McGraw Wentworth

BENEFIT Advisor

Volume Six, Issue Eleven

November 2003

In This Issue

In this eleventh issue of the McGraw Wentworth Benefit Advisor for 2003, we will revisit Section 125 of the Internal Revenue Code. Section 125 governs the ability for individuals to deduct certain expenses on a pre-tax basis. In particular, employers can sponsor Premium Only Plans that allow for employee contributions to certain benefit programs to be deducted on a pre-tax basis. Section 125 also governs Flexible Spending Accounts, both for medical and dependent care expenses. The initial rules established in Section 125 were instituted well over 10 years ago. However, the plans have had a great deal of activity regarding covered expenses, claims substantiation and family status changes. We will overview the basics of Section 125 plans and discuss the new guidance regarding these plans.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit our web site at www.mcgrawwentworth.com.

"Flexible Spending Accounts - A Refresher Course"

Many employers sponsor flexible spending accounts allowing employees to maximize tax savings on certain eligible expenses. Flexible spending accounts are governed by Section 125 of the Internal Revenue Code. Though the basics of spending accounts have not changed much in the last ten years, many clarifications and coverage enhancements have occurred over the last few years.

We will review the basics. If your organization sponsors spending accounts, it is important to keep in mind your basic responsibilities as a plan sponsor.
Then, we will review "what's new" in the spending account legislation, ranging from clarifications on eligible benefits to simplified filing requirements.

The Basics

Section 125 refers to the section in the Internal Revenue Code that addresses the ability to have pre-tax contributions for certain benefit options. The section is split into three core parts:

- **Premium Only Plans** – addresses the ability to take contributions for specific benefit programs on a pre-tax basis.
- **Health Flexible Spending Accounts** – addresses the ability of an employer to sponsor a plan allowing employees to set aside funds on a pre-tax basis to pay for certain non-reimbursed medical expenses.
- **Dependent Care Spending Account** – addresses the ability of an employer to sponsor a plan for employees to be reimbursed for certain eligible dependent daycare expenses on a pre-tax basis.

These plans can offer significant tax savings to employees and possibly even tax savings for employers. Section 125 requires employers who sponsor these programs meet the requirements outlined in the next section.

The Requirements

Prior to Section 125, a plan that allowed employees a choice between cash and non-taxable benefits was

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taxed under a doctrine called "constructive receipt". Under this doctrine, employees who had the option of choosing between cash and a non-taxable benefit would be taxed as if they received the taxable income, even if the employee(s) chose the non-taxable benefit. Section 125 provides an exception to the doctrine of constructive receipt, providing a plan meets the following criteria:

- **Written Plan Document**: All Section 125 plans must be established pursuant to a written plan document.
- **Non-Discrimination Rules**: Section 125 has its own rules established for meeting the non-discrimination requirements. The protocols are not the same that are set forth in Section 105(h). The non-discrimination requirements are fairly complex, but basically a plan cannot discriminate in favor of highly compensated participants or key employees. Although Section 125 requires your plan to operate in a non-discriminatory manner, it does **not** include a requirement for your plan to perform non-discrimination testing on a periodic basis. If your plan is audited, however, your organization will be expected to provide documentation your plan operates in a non-discriminatory manner.

- **Deferred Compensation**: A Section 125 plan cannot allow a plan participant to set aside funds pre-tax in one plan year and benefit from those pre-tax contributions in the following year.
- **Use it or Lose it Rule**: The Internal Revenue Service requires a plan have some element of employee risk. Employees are required to make their plan elections prior to the beginning of the plan year. They must use their annual election on eligible expenses incurred during the plan year or they lose any amounts not used. A plan can use employee forfeitures for any of the following purposes:

  - Offset plan administrative cost
  - Charitable donation
  - Distribute to all plan participants equally

  Employees are required to make their elections for the entire plan year. Employees can only make changes to elections mid-year if they experience a qualified change in family status. In early 2001, the IRS issued final regulations that governed the circumstances when a participant could make election changes mid-year.
- **5500 Filing:** Prior to April 22, 2002, employers were required to file a Form 5500 for their Section 125 plan. The filing was required even if your plan had fewer than 100 participants. This requirement has changed for many organizations and the specifics are outlined in the "What's New" portion of this newsletter.

What's New

Over the last several years, many changes have been made from an administrative and coverage standpoint for Section 125 plans. The key issues are outlined below.

Dependent Care Tax Credit: Beginning in 2003, the benefit of taking a dependent care tax credit improved for many. For the 2003 tax year, the amount of the tax credit increased to $3,000 of employment related care for one qualifying dependent and $6,000 for two or more qualifying dependents. Additionally, the percentage associated with the dependent care tax credit increased.

This change did not increase the $5,000 maximum on dependent daycare accounts. These changes, however, made the tax credit more appealing to higher income individuals. Your organization may have seen a reduction in dependent daycare account participation associated with the increased attractiveness of the dependent daycare credit taken on an individual's taxes.

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Notable Thoughts

Better to do something imperfectly than to do nothing flawlessly.

Dr. Robert Schuller

Debit Cards: In May, the IRS released a Revenue Ruling that outlined under what circumstances a plan could use a debit card to process claims under a medical flexible spending account. Prior to the Ruling, several vendors offered the debit card technology but it was not clear if that method of claim processing would meet the claim substantiation requirements of Section 125.

The Ruling outlined what steps employers could take to ensure their claim process associated with the debit card met the substantiation requirements of Section 125:

- ***Participant Verification*** – Participants are required to certify that they will only use the card for eligible medical expenses that cannot be reimbursed under any other plan.
- ***Card Limit*** – The card limit should be set at the annual election for the medical spending account. The annual limit must be reduced as eligible claims are paid from the account.
- ***Limit Use to Specific Vendors*** – The card's use must be limited to a very specific list of merchant codes. These merchant codes must be related to health care. For example, physician offices, hospitals and pharmacies would have approved merchant codes, allowing participants to use the debit card at those locations.
- ***Claim Verification Procedure*** – All claims processed by the debit card must be substantiated in some manner. Substantiation will often require a plan participant to submit a receipt to the FSA claims administrator, but there are a few situations where a claim will be considered automatically substantiated:
  - ➢ The actual transaction amount matches exactly a required co-pay of the medical plan. For example, a $20 charge from a doctor's office when a plan has a $20 office visit co-pay will not require the employee to submit follow up receipts. The expense processed under the card must match the actual co-pay. If a participant takes two children to the doctor and the office swipes the $40 in office visit co-pays, this claim cannot automatically be substantiated because it is not the flat $20. The plan participant would be required to send in supporting documentation.
  - ➢ A recurring expense that matches the timing, provider and amount of a claim previously approved with a paper claim submission. For example, an individual visits a psychiatrist every two weeks for the treatment of depression. The FSA administrator has a 10-week history of paying these claims and the employee's portion of the expense is $40. This expense can be paid with the debit card and can be considered automatically substantiated.
  - ➢ If the medical provider provides real time substantiation that the claim is for an eligible medical expense, the claim can be considered automatically substantiated.

Many employers were initially excited by this guidance; however, there still are many administrative concerns that may affect the decision to add this plan enhancement:

- **Account funding may be an issue:** Most debit card vendors require a pre-funding of the account that will fund claims processed by the card. Claims for the spending account are processed in real-time. Employers provide the seed money for the "pre-fund" and the amount is generally set between 2-4 months of employee elections. This creates an issue under ERISA. Self-funded medical plans are exempt from certain trust and reporting requirements of ERISA when they pay benefits from the general assets of the employer. When the accounts are pre-funded, benefits are no longer being paid from the general assets; this situation may create additional trust and reporting requirements.
- **1099 Reporting**: When you use a debit card, the funding mechanism of the plan changes. Instead of being a reimbursement-based model, the plan makes direct payments to providers. If the plan

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makes direct payments for certain types of providers in excess of $600 annually, the plan has responsibility of issuing 1099s to these providers.

- **Employer/Administrator Additional Responsibilities in the Claim Process**: Since the card can be used at a variety of merchant codes, opportunity for it to be used for ineligible expenses arises. If the employee does not provide substantiation, the administrator needs to pursue the employee to provide proper claim substantiation. If the card pays for an ineligible expense, the employee is required to repay the plan. All repayment action steps must be outlined in the plan document. Repayment options include direct payment to employer, offsetting payment of future eligible claims, withholding amounts from payroll if permitted by state law, and deactivating card.

- **Card Administrative Concerns**: There are some day-to-day concerns with using these cards that will affect employee satisfaction. The following issues should be addressed with employees choosing to use this technology:
  - Many merchants acquire used credit card swipe machines. Often the merchant code is not changed. A plan participant could use the card at a doctor's office but if the doctor bought a used machine and the merchant code was not changed, the charge may be declined.
  - The card will be called a debit card, but it is processed like a credit card. When a participant swipes the card, they will need to select credit versus debit for it to work properly. There is no PIN associated with the card.
  - Debit cards will not be accepted for partial payments. If a plan participant uses the card for a $1200 Lasik eye surgery and the credit limit on the card is $800, the claim will not process.

Using a debit card eliminates the time lag associated with payments under the medical flexible spending account, but creates a host of administrative concerns. Many employers are under the impression debit cards save time in the claim process. In reality, the time and work involved in claim processing increases when debit cards are added as a claim payment option.

5500 Form Filing: On April 22, 2002, the IRS suspended the requirement for certain plans, including Section 125 plans, to file the Form 5500. Since the IRS issued this suspension, there has been confusion regarding when a plan should file a 5500.

- The suspension does not apply to any Title I ERISA plans sponsored by the employer. For example, if an employer sponsors a medical plan with over 100 participants, a Form 5500 must be filed for the medical plan.
- An employer still needs to file a Form 5500 if flexible spending account funds are held in trust or held in an account separate from the employer's general assets.

Eligible Expenses: The IRS has issued significant guidance of what constitutes an eligible expense under a Flexible Spending Account:

- ***Over the Counter Medications***: In a early September, the IRS released a Revenue Ruling that addressed covering over the counter medications as an eligible expense under flexible spending accounts and other employer sponsored health plans. The Ruling allows coverage for medications purchased by the employee without a physician prescription providing the medication is used for the treatment of a medical condition that meets the definition of medical care under Section 213(d) of the Internal Revenue Code. The only explicit exclusions are items that are merely beneficial to the general health of the employee or dependent, such as vitamins.

  Please refer to Volume 6, Issue 10 of the McGraw Wentworth Benefit Advisor for all the details regarding this Revenue Ruling. Although early in its application, this Ruling creates some confusion regarding what medications should be considered an eligible over the counter expenses. To alleviate possible misunderstandings, your plan

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should communicate clearly with participants what over the counter medications will be processed as eligible expenses by your plan.

- ***Cosmetic Surgery***: In general, cosmetic surgery is not considered a qualified expense under a flexible spending account. If, however, it is required to correct a deformity caused by a congenital defect, disfiguring disease or injury, the surgery then can be considered an eligible expense.
- ***Breast Reconstruction Surgery***: This surgery is primarily not an eligible expense as it is considered cosmetic. In keeping with the logic set forth in the Women's Health and Cancer Rights Act, expenses related to the reconstruction of a breast following a mastectomy that is performed to treat breast cancer is considered an eligible expense.
- ***Vision Correction Surgery***: Most administrators already reimburse expenses related to Lasik or radial keratotomy vision correction surgery. In May 2003, the IRS formalized its position that this is an eligible expense as a treatment corrects vision defects and promotes proper function of the body.
- ***Teeth Whitening***: The IRS confirmed teeth whitening procedures do not treat a physical or mental disease, nor promote proper functioning of the body and, therefore, are not considered an eligible expense under a medical FSA.
- ***Weight Loss Programs for Treatment of Obesity***: In a Revenue Ruling in April 2002, the IRS clarified the treatment of medical expenses for weight loss programs. Health FSAs may only reimburse expenses incurred for the treatment of a medical condition and the costs of procedures to improve physical appearance are not deductible as medical care.

  In this Ruling, the IRS recognized obesity as a medically accepted disease that can be treated on its own (not just in conjunction with co-morbid conditions such as high blood pressure or diabetes). The ruling outlined a scenario in which two individuals joined a weight loss program at the recommendation of their physicians. There was a fee to join the program, a fee for regular meetings and finally the program required participants to purchase special food. In both scenarios, since the covered participant was obese, the fee to join and the regular meeting fees were considered deductible expenses, but the cost of the food did not qualify as an eligible expense.

- ***Fertility Treatment***: Medical expenses incurred to overcome the inability to have children are considered eligible expenses under Section 125. The key for these expenses to be eligible is that the procedure that is performed must be on an eligible participant. Expenses that involve treatment of an eligible participant will be covered. The same expenses for a surrogate mother, however, would not be covered, because the expenses are not due to the medical treatment of an eligible participant.
- ***Massage Therapy***: Typically, massage therapy is considered a personal expense item and many plans exclude massage therapy as an eligible expense. However, massage therapy could be prescribed to treat a medical condition. If a plan allows this service as an eligible expense, the plan should require a letter from a physician certifying the massage therapy is required to treat a medical condition.
- ***Body Scans and Other Diagnostic Procedures***: Verbally, the IRS has indicated that diagnostic procedures could be considered eligible medical expenses without an underlying medical condition. Therefore, items such as home pregnancy tests and ovulation kits can be considered eligible expenses.

Mid-Year Election Changes: In January 2001, new proposed and final regulations went into effect for Section 125 plans. The new regulations clarified what events can be considered change events.

The events included:

- Change in Status Events:
  - Change in residence
  - Change in employment status
  - Change in number of dependents
  - Change in legal marital status

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- Change in dependent's eligibility for plan
- Change in COBRA coverage.
- Issuance or change in Domestic Relations Order or Qualified Medical Child Support Order.
- Taking a qualified FMLA leave.
- Qualifying for special enrollment rights of HIPAA.
- Entitlement or loss of entitlement to Medicare or Medicaid.

The change in election under the Section 125 must be consistent with the status change.

New proposed regulations were also released at the same time. The proposed regulations addressed when election changes could be made due to:

- Changes in cost.
- Changes in coverage.
- Change in coverage under another employer's plan.
- Change in dependent care status.
- Employer initiated changes.

These final and proposed regulations offered much more flexibility to adjust certain elections mid-year. For employees to benefit from these enhancements, however, employers needed to amend their plan document to describe what mid-year plan changes would be permitted under their plan.

Conclusion

Section 125 plans offer employees the opportunity to save tax dollars on:

- Premiums paid for certain health care benefits
- Certain medical expenses that are not reimbursable under any coverage available to the plan participant
- Certain eligible daycare expenses an individual incurs in order to work or attend school

Section 125 has changed since its inception; the last few years have brought significant activity that has had a positive effect, for the most part, on plan participants. The positive changes may account for the increased participation in these plans.

According to Mercer's National Survey of Employer Sponsored Health plans in 2002, 74% of employers currently offer flexible spending accounts. This has increased from an average 69% in 2001. On average, 18% of employees participate in a health care spending account. The average contribution for 2002 was $1,135 and the average forfeiture was about $57. Dependent care accounts for 2002 had 7% average participation. The average contribution for 2002 was $3,012. The average forfeiture for 2002 was $60.

Increased participation means increased tax saving for your employees and possibly even your organization. Make sure your plan documents and administrative procedures take into account the changes your organization is interested in implementing as a result of clarifying guidance from the IRS. MW

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