In this sixth issue of the McGraw Wentworth Benefit Advisor for 2014, we review the Internal Revenue Code Section 125 rules. Employers need to follow the rules to allow employees to pay for certain benefits with pre-tax dollars. Health care reform has affected Section 125 rules. Employers need to be aware of these changes.

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 web site at www.mcgrawwentworth.com.

"A Recap of Section 125"

Section 125 of the Internal Revenue Code allows most employees to pay for certain benefits with pre-tax dollars, but complex and specific rules apply.

This Advisor reviews the Section 125 rules including:

- Basic Legal Requirements
- Mid-year Changes
- Flexible Spending Accounts (FSAs)
- Non-Discrimination Requirements

Health care reform has now changed several aspects of the Section 125 rules. While most employers try to comply with all the Section 125 details, some do not realize that failing to meet the requirements can have serious consequences. The IRS could even disqualify the plan.

With that in mind, it makes sense to review your documents and processes.

Basic Legal Requirements

Section 125 allows employees to pay for qualified benefits with pre-tax dollars. To qualify as a Section 125 plan, 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 qualified benefits, your plan meets this requirement.

Employers must meet these specific Section 125 requirements:

1. The plan must be described in a plan document. The plan document must include the following:
   - Benefits and coverage periods. A specific description of benefits and the coverage period.
   - Participation rules. The plan 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 timeframe for making elections. In general, elections are good for the entire plan year. The plan document also needs to specify when the plan allows mid-year changes and the timeframe for making those changes. Section 125 allows mid-year changes in up to 14 situations. Your plan document must include the situations you want to allow to trigger mid-year changes.
Contribution rules. Employer and employee contribution options must be stated. These options include allowing employees to pay either through salary reductions or a credit-based flex system.

Benefits offered. This needs to address what benefits will be offered under the plan. They need to be qualified benefits under Section 125. Additional benefits the plan offers should also be included. This could include opt-out bonuses, vacation buy or sell arrangements, medical and dependent care FSAs, and so on.

Plan year. Generally, Section 125 requires a 12-month plan year. A plan can have a short plan year, but only for a valid business reason. The plan year can never exceed 12 months. The employer must let employees know before the beginning of a short plan year. In general, 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 the following Section 125 rules:
   - It must offer only qualified benefits.
   - It must offer a choice between cash or benefits. This means full salary or a reduced salary to pay for benefits.
   - The plan document must include all mid-year changes the employer wants to permit.
   - 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 future years. However, 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.
     - Contributions to a Health Savings Account (HSA).
     - 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 qualified benefits can be paid for with pre-tax dollars. These include:

- Employer-sponsored benefits such as:
  - Accident and health benefits (medical, dental, vision and so on).
  - Accidental death and dismemberment benefits.

- Employee paid group term life insurance. However, pre-tax term life insurance could create imputed income issues. Please read our Benefit Advisor at [http://www.mcgrawwentworth.com/Benefit_Advisor/2013/BA_Issue_4.pdf](http://www.mcgrawwentworth.com/Benefit_Advisor/2013/BA_Issue_4.pdf) to learn more about imputed income.

- 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. Take care here; make sure your disability plan vendor can administer this option.

- Medical and dependent care FSAs.
- Vacation buy or sell arrangements.
- Adoption assistance programs. However, offering these plans under Section 125 is more limiting than an employer-sponsored plan outside Section 125.
- COBRA premiums. 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.

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• Certain educational institutions’ plans

Neither legal service plans nor long-term care insurance can be paid for with pre-tax dollars. Also, under health care reform, employers cannot allow pre-tax payment of individual health insurance premiums. Although some employers did allow employees to pay for individual coverage under a Section 125 plan, it is no longer permitted.

Any employer can sponsor a Section 125 plan and set the eligibility requirements. The law specifically excludes the following individuals from participating in a Section 125 plan:

- Self-employed individuals
- Sole proprietors
- Partners in a partnerships (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 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.

**Mid-year Changes**

Mid-year changes have always posed a challenge for employers. Employers should first understand the Section 125 rules for employee elections listed below before trying to make sense of the changes.

- 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
- Section 125 does not set timeframes for mid-year changes and notifying employee’s of changes. However, HIPAA special enrollment rules require 30-day notice for most changes and 60-day for Children Health Insurance Program (CHIP) changes. Most 125 plans adopt these time periods to coincide with HIPAA requirements.
- Almost all elections and most changes must be made before their effective date. Retroactive changes are permitted only in these two situations:
  - Addition of a newborn or newly adopted child
  - 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. Election can be made retroactive 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 permits mid-year changes in just 14 situations. Your plan document must state which specific mid-year changes your plan permits. Any mid-year change must also be consistent with the status change prompting it.

To verify whether a mid-year change is permitted, employers need to ask these four key questions:

1. Is the change allowed under Section 125?
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 by the underlying medical, dental, or life plan?

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

Mid-year changes to medical or dependent care FSAs are more limited than the changes allowed for other pre-tax contributions. Below is a list of the 14 mid-year change events and whether the changes are allowed:

1. **Specific changes in family status (allows medical and dependent care FSA changes):**
   - Change in legal marital status, which now includes same sex marriages. A same-sex marriage is recognized if the ceremony is performed in a jurisdiction that recognizes same-sex marriage. Section 125 defers to the federal legal definition of marriage.
   - Change in number of dependents as defined by Section 152 of Internal Revenue Code.
NOTABLE THOUGHTS

THE MAN WHO DOES NOT READ GOOD BOOKS HAS NO ADVANTAGE OVER THE MAN WHO CANNOT READ THEM.

MARK TWAIN (1835-1910)

- Change in employment status of employee, 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. Mid-year insignificant cost changes will allow automatic increases or decreases in elective contributions. This means employers can change employee contributions for coverage mid-year. Employees cannot make any election changes if the amount is “insignificant.” Unfortunately, the law does not define “insignificant.” Insignificant is a facts and circumstances determination.

3. Mid-year significant cost changes will allow mid-year 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 it is more expensive.

4. Significantly reduced coverage with or without coverage loss allows mid-year changes (dependent care FSA 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 or a significant improvement to a benefit will allow mid-year changes. Employers must allow employees to elect the new benefit even if they previously declined coverage. Employees can also switch from alternative coverage to the new plan.

6. A change in coverage under another employer’s health plan may allow mid-year changes (DCRA allowed). If a spouse’s plan significantly curtails coverage or significantly increases cost, the employee can change coverage. You can also allow mid-year changes if a spouse’s plan has a different open enrollment period from your plan. Be careful in this situation. The underlying health plan will likely not allow a coverage election mid-year for a change in coverage or another plan’s open enrollment.

7. The loss of coverage under a government or educational institution’s health plan allows mid-year changes. 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. You need to be careful. Your 401(k) plan may allow changes on a more limited schedule, for example monthly or quarterly.

9. Any HIPAA special enrollment rights will allow mid-year changes. (Medical FSA 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

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Eligibility for premium assistance under the CHIP program

10. A COBRA qualifying event will allow mid-year changes. 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 will allow a mid-year change (medical FSA changes only allowed). For example, if a plan receives a qualified medical support order for a child, it must cover the child mid-year.

12. Medicare or Medicaid entitlement occurring mid-year also allows mid-year changes. When employees become eligible for Medicare or Medicaid mid-year, they can drop employer coverage. If they lose their Medicare or Medicaid coverage, they can enroll in the employer’s plan mid-year.

13. FMLA leaves allow mid-year changes (both medical and dependent care FSA 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. Pre-tax contributions can be changed accordingly.

For paid FMLA leaves, employers can 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 when the pre-payment straddles plan years. Coverage paid for beyond the first month of the new plan year could violate the deferred compensation rule.

14. HSA contributions can be changed mid-year. The IRS has only a few rules related to mid-year HSA changes. The changes must be made prospectively. Employers must allow these changes at least monthly. The rules on HSA mid-year funding changes must be stated in the plan document.

In September 2014, the IRS added two new mid-year changes in response to health reform.

1. Coverage can be revoked mid-year in response to election rights in the Marketplace. Employee must indicate that they are revoking group coverage to secure Marketplace coverage.

2. Coverage can be revoked if an employee reduces work hours to less than 30 hours per week, even if it does not affect eligibility. It is only permitted if employee is electing other health plan coverage.

Mid-year changes can be confusing. Not only must employers list permissible mid-year changes in the plan document, but also the underlying plan must allow the changes. In some cases, Section 125 may allow the change, but the underlying plan will not.

Section 125 does not deal with smoker surcharges directly. There are two schools of thought on handling these surcharges. A conservative approach would be to take the surcharge amount only post-tax. If the surcharge amount is post-tax, employers can make changes throughout the year. A more aggressive approach would be to allow the surcharge amount to be taken pre-tax. Employers could still change the smoker surcharge during the year. The changes to a pre-tax surcharge throughout the year would be permitted because it is not viewed as a change in election, just a modification of premium contribution. Hopefully, at some point the IRS will clarify how employers should handle mid-year smoker surcharge changes.
Flexible Spending Accounts

Under Section 125 employers may decide to offer employees medical or dependent care flexible spending accounts. These accounts allow employees to set aside some of their income 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.

The following rules apply to medical FSAs:

- These accounts must comply with the uniform coverage rule. The full annual amount 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 has lasik eye surgery in January costing $2,500. The employee could submit a claim and be reimbursed for the full $2,500, even though the account had only one month’s contributions. The employee can reimburse 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 employer can’t collect the outstanding balance.

- 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 offer a grace period for eligible claims or even a rollover option to mitigate the impact of the “use it or lose it” rule.

- The employee must prove and the plan must substantiate that each claim is for an eligible expense.

- Health care reform limits annual contributions to $2,500 per employee.

- 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.

Section 125 has been modified over the years to lessen the impact of the “use it or lose it” rule. Many employees would not participate in an FSA for fear of losing any unused funds at the end of the year. Employers can adopt one of the following (employers can’t have both of these options):

- Grace period – Employers can add up to a 2.5 month grace period to their FSAs. The grace period effectively extends the plan year for 2.5 months. If an employee has an eligible claim during the grace period, it can be paid out of any funds remaining in the account at the end of the previous plan year. For example, employers with a calendar year plan can add a 2.5 month grace period. Claims incurred up to March 15 can be paid using the amount remaining in the account from the previous year.

- Rollover or carry over – Employers can allow up to $500 in a medical FSA to rollover or carry over into the next plan year. If the employer adds the rollover to the plan, the rollover funds can be used for any claims in the current plan year.

Neither of these options will offset the $2,500 annual maximum, and both can affect an employee’s ability to contribute to a health savings account (HSA). Employers planning to launch a high deductible health plan with an HSA need to be aware of the potential impact. There are options that can minimize the effect on the employee’s ability to contribute to an HSA.

Health care reimbursement accounts are treated like self-funded medical plans. These accounts also need to comply with other federal laws, including COBRA. However, COBRA applies only in certain circumstances. Employers must offer COBRA when employees lose coverage because of a qualifying event. When it comes to medical FSAs, the account benefits available have to exceed the premiums required to continue the account until the end the plan year. 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. In general, if the employer does not charge a 2 percent administrative fee, the employee has to have some level of contribution in the FSA that has not been used in order for COBRA to apply.

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Health care reform also made another key change to Section 125. Since health care reform applies to group health plans, it should apply to medical FSAs. That would be true, if the ACA did not include an exception for many of its requirements if a medical FSA is considered “excepted.” An “excepted medical FSA” meets both of the following requirements:

- FSA eligible individuals must be eligible for other medical coverage through the employer
- The maximum benefit payable to any participant cannot exceed:
  - two times the participant’s salary reduction election for the year or
  - if greater, cannot exceed $500 plus the amount of the participant’s salary reduction election

Non-excepted FSAs are no longer permitted as a result of health care reform. Employers that cover any employees not eligible for other medical coverage likely are offering a non-excepted FSA. Also, it could be an issue if the waiting period for your medical FSA plan is shorter than the waiting period for your medical plan.

Employers can allow employees to use a debit card so that they can have immediate access to medical FSA 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 the annual election amount, less any claims paid to date.
- Card should be canceled when the employee terminates.
- 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.
- 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 are limited to using only the funds currently in the account.

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.
- The “use it or lose 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.
- 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 care tax 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 (if the employer adds 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.
- The employee and the spouse must need to pay for dependent care so that they can work.
- Child care centers, in-home day care providers with social security numbers and back-up day care providers must meet certain requirements.

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These medical and dependent FSAs are mutually exclusive. Funds set aside in the medical FSA can be used only for eligible health care expenses. Funds set aside in the dependent care account must be used only for eligible 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.

Initially, the non-discrimination tests under Section 125 were vague. The testing process and timeframe for conducting the tests were unclear. Many 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 clearer. The IRS expects employers to conduct the tests as of 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 mid-year changes to correct the situation.

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

1. **Eligibility Test**: Each plan needs to pass three tests:
   - **Employment requirement**: New-hire waiting period must be less than three 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 three 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.

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 percent 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/resources_benefitsadvisor.html](http://mcgrawwentworth.com/resources_benefitsadvisor.html). Employers should find out if their Section 125 plan administrator can conduct the non-discrimination tests. If they can, 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 non-compliance are significant.
To avoid potential problems, take the following steps.

1. Check your Section 125 plan document. 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. For example, does your plan accurately reflect the tax-favored status of same-sex spouses married in a jurisdiction that recognizes the union?

2. Review your process for allowing mid-year changes. Are you allowing all the changes the IRS permits and are those changes included in your document? Are you making sure the changes are consistent with the event?

3. Do you need to make any changes as a result of health care reform:
   - Does your medical FSA accurately reflect the $2,500 annual limit?
   - Were you allowing individual insurance plan premiums to be paid pre-tax? Has your document been changed to inform employees this is no longer permitted?
   - Is your medical FSA considered a non-exception benefit? Non-exceptional medical FSAs are no longer permitted. Make changes needed to create an “excepted benefit” for your medical FSA.

4. Are you conducting non-discrimination tests annually? If not, investigate whether your FSA vendor can conduct the tests for you.

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