Compliance Corner Webinar:

Section 125 – Best Practices

March 21, 2019

Q1: What types of plans are included in a "cafeteria" plan?

A1: **Qualified benefits include**:

- Accident or health plan coverage (HMO, PPO, HDHP, etc.)
- Accidental death and dismemberment (AD&D) coverage
- Adoption assistance benefits
- COBRA coverage (if participant has compensation that can be used to pay for COBRA pre-tax)
- Dependent care assistance benefits
- Dental benefits
- Disability benefits (short-term or long-term coverage)
- Health FSA contributions
- Health savings account (HSA) contributions
- Group-term life insurance coverage (on employee's life)
- Vision benefits

Non-qualified benefits:

- Educational assistance plans
- Employer-provided meals and lodging
- Fringe benefits
    - Transportation fringe benefits
    - Moving expense reimbursements
    - Retirement planning services
- Health Reimbursement Arrangements (HRA)
- Individual insurance policies (major medical coverage) – Exchange or non-Exchange plans
- Life insurance on spouse's or dependent's life
- Long-term care insurance or services
- Pet insurance

Q2: When there's an operational failure, does that mean any & all employees' elections premiums that were withheld pre-tax are now invalid? What does this look like? How far back can an audit go?

A2: The IRS can include returns filed within the last three years in an audit. If a substantial error is identified, the IRS may add additional years. The threshold for additional years is generally an understatement of income by 25% or more, or fraud. They general do not go back more than six years.

https://www.irs.gov/businesses/small-businesses-self-employed/irs-audits

The penalties are enumerated in the IRS Code Section 125 to include the following:

- Fines of up to $5,000, or imprisonment of up to one year for willful violation of ERISA provisions;
- Fines of up to $10,000 and/or imprisonment of up to 5 years for making any false statement or representation of fact, knowing it to be false, or for deliberate non-disclosure of any fact required by

ERISA;

- A penalty of $110/day for failure to distribute a Summary of Plan Description or SPD to participants within 30 days of request;
- A penalty of $156/day for failure to provide an SPD to the Department of Labor (DOL) within 30 days of request.
- The employer could be held liable for claims against the plan if the documents do not give participants accurate information of the plan policies.
- The pre-tax deductions may be disallowed from the beginning, leading to an IRS assessment of an overdue back taxes plus interest and corresponding penalties for both employees and the plan sponsor.

Q3: What mom has children covered on her plan and has another baby...once baby is born is it a qualifying event to move all dependents to dad's plan or can they just add newborn to dad's plan?
A3: Yes. The birth of a child allows the covered employee to enroll any other dependents not previously covered under the plan. The plan document must include this event as a permitted change.

Q4: On slide 13, what do you mean by dental and vision "integrated" with the medical? Do you mean the same "policy" number or the same ERISA Plan Number like 501?
A4: A dental and/or vision plan is integrated with the medical when elections for these benefits are not independent from the medical. For example, if an employee elects medical coverage and they are unable to waive the vision and/or dental plan or they are unable to elect these benefits unless they enroll in the medical plan.

Q5: I've seen situations where benefits were offered to hourly employees, most of whom were working ~35 hours per week. Then the employer cuts hours, & suddenly the hourly employees want to drop their coverage. Does the change in hours count as a qualified change?
A5: A reduction of hours would be consider a permitted change. The plan document must include this event as a permitted change.

Q6: is there an accepted "rule of thumb" for "significant" ,e.g., 10% increase/decrease
A6: Unfortunately, the regulations provide little guidance as to when a cost change will be significant. An example relating to DCAP benefits indicates that, under the particular facts, a 12.5% change in the cost of care (from $4,000 to $4,500) may be significant. However, IRS officials have cautioned that this should not be viewed as a safe harbor. Consequently, plan sponsors will need to make the “significant vs. insignificant” determination based upon all the facts and circumstances, including the dollar amount or percentage of cost increase. It is unclear what role (if any) affordability to participants may play.

Presumably, a $10 per month increase for minimum-wage employees is more significant than is a similar increase for highly paid professionals. Likewise, a $10 per month increase may not be significant for major

medical coverage, but it may be for vision or dental care. Employers should also look at past plan experience. For example, if most plan increases have been small percentages (e.g., 2% or 3%), then a 16% increase may be significant. While some degree of flexibility in determining significance under the rule is desirable, additional guidance from the IRS as to the factors to be considered would be helpful.

See attachments for further information on cost and benefit changes.

Q7: What proof is required of an employee who wants to drop coverage, saying, "I got insurance from my spouse, now"?
A7: An employer has the ability to define the requirements for proof of qualifying event. Most employers require written request for eligible changes.

Q8: If an EE wishes to terminate coverage outside of open enrollment because he can no longer afford that deduction out of his check, is that enough info to determine it's an "unqualified" event? Or would you advise the employer to determine what the significant increase really is...? How would you advise the employer?
A8: An employee must have a qualified event in order to change their election. Unless the plan cost changed, simply not being able to afford the coverage is not a permitted election change. One exception could be a change in the employee's income prompting ***new eligibility*** for a premium tax credit in the marketplace. The plan document must include this event as a permitted change.

Q8: Please explain the "finding-a-new-provider" exception again.
A8: ***Finding a new provider*** most commonly refers to a dependent care account election. A parent finding a new child care provider would be consider a permitted change in their elected amount.

Q9: If an employee enrolls in "marketplace" coverage, this would be coverage inside an exchange but not in an individual plan outside the exchange, correct?
A9: correct

Q10: Is an increase in HSA contributions considered an "improvement in coverage"?
A10: An increase in HSA contributions would be considered an improvement in coverage.

Q11: What are the consequences of an operational failure?
A11: The penalties are enumerated in the IRS Code Section 125 to include the following:

- Fines of up to $5,000, or imprisonment of up to one year for willful violation of ERISA provisions;
- Fines of up to $10,000 and/or imprisonment of up to 5 years for making any false statement or representation of fact, knowing it to be false, or for deliberate non-disclosure of any fact required by ERISA;
- A penalty of $110/day for failure to distribute a Summary of Plan Description or SPD to participants

within 30 days of request;

- A penalty of $156/day for failure to provide an SPD to the Department of Labor (DOL) within 30 days of request.
- The employer could be held liable for claims against the plan if the documents do not give participants accurate information of the plan policies.
- The pre-tax deductions may be disallowed from the beginning, leading to an IRS assessment of an overdue back taxes plus interest and corresponding penalties for both employees and the plan sponsor.

Q12: For a dependent day care plan, it's not a health plan, so an employee can change that election amount whenever the cost of care or day care provider changes, correct?

A12: The permitted change rules apply to all qualified benefits under the Section 125 plan. A dependent care account election change may be permitted for a change in cost and/or coverage (provider change). The plan document must include this event as a permitted change.

Q13: Request for clarification please. You mentioned changes cannot be back dated. Does this apply to a person who lost coverage on March 1st, but did not submit their request until March 15th?

A13: Correct. The insurer may allow the change to be retroactive but the Section 125 permitted changes rules allows back dating only in the case of HIPAA Special Enrollment events for birth, adoption or placement for adoption.

Q14: ER mistake: they have been deducting EE contributions pre-tax assuming it is okay, but finds out a year or two later they should have had a plan document via a POP/Section 125 plan. What consequences might they face if they try to fix the issue immediately by enrolling in a plan?

A14: An employer is required to have a plan document in order to provide the choice between receiving the full amount of their pay or paying their portion of approved benefits on a pre-tax basis. The employer should immediately rectify the issue by executing a valid plan document. The previous years would be subject to potential IRS audit.

Q14: Are med share plans offered through an employer, are the membership fees eligible to come out of an HRA?

A14: No. Individual premiums/membership fees are not qualified benefits under a Section 125 plan.

Q15: May you offer a discount dental plan that is not insurance in a cafeteria plan?

A15: No. Employer-sponsored benefits are the only plans permitted.

Q15: Are Health Share plans allowed under 125?

A15: No. Employer-sponsored benefits are the only plans permitted. Individual premiums/membership fees are not qualified benefits under a Section 125 plan.

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Q16: Are two separate enrollments allowed under section 125? For example: If an employer has a plan year that begins 4/1 and enrolls their core benefits (Medical, Dental, Vision) for a 4/1 effective date and then also holds a separate enrollment in August for voluntary benefits (Accident, Critical Illness, and Cancer) for a 9/1 effective date.

A16: Yes. You are able to have separate plan dates for different benefits. The plan documents must specify the applicable plan years.

Q16: So with "integrated dental/vision", that would mean having a medical policy with Carrier #1, and a dental and/or vision policy with Carrier #2 is NOT integrated dental/vision, correct?

A16: A dental and/or vision plan is integrated with the medical when elections for these benefits are not independent from the medical. For example, if an employee elects medical coverage and they are unable to waive the vision and/or dental plan or they are unable to elect these benefits unless they enroll in the medical plan.

Q17: As far as discrimination testing - do you know of any outlet for employers to initiate this testing on an annual basis?

A17: Discrimination testing can be performed by most vendors specializing in account administration.

Q17: Should cafeteria plan document number with Health care FSA be different than wrap plan document plan number even if wrap incorporates cafeteria plan FSA? for example, should both be 501 or should wrap be 501 and cafeteria plan with FSA be 502 or can they both be 501

A17: A healthcare FSA can use the same plan number as the wrap plan document number.

Q18: Can an employee drop medical coverage retro-actively due to marriage, enroll in spouses employer plan and have POP deductions end?

A18: Retroactive changes to elections are not permitted under Section 125 rules. The only exception is for a HIPAA special enrollment event through birth, adoption or placement for adoption.

Q19: Can you review what is required to be given to an employee and what is the best practice to do this?

A19: For Section 125 purposes, an employer is required to provide a plan document that outlines the benefits offered under the Section 125 plan and permitted mid-year changes.

Q20: Can you please review the HSA FSA example again in regards to not being able to participate until April 1?

A20: Correction Election Mistakes - Example #4:

- Tom has always been enrolled in the PPO/Health FSA, but decided to switch to the HDHP/HSA in 2019
- Tom did not have a zero balance in his health FSA as of Dec. 31, and is ineligible to make contributions

to his HSA until April 1, 2019

- Tom claims he did not understand this, but the employer has proof this was communicated to its participants.
- Tom is requesting to switch his election back to the PPO/health FSA.
- Tom does have evidence of past benefit usage to support his request.
- However, not understanding the communications is not a mistake
- If the employer had not communicated that he would be ineligible to use the HSA until April 1 unless his health FSA had a zero balance would change the answer.

Q21: If an ER assumes it's okay to deduct EE premium contributions pre-tax, but did not know that they should have had a POP in place, can the Broker be held responsible if the discussion was never raised?
A21: It is the employer's responsibility to provide a plan document. The employer would ultimately be held responsible for failure to provide. While there is no legal obligation for a broker to advise a client on the need for a plan document, a case could be made that it is advice the employer would expect. It is our recommendation that the requirement for plan documents on all benefits be a routine part of your conversation with the client.

Q22: Can both spouses working for different employers maximize FSA plans?
A22: Both spouses would each be able to contribute up to the annual maximum for the medical FSA . The $5,000 limit for the dependent care account is a household limit.

Q23: What if mom has children covered on her plan and has another baby...once baby is born is it a qualifying event to move all dependents to dad's plan or can they just add newborn to dad's plan?
What mom has children covered on her plan and has another baby...once baby is born is it a qualifying event to move all dependents to dad's plan or can they just add newborn to dad's plan?
A23: Yes. The birth of a child allows the covered employee to enroll any other dependents not previously covered under the plan. The plan document must include this event as a permitted change.

Q24: How often should plan docs be updated, just to be sure it is still compliant?
A24: A material modification notice should be provided at the time of change. An updated SPD must be provided every five years if material modifications are made to the SPD's information during that time period. If no changes are made, then an updated SPD must be provided every 10 years.

Q25: Under a 125 must all benefits be offered to every employee? i.e. one employee is offered a traditional plan and all others must enroll in the HSA HDHP?
A25: Discrimination rules apply under Section 125 rules, as well as Section 105. It is imperative to perform discrimination testing if different benefits are offered in any manner that discriminates in favor of highly compensated employees.