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EMPLOYEE BENEFIT SOLUTIONS

Compliance Q&A

What is the 'Excepted Benefit' status and why does it matter?

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Question: My company offers a health flexible spending account (FSA) funded by employees. I saw on the IRS website that health FSAs are subject to Patient-Centered Outcomes Research Institute (PCORI) fees unless they are an excepted benefit. When is a benefit considered "excepted" and why else might this status matter?

Summary:

Broadly speaking, excepted benefits are types of coverage that are not subject to Affordable Care Act (ACA) mandates in the way traditional medical group health plans are. The term "excepted benefits" originates from the Health Insurance Portability and Accountability Act (HIPAA), and the ACA later used the same definitions to describe benefits that are not required to comply with certain mandates.[1] Common examples of excepted benefits include dental, vision, flexible spending arrangements, disability, and employee assistance programs (EAPs).

It is important to know whether or not a plan is considered an excepted benefit because, as the name suggests, excepted benefit status means the benefit is not subject to some onerous rules. For example, excepted benefits are not subject to ACA lifetime and annual dollar limit rules, the ACA preventive services mandate, PCORI fees, HIPAA portability rules, and the Mental Health Parity and Addiction Equity Act (MHPAEA). Excepted benefits are also not subject to newer rules such as the Consolidated Appropriations Act, 2021's prescription drug and health care reporting requirements or the anti-gag clause rules.

There are two conditions health FSAs must meet to be considered an excepted benefit – the *Availability Condition* and the *Maximum Benefit Condition*.[2]

Detail:

Excepted benefits generally fall into four categories: (1) benefits that are generally not health coverage (auto, workers' compensation, and liability insurance, for example), (2) limited-scope excepted benefits, (3) non-coordinated excepted benefits, which includes coverage for a specified disease or illness and hospital indemnity or other fixed indemnity insurance, and (4) supplemental excepted benefits.

While the first category is excepted in all circumstances, the latter three have certain conditions that must be met. These conditions are worth paying attention to because there are creative vendors that offer what they claim to be excepted benefits but might not actually be considered as such if investigated by regulators. If it is unclear whether a benefit or program that provides medical care should actually qualify for excepted benefit status, a legal opinion may be necessary. Seasoned vendors will be able to speak more to the specifics of their program.

The remaining three categories are discussed in more detail below.

Limited-scope excepted benefits

The most common limited excepted benefits are limited-scope dental or vision care, although long-term care also falls under this category. These limited benefits must either be provided under a separate policy, certificate or insurance contract, or otherwise not be integrated into the group health plan.[3] These coverages can be offered through the same plan as other benefits, a separate plan, or as the only plan so long as participants can decline the coverage, or the claims are administered separately from other benefits under the plan.[4] Typical standalone dental and vision benefits meet these requirements.

Non-coordinated excepted benefits

Independent, non-coordinated benefits include coverage for a specific disease or illness, as well as group hospital indemnity or other fixed indemnity benefits. Cancer-only policies are a classic example of coverage for a specified disease or illness. Rather than medical coverage, fixed indemnity coverage provides a cash-replacement benefit for individuals with other health coverage. To fall under this exception, a fixed indemnity benefit must meet several conditions: It must be provided under a separate policy, certificate or contract, such that benefits cannot be coordinated, and it must pay benefits for an event regardless of whether the group health plan pays for the same benefits.[5] Fixed indemnity benefits also must pay a fixed dollar amount rather than an amount based on a specific service.[6]

A final rule published in April of 2024 confirms that, to be considered "excepted," hospital and other fixed indemnity policies must pay benefits regardless of the amount of expenses a consumer incurs.[7] What this practically means is that, while a benefit payment might happen to equal all or a portion of the cost of care related to an event, such payments must be made without regard to the amount of costs incurred for the event. For example, a period of hospitalization or illness might ultimately cost a consumer thousands of dollars, while a policy paying a fixed amount might only provide income replacement of $100 per day. These limitations are consistent with the primary purpose of this type of coverage, which is to provide income replacement benefits.

For plan years beginning on or after January 1, 2025, a consumer notice must be provided for fixed indemnity excepted benefits policies, so that individuals can make informed purchasing decisions and do not mistake these

benefits as a primary source of coverage. (A consumer notice for individual policies has been required for some time, but the notice for group market plans is a product of the 2024 final rule.) The consumer notice must be provided before participants' opportunity to enroll or reenroll in coverage and must be "prominently" exhibited when coverage is marketed, during an application, and in enrollment materials for the coverage.

Supplemental excepted benefits

Supplemental excepted benefits also must be provided under a separate policy, certificate, or contract of insurance. Medicare supplemental health insurance and coverage supplemental to TRICARE are specifically exempted by the regulations, which then go on to exempt "similar supplemental coverage provided under a group health plan."[8] The scope of what constitutes similar supplemental coverage has been expounded upon in regulations, including a safe harbor for meeting this requirement. The regulations require that such coverage be insured, as it must be provided "under a separate policy, certificate, or contract of insurance." By its nature, a self-insured plan providing these benefits would not qualify. In addition, supplemental coverage must "fill gaps in primary coverage, such as coinsurance or deductibles."[9] Regulations issued in 2016 clarify that not just gaps in cost-sharing may qualify, but that this gap-filling function may be achieved by filling gaps in limited categories of benefits covered by the primary group health plan.[10] Importantly, these categories are limited to benefits that are not essential health benefits in the state where the product is being marketed. One difficulty with this limitation is that it requires familiarity with the essential health benefits in various states. With these clarifications in mind, the safe harbor itself was established in 2007 by the Department of Labor, Department of Health and Human Services, and the IRS. Under the safe harbor, similar supplemental coverage (issued under a separate policy, certificate, or contract of insurance) is considered to be excepted if it meets four specific criteria:

1. it must be issued by an entity that does not provide primary coverage under the plan,
2. it must be specifically designed to supplement gaps in primary coverage, such as payment of deductibles or coinsurance, and may not become merely secondary or supplemental to the primary plan via a coordination-of-benefits provision,
3. the cost of the supplemental coverage may not exceed 15% of the cost of primary coverage (calculated in the same manner as applicable COBRA premiums), and
4. it must not differentiate among participants in eligibility, benefits, or premiums based on health factors of any participant.[11]

Employee Assistance Programs

EAPs are prevalent programs that may be considered excepted benefits if structured properly, and interestingly require their own examination and analysis.

As an initial matter and a basic principle to bear in mind, an EAP that provides medical care is a group health plan. Some EAPs are tied into a medical plan, such that only medical-eligible individuals may participate. In a circumstance where the EAP is tied to the underlying medical plan, it would not be an excepted benefit but would have the advantage of being able to meet the mandates mentioned above by virtue of being part of that larger medical benefit. However, even where they are technically group health plans, EAPs are often designed to fall under an exception. Plan sponsors should proceed with caution, however, as it is not safe to assume that an EAP vendor has designed their program as an excepted benefit. Rather, when considering a standalone EAP, sponsors should pay close attention to the benefit's design and look for four conditions.

The four conditions an EAP must meet to be considered an excepted benefit are:

1. it cannot provide "significant benefits in the nature of medical care;"
2. it cannot be coordinated with benefits under another group health plan;
3. premiums or contributions are not required to participate; and
4. there is no cost-sharing as part of the EAP.[12]

While "significant benefits in the nature of medical care" is not a clearly defined standard, there are some illustrative examples in the regulations. After stating that the "amount, scope and duration of covered services" should be taken into account, the Agencies provide examples of what would not and would, in their view, constitute significant benefits in the nature of medical care. "[A]n EAP providing limited, short-term outpatient counseling for substance use disorders (and not covering inpatient, residential, partial residential or intensive outpatient care) without requiring prior authorization or medical necessity review" would not be considered to provide significant benefits in the nature of

medical care (and could therefore be considered an excepted benefit if the other three criteria are met). Conversely, a benefit that "provides disease-management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions such as diabetes" would be regarded as providing significant benefits in the nature of medical care. While the Agencies noted that future clarification may be provided regarding these issues, none has been provided so far.

Health Flexible Spending Accounts

Health FSAs generally must be designed as excepted benefits or integrated with another group health plan in order to comply with health care reform. Assuming the goal is to offer an FSA that is separate from the group health plan, plan sponsors must ensure the FSA is designed as an excepted benefit and there are specific criteria that must be met to do this. Health FSAs, defined in Code Section 106(c)(2),[13] have their own set of rules that must be adhered to for them to qualify as excepted benefits. There are two conditions, known as the *Maximum Benefit Condition* and the *Availability Condition*.[14]

First, the maximum benefit payable under the health FSA to any participant cannot exceed twice the participant's salary reduction election under the health FSA for the year or the amount of the participant's salary reduction election plus $500.[15] In other words, the employer can contribute up to $500 or a match of the employee's contribution up to a specific amount that changes annually. Second, there is an availability condition that says that other non-excepted group health plan coverage (major medical) must be made available for the year to those eligible to participate in the health FSA.[16] In other words, individuals must be eligible for both a group medical plan and a health FSA, but they do not have to be enrolled in both. These excepted benefit determinations for health FSAs (and, really, any other benefit purporting to be excepted) can get complex, but most vendors are very familiar with and can guide plan sponsors to ensure the FSA program meets excepted benefit criteria. Most health FSAs will qualify for the exception.

Conclusion:

Given the increasing complexity and creativity of employee benefit programs, it is important to know whether or not such programs may be considered excepted benefits and thus exempt from certain mandates – a determination that often requires a legal opinion. As a best practice, plan sponsors should consider, prior to implementation, whether benefits under consideration can be designed to fall under one of the categories of excepted benefits.

References

1 - Code §§ 9831(b) and (c); ERISA §§ 732(b) and (c); PHSA §2722.

2 - Treas. Reg. §§ 54.9831 -1(b) and (c); DOL Reg. §§ 2590.732(c)(3)(v)(A) and (B); HHS Reg. §§ 146.145(b)(3)(v)(A) and (B).

3 - Code § 9831(c)(1); ERISA § 732(c)(1); PHSA § 2722(c)(1); PHSA § 2791(c)(2).

4 - Treas. Reg. §54.9831-1(c)(3)(ii)(A); DOL Reg. § 2590.732(c)(3)(ii)(A); HHS Reg. § 146.145(b)(3)(ii)(A).

5 - Code §§ 9831(c)(2) and 9832(c)(3); ERISA §§ 732(c)(2) and 733(c)(3); PHSA § 2791(c)(3); Treas. Reg. § 54.9831-1(c)(4); DOL Reg. § 2590.732(c)(4); HHS Reg. § 146.145(b)(4).

6 - See Treas. Reg. § 54.9831-1(c)(4)(iii), DOL Reg. § 2590.732(c)(4)(iii), and HHS Reg. § 146.145(b)(4)(iii).

7 - Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage, 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 144, 146 and 148, 89 Fed. Reg. 23338 (Apr. 3, 2024).

8 - Treas. Reg. § 54.9831(c)(5); DOL Reg. § 2590.732(c)(5); HHS Reg. § 146.145(b)(5).

9 - Treas. Reg. § 54.9831-1(c)(5); DOL Reg. § 2590.732(c)(5); HHS Reg. § 146.145(b)(5).

10 - Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Parts 144-148; 81 Fed. Reg. 75316, 75319 (Oct. 31, 2016).

11 - DOL Field Assistance Bulletin 207-4 (Dec. 7, 2007); CMS Program Memorandum, Transmittal No. 08-01 (May 2008); IRS Notice 2008-23.

12 - Amendments to Excepted Benefits, 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 146, 79 Fed. Reg. 59130, 59123 (Oct. 12, 2014).

13 - Code § 106(c)(2) defines flexible spending arrangements as benefit programs which provide employees with coverage under which "(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and reasonable conditions), and (B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage."

14 - Treas. Reg. §§ 54.9831 -1(b) and (c), DOL Reg. §§ 2509.732(c)(3)(v)(A) and (B), HHS Reg. §§ 146.145(b)(3)(v)(A) and (B).

15 - Treas. Reg. § 54.9831-1(c)(3)(v)(B); DOL Reg. § 2590.732(c)(3)(v)(B); HHS Reg. § 146.145(b)(3)(v)(B).

16 - Treas. Reg. § 54.9831-1(c)(3)(v)(A); DOL Reg. § 2590.732(c)(3)(v)(A); HHS Reg. § 146.145(b)(3)(v)(A).

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