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Medical and Dependent Care Flexible Spending Accounts

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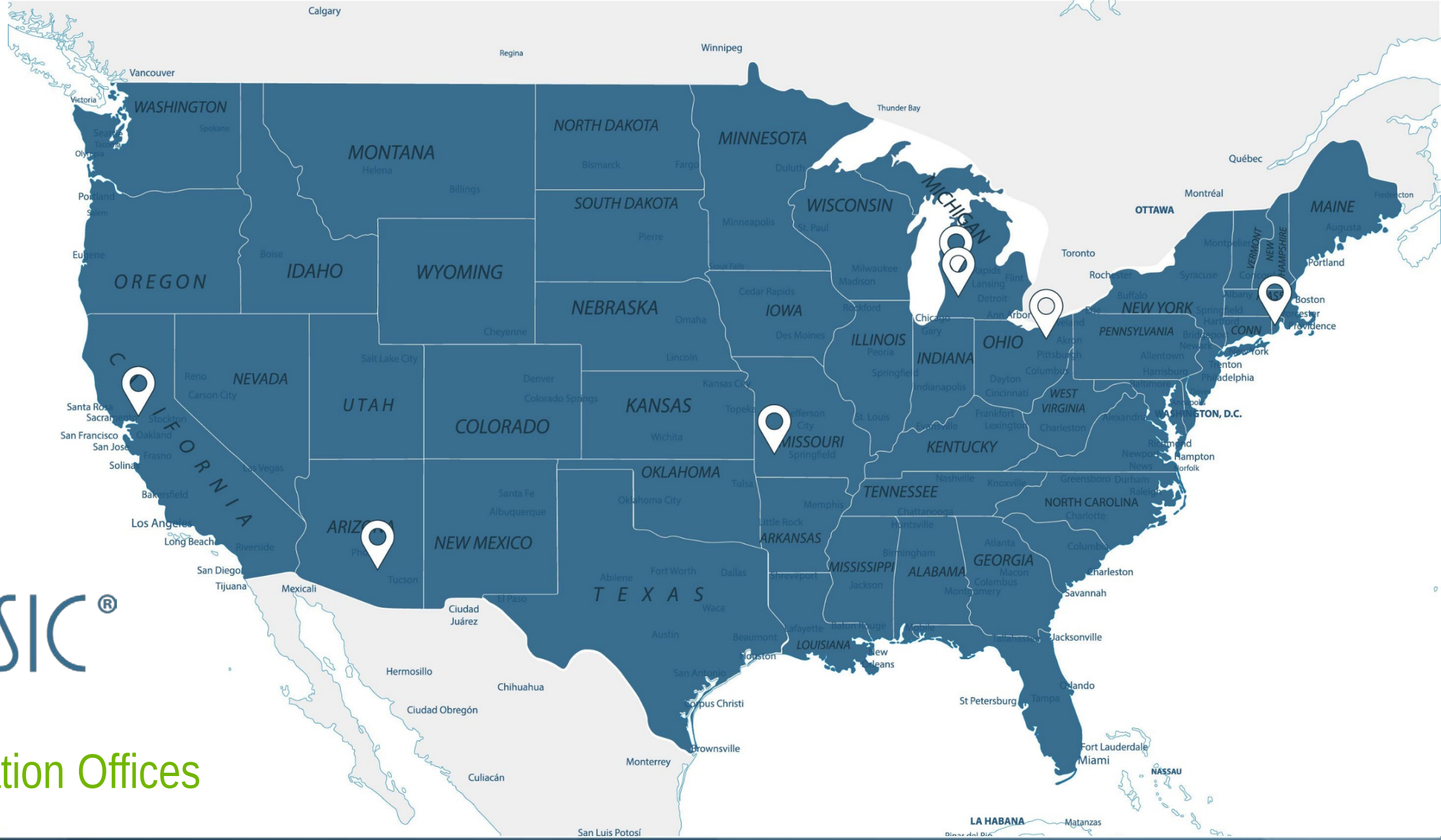

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Presenter

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Background

- A Flexible Spending Arrangement (“FSA”) is a self-funded benefit program that reimburses specified, incurred expenses, subject to reimbursement maximums (and any other reasonable conditions):
  - Medical FSAs are governed under §105 of the Code
  - Dependent Care FSAs are governed under §129 of the Code

Background

- FSAs may be funded with employee and, subject to some restrictions, employer contributions
- Employee contributions to FSAs must be made through a Section 125 cafeteria plan

Medical FSAs - Overview

- Medical FSAs are subject to the following laws:
  - ACA
  - Internal Revenue Code
  - ERISA
  - COBRA
  - HIPAA
    - Privacy, Security and Breach Notification rules (Administrative Simplification Rules), unless self-administered with less than 50 participants
    - Portability rules, unless an excepted benefit

Medical FSAs - ACA

- Prior to the ACA, a medical FSA was not required to be an excepted benefit
- Beginning in 2014, medical FSAs are required to be structured as excepted benefits to avoid the ACA market reforms

Medical FSAs - ACA

- Medical FSAs violate the ACA market reform that requires first-dollar coverage of preventive care services, unless
  - The medical FSA is “integrated” with another group health plan; or
  - The medical FSA is an excepted benefit

Medical FSAs - ACA

- Requirements to be “integrated” with another group health plan:
  - The employer sponsoring the medical FSA must offer a group health plan (other than the medical FSA) that does not consist solely of excepted benefits;
  - Employees participating in the medical FSA must actually be enrolled in another group health plan that does not consist solely of excepted benefits (regardless of who offers the other group health plan)

Medical FSAs - ACA

- The medical FSA must be available only to employees who actually enrolled in another group health plan (regardless of who offers the other group health plan); and
- Employees (and former employees) must be:
  - Annually offered the opportunity to permanently opt-out of and waive future reimbursements; and
  - Upon termination of employment, the medical FSA must be either forfeited or allow the employee to permanently opt-out of and waive future reimbursements

Medical FSAs - ACA

Requirements to be excepted benefits:

Availability Condition

- Other non-excepted group health plan coverage (e.g., major medical coverage) must be offered to any employee who is eligible for the medical FSA

Maximum Benefit Condition

- The maximum benefit available under a medical FSA cannot exceed two times the participant's salary reduction election (or, if greater, the amount of the participant's salary reduction plus $500)

Medical FSAs - ACA

- The ACA limits the amounts that employees may contribute to a medical FSA
  - Limit is $2,700 for 2019 (annually adjusted for inflation)
  - Limit applies on a plan year basis
  - Limit must be prorated for short plan years, but not for new employees hired mid-plan year
  - Limit applies on a per-employee basis
  - Limit doesn’t apply to medical FSAs maintained by unrelated employers

Medical FSAs – IRC

- Medical FSAs must be maintained using a written plan document
- Reimbursement requirements:
  - Only available for expenses incurred for medical care under § 213(d) of the Code
  - With respect to over-the-counter (“OTC”) drugs, reimbursement of OTC drugs require a prescription, unless the OTC drug is insulin

Medical FSAs – IRC

- Expenses must be incurred by the employee, spouse, employee's children who have not attained age 27 as of the end of the taxable year, or the employee's other "tax dependents"
- For any expense that is reimbursed from a medical FSA, the employee is not eligible for a deduction under § 213(d) of the Code on his or her personal income tax return (Form 1040)

Medical FSAs – IRC

- Expenses must be incurred after the employee was a participant in the health FSA and, with limited exceptions, within the health FSA's plan year
- Claims for reimbursement must be adequately substantiated:
  - Information from an independent third party describing the service or product, the date of the service or sale, and the amount of the expense
  - A statement from the participant providing that the medical expense has not been (and will not be) reimbursed under any other health plan coverage

Medical FSAs – IRC

- Prohibited reimbursements:
  - Insurance premiums;
  - Long-term care expenses; and
  - Expenses that are not properly substantiated

Medical FSAs – IRC

Uniform coverage rule

- The maximum reimbursement amount for a plan year (reduced for previous reimbursements for that plan year) must be available at all times under the medical FSA
- Example - Employee elects salary reductions under a medical FSA of $2,500 for the plan year; employee incurs a $2,000 medical expense on the first day of the plan year, employee is entitled to reimbursement of entire $2,000 expense, even if employee hasn't contributed $2,000 to medical FSA

Medical FSAs – IRC

Uniform coverage rule

- Prohibits employers from recouping experience losses upon an employee's termination of employment

- Example – Same facts as previous example, but the employee terminated employment on the second day of the plan year, employer cannot require the employee to repay any reimbursement in excess of the employee's contributions to the medical FSA (IRS Chief Counsel Advice 201012060)

Medical FSAs – IRC

- Nondiscrimination requirements under § 105(h):
  - A health FSA cannot discriminate in favor of highly compensated individuals as to eligibility to participate in the health FSA;
  - Benefits provided under the health FSA cannot discriminate in favor of highly compensated individuals
  - Generally, a “highly compensated individual” is any employee in the top 25% of employees, as ranked by pay

Medical FSAs – IRC

- Use-it-or-lose-it-rule:
  - Reimbursement cannot constitute deferred compensation. In other words, unused contributions remaining at the end of the year must be forfeited. Exceptions to forfeiture:
    - 2.5 month grace period
    - Carryovers up to $500

Medical FSAs - ERISA

- Must be maintained using a written plan document
- Summary plan description is required
- If the medical FSA has 100+ participants, a Form 5500 is required
- Subject to claims and appeals procedures,
  - If an excepted benefit, a medical FSA is not subject to the ACA's enhanced internal claims and appeals procedures and external review requirements

Medical FSAs - COBRA

- Medical FSAs are eligible for a special “limited” COBRA obligation:
  - COBRA need not be offered to qualified beneficiaries who have “overspent” their accounts as of the date of the qualifying event
  - For those qualified beneficiaries with underspent accounts, COBRA only needs to be offered through the end of the plan year (plus any grace period or carryover)

Medical FSAs - HIPAA

- Medical FSAs that are excepted benefits are exempt from HIPAA's portability requirements
- Medical FSAs are subject to HIPAA's administrative simplification rules (privacy, security, and breach notification rules), unless:
  - There are less than 50 participants in the medical FSA; and
  - The medical FSA is self-administered (no TPA)

Dependent Care FSAs - Overview

Dependent Care FSAs are subject to the following laws:

- Internal Revenue Code
- State unclaimed property and escheat laws

Dependent Care FSAs are not subject to:

- ERISA*
- COBRA
- HIPAA
- ACA

Dependent Care FSAs - Overview

- ERISA – Only in rare events will a Dependent Care FSA be subject to ERISA:
  - Participants are required to use a specific dependent care provider (i.e., it may qualify as an employer-sponsored day care center)
  - Reimbursements are provided for benefits listed in ERISA (e.g., for the purpose of assisting persons who are disabled)

Dependent Care FSAs - IRC

- Dependent Care FSAs must be maintained using a written plan document
- Income exclusion limited (on a calendar year basis) to the smallest of the following:
  - $5,000 if the participant is married and filing a joint return, or if the participant is filing single ($2,500 if the participant is married filing separate)
  - The employee's "earned income" for the year; or
  - If the employee is married at the end of the year, the spouse's earned income

Dependent Care FSAs - IRC

- Reimbursement requirements:
  - Dependent care expenses must be for qualifying expenses:
    - Incurred for the care of qualifying dependents (i.e., the primary purpose is to ensure the individual's well-being and protection)
    - Qualifying dependents are:
      - A dependent child who has not attained the age of 13; or
      - A spouse or other dependent who is physically or mentally incapable of caring for himself/herself and who has the same principal residence as the participant for more than half the year

Dependent Care FSAs - IRC

- Employee and spouse, if any, must be “gainfully employed”:
  - Employee must be working
  - Spouse, if any, must be working, looking for work, or a full-time student
- Incurred during the plan year in which the employee was a participant, unless the Dependent Care FSA includes a “spend-down” feature

Dependent Care FSAs - IRC

- Reimbursement requirements:
  - Adequately substantiated:
    - Information from an independent third party describing the service, date, and amount; and
    - A statement from the participant that the expense has not been reimbursed and the participant will not seek reimbursement from any other coverage
  - Claim must be submitted by deadline and run-out period, if any

Dependent Care FSAs - IRC

- Use-it-or-lose-it rule – reimbursements cannot constitute deferred compensation. In other words, unused contributions remaining at the end of the plan year must be forfeited.
  Exception:
  - 2.5 month grace period;
  - No carryover

Dependent Care FSAs - IRC

- No Uniform Coverage Requirement – Participants can only be reimbursed to the extent that they have sufficient funds in their Dependent Care FSA

Dependent Care FSAs - IRC

- Nondiscrimination requirements:
  - Cannot discriminate in favor of highly compensated employees (or dependents) with regard to eligibility
  - Cannot discriminate in favor of highly compensated employees (or dependents) with regard to contributions and benefits
  - A “highly compensated employee” is generally any employee with more than $120,000 in compensation in the previous plan year

Dependent Care FSAs - IRC

- No more than 25% of the amounts paid or incurred under the Dependent Care FSA during a plan year may be provided to shareholders or owners (only shareholders or owners of a C corporation are eligible to participate under Section 125 of the Code)
- The average Dependent Care benefits provided to non-highly compensated employees must be at least 55% of the average benefits provided to highly compensated employees

Dependent Care FSAs - IRC

- Reporting requirements –
  - Employers must report the total amount incurred for dependent care assistance in Box 10 of the employee's Form W-2;
  - Employees must file Form 2441 with their annual Form 1040

Dependent Care FSA v. Tax Credit

- A taxpayer may be able to claim the Dependent Care Tax Credit if the taxpayer pays someone to care for a “qualifying individual”
- The Dependent Care Tax Credit is a percentage (35% - 20%) of dependent care expenses up to a maximum:
  - $3,000 for one qualifying individual; and
  - $6,000 for two or more qualifying individuals
- Percentage is inversely related to AGI

Dependent Care FSA v. Tax Credit

- No double-dipping – a taxpayer's dependent care expenses when calculating the Dependent Care Tax Credit are reduced by the amount of any reimbursements from a Dependent Care FSA
- Employers should advise employees that:
  - No double-dipping is allowed
  - In some cases the Dependent Care Tax Credit may be more advantageous than a Dependent Care FSA
  - Consult their tax advisors

Improper Reimbursements

- Correcting improper mistakes found before the end of the plan year (steps 1 – 3 can be taken in any order, if done uniformly):
  - *Step 1:* Seek repayment from the participant
  - *Step 2:* Withhold repayment from a participant's pay (consider any state wage withholding law restrictions, especially for Dependent Care FSAs)
  - *Step 3:* Offset the repayment against future valid claims
  - *Step 4:* Treat as business indebtedness and as taxable compensation to employee in same year

Withholding Errors

- General principal – put the plan and the participant in the same position as if the mistake had not occurred:
  - If too much compensation has been withheld, the amount withheld in error should be repaid to the participant as regular taxable compensation
  - If too little has been withheld, the employer should:
    - Seek repayment from the participant
    - As a last resort, include the amount as taxable income to the participant

Withholding Errors – Too Much

- Discovered before the end of the calendar year:
  - Refund the excess to the participant as regular taxable compensation
  - No Form W-2 adjustment necessary
  - May require Form 941 adjustment (Forms 941 are filed on a quarterly basis)

Withholding Errors – Too Much

- Discovered after the end of the calendar year:
  - Refund the excess to the participant as regular taxable compensation
  - Forms 941 and W-2 adjustment:
    - Cautious approach is yes (however only FICA can be adjusted for a prior year, not federal income tax withholding)
    - Some employers forgo Forms 941 and W-2 adjustments

Withholding Errors – Too Little

- Discovered before the end of the calendar year:
  - Seek repayment:
    - Additional pre-tax withholding
    - Participant writes check to the employer (this should only be used when withholding is not available as it cannot be done pre-tax)
  - If repayment efforts are unsuccessful, leave things as they are
    - No Form W-2 adjustment is necessary
    - No Form 941 adjustment is necessary

Withholding Errors – Too Little

- Discovered after the end of the calendar year:
  - Seek repayment:
    - Additional pre-tax withholding
      - Forms W-2 and 941 will be off for both years, but the IRS has informally commented that this is okay
    - Participant writes check to the employer (this should only be used when withholding is not available as it cannot be done pre-tax)
      - Form W-2 and 941 will be off for the year of the error, but proof of subsequent payment should be sufficient evidence of error and correction
  - If repayment is unsuccessful, leave things as they are

QUESTIONS

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