COMPLIANCE OVERVIEW

Provided by BBP Admin

Health Flexible Spending Accounts (FSAs)

A health flexible spending account (FSA) is a type of tax-advantaged medical account that reimburses employees for eligible health care expenses that are not covered by their health plans. Both employees and employers can contribute to a health FSA, subject to certain limits.

Although employers have some flexibility when it comes to designing their health FSAs, there are numerous legal compliance issues to take into account. As group health plans, health FSAs are subject to various employee benefit laws, such as ERISA, COBRA, HIPAA and the Affordable Care Act (ACA). In addition, when designing their health FSAs, employers should be aware of:

- ✓ The restrictions on employee eligibility, contribution amounts and reimbursement provisions; and
- ✓ The strict coverage rules for health FSAs, including the uniform coverage rule and the "use or lose" rule.

LINKS AND RESOURCES

- IRS Notice 2012-40 includes rules on the health FSA contribution limit
- IRS Notice 2013-71 provides guidance on health FSA carryovers
- The Department of Labor's web page for health plan compliance assistance

HIGHLIGHTS

ACA CHANGES

- The ACA limits employees' pre-tax health FSA contributions to $2,750 per year for 2020.
- The ACA requires most health FSAs to qualify as "excepted benefits." This means that other health coverage must be offered and employer contributions to the health FSA are limited.

COVERAGE RULES

- **Use or Lose Rule:** Employees must use their health FSA funds during the coverage period or they forfeit them. Exceptions apply for health FSAs with a grace period or carryover.
- **Uniform Coverage Rule:** An employee's maximum reimbursement amount must be available from the beginning of the plan year, even if it exceeds the employee's current contributions.

BBP Admin
BENEFITS ADMINISTRATION
COBRA, FMLA, FSA, HRA, HSA, TRANSIT
info@bbpadmin.com
www.bbpadmin.com
630 773 2337

OVERVIEW OF LEGAL REQUIREMENTS

A health FSA is a self-insured medical reimbursement plan sponsored by an employer for its eligible employees. Both employers and employees may contribute to a health FSA on a tax-advantaged basis. Typically, health FSAs are offered as a benefit under an employer's cafeteria plan (or Section 125 plan) in order to allow employees to make their contributions on a pre-tax basis. Amounts in the health FSA can be withdrawn to reimburse employees' eligible medical expenses that are not reimbursable by another source.

Health FSAs are subject to a number of federal employee benefit laws, including the following:

ERISA	A health FSA is an employee welfare benefit plan under ERISA. Unless an employer is exempt from ERISA because it qualifies as a church or governmental employer, its health FSA must comply with ERISA's standards. This means, for example, that the health FSA must have a plan document and summary plan description (SPD) and is subject to the Form 5500 annual filing requirement (unless a filing exception applies). ERISA-covered health FSAs are also subject to ERISA's fiduciary duty standards and claims procedures requirements.
COBRA	Health FSAs are group health plans that are subject to COBRA, unless the employer sponsoring the plan is a small employer (with fewer than 20 employees) or a church. Employers with health FSAs that are subject to COBRA should make sure that they are providing the required COBRA notices and are offering COBRA coverage to participants who would lose health FSA coverage due to a qualifying event. Keep in mind that there is a special rule that applies to most health FSAs. Under this special rule, a health FSA sponsor: • Is not required to offer COBRA coverage to qualified beneficiaries who have "overspent" their health FSA accounts; and • Must offer COBRA coverage to qualified beneficiaries who have "underspent" their health FSA accounts, but the COBRA coverage may terminate at the end of the year in which the qualifying event occurs.
HIPAA	Health FSAs are group health plans that are subject to HIPAA's Privacy and Security Rules, unless they qualify for the exemption for small plans (with fewer than 50 participants) that are self-insured and self-administered.
Code Section 125	Health FSAs that are offered under a cafeteria plan must satisfy the Internal Revenue Code (Code) Section 125 rules for tax-advantaged benefits. Among other requirements, the Section 125 rules impose restrictions on the types of expenses that may be reimbursed under the health FSA and limit when participants can make changes to their contribution elections during a coverage period.

Code Section 105(h)	Health FSAs must comply with nondiscrimination rules for self-insured health plans under Code Section 105(h). Under these rules, a health FSA cannot discriminate in favor of highly compensated individuals in regards to eligibility to participate in the plan, and the benefits provided under the health FSA must not discriminate in favor of participants who are highly compensated individuals.
Affordable Care Act	As group health plans, health FSAs are subject to certain reforms under the Affordable Care Act (ACA). For example, the ACA imposes a limit on employees' pre-tax contributions to a health FSA and requires most health FSAs to qualify as "excepted benefits" to satisfy the ACA's market reforms. In general, health FSAs must satisfy the availability AND maximum benefit requirements to qualify as excepted benefits. • **Availability**: Other non-excepted group health plan coverage (for example, coverage under a major medical group health plan) must be made available to health FSA participants. • **Maximum Annual Benefit**: The maximum annual benefit payable to the employee under the health care FSA cannot exceed two times the employee's salary reduction under the health care FSA for that year (or, if greater, the amount of the employee's salary reduction election plus $500). Retiree-only health FSAs and health FSAs that only provide limited-scope dental or vision benefits qualify as excepted benefits under the ACA based on their design, and do not have to satisfy the availability and maximum benefit requirements.

PLAN DESIGN ISSUES

Because health FSAs are an employer-sponsored benefit, employers have some flexibility when it comes to designing their health FSAs. For example, subject to some legal requirements for health FSAs, employers can decide who will be eligible to participate in their health FSA, what contribution limits will apply and which expenses will be eligible for reimbursement from the health FSA.

Eligibility Rules

As a general rule, an employer may allow any **common law employee** to participate in its health FSA. It may also impose a waiting period before new employees are allowed to participate. However, to qualify as an excepted benefit, a health FSA must generally meet the availability requirement described above. To satisfy this requirement, only employees who are eligible to participate in the employer's group medical plan should be eligible for the health FSA.

Also, individuals who are not considered employees, such as self-employed individuals, partners in a partnership and more-than-2 percent shareholders in a Subchapter S corporation cannot participate in a Section 125 plan.

In addition, the nondiscrimination rules of Code Section 105(h) should be taken into account when designing a health FSA's eligibility rules. Code Section 105(h) prohibits self-insured health plans

(including health FSAs) from discriminating in favor of highly compensated individuals with respect to eligibility or benefits.

Contribution Rules

Most health FSAs are designed so that eligible employees contribute on a pre-tax basis through a Section 125 plan. These contributions are commonly referred to as "salary reduction contributions." Employers may also decide to contribute to employees' health FSA accounts, subject to the Code's nondiscrimination rules. When designing a health FSA, employers should consider the ACA's limits on contributions as well as the restrictions on midyear election changes under Section 125.

Limit on Amount of Contributions

The ACA imposes a maximum dollar limit on salary reduction contributions to a health FSA, effective for plan years beginning on or after Jan. 1, 2013. This limit is applicable to both grandfathered and non-grandfathered health FSAs. The limit is **$2,750** for plan years beginning on or after January 1, 2020.

In addition, an employer that makes health FSA contributions must comply with the maximum benefit requirement in order for the health FSA to qualify as an excepted benefit. To comply with this requirement, the maximum benefit payable under the health FSA to any participant for a year cannot exceed the greater of:

- ✓ Two times the participant's salary reduction election under the health FSA for the year; or
- ✓ The amount of the participant's salary reduction election for the health FSA for the year, plus $500.

For example, a health FSA with a one-to-one employer match ($700 employee, $700 employer) would satisfy the maximum benefit requirement. Also, a health FSA with an employer contribution of $500 or less would satisfy the maximum benefit requirement.

Midyear Election Changes

Under the rules for cafeteria plans, participants' elections generally must be irrevocable until the beginning of the next 12-month coverage period. This means that participants ordinarily cannot make changes to their cafeteria plan elections, including their elections for health FSA contributions, during a coverage period. However, as a plan design option, a cafeteria plan may allow health FSA participants to make election changes for the remaining portion of the 12-month period on account of and consistent with certain events, including "change in status" events (such as marriage, divorce or the birth or adoption of a child).

Reimbursement Rules

A health FSA can only reimburse employees for amounts spent on medical care, as defined under Code Section 213(d). Code Section 213(d) defines "medical care" to include amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."

> **Caution Regarding IRS Publication 502:** Employers and third party administrators should be cautious about using IRS Publication 502 (Medical and Dental Expenses) to administer FSA claims. IRS Publication 502 explains the itemized deduction for medical and dental expenses that individuals can claim on their federal tax return. The medical expenses that can be deducted on an individual's tax return are not exactly the same as the expenses that can be reimbursed under a health FSA. Not all expenses that are deductible are reimbursable under a health FSA.

A health FSA can only reimburse medical care expenses that are not reimbursed from other health plan coverage and that the employee does not claim a deduction for on his or her tax return. An employee must also be covered by the health FSA when the medical expense is incurred in order for the expense to be eligible for reimbursement.

In addition, a health FSA can only reimburse medical care expenses that are incurred by the employee, the employee's spouse, the employee's child who has not attained age 27 as of the end of the employee's taxable year, or the employee's tax dependent.

Health FSA claims must be **substantiated with information from a third party** that describes the medical care expense, such as a health care provider's receipt or bill. Also, health FSA claims must include a statement from the participant that the medical expense has not been reimbursed from another source and that the participant will not seek reimbursement from another health plan.

The following chart indicates whether some common expenses are medical care expenses that may be reimbursed by a health FSA. Employers that sponsor health FSAs can also further limit the expenses eligible for reimbursement. For example, some health FSAs exclude certain expenses that are difficult to administer, such as expenses that could be for personal as well as medical reasons.

Type of Expense	Medical Care Expense?
Acupuncture	Yes
Body scans (MRIs and similar technology)	Yes
Breast pumps, lactation supplies and lactation consultant	Yes

Type of Expense	Medical Care Expense?
COBRA premiums	No
Car seats	No
Cosmetic procedures (for example, laser hair removal or teeth whitening)	No
Deductible, copayment or coinsurance	Yes, if underlying service/item is for medical care
Dental exams and procedures	Yes
Drug addiction treatment	Yes
Eye exams, eyeglasses or contact lenses	Yes
Fertility treatments	Yes
Genetic testing/counseling	Yes, to the extent the testing is done to diagnose a medical condition or to determine possible defects
Hearing exams and hearing aids	Yes
Insurance premiums	No
Long-term care premiums or services	No
Orthodontia	Yes
Over-the-counter medicine or drug expenses	Yes, if the medicine or drug is prescribed (even if it is available without a prescription). The prescription requirement does not apply to insulin or to over-the-counter items for medical care that are not medicines or drugs.
Smoking cessation programs	Yes
Special foods	Yes, if prescribed by a medical practitioner to treat a specific illness or ailment and if the foods do not substitute for normal nutritional requirements.
Vision corrective surgery	Yes

COVERAGE RULES

Uniform Coverage Rule

A health FSA is required to provide coverage for a period of 12 months (except for short first plan years or short plan years when the entire plan year is being changed). The uniform coverage rule causes a health FSA to act like insurance during a coverage period, with the employer assuming the risk of loss.

How the Uniform Coverage Rule Works

Once the plan year begins, an employee's maximum amount of reimbursement from the health FSA must be available at any time during the coverage period (reduced only for any prior reimbursements during the same coverage period), even if a reimbursement would exceed the year-to-date contributions to the employee's health FSA.

For example, an employee decides to put $1,000 in her health FSA for the plan year, and her employer contributes an additional $600 to the employee's health FSA for the year. If the plan year begins on Jan. 1, and the employee has an eligible $1,200 claim in February, the health FSA is required to make the $1,200 available to the employee for reimbursement, even though only a fraction of that amount has been contributed to the health FSA so far.

The uniform coverage rule may result in an experience loss to the health FSA if a participant terminates employment during a coverage period or makes a permissible midyear election change after incurring significant medical expenses. An employer cannot require employees to pay back these excess reimbursements when they terminate employment (or change their elections midyear).

"Use or Lose" Rule

Health FSAs are subject to a "use or lose" rule under the Internal Revenue Code (Code). Under this rule, any unused funds in the health FSA at the end of the coverage period generally cannot be carried over to the next coverage period and must be forfeited. However, the Internal Revenue Service (IRS) has provided some exceptions to the "use or lose" rule for health FSAs.

When electing a health FSA during open enrollment, an employee must specify how much he or she would like to contribute to the FSA for the year. The goal is choosing an amount that will cover eligible medical expenses, but that is not so high that the money will be forfeited and wasted.

Exception for Grace Periods

The IRS allows employers to design their health FSA with an extended deadline, or grace period, of **two and a half months** after the end of a plan year to use FSA funds. Thus, for a plan year ending Dec. 31, the employees would have until March 15 to spend the funds in their health FSA.

Allowing a health FSA grace period is strictly optional; the employer must choose to implement it as part of its health FSA's design. Also, a grace period under a health FSA is an alternative to offering carryovers—a health FSA that allows carryovers cannot also have a grace period.

Also, a health FSA grace period is different from a "run-out" period for submitting claims. Most health FSAs are designed with a run-out period that gives participants time after the end of the coverage period for submitting claims for medical expenses that were incurred during the coverage period. Unlike a grace period, a run-out period does not allow a health FSA to reimburse claims incurred after the coverage period ended.

Exception for Carryovers

Employers with health FSAs may allow **up to $500 of unused funds** remaining at the end of a coverage period to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following coverage period. For this purpose, the remaining unused amount as of the end of the coverage period is the amount unused after medical expenses have been reimbursed at the end of the plan's run-out period.

Similar to health FSA grace periods, permitting carryovers is strictly optional, and employers must choose to implement it. Also, the carry-over provision is only available if the plan does not also incorporate the grace period rule.

Forfeitures

Health FSA forfeitures occur when the contributions to the health FSA for a coverage period (after taking into account the health FSA's grace period or carry-over rule) exceed health FSA reimbursements for that same period. When deciding how to use forfeitures, an employer should consider both the IRS' regulations for Section 125 plans and ERISA's exclusive benefit rule.

In general, the simplest way to handle forfeitures is to use them to offset any experience losses. Using forfeitures to offset experience losses for the same year is permitted under the IRS' regulations and it is consistent with ERISA's exclusive benefit rule. Sometimes, however, the forfeitures for a plan year will exceed the plan's experience losses for the plan year.

The **exclusive benefit rule** states that "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan."

Under the IRS' regulations, forfeitures may be retained by the employer maintaining the cafeteria plan, or, if not retained by the employer, they may be:

- Used to reduce required salary reduction amounts for the immediately following plan year, on a reasonable and uniform basis;
- Returned to the employees on a reasonable and uniform basis; or
- Used to defray expenses to administer the cafeteria plan.

However, forfeitures that arise from participant contributions (as opposed to employer contributions) are subject to ERISA's fiduciary duty rules, including the exclusive benefit rule. Participant forfeitures under a health FSA that is subject to ERISA cannot be retained by the employer, as this would violate the

exclusive benefit rule. ERISA's exclusive benefit rule is also likely violated if health FSA forfeitures are used to provide or pay for coverage under a plan other than the health FSA, even if both plans cover the same participants. Many employers choose to use the forfeitures to pay for reasonable administration expenses of the plan before looking at other options.