On Friday, September 13, 2013 Treasury published Notice 2013-54 (Notice) which preserves all health flexible spending accounts (health FSAs) that are considered excepted benefits but eliminates an employer’s ability to use a stand-alone health FSA or other tax-favored arrangements, including Premium Reimbursement Arrangements or health reimbursement arrangements (HRAs), to help employees pay for individual health policies on a tax-free basis. In addition, the Notice addresses a number of specific topics related to FSAs and HRAs. As such, this Alert is the second of two.

**Keeping health FSAs as excepted benefits¹**

Prior to this guidance, assuring a health Flexible Spending Account (FSA) was classified as an excepted benefit for purposes of HIPAA was important for two primary reasons: so COBRA continuation was not offered when the account was "overspent" and to avoid HIPAA portability requirements. But now, in addition to assuring Health FSAs are not swept into the W-2 reporting rules, FSA plans must also meet HIPAA excepted benefit rules to be offered in compliance with the new Affordable Care Act (ACA) requirements.

Generally, this means health FSAs must meet two conditions to be offered:

1. Only individuals eligible for employer-provided major medical coverage can be offered the health FSA. Employers with health FSAs must have an underlying ACA-compliant group health insurance plan. As an example, XYZ Co. offers a health FSA to full-time employees and part-time employees. However; the part-time employee population is not eligible to enroll in XYZ Co.’s major medical plan. Under this scenario, part-time employees can no longer enroll in an FSA. An amendment is required to XYZ Co.’s Plan Document to remove this group as eligible employees under the FSA.

2. In addition, the health FSA must limit the maximum payable to 2 times the participant's salary reduction or, if greater, the participant's salary reduction plus $500. What does this mean? Simply that health FSAs can include employer contributions of $500 or up to a dollar for dollar match of each participant's election. If the health FSA fails either of these conditions, it is subject to ACA’s market reforms, such as no cost sharing for preventive services and the prohibition against annual and lifetime limits. By definition, the health FSA will not meet these ACA requirements.

**Cafeteria plans may no longer reimburse individually-owned insurance policies¹**

This may not affect most employers - however for the few employers sponsoring cafeteria plans that allow for participants to pay their individually-owned policy premiums with pre-tax dollars - the IRS and Treasury just eliminated this as an option. The reason for the change is to discourage employers from eliminating group coverage and to make it impossible for employers to send their employees to the Public Exchange and perhaps reimburse them with tax-free dollars for their cost for Exchange coverage.

Employers need to be aware that any reimbursement or payment of individual health coverage, whether it be inside or outside of an Exchange, cannot be made with tax-advantaged funds.

**Amendment for fiscal year cafeteria plans²**

This may be one of the most misunderstood ACA provisions issued to date and applies only to employers with non-calendar year plans (Example: July 1 thru June 30 plans). Employees who wish to seek coverage on the Exchange, but would otherwise be prevented from doing so because their elections are generally irrevocable for
the plan year, can be allowed to make a change if the employer amends their plan to allow this additional change-in-status event. A couple of points to remember: because of the employer shared responsibility rules, the guidance applies only to “applicable large” employers. These are employers who employed an average of at least 50 full-time employees, or full-time equivalents, based on hours of service during the preceding calendar year. Many industry experts, however, believe there may be relief to allow the same treatment for small employers.

It's also only applicable to cafeteria plans that have a plan year beginning in 2013 and that run benefits on a fiscal plan year rather than a calendar year.

While the guidance came out before the "Employer Mandate" (shared responsibility or play or pay) was delayed until 2015, it allows employers to amend their plan and permit employees who enroll for Exchange coverage to drop their employer coverage - essentially providing an additional qualified change in status reason.

Why would this be a critical amendment? ACA was written to assure that employees and individuals could purchase insurance coverage through state Exchanges. Allowing employees to change cafeteria elections mid-year allows maximum flexibility for employees.

90-day waiting period

Health plan years that start on or after January 1, 2014 may not contain a waiting period for entry into the plan that exceeds 90 days (60 days in California plus other states may vary). In order for health FSAs to retain their status as an excepted benefit, they can only be made available to employees who are also eligible for underlying ACA-compliant health coverage. Thus, Health FSAs must assure that their waiting periods are no less than that of the underlying health coverage.

Therefore, employers should be sure that the waiting period for the premium-only and the health FSA portion of employers' cafeteria plans mirror the waiting periods for underlying health insurance plans or, in the case of the health FSA, may be longer.

If the cafeteria plan document does not currently reflect these terms, a simple amendment to the cafeteria plan can be adopted that states that the eligibility and entry dates into the cafeteria plan are the same as the underlying health insurance plan. This ensures no disconnect if the waiting period changes in the health insurance plan.

Amendment Action Steps

<table>
<thead>
<tr>
<th>Plan</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium Only Plan - Fiscal Year Plans (example July 1 - June 30)</td>
<td>Amend your Plan Documents to allow a one-time qualifying event giving permission for employees to enroll in the Exchange and opt out of their current health insurance plan and the premium only portion of the cafeteria plan.</td>
</tr>
<tr>
<td>January 1, 2014 Health FSAs and Premium Only Plans</td>
<td>Amend your plan to adjust the waiting period so that it is not more than 90 days (in most states). The waiting period adopted should be the same as the underlying insurance plan or for FSAs can be longer but in no case a shorter waiting period than the underlying health insurance plan.</td>
</tr>
</tbody>
</table>
This table may help you assess your current FSA plan and next steps:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Subject to Annual dollar limit prohibition?</th>
<th>Subject to preventive services requirements?</th>
<th>Regulatory Status</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excepted benefit health FSA</td>
<td>No</td>
<td>No</td>
<td>Not subject to the annual dollar limit prohibition and preventive services requirement, and does not provide minimum essential coverage (participant remains eligible for premium tax credits)</td>
<td>Consider employer contributions to $500 or matching a maximum of $1 for every dollar elected by the participants.</td>
</tr>
<tr>
<td>Non-excepted benefit health FSA funded under a 125 cafeteria plan</td>
<td>No</td>
<td>Yes</td>
<td>Fails to satisfy the preventive services requirement</td>
<td>Plan must be terminated.</td>
</tr>
<tr>
<td>Non-excepted benefit health FSA not funded under a 125 cafeteria plan</td>
<td>Not yet determined</td>
<td>Yes</td>
<td>Fails to satisfy the preventive services requirement; may also fail the annual dollar limit prohibition</td>
<td>Plan must be terminated.</td>
</tr>
<tr>
<td>After-tax employee contributions which participant may use to purchase individual market coverage</td>
<td>No</td>
<td>No</td>
<td>An arrangement under which after-tax employee contributions may be used to purchase individual market coverage and are structured as an employer payroll practice are permissible.</td>
<td></td>
</tr>
<tr>
<td>Pre-tax employee contributions which participant may use to purchase individual market coverage</td>
<td>Yes</td>
<td>Yes</td>
<td>Fails to satisfy annual dollar limit prohibition and preventive services requirement</td>
<td>Plan must be terminated.</td>
</tr>
</tbody>
</table>

Need assistance with any of these new requirements? Contact your Relationship Manager.

- [3] IRS Notice 2012-17

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