Employee Health & Benefits

COMPLIANCE CENTER OF EXCELLENCE

Volume 7

2019 COMPLIANCE NEWSLETTER

IN THIS EDITION:

All That Glitters is not Gold

A Cautionary Tale about Certain Claimed Tax Savings Arrangements Disguised as Wellness Programs

Promoters have long pitched some variation of the following wellness program to employers:

- Employees pay pre-tax contributions to participate in a self-insured group health plan;
- During the course of the plan year, the plan returns most or all of the employee contributions to the employees for the completion of wellness-related activities[1]; and
- The reimbursements are tax free to the participants.

This proposal obviously sounds amazing to prospective employers due to the potential payroll tax savings to the employer and the payroll and income tax savings to employees. Many promoters will even provide some sort of memorandum from the promoter's legal counsel and/or other written articles supporting the arrangement's compliance with applicable laws, such as the Internal Revenue Code (IRC).

As the old saying goes, "If it sounds too good to be true, it usually is."

Buyer Beware

At least three of these types of arrangements have been either rejected outright or limited by the IRS for impermissible tax avoidance.

[1] *The difference, if any, tends to be used to compensate the promoter unless the promoter is paid through other means.*

1. The Double Dip

This arrangement is the oldest of the three and generally works as described above. Participants typically receive large reimbursements greatly exceeding any actual out-of-pocket medical expense and/or for completing pretty nominal wellness-related activities. These may include watching a webinar, attending a presentation providing general health information, or attending general health counseling sessions. It may also include participating in more robust wellness activities such as biometric screening.

The IRS has explicitly stated on several occasions that programs whose primary purpose is to refund pre-tax contributions as tax free reimbursements do not qualify for an income tax exclusion for the employee under IRC Sections 105 or 106 when the reimbursements are disproportionately larger than any actual out-of-pocket medical expense (please see Revenue Ruling 2002-3). Despite this clear position, the Double Dip continues to pop up. The U.S. Department of Justice recently convicted the promoters of a Double Dip known as the Classic 105.

2. The Sleight of Hand

Under the Sleight of Hand arrangement, employees pay a small contribution toward the self-insured group health plan on an after-tax basis. The arrangement may or may not also involve the employees paying significantly larger pre-tax contributions toward coverage. Similar to the Double Dip, participants typically receive large reimbursements greatly exceeding any actual out-of-pocket medical expense and/or for completing wellness-related activities.

The Sleight of Hand is an attempt to move the tax exclusion away from IRC Sections 105 and 106 to IRC Section 104(a)(3) and avoid the IRS' unfavorable Double Dip guidance on disproportionately large reimbursements. Under IRC Section 104(a)(3), benefits are not taxable to the recipient if the health insurance coverage (or an arrangement that operates like health insurance) is not paid for on a tax free basis.

In IRS Chief Counsel Memorandum 201719025 (released May 12, 2017), the IRS indicated that IRC Section 104(a)(3) does not apply to these arrangements, because the plan cannot qualify as health insurance (or an arrangement that operates like health insurance). This is because there is no actual insurance risk for the participants, all or nearly all of whom are virtually guaranteed to receive benefits far in excess of their after-tax contributions. In addition, the IRS believes this demonstrates a significant portion of the coverage is really being provided on a tax free basis. As a result, the excess of the benefits received over the amount of any after-tax contribution should be treated as taxable income to the employee.

3. The Flex Credit Switch

This arrangement is similar to the Double Dip or Sleight of Hand, but with a twist. Under the Flex Credit Switch, some or all of the benefits received from the self-insured group health plan are provided as flex credits that can be used to purchase other benefits on a pre-tax basis through the client's IRC Section 125 cafeteria plan instead of being provided as direct reimbursements.

If the flex credits are used to purchase non-taxable benefits under the cafeteria plan, the flex credits are excluded from the employee's taxable income. A "non-taxable benefit" is a benefit that can both be paid for on a pre-tax basis ***and*** provide tax free benefits to participants. In other words, the Flex Credit Switch works when the flex credits are used for non-taxable benefits. This makes sense, because the entire exercise amounts to the employee deferring otherwise taxable income to make pre-tax cafeteria plan elections. But…there's a catch.

Under many Flex Credit Switch arrangements, the benefits that can be purchased with the flex credits are actually taxable benefits. This means the benefits ***cannot*** both be paid for on a pre-tax basis and provide tax free benefits. When this is the case, the flex credits are included in the employee's taxable income (please see IRS Chief Counsel Memorandum 201719025, Situation #2).

Examples of problematic taxable benefits include:

- Most accident and disability benefit products;
- Whole and variable life insurance products;
- Supplemental term life insurance products in excess of $50,000;[2]
- Most fixed indemnity products;[3] and
- Gym memberships.[4]

ERISA Note

We believe permitting employees to pay pre-tax for many fixed indemnity products will also cause them to be considered ERISA plans sponsored by the employer if this wasn't already the case.

Our Recommendation

We strongly recommend against relying on an opinion letter, memorandum, or articles provided by a promoter selling the claimed tax saving arrangement. We strongly recommend reviewing any claimed tax savings arrangement with your own legal counsel and/or tax advisor before signing up and offering the program to your employees.

ABOUT THE AUTHOR

Christopher Beinecke is the Employee Health & Benefits National Compliance Leader for Marsh & McLennan Agency.

[2] The IRC and related rules only permit the first $50,000 of coverage to be paid for on a tax free basis.
[3] Most indemnity products can provide benefits in excess of unreimbursed medical expenses and are considered at least partially taxable benefits.
[4] We addressed the tax consequences for employer-provided gym memberships in an earlier article.

The Affordable Care Act's Employer Mandate: Part 3

Offers of Coverage and Avoiding Penalties

This article is Part 3 in a series intended to provide an overview of the Employer Shared Responsibility provisions (also known as the "employer mandate") under the Affordable Care Act (ACA). The employer mandate generally requires applicable large employers (ALEs) offer affordable, minimum value medical coverage to its full-time employees in order to avoid potential employer mandate penalties. These employer mandate penalties are better known as "employer shared responsibility payments" or ESRPs.

We covered how to determine whether an employer is and ALE in Part 1, and how to determine ACA full-time employees (FTEs) in Part 2. This article addresses the ESRPs and how to avoid them through offers of coverage to FTEs.

Remember Why We Care

The employer mandate has two potential penalties, each indexed annually and assessed monthly on a pro-rated basis.

Plan year beginning on or after	Section 4980H(a) Annual Penalty	Section 4980H(b) Annual Penalty
January 1, 2019	$2,500	$3,750
January 1, 2020	$2,580 (projected)	$3,870 (projected)

The Section 4980H(a) penalty (the "no offer" penalty) is triggered when an ALE fails to offer minimum essential coverage to at least 95% of its FTEs, and at least one FTE qualifies for a subsidy in the public health insurance exchange.

The Section 4980H(b) penalty (the "inadequate offer" penalty) is triggered when an ALE offers minimum essential coverage to at least 95% of its FTEs but fails to offer affordable, minimum value coverage to an FTE who qualifies for a subsidy in the public health insurance exchange.

Aggregated ALE Groups

ALE status is also determined in the aggregate for certain groups of related legal entities identified under the Internal Revenue Code, and each member employer of an aggregated ALE group is known as an "applicable large employer member" or ALEM. An ESRP triggered by one ALEM does not affect the other ALEMs within the aggregated ALE group. In other words, if one ALEM triggers a penalty it does not "poison the well" for the others.

Avoiding the No Offer Penalty

Coverage is shorthand for "minimum essential coverage" or MEC. In general, MEC is any employer-sponsored medical plan, including the new individual coverage HRA (ICHRA).[5]

In order to avoid ESRPs, an offer of MEC must be made to FTEs at least annually. Active or passive enrollment can be used provided the FTEs have an effective opportunity to elect or decline coverage.[6] An ALE does not have to provide FTEs with the ability to decline coverage if the coverage provides minimum value and employee-only coverage is either 100% employer paid or the employee's required contribution toward employee-only coverage meets the federal poverty level affordability safe harbor (addressed under *Federal Poverty Level Safe Harbor* later in this article).

The Offer Must be Made for the Entire Month to Most FTEs

An ALE only receives credit for offering coverage to an FTE for a given month if the offer of coverage includes every day of the month. For example, if coverage begins on the date of hire, FTEs who are hired on any day after the 1st of the month do not count as having received an offer for that month. This is relevant when determining if the ALE offered coverage to at least 95% of its FTEs for that particular month.

> **Note:** If an FTE is hired after the first of the month and is offered coverage effective as of the date of hire or is in a permitted waiting period before coverage is effective, the ALE may exclude the FTE from the 95% calculation for the applicable month or months. On the FTE's corresponding IRS Form 1095-C for that year, the ALE would reflect Code 2D (limited non-assessment period) in Part II, Line #16. This would avoid a potential ESRP.
>
> Similarly, an ALE may exclude an FTE who loses coverage mid-month from the 95% calculation. The Form 1094-C/1095-C instructions indicate an ALE should reflect Code 2B (not full-time) in Part II, Line #16 in this situation. This would also avoid a potential ESRP.

Believe it or not, an ALE does not receive credit for making an offer of coverage to an FTE unless the FTE can also enroll his or her natural and adopted children up to age 26, if any. In other words, an ALE that limits its offers of coverage to employee-only coverage cannot meet the 95% offer standard. This special rule does not include spouses, stepchildren, or foster children.

> **Reminder:** Within an aggregated ALE group, the 95% standard and any applicable ESRP penalties are determined on an ALEM-by-ALEM basis.

[5] MEC does not include HIPAA-excepted benefits, such as dental and/or vision only coverage, spending accounts (FSAs, HRAs) limited to dental and/or vision only coverage, and many types of fixed indemnity and supplemental coverage.
[6] Whatever election approach is used, we recommend employers maintain some sort of record in order to be able to demonstrate that the offer was made.

The Offer May be Made by Another Employer

1. *Aggregated ALE Groups*. If one ALEM makes an offer of coverage to an employee, that offer of coverage is considered to be made by every ALEM in the aggregated ALE group. If an individual is employed by two or more ALEMs, only one ALEM needs to offer coverage for all of the ALEMs to receive credit.

2. *Professional Employer Organizations and Staffing Firms*. Employers often use professional employer organizations (PEOs) and staffing agencies to outsource staffing, human resources, and payroll duties. The IRS allows the client-employer to take credit for an offer of coverage made to the worker by the PEO/staffing agency so long as the client-employer pays a higher fee in exchange for the PEO/staffing firm assuming the responsibility to provide health insurance. We recommend this be reflected as a line-item in the amount billed by the PEO/staffing agency and paid by the client-employer.

3. *MEWAs*. Multiple employer welfare arrangements (MEWAs) are formed when two or more unrelated employers join together to sponsor a health plan. Similar to the ALEMs above, an offer of coverage made to an employee by a MEWA will count as an offer of coverage made by the employer participating in the MEWA.

Calculating the No Offer Penalty

An ALE that fails to make an offer of coverage to 95% of its FTEs is vulnerable to the no offer penalty, which is triggered if a ***single*** FTE qualifies for subsidized coverage in the public health insurance exchange.

This no offer penalty amount is calculated by multiplying the applicable penalty amount by ***all of the ALE's FTEs***, but the ALE gets to subtract 30 FTEs from this total ("free FTEs"). This 30 free FTEs exclusion applies at the aggregated ALE group level, and each ALEM is assigned a share based on its proportion of all FTEs in the aggregated ALE group.

Example 1

This example uses the projected 2020 no offer penalty. Pro-rated monthly, the penalty is $215/month ($2,580 / 12).

WiseCorp has 65 total employees, 50 of whom are FTEs for the year. WiseCorp fails to offer MEC to at least 95% of its FTEs (48 FTEs). Bob, an FTE, enrolls in coverage in the public health insurance exchange and receives a subsidy for 8 months during 2020.

WiseCorp's no offer penalty is calculated as follows:

$215 x (50 FTEs – 30 "free FTEs") = $4,300/month
$4,300 x 8 months = $34,400

Example 2

The same facts as in Example 1, except that WiseCorp is an ALEM in an aggregated ALE group with 300 total FTEs.

WiseCorp may exclude 5 free FTEs from its no offer penalty calculation.

50 WiseCorp FTEs / 300 total FTEs = 16.67%
30 free FTEs x 16.67% = 5 free FTEs

WiseCorp's no offer penalty is calculated as follows:

$215 x (50 FTEs – 5 "free FTEs") = $9,675/month
$9,675 x 8 months = $77,400

Avoiding the Inadequate Offer Penalty

Just because an ALE makes an offer of coverage does not mean it has avoided all potential ESRPs. Even if an ALE offers MEC to at least 95% of its FTEs, an FTE can still trigger an inadequate offer penalty if the IRS finds that the offer of coverage does not provide minimum value AND/OR is unaffordable.

Minimum Value

Coverage is considered to provide minimum value (MV) if the plan covers at least 60% of the total allowed cost of covered services that are expected to be incurred by a standard population. The plan must also include coverage for hospital and physician services.[7] MV can be determined by an actuarial valuation or by using an MV calculator jointly developed by the IRS and Department of Health and Human Services.

Affordability

A plan is deemed affordable if the employee's portion of the premium does not exceed an annually indexed amount of their household income.

Plan year beginning on or after	Section 4980H(b) Annual Penalty	Employer Affordability Safe Harbor
January 1, 2019	$3,750	9.86 %
January 1, 2020	$3,870 (projected)	9.78 %

Remember, the penalties are actually pro-rated monthly.

Note: If wellness incentives can affect the employee's contribution toward the cost of coverage, employees must be treated as satisfying any tobacco-related incentive and failing all other incentives no matter what the employee actually does.

[7] *This prevents many benefits from meeting the MV standard including "skinny" MEC plans, telemedicine, and onsite/offsite clinics.*

Since it's generally impossible for an employer to know an employee's household income, the IRS created three affordability safe harbors. Each safe harbor is based on the employee's required contribution toward the cost of employee-only coverage for the lowest cost, MV plan the employee could have elected for that plan year. It doesn't matter if the employee waived coverage, elected a more expensive plan option, or enrolled a spouse or dependent(s).

1. *Form W-2 Safe Harbor*. Under the Form W-2 safe harbor, coverage is deemed affordable if the employee's share does not exceed 9.86% (9.78% in 2020) of wages reported in Box 1 of the employee's W-2. Box 1 does not include pre-tax payroll deductions, such as 401(k) contributions and many other benefit elections. Employers can reasonably estimate employee W-2 earnings when pricing coverage, but affordability may not be certain until the end of the year. This safe harbor method cannot be combined with another safe harbor method during the same calendar reporting year. This might affect some employers with non-calendar year plans whose premiums change during the calendar year.

2. *Rate of Pay Safe Harbor*. The rate of pay safe harbor is a formula that operates differently for salaried and hourly employees:

   a. For salaried employees, coverage is deemed affordable if it does not exceed 9.86% (9.78% in 2020) of the employee's gross monthly salary as of the first day of the plan year.[8]

   b. For hourly employees, coverage is deemed affordable if it does not exceed 9.86% (9.78% in 2020) of 130 paid hours multiplied by the ***lower*** of the employee's rate of pay as of the first day of the plan year or the employee's rate of pay at the beginning of a given month.

   This safe harbor does not exclude pre-tax benefit deductions, but it misses bonuses, commissions, and tips.

3. *Federal Poverty Level Safe Harbor*. Under the Federal Poverty Level (FPL) safe harbor, coverage will be deemed affordable if the employee's share of the premium does not exceed 9.86% (9.78% in 2020) of the mainland FPL for a single individual. For 2019, the FPL safe harbor is $102.62 (($12,490 / 12) x 9.86%). This safe harbor ignores an employee's actual compensation.

Calculating the Inadequate Offer Penalty

The inadequate offer penalty is triggered if the coverage offered doesn't provide minimum value and/or was unaffordable, and an FTE qualifies for a subsidy in the public health insurance marketplace. The employer would be assessed an inadequate offer penalty for each FTE who receives a subsidy. For 2020, the maximum [projected] annual inadequate offer penalty is $3,870 per FTE. This penalty is pro-rated monthly.

Intentional Strategy

The inadequate offer penalty only applies to FTEs who waive coverage and actually receive a subsidy in the public health insurance exchange. For 2020, this penalty is approximately $322.50 per FTE per month, which may be less than the employer's cost to offer affordable, minimum value coverage (and absorb additional claims experience). As a result, some employers might make a business decision to willingly accept potential inadequate offer penalties.

[8] *The rate of pay safe harbor cannot be used for an employee whose salary decreased during the year.*

Example 3

This example uses the projected 2020 no offer penalty. Pro-rated monthly, the penalty is $322.50/month ($3,870 / 12).

TFL Inc. is an ALE and offers a “skinny plan” that does not meet MV to its FTEs. Sally enrolls in coverage in the public health insurance exchange and receives a subsidy for 8 months of the calendar year.

TFL’s inadequate offer penalty is calculated as follows:

$322.50 x 8 months = $2,580

ABOUT THE AUTHOR

Allie Waits is a Compliance Consultant for Marsh & McLennan Agency’s Upper Midwest Region.

Medical Loss Ratio Rebates

Show Me the Money

The Affordable Care Act’s (ACA) Medical Loss Ratio (MLR) standards require health insurance carriers to spend a specific percent of premium on health care services and activities that could improve quality of care. [9] If the carrier does not meet the MLR standards, it must provide rebates to the policyholders – the employer in the group market and the individuals in the individual market. Each year, insurance carriers calculates their MLR across the particular market segments’ books of business and issues rebates to policyholders if the money spent on health care and quality care activities is less than the required MLR standards.

When an employer receives a rebate, it has 90 days to determine what portion of the rebate is allocable to plan participants and distribute the rebate to participants or use the rebate for their benefit.

[9] *These are 85% in the large group market and 80% in the small group market.*

Who Gets the Money?

Step 1

Determine if any portion of the rebate is a "plan asset." Plan assets belong to the participants and may not be kept by the sponsoring employer or used to pay its expenses. The relevant plan documents should indicate the source of the premiums paid to the insurance carrier and might describe the ownership interest in rebates or refunds of premiums received by the plan.

In many instances, the plan documents will not resolve ownership interests, and the employer will need to rely on the sources and relative ratios of paid premiums in order to determine what portion of the rebate is a plan asset.

Step 2

If the plan documents do not resolve ownership interests, determine what portion of the rebate is a plan asset.

How Premiums are Paid	Plan Asset	Who Receives the Rebate
100% from the plan's trust assets	Yes	100% belongs to the trust as a plan asset and must be used for the benefit of participants
100% by participants	Yes	100% belongs to the participants
100% by employer	No	100% belongs to the employer and may be used for any purpose
Employer and participants each pay a fixed % of the premium (Example: Employer pays 70% and participants pay 30%)	Yes, partially	A % of the rebate belongs to the participants equal to the % of the total premium paid by the participants[10] The remainder of the rebate belongs to the employer and may be used for any purpose
Participants pay a fixed dollar amount and the employer pays the balance	Possibly	The portion of the rebate that exceeds the employer's contributions is plan assets The remainder of the rebate belongs to the employer and may be used for any purpose

Step 3

Determine how to use the portion of the rebate allocated to plan participants.

[10] *If the fixed percentage of premiums paid vary by tier of coverage, an employer could choose to use a single average percentage rate for all tiers or determine a weighted average percentage rate for each tier.*

Rebate Considerations

1. ***Plan Participants***. For the MLR rebate, the employer may determine it is reasonable to use the rebate for current plan year participants and not the exact participants from the plan year for which the rebate applies. This includes current COBRA participants. Factors used to make this determination can include the cost and administrative difficulty of locating former employees and/or whether a large number of the same individuals are participants in both plan years.

   The available guidance prefers the rebate be used for participants in the same insurance policy (or policies) that generated the rebate, but it should be reasonable to share the rebate with participants in the employer's other medical coverage depending upon the facts and circumstances.[11] For example, if the plan option that generated the rebate has been replaced, it should be reasonable to use the rebate for participants in the plan option(s) that replaced it.

2. ***Preferred Rebate Methods***. The most common approaches are to pay the rebate in cash, use it to reduce future premiums in the current year (a full or partial "premium holiday"), or apply it to enhance benefits. Enhanced benefits might include HSA contributions or additional wellness benefits. For small rebates or small remainders of larger rebates, an employer could use the rebate to pay for flu shots or educational presentations.

   > **Note:** We do not support the use of rebates to fund opportunities for a relatively few number of participants to win prizes such as through a raffle. This is contrary to the policy that employers should provide a reasonable, fair, and objective rebate allocation method that benefits the entire class of participants.

3. ***Tax Consequences***. If the participant premiums were paid pre-tax through an Internal Revenue Code Section 125 cafeteria plan, a rebate paid as cash or as a cash equivalent will be treated as taxable income. This will also be the case when provided as a premium holiday as the employee's taxable take-home pay will increase.

4. ***Timing.*** The employer must distribute or use the participant's portion of the rebate within ninety (90) days of receipt.

---

[11] In theory, this could extend to all participants in benefits incorporated under the same ERISA plan number, but we generally recommend against this.

ABOUT THE AUTHORS

Allie Waits is a Compliance Consultant for Marsh & McLennan Agency's Upper Midwest Region.

Jennifer Stanley is a Compliance Consultant in the Employee Health & Benefits Compliance Center of Excellence for Marsh & McLennan

California Mandates a Notice Requirement for Flexible Spending Accounts

But California gets an incomplete

California recently enacted AB 1554, which requires employers sponsoring flexible spending accounts to notify employees of "any deadline to withdraw funds ***before*** the end of the plan year." [Emphasis added].

The law does not define the term "flexible spending account," but it does indicate this term is intended to include dependent care flexible spending accounts ("DCFSAs"), health care flexible spending accounts ("HCFSAs"), and adoption assistance flexible spending accounts. We'll refer to these collectively as FSAs in this article. It is not immediately clear what other benefits, if any, might be considered FSAs subject to this law.[12] As written, it does not appear this includes pre-tax transportation benefit plans.

The Bottom Line

We'll address the rules in more depth later in this article, but the main takeaways are:

1. Employers offering FSAs to employees working in California will be required to provide two forms of notification regarding forfeiture deadlines for unused funds.
2. California will need to clarify certain items not addressed in the law.
3. The notification requirements appear limited to mid-plan year forfeitures.
4. Most HCFSAs should be exempt from the notification requirement due to ERISA preemption.

[12] A health reimbursement arrangement (HRA) could theoretically qualify as an HCFSA, but most cannot due to an unrestricted carryover feature for unused funds. We will not discuss HRAs further in this article.

The basics

Participants forfeit unused FSA funds at the end of the plan year. This is commonly referred to as the "use it or lose it" rule, and it is delayed and/or affected only by the FSA's use of a run-out period, grace period, or a carryover (in the case of an HCFSA).

California's new law requires employers to notify employees of an FSA forfeiture deadline, presumably to help the employees avoid forfeitures. **Employers must communicate this notice in at least two different forms**. The following is a non-exhaustive list of permitted forms of this notice:

- Email,
- Telephone,
- Text message,
- Postal mail, and
- In-person notification.[13]

An employer can only satisfy one of the two forms of notification electronically, meaning the second form of notice must be verbal or printed. An FSA's summary plan description (or comparable document) should describe the FSA's forfeiture rules. Delivery through a web portal, email, or in printed form will satisfy one of the required forms of notification. While a variety of forms of alternative notices could be used to satisfy the second form of notification, we suspect FSA vendors will develop template notices that can be used for this purpose and will likely assist employers with delivery.

[13] *Hand delivery of a printed document should qualify as in-person notification.*

Missing pieces…

AB 1554 is only three sentences long and leaves several unanswered questions.

1. Timing requirement?

Although the law is effective beginning January 1, 2020, it does not include any specific timing requirement for notice delivery. As written, an employer could comply with the letter of the law by frontloading two forms of notification at the beginning of a plan year. The spirit of the law seems to be designed to provide a warning about an impending forfeiture. We believe later guidance will require one of the notifications to be closer in time to the forfeiture deadline.

2. Two forms of notice?

The law specifies two forms of notice are required, but does this mean an employer can satisfy the law by delivering the same notice in two different ways? We believe later guidance will clarify that two separate types of notice are required.

3. Consequences for non-compliance?

The law doesn't indicate what happens if an employer fails to comply. Is the employer subject to a fine? Do affected employees receive more time to submit claims before forfeiture occurs? This must be addressed in later guidance.

Appears limited to mid-plan year forfeitures

Again, the law requires employers sponsoring flexible spending accounts to notify employees of "any deadline to withdraw funds ***before*** the end of the plan year." [Emphasis added]. This appears intended to require employers to notify employees who may be subject to mid-plan year forfeitures of unused FSA funds.

Although technical, participants are not required to withdraw funds ***before*** the end of the plan year to avoid normal plan year end FSA forfeitures. Forfeiture could be avoided by withdrawing funds ***by*** or ***as of*** the end of the plan year. This may simply be a case of

imprecise language, and California could certainly clarify one way or the other. In any event, this will usually be moot. The overwhelming majority of FSAs provide for run-out and/or grace periods that delay forfeiture until after the end of the plan year. As a result, California's notice requirement wouldn't apply to most plan year end FSA forfeitures anyway.[14]

Some FSAs do not accelerate forfeitures for mid-plan year losses of eligibility and should also avoid the notice requirements.[15] By contrast, mid-plan year losses of FSA eligibility usually can result in a need to use funds before the end of the plan year to avoid forfeitures. This appears to be the real target of California's law. For example, an FSA might require a former employee to submit already incurred claims within 60 days of the loss of employment before the funds are forfeited.

It's not clear how the notice requirement might apply to a short plan year as a result of a plan amendment or termination.

ERISA preemption

Most HCFSAs are self-insured ERISA plans, and ERISA preemption should apply to California's notice requirement. It is a slam dunk that ERISA will preempt the law from any modification of the HCFSA's forfeiture rules. California does not always automatically recognize ERISA preemption, and it may take a successful challenge before California backs off. An employer can always voluntarily comply with the notice requirements, and a conservative employer will want to comply until someone [else] is successful with an ERISA preemption challenge.

ERISA preemption is not available for the HCFSAs of governmental entities or church plans, DCFSAs, or adoption assistance flexible spending accounts. Employers should be ready to comply with the notice requirements for these FSAs by January 1, 2020.

ABOUT THE AUTHOR

Christopher Beinecke is the Employee Health & Benefits National Compliance Leader for Marsh & McLennan Agency.

14 Various FSA rules generally require some sort of notification to participants about the plan and its operations, so this just means the employer likely doesn't have to provide a second form of notice.
15 This should include DCFSAs with a permitted spend down feature for terminated participants.