Brown & Brown

EMPLOYEE BENEFITS

Health Flexible Spending Account (Health FSA) Guide

From the Brown & Brown Regulatory and Legislative Strategy Group

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Introduction

A Health Flexible Spending Account (Health FSA) is an employer-sponsored health expense reimbursement account that can be funded on a pre-tax basis and used for qualified medical expenses of a participant and any eligible family members. Participants may receive qualified reimbursements from a health FSA on a tax-free basis. The maximum amount a participant may contribute to a health FSA is contingent upon the maximum health FSA contribution amount set by the Internal Revenue Service each year, which can be further limited by a health plan sponsor's maximum permitted contribution amount.

ERISA

As a self-funded medical reimbursement plan that provides medical care, health FSAs will be considered group health plans subject to ERISA—assuming the plan is maintained by the employer and no exemptions apply. Health FSAs maintained by governmental or church employers are exempt from ERISA. Health FSAs subject to ERISA are required to satisfy ERISA's group health plan rules on claims procedures, Form 5500 filing requirements, plan document requirements, SPD/SMM distribution requirements, and plan asset requirements.

Eligibility

Under IRS rules, health FSA eligibility is generally extended only to common-law employees of the employer. Employers may incorporate further eligibility restrictions into their health plan. As a practical matter, they often limit health FSA eligibility only to employees also eligible to participate in the employer's major medical plan if the health FSA provides more than limited-scope dental/vision benefits. The primary reason eligibility is restricted only to employees eligible for the employer's major medical plan is to ensure the health FSA qualifies as an excepted benefit (discussed in more detail below).

Individuals not considered common-law employees for Section 125 cafeteria plan purposes are generally ineligible to participate in a health FSA. This includes sole proprietors, more-than-2% shareholders in a Subchapter S corporation (and family members), partners, and LLC members.

Contributions

As a benefit arrangement offered under a Section 125 cafeteria plan, health FSAs are designed to be funded with pre-tax salary reduction contributions made by eligible employees. In addition to employee contributions, employers may choose to provide additional funds through matching or seed contributions that do not count towards employees' IRS maximum annual contribution limits (so long as employees are unable to waive the employer contributions in exchange for taxable income or other taxable benefits). However, employers may be limited as to how much they may contribute in many instances.

Contribution Limit

Health FSA salary reduction contributions are subject to an annual limit established by the Internal Revenue Code (IRC). The contribution limit is indexed annually for cost-of-living adjustments and applies on a plan year basis. As a matter of plan design, employers may set the plan's maximum contribution limit below the maximum annual contribution limit established by the IRS each year. The employer's cafeteria plan document must reflect the Code's health FSA salary reduction contribution limit or a lower limit established by the employer. Most often, the terms of the plan will account for automatic changes when the limit is indexed annually for cost-of-living adjustments.

The health FSA contribution limit applies on a per-employee basis regardless of the number of other individuals (e.g., spouse and dependents) whose expenses could be reimbursable by the health FSA. In addition, the health FSA contribution limit applies separately to each FSA in which an employee is enrolled if they are sponsored by separate employers. For these purposes, employers that are a part of a controlled group or affiliated service group are considered the same employer.[1]

As discussed below, the maximum contribution limit is prorated for any plan year that is less than 12 months.

Any non-elective health FSA contributions made by an employer to a health FSA do not count towards an employee's annual maximum contribution limit[2]. However, employers may be limited as to the amount of employer contributions made to employees' health FSAs for the coverage to remain a HIPAA excepted benefit. This topic is later addressed in this document.

What if the health FSA salary reduction limit is not announced until after open enrollment?

It is common for the IRS to announce the following year's health FSA salary reduction limit after an employer has conducted its open enrollment. For example, an employer may conduct open enrollment for the 2024 plan year from November 1st, 2023, to November 14th, 2023. What happens if the IRS announces the 2024 health FSA contribution limit on November 17th after open enrollment has finished and the limit has increased by $50 from the prior year? In this case, employers must decide whether to leave employees' health FSA elections as they are or allow employees who based their election on the prior year's limit to change their health FSA election before the start of the new plan year. It may be possible for the employer to incorporate an automatic change by including language in the health FSA enrollment material, providing an option to elect the annual limit for the current plan year as adjusted for any increase announced prior to the start of the next plan year.

[1] IRS Notice 2012-40

[2] However, if employees are provided a choice to receive employer contributions as either a health FSA contribution or cash (or as any other taxable benefit) or other non-health coverage related contribution (e.g., 401(k) contribution), then these contributions must count towards the employee's annual contribution limit.

Reimbursements

Qualified Medical Care

As a self-insured medical reimbursement plan subject to Code §105, health FSAs may only reimburse expenses for qualified medical care.[3] Medical care is defined in Code §213(d) as "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."

Tax-Free reimbursements

Health FSA participants are permitted to receive health care reimbursements from their health FSA for their own qualified medical/health care expenses and the qualified medical/health care expenses of their spouse and qualified healthcare tax dependents[4], so long as the expense is not otherwise reimbursed through insurance or elsewhere. The ACA requires group health plans to provide coverage to dependent children until age 26; therefore, if an FSA reimburses the health care expenses of a dependent child, it must provide reimbursement for expenses incurred by a dependent child until age 26.[5] Health FSA participants should retain any medical/health care expense receipts in the case of an IRS audit.

Reimbursements for a Domestic Partner or Other Individual who does not Qualify as a Spouse/ Dependent Child

As mentioned above, health FSAs (similar to other self-funded plans) may only reimburse the healthcare expenses of an employee, an employee's spouse and qualified healthcare tax dependents on a tax-free basis. However, a self-funded health plan may also be permitted to reimburse the health care expenses of an employee's other Code Section 105(b) tax dependent(s)[6]. Therefore, an employee may receive tax-free reimbursement for the healthcare expenses of a domestic partner (or other individuals with a relationship to the employee, such as a non-dependent child) only if they are a qualified healthcare tax dependent of the employee under Code Section 105(b).

Qualified

- Medical care that is subject to an individual's deductible
- Copays
- Coinsurance
- Doctor visits
- Inpatient or outpatient treatment
- Prescription and over the counter drugs
- Insulin (with or without a prescription)
- Dental and vision care

NOT Qualified

- Insurance premiums
- Surgery purely for cosmetic reasons
- Expenses covered by another insurance plan
- General health items such as tissues, toiletries and hand sanitizer

[3] Code §105(b).
[4] Qualified healthcare tax dependents include an employee's child who has not attained age 27 as of the end of the employee's taxable year and other individuals who meet the requirements to be a Code §105(b) dependent, including qualifying children and qualifying relatives under Code §152.
[5] Health FSAs that qualify as HIPAA excepted benefits are not subject to health care reform's requirement to make dependent coverage available until age 26.
[6] In addition to spouses, a healthcare tax dependent under 105(b) includes "dependents (as defined in section 152 , determined without regard to subsections (b)(1) , (b)(2) , and (d)(1)(B) thereof), and any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27." IRC Section 152

Incurred During the Period of Coverage

Health FSAs may only reimburse qualified medical expenses that are incurred during the period of coverage.[7] The regulations state that a medical expense is incurred "when the employee (or the employee's spouse or dependents) is provided with the medical care that gives rise to the medical expenses, and not when the employee is formally billed, charged for, or pays for the medical care."

The following rules stem from the general requirement that expenses must be incurred during the coverage period:

1. Health FSAs are prohibited from reimbursing expenses before the participant receives medical care. In other words, a health FSA may not provide an advanced payment for a medical expense for an anticipated medical claim that will be incurred in the future.

2. Health FSAs are prohibited from reimbursing expenses incurred prior to the health FSA's adoption, prior to an employee's enrollment, or prior to the commencement of the period of coverage (i.e., plan year). Employees must be actively enrolled in the health FSA when the medical expense is incurred, and it must be incurred during the applicable plan year (unless an applicable grace period/carryover exception applies after the end of the plan year).

3. Evidence of a bill for the medical expense or even payment of the medical expense does not necessarily mean the expense has been "incurred." The date the expense is incurred is the date that the medical care was provided to the participant that gave rise to the medical expense.[8] There are, however, some exceptions with respect to medical treatment programs spanning multiple plan years (e.g., orthodontia) and medical equipment with a useful life that extends beyond the period of coverage in which the expense is incurred (e.g., wheelchairs, eyeglasses, or hearing aids).

4. There is no requirement that the medical expense be paid for before the participant receives a reimbursement of that medical expense from the health FSA. In other words, a participant need not have paid for the medical service before receiving the reimbursement from the health FSA. In fact, requiring payment as a condition of reimbursement may violate the uniform coverage rule.

Claim Substantiation

All health FSA claims must meet the IRS' claim substantiation requirements, which are designed to ensure that the health FSA only reimburses qualified and legitimate healthcare/medical claims expenses. Specifically, qualified health FSA claims must be—

- Substantiated with information from an independent third party (e.g., a receipt or bill) describing the service or product, the date of the service or sale, and the amount of the expense.[9] For this purpose, "independent" means independent of the employee and the employee's spouse/dependents.
- Accompanied by a written statement from the participant indicating that the medical expense has not been reimbursed and that the participant will not seek reimbursement for the expense under any other health plan coverage.
- Independently adjudicated by an entity other than the plan participant (e.g., the employer or TPA). To satisfy this requirement, every health FSA claim must be adjudicated. For example, plans cannot review only a percentage of claims below a threshold dollar amount or only from certain providers.

Failure to satisfy the substantiation requirements can result in the IRS treating all reimbursements made by the employer's/plan sponsor's health FSA as taxable to the employee, regardless of whether those reimbursements/ payments are properly substantiated.

[7] Prop. Treas. Reg. §1.125-6(a)(2
[8] Prop. Treas. Reg. §1.125-6(a)(2)(ii)
[9] Prop. Treas. Reg. §1.125-6(b)(3)(i)

Substantiation and Adjudication Under Electronic Payment Card (debit card) Programs

The IRS proposed regulations require that every medical claim paid with an electronic payment card be reviewed and substantiated by an employer/plan sponsor. However, under certain circumstances, the IRS permits claims processed through card transactions to be auto-adjudicated (i.e., they do not require further substantiation once the transaction is approved at the time the card is used).

Debit card transactions for medical expenses at medical care providers and pharmacies in which 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as Code §213(d) medical expenses may be treated as auto-substantiated/adjudicated when—

- The dollar amount of a transaction equals an exact multiple of not more than five times the dollar amount of the copayment imposed for that service under the participant's health plan.
- There is a recurring claim that is the same as a previously approved claim as to amount and medical care provider at regular intervals (e.g., for prescription drugs refilled on a regular basis at the same provider for the same amount).
- The electronic payment is accompanied at the time and point of sale with verifying information from a third party that the claim is for an eligible medical expense.

Debit card transactions at merchants using an Inventory Information Approval System (IIAS) may also qualify for auto-adjudication.

Health FSA claims that do not qualify for auto-adjudication must be adjudicated after the fact. In such cases, the participant must provide substantiation, such as copies of an itemized receipt, billing statement or an Explanation of Benefits (EOB), before obtaining reimbursement of the claim. Regardless of whether a claim is auto-adjudicated, IRS regulations require that participants be able to produce backup documentation for all electronic payment card transactions.

Failure to Substantiate Incurred Health Care Expense – Correction Procedures

When a health FSA participant fails to satisfy the IRS' claim substantiation requirement (e.g., failing to appropriately provide after-the-fact substantiation of incurred claims) (or if the health FSA otherwise improperly pays a claim), the IRS proposed regulations set forth specific correction procedures, employers/health FSA plan sponsors must follow.[10] Although the proposed regulations do not provide a timeline for when these steps should be taken following an improper payment/reimbursement of an unsubstantiated claim, plans should establish appropriate timelines and document that they have satisfied the following actions to ensure that the guidelines are applied uniformly and consistently in all cases for all participants.

Step 1: Deactivate the debit card. Until the improper payment amount is recovered, the health FSA debit card should be deactivated, and the employee must request payment/reimbursement of medical expenses using other methods (e.g., by submitting paper receipts).

Step 2: Request employee repayment. The proposed regulations state that the employer must "demand that the employee repay the cafeteria plan in an amount equal to the improper payment."[11]

Step 3: Withhold from pay. If repayment is not received following the demand described above, the employer should withhold the amount of the improper charge from the employee's pay or other compensation to the extent permitted under applicable law. Employers should consult with qualified legal counsel regarding the application of any state laws that may prohibit withholding amounts in these circumstances. In addition, employers should confirm that their plan document, SPD, and debit card enrollment material authorize withholding improper payment amounts from an employee's pay.

Step 4: Offset future claims. If any portion of the improper payment amount remains after completing the previous steps, the employer must apply a claim substantiation or offset future substantiated claims by the amount of the improper payment. For example, "if an employee has received an improper payment of $200 and subsequently submits a substantiated claim for $250 incurred during the same coverage period, a reimbursement for $50 is made."[12]

Step 5: Treat as business indebtedness. If the improper payment has not been corrected after applying steps 1-4, the employer must treat the improper payment as it would any other business indebtedness consistent with its standard business practices.

[10] Prop Reg §1.125-6 Substantiation of expenses for all cafeteria plans.
[11] Prop. Treas. Reg. §1.125-6(d)(7)(ii)
[12] Prop. Treas. Reg. §1.125-6(d)(7)(iv)

Coverage Period and Use-It-or-Lose-It Rule

12-Month Coverage Period

Except in limited circumstances, a health FSA's period of coverage must be 12 months. Employers may choose to use the same or a different 12-month period for the health FSA than other cafeteria plan benefits (e.g., medical/dental/vision coverage).

One exception to the 12-month coverage period applies for short plan years. Plan sponsors may utilize a short plan year (i.e., a plan year of less than 12 consecutive months) if there is a valid business purpose. The impact of a short plan year is that the maximum contribution limit to a health FSA must be reduced proportionally to a typical 12-month plan year (e.g., 9/12 of the maximum annual contribution amount for the applicable health FSA for a health FSA with a shortened plan year of 9 months) because the period of coverage for the plan year occurs over a shorter time period. As a best practice, employers may want to provide advanced notice to employees of an upcoming short plan year so that employees can make appropriate health FSA elections in accordance with the shorter coverage period.

A second exception to the 12-month coverage period requirement may exist when participants make a health FSA election change due to a permitted status change event (a discussion of the permitted Section 125 status change events is provided here): "A cafeteria plan may permit an employee to revoke an election during a period of coverage…and make a new election for the remaining portion of the period."[15] Employers who do not wish to utilize the separate coverage period approach might adopt a blended approach to limit exposure under the uniform coverage rule. Under the blended approach, the health FSA election before and after the midyear election change is merged for the coverage period.

The third and final exception to the 12-month coverage period is for employees whose participation in the health FSA terminates. When participation terminates, the coverage period will end, and any prepayments for coverage after the termination date must be refunded.[16] Typically, health FSA coverage will terminate on the date the participant's employment terminates, or the last day of the month the employee's employment termination occurs. Employers may need to consider whether they have a potential COBRA obligation when employment terminates or an employee otherwise loses eligibility for health FSA coverage (see below discussion on health FSAs and COBRA).

[15] Treas. Reg. §1.125-4(c)(1).
[16] Prop. Treas. Reg. §1.125-5(d)(3).

Examples

Blended Approach: Employee D works for a company that sponsors a calendar year health FSA. Employee D elects $1,800 of health FSA coverage with a $150 monthly premium. After six months, Employee D makes an election change and pays a monthly premium of $100 for the remaining six months. Employee D would have $1,800 of coverage for the first six months. For the last six months, Employee D would have $1,500 of coverage ($1,500 = $900 of premiums for the first six months + $600 of premiums for the last six months). If Employee D incurred claims of $900 in February and $700 in August, they would be reimbursed $900 for the February claim but only $600 for the August claim ($600 = $1,500 maximum for last six months minus the $900 paid for first six months). Any forfeitures would not apply until the end of the 12-month coverage period (i.e., plan year).

Separate Period of Coverage Approach:
Employee D works for a company that sponsors a calendar year health FSA. Employee D elects $1,800 of health FSA coverage with a $150 monthly premium. After six months, Employee D makes an election change and pays a monthly premium of $100 for the remaining six months. Employee D would have $1,800 of coverage for the first six months. Employee D would have $600 of coverage for the last six months. Employee D could be reimbursed up to $1,800 for claims incurred in the first six months and up to $600 for claims incurred in the last six months for a total maximum reimbursement of $2,400 even though Employee D would only pay a total of $1,500 in premiums for the year ($900 for first six months + $600 for last six months = $1,500). If, after a change in status after six months, Employee D elected $0 in health FSA contributions, they would lose any remaining balance from the period prior to the change.

Under either approach, it is unclear how the annual health FSA salary reduction limit would apply. Employers are encouraged to discuss these plan design considerations with their employee benefits legal counsel.

Use-It or Lose-It Rule

Health FSAs are subject to the use-or-lose rule, meaning that any salary reduction contributions that have not been used to reimburse expenses incurred during the coverage period (e.g., a 12-month plan year) will be forfeited at the end of the plan year or when FSA participation otherwise terminates, unless an exception applies. The use-or-lose rule applies to FSAs in general due to the Code's prohibition on pre-tax salary reduction plans being deferred to the following plan/calendar year.

A few exceptions to the use-it or lose-it rule do exist. Employers may adopt health FSA features that allow employees to continue submitting expenses incurred in an immediately preceding plan year in the current plan year (i.e., an annual run-out feature). In addition, employers may adopt either an optional grace period or a carryover provision. Under a grace period, the employer may allow a health FSA participant to continue incurring health care expenses after the end of an immediately preceding plan year in the current plan year for a limited period of time and receive reimbursements from the remaining health FSA balance from the prior year. Under a carryover, the employer may allow a health FSA participant to "carry over" unspent amounts/balances remaining in employees' FSAs at the end of a plan year that can be used to reimburse health care expenses incurred during the entire duration of a subsequent plan year. These exceptions to the general use-or-lose rule that apply after the end of the plan year must be adopted/permitted by the plan sponsor. They must also be included in the cafeteria plan document. Plan sponsors cannot adopt both a carryover and a grace period under a health FSA plan and can only elect one or the other.

Annual Run-Out Period – The IRS permits health plan sponsors to allow employees to continue to seek reimbursement for health care expenses after the plan year's end, for expenses incurred during the plan year/coverage period. This is referred to as an annual run-out period. This typically lasts for a period of 3 months after the end of the plan year but can be shorter or longer depending on the preference of the plan sponsor. Participants cannot seek reimbursement for expenses incurred after the plan year's end (i.e., incurred during the annual run-out period) unless the employer adopts a grace period or carryover provision.

Grace Periods – Plan sponsors may amend their cafeteria plan to allow participants to access unused funds remaining in their health FSA account beyond the end of the plan year to pay or reimburse healthcare FSA expenses incurred during a grace period of up to 2-1/2 months immediately following the end of the plan year. Any health FSA balance maintained during the grace period will not count against the annual maximum health FSA salary reduction limit set by the IRS in the subsequent plan year.

If the cafeteria plan includes a grace period, the grace period can be used to both submit claims incurred during the applicable plan year (i.e., related plan year for which the grace period applies) and allow during that same time period the submission of claims for reimbursements that are incurred during the grace period (if the employer overlaps a run-out period with the grace period). Unused amounts remaining after the expiration of the grace period and any applicable run-out period that may run during or after the grace period are forfeited by the participant.

Example:

Employer Z's calendar year cafeteria plan includes a grace period for the 2023 plan year. The grace period begins on January 1, 2024, and ends March 15, 2024 (2-1/2 months).

During open enrollment for the 2023 health FSA plan year, Employee M elected to make a salary reduction of $2,000 for the 2023 plan year. As of December 31, 2023, Employee M has $500 remaining in their health FSA. During open enrollment for the 2024 health FSA plan year, Employee M elected to make a salary reduction of $1,800 to their health FSA for the 2024 plan year.

During Employee M's grace period from January 1, 2024, through March 15, 2024, Employee M incurs $800 of qualified medical expenses that have not yet been reimbursed. The unused $500 from the previous 2023 plan year (ending on December 31, 2023) is first applied to pay or reimburse Employee M's first $500 of unreimbursed medical expenses incurred during the grace period. Therefore, as of March 16, 2024, Employee M has no unused benefits or contributions remaining from the 2023 plan year.

The remaining $300 of medical expenses ($800 of qualified medical expenses - $500 reimbursement of the remaining amount in the health FSA for the 2023 plan year = $300) incurred between January 1 and March 15, 2024, is paid or reimbursed from Employee M's 2024 health FSA election (which begins January 1, 2024, and ends December 31, 2024). As of March 16, 2024, Employee M has $1,500 ($1,800 salary reduction election for 2024 - $300 of incurred and reimbursed expenses in 2024 = $1,500) remaining in the health FSA for the 2024 health FSA plan year that ends on December 31, 2024.

Carryover – As an alternative to a grace period, the IRS permits health plan sponsors to allow employees to "carry over" unspent amounts/balances remaining in employees' FSAs at the end of a plan year that can be used to reimburse health care expenses incurred during the entire duration of a subsequent plan year. However, the IRS limits the amount an employee may carry over to a subsequent plan year, and such prescribed carryover limits may further be decreased/limited as to amount by a plan sponsor. Carryover amounts do not count against employees' annual maximum contribution limit imposed by the IRS on the applicable maximum contribution amount to a health FSA in the applicable plan year.

Carryover Example:

Employer X sponsors a Section 125 cafeteria plan and health FSA with a calendar year plan year (January 1st – December 31st), with a November open enrollment period. The FSA has a contribution limit of $3,050, with an annual run-out period from January 1 through March 31, in which participants can submit claims for expenses incurred during the immediately preceding plan year. The plan includes a carryover feature that allows up to $610 of unused health FSA funds from a previous plan year to be carried over to a subsequent plan year. The plan does not provide for a grace period with respect to the health FSA. The plan also does not provide for non-elective employer flex credits.

In November of 2022, Employee A elects a salary reduction amount of $2,000 for the 2023 health FSA plan year. By December 31, 2022, Employee A's unused amount from the 2022 plan year is $500. On February 1, 2023, Employee A submits claims and is reimbursed with respect to $200 of expenses incurred during the 2022 plan year, leaving a carryover amount of $300 on March 31, 2023 (the end of the run-out period) of unused health FSA amounts from 2022. The $300 amount is not forfeited; instead, it is carried over to the 2023 plan year and is available to pay any claims incurred in the 2023 plan year. Employee A, therefore, has $2,300 (a $2,000 FSA election for the 2023 plan year + $300 carryover amount from the 2022 plan year = $2,300) available to pay claims incurred in 2023. Employee A incurs and submits claims for expenses of $2,100 during July 2023 and does not submit any other claims during 2023. Employee A is reimbursed with respect to the $2,100 claim, leaving $200 as a potential unused amount from 2023 to be carried over to the 2024 plan year (depending upon whether Employee A submits additional claims incurred during the 2023 plan year during the annual run-out period in early 2024, and so long as the plan continues to have a carryover feature at the end of the 2023 plan year).

In addition to the ability for plan sponsors to further limit employees' IRS-prescribed maximum health FSA carryover amount, the IRS also permits plan sponsors to limit/restrict carryovers in several other ways. For example, employers may restrict carryovers only to employees participating in the health FSA in the subsequent plan year.[17] Employers may also require that any carryover amounts be used within a specified period before the amounts are forfeited.[18] A common question plan sponsors ask is whether a minimum carryover amount can be established to avoid having to administer carryovers of de minimis amounts. IRS guidance does not clarify whether this plan design is permitted, although IRS officials have informally commented that it may be reasonable to establish small minimum carryover limits.

[17] IRS Notice 2015-87, 2015-52 I.R.B. 889, Q/A-24.
[18] IRS Notice 2015-87, 2015-52 I.R.B. 889, Q/A-25.

Experience Gains - ERISA Plan Assets

To the extent the health FSA is subject to ERISA, plan sponsors must consider ERISA's plan asset rules when determining how to handle health FSA forfeitures (also referred to as experience gains). Under ERISA, participant contributions (including salary reductions under a Section 125 cafeteria plan) are considered plan assets the moment they can reasonably be segregated from an employer's general assets. Consequently, any health FSA participant contributions that are considered plan assets that are later forfeited back to the health plan will continue to be considered plan assets of the health plan under ERISA.

ERISA's fiduciary rules, including the exclusive benefit and prohibited transaction rules, stipulate how a plan administrator must handle plan assets resulting from health FSA forfeitures. To avoid violation of these rules, plan administrators must use forfeited health FSA amounts in one of the following ways:

- **To pay reasonable and proper administrative expenses.** The DOL requires the following be satisfied in order for the expense to constitute a reasonable and proper administrative expense: (1) the plan document must allow the use of experience gains to pay administrative expenses, (2) the expense must be related to administration of the health FSA and not another plan or for establishing the plan, (3) the expense must not be an ERISA prohibited transaction, and (4) the expense must be reasonable, meaning it is "a direct expense properly and actually incurred in the performance of a fiduciary's duties to the plan."[19]
  In addition, the DOL requires plan sponsors to maintain records of the nature of the expense, the amount of the expense, and the dates they were incurred.
  - *TPA Administration Expenses.* Plan sponsors that utilize a TPA or other service provider may use forfeited amounts to pay costs associated with the TPA's administration of the health FSA (e.g., claims processing fees) so long as the costs are reasonable and are not used to offset costs in the administration of a plan other than the health FSA.
  - *Plan Sponsor's Own Administrative Expenses.* ERISA §406(b) prohibits ERISA fiduciaries from dealing with plan assets in the fiduciary's own interest (referred to as "self-dealing"). Plan sponsors will need to consider the potential that benefiting or being paid from plan assets violates this self-dealing prohibition. For example, whether the health FSA forfeitures can be used to reimburse the plan sponsor for costs associated with the in-house administration of the health FSA must be closely scrutinized.

[19] *DOL Information Letter to Gary E. Henderson (July 28, 1998).*

- **By allocating the experience gains to employees.** The health FSA forfeitures must be allocated on a uniform and reasonable basis (e.g., on a per capita or weighted average based on coverage level). In no way may they consider individual claims experience or individual forfeiture amounts. So long as these general requirements are satisfied, plan sponsors have three options for allocating the health FSA forfeitures to employees[20]:
  - *Reducing required salary reductions ("premium holiday").* Plan sponsors can use health FSA forfeitures to reduce employee salary reductions for the immediately following plan year. Agency guidance is unclear on which employees are eligible for the reduced salary reduction (e.g., whether the reduction can apply to employees other than those who created the experience gains).
  - I*ncreasing annual coverage amounts.* Health FSA forfeitures may be used to reimburse claims incurred in the following plan year above the elective limit using either a per capita method or a weighted average method.
  - *Providing cash refunds.* Given the lack of guidance on which employees are eligible to receive the refund, employers will seldom use this method. Employers that do use this method must remember that refunds cannot be based on an employee's individual claims experience or forfeitures. Any cash refunds provided to employees must be included as W-2 wages for FICA and federal income tax withholding purposes.

Forfeited amounts under the health FSA (that are plan assets) cannot be retained by the employer and forfeitures may only be used for the benefit of the health FSA plan participants. Plan administrators should review their health FSA plan document to understand how participant forfeitures and experience gains are specifically administered under the health FSA plan. They should also consult with qualified legal counsel for specific guidance on handling plan assets.

Note: Health FSAs that are not subject to ERISA (e.g., health FSAs sponsored by government or church employers) will not be subject to ERISA's fiduciary rules, but they can be subject to the IRS' cafeteria plan requirements on handling experience gains, which are independent of ERISA's requirements.

[20] Under ERISA, if a plan sponsor retains plan assets longer than a 90-day period, the plan assets must be held in trust by the plan sponsor/administrator. This rule could potentially apply to plan assets that are used towards a health plan sponsor's future plan year's premium holiday or plan assets that are used to reimburse the future plan year claims of participants. Finally, pursuant to the maximum benefit rule previously discussed in this document, plan sponsors should be cautious if the amount of the plan asset benefit being provided to a participant is greater than $500 for the entire plan year, as this could cause the health FSA to lose its excepted benefits status.

Correcting Excess Contributions

As a general rule, a cafeteria plan offering a health FSA that fails to comply with the IRC Section 125 limit on salary reduction contributions will lose its tax-favored status.[21] However, IRS guidance provides that if employees are mistakenly allowed to elect salary reductions in excess of the limit, a cafeteria plan will not fail to qualify as a cafeteria plan for the year so long as certain requirements are satisfied. This relief may be beneficial in situations where the employer's payroll system or TPA erroneously withholds health FSA salary reductions in excess of the IRS limit.

For the relief to apply, the cafeteria plan document must be amended (when applicable) to reflect the appropriate limit on health FSA salary reductions, and the following requirements must be met:

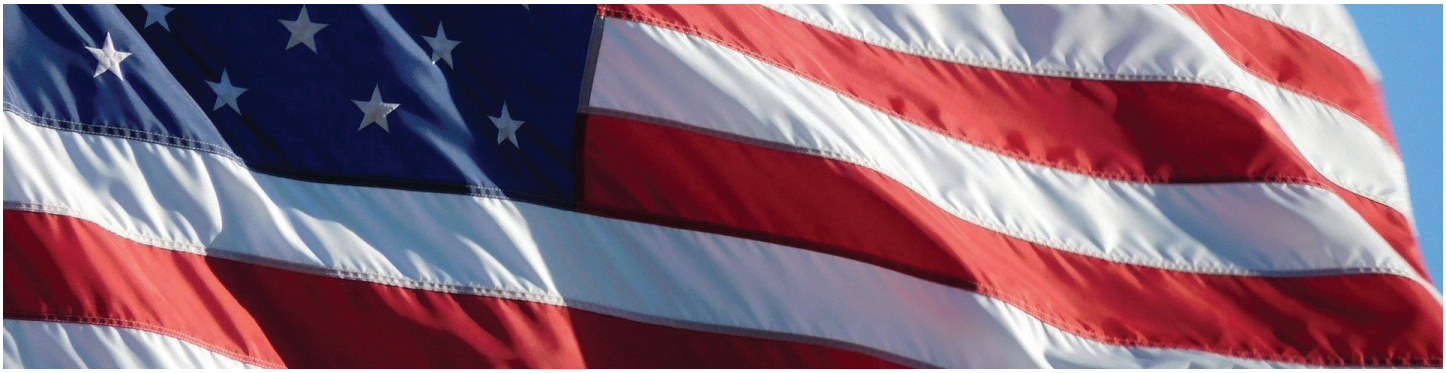
(1) "the terms of the plan apply uniformly to all participants (consistent with Prop. Treas. Reg. § 1.125-1(c)(1));

(2) the error results from a reasonable mistake by the employer (or the employer's agent) and is not due to willful neglect by the employer (or the employer's agent); and

(3) salary reduction contributions in excess of $2,500 (as indexed for inflation) are paid to the employee and reported as wages for income tax withholding and employment tax purposes on the employee's Form W-2, Wage and Tax Statement (or Form W-2c, Corrected Wage and Tax Statement) for the employee's taxable year in which, or with which, ends the cafeteria plan year in which the correction is made."[22]

The guidance notes that this relief is available to employers only if the employer's federal tax return is not under examination with respect to benefits provided under a cafeteria plan with respect to any cafeteria plan year during which the failure occurred.

[21] IRS Notice 2012-40.
[22] Notice 2012-40.



Uniform Coverage Rule

For health FSAs offered through a cafeteria plan, the Uniform Coverage Rule requires that the "maximum amount of reimbursement from a health FSA must be available at all times during the period of coverage (properly reduced for prior reimbursements for the same period of coverage)."[23] The regulations also provide that "the maximum amount of reimbursement at any particular time during the period of coverage cannot relate to the amount that has been contributed to the FSA at any particular time prior to the end of the plan year."[24] In other words, the employee must be able to seek reimbursement for all expenses incurred up to the amount of their entire annual election amount (comprised of both the employee's salary reduction election plus any employer contributions) beginning on the first day of the health FSA plan year, regardless of the amount of prior contributions into their health FSA. The employer cannot limit reimbursements to the amount the employee has contributed to the health FSA at that time, accelerate an employee's salary reductions based on their incurred claims and reimbursements, or require employees to reimburse the employer for amounts spent in excess of amounts contributed when an employee terminates participation in the health FSA.

[23] Prop. Treas. Reg. §1.125-5(d)(1).
[24] Prop. Treas. Reg. §1.125-5(d)(1).

Uniform Coverage Example:

For the 2023 plan year, Employee B timely elects a salary reduction amount of $3,000 for a health FSA under their employer's calendar year cafeteria plan. The employer makes no contributions. Employee B pays the $3,000 salary reduction amount through a salary reduction of $250 per month throughout the coverage period. Under the Uniform Coverage Rule, Employee B is eligible to receive reimbursement of eligible health care expenses (up to $3,000) from day 1 of the coverage period/plan year and at all times throughout the coverage period/plan year (reduced by prior reimbursements).

Employee B incurred $2,500 of eligible medical expenses on January 15, 2023. Even though Employee B has only made one salary reduction payment of $250 to their health FSA, the full $2,500 medical expense must be reimbursed. Employee B incurred $500 in medical expenses on February 15, 2023. The remaining $500 of the initial $3,000 is reimbursed to Employee B, despite Employee B contributing a lesser amount to their health FSA by this point in the plan year. After Employee B submits a claim for reimbursement and substantiates the medical expenses, the cafeteria plan must reimburse Employee B for the $2,500 (January) and $500 (February) in medical expenses within a reasonable amount of time. In this example, the employer's cafeteria plan satisfies the Uniform Coverage Rule.

Nondiscrimination Testing

A health FSA is considered a self-funded health benefit plan and is therefore subject to both Code Section 125 nondiscrimination testing (due to pre-tax contributions being made to the health FSA) and Code Section 105(h) testing due to its self-funded health plan status. Therefore, a health FSA plan is directly prohibited from discriminating in favor of highly compensated individuals[25] with respect to eligibility/coverage and benefits. In addition, the Section 125 plan through which the health FSA is provided is prohibited from discriminating in favor of highly compensated employees[26] (in terms of eligibility and contributions and benefits) and in favor of key employees[27]. If the health FSA is found to be discriminatory in favor of highly compensated individuals, all or a portion of the health FSA benefits received by the highly compensated individuals will be taxable income. If the Section 125 plan is found to be discriminatory in favor of highly compensated individuals or key employees, the pre-tax elections of all highly compensated participants or key employees (as the case may be) become taxable.

Highly compensated/key employees typically participate in tax-favored benefits such as health FSAs to a greater extent than other employees, so employers should closely monitor and review the health FSA plan for potential discrimination issues every year prior to the end of the plan year. Specifically, the more highly compensated employees contribute to a health FSA, as opposed to other non-highly compensated workers that receive less compensation (e.g., hourly employees), the more likely the Section 125 plan is to fail the Section 125 key employee concentration test.

[25] Defined in Section 105(h) as (1) the five highest-paid officers, (2) a shareholder who owns more than 10% of the value of the employer's stock; and (3) the highest-paid 25% of all employees (other than excludable employees who are not participants).

[26] Defined in Section 125 as (1) officers during the preceding plan year (or the current plan year in the case of an individual's first year of employment), (2) shareholders owning more than 5% of the voting power or value of all classes of stock of the employer in the current or preceding plan year, (3) an employee with compensation in the preceding plan year (or the current plan year in the case of the first year of employment) in excess of the Code §414(q)(1)(B) compensation threshold and, if elected by the employer, who was also in the "top-paid group" of employees (as determined under Code §414(q)(3)), and (4) spouses and dependents (as defined in Code §125(e)(1)(D)) of an individual described in categories (1) through (3).

[27] Defined in Code Section 416 as (1) officers with annual compensation for the plan year in excess of a statutory indexed amount, (2) more-than-5% owners, and (3) more-than-1% owners with annual compensation in excess of $150,000 (not indexed).

HIPAA Excepted Benefit

Since the Affordable Care Act (ACA) was enacted, health FSAs typically must be offered as a HIPAA excepted benefit to plan participants[28]. For a health FSA to be considered a HIPAA excepted benefit, it can either be offered as a limited purpose health FSA that only reimburses qualified limited health benefits (e.g., dental or vision benefits), or if it offers medical benefits, it only offers those benefits subject to certain requirements. For a general-purpose health FSA to be considered a HIPAA excepted benefit, it must meet both the Availability Condition and the Maximum Benefit Condition, more thoroughly described below.

Health FSA Qualifies as a HIPAA Excepted Benefit

For a general-purpose health FSA to be considered a HIPAA excepted benefit, it must meet both the Availability Condition and the Maximum Benefit Condition:

1) ***Availability Condition***
   a. Other group health plan coverage (e.g., major medical coverage) that is not an excepted benefit (e.g., standalone dental/vision coverage) must be made available to each class of FSA participants (The FSA participant need only be offered the group health plan coverage, but need not enroll in such other group health plan coverage);

2) ***Maximum Benefit Condition***
   a. The maximum amount the health FSA participant can receive in reimbursements from the health FSA cannot exceed the greater of:
      i. Two times the participant's salary reduction election for the plan year (i.e., employer contributions to the health FSA are a dollar-for-dollar match to the employee's contributions) or
      ii. The health FSA participant's salary reduction election for the plan year, plus $500

Typically, a general-purpose health FSA can only be offered as a HIPAA excepted benefit, meaning an employer offering a general-purpose health FSA must meet the above conditions with limited exceptions due to certain prohibitions imposed on general-purpose health FSAs under the ACA.

[28] *Typically, a health FSA that is not considered a HIPAA excepted benefit cannot be offered on a stand-alone basis because it would violate the ACA.*

HIPAA Privacy & Security

Health FSAs (even those that qualify as excepted benefits) are subject to HIPAA's administrative simplification provisions (including HIPAA's privacy and security rules) unless the health FSA is a self-funded, self-administered health plan with fewer than 50 participants. For this purpose, "self-administered" means the employer/plan sponsor administers the plan without a TPA. Plan sponsors of health FSAs that are subject to HIPAA's privacy and security rules need to ensure that they properly handle participant's protected health information (PHI) and must maintain reasonable and appropriate safeguards to ensure the integrity, availability, and confidentiality of any electronic health information (ePHI) related to the health FSA plan.

COBRA

Health FSAs are group health plans for purposes of COBRA. Unless an exception applies (e.g., small employer, church plan, or federal governmental plan), a group health plan is required to offer COBRA when a participant experiences a qualifying event. While health FSAs have similar rules to other group health plan benefits under COBRA, the rules for health FSAs can be more complicated due to issues such as:

1) The calculation of the COBRA premium (i.e., because of its self-funded status)

2) Each covered member in a health FSA must have an independent right to elect COBRA under the health FSA and assess what the appropriate COBRA premium is for each of those family members; and

3) The special limited COBRA obligation applicable to certain health FSAs.

The following sections explain these concepts in more detail.

Calculation of the Applicable Health FSA Maximum COBRA Premium

Under COBRA, the "applicable premium"[29] is generally a reasonable estimate of the cost to the plan (claims paid to participants through the health FSA, plus any applicable administrative expenses) of providing coverage. Most often, this is the amount of health FSA coverage elected by the participant because most participants utilize most (if not all) of the monies within their health FSA during a typical plan year.[30] This is especially true if the health FSA is funded solely with employee salary reduction contributions. If an employer contributes to employees' health FSAs, the employer may find that some participants do not utilize the full health FSA account balance. That will impact the calculation of the applicable premium under COBRA.

Each Covered Member of an Employee's/ Participant's Health FSA has an Independent Right to Elect COBRA

Each covered member of a health FSA has an independent right to elect COBRA when coverage is lost due to a qualifying event. This means that each qualified beneficiary of a health FSA has the right to elect COBRA, regardless of whether other family members/covered members of the health FSA elect COBRA. Accordingly, it is possible that multiple qualified beneficiaries could each have the ability to receive reimbursements up to the maximum annual election (e.g., four family members would each have the ability to elect to continue the full amount of pre-qualifying event coverage, meaning the plan could be responsible for paying four times the applicable health FSA election). Employers should consult with legal counsel on strategies to limit this potential exposure.

[29] The maximum COBRA premium that may be charged to COBRA participants is 102% of the applicable premium.

[30] Unused health FSA funds at the end of the plan year could reduce the cost of coverage to the plan due to the use-or-lose rule that allows a plan sponsor to retain monies remaining in employees' health FSAs, which could decrease the maximum COBRA premium. However, many times these monies are used to offset plan losses or administrative expenses of the health FSA and therefore have little impact on the actual cost of the plan.

Special Limited COBRA Obligation

Health FSAs that qualify may benefit from "a special limited COBRA" obligation if the health FSA meets both the HIPAA excepted benefit requirements (as described above) and the COBRA Premium Condition, further described below.

Health FSA that Qualifies as an Excepted Benefit Must Also Meet the COBRA Premium Condition to Qualify for the Special Limited COBRA Obligation

To qualify for the health FSA special limited COBRA obligation, a health FSA plan sponsor must confirm that the health FSA qualifies as a HIPAA excepted benefit and then determine whether the health FSA meets the COBRA Premium Condition. The health FSA limited COBRA obligation allows a plan sponsor to reduce exposure to losses within the health FSA by requiring that FSA participants only be offered COBRA coverage in very limited circumstances and only until the end of the health FSA plan year (rather than for 18 to 36 months under applicable federal COBRA rules).

COBRA Premium Condition

A health FSA meets the COBRA Premium Condition if the maximum annual COBRA premium equals or exceeds the maximum annual health FSA coverage amount. In most cases, this condition would be met if a health FSA does not include employer contributions. However, if the health FSA does include employer contributions and employees do not exhaust their health FSA at the time of the qualifying event, this most likely causes the health FSA plan to be subject to the typical COBRA coverage period and not the special limited COBRA obligation.

Special Limited COBRA Obligation if Health FSA Qualifies as a HIPAA Excepted Benefit and Meets the COBRA Premium Condition

A health FSA that qualifies as a HIPAA excepted benefit and satisfies the COBRA Premium Condition must only comply with a special limited COBRA obligation. This special limited COBRA obligation allows a plan sponsor to offer COBRA for the health FSA in the following manner:

1) Health FSA participants that have "overspent" their accounts at the time of a qualifying event need not be offered COBRA under the health FSA; and

2) Health FSA participants that have "underspent" their accounts must be offered COBRA under the health FSA, but such COBRA coverage need only be provided until the end of the plan year (including any applicable grace period) for which the qualifying event occurred.

Overspent or Underspent Account

To test whether the health FSA is overspent or underspent, three things must be considered:

1) The salary reduction amount the qualified beneficiary elected for the plan year;

2) The total claims submitted for reimbursement from the health FSA for the applicable plan year prior to the qualifying event; and

3) The maximum amount that can be charged for COBRA coverage under the health FSA for the remainder of the plan year.

Overspent Account

The account is treated as overspent when the remaining annual limit is equal to, or less than, the maximum COBRA premium that can be charged for the rest of the year. The term “remaining annual limit” reflects the elected salary reduction amount for the year minus the total claims submitted for reimbursement from the health FSA.

Example: Overspent Account

Employee A is unmarried and has no dependents. Employee A elects health FSA coverage with an annual limit of $2,400. The health FSA qualifies for the special limited COBRA obligation, has a calendar plan year and is financed entirely by employee salary reductions. The health FSA plan document states that coverage ceases on the date employment terminates (or at the time of another qualifying event). Employee A terminates employment on May 31. As of that date, the employee has submitted reimbursable claims totaling $1,100 and has made salary reductions of $1,000 (five months × $200). The annual cost to the plan, and thus the applicable COBRA premium, equals the annual salary reductions multiplied by 102%.

This employee has overspent their account because the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year. The remaining annual limit is $1,300 (i.e., $2,400 minus $1,100). The maximum COBRA premium that can be charged for the seven months remaining in the year is $1,428 (i.e., $200 a month X 7 months = $1,400; $1,400 X 102% = $1,428). Because the health FSA is subject to the limited COBRA obligation and the employee has overspent their account, the employer is not obligated to offer COBRA coverage under the health FSA.

Underspent Account

When the remaining annual limit exceeds the maximum COBRA premium that can be charged for the rest of the year, the account is treated as underspent. The term “remaining annual limit” reflects the elected salary reduction amount for the year, minus the total claims submitted for reimbursement from the health FSA.

Example: Underspent Account

Employee B is unmarried and has no dependents. Employee B elects health FSA coverage with an annual limit of $2,400. The health FSA qualifies for the special limited COBRA obligation, has a calendar plan year and is financed entirely by employee salary reductions. The health FSA plan document states that coverage ceases on the date employment terminates (or any other qualifying event). The employee terminates employment on May 31. As of that date, the employee has submitted reimbursable claims totaling $900 and has made salary reductions of $1,000 (five months × $200). The annual cost to the plan, and thus the applicable COBRA premium, equals the annual salary reductions.

The remaining annual limit for Employee B is $1,500 (i.e., $2,400 minus $900). The maximum COBRA premium that may be charged for the seven months remaining in the year is $1,428 (i.e., $200 a month X 7 months = $1,400; $1,400 X 102% = $1,428). Because the employee has underspent their account, the employer is obligated to offer the employee COBRA coverage under the health FSA. However, since the health FSA is subject to the special limited COBRA obligation rule, the employer can discontinue that coverage at the end of the year (with no annual open enrollment rights).

Qualifying Event is Divorce or a Child No Longer Qualifies as a Dependent

When a participant may be reimbursed for not only their own health care expenses but also those of their spouse or dependent child, it is much more challenging to decipher whether the plan has been overspent/underspent. The reason this issue arises is because there is little guidance available under the COBRA regulations as to whether the total claims submitted to the FSA should only be allocated to each individual that incurred the expense (e.g., spouse accounts for only $350 of the total reimbursable expenses of $1,000 from the health FSA) or to all expenses that were incurred against the health FSA (e.g., when added together, the participant and their family members incurred $1,000), regardless of the amount each individual incurred during the plan year.

In these instances, the employer/plan sponsor should seek legal counsel when deciding which method to follow and whether to offer special limited COBRA coverage to the participant or their family members.

Impact of Carryovers on Special Limited COBRA Obligation

When calculating the maximum COBRA amount that can be charged to a qualified beneficiary, which then determines whether an account is "overspent" or "underspent," the plan administrator must subtract year-to-date reimbursements from the employee's annual election (and any non-elective employer contributions). If the result exceeds the required premium for the COBRA coverage period, the account is "underspent," and an offer of COBRA is required. If a health FSA has a carryover feature, the remaining carryover should also be included in the maximum benefit available to the qualified beneficiary. However, the timing of when the employee is terminated (before, during, or after the run-out period) could impact the calculation of whether the account has been overspent/underspent.

Example: Carryover Causing Health FSA to be Underspent.

Employee X elects salary reductions of $2,400 ($200/month) for 2023 under their employer's calendar-year health FSA and carries over $500 in unused benefits from 2022. Thus, the maximum health FSA benefit they can receive for 2023 is $2,900. Employee X's employment terminates on April 30, 2023. As of that date, they have submitted reimbursable health FSA claims totaling $1,000. The maximum health FSA benefit that Employee X is entitled to receive for the remainder of 2023 is $1,900 ($2,900 minus $1,000). The health FSA is subject to the special limited COBRA rule.

Employee X's health FSA is underspent because their remaining annual limit is greater than the maximum COBRA premium that they can be charged for the rest of 2023. Their remaining annual limit is $1,900, while the maximum COBRA premium that can be charged for the eight months remaining in the year is $1,632 (i.e., $200 × 8, plus the 2% add-on). Because Employee X has underspent their account, the employer must offer Employee X COBRA coverage under the health FSA.

The following example is an example of how the timing of the termination of the employee impacts whether the health FSA could be overspent/underspent.

Example: Run-Out Period that Coincides with a Qualifying Event.

Company X's health FSA has a calendar-year plan year, is subject to the special limited COBRA rule, and permits carryovers of up to $500. Its run-out period for claims incurred during the January 1, 2022 – December 31, 2022, plan year ends on March 31, 2023. As of December 31, 2022, Employee Y has unused health FSA benefits of $600. For the 2023 calendar year plan year, Employee Y elects salary reductions of $2,400 ($200 per month). Employee Y was terminated on February 28, 2023. As of that date, they have submitted no additional claims for 2022 but have submitted $700 in claims for the 2023 plan year. Whether Employee Y is eligible for COBRA coverage under the health FSA depends on whether they have "underspent" or "overspent" their account as of February 28, 2023 (the date of the qualifying event).

If Employee Y is eligible for COBRA, the maximum premium they can be charged for the 10 months remaining in 2023 is $2,040 ($200 × 10, plus a 2% administrative fee). If Employee Y's "remaining annual limit" for 2023 as of February 28, 2023, is more than $2,040, their account is underspent, and Employee Y is eligible for COBRA for the rest of 2023. Employee Y's "remaining annual limit" is their maximum annual limit (elected $2,400 in 2023, plus the allowed carryover amount of $500 from 2022) minus the number of claims already submitted for 2023 ($700). But on February 28, 2023, Employee Y's maximum annual limit is unknown because their carryover amount from 2022 will not be known until March 31, when the 2022 run-out period ends.

Employee Y's carryover amount will depend on the amount of claims they submit during the remaining run-out period and could range from $0 to $500. For example, if the carryover amount ends up being $500, Employee Y will have underspent their account (($2,400 + $500 – $700) = $2,200 > $2,040) and would be eligible for COBRA for the remainder of 2023. But if the carryover amount is $0, Employee Y will have overspent their account (($2,400 + $0 – $700) = $1,700 < $2,040) and would not be eligible for COBRA.

Due to the complexity of this situation and the potential issues with a plan administrator/sponsor failing to offer COBRA coverage in a situation where the account is underspent, an employer should seek legal advice from legal counsel in these situations.

The Special Limited COBRA Obligation and Health FSAs with a Grace Period or Carryover

Under the special limited COBRA obligation rule, a plan sponsor need not extend coverage beyond the end of the plan year to a COBRA qualified beneficiary. A plan sponsor is not required to provide an opportunity to a COBRA qualified beneficiary to re-enroll into the health FSA in a subsequent year despite active employees having the opportunity to enroll in the health FSA. However, if a health FSA provides a grace period or carryover after the end of the plan year, COBRA qualified beneficiaries that participate in the health FSA on the last day of the plan year continue to have the ability to both incur and seek reimbursement for expenses during the entire grace period or carryover period following the end of the plan year, despite not paying their COBRA premium during that period. However, for health FSAs with a carryover feature, if further limitations on the ability to benefit from the carryover feature are applied to similarly situated active employees, these same restrictions would apply to COBRA qualified beneficiaries (e.g., a health FSA plan's rule that an active employee must have at least $100 in their health FSA to carry over to the next plan year would also be applied to COBRA qualified beneficiaries that are participating in the health FSA at the end of the plan year).

Example: Carryover After End of Plan Year

Company X maintains a calendar year health FSA that qualifies as an excepted benefit and allows carryovers of up to $500. Employee Y elects health FSA salary reductions of $2,400 for 2022 and terminates employment on June 30, 2022. As of that date, Employee Y had submitted reimbursable health FSA claims totaling $300. Employee Y elects COBRA, pays the required premiums for the rest of the year, and submits additional reimbursable claims of $1,600. At the end of 2022, Employee Y has $500 of unused benefits remaining. Employee Y can continue to submit claims under the same terms as similarly situated non-COBRA beneficiaries in 2023 for up to $500 in reimbursable expenses. No COBRA premium can be charged for the additional coverage. However, the carryover is not required to be made available after the end of Employee Y's maximum COBRA period.

Interaction with Health Savings Accounts (HSAs)

General-Purpose Health FSA and HSAs

If an employee is covered under a general-purpose health FSA either through their employer or a spouse's employer, typically that employee would not be considered HSA eligible unless the general-purpose health FSA is a post-deductible health FSA (i.e., the health FSA only reimburses expenses after an individual meets their IRS HDHP minimum deductible). This rule regarding disqualifying general-purpose health FSA coverage applies whether the individual is a participant in the general-purpose health FSA or merely someone whose expenses can be reimbursed. For example, if an employee is covered under a general-purpose FSA that reimburses expenses before the deductible is satisfied, it is likely that the employee's spouse's medical expenses could also be covered under that FSA. Because of this, neither the employee nor the spouse would be considered eligible for HSA under these circumstances. This is true even if the employee does not submit the spouse's health care expenses for reimbursement from the employee's health FSA because the employee can submit their spouse's health care expenses to the health FSA.

General-Purpose Health FSA and HSAs: Run-Out Periods, Grace Periods, Carryovers

In general, when an individual is covered under a general-purpose health FSA, they will be ineligible to contribute to an HSA for the entire period of coverage under the general-purpose health FSA (typically the health FSA plan year), even if their health FSA balance is $0 during the plan year. If the participant does not exhaust their general-purpose health FSA funds by the end of the plan year, they will forfeit the amount remaining in the account. However, the IRS allows plan sponsors to incorporate various optional plan designs that provide participants extra time to use their remaining general-purpose health FSA funds after the end of the plan year. These designs and their impact on HSA eligibility are discussed below:

Run-out Period: A run-out period is a period of time designated into the next plan year, during which time an individual may continue submitting incurred expenses for reimbursement from an immediately preceding plan year. A run-out period does not impact HSA eligibility during the plan year in which the run-out period concurrently runs. For instance, if an employee elects coverage in a general-purpose health FSA for the 2023 calendar plan year, with a run-out period from January 1, 2024, to March 31, 2024, and the employee waives general-purpose health FSA coverage for the 2024 calendar year plan year, an employee could be HSA eligible as of January 1, 2024.

Grace Period: Plan sponsors may choose to include a grace period in the health FSA, under which participants may receive reimbursements for expenses incurred following the end of a plan year from the account balance remaining at the end of the plan year. Also, during this grace period that follows the end of a plan year, employees may be able to seek reimbursement for expenses incurred during the plan year associated with the grace period under the run-out period (described above). The grace period cannot be longer than 2 ½ months following the end of the applicable plan year.

Even if a participant does not elect a general purpose health FSA in the plan year that runs concurrently with the grace period, if they have any remaining funds at the end of the plan year, they will be HSA-ineligible until the first full calendar month commencing after the grace period ends (e.g., for a 2.5 month grace period occurring from January 1st to March 15th, an employee would only be considered HSA eligible on and after April 1st if the employee is otherwise HSA eligible at that time). This is true even if the employee spends the entire amount still available at the end of the plan year before the end of the grace period. However, if the participant has a $0 balance in their general-purpose health FSA at the end of the plan year (e.g., December 31st of a calendar year FSA plan year) and before the grace period begins, the grace period will be disregarded for purposes of HSA-eligibility and an individual would be considered HSA eligible on the first day following the end of the FSA plan year (e.g., January 1st for a calendar year FSA plan year). To avoid this issue, the plan sponsor may choose to design the plan so that all reimbursements under the health FSA for all health FSA participants are converted to a limited-purpose health FSA that reimburses only dental and vision expenses or post-deductible medical expenses (after the minimum annual deductible to qualify to open and contribute to an HSA) during the grace period.

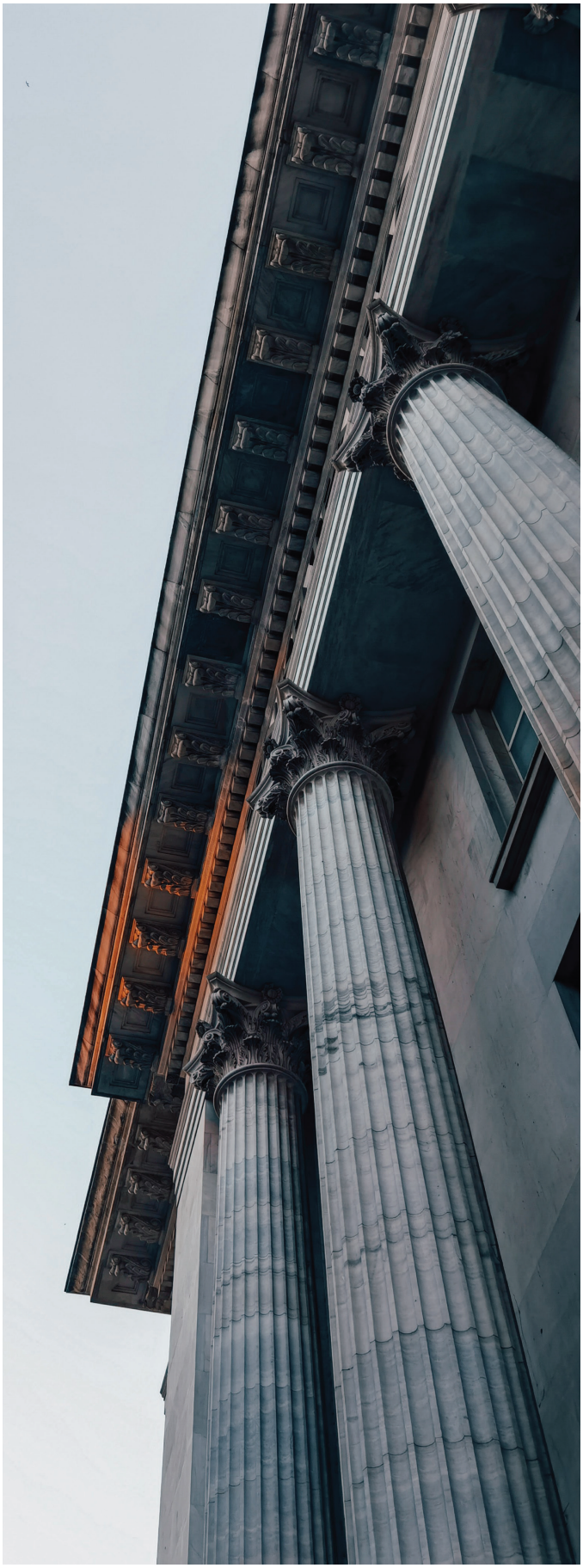
Carryover ("Rollover"): Health FSAs may offer carryovers of unused health FSA funds of up to $500 (indexed) remaining at the end of a plan year to be used for qualified medical expenses incurred in a subsequent plan year. If the employer offers a carryover feature that allows an employee to "carry over" any remaining balance at the end of a plan year under a general-purpose health FSA into the next plan year, the participant will be considered HSA ineligible for the entire subsequent plan year (regardless of when the carryover funds are exhausted), unless the participant opts out of receiving the carryover or the carryover is a specially designed health FSA carryover feature that does not prevent HSA eligibility (e.g., a limited-purpose health FSA).

Considerations for Plan Sponsors offering a General-Purpose Health FSA and an HDHP/HSA Plan

To help address HSA eligibility issues, these are a few approaches plan sponsors can take:

- Limit the situations in which employees enrolled in a general-purpose FSA contribute to an HSA. This can be done by prohibiting employees from enrolling in HDHP coverage and general-purpose health FSA coverage at the same time. Alternatively, for employees who elect HDHP coverage, the employer could automatically enroll the employee in an HSA-compatible health FSA.
- Allow unused general-purpose health FSA amounts to be carried over to an HSA-compatible health FSA (e.g., limited-purpose FSA) or allow participants to waive the carryover.
- Advise employees that if their spouse (or parent of dependent children) is covered under a general-purpose health FSA that could reimburse the employee's medical expenses, they may not be eligible to make or receive contributions to an HSA.
- Advise any employee who enrolls in a general-purpose health FSA with a grace period or a carryover feature of the impact of the grace period or carryover on HSA eligibility. An employer may adopt a carryover feature, whereby an employee may choose to have the carryover become a limited-purpose health FSA, or an employer may automatically adopt a policy whereby an employee who is enrolled in a general purpose health FSA and enrolls in an HDHP/HSA plan, the general purpose health FSA carryover amount (if any) will be automatically converted to a limited purpose health FSA carryover. However, an employee cannot individually choose to convert their general-purpose health FSA grace period to a limited-purpose health FSA grace period, but an employer can implement a policy whereby all general-purpose health FSA grace periods automatically convert to a limited-purpose health FSA carryover for all employees (regardless of whether the employee enrolls in an HDHP/HSA for the following the applicable plan year).

As always, plan sponsors need to consult with their legal counsel and tax advisors before making any decisions relating to HSAs.



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