



An Overview of the New Proposed Cafeteria Plan Regulations

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At the beginning of August, the Internal Revenue Service released new Proposed Regulations relating to Cafeteria Plans. These Proposed Regulations have been long anticipated and are very comprehensive. These new Proposed Regulations replace previously Proposed Regulations issued in 1984 and 1989 which were never finalized but nevertheless were widely accepted as governing Cafeteria Plans. Most of the major provisions contained in the 1984 and 1989 Proposed Regulations remain but the new Proposed Regulations also formalize many other issues about which the IRS had provided informal guidance during the intervening years. In addition to expressly stating rules that were only previously implied by the IRS, new rules were also needed to address changes to the administration of Cafeteria Plan benefits that had occurred over the last 20 years – such as the use of electronic payment cards to fund Employee benefits.

The new Proposed Regulations provide for a period of public comment and a scheduled public hearing later this year. The intention is for the Proposed Regulations to take effect for Plan Years beginning on or after January 1, 2009 however, Employers are authorized to rely on the rules effective immediately.

The purpose of this overview is to break the new Proposed Regulations into their major component parts and to provide an explanation of the practical effect the rules have on Cafeteria Plans and the Flexible Spending Arrangements inside those plans. Unfortunately, the number of provisions in the new Proposed Regulations makes it impossible to keep this overview particularly brief. The intention therefore, is to present the rules in a manner that distinguishes each one so that the reader can quickly locate the specific provision(s) of interest to their situation.

Organization of the New Proposed Regulations

The new Proposed Regulations are organized into five different sections. This overview will highlight the provisions of the new Proposed Regulations section by section. The five new sections are:

- Section 1.125-1: general rules governing Cafeteria Plans;
- Section 1.125-2: rules governing Participant elections within Cafeteria Plans;
- Section 1.125-5: rules governing Flexible Spending Arrangements within Cafeteria Plans;
- Section 1.125-6: substantiation requirements for reimbursements made through Cafeteria Plans; and
- Section 1.125-7: nondiscrimination requirements for Cafeteria Plan

Sections 1.125-3 and 1.125-4 are not part of the new Proposed Regulations. The IRS previously finalized those two sections. They govern the interaction between Cafeteria Plans and the Family Medical Leave Act and mid-plan year Participant election changes respectively. No changes were proposed to those regulations and they are not addressed in this overview.

General Rules Governing Cafeteria Plans – Section 1.125-1

The first section of the new Proposed Regulations is the most comprehensive. It offers numerous rules which apply to all or most Cafeteria Plans. These general rules contain few departures from previous guidance offered by the IRS, whether in the previous Proposed Regulations or in other agency releases. However there are a few notable distinctions that will be pointed out in turn as they arise in this overview.

Definition of a Cafeteria Plan – A Cafeteria Plan is written plan maintained by an Employer for the benefit of its Employees that complies with the rules of Section 125 of the Internal Revenue Code. A Cafeteria Plan must offer Employees a choice between at least one permitted taxable benefit (such as cash compensation) and one permitted tax-free benefit (such as insurance benefits). Cafeteria Plans are the only mechanism for Employers to offer their Employees a choice between taxable and non-taxable benefits without the choice itself resulting in gross income by the Employees. Therefore, if the Cafeteria Plan requirements are not met, the choice between taxable and otherwise tax exempt benefits results in gross income to the Employee regardless of which benefit the Employee elects.

Premium Only Plans - Another helpful general provision contained in the new Proposed Regulations is a formal definition of Premium Only Plans, also commonly referred to as POPs. These are plans that offer as their sole benefit an election between cash and payment of the Employee share of the Employer-provided accident and health insurance premium. While many Cafeteria Plans also contain provisions for FSAs, this rule clarifies that they are not required to do so.

Requirement of a Written Plan Document - The new Proposed Regulations confirm that in order for a Cafeteria Plan to be valid, there must be a written document (the Plan Document) setting out the provisions of the Plan. This rule re-emphasizes the need for Employers who are operating a Cafeteria Plan to make sure they have a written Plan Document in their possession. Otherwise, there is no safe harbor from income tax for elections made by Employees under the plan. That means Employers deducting insurance premiums from their Employees' pay checks on a pre-tax basis without a written Plan Document are exposing both their companies and their Employees to tax liabilities in the form of penalties and interest for under reporting their Employees' gross income.

Specific Provisions That The Written Plan Document Must Contain - Among the rules required to be defined in the Plan Document is the list of at least one taxable benefit and one tax-qualified (tax free) benefit that Participants can choose between. If there is no such choice, the Plan is not a Cafeteria Plan. The Plan Document also must define:

- a specific description of each of the benefits available through the Plan including the periods during which benefits are provided (the periods of coverage);
- the Plan Year;
- the Plan's eligibility requirements and specific requirements that all Participants be Employees;
- the procedures for eligible Employees to elect participation;
- how Employer contributions may be made to the Plan (i.e., via salary redirections or Employer credits); and
- the maximum amount Participants may elect to apply to qualified benefits through salary reduction (either as a dollar amount or as a percentage of compensation).

The Proposed Regulations set out further requirements for Plans that include a Flexible Spending Arrangement. Plan Documents for Plans that include a Health FSA must include provisions complying with the uniform coverage rule and the use-or-lose rule (both rules will be discussed further in the section related to FSA provisions). The Plan Document for such Plans must also include provisions regarding the FSA grace period, if applicable, as well as provisions defining qualified distributions to an HSA, if applicable. Plan Documents for Plans that include a Dependent Care Assistance FSA or an Adoption Assistance FSA must include provisions related to the requirements of Code Sections 129 and 137 respectively. The new Proposed Regulations clarify that Cafeteria Plans that include FSA benefits may combine all of the necessary provisions under one written plan document or the provisions governing the FSA benefits may be part of a separate written plan that is not a part of the Cafeteria Plan Document.

Requirements for Plan Amendments - Furthermore, the new Proposed Regulations clarify that any amendment to a Cafeteria Plan must also be in writing and such amendments may not be retroactive. Just as important, if a Plan Sponsor fails to comply with the written provisions of the Plan Document, the Cafeteria Plan is disqualified from the preferential tax treatment offered under Section 125.

Tax-qualified benefits that may be offered through a Cafeteria Plan. The new Proposed Regulations authorize Cafeteria Plans to offer the following benefits:

- accident or health coverage (major medical, dental, vision, health FSA, LTD, STD, and/or AD&D);
- COBRA coverage for Employees;
- group term life insurance for Employees;
- Dependent Care Assistance FSA;
- Adoption Assistance FSA;
- contributions to an HSA;
- contributions to a 401(k) plan; and

- certain post-retirement group life insurance plans of educational institutions

Just as helpful, the Proposed Regulations itemize several types of benefits which may not be offered through a Cafeteria Plan. These include:

- scholarships;
- Employer-provided meals and lodging;
- educational assistance;
- fringe benefits;
- long-term care insurance;
- long-term care services;
- group term life insurance for spouses and/or dependents;
- Health Reimbursement Arrangements (HRAs);
- contributions to an MSA; and
- contributions to a 403(b) plan.

Any Cafeteria Plan permitting elective deferrals to any of the above listed prohibited benefit types, even on a taxable basis, should remove those benefits from the Plan.

Operational Failure of a Cafeteria Plan – In addition to the requirement that there be a written Plan Document for all Cafeteria Plans, the new Proposed Regulations make clear that Plans that fail to follow the terms of their Plan Documents also are not considered to be Cafeteria Plans and therefore elections made under such plans will result in gross income to the Participants. The regulations cite several examples of operational failures that result in the loss of the tax preferred treatment under § 125:

- paying or reimbursing expenses for qualified benefits incurred before the later of the adoption date or the effective date of the Cafeteria Plan;
- paying or reimbursing expenses for qualified benefits incurred before the later of the adoption date or the effective date of a Plan Amendment;
- offering benefits other than permitted taxable benefits and qualified benefits;
- operating to defer compensation (except as expressly allowed);
- failing to comply with the uniform coverage rule;
- failing to comply with the use-or-lose rule;
- allowing employees to revoke elections and make new elections except as authorized under the Final Regulations related to mid-year election changes;
- failing to comply with the FSA substantiation requirements; and
- failing to comply with the qualified HSA distribution rules.

The General Requirement for a 12 Month Plan Year and Valid Exceptions - The Proposed Regulations expressly define a Plan Year as a recurring 12 month period of time unless there is a “valid business purpose” for a short Plan Year. Any change to a Plan Year made in order to circumvent Cafeteria Plan rules is deemed not to be a “valid business purpose”. Plan Year changes for the purpose of allowing Participants to have multiple open enrollment periods per year would be an example of a prohibited change. Examples cited of Plan Year changes that do constitute a “valid business purpose” are short initial Plan Years which end on the anniversary date that the Plan Sponsor intends

to use indefinitely and Plan Year changes corresponding to the policy year of the Plan Sponsor's insurance policy.

Who may participate in a Cafeteria Plan - The new Proposed Regulations clarify that only Employees or former Employees can be Participants in a Cafeteria Plan. The rules specify that for the purposes of Section 125, the term "Employees" does include leased Employees and full-time life insurance salesmen. While spouses and dependents of Employees may not be Participants (unless they are also Employees) they can be provided benefits through their relationship to the Participant. The rules also expressly clarify that sole proprietors, partners in partnerships and non-Employee directors of corporations are not Employees and therefore are not eligible to participate in a Cafeteria Plan. Furthermore, more-than-2% shareholders of an S corporation as well as their family members are also disqualified from participating in a Cafeteria Plan. For those individuals, disqualification at any point during the year results in disqualification for the entire year. Unfortunately, the wording of the new Proposed Regulations on this topic creates an ambiguity. It is clear that if an individual that is disqualified at the beginning of the year changes their ownership role mid-year that individual remains disqualified for the remainder of the year. However it is not clear if an eligible individual, who becomes disqualified because of a change in their ownership role mid-year, is disqualified retroactively to the beginning of the year or just from that point forward. Hopefully, this ambiguity will be cleared up before the regulations are finalized.

Benefits for Domestic Partners Under a Cafeteria Plan - Another provision contained in the general rules clarifies that even though benefits provided to a non-dependent domestic partner of an Employee are not eligible for tax-free treatment¹, they can be a qualified benefit in a Cafeteria Plan so long as the fair market value of the coverage is included in the Employee's income. While this provision does nothing with regards to the tax status of such benefits for Employees with domestic partner coverage, it does simplify the administrative burden for Employers who allow such Employees to purchase domestic partner coverage.

The FSA Grace Period - In 2005, the IRS introduced the concept of a "Grace Period" which allows Participants in a Section 125 Plan to carry over benefits from one Plan Year for up to 2 ½ months into the next Plan Year. The new Proposed Regulations formalize the rules related to Grace Periods. The new rules confirm that the Grace Period provisions may apply to any benefits offered under a Section 125 Plan but Plan Sponsors may also pick and choose which benefits in their specific Plan the Grace Period applies to. Plan Sponsors may set the length of the grace period (subject to the 2 ½ month limit) and they also may place dollar limits on the amount of unused contributions that can be used during a grace period (although the limit can not be based on a percentages of unused contributions). Finally, the new rules confirm that Plan Sponsors can wait until the end of the grace period before allocating expenses incurred during the grace period as applying to the current Plan Year or the previous Plan Year. This allows Plan

¹ DOMA, otherwise known as the federal Defense of Marriage Act, prohibits tax qualified treatment for benefits provided for non-dependent domestic partners.

Participants to maximize their benefits in the event current year claims are submitted prior to the submission claims incurred during the previous Plan Year.

The Period for Submitting Claims for Reimbursement from a Cafeteria Plan

- Somewhat related to the Grace Period, the new regulations confirm that Plan Sponsors have the right to determine the “Run Out Period” for Participants to file claims after the end of each Plan Year (and subsequent Grace Period). There is no limit as to how long the Run Out Period may be but it must be the same for all Plan Participants. The rule is not clear as to whether a shorter Run Out Period may be applied to former Plan Participants (for example for Participants who terminate employment mid-year).

Group Term Life Insurance Benefits Under a Cafeteria Plan – Group Term Life insurance benefits are a qualified benefit under Section 125. The tax code limits the exclusion from gross income for Employer provided Group Term Life Insurance to \$50,000 of coverage. However, coverage amounts offered through a Cafeteria Plan in excess of \$50,000 do not cause the Group Term Life Insurance to fail to be a qualified benefit under the Cafeteria Plan. Rather, the cost of the coverage in excess of \$50,000 merely must be included in the Employee’s gross income. The new Proposed Regulations provide the mechanism for determining the amount of the inclusion. For any aggregate amount of Employer provided Group Term Life Insurance coverage in excess of \$50,000, whether provided inside the Cafeteria Plan or outside the Cafeteria Plan, Table I (*Uniform Premiums for \$1,000 of Group-Term Life Insurance Protection*) is used to determine the amount includible in the Employee’s gross income. The amount included is reduced by the amount, if any, that the Employee paid for the coverage with after-tax contributions. Unlike almost all of the other provisions of the new Proposed Regulations (which are scheduled to be effective for Plan Years beginning on or after January 1, 2009), the rules governing Group Term Life Insurance Benefits in a Cafeteria Plan are effective immediately.

Paying for or Reimbursing COBRA Premiums Through a Cafeteria Plan –

The new Proposed Regulations expressly permit a Cafeteria Plan to offer benefits to Employees in the form of premiums for COBRA. Among the examples cited in the Proposed Regulations, situations where this would be applicable include when an Employee under the Employer’s group health plan loses coverage due to a reduction in hours but wishes to retain their coverage through COBRA. An additional situation cited is where a new Employee who is not yet eligible for group health insurance under the Employer’s Plan wishes to utilize salary reduction in exchange for the Employer paying the required COBRA premiums to the Employee’s former Employer. **Note** that if the eligibility requirements for the Cafeteria Plan are linked to the eligibility requirements for the group health insurance, both of these opportunities would not be available under the Cafeteria Plan. Therefore, Plan Sponsors may wish to make their Cafeteria Plan eligibility requirements more lenient than the group health insurance eligibility requirements in order to provide more flexibility within their plan.

Paying for or Reimbursing Employees' Individual Insurance Premiums

Through a Cafeteria Plan – The new Proposed Regulations expressly state that the payment or reimbursement of an employee's substantiated individual health insurance premiums is a qualified benefit under a Cafeteria Plan. According to the examples cited in the rules, the Plan can reimburse the Employee directly for the amount of his or her substantiated health insurance premium. Alternatively, the Plan can issue a check to the Participant payable to the insurance company for the amount of the premium or the Plan can issue a check payable jointly to the employee and the insurance company.

Prohibition Against Deferred Compensation – One of the major principles of Cafeteria Plans that works its way through most of the new Proposed Regulations is the rule prohibiting Cafeteria Plans from offering benefits that defers compensation. The essence of the rule is that benefits elected in one year in lieu of taxable compensation but not used in that year may not be carried over into subsequent years – the Participants must either use the elected benefit, or lose it. For benefits such as a Health FSA, this is simple concept to administer. However, with other benefits, Plan provisions that seem innocuous can result in an unlawful deferring of benefits into a subsequent plan year. An example of such a provision is an investment feature in a life insurance benefit. Plan Sponsors should be very careful to make sure that any plans which they offer under their Cafeteria Plan do not contain provisions which work to defer compensation in a way that prohibits them from being qualified benefits under their Plan. Otherwise the Cafeteria Plan is subject to operational failure and the inclusion in gross income of their employees of all benefits offered through the Plan. This result is expressly warned about in the new Proposed Regulations.

Exceptions To The Prohibition Against Deferred Compensation – Despite the general principle that benefits offered through a Cafeteria Plan may not operate to defer compensation, there are some exceptions to the rule. One of the most obvious is the FSA Grace Period (discussed in more detail later) which allows FSA Plans to allow their Participant to use benefits elected in one Plan Year to use those benefits for up to two and one half months into the subsequent Plan Year. Another exception to the prohibition against deferred compensation under Cafeteria Plans is the inclusion of elective deferrals to a 401(k) Plan as a qualified benefit. A very rarely utilized type of benefit defers compensation but that is a qualified benefit under a Cafeteria Plan is a plan maintained by an educational organization that provides for post-retirement group life insurance.²

In addition, the new Proposed Regulations specify several features of health insurance benefits which typically relate to more than one year but are deemed not to defer compensation:

- credits toward deductibles for unreimbursed covered expenses incurred in a prior year
- reasonable lifetime maximum limits on benefits
- level premiums
- premium waivers during disability

² These plans are governed by Code § 170(b)(1)

- guaranteed policy renewability of coverage without evidence of insurability
- coverage for a specified disease or illness

A condition of each of these exceptions being exempt from the prohibition against deferred compensation is that the policies under which they are provided may only remain in force so long as current premium is being paid – if the current premiums are no longer paid, all coverages for new diseases or illnesses must lapse. There can be no investment fund or cash value which may be used to pay future premiums.

In addition, a long term disability policy that pays benefits over more than one year is not considered to be a benefit that defers compensation under the new Proposed Regulations.

In addition, reasonable premium rebates or dividends for plans purchased through the Cafeteria Plan do not constitute deferred compensation so long as they are paid within 12 months of the end of the Plan Year to which they relate.

Mandatory two-year coverage periods (“two-year lock-in”) for dental and vision insurance do not constitute deferred compensation so long as the premiums are paid no less frequently than annually and the Plan does not permit salary reductions or flex-credits relating to the first year be used to pay for insurance in the second year of the two-year election.

The new Proposed Regulations expressly allow that salary reduction amounts withheld in the last month of one Plan Year may be applied to pay for health insurance premiums for coverage during the first month of the immediately following plan year if done on a uniform and consistent basis with respect to all Plan Participants. This is not a prohibited deferral of compensation. This is a new rule that should prove to be very helpful to Employers.

Paid Time Off as a Permitted Taxable Benefit Under a Cafeteria Plan – A Cafeteria Plan is permitted to include paid time off as a permitted taxable benefit. If the plan only offers a choice between paid time off and cash, it is not a cafeteria plan and is not subject to the rules of Section 125. Therefore, a Cafeteria Plan that included paid time off as a permitted taxable benefit usually offers the time off in lieu of a qualified benefit, such a health insurance (perhaps to individuals who are covered under their spouse’s group health insurance). The major issue with Cafeteria Plans that offer paid time off as a permitted benefit is making sure that the plan does not operate to permit the deferral of compensation. In order to accomplish that, the elective paid time off must be used in the same year that it is accrued. Therefore there are several provisions such plans should have to avoid deferring compensation. First, the Plan should require that a Plan Participant must use all of his or her nonelective paid time off before using their elective paid time off. The Plan should then either provide that any elective paid time off that is not used by the end of the Plan year must be paid out in cash to the Participant prior to the end of the Plan Year or that the unused Paid Time Off is forfeited. No grace period is permitted for the use of the Paid Time Off after the end of the Plan Year. Paid Time Off Benefits are not subject to a mandatory use-or-lose rule

which applies to FSA Plans but the Employer can provide for such a provision if they wish.

Rules Governing Cafeteria Plan Elections for Participants – Section 1.125-2

Making Elections and Revoking Elections – The new Proposed Regulations clarify that Cafeteria Plans must allow Employees to make elections among taxable benefits and qualified non-taxable benefits for each Plan Year and that the elections must be irrevocable for the Plan Year (subject to exceptions defined in the previously finalized change in status rules). The required elections must be made before the beginning of the Plan Year. Elections do not necessarily need to be made using written paper documents; elections made using electronic media are permitted.

Automatic Elections – Cafeteria Plans are permitted, but not required to, provide default elections for one or more qualified benefits. For example, a Plan could deem that elections made in a prior year are continued in subsequent Plan Years unless changed or a Plan could deem that if no election is timely made by a Participant, an election to receive taxable cash compensation is the default election. Employees must be given the opportunity to affirmatively make a different election but if they fail to do so, the automatic election is valid.

Election Rules for Salary Reduction Contributions to HSAs – Cafeteria Plans may allow Participants to make salary reduction contributions to an HSA. The contribution must be made pursuant to a prospective election (retroactive elections are not permitted) made prior to the time the affected salary becomes currently available. If a Cafeteria Plan allows salary reduction contributions to an HSA, the Plan Document must describe the HSA contribution benefit, allow Participants to make mid-Plan Year changes to their HSA contribution election prospectively at least on a monthly basis, and allow those Participants who become ineligible to make HSA contributions to prospectively revoke their election.

Optional Election for New Employees – One of the changes contained in the new Proposed Regulations allows new Employees 30 days after their date of hire to make elections under a Section 125 Plan and the election would be effective as of the Employee's date of hire. Despite the retroactive effective date of the election, any salary reductions resulting from the election only affect compensation received by the Employee after the date of the election. This 30 day new hire election provision must be provided for in the Plan Document and may not apply to individuals rehired within 30 days of terminating employment from the Plan Sponsor.

Rules Governing Flexible Spending Arrangement In Cafeteria Plans – Section 1.125-5

Definition of Flexible Spending Arrangement – The new Proposed Regulations define an FSA as a benefit program that provides Employees with coverage which reimburses, specified, incurred expenses (subject to reimbursement maximums and other conditions). There are three different types of FSA Plans: health FSAs,

Dependent Care Assistance FSAs, and adoption assistance FSAs (the new Proposed Regulations provide very little guidance regarding adoption assistance FSAs and because so few Plan incorporate them, they will be addressed minimally in this review as well).

Use-or-Lose Rule – In keeping with the general rule that Cafeteria Plans may not defer compensation, the new Proposed Regulations confirm the rule previously known as “use it or lose it”. Under this rule, no contributions or benefits from an FSA may be carried over from one Plan Year to a subsequent Plan Year (except pursuant to the “Grace Period” rules described earlier). Unused benefits or contributions remaining at the end of the year must be forfeited by the Participant.

Uniform Coverage Rule – Simply stated, the Uniform Coverage Rule requires that the maximum amount of reimbursement from a health FSA must be available at all times during the Plan Year (except to the extent reimbursements have been previously paid for the same Plan Year). Therefore, health FSA Plans are not allowed to limit reimbursements based on the amount that has been contributed to the plan at the time the reimbursement is made. Likewise, a Participant’s contribution schedule may not be based on or accelerated due to the Participant’s claims and reimbursements. An additional element of reimbursements being “available at all times” is that claims must be reimbursed at least monthly or when the total amount of a Participant’s claims reach a specified reasonable limit (such as \$50).

The uniform coverage rule does not apply to Dependent Care Assistance FSA Plans and adoption assistance FSA Plans.

Separate Period of Coverage For Different FSA Benefits – A Cafeteria Plan may establish different periods of coverage for health FSAs, Dependent Care Assistance FSAs and adoption assistance FSAs and each type of FSA can have a different period of coverage than the Plan Year for the Cafeteria Plan.

Tying FSA Eligibility to Participation in the Employer’s Group Health Plan – An Employer sponsoring a Cafeteria Plan may, but need not, condition eligibility in the Cafeteria Plans health FSA on an Employee’s participation in the Employer’s group health insurance plan.

Plan Restrictions on Eligible Expenses Under a Health FSA – An Employer sponsoring a Cafeteria Plan may, but need not, limit reimbursement under the Plan to only certain expenses that are eligible medical expenses under federal law. For example, although federal law allows health FSA plans to reimburse Employees for mileage expenses related to medical services, a Plan Sponsor could exclude such expenses from eligibility for reimbursement under their specific plan in order to simplify the administration of their plan.

Special Rule for Advanced Payment of Orthodontia Expenses – Generally, a health FSA plans may not reimburse Participants for medical expenses paid in advance of receiving the services to which the payment corresponds. However, under a special rule formalized in the new Proposed Regulations, a health FSA may, but is not required

to, reimburse Participants for orthodontia expenses actually paid even if the services for which the payment correspond have not yet been provided. The services are deemed to be incurred when the Participant makes the advance payment.

Special Rule for Reimbursements of Durable Medical Equipment – As stated previously, generally health FSA plans may not reimburse Participants for medical expenses paid in advance for receiving the services to which the payment corresponds. Whenever durable medical equipment (like a wheelchair) is purchased, by definition, the utility of the equipment is for an indefinite period of time and therefore, some value of the purchase likely is obtained in future plan years. The new Proposed regulations clarify that a health FSA may reimburse for durable medical equipment despite the fact that some of the reimbursement is for value received in a future plan year.

Health FSA Plans and HSA Eligibility – Individuals who are covered by a qualifying High Deductible Health Plan (“HDHP”) who do not have other disqualifying health coverage may make tax preferred contributions to a Health Savings Account (“HSA”). Traditional health FSA plans that reimburse for all (or almost all) out of pocket medical expenses are “other disqualifying health coverage”. Therefore, individuals covered under a traditional health FSA plan may not make contributions to an HSA. However, the new Proposed Regulations clarify that health FSAs that only reimburse certain specified expenses are compatible with HSA eligibility.

The first type of HSA-compatible health FSA is known as a Limited-Purpose health FSA. The Limited-Purpose health FSA only reimburses Participants for dental, vision and preventative care expenses. For the purposes of this rule, preventative care expenses are specifically defined by federal law.

The second type of HSA-compatible health FSA is known as a Post-Deductible health FSA. The Post-Deductible health FSA only reimburses Participants for preventative care expenses and for medical expenses above and beyond the minimum annual HDHP deductible under federal law is covered (currently \$1,100 for single coverage and \$2,200 for family coverage for 2007 and 2008). For example, if a Participant with Employee only health insurance coverage has a medical procedure with an out of pocket expense of \$1,400, only \$300 of the expense would be eligible for reimbursement from a Post-Deductible health FSA.

In addition to the two special types of FSA plans described above, the new Proposed Regulations confirm that FSA plans that combine the coverages of a Limited-Purpose health FSA and a Post-Deductible health FSA do not disqualify Participants from making contributions to an HSA.

Distribution of Unused Health FSA Funds to Participants’ HSAs – Late in 2006, Congress passed legislation allowing Plan Sponsors of health FSA Plans to distribute a Participant’s unused FSA account balance to the Participant’s HSA. The purpose of the legislation is to create a source of funds for individuals entering into HSAs for the first time. The intent is to make the transition from low deductible health plans to high deductible health plans easier for individuals.

The new Proposed Regulations set out the rules for such transfers. The transfer must be made according to the terms of a written amendment to the Plan Document of the health FSA prior to the end of the relevant Plan Year. The distribution must be made available to all Participants but each Participant must be given the right to elect to receive the distribution for that year or not. In addition, the distribution may only occur once per Participant (distributions are not available for multiple Plan Years) and the distribution must be made directly from the FSA Plan Sponsor directly to the trustee of the Participant's HSA no later than December 31, 2011. The distribution is limited to the lesser of each Participant's health FSA balance on September 21, 2006 and the date of the distribution.

If the rules described above are followed, the transfer is not included in the Participant's gross income. However, once the distribution is made, the Participant must remain a qualified individual for HSA contributions (they must retain their coverage under a qualifying HDHP and not have any other disqualifying coverage) for a period of 12 months or the distribution is included in the Participant's gross income and subject to a 10% excise tax.

Rules Governing What Plan Sponsors Can Do With Experience Gains –

When FSA Participants forfeit unused contributions, the Participant's Employer has several options regarding what they may do with those funds. The Employer is allowed to either retain those funds as a general asset or to use the funds in one of three ways. The Employer may use the funds to reduce salary reduction amounts for Plan Participants during the immediately following plan year or to defray the administrative costs of the Plan. Additionally, the Employer is allowed to return the funds to Employees on a reasonable and uniform basis but in no case may funds be returned to Employees based in any way on their individual claims experience under the Plan. In addition, experience gains may not be returned to Employees in any way through a deferred compensation benefit plan.

Substantiation Requirements For Reimbursements Made Through Cafeteria Plans – Section 1.125-6

Third-Party Substantiation is Required for All Reimbursements – According to the new Proposed Regulations, a Cafeteria Plan may only reimburse expenses that have been substantiated by the Plan’s representative to have been incurred on or after the later of the effective date of the Plan and the Employee’s date of enrollment in the Plan. In addition, in order for expenses to be reimbursed from a Health Care FSA or a Dependent Care Assistance FSA, the expense must have been incurred during the defined Period of Coverage (typically, the Plan Year) for the specific FSA. The actual reimbursements for eligible expenses incurred during the Period of Coverage may be made after the applicable Period of Coverage ends.

All claims for reimbursements must be substantiated. The new Proposed Regulations expressly forbid substantiation of claims for reimbursements by sampling among a percentage of all claims. Substantiating only claims that exceed a certain dollar amount is also expressly prohibited.

Substantiation of claims for reimbursement through a Cafeteria Plan must be through information provided by a third-party that is independent of the Plan Participant (or their covered dependent). The independent third party generally must provide the following information: a description of the service or product, the date of the service or sale and the amount of the expense related to the service or product. Self-substantiation and/or self-certification are expressly prohibited. All amounts paid under a plan that permits self-certification of any claims for reimbursement are includable in gross income, including amounts reimbursed for medical expenses that were properly substantiated.

Explanation of Benefits (EOBs) as Substantiation – The new Proposed Regulations expressly permit a Plan to rely on an Explanation of Benefits indicating the date eligible medical care was incurred and the Employee’s responsibility to pay for that medical care to serve as sufficient substantiation of a claim for reimbursement through a Cafeteria Plan. The EOB should be accompanied by the Employee’s certification that the expense has not been reimbursed from any other source and that the Employee will not seek reimbursement from any other health plan. Those certifications are typically made through the use of standard language on a FSA Plan claim form which the Employee signs and submits to the Plan along with their EOB.

Prohibition Against Arrangements That Eliminate Risk – In order for reimbursements made for medical expenses to be exempt from an Employee’s gross income, a Health FSA Plan (or any other medical reimbursement plan) may not operate in a manner that entitles Employees to receive a benefit regardless of the amount of medical expenses incurred. In other words, a Plan that provides that any amount of unused medical reimbursement benefits are to be paid to Plan Participants as taxable cash compensation at the end of the year results in gross income to the Participants for all benefits paid through the Plan, even if they were reimbursing otherwise eligible medical expenses. The new Proposed Regulations indicate that any formal arrangements outside of a Cafeteria Plan to adjust an Employee’s compensation on the basis of reimbursements the Employee received under the Cafeteria Plan “are considered” in determining if reimbursements made through the Cafeteria Plan are exempt for gross income for Participants.

Definition of When Expenses Are Incurred – For the purposes of a Health FSA and/or a Dependent Care Assistance FSA, eligible expenses are considered to be incurred when the service or product that constitutes medical care or dependent care is provided to the covered individual and not when the Plan Participant or covered individual is formally billed, charged for, and/or pays for the medical care or dependent care. The date of payment for any service is irrelevant for the purposes of a Health FSA or a Dependent Care Assistance FSA.

Advance Reimbursements of Expenses Prohibited – The new Proposed Regulations confirm that neither Health FSA Plans nor Dependent Care Assistance FSA Plans may reimburse expenses before they are incurred. This situation often arises when a Participant pays a required deposit to a dependent care facility in advance of the receipt of services. Such deposits are not reimbursable by the plan until such time when the dependent care service related to that deposit is actually provided.

In addition, the new Proposed Regulations expressly prohibit reimbursement of expenses prior to the time when the expense is substantiated in anticipation of future substantiation. In determining if Employees are being reimbursed for unsubstantiated claims, “special scrutiny” will be given to other arrangements such as Employer-to-Employee loans based on actual or projected Employee claims.

Substantiation of Debit Card Expenses – General Rules – The new Proposed Regulations formalize several rules applicable to all debit cards that are usable to pay or reimburse medical expenses and separate rules related to debit cards that are usable to pay or reimburse dependent care expenses. In summary, the rules proscribe several conditions which all must be followed in order for reimbursements or payments to be exempt from gross income for the Plan Participant.

First, every Employee participating in a FSA Plan that is to be issued a debit card linked to the Plan must agree in writing that he or she will only use the card to pay for eligible medical or dependent care expenses for themselves or their spouse or dependent. They must also agree not to use their debit card for any expense that has already been reimbursed and that they will not seek reimbursement under any other plan for any expense paid with the debit card.

Second, the debit card must include a statement providing that the rules of the foregoing paragraph are reaffirmed by the Participant each time they or an eligible family member use their card.

Third, in the case of a Health FSA, the amount available through the debit card must equal the amount elected by the Employee for the Health FSA for the Plan Year, reduced by amounts previously reimbursed to or paid on behalf of the Participant for the Plan Year.

Fourth, the debit card must automatically be cancelled when the Employee ceases to participate in the FSA Plan.

Fifth, the debit card's use must be limited by the Plan to physicians, dentists, vision care offices, hospitals and other medical care providers as identified by the Merchant Category Code (MCC) of the vendor. In addition, the Plan may allow the debit card to operate at drugstores and pharmacies, but only at specific locations where 90 percent of the store's gross receipts during the prior taxable year consisted of items that qualify as medical care expenses under the provisions of federal law. Obviously, that is a very high threshold to satisfy – one that most common pharmacies will not meet. However, there is another exception: Plans may allow the debit card to work at stores that have implemented a specified Inventory **Information Approval System (IIAS)**. Most major retail pharmacies are expected to implement such a system prior to the January 1, 2009 deadline established under the regulations. More details are provided about the IIAS are provided in a separate paragraph.

Sixth, the Plan must substantiate all claims according to specific guidelines. Unless a transaction is permitted to be automatically substantiated, all transactions must be treated by the Plan as conditional until the Participant submits documentation to the Plan from an independent third party which describes the goods or services which the payment was used to pay for, the date of the service or sale and the amount of the transaction. There is no *de minimus* amount for which substantiation is not required. More details are provided about transactions which may be automatically substantiated in following paragraphs.

Seventh, the Plan must follow several specified correction procedures for any improper payments made on behalf of Participants using the debit card. More details are provided about the specified correction procedures in a separate paragraph.

Correction Procedures for Improper Debit Card Payments – The new Proposed Regulations list the following procedures that a Plan must follow in the event a Participant uses their debit card in a manner inconsistent with the terms of the Plan or federal law. First, the Plan must de-activate the Employee's card and require the Employee to submit future claims for reimbursements through other methods (such as manually submitting properly documented claims to the Plan). The Plan must then demand that the Employee repay the Plan an amount equal to the improper reimbursement or payment. If the Employee fails to repay the reimbursement after demand by the Employer, the Employer must withhold the amount of the improper

reimbursement or payment from the Employee's compensation, to the extent allowed by applicable law (for example, state garnishment laws may limit the amount that may be withheld from any one pay check). If any portion of the improper payment remains outstanding after the Employer pursues demand for repayment and has exhausted their ability to withhold repayment from the Employee's compensation, the Employer must then offset the amount of any future valid claims submitted by the Employee by the amount of the remaining portion of the improper payment. If the steps detailed above all fail to allow the Employer to retrieve the improper payment, the Employer must treat any outstanding portion of the improper payment as they would treat any other business indebtedness consistent with the Employer's business practice.

Automatic Substantiation of Debit Card Payments to Medical Care

Providers – The new Proposed Regulations codify previously released guidance from the IRS regarding several different methods of automatic substantiation which may be used under different circumstances if the payment is made to a Medical Care Provider (as that term is defined by the rules) . For the purposes of automatic substantiation, a Medical Care Provider is a vendor for whom the Merchant Category Code (MCC) from the transaction identifies the provider as a physician, hospital, dentist, vision care office, pharmacy (the rules specifically differentiate "pharmacies" from general merchandise retailers that offers pharmacy services such as grocery stores) or other medical care provider. For such providers there are three different types of transactions which may be substantiated automatically without the need for submission of receipts after the transaction. Those three types of transactions are debit card transactions which match a co-payment from the Employer's health plan, recurring transactions which meet specified criteria, and transactions that are substantiated in real-time by the provider.

If the Employer's health plan that covers the Participant using their debit card has co-payments in specific dollar amounts and the dollar amount of a transaction made by that Participant at one of the Health Care Providers listed above equals an exact multiple of not more than five times the dollar amount of a co-payment for a specific service under that Participant's health plan, the charge is fully substantiated without the need for submission of a receipt or further review. In the event that health plan has multiple co-payments for the same benefit, transactions exactly matching combinations of up to five co-payments are similarly substantiated without the need for the submission of a receipt or further review. For example, a \$35 charge at a pharmacy may be automatically substantiated for a Participant covered by a group health plan with a \$10 co-payment for generic prescription drugs and a \$25 co-payment for brand name prescription drugs. Likewise, the same Participant making a charge of \$60 or \$85 at a pharmacy could have those transactions automatically substantiated. In order for this form of automated substantiation to be valid, the amount of co-payments for the health plan under which a specific Participant is covered must be verified by a party other than the Participant. Usually the Employer has this information as part of their group health plan but co-payments under individual group health plans are acceptable under the rules.

A second form of automatic substantiation authorized for debit card payments made to a Health Care Provider involves recurring expenses. If an expense matches an expense previously approved as to its amount, the medical care provider and the time period, the

subsequent expense may be automatically substantiated without the need for submission of a receipt or further review.

The third form of automatic substantiation authorized for debit card payments made to a Health Care Provider is real-time substantiation by an independent third party. In such an instance, the third party (such as the physician's office) provides information to the Plan at the time and point of sale that the charge is for an eligible expense for the Participant (or a covered dependent). The information may be communicated to the Plan by the third party via e-mail or telephone, among other methods. Once the information is provided by the third party to the Plan, the subsequent use of the debit card to pay the expense may be automatically substantiated without the need for the Participant to submit documentation for the expense after the transaction is processed.

Debit Card Payments Made to Vendors Utilizing an Inventory Information Approval System – For Plan Years that begin on or after January 1, 2009, debit card payments made to merchants and service providers who are not Health Care Providers (as defined in the previous topic) and who are not qualified Drug Store locations as defined by the regulations³, are only permissible by Health FSA plans that utilize debit cards if the merchant or service provider utilizes a compliant Inventory Information Approval System (IIAS). Unfortunately, this means that Participants will be unable to use their Health FSA debit cards for merchants they currently use if the merchant does not implement IIAS procedures. This creates the potential for some degree of Participant dissatisfaction with their Health FSA debit card. Fortunately, any such dissatisfaction should be mitigated by the fact that all Health FSA debit card payments made to merchants utilizing IIAS procedures can be automatically substantiated by the Health FSA Plan. Therefore, Participants will have to submit documentation for fewer Health FSA debit card transactions than in the past.

When a merchant implements and uses compliant IIAS procedures, the debit card will only be authorized at the point of sale to pay for items that qualify as medical expenses under federal law. The merchant's system compares information about the items the Participant is purchasing via an inventory control system (such as SKUs – stock keeping units) to a list of items that are considered medical expenses. The price for all of the items that are medical expenses is calculated and the merchant's debit card processing system only approves the transaction for that amount. If any of the items the Participant is purchasing are not categorized as medical expenses in the inventory control system, the Participant must pay the vendor for those items using another method of payment. Of course, if the Participant does not have sufficient funds in their Health FSA account to cover the cost of the items that are medical expenses, they will also have to use another method of payment to pay the vendor the amount of the deficiency.

Debit Card Reimbursements for Dependent Care Assistance FSAs – The new Proposed Regulations confirm that Dependent Care Assistance FSAs may use debit cards to reimburse Participants. The rules set out requirements that are different than

³ For the purposes of this review, qualified drugstore locations are those individual stores for which 90% of their gross receipts during the prior taxable year consisted of items which qualify as medical expenses under the tax Code.

the rules related to Health FSA debit card transactions. Before a Participant may use a debit card to pay for dependent care services, the Participant must first pay their initial expenses to their day care provider via another method of payment. The Participant then substantiates the initial expenses by submitting documentation of the expense to the Plan. The documentation must substantiate the dates and the cost of the dependent care service provided. Once the required documentation is provided to the Plan, the Plan may then fund the Participant's debit card for the lesser of the amount of the previously incurred dependent care expense or the Employee's Dependent Care Assistance FSA salary reduction to date for the Plan Year (less any previous reimbursements for the Plan Year). The Participant may then use the card for any subsequently incurred dependent care expenses. If the debit card is subsequently used to pay the same dependent care provider for the same time period as the previously substantiated claim and the amount of the debit card transaction is equal to or less than the previously substantiated transaction, the debit card transaction may be substantiated with the requirement for the Participant to submit any documentation or without further review by the Plan. If however, the amount of any subsequent transactions exceeds the prior substantiated transaction or if the dependent care provider changes, the Participant must submit substantiation for the claimed expenses before additional funds can be re-added to the Participants debit card for their Dependent Care Assistance FSA.

Non-Discrimination Requirements for Cafeteria Plans – Section 1.125-7

Highly Compensated Individuals Defined – There are four categories of individuals that are classified as “Highly Compensated Individuals” for the purposes of non-discrimination testing for Cafeteria Plans under the new Proposed Regulations. Two of the classifications are very straightforward: first, a 5% or more shareholder of the Employer; and second, a spouse or dependent of an individual who is otherwise a Highly Compensated Individual.

The third classification is individuals who are an Officer of the Employer. In determining who is an officer, you generally look at the previous plan year unless the current year is the individual's first year of employment with the Employer. Mere title alone does not determine if an individual is an Officer or not, rather it is determined by all of the facts and circumstances such as the individual's level of autonomy and the source of their authority.

The fourth classification is not new but the new Proposed Regulations thankfully provide a definition. Under the previous rule, one of the categories of individuals that were considered to be Highly Compensated Individuals was individuals who are highly compensated. This circular definition was not very helpful. The new Proposed Regulations retain the category but define the term to mean any individual who for the preceding plan year (or the current year if it is the Employee's first year of employment with the Employer) had income from the Employer in excess of a statutory⁴ amount.

⁴ IRC § 414 (q)(1)(B)

The relevant statute comes from the rules applicable to deferred compensation plans, such as 401(k) plans. For 2007, that amount is \$100,000. Before the new Proposed Regulations were issued, this statutory amount was presumed to be the definition but Plan Sponsors could not be sure.

Key Employee Defined – For the purposes of non-discrimination testing of Cafeteria Plans, the new Proposed Regulations confirm that a Key Employee is a Plan Participant who meets a specified statutory⁵ definition at any time during the previous Plan Year. This is the same standard that was used prior to the issuance of the new Proposed Regulations except the previous rule was that Key Employee status was determined based on a Participant’s status during the current year whereas the new rule is that Key Employee status is determined based on a Participant’s status during the previous year. Under the statute, a Key Employee is a Plan Participant who: is an Officer of the Employer who earns more than a specified limit (\$145,000 for 2007), is a more-than-1% Owner of the Employer and earns more than a specified limit (\$150,000 for 2007), or is a more-than-5% Owner of the Employer.

Eligibility and the Three Year Maximum Waiting Period– The new Proposed Regulations reiterate the rule set out in Code Section 125 that Cafeteria Plans may not impose a waiting period for eligibility in excess of three years. Any Employee who has completed three years of employment must be allowed to elect participation in the Plan no later than the first day of the Plan Year following the date the Employee completed three years of employment (unless the Employee fails to satisfy a separate condition of eligibility unrelated to service time).

The “Eligibility Test” for Non-Discrimination - The new Proposed Regulations also confirm that in testing the Eligibility provisions of a Cafeteria Plan for non-discrimination, the proper methods to use are the statutorily defined “Reasonable Classification / Safe Harbor” Tests.⁶ These tests come from the rules applicable to deferred compensation plans. These tests provide that a Cafeteria Plan does not discriminate in favor of highly compensated individuals if the Plan benefits a group of Employees who qualify under a reasonable classification established by the Employer (such as full time vs. part time or hourly vs. salaried) and the group of Employees included in the classification satisfies a mathematical Safe Harbor percentage test as well as a complimentary mathematical Unsafe Harbor percentage component. These mathematical tests measure the ratio of the percentage of non-Highly Compensated Individuals who are eligible to participate in the plan compared to the percentage of Highly Compensated Individuals who are eligible to participate in the plan. If that ratio exceeds the Safe Harbor percentage, the Plan passes the Eligibility Test. If the ratio is below the Unsafe Harbor percentage, the Plan fails the Eligibility Test. If the ratio is between the two limits, whether the Plan passes the Eligibility Test is subject to the facts and circumstances surrounding the eligibility provisions. Such an evaluation is inherently subjective and exposes a Plan to an adverse determination which could have very negative consequences for an Employer in the future. Therefore, Employers should

⁵ IRC § 416(i)(1)

⁶ The test is set out in IRC § 410(b).

design their Plan's eligibility provisions in such a way that the Safe Harbor percentage is exceeded. This eliminates the risk that the Plan will later be classified as discriminatory.

The “Contributions and Benefits” Test for Non-Discrimination – Under the new Proposed Regulations a new objective mathematical test is provided to determine if qualified benefits are being disproportionately elected by Highly Compensated Participants. By way of background, a Cafeteria Plan does not discriminate with respect to contributions and benefits if either qualified benefits and total benefits, or Employer contributions allocable to statutory nontaxable benefits and Employer contributions allocable to total benefits do not discriminate in favor of Highly Compensated Participants. In order to satisfy these conditions, a Cafeteria Plan must give each similarly situated Participant the same opportunity to elect qualified benefits and the actual election of qualified benefits may not be disproportionate by Highly Compensated Participants. The new objective mathematical test compares the aggregate qualified benefits elected by Highly Compensated Participants, measured as a percentage of the aggregate compensation of the Highly Compensated Participants, to the aggregate qualified benefits elected by non-Highly Compensated Participants, measured as a percentage of the aggregate compensation of the non-Highly Compensated Participants. If the percentage for the non-Highly Compensated Participants is higher than the percentage for the Highly Compensated Participants, the Plan passes this part of the Contributions and Benefits Test.

In addition, the Plan must measure the aggregate Employer contributions utilized by Highly Compensated Participants, measured as a percentage of the aggregate compensation of the Highly Compensated Participants, compared to the aggregate Employer contributions utilized by non-Highly Compensated Participants, compared to the aggregate compensation of the non-Highly Compensated Participants. Again, the percentage utilized by the Highly Compensated Participants must be lower than the percentage utilized by the non-Highly Compensated Participants in order for the Plan to pass this part of the Contributions and Benefits Test.

The Key Employee Utilization Test (The 25% Test) - The new Proposed Regulations reiterate the rule found in Section 125 limiting the statutory nontaxable benefits provided to Key Employees through a Cafeteria Plan to 25% of aggregate statutory nontaxable benefits provided for all Employees. If a Plan fails to adhere to the 25% benefit limitation for Key Employees, each Key Employee must include in their gross income the amount equal to the maximum amount of taxable benefits they could have elected for the year. However, there is a Safe Harbor exception to this rule for Premium Only Plans. This exception allows Premium Only Plans to disregard the 25% Key Employee Utilization Test so long as the Plan satisfies the Safe Harbor percentage test for Eligibility described above. Fortunately, this is a very easy standard for most Premium Only Plans to pass therefore this new Safe Harbor exception will usually resolve most difficulties small Premium Only Plans have had in the past in passing the utilization test.