Q&A from Assurex Global Webinar "Benefit Plan Transition Issues"	September 28, 2017
Question	**Answer**
Can they contribute to an HSA (calendar year plan) if they were in an FSA with a different plan year (April - March), once that FSA plan year ends? I thought it was based on the tax year, not the plan year. For example, if an employee HAS a balance on their FSA with carryover and grace period parameters in their plan, can they opt to forfeit their balance to transition to an HSA? Or would any balance automatically make them ineligible to elect the HSA at renewal?	Keep in mind, the ability to participate in HDHP coverage is separate from eligibility to contribute to an HSA. An individual may enroll and have coverage under an HDHP even if the individual is not eligible to contribute to an HSA. The amount an individual is eligible to contribute to an HSA is calculated monthly. For any month an individual is enrolled in a qualifying HDHP, does not have any other disqualifying coverage (e.g. general-purpose health FSA), and cannot be claimed as a tax dependent, the individual may contribute up to 1/12 of the annual maximum contribution amount. So for an individual participating in a general-purpose health FSA with an April - March plan, the individual could not contribute to an HSA January - March. If the health FSA funds are exhausted at the end of March, the individual could then begin contributing to an HSA beginning in April so long as the individual does't reenroll in the general-purpose health FSA. The individual could contribute 9/12 of the annual contribution limit (unless taking advantage of the full contribution rule). If the health FSA funds are not exhausted, the individual may continue to be ineligible to contribute to the HSA if there is a grace period or carryover. • If there is a grace period, the individual is ineligible to contribute to an HSA through the end of the grace period, unless the grace period converts to limited-purpose for all participants. • If there is a carryover, the individual is ineligible to contribute to an HSA through the end of the next plan year, unless the individual waives the carryover or the carryover is limited-purpose.
For the HSA section in the beginning, if the spouse of an employee contributes to a FSA with their employer, does that mean that our employee, who is enrolled in a HDHP that covers their spouse, would not be able to contribute to a HSA?	Yes, assuming this involves a general-purpose health FSA (versus a limited-purpose or post-deductible health FSA). Typically both the employee and spouse are eligible for reimbursement under a health FSA, and therefore both are ineligible to contribute to an HSA.
I was recently told that if you offer Health FSA, Limited FSA and HSA and you have the 2.5 month extension the following year, that all FSA members are "limited" to Limited FSA only for that duration. Is this correct?	The employer has a bit of flexibility in designing the health FSA… • If the general-purpose health FSA has a grace period, the grace period must either be general-purpose or limited-purpose for all participants. It is not possible to make it limited-purpose only for some participants (e.g. those who enroll in the HDHP). • If the general-purpose health FSA has a carryover, there is more flexibility than for the grace period. Assuming the employer offers both a general-purpose and a limited-purpose health FSA, those participating in the general-purpose health FSA and who have carryover dollars could elect to have the monies carryover either into the general-purpose health FSA or the limited-purpose health FSA; it's not necessary to make it the same for all participants. See IRS Chief Counsel Advice 201413005 (Feb. 12, 2014) .

if the change occurs at renewal is an smm required knowing that the renewal documents identify the new coverage	An SPD is required to be provided within 90 days of plan enrollment, and then every 5 years thereafter. The summary of material modification (SMM) is required to be issued any time there is a change in a plan provision that is "material," or any time there is a change in a plan provision that would otherwise appear in the SPD. The SMM is required to be provided 60 days after the date of adoption of a material reduction in plan benefits, but otherwise 210 days after the close of the plan year in which a material modification to a plan provision is adopted. If a change occurs at renewal triggering a change to information found in the SPD, an SMM is required according to the timeframes set forth above, unless an updated SPD is provided.
Is there a timeline on how many years you need to keep prior Insurance contract information	While there are a variety of requirements for different benefit documents, 7-8 years for retention of benefit-related documents is a good rule of thumb. However, we also recommend consulting with legal counsel for a definitive recommendation, as they will be able to take into account the particular requirements of the client, statutes of limitations that could apply to lawsuits filed in jurisdictions where the plan operates, and any applicable state requirements.
What is considered mid-plan year? If our insurance renewal period is February, is that considered mid-plan year for the purpose of the rules?	A change is considered to be "mid-plan year" if it happens in the middle of the benefit plan year. So if the benefit plan year is February - January (non-calendar), a change occurring outside of the February renewal would be considered a mid-plan year change. If the mid-year change is a material modification in any of the terms of the plan that would affect the content of the Summary of Benefits and Coverage (SBC), then an updated SBC or notice of modification should be provided 60 days in advance of the effective date. If the change occurs upon plan renewal (e.g. effective Feb. 1st), then advance notice is not required, but the changes should be reflected in the SBC provided during open enrollment.
What obligations for reporting under ACA fall to the employer when fully insured?	An employer offering a fully-insured plan is not required to report information about who is actually covered/enrolled in the fully-insured plan. The insurance carrier will handle that by completing Form 1094-B and corresponding Form 1095-Bs. However, regardless of what type of coverage is offered (if any), all applicable large employers (50 or more FTEs) are required to report information about offers of coverage to full-time employees using Form 1094-C and corresponding Form 1095-Cs. Therefore: • A small employer (less than 50 FTEs) offering a fully-insured plan does not have to do any reporting. • A small employer (less than 50 FTEs) offering a self-funded plan should complete a Form 1094-B and Form 1095-Bs for individuals covered under the self-funded plan. • An applicable large employer offering a fully-insured plan will complete a Form 1094-C and only Parts I and II of Form 1095-C for all full-time employees. Part III is left blank. Those enrolled will receive both a Form 1095-B from the insurance carrier and a Form 1095-C from the employer. • An applicable large employer offering a self-funded plan will complete a Form 1094-C. The employer will complete Parts I and II of Form 1095-C for all full-time employees and Part III for those who enrolled in the self-funded plan.

If an employer determines the change in cost as "significant" does this require a notice of Material modification?	The employee contribution (cost of coverage) does not generally appear in the SBC and therefore 60 days' advance notice of the change would not be required under SBC rules. However, there may be state payroll or other notice requirements that will require advance notice of the change when there is a significant change in compensation, and of course, employees will appreciate advance notice of the change. In addition, it is necessary to provide a summary of material modification (SMM) no later than 60 days following the adoption of the change as required under ERISA.