



# BENEFIT *Advisor*

## In This Issue

*In this tenth issue of the McGrawWentworth Benefit Advisor for 2007, we will examine the recently released proposed Section 125 regulations. The new proposed regulations delete areas of the Code that no longer apply and incorporate new sections that address changes and clarifications to the rules that have been issued over the last decade.*

*If your organization has stayed on top of the guidance that has been issued over the last decade, the new proposed regulations will require very little change. However, it does make tremendous sense to carve out some time over the next year to review your document and procedures in light of these new regulations.*

*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 McGrawWentworth web site at [www.mcgrawwentworth.com](http://www.mcgrawwentworth.com).*

## “New Proposed Section 125 Regulations”

In August 2007 the IRS proposed new Section 125 regulations. For the most part, these proposed regulations will become effective for plan years beginning on or after January 1, 2009. The IRS has requested comments on the proposed regulations. Public comments need to be submitted by November 5, 2007; it will also hold a public hearing on these rules on November 15, 2007. Since the IRS is soliciting public comments, it is likely these rules may change slightly before final rules are released.



These proposed regulations are a bit like a Section 125 spring cleaning. They delete provisions that no longer apply and add new provisions regarding numerous revenue rulings, private letter rulings, notices and informal guidance released since 1984. The new rules also clarify some gray areas that employers have struggled with over the last few years.

This *Advisor* explains the following key issues employers need to review:

- General Rules and Requirements
- Qualified Benefits
- Individuals Who May Participate in Cafeteria Plans

- Election Rules
- Flexible Spending Accounts
- Paid Time Off
- COBRA Rules

The proposed regulations also clarify many issues relating to the non-discrimination testing process. A separate *Benefit Advisor* will explain those clarifications.

### General Rules and Requirements

Section 125 allows an employer to offer employees a choice between taxable benefits and non-taxable benefits. In fact, all Section 125 plans must allow all participants to choose between cash and non-taxable benefits. If a plan does not offer this choice, all benefits are considered part of the participant’s gross income and taxed accordingly.

Under the new rules cash is defined as:

- Current compensation (including salary reduction)

- Payment for annual leave, sick leave or other paid time off
- Severance pay
- Property
- Employer-provided taxable benefits
- Certain after tax contributions

Your plan must satisfy all Section 125 requirements in order to qualify as a Section 125 plan. If your plan does not qualify, all participants lose tax-favored status. To qualify under Section 125, your plan must:

- **Provide a Document:** All plans must operate subject to a plan document including the following information:
  - A specific description of benefits including coverage periods.
  - Plan participation rules; the plan must limit participation to eligible employees.
  - Rules governing employees' elections; the document must state the time limit for making an election and the time frame the elections apply. It must also state that the election is irrevocable unless the employee experiences a qualified change in family status. The plan must define eligible changes in family status.
  - Employer and employee contribution options; for example, reduced salary or non-elective employer contributions (flex credits in credit based plans).
  - The maximum amount of employer contributions.

- The plan year definition; the plan year must be specified in the document.
- Additional details depending on the benefits the plan offers. For example, if your plan offers vacation buy-sell, the document must inform employees they are required to use non-elective time off before using elective time off.
- Detailed Flexible Spending Account rules (if the plan offers FSAs) including the uniform coverage rule, the use-it or lose-it rule, the grace period, and so on.
- Details of the IRS requirements for rollovers from a health FSA into a Health Savings Account.

- **Be Maintained for Employee Benefit:**

An employer must maintain the plan solely for the benefit of employees. Only the employer can sponsor the plan and only eligible employees can elect benefits from the plan.

- **Comply with Section 125**

**Rules:** The plan must comply with the rules of Section 125. A plan **does not** meet Section 125 requirements if:

- It offers non-qualified benefits.
- It does not offer an option between at least one taxable and one qualified non-taxable benefit.

- Its flexible spending accounts (if offered):
  - ◆ Do not comply with uniform coverage rule.
  - ◆ Do not comply with "use it or lose it" rule.
  - ◆ Do not follow steps to verify a claim.
  - ◆ Reimburse any claims before the beginning of the plan year or coverage period.
  - ◆ Allocate experience gains in a manner that Section 125 does not permit.
- It allows mid-year plan changes Section 125 does not permit or your plan document does not address.

The new regulations spend some time discussing the plan year. The plan year must be 12 consecutive months and must be designated in the plan document.



A shorter plan year is permitted only for a valid business reason such as launching a calendar year plan mid-year or changing health insurance arrangements. If an employer designates a shorter plan year just to avoid meeting the Section 125 requirements, the plan will be disqualified and all participants will lose tax-favored benefits.

## Qualified Benefits

The new regulations set forth the requirements a benefit must meet in order to be considered a qualified benefit under Section 125. The benefit must be excludible from an employee's gross income under a specific provision of the Internal Revenue Code and the benefit must not defer compensation. Deferring compensation means paying for a benefit in one year that will be received in future years.

The stated exceptions to the deferred compensation requirement include:

- Pre-tax contributions to a 401(k) plan or a trust that is part of a profit-sharing, stock bonus plan or rural cooperative plan.
- Contributions made by certain educational institutions to a post-retirement group life insurance plan, if they meet certain conditions.
- Contributions to Health Savings Accounts (HSAs).
- Reduced salary in the last month of a plan year to pay for benefits for the first month of the following year.
- A mandatory "two year lock in" or "two year lock out" on vision and dental plans. These "lock in" or "lock out" provisions help protect plans from adverse selection. These arrangements are permissible, if:
  - The premiums for each plan year are paid at least once a year.
  - The premium collected in one 2-year coverage period is not used to pay for the next 2-year coverage period under any circumstances.

The new rules confirm the following benefits can be considered qualified under Section 125:

- Group term life insurance covering the employee.
- Employer-provided accident and health insurance plans.
- Short- and long-term disability benefits.
- Dependent Care Flexible Spending Accounts.
- Contributions to a 401(k) plan.
- COBRA premiums.
- Health FSAs.
- Accidental death and dismemberment policies.
- Adoption assistance programs.
- Contributions to HSAs.
- Contributions for certain plans maintained by educational institutions.

Two benefits noticeably absent as qualified benefits are legal service plans and long-term care insurance.

The new rules provide more details on calculating the tax consequences of certain term life insurance coverage arrangements. Section 79 of the Internal Revenue Code addresses the taxability of employer-provided group term life insurance coverage. In general up to \$50,000 of group term life insurance can be excluded from the employee's income. The term life

coverage cannot be combined with any permanent life insurance.

The new regulations change the way employers need to calculate imputed income for term life coverage provided through a Section 125 plan. The new method is different and quite simple. Section 79 allows \$50,000 of employer-provided coverage to be tax-favored.

The following examples show how to calculate imputed income:

### Example #1 - When Contributions Are Pre-tax

- ABC Company offers group term life insurance through its cafeteria plan. John Smith is 42 and elects \$150,000 in coverage. His annual pre-tax premium is \$200.
- The \$200 premium is tax-free because it is made under the cafeteria plan.
- Section 79 allows for \$50,000 in coverage to be tax-favored. Total coverage \$150,000 - \$50,000 = \$100,000
- ABC Company must impute income on the \$100,000 of coverage according to Section 79. The Table I rate for \$100,000 of coverage for ages 40-44 is \$120. ABC Company should impute income on the \$120 Table I value of the \$100,000 of coverage.



### Example #2 - When Some Contributions Are Post-tax

- Same circumstances as example one, except, John Smith pays \$100 of his premium with post-tax dollars.
- Only \$100 of the premium is tax-free because it is made under the cafeteria plan.
- Section 79 allows for \$50,000 in coverage to be tax-favored. Total coverage \$150,000 - \$50,000 = \$100,000
- ABC Company must impute income on the \$100,000 of coverage according to Section 79. The Table I rate for \$100,000 of coverage for ages 40-44 is \$120. Since John paid his \$100 premium post-tax, ABC Company takes the Table I value of \$120, subtracts the \$100 paid after-tax, and the company needs to impute income on only \$20.

The new rules refer only to calculating imputed income for group term life policies offered through a Section 125 plan. An employer still must conduct the non-discrimination testing annually to determine whether the plan is discriminatory. Please see next month's *Advisor* for more details on Section 79 non-discrimination rules.

The new regulations also allow an employee to pay for an individual health insurance policy on a pre-tax basis through a Section 125 plan. The employer must allow this option and the employer is required to verify the funds were used to pay for the policy.

The new rules clarify 401(k) contributions are permitted through Section 125. The contributions are

also subject to all 401(k) rules. Contributions to the 401(k) plan can be expressed as a percentage of income.

### Individuals Permitted To Participate in Cafeteria Plans

Only employees may participate in an organization's Section 125 plan. Employees can include any of the following:

- Common law employees.
- Leased employees.
- Full-time life insurance salesmen.
- Former employees may participate; however, a plan may not operate predominately to benefit former employees. The new rules indicate laid-off employees and retired individuals are both considered "former" employees.



The following individuals are not eligible to participate in a cafeteria plan:

- Self-employed
- Sole proprietors
- Partners in a partnership
- Directors of corporations
- 2 percent shareholders of a subchapter S corporation

Family members of the partners or 2% shareholders in a subchapter S corporation, even if they are also employees, cannot participate in the Section 125 plans.

The new rules also clarify tax issues for employees with dual responsibilities; for example, an employee also serving as an independent contractor or a director. In this case, even if one of the roles does not qualify for a Section 125 plan, the individual may still participate as an employee. However, the employer must be careful to take pre-tax deductions only from the pay earned as an employee, not fees earned as an independent contractor or compensation earned as a director.

### Election Rules

The election rules for Section 125 remain largely unchanged. Elections are irrevocable for the 12 month plan year, unless the participant's family status changes. The family status rules are still the same. Elections

must be made before the effective date of the plan.

The new rules also cover Health Savings Account contributions. Under a Section 125 plan, contributions to an

HSA can be changed as frequently as your payroll cycle as long as the changes are made prospectively. Your Section 125 plan must be amended to allow contributions to HSAs.

If your plan has automatic enrollment (referred to as negative elections or default elections), your plan document must describe this feature. Although enrollment may be automatic, employees must still be given the option not to enroll. For example, a plan may automatically

enroll an employee in single medical coverage. The employee must be given the option to change the election in a number of ways:

- Choose not to be covered by the plan.
- Change health plan options.
- Cover eligible dependents.

The plan needs to clearly communicate the process and timing for changing an automatic enrollment. The new rules specify an election made for the prior year can continue for succeeding years as long as the employee has the option to make changes at open enrollment.

### Flexible Spending Accounts

The new rules formally incorporate many of the previous guidelines on flexible spending accounts. They also allow employers to offer adoption assistance programs designed like flexible spending accounts.

Medical flexible spending accounts must include the following key provisions:

- The participant may access the full amount of the annual election on the first day of the plan year. The employer must bear some risk as part of offering these plans. If a participant exhausts all benefits and quits before the end of the plan year, the amount paid out and not collected through employee contributions is the employer's responsibility. Employers cannot *require* former employees to repay the plan.
- The coverage period must be 12 months. It can be extended for 2 ½ months if the

employer chooses to offer a grace period.

- Employees can use a medical FSA only for medical expenses. They cannot use these funds to pay health plan premiums.
- A third party must verify a claim is for an eligible medical expense. The regulations permit the third party to verify a claim in a number of ways.
  - Expenses must be incurred during the plan's coverage period (and grace period, if applicable).
  - Any funds remaining in the account at the end of the plan year (or grace period if applicable) must be forfeited to the plan as an experience gain.
- Employers may allow FSAs only for those employees participating in the employer's health plan.
- Plans are not required to cover all Section 213 medical expenses; the plan can limit coverage to a subset of Section 213 expenses but the document must clearly identify the expenses the plan covers.
- The new regulations make an exception to the deferred compensation rules for orthodontia care. Many orthodontists require a larger upfront payment at the beginning of treatment and maintenance fees for the remainder of the treatment. Under the new rules employees can be reimbursed for an

upfront payment to an orthodontist.

The new rules also detail how to handle forfeitures (experience gains). Employers may use forfeited funds as follows:

- Offset plan administrative costs.
- Distribute the funds equally to plan participants.
- Decrease salary reductions for plan participants in the next plan year, providing the decreases are reasonable and uniform.
- Keep any forfeited funds (even if they are not used to defer plan expenses). Surprisingly, the rules do allow this option. Employers are questioning this option because the DOL has fiduciary requirements and rules dictating how employers

must manage plan assets. This provision may violate the DOL's prohibited transaction rules for plan sponsors. Employers choosing this

route should be cautious until more information is available on whether this transaction may be considered prohibited.

Interestingly, the new rules do not specify if experience gains can be donated to charity, which was an option permitted by the initial regulations.



The new rules make very few changes in dependent care accounts. Employers still have the option of reimbursing dependent care expenses for terminated employees if funds remain in the account. If you decide to reimburse these expenses, find out whether your administrator can administer claims post-termination.

Under the new rules all dependent care account or medical flexible spending account claims must be incurred during the coverage period (plan year plus any applicable grace period) and be verified by an independent third party (employee self-substantiation is not an option). The expenses must not be covered by any other source whether it is a formal plan or an employer reimbursement.

Section 125 regulations now include the following guidelines on stored value cards or debit cards:

- Employees must meet all IRS requirements when they use debit cards to pay or reimburse qualified medical and dependent care expenses.
- Rules for using debit cards to pay or reimburse medical expenses are as follows:
  - Employees must agree in writing before receiving the debit card that they will use it only for qualified expenses for a qualified plan participant or dependent. The employee must affirm that expenses paid with the debit card are not covered by any other health plan



or reimbursement arrangement. Employees need to keep the documents necessary to substantiate debit card claims.

- The actual debit card states the conditions in Bullet 1 and by using the card, the employee reaffirms the agreement.
- The amount available on the card for medical claims should reflect the participant's annual election minus any claims already paid during the year to date.
- The debit card is automatically canceled when an employee ceases to participate in the FSA.
- The debit card can cover only qualified 213(d) medical expenses. Employees can use it

to pay for services only from providers with merchant codes such as physicians, dentists, vision care providers and

other medical care providers. They can use it at pharmacies as long as 90% of the store's prior year's gross receipts reflect qualifying Section 213(d) expenses. They can also use it in stores that have an inventory information approval system for products with a SKU coding.

- The employer or administrator verifies all debit card claims using methods outlined in the regulations.

- The employer must adhere to all the collection procedures listed below when a participant uses the debit card improperly:

- ◆ The employer must require the employee to repay the plan.
- ◆ Until the improper payment is repaid, the debit card must be shut off.
- ◆ If the employee submits a claim for a qualified medical expense under the plan, reimbursement for that expense may be offset by the improper amount owed to the plan.
- ◆ If the improper amount remains unpaid after the employer makes several attempts to recover the funds, the employer can withhold the improper payment amount from the employee's paycheck to the extent allowed by federal and state law.
- ◆ If the amount remains uncollected, employers can treat the expense as a business debt and pursue repayment as they would any other vendor that has incurred a debt and not paid.

The substantiation rules are modified when a plan uses a debit card. The new regulations incorporate the Revenue Ruling in 2006 that documented when the use of a debit card could be considered automatic claim substantiation. The rules

were outlined in the following Special Alert, [http://www.mcgrawwentworth.com/Special\\_Alert/2006/Special\\_Alert\\_Issue\\_5.pdf](http://www.mcgrawwentworth.com/Special_Alert/2006/Special_Alert_Issue_5.pdf) and were not changed when incorporated into the regulations.

### **Paid Time Off**

The new regulations discuss paid time off under a cafeteria plan. It is not common, but some employers do allow employees to buy additional vacation time under a cafeteria plan. The rules regarding paid time off are complicated and your plan needs to manage this benefit carefully so that it does not violate the deferral of compensation requirement.

If a plan allows employees to buy vacation time under the cafeteria plan, it must meet the following requirements:

- The plan must require employees to use any non-elective paid time off first. Once employees exhaust all non-elective time off, they can begin to use elective time off.
- The plan must require that all **unused** elective paid time off (as of the last day of the plan year) must be paid out in cash (taxable) to the employee or forfeited. Employers must include this provision in the plan document and apply it uniformly to all plan participants that purchase additional vacation.
- If the employer allows the cash out of any elective time off remaining at the end of the plan year, the employee must receive the cash on or before the last day of the cafeteria plan's plan year.

- The grace period does not apply to paid time off.

The new regulations do state that **non-elective** vacation time may carry over into the following year without violating the deferred compensation rules. However, employees must use non-elective vacation first. The document must specify how the unused elective vacation time will be handled at year end.

### **COBRA Rules**

The new regulations continue to allow employees to pay COBRA premiums with pre-tax dollars through a Section 125 plan. Employers may want to allow this option in the following circumstances:

- An employee moves from full-time to part-time and is offered COBRA. The employee can pay for COBRA premiums with pre-tax dollars if your plan allows.
- A new employee wants to continue COBRA coverage until he or she is eligible under the group health plan. The employer can allow the new employee to deduct the COBRA premiums pre-tax. Employers should allow the employee to pay COBRA premiums directly to the former employer and reimburse the employee with pre-tax dollars after the employee proves the premium was paid.

Employers may choose to allow employees to pay their COBRA premiums pre-tax. The new rules stress the premiums are to be deducted

pre-tax under the premium only portion of a plan. COBRA premiums are not an eligible expense under a health FSA.

### **Concluding Thoughts**

It seems like a lot to absorb, but these proposed regulations really incorporate many of the Section 125 plan guidelines that have been in place for years. If your organization has managed to stay on top of the changes over the years, your plan is probably consistent with the new guidelines.

However, there are new issues addressed in these regulations that

should be reviewed. Your organization should plan to review your Section 125 plan document and administrative practices over the next several



months. Make sure your document contains the necessary requirements of the plan and it encompasses all of the concepts addressed in this *Advisor*. These proposed regulations may change slightly when they are issued in a final format. Since the IRS has requested feedback, concerns may be voiced by employers and administrators. However, the content of the regulations is not likely to change substantially and it makes sense to work through your document to make sure it reflects these proposed regulations.

If you have any questions, please call your McGraw Wentworth Account Manager. **MW**

