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Plan Designs

Flexible Spending Accounts (FSA)

What is an FSA?
A flexible spending account is an account in an employee's name that can reimburse the employee for qualified health care or dependent care expenses. It allows an employee to fund qualified expenses with pretax dollars deducted from the employee's paychecks. The employee can receive cash reimbursement up to the total value of the accountfor covered expenses incurred during the benefit plan year and any applicable grace period.

"Use it or lose it"
As required by the Internal Revenue Service (IRS), an FSA has a "use it or lose it" provision stating that any unused funds at the end of the plan year (plus any applicable grace period) will be forfeited. When electing an FSA during open enrollment, the 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 medical or dependent care expenses, but that is not so high that the money will be forfeited and wasted.

The IRS allows employers to offer 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 FSA. This provision is strictly optional; the employer must choose to implement it.

On Oct. 31, 2013, the IRS released Notice 2013-71, which relaxed the "use it or lose it" rule for health care FSAs. Under the relaxed rule, employers may allow participants to carry over **up to $500 in unused funds** into the next year. Similar to the grace period rule, thenew carry-over rule 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.

Types of accounts
There are two different types of FSAs: health care accountsand dependent care accounts. One employee can elect to have both types of accounts and contribute separate pretax dollar amounts to each. These accounts are kept completely separate; for instance, an employee could not be reimbursed for dependent care expenses from the health care account.

Health care accounts
A health care FSAcan reimburse employees for eligible medical expenses, up to the amount contributed for the plan year. Beginning in 2013, a health care FSA offered through a cafeteria plan must limit the amount of salary reduction contributions that employees can make. Effective for planyears beginning after Dec. 31, 2012, employee contributionsto a health care FSA are capped at**$2,500 per year**. The health FSA limit remained unchanged at $2,500 for the taxable years beginning in 2014. However, **for**

taxable years beginning in 2015, the dollar limitation on employee salary reduction contributions to a health FSA **increased from $2,500 to $2,550**.

The Affordable Care Act (ACA) revised the definition of "qualified medical expenses" for purposes of reimbursement from health care FSAs. Under the revised definition, qualified medical expenses include amounts paid for medicines or drugs **only if the medicine or drug is a prescribed drug** (determined without regard to whether the drug is available without a prescription) or is insulin. This means that health care FSAs may not reimburse the cost of over-the-counter medications that do not have a prescription.

In addition, under the ACA, health care FSAs that do not qualify as **excepted benefits**under HIPAA generally will be prohibited, effective for plan years beginning on or after Jan. 1, 2014. Health care FSAs qualify as excepted benefits if they satisfy availability and maximum annual benefit requirements under HIPAA, which are described below.

Coverage Period
A health care 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). Once the plan year begins, an employee's full FSA amount is available at any time in the year, regardless of how much the employee has contributed to that point.

- For example, an employee decides to put $500 in an FSA for the plan year. FSA contributions are made bi-weekly as pretax payroll deductions. If the plan year begins on Jan. 1, and the employee has an eligible $400 claim in February, the FSA is required to make the $400 available to the employee for reimbursement, even though only a fraction of that amount hasbeen contributed.

If an employee leaves the company or is terminated within the plan year:

- Theformer employee may have the right to elect COBRA coverage and continue receiving health care FSA reimbursements.
- If the former employee had been reimbursed for an amount that exceeded the contributions paid to that point, the employer cannot recover that money if the former employee chooses not to continue coverage.

Claims
Any medical expenses reimbursed from a health care FSA must be incurred during that plan year (or grace period, if applicable to the FSA).

- For instance, a doctor visit that occurred on Dec. 15 of the previous year, but was not billed until January of the current plan year, cannot be reimbursed from current plan year amounts.

ACA Implications—Excepted Benefits
Federal agencies have indicated that, effective for plan years beginning on or after Jan. 1, 2014, health care FSAs generally must qualify as excepted benefits under HIPAA to comply with the ACA's market reforms. Health care FSAs qualify as excepted benefits if the following conditions regarding maximum annual benefit and availability are met:

- The **maximum annual benefit** payable to the employee under the health care FSA does not 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).
- Other employer-sponsored group health coverage is **available to the employee**, and this coverage is not also HIPAA-exempt (such as certain types of supplementary coverage).

HIPAA Implications
HIPAA regulations state that health care FSAs are considered a "covered entity" and thus subject to HIPAA privacy and security rules.

COBRA Rights
A health care FSA may have the obligation to make COBRA coverage available to a qualifying beneficiary who experiences a qualifying event in that plan year, unless both of the following conditions are met:

- The health care FSA is an excepted benefit under HIPAA.
- The maximum annual benefit allowed or remaining on the health care FSA is less than the maximum amount required to be paid for a year of COBRA coverage.

If the above conditions are satisfied, then the health care FSA is not required to offer COBRA coverage to participants who have overspent their accounts. The health care FSA is required to offer COBRA coverage to participants who have underspent their accounts, but the COBRA coverage may terminate at the end of the year in which the qualifying event occurred.

- If the participant's maximum annual benefit minus the amount of submitted reimbursable claims is less than the maximum COBRA premium that can be charged for the rest of the year, then the FSA is "overspent."
- On the other hand, if the remaining annual benefit (participant's maximum annual benefit minus amount of submitted reimbursable claims) is more than the maximum COBRA premium that can be charged for the rest of the year, then the FSA is "underspent."

Typical Eligible Health Expenses
A health care FSA can only reimburse employees for amounts spent on **medical care**, as defined under Section 213(d) of the Tax Code. Section 213(d) of the Tax Code 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." The following is a partial list of typical expenses eligible for health care FSA reimbursement. FSA sponsors can also further limit the expenses eligible for reimbursement.

- Deductible for group health and/or dental plan (amount depends on specific plan)
- Copayments for group health and/or dental plan (amount depends on specific plan)
- Many charges that are not covered by health/dental plan are eligible for FSA reimbursement, such as:
    - Eye exams, eyeglasses, contact lenses;
    - Hearing exams, hearing aids;
    - Physical exams and mammograms in excess of one per year;
    - Pap smears in excess of two per year;
    - Various types of treatment in excess of the allowed number of days through a health plan (treatment of mental/nervous condition, extended care facility, home health careand hospice care);
    - Medical expenses of a dependent not covered by a health plan;
    - In vitro fertilization and other fertility treatments;
    - Orthodontia ;

- Fluoride treatments, dental sealants and space maintainers for patients over 18 years;
- Teeth cleaning and routine exams in excess of two each per year;
- Vision corrective surgery (such as Lasik); and
- Smoking cessation programs and related prescription drugs.

➢ The IRS expanded the list of reimbursable expenses to include expenses paid for breast pumps and supplies that assist lactation.

Ineligible Health Expenses
The following is a partial list of expenses that are not eligible for health care FSA reimbursement:

➢ Over-the-counter drugs, unless the individual obtains a prescription (for plan years beginning on or after Jan. 1, 2011)
  - Insulin is an exception

➢ Premiums for independent insurance coverage or Medicare

➢ Premiums for group health coverage under spouse's employer

➢ Elective cosmetic surgery (unless to repair a congenital abnormality or injury or to restore bodily function)

Dependent care accounts
The second type of FSA is a dependent care account. This can be used to pay for care of dependent children under age 13 by a babysitter, daycare center, or before-school or after-school program. Care for a disabled spouse, parent or child over age 12 is also eligible for reimbursement.

Many of the same general rules that apply to health care FSAs also apply to dependent care accounts, such as the "use-it or lose-it" rule and the 12-month coverage period requirement. However, there are also some important differences between the two types of accounts. For dependent care accounts:

➢ There is an annual limit as to how much an employee can contribute. This amount is $5,000 or, if lower, the maximum amount that can be excluded from the employee's income under Section 129 of the Tax Code when the employee's election is made;

➢ The money in a dependent care account is not available until it has been deposited by the employee; and

➢ Dependent care expenses cannot be reimbursed until they are actually incurred. This can be an issue when child care centers "pre-bill" for services, and employees are required to pay in advance

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