In This Issue

In this fourth issue of the McGraw Wentworth Benefit Advisor for 2010, we will re-
view the requirements of Section 125. Section 125 of the Internal Revenue Code outlines the rules employers need to follow to allow employees to pay for certain benefits on a pre-tax basis.

The rules are more complicated than most employers realize. Failing to follow the rules could result in the plan being disqualified. All employees are taxed on pre-tax deductions when a plan is disqualified.

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 the McGraw Wentworth website at www.mcgrawwentworth.com.

“A Refresher on Section 125”

Section 125 of the Internal Revenue Code allows most employees to pay for certain benefits with pre-tax dollars. For that reason, employers need to understand the complex, specific rules they must follow.

This Advisor reviews the Section 125 rules including:

- Basic Legal Requirements For The Plan
- Midyear Changes
- Reimbursement Accounts
- Non-Discrimination Requirements

While most employers struggle with Section 125 details, some do not realize that failing to meet the requirements can have serious consequences. The IRS could even disqualify the plan. If this happens, all employees will be taxed on all the deductions that were made with pre-tax dollars during the year.

It makes sense to review your current documents and administrative practices to make sure your organization is meeting all the Section 125 requirements.

Basic Legal Requirements For The Plan

Section 125 provides a tax-favored method for employees to take advantage of employer-sponsored benefits. To qualify, your plan must offer employees a choice between cash and non-taxable benefits. If you allow your employees to either take their full pay or contribute part of it to their health insurance premium, your plan meets this requirement.

Employers must meet these specific Section 125 requirements:

1. The plan must have a plan document that includes the following elements:
   - A specific description of benefits and the coverage period.
   - Participation rules. Participation must be limited to eligible employees. Former employees can participate if your organization allows pre-tax payments from their severance pay.
   - Election rules. This section should include the new hire waiting periods and the

Continued on Page 2
timeframe for making elections and time period elections apply, generally the plan year. The plan also needs to specify when it allows midyear changes and the timeframe for making those changes.

- **Employer** and employee contribution options such as salary reductions or a credit-based flex system.

- Additional benefits the plan offers; for example, opt-out bonuses, vacation buy or sell arrangements, medical and dependent care reimbursement accounts, and so on.

- **Plan year.** Generally, Section 125 requires a 12-month plan year. A plan can have a short plan year if necessary; in this case, the employer must let employees know before the beginning of the plan year. Employers should avoid back-to-back short plan years. Although the IRS allows short plan years for business reasons (for example, to change from a July year to a calendar year), consecutive short plan years will send a red flag.

2. The plan must be maintained solely for employees.

3. The plan must comply with these Section 125 rules:
   - It must offer only qualified benefits.
   - It must offer a choice between cash or benefits.
   - The plan document must include all permissible midyear changes.
   - The plan must not allow employees to defer compensation. In other words, an employee can’t pay for a benefit in one year and expect to use it in the following year. Section 125 has a few stated exceptions to the deferred compensation requirement, including:
     - Pre-tax contributions to a 401(k) plan or a trust that is part of a profit-sharing stock bonus plan or a rural cooperation plan.
     - Contributions to a Health Savings Account.
     - Salary reductions made in the last month of the plan year to pay for benefits in the first month of the next plan year.
     - Mandatory two year “lock-in or lock-out” on voluntary dental or vision plans.

Only certain benefits can be paid for with pre-tax dollars. These benefits include:

- Employer-sponsored accident death and dismemberment benefits.

- Employer-provided short- or long-term disability plans. Employees can choose to pay tax on the employer-paid premiums. In general, if employees pay for disability coverage with post-tax dollars, they do not pay tax on disability benefits.

- Health care and dependent care reimbursement accounts.

- Vacation buy or sell arrangements.

- Adoption assistance programs.

- COBRA premiums; however, the COBRA premiums must be for an employee or IRS-qualified dependent. An employee can’t pay COBRA premiums for an ex-spouse pre-tax.

- Certain educational institutions’ plans.

Interestingly, two fairly common benefits do not make the list: legal service plans and long-term care insurance. Neither of these benefits can be paid for with pre-tax dollars.
Any employer can sponsor a Section 125 plan and set the eligibility requirements; however, the law specifically excludes the following from participating in a Section 125 plan:

- Self-employed individuals.
- Sole proprietors.
- Partners in a partnership (including their family members).
- Two percent or more shareholders in a subchapter S corporation and their family members.

Employers need to make sure they follow the Section 125 legal requirements if they intend to allow pre-tax deductions on benefits. The August 2007 round of guidance on Section 125 plans stressed the importance of following the rules. In fact, the IRS can disqualify plans that do not meet basic requirements, such as operating a plan without a plan document. In that case, all of your employees would lose the tax-favored status of any contributions they made through the plan.

**Midyear Changes**

Midyear changes have always posed a challenge for employers. Employers must first understand the following Section 125 rules for employee elections before they dive into the change rules.

- Only participants are allowed to make elections.
- The plan must state its rules on elections, including:
  - New hire waiting period.
  - Open enrollment timeframe for making annual elections or changes.
  - Midyear changes and the timeframe for notifying the employer of changes: plans usually allow 30 to 60 days from event date to make changes.
  - Almost all elections and most changes must be made before their effective date. The only two exceptions are as follows:
    - An eligible employee can add a newborn or adopted child retroactively.
    - For benefit plans that have an effective date based on date of hire, employees have a 30-day window to make initial elections under the plan and the employer can make elections effective retroactively to the date of hire.
  - The elections are made for the plan year. In most cases, this means 12 months.

Section 125 governs only pre-tax contributions to pay for benefits. It allows midyear changes in just 14 situations. Make sure your plan document states which specific midyear changes your plan permits. What’s more, any midyear change must be consistent with the status change prompting it.

Employers need to ask these four key questions to verify a given midyear change is permissible:

1. **Is the change allowed under Section 125 – the 14 situations where midyear changes are permitted?**

2. **Is the change consistent with the event prompting the change?**

3. **Is the change allowed under the employer’s Section 125 plan?**

4. **Is the change permitted under the underlying plan, such as the medical plan, the dental plan, the life plan and so on?**

If the answer to all the above questions is yes, then the employer can make the change midyear.

Midyear changes to health care or dependent care accounts (HCRA and DCRA) are more limited than the changes allowed for other pre-tax contributions. Below is a list of the 14 midyear allowed changes and if HCRA or DCRA changes allowed:

1. Changes in family status (allows HCRA and DCRA changes):
   - Change in legal marital status, which does not include same sex spouses because Section 125 defers to the federal legal definition of marriage.
   - Change in number of dependents as defined by Section 152 of Internal Revenue Code.
   - Change in employment status of employer, spouse or dependent but only if it affects eligibility for the Section 125 plan or the underlying benefit plan.
- Change in a dependent’s eligibility.
- Change in residence, but only if it affects eligibility for Section 125 plan or underlying benefit plan.
- Adoption proceedings if the Section 125 plan includes adoption assistance.

2. **Insignificant** cost changes allow automatic increases or decreases in elective contributions. In this case, employees cannot make any coverage changes as a result. Unfortunately, the law does not define “insignificant.” If the increase is significant, however, employees must have the option to make changes.

3. Significant cost changes; employees can choose to pay the new contribution or alter their coverage. If the cost decreases, eligible employees can enroll for coverage or switch to another plan option. If the cost increases, the employee can switch to another plan option. The employee can drop coverage only when no other coverage option is available. They cannot drop coverage if another coverage option is available even if that option is more expensive.

4. Significant reduction coverage with or without a loss of coverage (DCRA changes allowed). For example, plans may increase deductibles, decrease coinsurance and so on. Eliminating a benefit plan option, changing the employee’s HMO service area, or significantly reducing the number of local providers can constitute a loss of coverage. If coverage is reduced or lost, an employee can choose alternative coverage. If no other option is available, the employee can decline coverage.

5. The addition of a new benefit option or the significant improvement of a benefit option. In this case, employers must allow employees to elect the new benefit even if they previously declined coverage. Employees can also switch from an alternative coverage option to the new plan.

6. Change in coverage under another employer’s health plan (DCRA allowed). If a spouse’s plan significantly curtails coverage or significantly increases cost, the employer can allow the employee to change coverage. You can also allow midyear changes if a spouse’s plan has a different open enrollment period from your plan.

7. Loss of health plan coverage under a government or educational institution’s plan. These plans include Native American tribal government medical programs, state high risk pools, foreign government group health plans, and so on.

8. For 401(k) plans, Section 125 allows contribution changes any time during the year. Your 401(k) plan may allow changes on a more restrictive basis, for example, monthly or quarterly.

9. HIPAA special enrollment rights (HCRA changes allowed only when the special enrollment right is due to a loss of coverage). HIPAA special enrollment rights include:
   - Loss of eligibility for coverage under a group health plan.
   - A new dependent acquired through marriage, birth, or adoption.
   - Loss of SCHIP or Medicaid coverage.
   - Eligibility for premium assistance under the SCHIP program.

10. COBRA qualifying event. If an employee, spouse or dependent becomes eligible for COBRA, the plan can allow the employee to increase pre-tax contributions to pay for COBRA coverage. However, the COBRA premium must be for the employee or a Section 152 dependent. For example, an employee responsible for paying for an ex-spouse’s COBRA cannot pay for that coverage pre-tax because the ex-spouse is likely not a Section 152 dependent.

11. Judgments, decrees or court orders (HCRA changes only allowed). For example, if a plan receives a qualified medical support order for a child, it must cover the child midyear.

12. Medicare or Medicaid entitlement occurring midyear. When employees become eligible for Medicare or Medicaid midyear, they can...
drop employer coverage; if they lose their Medicare or Medicaid coverage, they can enroll in the employer's plan midyear.

13. FMLA leaves (both HCRA and DCRA changes allowed). When FMLA interacts with Section 125, the rules become complicated because a number of options can apply:

- If an employee revokes coverage at the beginning of an approved FMLA leave, that coverage must be reinstated when the employee returns to work.
- For paid FMLA leaves, employers can choose to require employees to continue coverage if they also require employees to continue coverage during other, similar paid leaves.
- The employer can also allow the employee to continue coverage through the leave and permit a number of ways to pay for that coverage – pay as you go, pre-pay or catch up contributions when the employee returns to work. If you allow pre-pay, be careful that the pre-payment applies only in the current plan year.

14. HSA contributions. The IRS has only a few rules related to midyear HSA changes. Namely, the changes must be made in advance, employers must allow these changes at least monthly and they must outline the rules in the plan document.

Midyear changes can be confusing; employers need to review midyear change options and include allowable changes in the plan document.

Smoker surcharges can affect mid-year change rules. If the smoker surcharge is pre-tax, a midyear change is limited to what Section 125 allows. Employers will have more flexibility to add or remove smoker surcharges midyear if the surcharge part of the premium is taken post-tax. For example, if your health plan charges smokers $20 more for coverage, only the $20 portion of the premium would be taken post-tax.

Finally, most employers limit the window for changing plan elections to 30 or 60 days.

Reimbursement Accounts

Under Section 125 employers may decide to offer employees the option of health care or dependent care reimbursement accounts. A reimbursement account allows employees to set aside some of their own pre-tax money at the beginning of the year for unreimbursed medical expenses or for dependent day care expenses.

These accounts operate under IRS rules. The rules differ depending on the type of account, so it makes sense to review each of the accounts separately.

The following rules apply to health care reimbursement accounts:

- The account must comply with the uniform coverage rule. In other words, the full annual election must be available at the beginning of the plan year if the employee or a dependent incurs an eligible expense. For example, let’s say an employee set aside $2,000 in the account and then got laser eye surgery in January costing $2,500. The employee could submit a claim and be reimbursed for the full $2,000, even though the account had only one month’s contributions. The employee reimburses the account throughout the year. However, if the employee then leaves the company during the year, the employer will lose the money paid in advance on the claim because the employee is no longer contributing to the account.

- The employee must use the funds in the account by the end of the plan year; any funds remaining after the end of the year are forfeited. This is called the “use it or lose it” rule. The employer can choose to offer a grace period for eligible claims, however, and reimburse employees for claims filed during this period.

- The employee must prove each claim is for an eligible expense.

- The IRS does not limit these accounts. Currently the employer must set an annual limit. The employer should take into account the possible risk when setting the limit. As of January 1, 2013, the government has set a limit on these plans as part of the health care reform acts. In 2013, the annual limit must be $2,500 or less and that limit will be indexed annually.
Claims must occur within the plan year or within the grace period.

The plan must distribute experience gains properly. Employers can use experience gains to offset experience losses or administrative expenses.

The plan must comply with Section 125 as outlined in the first section of this Advisor.

The “use it or lost it” rule applies to these accounts. The IRS does allow the employer to include a “spend down rule.” In other words, former employees can use any remaining funds to pay eligible expenses they incurred before the plan year ended. This is optional for employers.

The employee must prove each claim is for an eligible expense.

The IRS limits these accounts to $5,000 for married couples filing jointly. These accounts aren’t the only way to get tax-favored dependent care. The employee can also choose the dependent tax care credit if that is more favorable. IRS Publication 503 can help your employees decide which route to take.

Claims must occur within the plan year or within the grace period.

The plan must distribute experience gains properly. Gains associated with the dependent care account have the same options as the health care account, but employers can also choose to contribute dependent care account forfeitures to charity.

The plan must comply with Section 125 as outlined in the first section of this Advisor.

Dependent care expenses must be incurred in order for the employee and the spouse to work.

Child care centers, in-home day care providers with social security numbers and back-up day care providers must meet certain requirements to be considered eligible providers. For example, an employee’s child under age 19 does not qualify. The day care provider can’t be the employee’s Section 152 qualifying relative or child or the spouse or parent of a qualifying child.

Employers can allow employees to use a debit card so that they can have immediate access to reimbursement account funds. Some of the rules include:

Participants must agree in writing to use the card only for eligible expenses that cannot be reimbursed under any other plan.

The card must be limited to an annual election amount, less any claims paid to date.

Card should be canceled when the employee terminates participation in the health care reimbursement account.

Employees can use debit cards only at merchants with health care merchant codes and certain pharmacies that use IIAS inventory systems.

Employees must prove they used the card for eligible expenses. In certain circumstances, claims can be auto-substantiated if they meet IRS rules.

Health care reimbursement accounts are treated like self-funded medical plans. These accounts also need to comply with other federal laws including COBRA, although COBRA applies only in certain circumstances. If employees have received more in claim reimbursements than they have contributed, the employer does not need to offer COBRA. However, if the employee has contributed to the account more than their paid claims as of the qualifying event date, then COBRA must be offered. The date used to determine the account standing is the qualifying event date. Claims must have been paid in order to be considered; unpaid pending claims should not be counted.

Dependent care account rules are similar to the health reimbursement account rules, but they are not identical:

The uniform coverage rule does not apply. Employees can withdraw only the funds that they have already deposited. There is no employer risk for these accounts.
• If claim is paid improperly (debit card used for an ineligible expense or an employee fails to prove an expense was eligible), the plan must follow IRS requirements:
  ➢ The debit card must be turned off.
  ➢ The employee must repay the account using an IRS approved method.

Employees can use debit cards for dependent day care expenses as well, but the process is more complicated because they must use the funds already in the account.

These accounts are mutually exclusive. Funds set aside in the health care reimbursement account can be used only for eligible health care expenses. Funds set aside in the dependent care account must be used only for dependent care expenses.

Non-Discrimination Requirements

Section 125 prohibits plans from discriminating in favor of highly compensated and key employees. In order to prove the plan does not discriminate, employers must test it every year.

The first IRS non-discrimination tests were vague and the methods and timeframe for conducting the tests were unclear. Most employers simply ignored this requirement.

In 2007, the IRS issued new non-discrimination test regulations to help employers understand the testing requirement details. The rules are now clear. The IRS expects employers to conduct the tests on the last day of the plan year. The tests must include all employees that participated in the plan during that year.

Some employers may want to test the plan more than once during the year. If the plan does discriminate, highly compensated employees and key employees can lose tax-favored status. The earlier in the year employers test the plan, the earlier they can identify potential problems. The IRS does allow highly compensated and key employees to make midyear changes to correct the situation.

Employers must conduct three specific non-discrimination tests each year:

1. Eligibility Test: Each plan needs to pass three test elements:
   ➢ Employment requirement: New-hire waiting period must be less than 3 years and must apply to all employees.
   ➢ Entry requirement: As soon as employees complete the waiting period, they must be eligible.
   ➢ Non-discrimination test: The plan must ensure it does not discriminate in determining who benefits from the plan.

The IRS offers a safe harbor test. An employer can pass the test automatically if all employees are eligible to participate in the Section 125 plan, all employees have the same waiting period and the waiting period is less than 3 years.

2. The Contributions and Benefits Test: This test also has three standards:
   ➢ Availability: Similarly situated participants must be given the same opportunity to elect benefits.
   ➢ Utilization: The tax-free benefits available to highly compensated employees need to compare favorably with the tax-free benefits of the other participants.
   ➢ Non-discrimination in operation: Your plan does not discriminate in practice.

The IRS offers a safe harbor for this test as well. If an employer provides health benefits that meet the 100%/75% rule, the plan automatically passes. In other words, if an employer pays 100% of the health plan premium for the plan that most highly compensated employees elect or an equal amount for the most expensive health plan option and that amount is at least 75% of the cost, then the plan meets the 100%/75% rule and it passes this test.
3. **The Key Employee Concentration Test:** This simple mathematical test is not required for a government plan or a plan subject to a collective bargaining agreement. Your plan will pass this test if your key employee benefits under the Section 125 plan are not more than 25% better than all employees’ tax-free benefits.

Employers need to understand many more details to conduct these non-discrimination tests in-house. For more information, please review our first *Benefit Advisor* from 2008 at [http://mcgrawwentworth.com/Benefit_Advisor/2008/BA_Issue_1.pdf](http://mcgrawwentworth.com/Benefit_Advisor/2008/BA_Issue_1.pdf). Employers should find out whether the Section 125 plan administrator can conduct the non-discrimination tests and, if so, ask about the fees associated with these tests. It will likely be easier to have your administrator manage the testing process.

### Concluding Thoughts

Section 125 is more complicated than many employers realize. In order to allow employees to pay for certain benefits pre-tax, it is important to understand Section 125 employer requirements. In its last round of Section 125 guidance, the IRS clearly stated employers must follow Section 125 rules. If your plan violates the rules, your entire plan may be disqualified from allowing any pre-tax deductions. The implications of noncompliance are significant.

To avoid potential problems, take the following steps. First, check your Section 125 plan. Do you have a plan document? If not, you need to draft a document that includes all the information Section 125 requires. If you have a document, review it to make sure it includes all the required information. Then review your administrative process for allowing midyear changes. Are you allowing the changes the IRS permits and are those changes included in your document? Are you making sure the changes are consistent with the event? Finally, make sure to conduct non-discrimination tests annually.

If you have any additional questions about Section 125, please contact your McGraw Wentworth Account Manager. MW