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LeTourneau was one of the first people in the country to earn the Advanced Certification in Flexible Compensation Instruction designation sponsored by the Employers Council on Flexible Compensation. She is a certified trainer in the ACFCI program.

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The Benefits Brief…

New Rules For Excepted Benefits

On December 13, 2013, the Tri-Agencies—Internal Revenue Service (IRS), Department of Labor (DOL) and Health and Human Services (HHS)—released proposed regulations that provided clarification and requested comments to ensure that certain health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) could include specific benefits and still be considered excepted benefits. This clarification will make it easier for plan sponsors to continue to offer health FSAs and HRAs to their employees.

Background

New Affordable Care Act (ACA) rules kicked in on January 1, 2014, that affect flexible benefits plans. I discussed the new rules of Notice 2013-54 in my November and December articles. Bottom line, FSAs must be considered "excepted benefits" to be offered to employees, and HRAs must be integrated, a retiree-only plan or a limited scope HRA that provides only dental and vision expense reimbursement.

After release of Notice 2013-54, questions arose from employers and third party administrators (TPAs) about the rules surrounding limited scope vision or dental plans. These types of plans must be provided under a separate policy, not be an integral part of a group health plan, participants must have the right not to receive coverage for the benefit, and if the participant elects coverage he must pay an additional premium. This is problematic, since an HRA must be paid solely by the employer. The HRA could not accept employee salary reductions.

Clarification was requested by WageWorks and other TPAs from the Tri-Agencies to ensure that certain health FSAs and HRAs could include limited scope vision and dental plan benefits and still be considered excepted benefits.

Health Plan Excepted Benefits

The new proposed regulations amend the definition of limited excepted benefits to: 1) eliminate the requirement that participants in self-insured plans pay an additional contribution for limited scope vision or dental benefits; 2) allow plan sponsors in limited circumstances to offer "wraparound" coverage to individuals who, but for the unaffordability of the premium, would receive benefits from their group health plan; and 3) define "significant benefits" for employee assistance plans. Following a comment period, final regulations will be issued.

The proposed regulations outline four categories of excepted benefits:

- The first category is benefits that are generally not health coverage. This includes automobile insurance, workers compensation, and accidental death and dismemberment coverage.
- The second category is benefits that cover a limited list of medical conditions. For instance, limited scope vision and dental benefits and benefits for long term and nursing home care, home health care or community-based care. Limited benefits must either be: 1) provided under a separate

policy or 2) otherwise not be an integral part of a group health plan.

Certain health FSAs also fall into this category, provided that all health FSA participants are eligible for the underlying employer-provided major medical coverage and that employer contributions are limited to an amount up to $500 or a dollar-for-dollar match of each participant's election.

Also under this category are integrated HRAs that may only cover employees who are also eligible and participating in employer-provided major medical coverage and retiree-only HRAs.

• Category three is referred to as "non-coordinated excepted benefits" and includes specified disease or illness coverage and hospital indemnity or other fixed indemnity insurance. These benefits are only excepted if the benefits are provided under a separate policy, there is no coordination of these benefits and any exclusion of benefits under any employer-provided major medical coverage, and the benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.

• And finally, the fourth category includes supplemental excepted benefits. These are policies that offer coverage supplemental to Medicare, CHAMPVA, Tricare or similar coverage that is supplemental to coverage provided under a group health plan and is provided under a separate policy, certificate or contract of insurance.

Limited Wraparound Coverage

Some group health plan sponsors asked whether wraparound coverage could be provided for employees for whom employer group health insurance premiums are too expensive and who would rather obtain coverage through an exchange. This approach would allow employers to offer benefits to those acquiring coverage on the exchange that is comparable to the group health plan coverage. Wraparound coverage could not replace group coverage, but would provide additional coverage to individuals and families enrolled in non-grandfathered individual health insurance coverage.

Under specific circumstances, starting in 2015 proposed regulations would allow a wraparound plan to be an excepted benefit if:

• The participant is covered by a non-grandfathered individual health plan that does not consist solely of excepted benefits;

• Coverage is specifically designed to provide benefits beyond those offered by the individual health insurance coverage, such as reimbursing the cost of out-of-network provider costs;

• The wraparound is not an integral part of a group health plan. The plan sponsor must sponsor another (besides the wraparound) group health plan meeting minimum value. This primary plan must be affordable for the majority of those employees eligible for the primary plan and only individuals eligible for the primary plan may be eligible for the limited wraparound coverage;

• The wraparound plan must be limited in amount. The total cost of the coverage must not exceed 15 percent of the cost of coverage under the primary plan; and

• The wraparound plan must be non-discriminatory as to eligibility, benefits or premiums based on any health factor of an individual or impose any preexisting condition exclusion. It also must not discriminate in favor of highly compensated individuals.

Here's a simple example of a wraparound plan: The employer provides an HRA that covers chiropractic, adult vision and dental costs, or a hospital admission fee not covered by the individual policy, and meets all of the requirements outlined above.

Employee Assistance Programs

Employee assistance programs (EAPs) are programs offered by employers that typically provide very limited benefits to address circumstances that might otherwise adversely affect employees' work and health. Unfortunately, some EAPs that provide a few benefits beyond the scope of very limited benefits might be enough to disqualify employees from obtaining premium assistance on exchanges.

The DOL guidance provides welcome clarification that, starting in 2015, EAPs will be excepted benefits if the program:

• Does not provide significant benefits. This is defined as programs that provide 1) no inpatient care benefits, 2) no more than 10 outpatient visits for mental health or substance use disorder counseling, 3) an annual wellness checkup, 4) immunizations and 5) diabetes counseling;

• Cannot be coordinated with benefits under another group health plan;

• Does not require any employee premiums or contributions to participate; and

• Does not include any employee cost sharing.

WageWorks had prior conversations with the different departments and parties concerning these proposed rules and also submitted comments to the Tri-Agencies in response to these proposed regulations.

The information contained in this article is not intended to be legal, accounting, or other professional advice. We assume no liability whatsoever in connection with its use, nor are these comments directed to specific situations.