Reminder ~ Non-Excepted FSA PCOR Fees Due by July 31

If you sponsored a non-excepted FSA (see explanation below of a non-excepted FSA) for your 2013 Plan year, you are required to pay a fee to support clinical effectiveness research through an entity called the Patient-Centered Outcomes Research Institute (PCOR). This fee is applicable for the 2013 Plan year even if your FSA is no longer non-excepted for 2014.

In addition, health care reform requires that non-excepted FSAs comply with all requirements of the ACA (i.e. provide unlimited preventive care benefits). In light of this guidance, we recommend that non-excepted FSAs either 1) comply with the regulations as to be considered "excepted" or 2) terminate at the 2014 renewal. Please contact your FlexBank Account Manager to discuss next steps.

The fee applies to each plan year that ends after October 1, 2012, and before October 1, 2019. The first fees were to be reported and paid by July 31, 2013 (for a 2012 Plan year).

Fee Reporting and Collection
The fee is due no later than July 31 of the calendar year immediately following the last day of your FSA plan year. This means that FSA plan years that ended October 1 through December 31, 2013 must report and pay applicable fees by July 31, 2014.

Information regarding the fees must be reported by the employer (FlexBank cannot report on the employer's behalf) on IRS Form 720, which may be submitted electronically by the employer.

Plan Year Ending Date	Fee
October 1, 2012 – September 30, 2013	$1
October 1, 2013 – September 30, 2014	$2
October 1, 2014 – September 30, 2019	$2 (adjusted for medical inflation

Form 720
The IRS has issued Form 720 and instructions. Filers will enter covered lives subject to the $2 fee for the 2013 plan year in Part II of Form 720 (line 133) to calculate the amount owed. Though IRS Form 720 is used for quarterly excise taxes, filers should only complete line 133 when remitting the annual fee due July 31.

Link to Full text of Form 720:
http://www.irs.gov/pub/irs-pdf/f720.pdf

Link to Full text of Form 720 instructions for Part II, line 133:
http://www.irs.gov/pub/irs-pdf/i720.pdf

IRS webpage with Form 720, instructions, and related materials:
http://www.irs.gov/uac/Form-720,-Quarterly-Federal-Excise-Tax-Return

In a recently released memorandum, the IRS found that fees paid by plan sponsors to fund the Patient-Centered Outcomes Research Trust Fund (PCOR) were ordinary and necessary business expenses, and, thus, deductible business expenses.

Health FSAs as "Excepted Benefits"

An "excepted benefit" is a classification that defines certain health plans (including health FSAs) that are excepted certain provisions of the HIPAA portability rules as well as avoid the requirement to comply with the new group health plan reform mandates under Health Care Reform.

Typically, most health FSAs are excepted benefits. But there are some FSAs that may not qualify for this exception.

In order for an FSA to be considered an "excepted benefit" two conditions must be met:
1. Maximum Benefit Condition. The maximum benefit payable under the health FSA to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the health FSA for the year (or, if greater, the amount of the participant's salary reduction election for the health FSA for the year, plus $500). This is mainly applicable when employer FSA contributions are involved.

Employees must be permitted to personally contribute to the FSA.

Thus, the health FSA is an excepted benefit if:

- ✓ the employer does not make any contributions to the FSA,
- ✓ the employer makes a dollar-for-dollar match to the FSA, or
- ✓ the employer contributes no more than $500 to the FSA , or
- ✓ the employer contributes > $500, but the contributions are considered "cashable flex credits". This means the employee may take the employer contribution as tax-free FSA funds or post-tax per pay wages. This employer contribution in this situation counts toward the health FSA maximum of $2,500.

2. Availability Condition. Group major medical coverage (individual policies do not suffice) must be made available for the year to the class of FSA participants by reason of their employment.

Availability is the test. It does not matter whether anyone in the class of health FSA participants actually elects the other coverage. Thus, so long as all of the employees in a class of participants eligible for the health FSA are also eligible for major medical coverage and the entry dates for both are the same, the Availability Condition will be satisfied even if some eligible employees take health FSA coverage but opt out of major medical coverage. If, however, the eligibility provisions under the health FSA are more liberal (e.g., more employees are eligible for the health FSA than for the major medical plan), then the Availability Condition may not be met.

The FSA will not be an excepted benefit if:

1. The employer contribution >$500 and is not considered "cashable flex credits" nor a dollar for dollar match; and/or
2. The waiting period for the FSA is more liberal than for the major medical plan
   (i.e. employee may participate in the FSA as of date of hire; 60 day waiting period for group health plan); and/or
3. The criteria for participating in the major medical plan is different than for the FSA
   (i.e. part-time employees can participate in the FSA, but not in the medical plan); and/or
4. The employer does not offer a group health plan.

What if the FSA is not an excepted benefit?

Upon the 2014 FSA renewal, health care reform requires that non-excepted FSAs comply with all requirements of the ACA (i.e. provide unlimited preventive care benefits). In light of this guidance, we recommend that non-excepted FSAs either 1) comply with the regulations as to be considered "excepted" or 2) terminate at the 2014 renewal.

If you have a non-excepted FSA and it operates on a plan year (i.e. 12/1-11/30), and your FSA is still in operation, you must:

1. Provide a letter of non-creditable coverage for Medicare Part D purposes
   Creditable Coverage: If an employee passes up enrolling for Medicare Part D upon attaining age 65, he must show evidence of Creditable Coverage in order to enter at a later date without a premium penalty. Creditable Coverage is defined as coverage that is comparable to that which Medicare Part D would have paid for prescriptions. In order to qualify as comparable coverage, the plan must actually pay out at least 60% of the entire benefit offered in the form of prescription benefits.
   More information may be found at ***http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index.html?redirect=/CreditableCoverage/***
   This requirement is set to expire 12/31/14.
2. Health FSA COBRA continuation must be offered to employees even if they have overspent their account for the entire COBRA period.
3. The employer must distribute a summary of benefits and coverage (SBC).
   FlexBank can provide the required SBC for a fee of $150.
4. The employer must pay the applicable fee for the newly formed Patient-Centered Outcomes Research Institute (PCOR).
5. The waiting period for the health FSA cannot exceed 90 days.
6. The employer contribution must be offered as cashable flex credits (employee may choose to accept the funds tax-free in the FSA or as taxable per pay wages) and is subject to the $2,500 health FSA maximum. Otherwise, the employer contribution must be unlimited.
7. Provide unlimited preventive services upon 2014 renewal.