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IRS RELEASES FINAL VERSIONS OF 2018 INSTRUCTIONS AND FORMS 1094/1095 B & C

The Internal Revenue Service (IRS) released final versions of the 2018 Form 1094-C, 1095-C, 1094-B, and 1095-B, along with Final Instructions (Instructions). As a reminder, Form 1094-B and Form 1095-B are used to report certain information about individuals covered by minimum essential coverage (MEC), and Form 1094-C and Form 1095-C are used to report employer offers of coverage to employees.

2019 Due Dates for 2018 Forms 1094/1095 B & C

For 2019, entities should be prepared to file these Forms by the standard filing deadlines. These deadlines are as follows:

- January 31, 2019: Deadline to furnish to an employee their 2018 Form 1095-C (Applicable Large Employers) and Form 1095-B (insurance providers)
- February 28, 2019: Deadline to file Forms 1094/1095 B & C, if filing on paper
- April 1, 2019: Deadline to file 1094/1095 B & C, if filing electronically. Entities filing 250 or more returns **must** file electronically

B Forms

There appears to be no changes to the B Forms for 2018.

C Forms

Form 1094-C

There appears to be no changes to this Form for 2018.

Form 1095-C

No substantive changes were made to this Form. The “Name of Employee” box in Line 1 in Part I and Column (a) in Part III has been separated out into First Name, Middle Initial, and Last Name sections.

Instructions

The penalty amounts for reporting failures have been updated to reflect indexed increases. The penalties for failure to comply have increased from $260 to $270 per failure. That means that an employer who fails to file a completed form with the IRS and distribute a form to an employee/individual would be at risk for a $540 penalty.

The Form C Instructions confirm that the field indicating “Plan Start Month” in Part II continues to be optional on the 2018 Form 1095-C.

IRS Releases Final Versions of 2018 Instructions and Forms 1094/1095 B & C (continued)

The Instructions include the adjusted inflation percentages to the affordability threshold, which is 9.69% for plan years beginning in 2017, and 9.56% for plan years beginning in 2018.

Action Required

Employers subject to the reporting requirements should begin to prepare their 1094/1095-C Forms for the 2018 tax year. Despite continued attempts to repeal, replace, or change provisions of the Affordable Care Act, no changes have been made to the reporting requirements at this time.

For complete details, see:

Form 1094-B, here: https://www.irs.gov/pub/irs-pdf/f1094b.pdf

Form 1095-B, here: https://www.irs.gov/pub/irs-pdf/f1095b.pdf

Form 1094/1095-B Instructions: https://www.irs.gov/pub/irs-pdf/i109495b.pdf

Form 1094-C, here: https://www.irs.gov/pub/irs-pdf/f1094c.pdf

Form 1095-C, here: https://www.irs.gov/pub/irs-pdf/f1095c.pdf

Form 1094/1095-C Instructions, here: https://www.irs.gov/pub/irs-pdf/i109495c.pdf

For additional information and FAQs, see: https://www.irs.gov/affordable-care-act/employers/questions-and-answers-about-information-reporting-by-employers-on-form-1094-c-and-form-1095-c

IRS ANNOUNCES PCORI FEE INCREASE

On November 5, 2018, the Internal Revenue Service (IRS) issued IRS Notice 2018-85 which announces the updated Patient-Centered Outcomes Research Institute (PCORI) fee. The fee of **$2.45** per covered life applies to all policy and plan years **ending on or after October 1, 2018, and before October 1, 2019**. However, for policy and plan years **ending on or after October 1, 2017 and before October 1, 2018**, the PCORI fee is **$2.39** per covered life. Plan sponsors of self-insured group health plans must pay the PCORI fee using Form 720, and submit both the Form 720 and their payment to the IRS by July 31st of the calendar year immediately following the end of their plan year.

Action Required

Although no immediate action is required, plan sponsors with plan years ending on or before December 31, 2018 will need to determine the average number of covered lives participating in their policy or plan, and pay the correct PCORI fee amount by **July 31, 2019**.

For IRS Notice 2018-85, see: https://www.irs.gov/pub/irs-drop/n-18-85.pdf

WESTCHESTER COUNTY, NEW YORK PASSES PAID SICK LEAVE ORDINANCE

On October 12, 2018, Westchester County, New York passed the Earned Sick Leave Law ("Ordinance") requiring private employers in Westchester County, New York to provide covered employees paid sick leave each year. The effective date of the Ordinance is **April 10, 2019**, unless employees are covered by a collective bargaining agreement (CBA). If an employee is subject to a CBA, the law will take effect for those employees either when the CBA expires, or not at all, if the CBA provides more generous leave benefits. Details of the Ordinance are described below.

Covered Employers

The Ordinance applies to all private employers, but only employers with five (5) or more employees working in Westchester County, New York are required to offer **paid** sick leave to employees. Employers with less than five (5) employees working in Westchester County, New York only need offer **unpaid** sick leave to their employees. The Ordinance does not apply to Federal government or state government employers, but does apply to the employees of the Westchester County government that are not subject to a CBA.

Covered Employees

The Ordinance applies to employees who have worked at least eighty (80) hours in a calendar year for an employer in Westchester County, New York. The Ordinance does not apply to independent contractors or unpaid interns.

Accrual, Caps, and Carryover of Sick Leave

Accrual

Covered employees begin to accrue paid sick leave on the first day of employment or ninety (90) days after the law takes effect (i.e., April 10, 2019), whichever date is later. Covered employees accrue one (1) hour of sick leave for every thirty (30) hours worked within Westchester County, New York (domestic workers accrue one (1) leave hour for every seven (7) days worked). The Ordinance does not address the ability for an employer to "frontload" these hours for an employee.

Annual Caps

An employer may cap the amount of sick leave an employee accrues at forty (40) hours per year, but the Ordinance does not prohibit an employer from providing more than forty (40) hours of sick leave per year.

Carryover

Employees are permitted to carryover accrued but unused sick leave to the following calendar year. If an employee carries over accrued sick time to the following calendar year, the Ordinance is vague in defining whether carryover hours are capped in the following year, by stating that leave may carry over "provided that the maximum amount of sick leave for any given year remains at forty (40) hours." More clarification from the drafters of the Ordinance on this provision may be necessary.

Permitted Uses of Sick Leave

Generally, employees may use sick leave as soon as the time is accrued. However, an employer may impose a ninety (90) day waiting period before a newly hired employee is permitted to **use** accrued sick leave.

Employees may use paid/unpaid sick leave for the following reasons:

- An employee or family member's mental or physical illness, injury, or health condition, medical care diagnosis, or the need for preventative care
- If an employee's place of business, or a child's day care, elementary, or secondary school is closed due to a public health emergency; or

Westchester County, New York Passes Paid Sick Leave Ordinance (CONTINUED)

- A public health authority determines the presence of an employee (or person with a familial relationship with the employee) in the community may jeopardize others' health because of the individual's exposure to a communicable disease, whether or not the individual has actually contracted the communicable disease.

The Ordinance defines "family member" as the employee's spouse, domestic partner, child, grandchild, grandparent, parent, or sibling. Also, other individual's related to the employee by blood or affinity, persons with a child in common (regardless of relationship status), or persons not related by blood or affinity, who are or have been in an intimate relationship (regardless if they lived together).

Request for Use of Sick Leave

Under the Ordinance, if an absence is foreseeable, a covered employee must make a reasonable effort, in a timely manner (specific definition not prescribed by statute), to schedule leave in a way that does not unduly disrupt an employer's operations.

An employer may require an employee to verify that sick leave was taken for a permitted use if the employee requests the use of sick leave time for more than three (3) consecutive working days.

Records and Notice for Use of Sick Leave

Employers must keep records documenting the amount of sick leave accrued and used by each covered employee for the prior three (3) years of an employee's employment.

An employer must provide a notice to employees of the paid sick leave ordinance within ninety (90) days of the law's effective date, and to all new hires thereafter. An employer must also post a notice about the Ordinance's requirements in a conspicuous place within the workplace.

No Retaliation

An employer may not interfere with an employee taking paid sick leave, nor may an employer retaliate against an employee for requesting or using sick leave provided under this Ordinance by demoting, terminating, suspending, threatening, or reducing the hours of that employee. An employer may not require a doctor to provide a note that would be in violation of HIPAA. An employer may be subject to civil penalties for retaliation under the Ordinance.

Enforcement and Violations

The Westchester County Department of Weights and Measures will enforce the requirements of the Ordinance.

Action Required

Employers in Westchester County, New York should review their sick leave policies with their legal counsel to ensure their policies are in compliance with this Ordinance, or revise their policies as needed.

For the text of the Ordinance, see:

https://library.municode.com/ny/westchester_county/ordinances/code_of_ordinances?nodeId=919596

SEATTLE, WASHINGTON PASSES COMMUTER BENEFIT ORDINANCE

On October 1, 2018, the Seattle City Council passed the Commuter Benefit Ordinance ("Ordinance"), requiring covered employers to offer certain employees in Seattle the ability to use pre-tax payroll deductions to purchase commuter benefits. The Ordinance requires employers to offer a commuter benefits program by **January 1, 2020**. Highlights of the Ordinance are detailed below.

Covered Employer

The Ordinance applies to employers who employ twenty (20) or more employees. The Ordinance does not apply to governmental entities or nonprofit organizations.

To determine whether an employer is subject to the Ordinance for a current calendar year, the employer must calculate the average number of employees who worked for compensation per week in the preceding calendar year. For new employers, the number of employees is calculated based on an average number of employees who worked for compensation per week during the first ninety (90) days of the current year. When determining the number of employees, employers must include the following employees in the calculation:

- employees who work in the city of Seattle
- employees who work outside the city of Seattle; and
- employees who are classified as full-time, part-time, jointly employed, temporary, or hired through a temporary staffing agency.

Covered Employee

The Ordinance applies to employees who worked an average of ten (10) or more hours per week in the city of Seattle in the previous calendar month, regardless of whether they are classified as a full-time employee, part-time employee, or temporary employee.

Commuter Expenses and Pre-Tax Payroll Elections

Employers must allow covered employees to deduct up to $255 per month from his/her paycheck for commuter benefits. Commuter benefits include vanpool expenses and transit expenses such as buses, light rail, ferry, and water taxi. The Ordinance does **not** apply to parking expenses.

Employees must be offered the opportunity to elect pre-tax commuter benefits within sixty (60) days of beginning employment. Once an employee elects to participate in the commuter benefit program, the employer must allow the employee to make his/her pre-tax payroll deduction within thirty (30) days of the election.

Notice Poster

The Seattle Office of Labor Standards will create and provide covered employers with a poster, detailing employees' rights under the Ordinance in English, Spanish, and any other language necessary for the employer. Employers must display the poster in a conspicuous and accessible location at any workplace where an employee works, in English and the primary language of the employees in that workplace. If displaying the poster is not feasible (e.g., an employee works remotely), employers should provide a poster to those employees, either physically or in a reasonably accessible electronic format, in the employee's primary language.

Seattle, Washington Passes Commuter Benefit Ordinance (CONTINUED)

Record Retention

Employers should retain records documenting compliance with the Ordinance for a period of at least three (3) years. These records should include written documentation of the employer's offer of pre-tax elections for commuter benefits. If an employer fails to maintain these records, there is a rebuttal presumption that the employer failed to comply with the Ordinance for the time period in which there are no records.

No Retaliation

Employers are prohibited from interfering with, restraining, denying, or taking adverse action against an employee who exercises his/her rights under the Ordinance.

Enforcement of the Ordinance

The Seattle Office of Labor Standards has the power to enforce the Ordinance, and investigate any alleged violations. Violations of the Ordinance may result in fines against the employer, reinstatement of an employee, payment of unpaid compensation to an employee, and other financial damages.

Action Required

Employers with twenty (20) or more employees should ensure they offer a commuter benefits program to covered employees in Seattle that complies with the requirements of the Ordinance, by January 1, 2020.

For the Seattle Commuter Benefits Ordinance, see:

http://seattle.legistar.com/View.ashx?M=F&ID=6683282&GUID=30BDF150-9BBB-43D0-85B0-DD2727B5B983

DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE DEPARTMENT OF TREASURY RELEASES NEW SECTION 1332 WAIVER GUIDANCE

On October 24, 2018, the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services and the Department of the Treasury (the Departments) published updated guidance (Guidance) relating to the application and approval process for states seeking Section 1332 waivers from certain Affordable Care Act (ACA) requirements. The Guidance supersedes guidance previously published on December 16, 2015 (2015 guidance). The Guidance is effective immediately and comments on the Guidance will be received until December 23, 2018.

Background

Under Section 1332 of the ACA, states may apply for Section 1332 waivers (now referred to as State Relief and Empowerment Waivers) to allow them the flexibility to develop innovative health coverage strategies that best meet the needs of their residents. In general, Section 1332 waivers were created to waive certain provisions within the ACA relating to health insurance coverage. The goal of the Section 1332 waivers is to provide states an opportunity to promote a stable health insurance market that offers more choices and affordability options to residents within a defined set of guardrails.

The ACA set forth the following statutory guardrails that states must meet in order for its proposal to be granted a Section 1332 waiver:

1. Provides coverage that is at least as comprehensive as coverage is defined in the ACA and offered through the Exchanges
2. Provides coverage and cost-sharing protections against excessive out-of-pocket spending making the plans under the proposal at least as affordable as those under the ACA
3. Provides coverage to at least a comparable number of the state's residents that would otherwise be covered under the ACA; and
4. Not increase the federal deficit.

The Guidance Sets Five Principles State Proposals Need to Demonstrate

The Guidance sets out five principles for future Section 1332 waiver applicants to consider. State applicants need to explain how their proposal advances some or all of the following principles:

1. Provide increased access to affordable private market coverage
2. Encourage sustainable spending growth
3. Foster state innovation
4. Support and empower those in need
5. Promote consumer-driven healthcare

Summary of New Guidance

A key objective was to provide greater flexibility to the states in applying for and obtaining Section 1332 waivers. The Guidance provides clarity on how the statutory guardrails under Section 1332 will be interpreted. Key details of the Guidance are highlighted below:

Comprehensive and Affordable Guardrail

The 2015 comprehensive and affordable guidelines under Section 1332 previously required states to offer coverage that was as comprehensive and affordable as coverage offered under the ACA if they were applying for a waiver. In a significant shift, the new Guidance that is the subject of this article, focuses on the *availability* of comprehensive and

Department of Health and Human Services and the Department of Treasury Releases New Section 1332 Waiver Guidance (CONTINUED)

affordable coverage. This important change allows states the opportunity to provide coverage similar to that provided under the ACA, which may be less comprehensive and less affordable but better suited to consumer needs and more attractive to many individuals.

Coverage Guardrail

A Section 1332 waiver proposal that is submitted by a state to the Federal government must demonstrate, for each year the waiver is in effect, that a comparable number of state residents eligible for coverage under the ACA will have health coverage under the proposal. The new Guidance provides that the Departments will consider the long-term impact of a state's proposal for the eligibility of a state's access to coverage under the new waiver requirements, but may approve a waiver proposal that could decrease coverage in the short-term if it was forecasted to increase coverage in the long-term.

Deficit Neutrality

The projected federal spending (net of federal revenues) under the Section 1332 waiver must be equal to or lower than if the waiver did not exist. The Guidance clarifies that a state's proposal must contain a ten-year budget plan that projects the changes in federal spending and revenues attributed to the waiver for each of the ten years.

Federal Pass -Through Funding

Section 1332 allows states to receive pass-through funding from the federal government to be used in implementing the state plan under the waiver. The pass-through amount is specific to each state and calculated annually. The state proposal must explain how the state intends to use the funding for purposes of implementing the Section 1332 state plan.

Economic Assumptions and Methodological Guidelines

A state proposal must include actuarial analyses and actuarial certifications to support the state's estimates that the proposed waiver will comply with the comprehensive and affordability requirements.

Operational Considerations

Previously, the Federally-facilitated Exchanges (FFEs) were unable to accommodate state eligibility and enrollment rules that were different from the federal rules. Now, the FFEs will be able to support increased variation and flexibility for states who may want to work with private industry partners to create its own consumer-facing technology that would still be able to utilize the back-end technology that supports the FFE. The Guidance recommends that states should engage with the Departments early in the Section 1332 waiver application to determine whether the federal platform could accommodate the state's needs.

Application Timing

States will be submitting their Section 1332 waiver applications during the first quarter of the year prior to the year health plans affected by the waiver would take effect to permit sufficient time for review and implementation of both the waiver application and affected plans.

No Action Required

Employers should be aware of the future impact of these Section 1332 waiver applications, and the choices that employees may make in taking coverage offered through a state, rather than through an employer sponsored plan.

For details of the Guidance, please see:

https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers

https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SRE-Waiver-Fact-Sheet.pdf

IRS ANNUAL INFLATION ADJUSTMENTS FOR 2019 RELEASED FOR FSA AND COMMUTER/TRANSIT BENEFITS

The Internal Revenue Service (IRS) has released IRS Revenue Procedure 2018-57, announcing the maximum dollar limit for employees to contribute to their Flexible Spending Accounts (FSAs). This applies to both an employee's General Health Care FSA and Limited Purpose Health Care FSA. The indexed annual limit for any plan years occurring in 2019, is $2,700, which is an increase of $50 from the 2018 maximum contribution limit of $2,650 to a Health Care FSA.

Employers may choose to leave the Health Care FSA limit at $2,650 (2018 limit), or increase the limit for January 1, 2019. However, the Compliance Department suggests that if an employer has already notified employees of the maximum limit being $2,650 for 2018, employers should adopt the 2018 limit of $2,650 for the 2019 plan year. Otherwise an employer has significant work to change the FSA limit before the new year, including re-communicating the new limit to all employees who are eligible for the Health Care FSA, and allow employees to revise (not necessarily re-enroll) in the Health Care FSA. Also, it is important to remember that potential changes may need to be made to an employer's Health Care FSA plan document/SPD Wraparound document.

In addition, IRS Revenue Procedure 2018-57 increased the commuter/transit benefit contribution limit to $265 (for parking and transit benefits), which is an increase of $5 from the 2018 limit of $260.

Plan Type	Adjusted Limit	Previous Limit	Change	Effective
Health FSA	$2,700	$2,650	$50 Increase	1/1/2019
Qualified Transportation Fringe Benefits- Monthly Mass Transit and Parking	$265	$260	$5 Increase	1/1/2019

Action Required

Employers that administer health plans should take note of any inflation-adjusted changes, and amend and administer their plans accordingly.

For the complete details, see IRS Revenue Procedure 2018-57:

Text of IRS Rev. Proc. 2018-57: Inflation-Adjusted Limits for 2019 (PDF)

MASSACHUSETTS HIRD FORM DUE BY NOVEMBER 30

On November 1, 2018, the Massachusetts Department of Revenue (DOR) and MassHealth released the new Health Insurance Responsibility Disclosure (HIRD) form, which collects information from Massachusetts employers about their employer-sponsored health insurance offerings to employees. Employers with six (6) or more employees in Massachusetts are required to file the HIRD form by November 30, 2018.

The Massachusetts DOR released Frequently Asked Questions (FAQs) regarding the new HIRD requirements. The link to the FAQs is included in the blue action box at the end of this article. Background and additional information about the HIRD form are detailed below.

Background

In 2006, Massachusetts enacted a state-specific health care reform law, requiring Massachusetts employers with eleven (11) or more employees to make a "fair share" contribution to employees' health insurance. The health care reform law also required employers and employees who declined employer-sponsored coverage to complete numerous health insurance responsibility disclosure forms.

In 2014, the "fair share" contribution and health insurance responsibility disclosure forms were repealed. To replace the "fair share" contribution requirement, Massachusetts implemented the Employer Medical Assistance Contribution (EMAC) in 2014. Under the EMAC, employers with six (6) or more employees who work in Massachusetts are required to make employer contributions to the state of Massachusetts, to assist in funding health insurance programs offered within the state.

New HIRD Requirements

Effective January 1, 2018, employers with six (6) or more employees in Massachusetts are required to annually file a new Health Insurance Responsibility Disclosure (HIRD) form by November 30th of each year. The first HIRD form filing is due November 30, 2018, and the Massachusetts DOR released the HIRD form on November 1, 2018. The new HIRD form is not related to the HIRD forms that were originally implemented in 2006.

Under the new HIRD requirement, employers will only be required to complete one HIRD form per year. This is in contrast to the previous HIRD requirement for both employers and employees to file separate disclosure forms. The HIRD form will provide MassHealth with information on the type of employer-sponsored plans offered to employees, to determine which employees may be eligible for premium assistance through MassConnect. Specifically, the HIRD form will request information from employers including plan eligibility requirements, whether the plan(s) meets Massachusetts Minimum Creditable Coverage requirements, employer and employee contributions, the plan's in-network deductible, and the maximum out-of-pocket costs for such coverage.

Employers are required to file the HIRD form on the MassTaxConnect web portal on Mass.gov. Once an employer logs into the web portal, the employer should select the "File health insurance responsibility disclosure" hyperlink under account alerts.

Massachusetts HIRD Form Due by November 30 (CONTINUED)

Penalties

Employers who knowingly falsify information on the HIRD form or willingly fail to file the HIRD form may be subject to penalties ranging from $1,000 to $5,000 per violation.

Action Required

Employers with six (6) or more employees in Massachusetts should ensure they file the HIRD form by November 30, 2018. Employers may receive emails from the Massachusetts DOR, reminding the employer of the requirement that they file the HIRD by November 30, 2018.

For the FAQs on the HIRD requirements, see:

https://www.mass.gov/files/documents/2018/10/24/health-insurance-responsibility-disclosure-FAQ.pdf

For the link to MassTaxConnect, see: https://mtc.dor.state.ma.us/mtc/_/#1

For the text of the law, see: https://malegislature.gov/Laws/SessionLaws/Acts/2017/Chapter110

QUESTION OF THE MONTH

How Does a Health FSA Grace Period Affect HSA Eligibility?

QUESTION: We are thinking of amending our company's calendar-year cafeteria plan to add a grace period. However, we have heard that a grace period under our general-purpose health FSA might adversely affect our employees who want to discontinue their health FSA coverage and make HSA contributions. Is this correct?

ANSWER: A health FSA grace period can adversely affect employees' (and other individuals') eligibility for HSA contributions. As background, employees who are covered under a general-purpose health FSA (i.e., a health FSA that reimburses all eligible Code § 213(d) medical expenses) are not eligible for HSA contributions. That's because a general-purpose health FSA imposes no deductible, is not limited to preventive care, and is neither "permitted insurance" nor "permitted coverage" under the HSA rules. If a general-purpose health FSA has a grace period, employees who are covered under the health FSA on the last day of the plan year and thus are entitled to the grace period will continue to have their disqualifying coverage under the health FSA for the grace period's duration. These employees are ineligible for HSA contributions until the first calendar month after the grace period ends (e.g., April 2019, in the case of a January 1, 2019—March 15, 2019 grace period). Their spouses are also ineligible for HSA contributions during this period if the spouses' medical expenses can be reimbursed from the health FSA. And because qualified beneficiaries who are receiving COBRA coverage under the health FSA on the last day of the plan year are also entitled to the grace period, they too are ineligible for HSA contributions during the grace period. However, grace period coverage is disregarded if the health FSA has a $0 balance at plan-year-end. The problem is alleviated by the "full-contribution" rule for HSAs, which allows an individual who is HSA-eligible on December 1st to make a full year's worth of HSA contributions if certain additional requirements are met. Therefore, being ineligible for three months due to a health FSA grace period affects the timing of HSA contributions but will not necessarily prevent an individual from making the full HSA contribution. Your company could also avoid these HSA eligibility issues by amending its cafeteria plan to convert the general-purpose health FSA to one of the following HSA-compatible arrangements for their entire grace period:

- a limited-purpose health FSA (i.e., a health FSA that reimburses only dental, vision, or preventive care expenses);
- a post-deductible health FSA (i.e., a health FSA that reimburses medical expenses only if incurred after the minimum annual HDHP deductible has been satisfied); or
- a combination limited-purpose/post-deductible health FSA.

The amendment must apply on a mandatory basis to all health FSA participants who are entitled to the grace period; thus, participants may not choose between general-purpose and HSA-compatible health FSAs for the grace period. Note that an alternative would be to offer health FSA carryovers. Note also that employee communications will be needed to explain how the grace period works, including its impact on HSA eligibility. Even if your company does not sponsor an HDHP or offer HSAs, some employees (or their spouses) may already have or may be considering HSAs and will need to understand how the grace period will affect eligibility for HSA contributions.

CONTACTS

Christopher K. Bao, Esq.
Manager, Employee Benefits Compliance
& Regulatory Affairs, MMA West
Chris.Bao@MarshMMA.com
+1 415 230 7224

Brittany D. Botterill, Esq.
Manager, Employee Benefits Compliance
& Regulatory Affairs, MMA West
Brittany.Botterill@MarshMMA.com
+1 858 587 7511

Leah N. Nguyen, Esq.
Manager, Employee Benefits Compliance
& Regulatory Affairs, MMA West
Leah.Nguyen@MarshMMA.com
+1 949 540 6924