Section 125 Plan Considerations

January 2017 Update

IMPORTANT: Your Section 125 Plan administrator should be consulted on all matters prior to making any amendments to your Plan. What follows is general guidance only. The detailed work of making sure your Section 125 Plan is in compliance with federal regulations rests entirely with the district business office and any third-party Plan administrator.

Issues to address in the Section 125 Plan:

1. The Plan document should communicate the employer's practices as it relates to offering and administering benefits, and future actions must be based strictly on the Plan document.
2. All pretax benefits must be included.
3. The Plan document must reflect the employer's current eligibility, waiting period, and enrollment processes.
4. If the CBA includes provisions that fall under the Section 125 Plan, the Plan must be written to accommodate these agreements. However, there are federal restrictions for Section 125 Plans and CBAs must adhere to what is allowed under federal law. Ultimately, neither document controls the other, but it's important to understand that a CBA does not absolve an employer from compliance requirements, nor does a compliance requirement permit a unilateral change to a CBA.
5. Cash-in-Lieu arrangements must be included – see separate memo from VEHI.
6. If offered, HRAs require their own separate Plan Document in addition to the Section 125 Plan. The Section 125 Plan document does not need to be amended.
7. If offered, Employer contributions to HSAs should be included to ensure the document comprehensively describes the full array of benefits.
8. If offered, FSAs must be included in the Plan document. Be sure to allow those employees who are enrolled in an HSA compatible health plan to retain their eligibility for an HSA when an FSA is also available.
    a. Consider a Limited Purpose FSA if combining with an HSA
    b. Understand the implications of a grace period
    c. Understand the implications of a roll-over provision
9. If offered, a Dependent Care Reimbursement account must be included in the Plan document.
10. Qualifying events should be outlined specifically in the Section 125 Plan Document, and employers should pay close attention to what qualifying events they are including or excluding in the document. There are both required qualifying events and optional qualifying events available to an employer, and an optional event may only be leveraged if the employer includes such events in their Plan document.

Calendar Year versus Fiscal Plan Year Considerations

Calendar Plan Year – Open Enrollment by December for January 1 Effective Date

1. Advantages
    a. Out-of-pocket (OOP) costs are based on a calendar year (CY).
    b. Federal rules for HSAs are based on a CY.
    c. HRAs and FSAs would be set up on calendar year to align with OOP costs.
    d. VEHI filed premium rates and any OOP cost changes are announced in the Fall, well ahead of next July effective date, and so are known in time for Open Enrollment.

2. Challenges
    a. Collective bargaining agreements (CBA) and other employment contracts are based on a FY.
    b. Budgets are based on a FY.
    c. Premium rates are set on a FY (but announced the Fall prior).
    d. HRA funds would be committed on a CY, which does not align with the FY budget, but allows, if desired, for a longer run-out period.

Fiscal Plan Year – Open Enrollment by June for July 1 Effective Date

1. Advantages
    a. Collective bargaining agreements (CBA) and other employment contracts are based on a FY.
    b. Budgets are based on a FY.
    c. Premium rates are set on a FY.
    d. HRA funds would be committed on a FY, which aligns with the FY budget.

2. Challenges
    a. OOP costs are based on a CY.
        i. If an employee elects a different VEHI health plan during a CY, all OOP costs for the CY to date are credited toward the new plan selection for the rest of the CY.
        ii. If an employee elects a VEHI health plan with lower OOP costs during a CY, s/he will **not** be refunded any OOP costs paid to date in that particular CY, even if they exceed the maximums of the new health plan selection.
    b. Federal rules for HSAs are based on a calendar year.
    c. HRA and FSA would be set up on a FY and NOT align with CY OOP costs.
    d. Any desired run-out period for claims processing would go beyond end of the FY.

Remember: A **short Plan year** is necessary to transition to a different Plan year, and an employer is **not** permitted to have **back-to-back** short Plan years**.**