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§ 125 Cafeteria Plan Regulations

This legislation was issued by the IRS in the form of Proposed Rules on August 6, 2007, with an effective date of January 1, 2009, and sets forth a number of changes in tax law. These regulations generally affect only those client group plans that have a cafeteria plan and include detailed rules governing the design and operation requirements of such plans. Additionally, they spell out many rules that must be followed both in revised language to formal cafeteria plan documents and in their day-to-day application.

Here at MedCost Benefit Services, we cannot stress enough the importance of addressing these regulations in your cafeteria plans. In the following paragraphs, we have provided a summary of the regulatory requirements. We will be happy to work with you to bring your cafeteria plan into compliance. Please contact your Account Manager for assistance.

KEY FACTS

- Must meet all regulatory requirements to be considered a § 125 Cafeteria Plan
- Must have a written plan document
- Must perform nondiscrimination testing every year

Cafeteria Plan General Rules. The new regulations contain a number of clarifications and requirements relating to the design and operation of a § 125 Cafeteria Plan. Following are highlights from the regulations:

- A cafeteria plan is defined as a separate written plan that permits employees to choose between at least one permitted taxable benefit and at least one qualified nontaxable benefit and, according to the IRS, is the only mechanism by which employees can be offered a choice between taxable and nontaxable benefits. The plan year must be 12 consecutive months; a short plan year is permitted only for valid business reasons.
- Qualified benefits include:
 - accident and health plans (including health FSAs)
 - group term life insurance providing no permanent benefits
 - dependent care
 - accidental death and dismemberment benefits
 - long- and short-term disability benefits
 - elective deferrals to a 401(k) (but not a 403(b))
 - HSA contributions
 - adoption assistance
 - contributions for certain post-retirement group life insurance plans maintained by educational organizations



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- Non-qualified benefits include:
 - scholarships
 - educational assistance
 - fringe benefits under IRS Code 132
 - employer-provided meals and lodging
 - group term life insurance for a person other than the employee
 - contributions to Archer Medical Savings Accounts (MSAs)
 - contributions to an HRA
 - contributions to a 403(b) arrangement
 - long-term care insurance or services (though may be paid from an HSA funded through a cafeteria plan)
- The plan must be in writing and must:
 - specifically describe all benefits
 - set forth the rules for eligibility to participate and the procedure for making elections
 - provide that all elections are irrevocable (except to the extent that the plan includes the 'change in status' rules)
 - state how employer contributions may be made, i.e. salary reduction or nonelective employer contributions)
 - state the maximum amount of elective contributions
 - state the plan year
 - if a plan includes FSAs, information must also be included about the uniform coverage rule, the use-or-lose rule, and any grace period
- A cafeteria plan, but not a health FSA, may also be used to pay or reimburse, on a pre-tax basis:
 - substantiated individual accident and health insurance premiums
 - COBRA premiums for an employee
- Only employees are eligible to participate; though spouses and dependents may receive benefits through the plan, they cannot make, revoke, or change elections. Under the regulations, the term employee includes common law employees, leased employees, and full-time life insurance salesmen, as defined by the IRS. Former employees, including laid-off and retired, may participate in the plan, but a plan cannot be maintained predominantly for former employees. Sole proprietors, partners, and directors of a corporation are not employees and cannot participate. Self-employed individuals, and 2% shareholders of an S corporation are not considered employees and cannot participate.
- A cafeteria plan may permit employees to elect employer-provided health coverage as a taxable benefit for a non-dependent (such as a domestic partner) provided that the fair market value of the coverage is included in the employee's income.
- The new regulations change existing guidance regarding the calculation of imputed income for group term life insurance in excess of \$50,000.



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- The new regulations permit a cafeteria plan to provide an optional grace period immediately following the end of each plan year, extending the period for incurring expenses for qualified benefits. A grace period may apply to one or more qualified benefits (for example, health FSA or dependent care assistance program), but in no event does it apply to paid time off or contributions to a 401(k). The grace period may extend to the 15th day of the third month after the end of the plan year but may be a shorter period. Amounts of unused benefits and contributions available during a grace period may be limited by the employer. (Example: An employee who is a participant in the plan at the end of the year and has money left in his account may use it to pay for expenses incurred during the established grace period.)
- Reasons a plan would fail to satisfy the requirements to be a § 125 Cafeteria Plan include (many of these are discussed in the following paragraphs):
 - offering non-qualified benefits
 - offering an election solely between paid time off and taxable benefits
 - not offering an election between at least one permitted taxable benefit and at least one qualified benefit
 - deferring compensation
 - failing to comply with the uniform coverage rule or the use-or-lose rule
 - allowing employees to change elections during a plan year (except when based on a valid qualifying event)
 - failing to comply with substantiation requirements
 - paying or reimbursing expenses incurred for benefits before the effective date of the plan or before a period of coverage
 - allocating experience gains (forfeitures) other than as permitted in the regulations
 - failing to comply with grace period rules

As you can see from this section, the regulations set forth many requirements that must be met in order for the plan to be a cafeteria plan according to the IRS. The regulations state that if a plan fails to be a cafeteria plan, the employee benefits are to be considered gross income. It is imperative that a written document be in place that contains the specifics of the plan. MedCost Benefit Services will work with all client group plans to ensure that the written documents meet the regulatory requirements and that the plan will be administered according to the regulations.



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Cafeteria Plan Elections. The new regulations provide some specific information regarding cafeteria plan elections:

- A plan is not a cafeteria plan unless it provides in writing that employees are permitted to make elections among taxable benefits and qualified benefits offered for the plan year.
- All elections must be irrevocable and may not be changed during the plan year.
- Mid-year plan changes are permitted based on certain changes in status, as long as such changes are incorporated in the written plan documents. (The list of permitted changes due to changes in status is quite lengthy; any or all are permitted, but not required.)
- Electronic elections are permitted; a safe harbor under other IRS regulations applies for purposes of cafeteria plan electronic elections, revocations, and changes in election.
- Only the employee can make, revoke, or change an election; a spouse or dependent cannot.
- Automatic elections (default/evergreen) are permitted.
- Under an optional election for new hires, employees may make elections within 30 days after their hire date with coverage retroactive to the date of hire, although salary reductions may only be taken from compensation that is not yet currently available. This rule does not apply to an employee who terminates employment and is rehired within 30 days (or returns to employment following an unpaid leave of absence of less than 30 days).
- Plans may permit offerings of dental and vision plans that require two-year election locks provided that the premiums are paid no less frequently than annually and salary reductions from one year are not used to pay premiums for the subsequent year.
- A cafeteria plan offering HSA contributions through salary reduction may permit employees to make prospective salary reduction elections or change or revoke salary reduction elections for HSA contributions at any time during the plan year with respect to salary that has not become currently available at the time of the election.

As you can see from this section, an employer has flexibility in the design of its cafeteria plan, and permissions should be clearly stated in plan documents. MedCost Benefit Services will take steps to ensure that the plan is administered in accordance with the regulations, and the plan design.

Flexible Spending Arrangements. Many of the rules remain the same for flexible spending arrangements; however, here are highlights of the regulation:

- The maximum amount of reimbursement reasonably available must be less than five times the value of the coverage.
- A cafeteria plan may limit enrollment in a health FSA to those employees who participate in the employer's accident and health plan.
- Adoption assistance is now considered an FSA: the three types of FSAs are dependent care assistance, adoption assistance, and medical care reimbursements.



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- *Uniform Coverage Rule:* The maximum amount of reimbursement from a health FSA must be available at all times during the period of coverage; however, this rule does not apply to FSAs for dependent care assistance or adoption assistance.
- *Use-or-Lose Rule:* All benefits and contributions must be used by the end of the plan year (or grace period, if applicable) or forfeited.
- The required period of coverage for all FSAs continues to be twelve months; short plan years are permitted only upon the satisfaction of new rules.
- A health FSA may only reimburse certain substantiated medical care expenses incurred by the employee or by the employee's spouse or dependents.
- A health FSA is permitted to exclude reimbursement of certain over-the-counter drugs.
- A health FSA may not reimburse premiums for accident and health insurance or long-term care insurance.
- Health FSAs may reimburse *advance* payments for orthodontia services and medical equipment.
- Nondiscrimination rules, as noted below, apply to health FSAs.
- *Experience gains* (forfeited contributions) may be: 1) retained by the employer; 2) used to defray expenses to administer the cafeteria plan; 3) returned to employees on a reasonable and uniform basis; or 4) used to reduce required salary reduction amounts for the immediately following plan year, on a reasonable and uniform basis.
- The new regulations clarify the rules for one-time transfers from an FSA to an HSA in order for it to remain tax free.
- Permitted, though not required, dependent care FSAs may allow participants to use FSA funds to pay for dependent care expense incurred after an employee terminates employment but before the end of the relevant plan year or grace period, so long as the former employee continues to satisfy all the conditions for dependent care under IRS rules.

Again, as noted above, an employer has flexibility in the design of its FSAs, and permissions should be clearly stated in plan documents. MedCost Benefit Services will take steps to ensure that flexible spending arrangements are administered in accordance with the regulations and the plan design. Note that health FSAs are subject to the nondiscrimination rules discussed below.

Substantiation of Expenses. The new regulations set forth specific provisions regarding the payment or reimbursement of expenses for qualified benefits under a cafeteria plan.

- Expenses not incurred during the coverage period may not be paid or reimbursed.
- Additionally, before an expense is paid or reimbursed, it must first be substantiated by a third-party independent of the employee; the regulation specifies the methods of substantiation that are permissible.



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- Reimbursement of expenses before the expense has been incurred fails to meet the requirements of the regulation; for example, dependent care expenses may not be reimbursed before the services are received.
- The regulations provide specific rules associated with the use of debit cards for the payment or reimbursement of both medical expenses and dependent care expenses.

MedCost Benefit Services will take steps to ensure that expenses are paid or reimbursed only in accordance with the regulations and that the administration of debit cards also meets all regulatory requirements.

Nondiscrimination Testing. One of the most significant changes in the new regulations is related to nondiscrimination testing. Discrimination in benefits has been an overlooked area and many employers have engaged in only modest or even no testing since past guidance has been insufficient and unclear. Employers who previously performed little or no testing will need to modify their practices.

- The new regulations require that nondiscrimination testing be performed every year, as of the last day of the plan year, and include any non-includible employees who were employees at any time during the year.
- Tests must be performed for both eligibility and contributions and benefits.
- As an example of the purpose of the eligibility testing, the regulations prohibit a cafeteria plan from discriminating in favor of highly compensated individuals as to eligibility to participate for that plan year.
- Regarding testing for contributions and benefits, a plan must give each similarly situated participant a uniform opportunity to elect qualified benefits, and the actual election of qualified benefits through the plan must not be disproportionate by highly compensated participants.

MedCost Benefit Services will provide nondiscrimination testing for client group health plans upon request; the testing will involve a fee and will be conducted near the end of each plan year as stated in the regulations.



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Medicare Secondary Payer Mandatory Reporting Provisions Of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007

New legislation has been issued that sets forth mandatory reporting requirements for group health plans (GHPs) with respect to Medicare eligible individuals. The reported information will be used to ensure that Medicare makes payment in the proper order (primary or secondary) and/or takes necessary recovery actions. Centers for Medicare and Medicaid Services (CMS) states that the data is necessary for both pre-payment and post-payment coordination of benefit purposes, including necessary recovery actions. You may recall that a similar voluntary data sharing program has been in place for some time; however, this new legislation makes the reporting mandatory. The new reporting will be 100 percent electronic.

According to the regulations, an entity serving as a third party administrator for a group health plan, and specifically, an entity that processes claims for a group health plan, has the responsibility for reporting in accordance with the regulatory requirements. As such, MedCost Benefit Services will be performing the reporting responsibilities on behalf of your group health plan. Failure to comply with the reporting requirements could result in severe civil money penalties; therefore, we request your full cooperation as we move through the registration, implementation, and ongoing reporting processes.

KEY FACTS

- MedCost Benefit Services will perform the reporting for client groups
- Assistance is needed in collecting data on all members, including spouses and dependents, covered under the plan as of 1/1/09
- The member's name must be provided as it appears on their Social Security Card
- Data is due to MedCost Benefit Services no later than 2/1/09; an Excel file format is attached

CMS has issued the following timeline for implementation of the new reporting requirements:

- Online registration for all reporting entities will be performed between April 1, 2009 and April 30, 2009.
- Testing will be conducted between April 1, 2009 and July 1, 2009.
- Submission of the first production file will be between July 1, 2009 and October 1, 2009.
- Production files will be submitted from October 1, 2009 and thereafter on a quarterly process.



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Data must be reported on active covered individuals* who meet the following conditions on January 1, 2009, or thereafter:

- All individuals covered in a GHP age 45 through age 64 who have coverage based on their own or a family member's current employment status.
- All individuals covered in a GHP age 65 and older who have coverage based upon their own or a spouse's current employment status.
- All individuals covered in a GHP who have been receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member's current employment status.
- All individuals covered in a GHP who are under age 45, are known to be entitled to Medicare, and have coverage in the plan based on their own or a family member's current employment status. When reporting on these under age 45 individuals, you must submit their Medicare Health Insurance Claim Number (HICN).

**An active covered individual is someone who may be Medicare eligible and currently is employed, or the spouse or other family member of a worker who is covered by the employed individual's GHP and who may be eligible for Medicare.*

MedCost Benefit Services will be able to extract most of the data noted above (you will not be responsible for providing this information to us). However, SSNs on all such individuals will be required. Therefore, we will need your assistance in collecting SSNs on all members, including spouses and dependents, who are covered under the plan on 1/1/09.

Also, to facilitate an efficient reporting process, enabling the Medicare 'match process' to work, it will be necessary to have names of members, as their names appear on their Social Security Cards. We ask that you capture all data immediately on all new hires, and submit any missing or corrected data on all other members to us no later than February 1, 2009. Attached is an Excel file layout; please utilize this format and submit the data as follows:

Email: mehaynes@medcost.com

Dedicated Fax: 336-760-3028

U.S. Mail: MedCost Benefit Services, P.O. Box 24042, Winston-Salem, NC 27114-4042

In the event you encounter resistance from members regarding the sharing of their SSNs, please provide them with a copy of the attached CMS notice. It is important to stress to them that this information is being requested *only* to enable us to comply with the reporting requirements of a new federal law.

If you have questions or need assistance, please contact your Account Manager. Thank you in advance for your cooperation as we take the necessary steps to ensure that your group health plan is in full compliance with the new regulations.