MedBen health benefits

Fundamentals of Cafeteria Plans, Health Reimbursement Arrangements and Health Savings Accounts

- **Cafeteria Plans** (FSAs) – 1978
- **Health Reimbursement Arrangements** (HRAs) – 2002
- **Health Savings Accounts** (HSAs) – 2003

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Cafeteria Plans
Flexible Spending Accounts (FSAs)

What is a Cafeteria Plan?

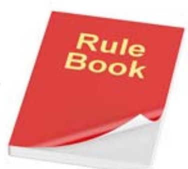
A program that employers can use to help employees pay for certain expenses with pre-tax dollars

- Health Insurance Premiums
- Certain Medical Expenses
- Qualified Child/Adult care expenses

Cafeteria Plans

Basic Code and Regulatory Requirements

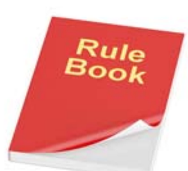
- Must have a written Plan Document
- Claims must be paid at least monthly
- Coverage must generally be 12 months
- Must be adequate substantiation
- Must have annual elections
- Must pass discrimination testing



Cafeteria Plans

Basic Code and Regulatory Requirements

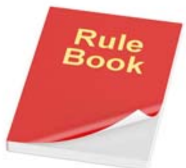
- Elections must be made prospective (in advance)
- Elections are irrevocable, except for qualifying change of status
- Unclaimed “balances” are forfeited (no deferred compensation -use or lose rule)
- Expenses must be substantiated



Cafeteria Plans

Basic Code and Regulatory Requirements

- Uniform Coverage Rule (Employees can receive the full elected funds prior to full payroll deduction for the plan year – Health FSA and LP FSA plans only)
- Expenses must be incurred in the coverage period (plan year) to be eligible



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Cafeteria Plans

4 Most Popular Cafeteria Plans

- Premium Only Payment Plan (POP)
- Health Flexible Spending Account (Health FSA)
- Limited Purpose Health FSA (LPFSA)
- Dependent Care Assistance Plan (DCAP)

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Cafeteria Plans

Premium Only Plans

- It is designed for one purpose… for the employee's share of the employer-sponsored health insurance plan premium.
- Employee contributes through pre-tax payroll deductions.
- Processed through payroll system.
- No reimbursement/claim forms.

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Cafeteria Plans

Internal Revenue Code Requirements

- Health Care Spending Accounts
  - Internal Revenue Code §125
  - The "no deferred compensation" and claims substantiation rules
  - The nondiscrimination, reporting, disclosures and other rules for Code § 125
  - Reimbursement must be for medical care (as defined by Code § 213(d))

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Cafeteria Plans

Traditional Health FSAs

- An individual account funded by employee salary reduction on a pre-tax basis.
- Amounts are used exclusively to reimburse qualified unreimbursed medical expenses incurred by the employee, spouse and/or dependents.
- Uniform Coverage Rule

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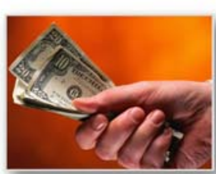
Cafeteria Plans

Traditional Health FSAs

- The Plan decides how much a Participant may contribute on an annual basis.
  (Plan years beginning on or after 1/1/2018 – IRS max $2,650 in Employee pre-tax contributions)



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Cafeteria Plans

Examples of Qualified Expenses

- Medical - includes o.v. co-payments, deductibles & co-insurance
- Dental and Orthodontic expenses
- Vision - Eye exams, eyeglasses, contact lenses (i.e., Lasik eye surgery)
- Prescription drug co-payments (Retail & mail order)
- OTC non-drug related items
- Prescribed OTC drugs/medicines

Cafeteria Plans

Limited Purpose Health FSA

- Design for employees enrolled in a qualified Health Savings Account (HSA)
- An individual account funded by employee salary reduction on a pre-tax basis.
- Amounts are used exclusively to reimburse qualified unreimbursed dental/vision expenses incurred by the employee, spouse and/or dependents.
- Uniform Coverage Rule

Cafeteria Plans

Examples of Qualified Expenses

- Dental / Vision o.v. co-payments, deductibles & co-insurance
- Dental and Orthodontic expenses
- Vision - Eye exams, eyeglasses, contact lenses (i.e., Lasik eye surgery)
- Qualified medical expenses that exceed the IRS minimum deductible (if permitted)

Cafeteria Plans

Deferred Compensation Prohibition (Use it or Lose it Rule)

- Prohibits Cafeteria Plans from allowing participants to carry over unused contributions from one year to another unless an exception applies.
- Participants are forced to "forfeit" unused balances.
- 2 exceptions to the rule

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Cafeteria Plans

Health FSA Grace Period

- IRS Notice 2005-42 permits a participant a 2-½ month extension from the end of the Plan Year to incur and spend down any funds remaining in the Health FSA Plan.
- Modifies but does not eliminate "Use-it-or-Lose It" rule
- January 1 to March 15
- Run-out period still applicable

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Cafeteria Plans

Health FSA Carryover

- IRS Notice 2013-71 permits Health FSA plan's to implement a carryover feature in their Plans
- Modifies but does not eliminate "Use-it-or-Lose It" rule
- Maximum of $500
- Run out period still applicable

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Cafeteria Plans

Internal Revenue Code Requirements

- Dependent Care Spending Accounts
  - Code §129 reimbursement rules
  - The “no deferred compensation” and claims substantiation rules contained in Prop. Treas. Reg. §1.125-2 Q/A7
  - The nondiscrimination, reporting, disclosures and other rules for Code § 129

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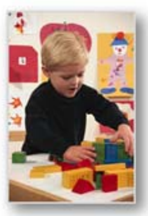
Cafeteria Plans

Dependent Care Assistance Program (DCAP)

- An individual account funded by employee salary reduction on a pre-tax basis.
- Amounts are used exclusively to reimburse the employee for employment-related dependent care
- Funds are available as funds are withdrawn from payroll check.
- DCAP contribution level
  - $5,000 per year maximum (IRS)



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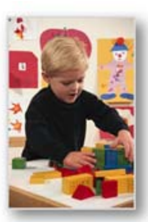
Cafeteria Plans

DCAP Spend Down (Optional)

- Spend down feature permitted after termination from plan during Plan Year
  - Prop. Regs. permit participants to spend down remaining balances in DCAP plans if they have terminated from the plan during the plan year.



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Cafeteria Plans

Advantages for Employee

- No Federal Income Tax
- No FICA Tax
- No Medicare/SS Tax
- No State Taxes

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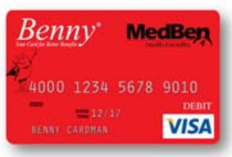
Cafeteria Plans

Debit Card

- IRS Revenue Ruling 2003-43
  - Allows use of cards for Health Care Spending Account
  - Retains substantiation requirements
  - Allows some auto-adjudication
  - Defines card parameters
  - Defines procedures for ineligible expenses



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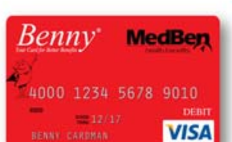
Cafeteria Plans

Debit Card

- What Is a Debit Card?
  - A debit card allows a participant to pay for a qualified medical expense at the time of service by simply swiping the card through an electronic machine.
  - It is connected directly to your Health FSA.



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Cafeteria Plans

Claims Substantiation

All expenses the card is used for must be substantiated with the exception of...

1. Co-Payment Match Claims
2. Recurring Previously Approved Claims
3. Real-Time Verified Claims

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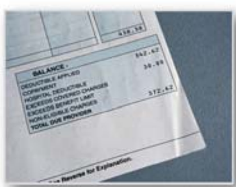
Cafeteria Plans

Do I have to substantiate my debit card expense?

Not all debit card transactions are automatically substantiated!!

The following need substantiation….

- Dental / Orthodontic expenses
- Vision Expenses
- Medical expenses applied to deductible and/or co-insurance
- Medical expenses excluded from plan
- 90 % Merchant purchases



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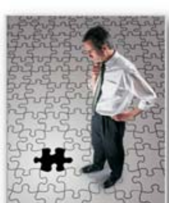
Cafeteria Plans

Debit Card Issues

- Ineligible claims expenses
- Claims not properly substantiated
  - Require Repayment
  - Offset Future Claims
  - Deny Access to Card
  - Withhold from Pay



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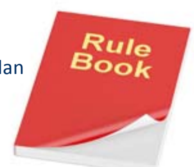
Health Reimbursement Arrangements (HRAs)

HRAs

Basic Code and Regulatory Requirements

- May only be funded with Employer contributions
- Cannot be offered under a Cafeteria Plan
- Must be integrated with group health plan coverage (some exceptions)
- No specific Code section governing HRAs
- Tax favored treatment under the general principles of Code § 105 and § 106



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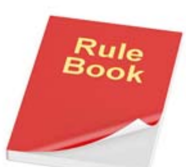
HRAs

Basic Code and Regulatory Requirements

- New rule defining QSEHRAs (Qualified Small Employer HRA)
- Tax exclusions for employee
  - Code § 105 – exclusion for payment or reimbursement from employer-provided health coverage
  - Code § 106 – exclusion for health care coverage provided by employer



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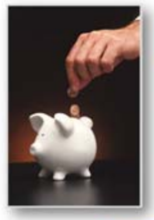
HRAs

What are HRAs?

- The HRA provides a specific "bank" of money that employees can access now or later for medical expenses.
- The employer offsets HRA expense by reducing basic health benefits (higher deductibles, co-pays, etc.)
- Offers the most control in CDHP options



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HRAs

HRA "Musts"

- HRAs **must** be funded solely with employer contributions.
- HRAs **must** pay only for substantiated (IRS Code Section 213) medical expenses.
- HRAs **must** only reimburse expenses for those enrolled in related medical plan

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HRAs

HRAs "Can" Be Designed to Cover Only Specific Expenses

- Medical
- Dental
- Vision
- Prescription Medication

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HRAs

HRA "Cans"

- HRAs **can** allow former employees (retirees) continued access to unused funds in the reimbursement account.
- HRAs **can** carry over unused funds from year to year.

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HRA Plan Design Trends

HRA Plan Design Trends

HRA Rollover Trends

MOST COMMON

- 100% rollover of unused funds
- Cap rollover ($10-$15,000)
- Maximum rollover ($ or %)
- No rollover – use it or lose it

LEAST COMMON

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HRA Plan Design Trends

HRA Rollover Trends

MOST COMMON

- Save for post-employment:
  - While enrolled in plan – use dollars for limited benefits
  - At retirement – use for Section 213 expenses, Medicare supplemental policies and COBRA premiums
- If no retirement or post-employment benefit, lose money when no longer an active employee (COBRA eligible)

LEAST COMMON

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HRA Plan Design Trends

HRA Funding

MOST COMMON

- $ based on single or family enrollment in health plan – usually a % of deductible and/or coinsurance
- Flat dollar – Everyone gets same amount

LEAST COMMON

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HRA Plan Design Trends

HRA Funding Schedule

MOST COMMON

- Total year contribution available on day one of plan year
- Monthly basis
- Pro-rate late enrollees

LEAST COMMON

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HRA Plan Design Trends

HRA Funding Schedule

MOST COMMON

- Can only be used for current plan year expenses (can apply run out)
- Reimburse any plan year expense as long as enrolled in medical plan
- 2 year plan

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HRA Plan Design Trends

HRA & FSA Coordination

MOST COMMON

- HRA is the first payor
- FSA dollars may be used first
- Participants choose which plan pays first

LEAST COMMON

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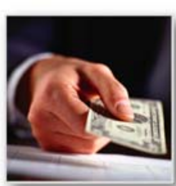
HRA Plan Design Trends

Employer Funding

- Do not have to physically fund account
- Can fund as expenses are reimbursed
- Considered Group Health Plan (subject to COBRA)
  - Can be included in medical premium
  - Can be separate premium
  - Can require enrollment in medical plan to continue under COBRA



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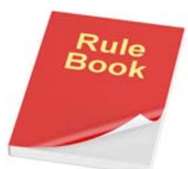
Health Savings Accounts
(HSAs)

HSAs

Basic Code and Regulatory Requirements

Basic rules contain in Code § 223

- Created as part of the Medical Prescription Drug, Improvement and Modernization Act of 2003 (MMA)
- May be funded on a pre-tax basis through a Cafeteria Plan



HSAs

2 Separate Plans!

1. Qualified High Deductible Health Plan (HDHP)
2. Health Savings Account (HSA)

HSAs

What is an HSA?

A tax-exempt trust or custodial account established by an individual exclusively for the purpose of paying qualified medical expenses.

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HSAs

Who Can Establish an HSA?

An individual who…

- Is covered by a Qualified High Deductible Health Plan (HDHP).
- Is not covered by another non-qualified health plan.
  - Traditional Health FSA
  - Traditional Health Reimbursement Arrangements

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HSAs

What Is a High Deductible Health Plan (HDHP)?

A medical plan that has specified minimum limits for the annual deductible and maximum limits for out-of-pocket expenses.

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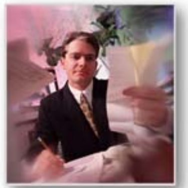
HSAs

Qualified HDHPs

- Self-Only Coverage
  - Minimum deductible of $1,350 and a maximum $6,650 out-of-pocket expense
- Family Coverage
  - Minimum deductible of $2,700 and a maximum $13,300 out-of-pocket expense

*Subject to COLA each year



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HSAs

Qualified HDHPs

- NO first dollar benefits can be paid below the deductible level.
  - i.e., office visit & RX co-payments
  - <u>All</u> qualified medical expenses must be applied to the deductible before the HDHP pays any benefits.
  - Only exception are the three "P's"

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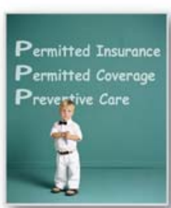
HSAs

The Three "P"s…

- Can have "first dollar" coverage for…
  - "**P**ermitted Insurance"
  - "**P**ermitted Coverage"
  - "**P**reventive Care"
- Cannot provide benefits for any year until the deductible is met.



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HSAs

“Permitted Insurance”

- Specified Disease or Illness
- Insurance that pays a fixed amount for hospitalization
- Workers Compensation
- Property / Casualty / Automobile

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HSAs

“Permitted Coverage”

- Dental coverage
- Vision coverage
- Qualified long-term care
- Accident coverage
- Disability coverage

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HSAs

“Preventive Care”

- Routine prenatal and well child care
- Child and adult immunizations
- Tobacco cessation programs
- Obesity weight loss programs
- Screening benefits

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HSAs

Who May Contribute to an HSA?

- HSA Established by an Employee
  - An Employee, Employer or both
- HSA Established by a Self-employed Individual
  - The Individual
- Can only contribute while enrolled in qualified HDHP
  - If no longer enrolled – can no longer contribute

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HSAs

Who May Contribute to an HSA?

- HSA Established by an Employee
  - HSA account is owned by the Employee
  - Yearly Contribution limits
    - Single $3,450
    - Family $6,900
  - Catch up Contribution (55 or older)
  - $1,000

* Subject to COLA each year

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HSAs

Record Maintenance

The individual who establishes the HSA is required to maintain records of expenses sufficient to show that distributions were made exclusively for qualified medical expenses.

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HSAs

What Can HSAs Be Used For?

- Reimbursement must be for medical care (as defined by Code § 213(d)) to obtain tax free distribution
- Non medical expenses (significant tax penalty)
- Employee, Legal Spouse, Children
- Can continue to receive distributions after eligibility ends

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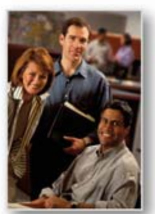
HSAs

Who Is Considered HSA Eligible?

- Any individual with qualifying HDHP coverage, so long as he or she has no other disqualifying health coverage
- 2 groups on NOT eligible
  - Those who can be claimed as a tax dependent under another individual
  - Those who are entitled to Medicare



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