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2018 Employee Benefits Webinar Series

Introduction to Consumer Directed Healthcare and Account-Based Plans (HSAs, FSAs, and HRAs)

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Stacy H. Barrow
Marathas Barrow Weatherhead Lent LLP

sbarrow@marbarlaw.com

Agenda

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  - Eligibility Rules
  - Contributions
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  - Coordination with FSAs & HRAs
- Health Reimbursement Arrangements under the ACA
- QSEHRAs (Qualified Small Employer HRAs)
- Health Flexible Spending Accounts under the ACA

Definitions

- FSA – Health Care Flexible Spending Account
- HDHP – Qualified High Deductible Health Plan
- HRA – Health Reimbursement Arrangement
- HSA – Health Savings Account
- QSEHRA – Qualified Small Employer HRA

HSA Background

- HSAs became available in 2004 as part of Congress' attempt to expand coverage and control costs through consumer-directed programs
- HSAs are tax-favored investment accounts that may be used to pay for an individual's current or future medical, dental and vision expenses
- To set up an HSA, an individual must be covered by an HDHP and satisfy certain other eligibility rules
- Within the statutory limits, employer contributions to an HSA are not taxable and individuals may make tax-deductible HSA contributions

HSA Eligibility

- There are four basic HSA eligibility rules
- Individuals must be:
    1. Covered by a qualified High Deductible Health Plan;
    2. Not covered by any non-HDHP plan;
    3. Not entitled to (*i.e.*, enrolled in) Medicare; and
    4. Not eligible to be claimed as a dependent on another individual's federal tax return

HSA Eligibility

- In order to qualify, the HDHP must have an annual deductible at or above the statutory minimum, and contributions and out-of-pocket limits at or below the statutory maximum

	2019 (single/family)	2018 (single/family)
Minimum Annual HDHP Deductible	$1,350 / $2,700	$1,350 / $2,700
Annual HSA Contribution Limit	$3,500 / $7,000	$3,450 / $6,900
Maximum Out-of-Pocket for HDHP (applies to all in-network benefits)	$6,750 / $13,500	$6,650 / $13,300

HSA Eligibility

1. (cont'd.) An HDHP may provide preventive care before the minimum annual deductible is satisfied, which include:
   - Periodic health evaluations, including diagnostic procedures ordered in connection with routine examinations, such as annual physicals
   - Routine prenatal and well-child care
   - Child and adult immunizations
   - Tobacco cessation programs
   - Obesity weight-loss programs
   - Screening services for: cancer; heart and vascular diseases; infectious diseases; mental health conditions; substance abuse; metabolic, nutritional, and endocrine conditions; musculoskeletal disorders; obstetric and gynecological conditions; pediatric conditions; and vision and hearing disorders

HDHPs may cover ACA-recommended preventive care services

HSA Eligibility – Preventative Care Technical Correction

- The preventive care exception for HSAs originally referred to preventive care within the meaning of Section 1871 of the Social Security Act (SSA)
  - This was unclear, as Section 1871 does not define preventive care, but merely allows HHS to prescribe regulations
  - In 2018, technical corrections legislation changed the reference to Section 1861, which defines preventive services to include screening and preventive services, an initial preventive physical exam "with the goal of health promotion and disease detection," and personalized prevention plan services
- IRS still generally considers preventive care to exclude services or treatments intended to treat an existing illness, injury, or condition
  - Disease-management programs geared toward specific conditions seem to fall outside the safe harbor definition for preventive care unless they do not provide "significant benefits in the nature of medical care"

HSA Eligibility

2. In order to be eligible to contribute to an HSA, an individual must not be covered under any non-qualified health care plan, with two exceptions: permitted insurance and permitted coverage

   – Permitted insurance: Worker's compensation, tort liability, ownership liability, specified disease coverage, per-diem indemnity insurance

   – Permitted coverage: Accident coverage, disability, dental, vision, long-term care

HSA Eligibility

3. Individuals who are entitled to Medicare are not eligible to establish or contribute towards an HSA

   – Entitled means actually covered under any part of Medicare: Part A, Part B, a Medicare Advantage Plan, or Part D

   – Individuals who are eligible for Medicare, but have not enrolled, may establish and contribute to an HSA

   – Medicare entitlement is not automatic at age 65!

      - Employees can maintain HSA eligibility by delaying enrollment in Medicare

      - *Caution*: Entitlement to Medicare can be retroactive up to 6 months when an individual enrolls in Medicare after age 65

HSA Eligibility

4. Any individual who is eligible to be claimed as a dependent on another person's federal tax return is not eligible to establish or contribute to an HSA

Example: A student who is eligible for an HDHP, but whose parents claim her as a dependent because she meets the IRS definition of "qualifying relative," is not HSA eligible.

Veteran Eligibility for HSAs

- Surface Transportation and Veterans Health Care Choice Improvement Act changed how veterans' health coverage affects HSA eligibility
- The "3-month" rule no longer applies to care received through the VA for a "service-connected disability"
  - In the past, an individual was not HSA-eligible for a month if he or she had received VA medical benefits during the previous three months
- This new rule only applies to VA coverage
  - For these purposes, any hospital care or medical services received from the VA by a veteran who has a disability rating is considered service-connected
- TRICARE coverage still disrupts HSA eligibility

HSA Eligibility

- 2 ½ month FSA grace period may not prevent HSA eligibility
- Generally, an individual may not participate in both an HSA and an FSA because FSA coverage is not an HDHP
- According to the IRS, this restriction includes any FSA “grace period,” even if there is no money left in the FSA
- However, individuals with a zero balance in their FSA at year end may contribute to an HSA at the start of the new year

HSA Contributions

- Full-year contribution allowed for mid-year enrollees
- Under this rule, individuals who first enroll in a high deductible plan after the start of the year may make a full HSA contribution for the year
- However, the individual must remain HSA-eligible for the next full calendar year, otherwise the ineligible amount is included in income, plus a 10% penalty applies
  - Ineligible amount is based on the amount contributed in excess of the applicable limit based on tier (single/family) and months of HDHP coverage

Employer Contributions to HSAs

- Employers may, but are not required to, contribute to their employees' HSAs
- If an employer contributes to an employee's HSA, the contributions are excludable from federal taxable income and are not taxable to the individual
- Employers can structure their contributions under one of two rule sets:
  - Comparable Contributions
  - Contributions through a Cafeteria Plan

Comparable Employer Contributions

- Comparable employees are employees in the same category (full-time, part-time, former) who have the same tier of coverage
- Employers may use up to 4 tiers:
  - Single (self only)
  - Employee & 1 Dependent
  - Employee & 2 Dependents
  - Employee & 3 or more Dependents
- **Restriction:** contributions to each family tier must be equal to or greater than the tier below

Comparable Employer Contributions

- Employees may be placed in the following categories only:
  - Full-time (30 hours)
  - Part-time (<30 hours)
  - Former Employees (does not include COBRA)
  - Union (collectively bargained health benefits)
- **Note:** the 30-hour threshold must be used
- Differences not permitted for: management, salaried, specific locations or subgroups (e.g., division or subsidiary)

Comparable Employer Contributions

- Contributions will be comparable only if they are calculated using one of two methods:
  - Same dollar amount by tier (single or family); or
  - Same percentage of the HDHP deductible (single or family level)
- When HSA contributions are not comparable, the penalty on the employer is a **35% excise tax**

Employer Contributions Through a Cafeteria Plan

- Employer contributions toward an employee's HSA offered under a cafeteria plan will generally be in one of 3 forms:

    1. Salary reductions;
    2. Employer credits (cashable or non-cashable); and/or
    3. Employer non-credit contributions such as:

    - Flat dollar amount
    - Specified percentage of deductible(s)
    - Matching contributions

Employer Contributions Through a Cafeteria Plan

- An employer's HSA contribution may not be considered to be "through" a cafeteria plan if the contribution is non-elective and non-cashable
- Example of a contribution not "through" a cafeteria plan:
  - Employees contribute to HDHP via salary reduction,
  - Employer contributes to HSA for all enrollees, and
  - Employer contribution is only for the HSA:
    - It can't be taken as cash,
    - It can't be used for other benefits, and
    - Employees cannot contribute pre-tax to HSAs
- Employer's HSA contribution is ***not*** through a cafeteria plan!

HSA Distributions

- Distributions from an HSA are tax-free if used to pay or reimburse “qualified medical expenses” incurred after establishment of the HSA
- Distributions for non-qualified expenses are subject to income tax and an additional 20% tax
  - The additional 20% tax does not apply if the HSA holder is age 65 or older

HSA Distributions

- "Qualified medical expenses" are those expenses that would generally qualify for a tax deduction as medical and dental expenses (see IRS Pub. 502) AND which are incurred by:
  - You or your spouse (as determined under federal law)
  - All dependents you claim on your tax return
  - Anyone you could have claimed as a dependent except that:
    - The person filed a joint return;
    - The person had gross income of $4,050 or more (2017 figure shown); or
    - You, or your spouse if filing jointly, can be claimed as a dependent on someone else's tax return

HSA Distributions

- “Qualified medical expenses” do not include insurance premiums, unless they are for:
  - Long-term care insurance (amounts are limited)
  - COBRA continuation coverage
  - Health care coverage while receiving unemployment compensation under federal or state law
  - Medicare and other health care coverage if the HSA holder is age 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap)

HDHPs and Embedded Deductibles

- How do embedded individual deductibles work?
  - A family HDHP cannot pay claims (other than preventive care) until the minimum annual deductible is satisfied ($2,700 in 2018-19)
  - Many HDHPs have deductibles for family coverage that exceed $2,700 in aggregate; however, they allow individuals to satisfy a lower deductible
  - As long as the embedded individual deductible is not lower than the minimum deductible for family coverage, HSA eligibility is not disrupted
    - For example, a $3,000 / $6,000 plan with an embedded individual deductible would not jeopardize HSA eligibility, as the embedded $3,000 deductible equals or exceeds $2,700

2019 HSA and ACA OOP Limits

	2019 (single/family)	2018 (single/family)
Minimum Annual HDHP Deductible	$1,350 / $2,700	$1,350 / $2,700
Annual HSA Contribution Limit	$3,500 / $7,000	$3,450 / $6,900
Maximum Out-of-Pocket for HDHP (applies to all in-network benefits)	$6,750 / $13,500	$6,650 / $13,300
ACA Maximum Out-of-Pocket Limits (applies to all in-network essential heath benefits)	$7,900 / $15,800	$7,350 / $14,700

- ACA requires family plans to have an embedded individual OOP limit
- Embedded OOP limit rule applies to all non-grandfathered group health plans, including HDHPs

Interaction between HSA Rules and ACA OOP Limits

- Recap:
  - **HSA Rule**: OOP limit for family HDHP coverage cannot exceed $13,500 in 2019
  - **ACA Rule**: Family coverage (whether HDHP or non-HDHP) must have an embedded individual OOP limit that does not exceed $7,900 in 2019
- This means that for the 2019 plan year, an HDHP subject to the ACA out-of-pocket limit rules may have a $6,750/$13,500 out-of-pocket limit (and be HSA-compliant) so long as there is an embedded individual out-of-pocket limit in the family tier no greater than $7,900 (so that it is also ACA-compliant)

Coordination of HSAs with FSAs and HRAs

- Employers implementing HSA-qualified HDHPs should consider the following five plan design examples and their effect on an employee's eligibility to contribute to an HSA
- For the purpose of the following five examples, the HDHP has the following features for calendar year 2019:
  - 80%/20% coinsurance
  - $1,350 deductible for individual, $2,700 for family
  - Maximum out-of-pocket cost of $6,750 for individual, $13,500 for family
  - HDHP covers standard medical and Rx expenses, and does not cover dental or vision expenses

1. HSA with “Traditional” FSA or HRA

- Both the FSA and HRA cover all qualified medical expenses not covered by the HDHP (co-payments, co-insurance, expenses not covered due to the deductible, any other medical expenses not covered by the HDHP)
- This individual is **not** eligible to contribute to an HSA
  - The FSA and HRA pay or reimburse medical expenses incurred before the annual deductible has been satisfied
  - The FSA and HRA are not limited to the exceptions for permitted insurance, permitted coverage, or preventive care
- **Note:** In this example, both the FSA and HRA are considered health plans that are NOT qualified HDHPs

2. HSA with “Limited Purpose” FSA or HRA

- Both the FSA and HRA are “limited purpose” arrangements that cover only vision or dental expenses, as well as preventive care (without regard as to whether the HDHP deductible has been satisfied)
- This individual **is** eligible to contribute to an HSA
  - The FSA and HRA pay or reimburse medical expenses incurred before the annual deductible has been satisfied
  - However, the medical expenses paid by the FSA or HRA include only vision and dental benefits (which are permitted or disregarded coverage) and preventive care

3. HSA with “Suspended” HRA

- The individual elects, before the beginning of the HRA coverage period, to suspend the payment of medical expenses during the upcoming HRA coverage period (permitted or disregarded coverage and preventive care is allowed)
- This individual is eligible to contribute to an HSA
  - The individual **is** eligible to contribute to an HSA until the individual is again entitled to receive, from the HRA, payments for medical expenses incurred after the suspension
  - **Note:** This allows an HRA and HSA to co-exist by permitting an individual to maintain an HRA (and to continue receiving accruals) and still be eligible to contribute to an HSA

4. HSA with “Post Deductible” FSA or HRA

- Both the FSA and the HRA are “post deductible” arrangements that only pay or reimburse medical expenses after the HDHP deductible has been satisfied (permitted or disregarded coverage and preventive care is allowed)
- This individual **is** eligible to contribute to an HSA
  - The FSA and HRA do not reimburse medical expenses incurred before the annual deductible has been satisfied
  - **Note:** The post deductible HRA or FSA will not qualify as a HDHP; the individual will need to be covered by a qualified HDHP in order to contribute to an HSA

5. HSA with “Retirement” HRA

- The HRA is a “retirement” HRA and only reimburses expenses incurred after the individual retires
- This individual is eligible to contribute to an HSA
  - The individual **is** eligible to contribute to an HSA before retirement because the HRA will only pay or reimburse medical expenses incurred after retirement
  - **Note:** This individual will not be eligible to make contributions to an HSA after retirement

Proposed HSA Expansion Bills

- H.R. 6199: Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018
  - Carryforward of FSA balances – up to 3x annual FSA limit may be carried over
  - Entitlement to Medicare Part A due to age will not disrupt HSA eligibility
  - Increase HSA contribution limit to out-of-pocket limit (6,650 / $13,300 for 2018)
  - Allow both spouses to make catch-up contributions to the same HSA
  - 60-day grace period rule – HSAs opened within 60 days after gaining HDHP coverage treated as having been opened with the HDHP
  - "Bronze" and catastrophic ("Copper") plans to be treated as HSA-qualified HDHPs
  - Allow Copper plans to be sold to all Marketplace enrollees, not just those under 30
  - Extends moratorium on HIT tax for 2020 and 2021 (already deferred in 2019)

Proposed HSA Expansion Bills

- H.R. 6311: Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018
  - Up to $250 per year ($500 family) in coverage may be provided before the deducible is met
  - Direct Primary Care (DPC) up to $150 per month ($300 fam.) would not disrupt HSA eligibility
  - Services at on-site or retail medical clinics would not disrupt HSA eligibility (so long as significant medical care benefits are not provided)
  - Spousal FSA enrollment will not disrupt an employee's HSA eligibility as long as the spouse doesn't submit the employee's expenses for reimbursement
  - Employers may allow employees to convert FSA or HRA balances into an HSA contribution upon enrolling in an HDHP (amount is capped at $2,650, 2X for family coverage)
    - Conversion occurring in same year as the FSA or HRA contribution counts against annual HSA limit
  - OTC medical products once again treated as qualified medical expenses
  - Amounts paid for qualified sports and fitness expenses excludable up to $500 (1,000 for joint filers) per year

HRAs under the ACA

- HRAs and FSAs must comply with the ACA's annual limit and preventive care requirements, unless they are ***integrated*** with a compliant group health plan (or are "excepted benefits" under HIPAA)
  - Most FSAs are excepted benefits
  - Most HRAs are not excepted benefits, unless they reimburse only dental or vision benefit or are offered only to retirees
  - These rules effectively prohibit employers from paying for individual market/Exchange plans
  - **Will the Trump administration rescind these HRA restrictions?**
    - Oct. 2017 Executive Order instructed DOL, HHS and IRS to consider expanding association health plans, short-term limited duration insurance, and HRAs
    - Proposed regulations for 2020 allow HRAs to be integrated with individual market/Exchange plans

HRAs under the ACA

- When is an HRA "*integrated*" with a GHP?
- **Method 1:** Minimum Value (MV) **Is** Required
- An HRA is integrated with another GHP if
  1. The employer offers a GHP that provides Minimum Value;
  2. The employee is enrolled in a GHP that provides MV (doesn't have to be sponsored by employer sponsoring the HRA);
  3. The HRA is available only to employees in a GHP; and
  4. The employee must be able to opt out of the HRA at least annually (and upon termination of employment)
- Employees must have the ability to opt-out because the HRA provides minimum essential coverage, which will preclude the individual from claiming a premium credit

HRAs under the ACA

- When is an HRA "*integrated*" with a GHP?
- **Method 2:** Minimum Value (MV) **Not** Required
- An HRA is integrated with another GHP if
  1. The employer offers a GHP (other than the HRA) to the employee that is not just "excepted benefits";
  2. The employee is enrolled in a GHP (doesn't have to be sponsored by employer sponsoring the HRA);
  3. The HRA is available only to employees in a GHP;
  4. The employee must be able to opt out of the HRA at least annually (and upon termination of employment); and
  5. The HRA only reimburses copays, co-ins., deductibles or premiums *under the GHP*, or *non-essential benefits*

HRAs & Individual Market Coverage

- IRS guidance provides that a group health plan, including an HRA, will not be considered “integrated” with an individual market policy for purposes of satisfying the ACA’s annual limit or preventive care rules
  - This means that employers will not be permitted to reimburse employees for the cost of individual insurance premiums on a non-taxable basis
  - **Note**: Exception for Qualified Small Employer HRAs

HRAs & Individual Market Coverage

- Employer Payment Plans
  - Employers may offer employees the choice of taxable compensation (cash) or an after tax payment to be applied to health coverage
  - IRS guidance also permits employers to establish a payroll practice of forwarding employee contributions to an insurance carrier without the arrangement being considered a group health plan; however, the arrangement generally must comply with the rules for “voluntary” plans under ERISA, with one such requirement being that the employees pay 100% of the cost of the coverage

Proposed Rule Expanding Premium Reimbursement HRAs

- Rule proposed to be effective 1/1/2020 would allow employers of all sizes to provide an HRA that is integrated with individual health insurance coverage
  - Employee and any dependents must be enrolled in individual health insurance coverage
  - Employers cannot offer choice between group health coverage and an integrated HRA
    - The following classes are permitted: (1) full-time, (2) part-time, (3) seasonal, (4) collectively bargained, (5) employees in a waiting period, (6) employees under age 25, (7) non-resident aliens, (8) employees whose primary site of employment is in the same rating area, and (9) certain combinations of the various classes
    - FT, PT and Seasonal can be defined under Section 105(h) or 4980H
  - HRA must be offered on the same terms (i.e., amount and conditions) to all participants within a certain class
    - There are exceptions for increased HRA contributions for older participants and those covering dependents; however, they must be offered to all similarly situated participants in a class
  - Employees must be able to opt-out of the HRA at least once per year
  - Procedures must be in place to verify individual health insurance coverage
  - HRA must provide written notices to each participant upon initial eligibility and at least 90 days before the beginning of each plan year

Proposed Rule Expanding Premium Reimbursement HRAs

- Premium reimbursement HRAs are minimum essential coverage (MEC)
- Employees may pay for the remainder of their individual market coverage pre-tax through a cafeteria plan
  - Individual market coverage is not necessarily a group health plan for ACA and ERISA purposes
- An HRA integrated with individual insurance coverage may be an eligible employer-sponsored plan for purposes of the ACA's employer mandate
  - IRS intends to issue guidance that provides a safe harbor for purposes of determining whether an employer that has offered an HRA integrated with individual health insurance coverage would be treated as having made an offer of affordable coverage that provides MV for purposes of the employer mandate

Proposed Rule for Excepted Benefits HRAs

- Rule proposed to be effective 1/1/2020 would treat certain types of HRAs as "excepted benefits" that are not subject to some ACA requirements
- Excepted benefits HRAs would not need to be "integrated" with a GHP
- This would allow employers offering traditional employer-sponsored coverage to offer an HRA of up to $1,800 per year (indexed annually for inflation) to reimburse an employee for certain qualified medical expenses, including premiums for:
  - Individual health coverage that consists solely of excepted benefits (such as stand-alone vision and dental plans, accident-only coverage, workers' compensation coverage or disability coverage);
  - Coverage under a group health plan that consists solely of excepted benefits;
  - Short-term, limited-duration insurance plans; and
  - COBRA coverage.
- An excepted benefit HRA cannot reimburse premiums for individual health coverage, coverage under a group health plan (other than COBRA or other group continuation coverage), or Medicare parts B or D.

Qualified Small Employer HRAs

- 21st Century Cures Act – allows establishment of QSEHRAs
- Enables small employers (non-Applicable Large Employers) to use an HRA to reimburse medical expenses and individual market health insurance premiums, up to a specified annual limit
- Limit for 2018 is $5,050 (individual) / $10,250 (family)
  - Must be prorated for partial years of coverage
  - Employer contribution generally must be the same for all eligible employees; however, certain variations are permitted based on age and number of covered family members

Qualified Small Employer HRAs

Conditions of offering a QSEHRA

- Employer cannot be an Applicable Large Employer (ALE)
- Employer cannot offer a group health plan to any employee
  - Cannot offer dental/vision coverage either
  - Employers may allow pre-tax HSA contributions for eligible employees (if the QSEHRA only reimburses premiums)
- QSEHRA must be funded solely by employer contributions
- Must be offered to all “eligible employees”
  - Generally, all full-time, non-union employees who have worked at least 90 days

Notice Requirements

- Employers must notify employees at least 90 days prior to the beginning of the plan year (or upon eligibility for employees who become eligible during the year)
- Notice must state:
  - The amount available under the HRA for the year;
  - That employees receiving federally subsidized coverage must disclose the HRA contribution to the Marketplace; and
  - That if the employee does not have MEC, an individual mandate penalty may apply and any reimbursement from the HRA may be included in gross income that month
- Notice failures may result in penalty of $50 per employee, not to exceed $2,500 per year

Federal Premium Subsidy Reduction

- Employees participating in a QSEHRA will have their monthly federal premium subsidy for Marketplace coverage reduced by 1/12th of the employer's annual QSEHRA contribution
  - For example, if an employee's subsidy is $250 per month and 1/12th of the employer's annual contribution is $200, the employee's subsidy will be reduced to $50 per month
  - In addition, if the QSEHRA provides "affordable" coverage, the employee's subsidy will be reduced to zero that month
    - A QSEHRA provides affordable coverage in any month where the difference between the cost of coverage under the second-lowest-cost silver plan in the Marketplace and the employer's HRA contribution does not exceed 9.5% (9.86%, as indexed for 2019) of the employee's household income

Effect on Other Laws

- QSEHRAs are not group health plans under ERISA and, with the exception of the Cadillac tax and PCORI, are not subject to the ACA's mandates, including Section 6055 reporting for self-insured plans
  - No plan document, SPD or Form 5500 requirement
  - QSEHRAs are also exempt from COBRA continuation requirements

Qualified Small Employer HRAs

- **Notice 2017-67 –** Includes guidance on the following topics:
  - Eligible employer and eligible employee
  - Same terms requirement
  - Statutory dollar limits
  - Written notice requirement
  - MEC requirement
  - Substantiation requirement
  - Reimbursement of medical expenses
  - Reporting requirement
  - Coordination with PTC
  - Failure to satisfy the requirements to be a QSEHRA
  - Interaction with HSA requirements

FSAs under the ACA

- Under the ACA, health FSAs must be “excepted benefits”
- FSAs will be “excepted” if the employer also offers non-excepted group health plan coverage and the FSA is structured so that the maximum benefit payable cannot exceed the **greater** of:
    a. 2x the participant’s salary reduction election to the FSA for the year; or
    b. $500 plus the participant’s salary reduction election
- If an employer provides a non-excepted FSA, it is subject to the market reforms, including the preventive services requirements
    – Because a non-excepted FSA is not integrated with a group health plan, it will fail to meet the preventive services requirements

FSA Carryovers

- Modification to the Use-It-Or-Lose-It Rule for FSAs
  - Can carryover up to $500 to following plan year
  - Plan cannot have both a grace period and a carryover feature
  - Employers may design FSAs to automatically carry over funds from a general purpose FSA to a limited purpose FSA for employees enrolling in HDHP coverage
- Employee contribution limit is $2,500 per year (as indexed, plus the $500 carryover)
  - 2018 indexed limit is $2,650 (plus carryover)
- What is more valuable—Grace Period or Rollover?

FSA Carryovers and COBRA

- Application of COBRA to FSAs with $500 Carryover Feature
- General rule: Employers that allow carryovers must also allow them for COBRA participants
  - This could extend COBRA past the end of the plan year
- **However**, an employer may limit the carryover to employees who elect to contribute to the FSA in the following year, in which case COBRA ends at the end of the plan year
- Employers may limit carryovers to a maximum period (e.g., one or more years)

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Questions?