PART I: CAFETERIA PLANS

3501. What is a cafeteria plan?

A cafeteria plan (or "flexible benefit plan") is a written plan in which all participants are employees who may choose among two or more benefits consisting of cash and "qualified benefits." With certain limited exceptions, a cafeteria plan cannot provide for deferred compensation. See Q 3502.[1]

Some cafeteria plans provide for salary reduction contributions by the employee and others provide benefits in addition to salary. In either case, the effect is to permit participants to purchase certain benefits with pre-tax dollars.

A plan may provide for automatic enrollment whereby an employee's salary is reduced to pay for "qualified benefits" unless the employee affirmatively elects cash.[2]

Under the 2007 proposed regulations (effective for plan years beginning on or after January 1, 2009), the written plan document must contain the following: (1) a specific description of the benefits, including periods of coverage; (2) the rules regarding eligibility for participation; (3) the procedures governing elections; (4) the manner in which employer contributions are to be made, such as by salary reduction or nonelective employer contributions; (5) the plan year; (6) the maximum amount of employer contributions available to any employee stated as (a) a maximum dollar amount or maximum percentage of compensation or (b) the method for determining the maximum amount or percentage; (7) a description of whether the plan offers paid time off, and the required ordering rules for use of nonelective and elective paid time off; (8) the plan's provisions related to any flexible spending arrangements (FSA) included in the plan; (9) the plan's provisions related to any grace period offered under the plan; and (10) the rules governing distributions from a health FSA to employee health savings accounts (HSAs), if the plan permits such distributions.[3] The plan document need not be self-contained, but may incorporate by reference separate written plans.[4]

Note that under the *Patient Protection and Affordable Care Act* (P.L. 111-148), the cost of an over-the-counter medicine or drug cannot be reimbursed from FSAs or health reimbursement arrangements (HRAs) unless a prescription is obtained. It does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles. This standard applies only to purchases made on or after Jan. 1, 2011. A similar rule went into effect on January 1, 2011, for HSAs and Archer Medical Savings Accounts (Archer MSAs). The IRS advises employers and employees to take these changes into account as they make health benefit decisions.[5] FSA and HRA participants may continue using debit cards to buy prescribed over-the-counter medicines, if requirements are met.[6] In addition,

1. IRC Sec. 125(d).
2. Rev. Rul. 2002-27, 2002-1 CB 925.
3. Prop. Treas. Reg. §1.125-1(c).
4. Prop. Treas. Reg. §1.125-1(c)(4).
5. See IRS News Release IR-2010-95 (Sept. 3, 2010).
6. IRS News Release IR-2010-128 (Dec. 23, 2010).

starting in 2013, there are new rules about the amount that can be contributed to an FSA. For instance, for plan years beginning after December 31, 2012, a cafeteria plan may not allow an employee to request salary reduction contributions for a health FSA in excess of $2,500. A cafeteria plan offering a health FSA must be amended to specify the $2,500 limit (or any lower limit set by the employer). While cafeteria plans generally must be amended on a prospective basis, an amendment that is adopted on or before December 31, 2014, may be made effective retroactively, provided that in operation the cafeteria plan meets the limit for plan years beginning after December 31, 2012. A cafeteria plan that does not limit health FSA contributions to $2,500 is not a cafeteria plan and all benefits offered under the plan are includible in the employee's gross income.

IRS Notice 2012-40 provides information about these rules (see Q 3503) and flexibility for employers applying the new rules, and requests comments about other possible administrative changes to the rules on FSA contributions. The Notice provides instructions on how to submit comments.

On June 28, 2012, the Supreme Court, in *National Federation of Independent Business v. Sebelius*, upheld the constitutionality of the *Patient Protection and Affordable Care Act*, with only minor changes to certain Medicaid provisions.

Former employees may be participants (although the plan may not be established predominantly for their benefit), but self-employed individuals may not.[1] A full-time life insurance salesperson who is treated as an employee for Social Security purposes will also be considered an employee for cafeteria plan purposes.[2]

3502. What benefits may be offered under a cafeteria plan?

Participants in a cafeteria plan may choose among two or more benefits consisting of cash and qualified benefits.[3] A cash benefit includes not only cash, but a benefit that may be purchased with after-tax dollars or the value of which is generally treated as taxable compensation to the employee (provided the benefit does not defer receipt of compensation).[4]

A qualified benefit is a benefit that is not includable in the gross income of the employee because of an express statutory exclusion and that does not defer receipt of compensation. Contributions to Archer Medical Savings Accounts (Q 387), qualified scholarships, educational assistance programs, or excludable fringe benefits are not qualified benefits. No product that is advertised, marketed, or offered as long-term care insurance is a qualified benefit.[5]

With respect to insurance benefits, such as those provided under accident and health plans and group term life insurance plans, the benefit is the coverage under the plan. Accident and health benefits are qualified benefits to the extent that coverage is excludable under IRC

1. Prop. Treas. Reg. §1.125-1(g).
2. IRC Sec. 7701(a)(20); Prop. Treas. Reg. §1.125-1(g)(1)(iii).
3. IRC Sec. 125(d)(1)(B).
4. Prop. Treas. Reg. §1.125-1(a)(2).
5. IRC Sec. 125(f); Prop. Treas. Reg. §1.125-1(q).

Section 106.[1] Accidental death coverage offered in a cafeteria plan under an individual accident insurance policy is excludable from the employee's income under IRC Section 106.[2] A cafeteria plan can offer group term life insurance coverage on employees participating in the plan. Coverage that is includable in income only because it exceeds the $50,000 excludable limit under IRC Section 79 also may be offered in a cafeteria plan.[3] The application of IRC Section 79 to group term life insurance and IRC Section 106 to accident or health benefits is explained in Q 224 to Q 232 and Q 315.

Accident and health coverage, group term life insurance coverage, and benefits under a dependent care assistance program remain "qualified" even if they must be included in income because a nondiscrimination requirement has been violated.[4] (See Q 3597). Health coverage and dependent care assistance under flexible spending arrangements are qualified benefits if they meet the requirements explained in Q 3514.

For taxable years beginning after December 31, 2012, a health flexible spending arrangement (FSA) under a cafeteria plan will not be treated as a qualified benefit unless the plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $ 2,500 made to such arrangement.[5] For plan years beginning after December 31, 2012, a cafeteria plan may not allow an employee to request salary reduction contributions for a health FSA in excess of $2,500. See Q 3501.

A cafeteria plan generally cannot provide for deferred compensation, permit participants to carry over unused benefits or contributions from one plan year to another, or permit participants to purchase a benefit that will be provided in a subsequent plan year. A cafeteria plan, however, may permit a participant in a profit sharing, stock bonus, or rural cooperative plan that has a qualified cash or deferred arrangement to elect to have the employer contribute on the employee's behalf to the plan (Q 3698).[6] After-tax employee contributions to a qualified plan subject to IRC Section 401(m) (Q 3732) are permissible under a cafeteria plan, even if matching contributions are made by the employer.[7]

A FSA may allow a grace period of no more than 2½ months following the end of the plan year for participants to incur and submit expenses for reimbursement (Q 3514).[8] FSAs may now be amended so that $500 of unused amounts remaining at the end of the plan year may be carried forward to the next plan year. However, plans that incorporate the carry forward provision may not also offer the 2½ month grace period.[9]

1. Prop. Treas. Reg. §1.125-1(h)(2).
2. Let. Ruls. 8801015, 8922048.
3. Prop. Treas. Reg. §1.125-1(k).
4. IRC Sec. 129(d); Prop. Treas. Reg. §1.125-1(b)(2).
5. IRC Sec. 125(i).
6. IRC Sec. 125(d)(2).
7. Prop. Treas. Reg. §1.125-1(o)(3)(ii).
8. Prop. Treas. Reg. §1.125-1(e); Notice 2005-42, 2005-1 CB 1204.
9. Notice 2013-71, 2013-47 IRB 532.

A cafeteria plan also may permit a participant to elect to have the employer contribute to a health savings account (HSA) on the participant's behalf (Q 369).[1] Unused balances in HSAs funded through a cafeteria plan may be carried over from one plan year to another.

Under the general rule, life, health, disability, or long-term care insurance with an investment feature, such as whole life insurance, or an arrangement that reimburses premium payments for other accident or health coverage extending beyond the end of the plan year cannot be purchased.[2] Supplemental health insurance policies that provide coverage for cancer and other specific diseases do not result in the deferral of compensation and are properly considered accident and health benefits under IRC Section 106.[3]

A cafeteria plan maintained by an educational organization described in IRC Section 170(b)(1)(A)(ii) (i.e., one with a regular curriculum and an on-site faculty and student body) can allow participants to elect postretirement term life insurance coverage. The postretirement life insurance coverage must be fully paid up on retirement and must not have a cash surrender value at any time. Postretirement life insurance coverage meeting these conditions will be treated as group term life insurance under IRC Section 79.[4]

To provide tax favored benefits to highly compensated employees and "key employees," a cafeteria plan must meet certain nondiscrimination requirements and avoid concentration of benefits in key employees (Q 3504).

The Affordable Care Act requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26.[5] To implement the expanded coverage, the ACA allows employers with cafeteria plans to permit employees to immediately make pre-tax salary reduction contributions to provide coverage for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals.

Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-based coverage. Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

Employees are eligible for the new tax benefit from March 30, 2010 forward, if the children are already covered under the employer's plan or are added to the employer's plan at any time. For this purpose, a child includes a son, daughter, stepchild, adopted child, or eligible foster child. This "up to age 26" standard replaces the lower age limits that applied under prior tax law, as well as the requirement that a child generally qualify as a dependent for tax purposes.

1. IRC Sec. 125(d)(2)(D).
2. Prop. Treas. Reg. §1.125-1(p)(1)(ii).
3. TAM 199936046.
4. IRC Sec. 125(d)(2)(C).
5. See IRC Sec. 105(b); IRS Notice 2010-38.

On June 28, 2012, the Supreme Court, in *National Federation of Independent Business v. Sebelius*, upheld the constitutionality of the *Patient Protection and Affordable Care Act*, with only minor changes to certain Medicaid provisions.[1]

3503. What are the income tax benefits of a cafeteria plan?

As a general rule, a participant in a cafeteria plan (as defined in Q 3501), is not treated as being in constructive receipt of taxable income solely because he has the opportunity – before a cash benefit becomes available – to elect among cash and "qualified" benefits (generally, nontaxable benefits, but as defined in Q 3502).[2]

In order to avoid taxation, a participant must elect the qualified benefits before the cash benefit becomes currently available. That is, the election must be made before the specified period for which the benefit will be provided begins—generally, the plan year.[3]

A cafeteria plan may, but is not required to, provide default elections for one or more qualified benefits for new employees or for current employees who fail to timely elect between permitted taxable and qualified benefits.[4]

Note that a benefit provided under a cafeteria plan through employer contributions to a health flexible spending arrangement (FSA) is not treated as a qualified benefit unless the plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to the FSA.[5] For any taxable year beginning after December 31, 2013, the $2,500 limit will be increased for changes in the cost-of-living.

Under IRS Notice 2012-40:

(1) the $2,500 limit does not apply for plan years that begin before 2013;

(2) the term "taxable year" in IRC Section 125(i) refers to the plan year of the cafeteria plan, as this is the period for which salary reduction elections are made;

(3) plans may adopt the required amendments to reflect the $2,500 limit at any time through the end of calendar year 2014;

(4) in the case of a plan providing a grace period (which may be up to two months and fifteen days), unused salary reduction contributions to the health FSA for plan years beginning in 2012 or later that are carried over into the grace period for that plan year will not count against the $2,500 limit for the subsequent plan year; and

(5) unless a plan's benefits are under examination by the IRS, relief is provided for certain salary reduction contributions exceeding the $2,500 limit that are due to a reasonable mistake and not willful neglect, and that are corrected by the employer.

1. 132 S. Ct. 2566 (2012)
2. IRC Sec. 125; Prop. Treas. Reg. §1.125-1.
3. Prop. Treas. Reg. §1.125-2.
4. Prop. Treas. Reg. §1.125-2(b).
5. IRC Sec. 125(i).

For the income tax effect of a discriminatory plan on highly compensated individuals, see Q 3504.

3504. What nondiscrimination requirements apply to cafeteria plans?

If a cafeteria plan discriminates in favor of highly compensated individuals as to eligibility to participate or discriminates in favor of highly compensated participants as to contributions or benefits, highly compensated participants will be considered in constructive receipt of the available cash benefit.[1] "Highly compensated" individuals are officers, shareholders owning more than 5 percent of the voting power or value of all classes of stock, those who are "highly compensated," and any of their spouses or dependents. For this purpose, "highly compensated" means any individual or participant who, for the preceding plan year (or the current plan year in the case of the first year of employment), had compensation from the employer in excess of the compensation amount specified in IRC Section 414(q)(1)(B) ($115,000 for 2012 through 2014, up from $110,000 for 2009 through 2011), and, if elected by the employer, also was in the top-paid group of employees (determined by reference to Section 414(q)(3)) for such preceding plan year (or for the current plan year in the case of the first year of employment).[2]

Participation will be nondiscriminatory if (1) it benefits a classification of employees found by the Secretary of Treasury not to discriminate in favor of employees who are officers, shareholders, or highly compensated, (2) no more than three years of employment are required for participation and the employment requirement for each employee is the same, and (3) eligible employees begin participation by the first day of the first plan year after the employment requirement is satisfied.[3]

According to proposed regulations, 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 and the group of employees included in the classification satisfies the safe harbor percentage test or the unsafe harbor percentage test. These are the same nondiscriminatory classification tests used for qualified plans (Q 3762).[4]

If a cafeteria plan offers health benefits, the plan is not discriminatory as to contributions and benefits if (1) contributions for each participant include an amount that either (x) equals 100 percent of the cost of the health benefit coverage under the plan of the majority of the highly compensated participants who are similarly situated (e.g., same family size); or (y) equals or exceeds 75 percent of the cost of the most expensive health benefit coverage elected by any similarly-situated participant; and (2) contributions or benefits in excess of (1) above bear a uniform relationship to compensation.[5]

A plan is considered to satisfy all discrimination tests if it is maintained under a collective bargaining agreement between employee representatives and one or more employers.[6]

1. IRC Sec. 125(b)(1); Prop. Treas. Reg. §1.125-7(m)(2).
2. IRC Sec. 125(e); Prop. Treas. Reg. §1.125-7(a)(3); IRS News Release IR-2011-103 (Oct. 20, 2011), IR-2012-77 (Oct. 18, 2012), IR-2013-86 (Oct. 31, 2013).
3. IRC Sec. 125(g)(3); Prop. Treas. Reg. §1.125-7.
4. Prop. Treas. Reg. §1.125-7(b)(1).
5. IRC Sec. 125(g)(2); Prop. Treas. Reg. §1.125-7(e).
6. IRC Sec. 125(g)(1).

In addition, a "key employee," as defined for purposes of the top-heavy rules (Q 3828), will be considered in constructive receipt of the available cash benefit option in any plan year in which nontaxable benefits provided under the plan to key employees exceed 25 percent of the aggregate of such benefits provided to all employees under the plan. For this purpose, excess group term life insurance coverage that is includable in income is not considered a nontaxable benefit.[1]

Employees of a controlled group of corporations, employers under common control, or members of an "affiliated service group" (Q 3832) are treated as employed by a single employer.[2]

Amounts that the employer contributes to a cafeteria plan pursuant to a salary reduction agreement will be treated as employer contributions to the extent that the agreement relates to compensation that has not been actually or constructively received by the employee as of the date of the agreement and subsequently does not become currently available to the employee.[3]

3505. What are the rules that apply to simple cafeteria plans for small businesses?

A "simple cafeteria plan" means a cafeteria plan that is established and maintained by an eligible employer and with respect to which contribution, eligibility, and participation requirements are met.[4]

For years beginning after December 31, 2010, the Patient Protection and Affordable Care Act of 2010 ("PPACA") provides a safe harbor "simple cafeteria plan" under which an "eligible employer" (generally an employer with fewer than 100 employees) is treated as meeting any applicable nondiscrimination requirements for the year.[5]

The employer is required to make contributions on behalf of each "qualified employee" in an amount equal to the following: (1) a uniform percentage (not less than 2 percent) of the employee's compensation; or (2) an amount not less than the lesser of (x) 6 percent of the employee's compensation for the plan year, or (y) twice the amount of salary deduction contributions of each qualified employee.[6] Contribution requirement option (2) is not met if the rate of contributions with respect to the salary contributions of any highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.[7]

All employees with at least 1,000 hours of service during the preceding plan year must be eligible to participate. Each employee who is eligible to participate must be able to select any benefit available under the plan.[8] An employee can be excluded if the employee:

1. IRC Sec. 125(b)(2).
2. IRC Sec. 125(g)(4).
3. Prop. Treas. Reg. §1.125-1(r).
4. IRC Sec. 125(j)(2), as added by PPACA 2010; IRS Publication 15-B.
5. IRC Sec. 125(j)(1), as added by PPACA 2010.
6. IRC Sec. 125(j)(3)(A), as added by PPACA 2010.
7. IRC Sec. 125(j)(3)(B), as added by PPACA 2010.
8. IRC Sec. 125(j)(4)(A), as added by PPACA 2010.

(1) is under age twenty-one;

(2) has less than one year of service;

(3) is covered by a collective bargaining agreement and the benefits of a cafeteria plan were the subject of good faith bargaining; or

(4) is a nonresident alien working outside of the United States.[1]

"Eligible employer" means, with respect to any year, any employer that employed an average of 100 or fewer employees on business days during either of the two preceding years.[2] An employer that initially qualifies for a simple cafeteria plan ceases to qualify in the year after the number of employees reaches 200.[3]

Planning Point: If the employer's business was not in existence throughout the preceding year, it is eligible to establish a simple cafeteria plan if the employer reasonably expects to employ an average of 100 or fewer employees in the current year. If the employer establishes a simple cafeteria plan in a year it employs an average of 100 or fewer employees, it is considered an eligible employer for any subsequent year as long as the employer does not employ an average of 200 or more employees in a subsequent year.

A qualified employee is any employee who is eligible to participate in the cafeteria plan and who is not a highly compensated or key employee.[4]

3506. When can benefit elections under a cafeteria plan be changed?

There are only certain instances when a cafeteria plan may permit an employee to revoke an election during a period of coverage and to make a new election relating to a qualified benefits plan.[5]

A cafeteria plan may permit an employee to revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights of IRC Section 9801(f). (This section deals generally with special enrollment periods for persons losing other group health plan coverage and dependent beneficiaries.)[6] An election change with respect to the Section 9801(f) enrollment rights can be funded through salary reduction under a cafeteria plan only on a prospective basis, except for the retroactive enrollment right under Section 9801(f) that applies in the case of elections made within thirty days of a birth, adoption, or placement for adoption.[7]

Certain changes are permitted with respect to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for an employee's child or for a

1. IRC Sec. 125(j)(4)(B), as added by PPACA 2010.
2. IRC Sec. 125(j)(5)(A), as added by PPACA 2010.
3. IRC Sec. 125(j)(5)(C), as added by PPACA 2010.
4. IRC Sec. 125(j)(3)(D), as added by PPACA 2010.
5. Treas. Reg. §1.125-4(a).
6. Treas. Reg. §1.125-4(b).
7. Treas. Reg. §1.125-4(b)(2).

foster child who is a dependent of the employee. A cafeteria plan may change the employee's election to provide coverage for the child if an order requires coverage for the child under the employer's plan. Also, the plan may permit the employee to make an election change to cancel coverage for the child if an order requires the spouse, former spouse, or other individual to provide coverage for the child and that coverage actually is provided.[1]

Additionally, if an employee, spouse, or dependent who is enrolled in the employer's accident or health plan becomes entitled to coverage (i.e., becomes enrolled) under Medicaid or Part A or Part B of Medicare, the plan may permit the employee to make a prospective election change to reduce or cancel coverage of that employee, spouse, or dependent under the accident or health plan. Note that this does not apply to coverage consisting solely of benefits under the Social Security Act Section 1928 program for distribution of pediatric vaccines.

If an employee, spouse, or dependent that has been entitled to Medicaid or Medicare Part A or Part B coverage loses eligibility for the coverage, the plan may allow the employee to make a prospective election to commence or increase coverage of that employee, spouse, or dependent under the accident or health plan.[2]

An employee taking a leave under the Family and Medical Leave Act ("FMLA") may revoke an existing election of accident or health plan coverage and make such election as provided for under the FMLA for the remaining portion of the period of coverage (Q 3509).[3]

Regarding contributions under a qualified cash or deferred arrangement, the regulations state that these provisions do not apply to elective contributions under such an arrangement, within the meaning of IRC Section 401(k), or employee contributions subject to IRC Section 401(m). Therefore, a cafeteria plan may allow an employee to modify or revoke elections as provided by these sections and applicable regulations.[4]

If a cafeteria plan offers salary reduction contributions to health savings accounts ("HSAs"), the plan must allow participants to prospectively change or revoke salary reduction elections for HSA contributions on a monthly, or more frequent, basis.[5]

Applicability Dates

In general, regulations addressing election changes are applicable for cafeteria plan years beginning on or after January 1, 2001. Regulations specifically addressing election changes as a result of cost or coverage changes are applicable for cafeteria plan years beginning on or after January 1, 2002. Likewise, the requirement that coverage must indeed be provided for a child by the spouse, former spouse, or other individual pursuant to a judgment, decree, or order before

1. Treas. Reg. §1.125-4(d).
2. Treas. Reg. §1.125-4(e).
3. Treas. Reg. §1.125-4(g).
4. Treas. Reg. §1.125-4(h).
5. Prop. Treas. Reg. §1.125-2(c).

a cafeteria plan may permit the employee to make an election change to cancel coverage for the child is subject to the later applicability date.[1]

3507. When can benefit elections under a cafeteria plan be changed due to a change in an employee's status?

A plan may permit an employee to revoke an election during a period of coverage with respect to a qualified benefits plan and make a new election for the remaining portion of the period if a change in status (as defined below) occurs and the election change meets the consistency rule (as explained below).[2] For this purpose, changes in status events include:

(1) events that change an employee's legal marital status, including marriage, death of a spouse, divorce, legal separation, and annulment;

(2) events that change an employee's number of dependents such as birth, death, adoption, and placement for adoption;

(3) events that change the employment status of an employee, an employee's spouse, or an employee's dependent, such as a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, or a change in work site, if the employee, spouse, or dependent becomes or ceases to be eligible under the plan;

(4) events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage due to reaching a certain age, student status, or any other similar provision;

(5) a change in the place of residence of the employee, spouse, or dependent; and

(6) for purposes of adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.[3]

Consistency Rule

The consistency rule states that an election change is not properly made with respect to accident or health coverage or group term life insurance unless it is on account of or corresponds with a change in status that affects eligibility for coverage under an employer's plan.

With respect to accident or health coverage, the consistency rule requires that any employee who wishes to decrease or cancel coverage because they become eligible for coverage under a spouse's or dependent's plan due to a marital or employment change in status can do so only if they actually obtain coverage under that other plan. Employers may generally rely on an employee's certification that the employee has or will obtain coverage under the

1. Treas. Reg. §1.125-4(j).
2. Treas. Reg. §1.125-4(c)(1); Prop. Treas. Reg. §1.125-2(a)(4).
3. Treas. Reg. §1.125-4(c)(2).

other plan (assuming that the employer has no reason to believe that the employee certification is incorrect).[1]

A change in status that affects eligibility under an employer's plan includes a change in status that results in an increase or decrease in the number of an employee's family members or dependents who may benefit from coverage under the plan.[2]

If a dependent dies or otherwise ceases to satisfy the eligibility requirements for coverage, the employee's election to cancel health insurance coverage for any other dependent, for the employee, or the employee's spouse does not correspond to the change in status.

The application of the consistency rule is illustrated as follows: If the change in status is the employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, an employee's election under the cafeteria plan to cancel accident or health insurance coverage for any individual other than the spouse involved in the divorce, annulment or legal separation, the deceased spouse or dependent, or the dependent that ceased to satisfy the eligibility requirements for coverage, respectively, fails to correspond with that change in status. Thus, if a dependent dies or ceases to satisfy the eligibility requirements for coverage, the employee's election to cancel accident or health coverage for any other dependent, for the employee, or for the employee's spouse fails to correspond with that change in status.[3]

There is an exception to the consistency rule for COBRA coverage. If the employee, spouse, or dependent becomes eligible for COBRA continuation coverage (Q 335) under the employer's group health plan, a cafeteria plan may allow the employee to elect to increase payments under the cafeteria plan to pay for the COBRA coverage.

With respect to group term life insurance and disability coverage, as well as coverage to which IRC Section 105(c) (coverage for permanent loss or loss of use of a member or function of the body) applies, an election under a cafeteria plan to increase or decrease coverage in response to any of the above listed changes in status is deemed to correspond to that change in status.[4]

An election change satisfies the consistency rule with respect to other qualified benefits if it is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. An election change also satisfies the consistency rule if it is on account of and corresponds with a change in status that affects dependent care expenses, as set forth in IRC Section 129 (Q 3597), or adoption assistance expenses, as described in IRC Section 137. Regulations provide examples of the application of the consistency rule.[5]

1. Treas. Reg. §1.125-4(c)(4).
2. Treas. Reg. §1.125-4(c)(3)(i).
3. Treas. Reg. §1.125-4(c)(3)(iii).
4. Treas. Reg. §1.125-4(c)(3).
5. Treas. Reg. §1.125-4(c)(3).

Applicability Dates

In general, regulations addressing election changes are applicable for cafeteria plan years beginning on or after January 1, 2001. Regulations specifically addressing election changes as a result of cost or coverage changes are applicable for cafeteria plan years beginning on or after January 1, 2002. Likewise, the requirement that coverage must indeed be provided for a child by the spouse, former spouse, or other individual pursuant to a judgment, decree, or order before a cafeteria plan may permit the employee to make an election change to cancel coverage for the child is subject to the later applicability date.[1]

3508. Can an employee change benefit elections under a cafeteria plan because of significant cost or coverage changes?

The rules regarding election changes due to a significant cost or coverage changes apply to all types of qualified benefits offered under a cafeteria plan, but not to health flexible spending arrangements ("FSAs").[2]

A plan may automatically make a prospective change in an employee's salary reduction amount if the cost of a qualified benefits plan increases or decreases during a period of coverage. If the cost of a benefit package option significantly increases during a period of coverage, the cafeteria plan may allow employees to either increase their salary reduction amounts or revoke their elections for this benefit and elect another benefit package option that offers similar coverage on a prospective basis. If the cost of a qualified benefits plan significantly decreases during the year, the cafeteria plan may allow all employees, even those who have previously not participated in the plan, to elect to participate in the plan for the option with such decrease in cost. A cost change applies in the case of dependent care assistance only if the cost change is imposed by a dependent care provider who is not a relative of the employee, as defined in IRC Section 152.[3]

If an employee has a significant curtailment of coverage under a plan during a period of coverage that is a "loss of coverage," the cafeteria plan may permit the employee to revoke his or her election under the plan and elect to receive, on a prospective basis, coverage under another option providing similar coverage. The employee may drop the coverage if no similar option is available. A "loss of coverage" means a complete loss of coverage under the benefit package option or other coverage option (e.g., the elimination of an option, an HMO ceasing to be available in the area, or losing all coverage under the option by reason of an overall lifetime or annual limitation).[4]

Other events constituting a loss of coverage include:

(1) a substantial decrease in medical care providers (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO),

1. Treas. Reg. §1.125-4(j).
2. Treas. Reg. §1.125-4(f)(1).
3. Treas. Reg. §1.125-4(f)(2).
4. Treas. Reg. §1.125-4(f)(3)(ii).

(2) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the employee or the employee's spouse or dependent is currently in a course of treatment, or

(3) any other similar fundamental loss of coverage.[1]

If an employee has a significant curtailment of coverage under a plan during a period of coverage that is not a "loss of coverage" (e.g., a significant increase in the deductible, the co-pay, or the out-of-pocket expense), the cafeteria plan may permit the employee to revoke his or her election under the plan and elect to receive, on a prospective basis, coverage under another option providing similar coverage.[2]

If a plan adds a new benefit package option or improves an existing benefit package option or other coverage option during a period of coverage, the cafeteria plan may allow eligible employees (whether or not they have previously made an election under the cafeteria plan) to revoke their election and to make an election on a prospective basis for coverage under the new or improved option.[3]

A cafeteria plan may allow an employee to make a prospective election change that corresponds to a change made under another employer plan (including a plan of the same employer or of another employer) or to add coverage under a cafeteria plan for the employee, spouse, or dependent if the employee, spouse, or dependent loses coverage under any group health plan sponsored by a governmental or educational institution.[4]

Applicability Dates

In general, regulations addressing election changes are applicable for cafeteria plan years beginning on or after January 1, 2001. Regulations specifically addressing election changes as a result of cost or coverage changes are applicable for cafeteria plan years beginning on or after January 1, 2002. Likewise, the requirement that coverage must indeed be provided for a child by the spouse, former spouse, or other individual pursuant to a judgment, decree, or order before a cafeteria plan may permit the employee to make an election change to cancel coverage for the child is subject to the later applicability date.[5]

3509. How are health-related benefits offered under a cafeteria plan affected by the Family and Medical Leave Act?

The interaction between IRC Section 125 and the Family and Medical Leave Act ("FMLA") of 1993 was first addressed in proposed regulations published in 1995. Final regulations were published in October 2001, and are applicable for plan years beginning on or after January 1, 2002.

1. Treas. Reg. §1.125-4(f)(3)(ii).
2. Treas. Reg. §1.125-4(f)(3)(i).
3. Treas. Reg. §1.125-4(f)(3)(iii).
4. See Treas. Regs. §§1.125-4(f)(4), 1.125-4(f)(5).
5. Treas. Reg. §1.125-4(j).

Under the 1995 proposed regulations, employers had to permit employees on FMLA leave to revoke an existing election of group health plan coverage (including a flexible spending arrangement, see Q 3514) under a cafeteria plan for the remainder of the coverage period.[1] Under the 2001 final regulations, employers may require employees to continue coverage if the employer pays the employee's portion of the coverage cost.[2]

Employees on FMLA leave are generally entitled to revoke or change elections in the same manner as the employees not on FMLA leave. Upon returning from the FMLA leave, the employee is entitled to be reinstated in the plan if the employee's coverage terminated during the leave, either by revocation or nonpayment of premiums.[3]

Health FSAs

A health flexible spending arrangement (health FSA, see Q 3514) is subject to the same general rules as a traditional cafeteria plan, as discussed above.

The employee must be permitted to reinstate his coverage under the plan following the FMLA leave, as if he had not taken the leave. The employer may require that employees be reinstated following an FMLA leave if it also requires reinstatement for employees returning from non-FMLA leave.[4]

For so long as the employee's coverage under the health FSA is continued (whether voluntarily or involuntarily), the entire amount of his health FSA, less any previous reimbursements, must be available for reimbursement of his health expenses. If the employee's coverage is terminated at any time during FMLA leave, he may not be reimbursed for expenses incurred while coverage was terminated.[5]

3510. How are non-health-related benefits offered under a cafeteria plan affected by the Family and Medical Leave Act?

Under both the proposed and final regulations, employers are not required to continue an employees' non-health benefits provided under a cafeteria plan (e.g., life insurance) during an FMLA leave. Rather, whether an employee is entitled to the continuation of non-health benefits must be decided under the employer's policy applicable to employees on non-FMLA leave.[6]

3511. What are the payment options that must be made available to employees on FMLA leave?

In general, whatever payment options are available to employees on non-FMLA leave must also be made available to employees on FMLA leave.[7] *Employers* must continue to contribute the same share of the premium cost that they were paying prior to the FMLA leave. *Employees* who

1. Prop. Treas. Reg. §1.125-3, A-1.
2. Treas. Reg. §1.125-3, A-1.
3. Treas. Reg. §1.125-3, A-1.
4. Treas. Reg. §1.125-3, A-6(a)(2).
5. Treas. Reg. §1.125-3, A-6(b).
6. Treas. Reg. §1.125-3, A-7.
7. Treas. Reg. §1.125-3, A-3(b).

choose to continue health coverage during an FMLA leave must pay the same portion of the cost of such coverage that they paid while actively at work.[1] Employers may choose to waive this requirement, provided that they do so, on a nondiscriminatory basis.

A cafeteria plan may generally offer employees on *unpaid* FMLA leave up to three options for paying for their health coverage under a cafeteria plan or health FSA.[2] These rules do not apply where paid leave is substituted for unpaid FMLA leave, in which case the employer must offer the payment method normally available during other types of paid leave.[3]

Any of the three payment options discussed below may generally be made on a pre-tax salary reduction basis to the extent that the employee on FMLA leave has any taxable compensation (including the cash value of unused sick days or vacation days). A restriction applies when an employee's FMLA leave spans two plan years. In such a case, the plan may not operate in a manner that would allow employees on FMLA leave to defer compensation from one plan year to a subsequent plan year.[4] Any of the three payment options may also be made on an after-tax basis.

A cafeteria plan may offer one or more of the following payment options, or a combination of these options, to an employee who continues group health plan coverage (including a health FSA) while on unpaid FMLA leave; provided that the payment options for employees on FMLA leave are offered on terms at least as favorable as those offered to employees not on FMLA leave.

"Pre-pay" Option. Under this option, the employer allows the employee to pay the amounts due for the FMLA leave period prior to the commencement of FMLA leave.[5] Under no circumstances may the pre-pay option be the only option offered to employees on FMLA leave. The employer may offer the pre-pay option to employees on FMLA leave even if such option is not offered to employees on other types of unpaid leave.[6]

"Pay-as-you-go" Option. Under this option, employees pay their portion of the health care costs according to a payment schedule. This schedule may be (1) the same as the schedule that would be in effect if they were not on FMLA leave; (2) the same schedule upon which COBRA payments would be made (see Q 347); (3) the same schedule as applies to other employees on other, unpaid non-FMLA leave; or (4) any other schedule that (a) the employee and the employer voluntarily agree upon and (b) is not inconsistent with the regulations. The employer may not offer employees on FMLA leave only the pre-pay option and the catch-up option if the pay-as-you-go option is offered to employees on unpaid non-FMLA leave.[7]

"Catch-up" Option. Under this option, an employer continues providing coverage during FMLA leave. The catch-up option may be the sole option offered by the employer only if it is the sole option offered to employees on unpaid non-FMLA leave.[8]

1. Treas. Reg. §1.125-3, A-2.
2. Treas. Reg. §1.125-3, A-3(a).
3. Treas. Reg. §1.125-3, A-4.
4. Treas. Reg. §1.125-3, A-5.
5. Treas. Reg. §1.125-3(a)(1)(i).
6. Treas. Reg. §1.125-3, A-3(b)(1).
7. Treas. Reg. §1.125-3, A-3.
8. Treas. Reg. §1.125-3, A-3.

In general, the employer and the employee must agree in advance that (1) coverage will continue during the FMLA leave, (2) the employer assumes responsibility for the payment of employee's portion of the health care costs during the FMLA leave, and (3) the employee will repay such amounts when he returns from FMLA leave.

Employer's Right of Recoupment. An employer is not required to continue the coverage of an employee on FMLA leave who fails to make the required premium payments when due. But if the employer *does* continue coverage, the employer is entitled to recoup the missed payments under the "catch-up" option, without the employee's prior agreement.[1]

Health FSAs. Health FSAs are generally subject to the same payment rules as traditional cafeteria plans.[2] The regulations do not make clear whether the employer's right of recoupment, discussed above, applies to health FSAs. If so, it would appear to represent a significant departure from the general risk-shifting rule applicable to health FSAs. See Q 3514.

3512. Are amounts received under a cafeteria plan subject to Social Security and federal unemployment taxes?

Amounts received by participants, or their beneficiaries, under a cafeteria plan are not treated as wages. Thus, these amounts are not subject to tax under the Federal Insurance Contributions Act (FICA) or under the Federal Unemployment Tax Act (FUTA) if such payments would not be treated as wages without regard to the plan, and if it is reasonable to believe that IRC Section 125 would not treat any wages as constructively received.[3]

3513. Must an employer sponsoring a cafeteria plan file an information return for the plan with the IRS?

Under IRC Section 6039D, an employer sponsoring a cafeteria plan was required to file an information return with the IRS. This return indicated the number of the employer's employees, the number of employees eligible to participate in the plan, the number of employees actually participating in the plan, the cost of the plan, the identity of the employer and the type of business in which it is engaged, and the number of its highly compensated employees in the above categories.

Under prior law, all employers that maintained cafeteria plans were required to file an information return (Form 5500 series with Schedule F) for each year.[4]

However, the IRS has currently suspended the operation of these reporting requirements with respect to cafeteria plans.[5] This suspension is in effect for plan years beginning prior to the issuance of further guidance from the IRS.

1. Treas. Reg. §1.125-3, A-3(a).
2. Treas. Reg. §1.125-3, A-6(a)(1).
3. IRC Secs. 3121(a)(5), 3306(b)(5).
4. IRS Office of Chief Counsel Training Manual No. 4213-018 (Rev. 5/98).
5. Notice 2002-24, 2002-1 CB 785.

The IRS action does not affect annual reporting requirements under Title I of ERISA, or relieve administrators of employee benefit plans from any obligation to file a Form 5500 and any required schedules (other than the Schedule F) under that title. However, many practitioners believe that, under ERISA, cafeteria plans containing Health FSAs with more than 100 participants are required to file Forms 5500 because the FSA is a welfare benefit. And because the IRS Section 6039D suspension does not affect ERISA filing requirements, such cafeteria plans are therefore required to file.

3514. What is a flexible spending arrangement?

A flexible spending arrangement (FSA) is a program under IRC Section 125 under which incurred expenses may be reimbursed. This benefit may be provided as a stand-alone plan or as part of a traditional cafeteria plan. The most common types are health FSAs and dependent care assistance FSAs.

In order for the coverage provided through an FSA to qualify for the exclusion from income under IRC Section 105 and IRC Section 106 health FSAs (see Q 315, Q 317) or IRC Section 129 dependent care FSAs (see Q 3597), the FSA must meet the requirements set forth below.

Health FSAs

Editor's Note: *The Patient Protection and Affordable Care Act of 2010* ("PPACA") imposes a new annual limitation on contributions to a health FSA. For taxable years beginning after December 31, 2012, FSA contributions will not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to the arrangement. The limit will be indexed for inflation.[1]

On June 28, 2012, the Supreme Court, in *National Federation of Independent Business v. Sebelius*, upheld the constitutionality of the *Patient Protection and Affordable Care Act*, with only minor change to certain Medicaid provisions.[2]

Although health coverage under an FSA need not be provided under commercial insurance, it must demonstrate the risk shifting and risk distribution characteristics of insurance. Reimbursements under a health FSA must be paid specifically to reimburse medical expenses that have been incurred previously. A health FSA cannot operate so as to provide coverage only for periods during which the participants expect to incur medical expenses, if such period is shorter than a plan year. In addition, the maximum amount of reimbursement must be available at all times throughout the period of coverage (properly reduced for prior reimbursements for the same period of coverage), without regard to the extent to which the participant has paid the required premiums for the coverage period, and without a premium payment schedule based on the rate or amount of covered claims incurred in the coverage period.[3] Before 2013, there was no statutory limit on contributions to a health FSA, but most employers imposed a limit to protect themselves against large claims that had not yet been funded by salary reductions.

1. IRC Sec. 125(i), as added by PPACA 2010.
2. National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012).
3. Prop. Treas. Reg. §1.125-5(d).

The period of coverage must be 12 months, or in the case of a short first plan year, the entire first year (or the short plan year where the plan year is changed). Election changes may not be permitted to increase or decrease coverage during a coverage year, but prospective changes may be allowed consistent with certain changes in family status. See Q 3506. The plan may permit the period of coverage to be terminated if the employee fails to pay premiums, provided that the terms of the plan prohibit the employee from making a new election during the remaining period of coverage. The plan may permit revocation of existing elections by an employee who terminated service.[1]

A plan may provide a grace period of no more than 2½ months following the end of the plan year for participants to incur and submit expenses for reimbursement. The grace period must apply to all participants in the plan. Plans may adopt a grace period for the current plan year by amending the plan document before the end of the current plan year.[2] Further, beginning in 2014, health FSAs may be amended so that $500 of each participant's unused amounts remaining at the end of the plan year may be carried forward to the next plan year. However, plans that incorporate the carryover provision may not also offer the 2½ month grace period.[3]

The plan may reimburse medical expenses of the kind described under IRC Section 213(d), but may not reimburse for premiums paid for other health plan coverage.[4] *Editor's Note*: Under prior law, the plan could reimburse for non-prescription over-the-counter drugs.[5] However, for taxable years beginning after December 31, 2010, reimbursements for medicine will be limited to doctor-prescribed drugs and insulin. Consequently, after 2010 over-the counter medicines will no longer be qualified expenses unless prescribed by a doctor.[6]

The medical expenses must be for medical care provided during the period of coverage with substantiation that the expense claimed has been incurred and is not reimbursable under other health coverage.[7] The IRS has approved the use of employer-issued debit and credit cards to pay for medical expenses as incurred, provided that the employer requires subsequent substantiation of the expenses or has in place sufficient procedures to substantiate the payments at the time of purchase.[8] On a one-time basis, a plan may allow a qualified HSA distribution. See Q 381.

Employer-provided coverage for qualified long-term care services provided through an FSA is included in the employee's gross income.[9]

1. Prop. Treas. Reg. §1.125-5(e).
2. Prop. Treas. Reg. §1.125-1(e); Notice 2005-42, 2005-1 CB 1204.
3. Notice 2013-71, 2013-47 IRB 532.
4. Prop. Treas. Reg. §1.125-5(k).
5. Rev. Rul. 2003-102, 2003-2 CB 559.
6. IRC Sec. 106(f), as added by PPACA 2010.
7. Prop. Treas. Reg. §1.125-6(b); Rev. Proc. 2003-43, 2003-1 CB 935. See *Grande v. Allison Engine Co.*, 2000 U.S Dist. LEXIS 12220 (S.D. Ind. 2000).
8. Notice 2006-69, 2006-2 CB 107. See also Notice 2007-2, 2007-1 CB 254.
9. IRC Sec. 106(c)(1).

Dependent Care Assistance FSAs

Substantially, the same rules apply to dependent care FSAs as health FSAs, except that the maximum amount of reimbursement need not be available throughout the period of coverage. A plan may limit a participant's reimbursement to amounts actually contributed to the plan and still available in the participant's account.[1] Contributions to a dependent care FSA may not exceed $5,000 (or $2,500 for a married individual filing a separate return) during a taxable year.[2]

Like a health FSA, a dependent care FSA may permit a grace period of no more than 2½ months following the end of the plan year for participants to incur and submit expenses for reimbursement.[3] The $500 carryover rule applicable for health FSAs after 2013, however, is not available for participants in a dependent care FSA.

The IRS has also approved the use of employer-issued debit and credit cards to reimburse for recurring dependent care expenses. Because expenses may not be reimbursed until the dependent care services are provided, reimbursements through debit cards must flow in arrears of expenses incurred.[4]

Plan Experience and Coverage

Any gain or income from an FSA may be (1) used to reduce premiums for the following year; or (2) returned to the premium payors as dividends or premium refunds on a reasonable basis, but in no case based on their individual claims experience.[5]

The maximum amount of reimbursement for a period of coverage under an FSA may not be substantially in excess of the total "premium" for the coverage. The maximum amount of reimbursement is not considered to be substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium. This definition is applicable to plan years beginning after December 31, 1989.[6]

Informal IRS Guidance on FSAs. In August of 2001, the IRS provided informal, *non-binding* guidance regarding FSAs. In a departure from previous informal guidance, the IRS informally indicated that orthodontia expenses should be treated differently from other medical expenses. Under this reasoning, if orthodontia expenses are paid in a lump sum when treatment commences, rather than over the course of treatment, they could be reimbursed under an FSA when paid. Finally, the IRS informally clarified that there is no *de minimis* claim amount that need not be substantiated; employers and plan administrators may not disregard the substantiation requirements for small claims.

1. Prop. Treas. Reg. §1.125-5.
2. IRC Sec. 129(a)(2)(A).
3. Notice 2005-42, 2005-1 CB 1204.
4. Notice 2006-69, 2006-2 CB 107.
5. Prop. Treas. Reg. §1.125-5(o).
6. Prop. Treas. Reg. §1.125-5(a).