liability and worker’s compensation insurance are also excepted benefits.

The Affordable Care Act (ACA) imposes numerous reform provisions on health plans. Many of these provisions apply only to non-excepted health benefits, such as the provisions that mandate a prohibition on annual limits to the coverage provided and the requirement that non-excepted health plans provide coverage for preventive services with no cost sharing<sup>2</sup>.

This whitepaper provides an explanation of which Health Care FSAs and health reimbursement arrangements (HRAs) are excepted benefits and the impact that the ACA has on Health care FSAs and HRAs that are non-excepted benefits.

### **Health Care FSA**

Most Health Care FSAs, as defined by Code § 106(c)(2), will qualify as an excepted benefit. To determine if a Health Care FSA is an excepted benefit the Health Care FSA must meet two conditions as a “class of participants” to be an excepted benefit from HIPAA’s portability requirements<sup>3</sup>. A flowchart has been included as an appendix to this whitepaper that depicts the decision tree for determining whether a health FSA is an excepted or non-excepted benefit.

### **Maximum Benefit Condition**

The Maximum Benefit Condition<sup>1</sup> states that the maximum amount payable to any participant in a class under a Health Care FSA (an employee’s “annual election”) cannot exceed two times the employee’s salary reduction for the plan year, or if greater, the amount of the employee’s salary reduction election for the Health Care FSA, plus \$500.00. If the Maximum Benefit Condition cannot be met for any participant, that employer’s Health Care FSA is non-excepted.

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<sup>1</sup> Code §§ 9831(b) and (c), PHSA §2722

<sup>2</sup> DOL Technical Release 2013-03

<sup>3</sup> DOL Reg. § 2590.732(c)(3)(v), HHS Reg. § 146.45(c)(3)(v)

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To better understand the Maximum Benefit Condition, it is best to pull the definition apart into separate pieces for analysis.

First, the annual election cannot exceed two times the employee's salary reduction for the plan year. The only way that the annual election can exceed two times the employee's salary reduction is when an employer provides additional contributions towards the Health Care FSA that exceed what the employee has salary deducted. Health Care FSAs solely funded by employee salary reductions will automatically satisfy the maximum benefit condition.

The second part of the Maximum Benefit Condition reads: "or if greater, the amount of the employee's salary reduction for the Health Care FSA, plus \$500.00." This means that if the employer does not provide a matching contribution, to satisfy the condition the employer's total contribution for any employee cannot exceed \$500.

*Example 1: Employer A provides a matching contribution. Employee Sasha elects \$700 for the plan year. The employer contributes a matching contribution of \$700 for a total annual election of \$1,400.*

*The Maximum Benefit Condition is met because \$1,400 is not more than two times Sasha's \$700 pre-tax election.*

*Example 2: Employer B contributes \$250 to all full time employees as a seed contribution to the Health Care FSA.*

*The Maximum Benefit Condition is met because the employer contribution will always be less than \$500.*

*Example 3: Employer C contributes \$500 to all Health Care FSA participants. Employee Bill elects to salary deduct \$300 towards the Health Care FSA. The annual election of \$800 is more than two times the salary reduction amount of \$300.*

*However, the Maximum Benefit Condition is met because the annual election is not more than \$500 in excess of the salary reduction amount using the "or if greater" definition. The Annual election amount is equal to \$500 more than the salary reduction amount. (Annual Election  $\leq$  Salary Reduction + \$500)*

*Example 4: Employer Z contributes \$800 to all Health Care FSA participants. Employee Jill elects \$200 in salary reductions for the plan year. The total annual election is \$1,000.*

*The Maximum Benefit Condition fails. The annual election is more than twice the employee's salary reduction amount **and** the employer's contribution amount is at least \$500 more than the employee's salary reduction amount.*

Employer contributions that can be cashed out are deemed to be salary reductions. If the employer contribution must be directed into the Health Care FSA or other account in the cafeteria plan, the amount is deemed to be an employer contribution.

### **Availability Condition**

The second condition that must be met is the Availability Condition. Participants must have other non-excepted group health benefits made available for the year to the class of participants<sup>4</sup>. Unlike the Maximum Benefit Condition test, this test is applied to a class of participants such as full time verses part time employees or union employees verses non-union employees.

Examples that meet the Availability Condition:

- Employer offers all employees the group major medical plan and Health Care FSA,
- Employer offers all full time employees the major medical plan and Health Care FSA,
- The group health plan and Health Care FSA have the same eligibility and waiting periods.

Examples that do not meet the Availability Condition (Health Care FSA is a non-excepted benefit):

- Employer does not offer a group major medical plan
- Employer offers group health plan coverage to full time employees and offers the Health Care FSA to both full time and part time employees
  - Part time employees do not have a non-excepted health plan available
- Employer offers the group major medical plan after a waiting period of 90 days and the Health Care FSA on date of hire.
  - For 90 days, employees eligible for the Health Care FSA are not yet eligible for the group major medical plan and have a non-excepted Health Care FSA.

### **Health Reimbursement Arrangement (HRA)**

Generally, an HRA will be subject to HIPAA's portability regulations because it is a group health plan. This means that most HRAs must comply with the preexisting condition exclusion limitations, special enrollment rights and certificates of creditable coverage.

However, some HRA plans will be excepted benefits and may not be subject to HIPAA's portability requirements. Most notably, retiree-only HRA plans or limited purpose HRA plans (i.e., those that provide dental or vision benefits only) would be excepted benefits.

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<sup>4</sup> Treas. Reg. § 54.9831-1(c)(3)(v), DOL Reg. § 2590.732(c)(3)(v)

### ***Dental/ Vision Only HRA***

HRA plans that offer limited scope dental or vision coverage may also be excepted benefits under HIPAA's portability requirements. For the dental and/or vision benefit to be considered limited in scope, three tests must be met:

- a) Limited in Scope – the benefits provided by the dental plan must be substantially only for treatment of the mouth<sup>5</sup> or vision benefits must be substantially only for treatment of the eye<sup>6</sup>
- b) Separate Policy – the limited scope benefit must be offered under a separate policy, certificate, or contract of insurance<sup>7</sup>
- c) Not Integral to Plan – the limited scope benefit must not be an integral part of the group health plan, meaning the limited scope plan is separately elected (or not elected at all) for a separate additional premium or contribution amount<sup>8</sup>

### **Affordable Care Act (ACA)**

The Affordable Care Act (ACA), health care reform, imposes several new requirements on group health plans. Many of these new requirements do not apply to group health plans that are excepted benefits under HIPAA's portability requirements. Most Health Care FSAs will qualify as excepted benefits. For those that do not, they must comply with these new requirements. Most health reimbursement arrangements (HRAs) are non-excepted benefits and are subject to the ACA provisions.

#### Health Care FSA and the ACA

Of particular interest is the application of the ACA to the Health Care FSA. In guidance provided in September 2013<sup>9</sup>, the regulators stipulated that a non-excepted Health Care FSA would fail to satisfy the no annual limit and preventive care services provisions of the ACA unless the FSA is a limited purpose Health Care FSA (reimburses only dental or vision expenses) or if the only employees covered by the non-excepted Health care FSA are also enrolled in the employer's group medical plan – what the guidance refers to as an “integrated” Health Care FSA. Therefore, an employer cannot offer a non-excepted Health Care FSA to any employees who are not enrolled in the employer's group medical plan unless the FSA is a limited purpose Health care FSA.

#### HRAs and the ACA

In the same IRS and DOL guidance provided for the Health Care FSA, the regulators stipulated that non-excepted HRAs must comply with the no annual limit provision unless the HRA is integrated with the

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<sup>5</sup> Treas. Reg. § 54.9831-1(c)(3)(iii)(A); HHS Reg. § 146.145(c)(3)(iii)(A)

<sup>6</sup> Treas. Reg. § 54.9831-1(c)(3)(iii)(B); HHS Reg. § 146.145(c)(3)(iii)(B)

<sup>7</sup> Treas. Reg. § 54.9831-1(c)(3)(i); DOL Reg. § 2590.732(c)(3)(i); HHS Reg. § 146.145(c)(3)(i)

<sup>8</sup> Treas. Reg. § 54.9831-1(c)(3)(ii); DOL Reg. § 2590.732(c)(3)(ii); HHS § 146.145(c)(3)(ii)

<sup>9</sup> IRS Notice 2013-54, DOL Technical Release 2013-03

employer's group medical plan or with the employee's non-HRA group medical plan coverage provided by another employer (such as the employee's spouse's employer provided coverage). In the FAQ guidance<sup>10</sup> issued in January 2013, the regulators stipulated that a stand-alone non-excepted HRA that reimburses expenses for active employees would fail to satisfy the no annual limit provision and could not be renewed in 2014.

Integrated non-excepted Health Care FSAs and HRAs are subject to the following ACA provisions.

### ***Summary of Benefits and Coverage (SBC)***

The Summary of Benefits and Coverage (SBC) is a new requirement under the ACA<sup>11</sup>. It was developed to help consumers compare various health plan benefits. The SBC is a four-page double sided document that describes the benefit coverage.

Health reimbursement arrangements (HRAs) are required to provide an SBC. HRA plans that are offered in conjunction with a group health plan may combine the SBC for the HRA and group health plan into one SBC. This may be difficult if the HRA and group health plan are administered by two different entities.

Health Care FSAs that do not meet the conditions to be an excepted benefit are also required to provide an SBC<sup>12</sup>.

### ***Patient-Centered Outcomes Research Fees***

Patient-Centered Outcomes Research Institute (PCOR) fees, also known as Clinical Effectiveness Research (CER) fees, are a temporary addition to the ACA<sup>13</sup>. These fees only apply to plan years ending on or after October 1, 2012 and before October 1, 2019. The fee the first year is \$1 times the average number of covered lives and \$2 per covered life until 2019<sup>14</sup>. The fees are to be paid by the insurer for fully insured plans or the plan sponsor, generally the employer, for self-funded health plans.

In general, the PCOR fees apply to most HRA plans. HRA plans integrated with insured coverage or offered as stand-alone coverage will be required to pay the fee. HRA plans integrated with other self-funded coverage will be allowed to count this as one self-funded health plan for fee purposes.

In addition, employers offering non-excepted Health Care FSAs will be responsible to timely report and pay the fee based on the number of employees participating in the non-excepted Health Care FSA each year. Employers will have to carefully determine if they are offering an excepted Health Care FSA.

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<sup>10</sup> FAQs About Affordable Care Act Implementation (Part XI), January 2013

<sup>11</sup> PHSA § 2715(a)

<sup>12</sup> Preamble to Final Rule: Summary of Benefits and Coverage and the Uniform Glossary, 77 Fed. Reg. 8668, 8670 - 8670 (Feb. 14, 2012)

<sup>13</sup> PPACA, Pub. L. No 111-148, § 6301

<sup>14</sup> Code §§ 4375 and 4376

### ***Limit on Waiting Period***

Effective for plan renewal on or after January 1, 2014, group health plans cannot impose a waiting period that exceeds a 90-day waiting period<sup>15</sup>. Temporary guidance was issued in August 2012 and will remain in effect at least through the end of 2014.

HRA plans integrated with a health plan will comply when the underlying health plan complies with this requirement since eligibility for the HRA is tied with participation in the health plan.

For stand-alone HRA plans and non-excepted Health Care FSAs, the waiting period will have to be modified if the HRA or Health Care FSA is a non-excepted benefit and the waiting period is greater than 90 days.

### ***External Claims Review***

For plan years beginning on or after September 21, 2010, certain group health plans are to comply with the health care reform appeal process and external review requirements<sup>16</sup>. Grandfathered plans and excepted benefits do not have to comply.

Non-excepted and non-grandfathered HRA plans and Health Care FSAs must comply with this requirement. The plan will have to utilize three Independent Review Organizations (IROs) and rotate reviews amongst them.

### ***Preventive Care Services***

Non-grandfathered health plans must offer certain preventive care services<sup>17</sup> at no cost for plan years that began on or after September 23, 2010. Most calendar year plans had to comply January 1, 2011.

HRA plans that are integrated with a group health plan will comply because the group health plan will cover the preventive care services with no deductibles, co-pays, co-insurance or other cost sharing.

Stand-alone HRA plans will require preventive care services to be paid first dollar as long as the HRA is a non-grandfathered health plan or a non-excepted benefit.

Health Care FSAs that are non-excepted benefits must also comply. Therefore, a non-excepted Health care FSA that is not integrated with the employer's group health plan are deemed to not satisfy this provision since the Health care FSA has an annual limit and that annual limit places a cost-sharing limit on preventive services<sup>18</sup>.

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<sup>15</sup> PHSa § 2708

<sup>16</sup> PHSa § 2719

<sup>17</sup> PHSa § 2713, Pub. L. No 111-148

<sup>18</sup> DOL Technical Release 2013-03

### COBRA

Both the HRA and the Health Care FSA are group health plans for the purposes of COBRA continuation. Both health plans must be offered to qualified beneficiaries for all COBRA triggering events. A special limited COBRA obligation applies to certain Health Care FSAs reducing the plan sponsor's obligations to offer COBRA.

#### ***Health Care FSA Limited COBRA Obligation***

To qualify for the special limited COBRA obligations a Health Care FSA must first be an excepted benefit. This means the Health Care FSA must meet both the Maximum Benefit Condition and Availability Condition<sup>19</sup>. Both of these tests are described in detail above.

In addition to the excepted benefits tests, the Health Care FSA must also satisfy the COBRA Premium Condition. This means the annualized Health Care FSA COBRA premium must equal or exceed the maximum annual Health Care FSA coverage amount<sup>20</sup>. The Health Care FSA will almost always meet this condition since the COBRA premium will be the same as or 102% of the maximum benefit.

*Example: The Maximum coverage amount is \$1,200. The annual COBRA premium would be \$1,200 or \$1,224 if including the 2% administration fee.*

*The COBRA premium equals or exceeds the maximum annual Health Care FSA coverage amount so this condition is met.*

Health Care FSAs that meet all three conditions qualify for the limited COBRA obligation. This means that the plan sponsor only has to offer COBRA to the end of the Plan Year, not for the full 18, 29 or 36 months of continuation coverage.

A special rule applies for overspent Health Care FSAs that qualify for the special limited COBRA obligation. If a Health Care FSA is overspent at the time of the event, the plan sponsor does not have to offer COBRA when the qualifying event takes place<sup>21</sup>. An overspent account means the remaining annual limit is less than the COBRA premium for the rest of the plan year.

*Example: Lloyd has elected \$2,000 annual limit for his Health Care FSA. Lloyd terminates employment on June 30<sup>th</sup>. Lloyd has made \$1,000 in salary reductions prior to his termination date. At the time of his termination he submitted a total of \$1,300 in reimbursable claims.*

*Lloyd's remaining annual limit is \$700. His total COBRA premiums for the remainder of the plan year are \$1,000. Lloyd's annual limit is less than his COBRA premiums so no COBRA has to be offered to Lloyd.*

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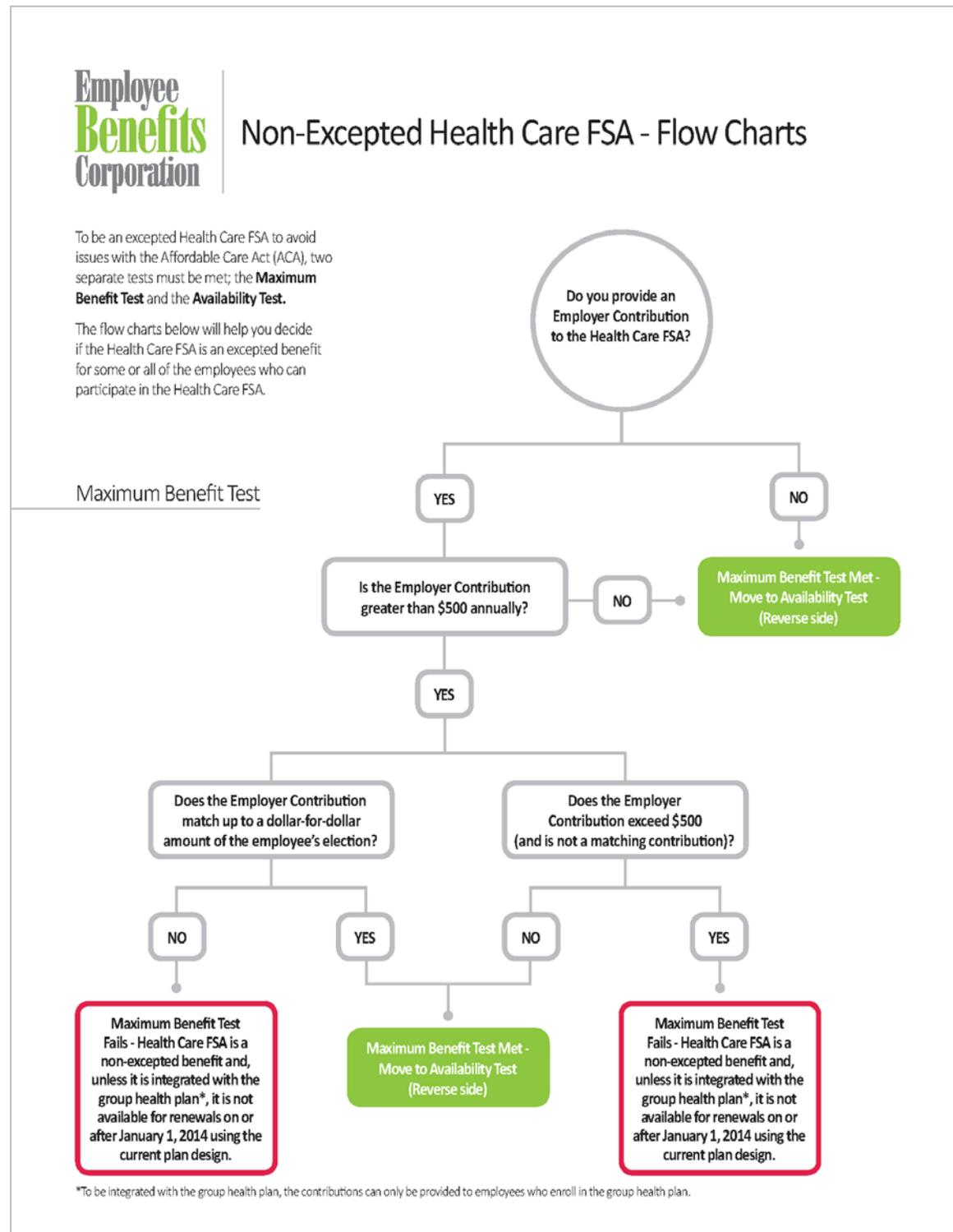
<sup>19</sup> Treas. Reg. § 54.9831-1(c)(3)(v), DOL Reg. § 2590.732(c)(3)(v)

<sup>20</sup> Treas. Reg. § 54.4980B-2, Q/A-8(c)(2)

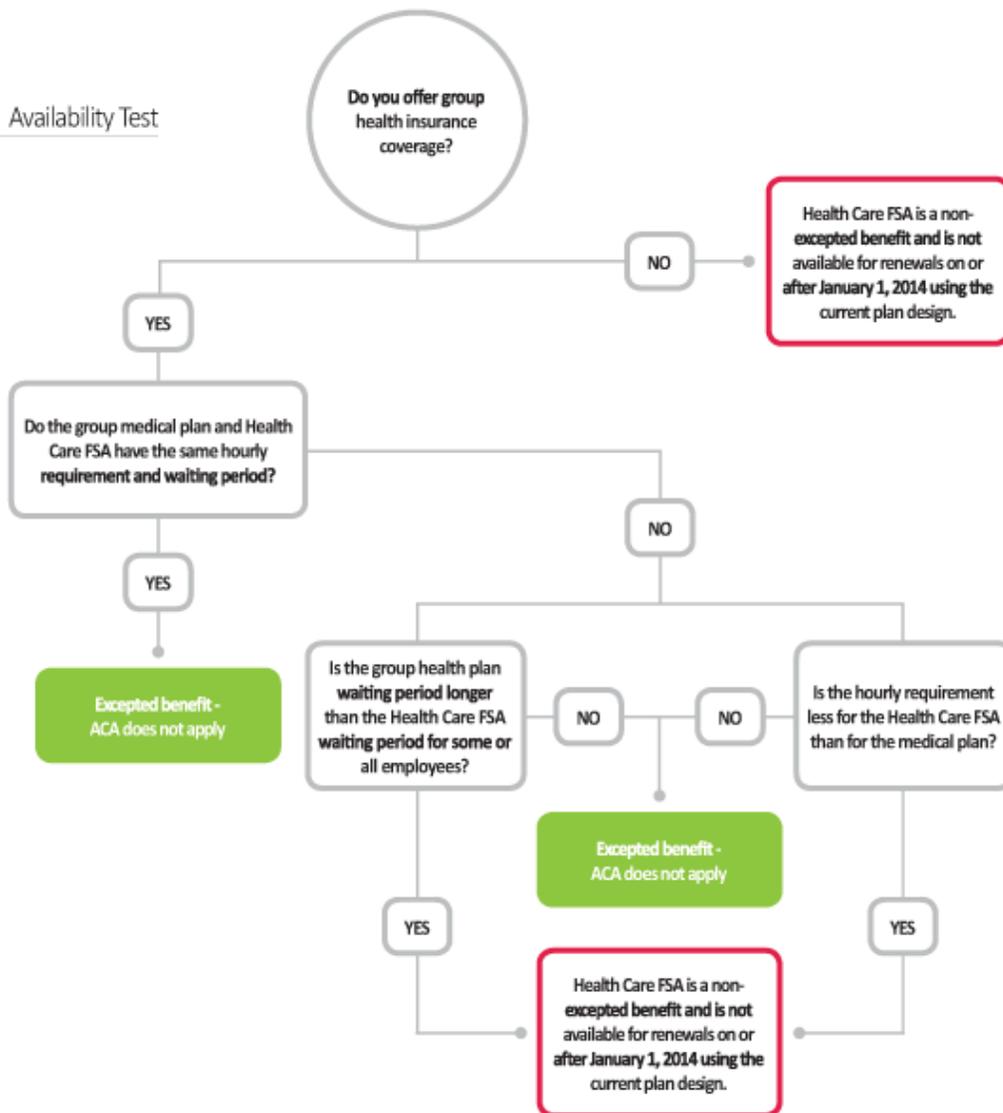
<sup>21</sup> Treas. Reg. § 54.4980B-2, Q/A-8(e)

In summary, if the Health Care FSA is an excepted benefit and the COBRA premium condition is met, the qualified beneficiary only has to be offered COBRA to the end of the plan year. When these conditions are met and the Health Care FSA is overspent, there is no COBRA obligation.

**Appendix: Non-Excepted Health Care FSA – Flow Chart**



Availability Test



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