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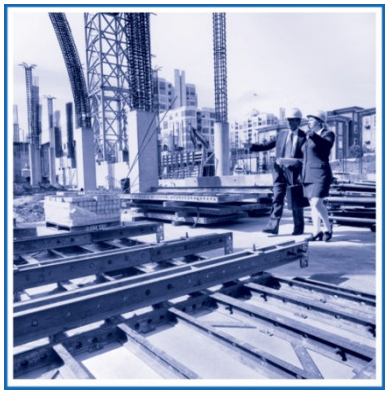


Cafeteria Plans - Section 125: POP/FSAs for NJ Public Entities

Webinar: Wednesday, August 24, 2011
2:00 pm – 3:00 pm EDT

Today's Speakers

Joe DiBella

Executive Vice President of the Health & Welfare Practice

Conner Strong & Buckelew

Phyllis Saraceni, Esq.

Senior Vice President and Compliance & Audit Practice Leader

Conner Strong & Buckelew

Introduction and Overview

This is Conner Strong & Buckelew's second webinar focused on the employee health benefit aspects of *NJ Chapter 78*, signed into law on June 28, 2011.

The focus of our webinars is on the health plan provisions under Chapter 78:

- Health related provisions of Chapter 78 primarily establish a new contribution arrangement that will require public workers and certain retirees to contribute more towards the cost of the employee health benefit coverage

- Additionally, all NJ public employers must offer a Section 125 Plan to collect contributions on a pre-tax basis, and they must also offer a Health Flexible Spending Account (FSA) to allow employees to cover eligible out-of-pocket medical expenditures

New Contribution Arrangement

Our first webinar provided background on Chapter 78 and primarily focused on the new contribution arrangement for health plans.

Overview of key highlights:

- New schedule or 1.5% of one's salary, whichever is greater, is the new floor.
- New contribution schedule shall take effect for bargaining units upon the expiration of their current, in-force agreement.
- Contributions will be based upon the actual cost of coverage, tiered by base salary.

New Contribution Arrangement

Our July webinar focused on the 4-tier rate structure set-up, changes in collective bargaining, key milestones, and next steps.

- July presentation covered a high-level overview of the main aspects of the law related to employee benefits, the effective dates of the law, and the implementation of the new contribution schedule.
- A recording of the webinar can be viewed and listened to by visiting our “Webinars Page” on the Conner Strong & Buckelew website. From there you can also view the webinar presentation and a Q&A document. Specific questions about our webinars can also be sent to EBwebinars@connerstrong.com.

Conner Strong & Buckelew is actively involved in facilitating strategic discussions as it relates to plan design alternatives and overall collective bargaining strategies.

Participant Questions

Q. Do new hires become part of the existing collective bargaining agreement (CBA) for health benefit contributions?

A. Yes. If a new employee's position is covered by a CBA in effect on 6/28/11 (the effective date of Chapter 78) this individual is covered under the CBA and their contribution based on Chapter 78 would begin at the CBA expiration and at that time the 4-year phase begins. New employees hired after the effective date of Chapter 78, covered by the CBA are treated the same as CBA employees who were employed before the effective date of Chapter 78**.**

Q. When does the health care contribution rate go up again - at the next renewal or after one calendar year?

A. For employees subject to the 4-year phase in period (i.e., employees not covered under a CBA or other agreement as of the law's effective date), the second raise in contribution will be effective July 1, 2012. Subsequent contribution increases will occur every July 1 until 4 years after the effective date upon which the contribution amounts have to be renegotiated. Note too that rate renewal increases may occur off of a July cycle (the member would see an additional adjustment in the contribution due to a policy renewal rate change.)

Today's Focus – Cafeteria FSA/POPs

Focus today is on the cafeteria plan/FSA provisions under Chapter 78 requiring that *all public employers, including local government employers and boards of education*, establish:

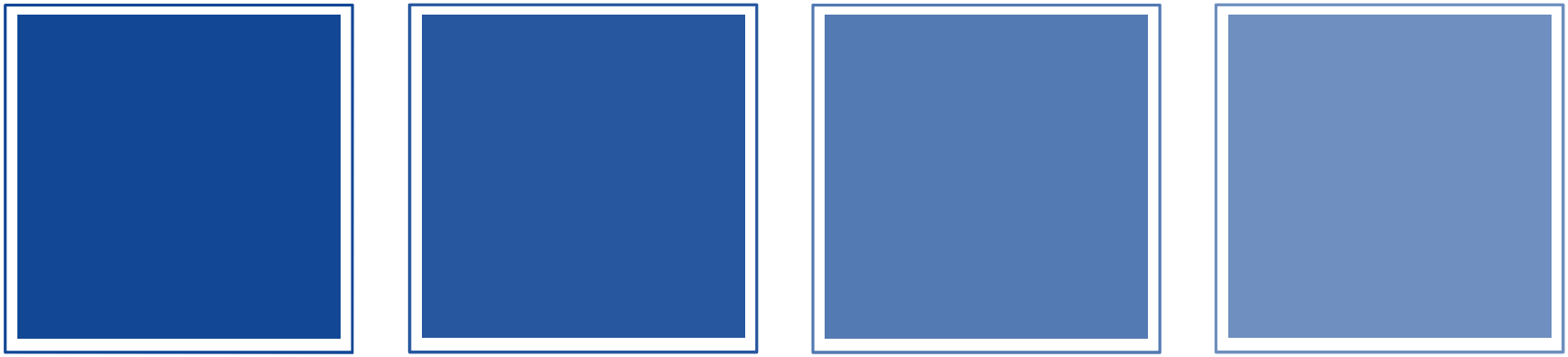
- A Section 125 cafeteria Premium Only Plan (POP) to allow employees to pay health contributions on a pre-tax basis and to allow cash-out waivers payment, and
- A medical Flexible Spending Account (FSA) to allow employees to set aside pre-tax money to fund eligible out of pocket medical, pharmacy, dental, and vision expenses not covered under a health benefit plan.

An employer may also chose to establish a dependent care FSA to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work, but it is not mandatory.

Note: The NJ State's Section 125/FSA plan, Tax$ave, is **not** available to local government or local education employers. These local employers must arrange and provide their own Section 125/FSA plans.

Agenda

- Cafeteria plan basics
- Enrollment and participant elections
- Flexible spending arrangements (FSAs)
- Administration issues
- Key next steps for NJ public entities
- Resources



Cafeteria Plan Basics

What Is a Cafeteria Plan?

- A program employers can use to help employees pay for certain expenses, like health expenses and dependent care, with pre-tax dollars.
- *Employers* like cafeteria plans because they enable the employer to save on its share of FICA (Social Security and Medicare) and FUTA (federal unemployment) taxes.
- *Employees* like cafeteria plans because they can buy benefits with pre-tax dollars, which allows then to save on taxes and gives them more take-home pay.

Note: Payments to a cafeteria plan are not subject to Social Security deductions. Although rare, some employees may choose not to participate in a Section 125 cafeteria plan because it lowers the annual earnings against which Social Security deductions are made. These employees should consider the financial advantages of saving on taxes now, compared to a slight reduction in future Social Security benefits.

How Does a Cafeteria Plan Work?

- Employer plan created subject to IRS rules under Section 125 of the Internal Revenue Code
- Employer contributions are made pursuant to salary reduction agreements between the employer and the employee in which the employee agrees to contribute a portion of his/her salary on a pre-tax basis to pay for “qualified benefits”.
- Contributions are not actually or constructively received by the participant so they are not considered wages--contributions to the plan reduce the employees federal income, FICA (Social Security and Medicare) and FUTA (federal unemployment) taxes they would otherwise pay on contributions.
- State tax treatment varies--NJ residents are not exempt from NJ state tax on cafeteria plan contributions; PA residents are not exempt from PA state tax on dependent care FSA contributions (but they are exempt from PA state income tax on POP and medical FSA contributions).
- If an employee elects to receive cash instead of any qualified benefit (a cash-out waiver payment), it is treated as wages subject to taxes.

Participant Questions

Q. Are deductions under Section 125 exempt from FICA and Medicare as well as federal Income tax?

A. So long as the Section 125 rules are followed including rules related to plan adoption and documentation, premium contributions made under a section 125 plan (premium and FSA contributions) are exempt from FICA and Medicare as well as federal Income tax.

Q. Currently the Authority is being paid under the County's payroll system. Medical deductions are coming out as "Med 125". Can the County's med 125 and cafeteria plan cover Authority employees?

A. Multiple related groups may be covered under one Section 125 plan. The County's section 125 plan may cover the Authority employees if the County's Section 125 plan is written to include the Authority employees. Alternatively, the Authority may have their own Section 125 plan. The decision to include one or multiple related groups under a Section 125 plan is typically determined by what is administratively practical and with the advice of legal counsel.

What is a Premium-Only Plan (POP)?

- simplest form of cafeteria plan
- designed for one purpose--help employees save money by letting them pay for their share of health coverage contributions/premiums with pre-tax dollars
- participation by the employee is *voluntary* as some employees may wish to pay their contributions or premiums share expenses from after-tax dollars
- to simplify administration, employer can automatically enroll all its employees in the POP and give employees the opportunity to opt-out (i.e., pay contributions on an after-tax basis)

POPs are also required if an employer provides health plan buy-out waivers for employees to waive their benefits and receive a cash payment.

What is a Flexible Spending Account (FSA)?

- not for health insurance premiums (POP is used for those)
- type of cafeteria plan benefit, funded by employee salary reduction, that reimburses employees for expenses they incur for medical or dependent care expenses
- FSA may be offered to fund dependent care expenses and reimbursements or for medical care expenses and reimbursements
- benefits are subject to annual minimum and maximum contributions
- annual “use-or-lose” rule applies–meaning an FSA cannot provide a cumulative benefit to an employee beyond the current plan year—accounts are funded and expenses reimbursed for the current year only--no carry-over

Participant Questions

Q. How will HSAs come into play with the new state public sector laws?

A. The School Employee's Health Benefit Program (SEHBP) and the State Health Benefit Program (SHBP) must implement three (3) plan options, and a Health Savings Account (HSA). This HSA set-up requirement does not apply to non-SEHBP/SHBP coverage.

Q. Are non-SEHBP/SHBP employers exempt from the maximum medical waiver limit of 25% or $5000?

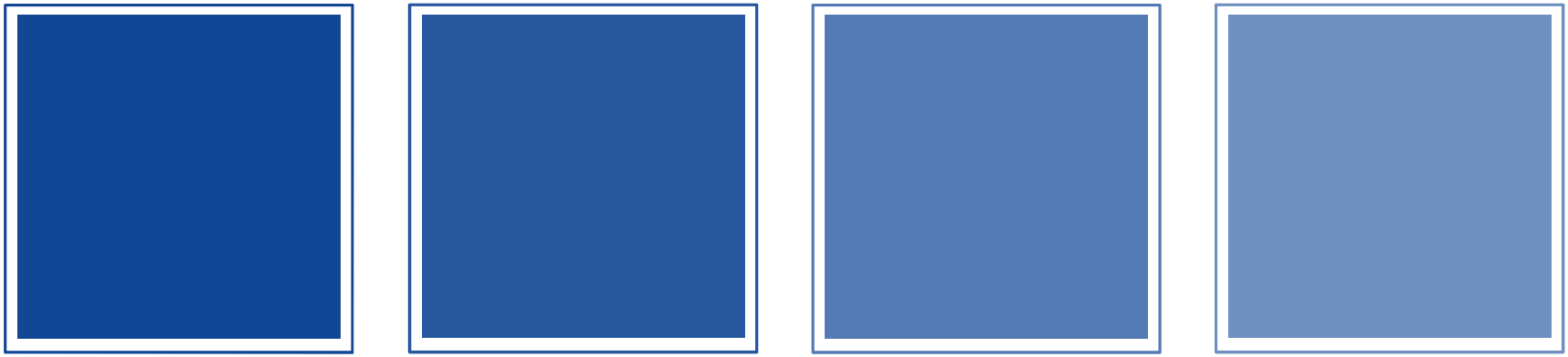
A. No, non-SEHBP/SHBP employers are not exempt from the maximum medical waiver limit. The 2011 NJ law (Chapter 78) did not make any changes to the 2010 law concerning waivers (waivers continue to be limited to "25% or $5,000, whichever is less, of the amount saved (by the local unit), because of the employee's waiver of coverage.")

Q. How is a waiver related to the FSA?

A. There is no relationship between the waiver and an FSA. A health benefits buy-out waiver is typically paid to an employee when the employee has other coverage and does not participate in the health plan. The FSA account set-up option is available to all employees whether they choose to participate in the health plan or choose the waiver option.

POP/FSAs Now Required for NJ Public Entities

- NJ public entities may have already established a Section 125 plan (POP) to accommodate the 1.5% of salary employee health cost contributions first required in 2010.
- POPs may have already been established by an employer that provides a cash opt-out payment for employees that waive their benefits in exchange for a cash payment.
- If not already established, the NJ public employer must now establish a POP plan and create an FSA program *as soon as administratively practical*. **Per NJ webinar on 8/18/11, there is no hard date to establish an FSA – NJ public employers must diligently move toward FSA set-up to avoid grievances from employees.**
- Third-party FSA contracts are subject to the insurance provisions of the Local Public Contracts Law and should be procured competitively if required.



Enrollment and Participant Elections

Enrollment

- Only participants can choose the type and amount of benefits they want --underlying benefits (e.g., health insurance) may cover spouses or dependents.
- The participant must be an employee who is eligible under the plan and who has satisfied any waiting period and entry date rules.
- Three types of events allow a participant to make elections:
  - when he/she first meets the eligibility requirements
  - at annual open enrollment, when new elections can be substituted for old ones
  - upon the occurrence of certain events identified by the IRS as permitting election changes
- Enrollment for pre-tax premium payments can be automatic each year (continue election from prior year)--participants re-enroll each year for waiver and FSA elections
- Can offer a variety of easy ways to enroll--by phone over an Interactive Voice Response system, by Intranet, or by obtaining an enrollment form (to be mailed or faxed).

Participant Elections

- Generally, elections must be prospective—employees must make their elections before the cash they could otherwise receive is available to them.
- Special rule allows plans to give new hires a window of up to 30 days after their hire dates to make their elections. Elections can be effective as of the employee's hire date (i.e., on a retroactive basis) although the salary reductions to pay for elected benefits must come from compensation that is not yet available when the election is made.
- Except for new hires, retroactive enrollment ordinarily is not permissible. For current employees, elections during the annual open enrollment period should be made before the first day of the plan year for which the benefit is provided.
- A cafeteria plan may also be designed to allow an employee to make a new election that corresponds with retroactive special enrollment rights required under HIPAA for birth, adoption, or placement for adoption.

Changing Elections

A cafeteria plan must provide that participant elections are irrevocable and cannot be changed during the period of coverage (generally the 12-month plan year).

- Employers do not have to allow any exceptions to this rule (except for HIPAA special enrollment events)
- Most employers allow participants to change their elections during the year if the employee experiences an event that falls under one of several exceptions allowed by the IRS ("permitted change in election events")
- Employers can design their cafeteria plan to permit an employee to change his/her election during the year if the employee experiences one of the permitted election change events (and provided the election change generally is on account of and corresponds with a change in status that affects eligibility for coverage under the employer's plan)

There are 14 different permitted election change events that can warrant a mid-year election change, if the employer provides in the plan (marriage, new dependent, etc.). Some events do not allow changes to certain benefits offered under a cafeteria plan (limited changes permitted for health FSAs).

Note: If health insurance contributions go up in the middle of the plan year, then the plan can provide for an automatic adjustment to payroll so that the excess will be paid with pre-tax dollars.

Participant Questions

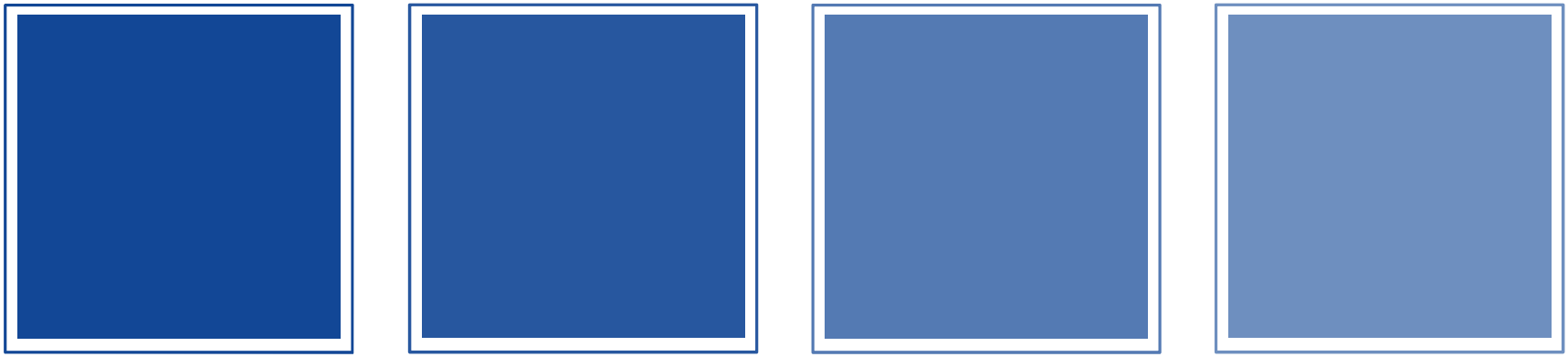
Q. Employees complete a salary redirection agreement for the POP during open enrollment. Under Chapter 78, the employee's standard contribution will vary as the employee's salary changes or he/she moves from one union to another, etc. Are these type of events considered status change events? Would that enable the employee to change the salary deduction under IRS rules?

A. Generally, this would not be considered a status change event and no change to the election would be permitted. When an employee's required contribution is a function of the employee's salary, and the employee experiences an increase in pay which results in an increase to the premium contribution, the increased contribution amount is not considered an election change. In this scenario, the participant's election is not changing, i.e., the employee is not moving from single to family coverage or from one coverage option to another during the plan year. Chapter 78 guidance confirms that a salary change during the plan year could result in an automatic contribution change. However, if a employee status change (such as a move from one union to another union) affects the individuals eligibility for coverage, this change may be considered a change in status permitting a mid-year election change.

Participant Questions

Q. The Tax$ave Fact Sheet states that IRS rules require that for an employee covered by a POP, payroll deductions remain the same for the entire plan year unless a status change event occurs. The health care contribution will vary by employee's base pay. Is a change in base pay considered a status change event?

A. A change in pay is generally not a status change event. If a participant's contribution is based on his/her salary and the individual's salary changes during the plan year, it is generally permissible under the Section 125 plan rules to automatically adjust the participant's contribution based on the participant's pay. So the pre-tax contribution payment can be automatically adjusted with no change in election required from the employee.



Flexible Spending Accounts (FSAs)

Health FSAs Now Required in NJ

Mandatory Health FSA

- All NJ public employers must offer a health FSA to allow employees to cover eligible out-of-pocket medical expenditures.

Optional Dependent Care FSA

- A NJ public employer may also choose to establish a dependent care FSA to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work, but it is not mandatory.

What is a Health FSA?

- Voluntary program that gives employees an option to set aside pretax dollars to pay for eligible medical, prescription drug, and dental expenses not covered by insurance for the employee and dependents, subject to certain maximum amounts and reasonable conditions. Note: Health FSAs are not allowed to reimburse insurance premiums
- Employees can use a health FSA to pay for medical expenses that are not reimbursed through insurance or any other arrangement. Insurance co-pays, deductibles, eyeglasses, and orthodontia are common examples of health FSA expenses.
- Under federal law, the maximum health FSA amount is currently limited only by plan design—the Internal Revenue Code does not expressly limit the amount (many employers limit the maximum amount to $5,000 or a lower limit). NJ laws appears to require at least a $2,500 health FSA maximum limit and a $100 minimum limit (per the Tax$ave arrangement).

Note: Health care reform law imposes a $2,500 cap (indexed for inflation) on annual salary reduction contributions to health FSAs beginning January 1, 2013.

Typical Health FSA

- Participants can elect coverage under a health FSA with an annual limit of $2,500. They pay for that coverage with pre-tax salary reduction dollars.
- The health FSA reimburses employees for medical and dental expenses not otherwise reimbursed (and for which participants will not seek reimbursement) under any other plan.
- Employees can only be reimbursed for allowable, documented expenses incurred during the plan year, after the expenses have been substantiated.
- A participant who elects the maximum $2,500 of coverage must reduce his or her annual taxable wages by $2,500 (the annual premium), thereby paying for the coverage with pre-tax dollars.

Why would someone reduce their pay by $2,500 just to get the $2,500 back as reimbursement for medical expenses?

Answer: To realize tax savings on the contribution amount paid to the health FSA.

What is a Dependent Care FSA?

- Voluntary program that gives employees an option to set aside pre-tax money to pay for dependent care expenses, subject to certain maximum amounts and reasonable conditions
- An employee can use a dependent care FSA to be reimbursed for employment-related expenses that allow the employee and his or her spouse to be “gainfully employed”
- Employment-related expenses apply only to certain individuals
- Typical dependent care FSA expenses are those incurred to have a babysitter or day-care provider take care of an employee's child (under the age of 13) while Mom and Dad are both working, or to take care of a spouse or other tax dependent who lives with the employee and is incapable of self-care

Typical Dependent Care FSA

- Participants elect coverage under a dependent care FSA with an annual limit of up to $5,000 (reduced to $2,500 for married employees filing separate returns). They pay for that coverage with pre-tax salary reduction dollars.
- At the end of each month, the dependent care FSA reimburses the dependent care expenses that they incur during the month.
- Example: Assume that Jane elects the full $5,000 of coverage. She must reduce her taxable wages by $5,000 (the annual premium) to pay for the coverage. By participating in the dependent care FSA, Jane would achieve tax savings on the $5,000.
- The employer reports the total dependent care benefits paid to the employee in Box 10 of the employee's Form W-2. Any amount over $5,000 is included as "wages," "social security wages" and "Medicare wages."
- Employees complete a Form 2441 when they file their Form 1040 tax return with the IRS to claim the income tax exclusion for amounts paid under the dependent care FSA.

FSA – General Legal Requirements

- Like cafeteria plans, all FSAs must meet certain legal requirements.
- For example, only expenses that are “incurred” during the plan year can be reimbursed. “Incurred” means that services giving rise to the expense were provided—it does not matter when the expenses are paid (e.g., an expense is incurred when an individual visits the medical practitioner, not when the practitioner's bill is received or paid by the participant).
- For a medical FSA and dependent care FSA, the employer must reimburse medical and dependent care expenses up to the maximum amounts elected by the employees in their election forms (and permitted under the plan and applicable law).
- Most (but not all) employees will use up the full amount of their coverage. Any unused amounts are forfeited and cannot be carried over to the next year (unused amounts can be returned to the employer and can be used to pay plan administrative expenses).

Participant Questions

Q. What is the implementation deadline/timeline to set up an FSA if we have never had one?

A. Chapter 78 does not specify an effective date for FSA implementation. In a recent webinar hosted by the Division of Pension and Benefits, it was suggested that the health FSA be implemented as soon as administratively possible, but no specific date was provided.

Q. Are all employees required to participate in the Section 125 under the new law?

A. We are not aware of any specific Section 125 participation requirements under the Chapter 78 law, other than that employees who are making a contribution for the health coverage may elect to pay for it with pre-tax dollars through the cafeteria (POP) plan. All benefits eligible employees now also must be permitted to elect participation in a health FSA.

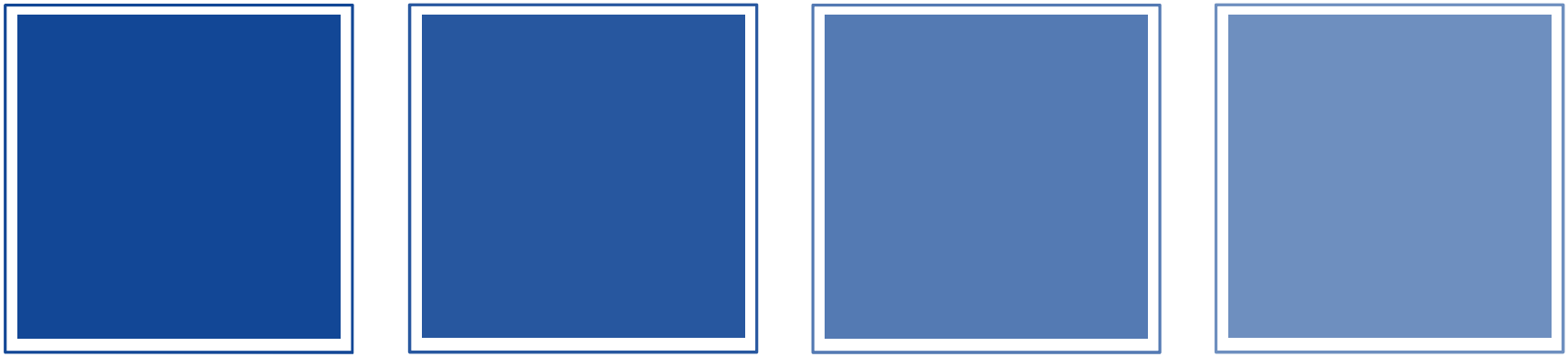
Q. What are the W-2 requirements regarding Section 125 and FSAs?

A. Currently there are no W-2 requirements for a Section 125 plan or a health FSA (health care reform will require W-2 reporting of certain limited health FSAs that have employer contributions but those rules will not be effective for a few more years). There is a W-2 reporting requirement for the dependent care contributions. An employer must report the amount of dependent care FSA benefits on each participant's Form W-2.

Participant Questions

Q. Can you please briefly explain the Optional Dependent Care FSA plans? How do they work and what is needed to prior to implementing them?

A. A dependent care FSA allows participants to exclude up to $5,000 from his/her income to pay for certain expenses related to child care. Typically dependent care FSAs are offered under a cafeteria plan and are funded by employee salary reductions. Accounts are established for participants from which dependent care expenses can by paid on the pre-tax basis as they are incurred by the participant. Setting up dependent care FSA as part of the Section 125 plan involves numerous steps. Some of the steps include considering the legal requirements for the plan, plan design, administration, payroll capabilities and potential limitations, plan documentation and plan adoption. Many of the complexities and issues that may arise with dependent care FSA implementation may be mitigated by consulting with an experienced FSA vendor and with the involvement of legal counsel.



Administration Issues

Administering a Health FSA

Basic Code and Regulatory Requirements

- must be a written plan document (this can be part of the cafeteria plan document)
- limits on maximum and minimum reimbursement amounts must be observed
- expenses must be for medical care incurred during the coverage period by the employee, his or her spouse, his or her child who is under age 27 as of the end of the calendar year (whether or not the child is the employee's tax dependent), or someone else who qualifies as the employee's tax dependent for health coverage purposes under the Code
- if a civil union partner or domestic partner is not a “qualified tax dependent” of the employee, premium deductions for the partner’s coverage must be made on an after-tax basis and funds in the Health FSA cannot be used for the partner’s medical expenses

Administering a Health FSA

Basic Code and Regulatory Requirements (continued)

- employee must be covered under the health FSA when the expense was incurred
- employees cannot be reimbursed for expenses for which they claim a tax deduction or are reimbursed under another health plan
- there must be uniform coverage throughout the coverage period--administrator cannot limit reimbursements according to how much the employee contributed to the plan.
- if the employee stops paying, then coverage stops (although COBRA may be available)

Example: Pat elects $1,200 coverage for the year. After contributing $100 in the first month, Pat immediately submitted a claim for $1,500 of medical expenses. Does the company have to pay all $1,500 of Pat's claim, even though only $100 is in the account so far? The company must pay the full $1,200 election amount immediately if the claim meets the other IRS requirements—this is the uniform coverage rule. The remaining $300 is not reimbursable by the plan.

Administering a Health FSA

Basic Code and Regulatory Requirements (continued)

- claims must be paid at least monthly, or when the total amount of claims submitted is at least a specified, reasonable amount (e.g., $50)
- the coverage period generally must be 12 months
- under the use-or-lose rule, contributions to the plan that are not used during one plan year generally cannot be carried over to the next plan year--limited exception, plans can offer a grace period of up to 2-1/2 months after the close of the plan year. The cafeteria plan documents must provide for the grace period—it is not automatic.
- in general, only expenses incurred during the coverage period (or grace period if offered) may be reimbursed
- participants usually are given a short time (e.g., 30 to 90 days) after the end of a coverage period to request reimbursement for expenses incurred during that period (the “run-out” period)

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Administering a Health FSA

Basic Code and Regulatory Requirements (continued)

- there must be adequate substantiation of the medical expenses
- administrator must obtain information from an independent third party describing the service or product, the date of the service or sale, and the amount
- participant must certify that the expense was not reimbursed (and will not be reimbursed) from any other health plan
- electronic payment card programs can be offered, as long as they are administered in accordance with IRS rules regarding such programs
- can offer direct deposit of reimbursement payments from a health or dependent care FSA
- can only reimburse expenses for medical care -- must diagnose, cure, mitigate, treat or prevent disease, or affect a structure or function of the body

Administering a Health FSA

Basic Code and Regulatory Requirements (continued)

- expense cannot be reimbursed if primarily to maintain general health, for other personal reasons, or for cosmetic procedures (unless necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury from an accident or trauma, or disfiguring disease)
- over-the-counter (OTC) medicines or drugs (other than insulin) must be prescribed in order to be reimbursable
- some expenses are not reimbursable at all, such as insurance premiums paid for other health coverage (e.g., premiums under the employee's plan or a plan of the spouse's employer, or COBRA premiums)
- special rules allow reimbursement of certain advance payments for orthodontia services, as well as durable medical equipment with a useful life that extends beyond the period of coverage (e.g., a wheelchair)

Health FSA – Additional Requirements

COBRA

- Health FSA must comply with COBRA and offer continuation rights to qualified beneficiaries who lose their FSA coverage as a result of a qualifying event
- There are two exceptions to this rule for health FSAs that meet certain HIPAA excepted benefit requirements:
  - COBRA does not need to be offered at all to qualified beneficiaries who have overspent their accounts as of the date of their qualifying events.
  - While COBRA must be offered to those who have underspent their accounts, it can be cut off at the end of the year in which the qualifying event occurs.

Example: Lou decided to contribute $50/month for $600 of health FSA coverage for the 2012 calendar year plan year. Lou quits in April of 2012 and by that date, Lou had contributed $200 to the medical FSA. However, Lou had not made any claims for reimbursement, so his account was "underspent." The health FSA will have to offer COBRA to Lou, but if certain requirements are met, COBRA can be cut off at the end of 2012.

Health FSA – Additional Requirements

HIPAA

HIPAA's portability (including preexisting condition exclusion rules, special enrollments, and nondiscrimination) and administrative simplification rules have to be considered.

- Benefits under many health FSAs will not be subject to the portability requirements because they are considered excepted benefits under HIPAA
- The HIPAA administrative simplification rules (covering privacy, security, and electronic data interchange (EDI)) will apply to a health FSA unless it qualifies for another exception. Self-funded health plans with fewer than 50 participants that are administered by the employer are not required to comply with the HIPAA administrative simplification rules—some health FSAs will fall within this exception.

Health FSA – Additional Requirements

ERISA and Other Group Health Plan Mandates

- ERISAs requirements (trust, plan asset, 5500 filing, etc.) do not apply to health FSAs maintained by public sector entities
- As a group health plan, a health FSA is subject to other federal group health plan mandates, unless an exception applies. Examples of such mandates include the Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), and the health care reform law, as well as laws requiring parity in mental health and substance abuse disorder benefits (MHPA), minimum hospital stays for newborns and mothers (NMHPA), and mastectomy-related benefits.

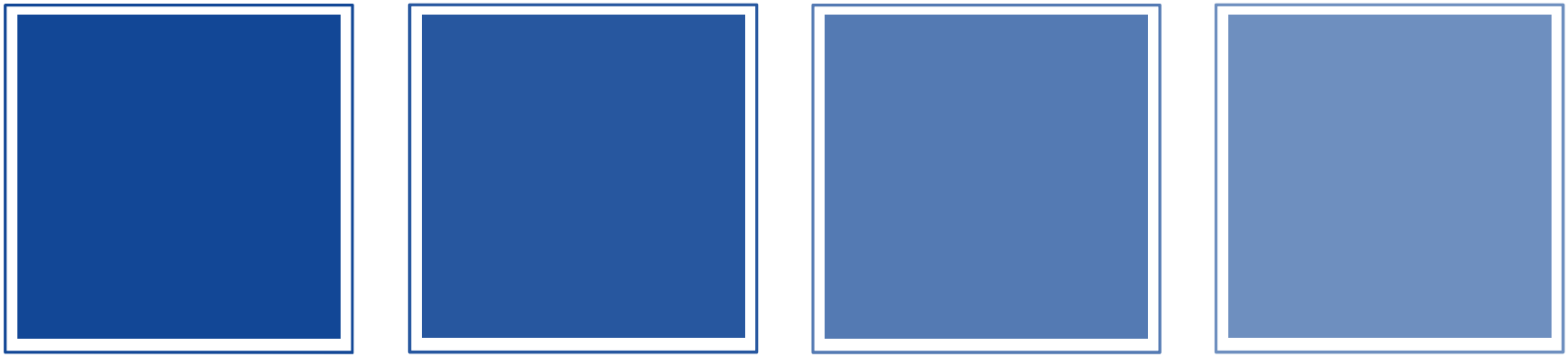
Health FSA – Additional Requirements

Nondiscrimination Rules

- The Code includes nondiscrimination rules that apply to the POP, the health FSA and the dependent care FSA

Record Retention and Reporting

- An employer must report the amount of dependent care FSA benefits on each participant's Form W-2
- No Form 5500 annual report is required for a non-ERISA plan
- Under IRS rules, employers must keep records to show that their cafeteria plans, health FSAs, and dependent care FSAs met the requirements of the Code under which benefits were excluded from income (rule of thumb is to keep all records for at least eight years).



Key Next Steps for NJ Public Entities

Decide Design Features

- decide whether to offer a dependent care FSA
- determine who should be eligible for the medical FSA and the dependent care FSA
- consider financial exposure under health FSA as a self-insurer--under the “uniform coverage” rule , if an employee elects the maximum amount of health FSA coverage and incurs a claim for that amount in the first month of the plan year, the employer must pay the claim even though almost no salary reductions will have been made)
- establish standards for expense substantiation (documentation that proves that an expense qualifies as reimbursable medical care or dependent care)
- decide the circumstances under which participants can change their elections

Decide Who Should Administer the Plan

- Cafeteria plans with FSAs involve more administration than do POPs, mostly because of the claims administration and payment requirements. Some companies have the time and expertise to handle FSAs internally; many prefer to outsource some functions to a third-party administrator (TPA) when FSAs are added.
- Like other plan services, employers need to contract with a third party administrator to administer the health FSA. Administrative costs are marginal and are usually charted on a monthly per enrolled participant basis.

Conner Strong & Buckelew offers clients access to preferred terms and pricing for FSA services with an FSA administrator.

Local units that participate in a JIF should check with their Fund Administrator regarding assistance with the creation of cafeteria plans.

Amend/Create Plan Documents/Materials

- The health FSA and dependent care FSA must meet special legal requirements under the Code
- The employer should adopt a new or amended plan before letting any employees participate in the health FSA or dependent care FSA
- Health FSAs and dependent care FSAs should not reimburse expenses that were incurred before the FSA is properly adopted

Conner Strong & Buckelew can provide clients with a sample POP and FSA document/SPD that will need to be reviewed, approved, adopted and implemented.

Distribute Communication Documents

- Reasonable notification of the FSA provisions must be given to employees.
- Most employers distribute a written summary of the cafeteria plan to employees along with enrollment material.
- Employees will need more help understanding how the health FSA and dependent care FSA work than they probably need for the POP--they have some new financial risk under the “use-or-lose” rule (e.g., if an employee elects the maximum amount of health FSA coverage, reduces his or her salary by that same amount to pay for the coverage, but incurs claims that add up to less than the maximum amount, then the employee will forfeit the unused salary reduction amounts)
- Use well-drafted communication documents to promote informed planning (and minimize the risk of employees being unpleasantly surprised)
- Election forms must be prepared reflecting the new options

Election Forms and Salary Reductions

Obtain Signed Election Forms

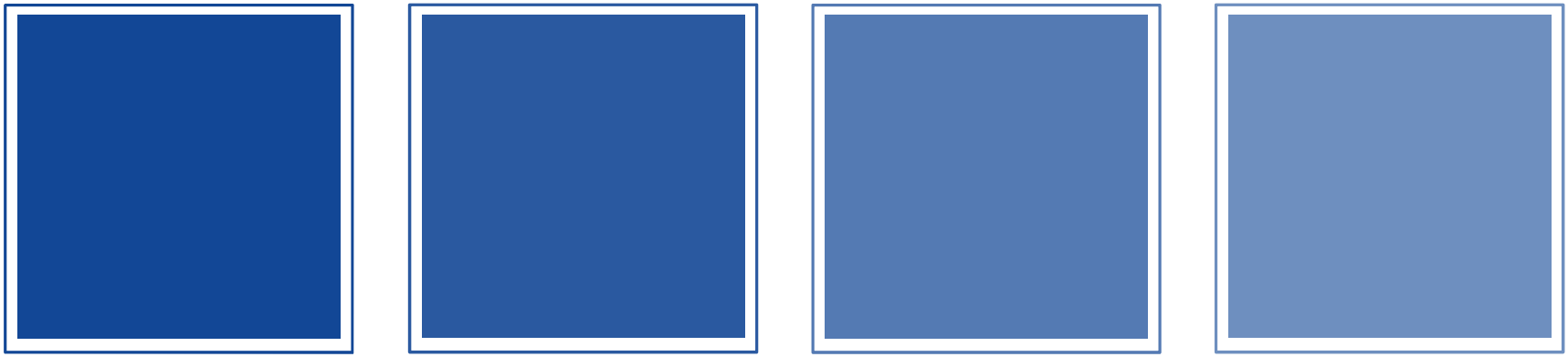
- Collect signed election forms from employees. Those who elect health FSA and/or dependent care FSA coverage will have to specify how much they want to contribute (through salary reductions) for the plan year.

Instruct Payroll and/or the TPA

- Upon receiving the signed election forms, employer should implement the employees' choices. The forms should be sent to the TPA, if any, and the payroll processor.

Pay Adjusted Salaries

- Employees' pay stubs will now reflect salary reductions for health insurance premiums, and health and/or dependent care FSA coverage, depending on their elections. Those who added FSA coverage will receive less taxable wages than under the POP. However, their net pay after expenses will be greater than if they had received their full salaries and then paid for out-of-pocket medical and dependent care expenses with after-tax dollars.



Resources

Resources

NJ Divisions of Local Government Services and Pensions and Benefits

- NJ "About" page http://www.nj.gov/treasury/pensions/reform-2011.shtml
- Full text of Chapter 78: www.nj.gov/treasury/pensions/pdf/laws/chapt78-2011.pdf
- Information on professional development seminars around the State to review the law and its implementation issues - posted on the NJ Division's GovConnect page http://www.nj.gov/govconnect/news/general/
- 2011 Tax$ave newsletter http://www.state.nj.us/treasury/pensions/pdf/newsletters/taxsavenews.pdf
- NJ link to Tax$ave information http://www.nj.gov/treasury/pensions/epbam/additional/taxsave.htm

Health insurance questions for non-SHBP members: dlgs@dca.state.nj.us.

Resources

Conner Strong Resources

- Preferred Vendor Relationship
  - Preferred pricing terms
  - Easy implementation
  - Available to CSB customers
  - Materials customized to accommodate Chapter 78 requirements
- Conner Strong Publications (Webinars, Email blasts, Perspectives, Health Reform Guidebook)