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New Commandments to Live By: After More Than 20 Years, IRS Issues New Proposed Cafeteria Plan Regulations

On Monday, August 6, 2007, after an almost 20-year gestation period, the IRS issued long awaited proposed cafeteria plan regulations under Internal Revenue Code ("Code") Section 125 (the "New Proposed Regs"). The New Proposed Regs withdraw the previously issued proposed cafeteria plan regulations, 1.125-1 and -2 (the "Old Proposed Regs"), replace them with a fresh set of proposed regulations that restate much of the Old Proposed Regs and incorporate both formal and informal guidance issued over the last 23 years. The New Proposed Regs also provide detailed guidance on a host of nagging cafeteria plan administration issues and even include a few surprises relating to enrollment and discrimination testing. The New Proposed Regs are generally effective for plan years beginning on or after January 1, 2009; however, taxpayers may rely on them now.

NOTE: If you are holding your breath awaiting repeal of the "use-it or lose-it" and/or "uniform coverage" rules for flexible spending arrangements (FSA) it's time to exhale. The New Proposed Regs are, in large part, a conglomeration of the Old Proposed Regs and guidance issued since the Old Proposed Regs were issued. So if much of it sounds familiar, it should. Where differences exist, the previously issued guidance remains in effect through the effective date of the final regulations despite the New Proposed Regs.

Executive Summary

The New Proposed Regs contain five different sections: -1 general rules; -2 elections; -5 flexible spending arrangements; -6 substantiation; and -7 nondiscrimination rules. As noted above, each section generally restates the fundamental cafeteria plan and flexible spending arrangement operational rules (e.g., written plan document, general election, Health FSA requirements and nondiscrimination rules) set forth in the Old Proposed Regs, with much needed clarifications; and they also incorporate rules and requirements from guidance (both formal and informal) issued over the last 23 years — the time period elapsed since the Old Proposed Regs were first issued.

NOTE: Existing final regulations address the impact of leaves of absence under the Family and Medical Leave Act on cafeteria plan elections (1.125-3) and permissible election changes (1.125-4). Consequently, the New Proposed Regs do not address topics covered in the -3 and -4 final regulations.

The New Proposed Regs also contain several new rules, including the following:

- A new method of imputing income on excess group term life insurance (over $50,000) offered through a cafeteria plan;
- A limited retroactive election period for new employees;
- An exception from the deferred compensation prohibition for premiums paid in the last month of the plan year for the first month of the following year; and
- A new nondiscrimination testing safe harbor for premium only plans (as defined by the New Proposed Regs) and new definitions of highly compensated individual and key employee.

Overall, the New Proposed Regs are generally more participant and plan sponsor friendly. There are areas of administration that are not addressed by the New Proposed Regs, such as mistaken elections, and there are other areas addressed by the New Proposed Regs, such as nondiscrimination testing, that will require additional clarification. In addition, the IRS has requested specific comments on tipped income and pre-tax elections, Health FSA coverage following an election change and multiple employer cafeteria plans. Written or electronic comments must be submitted to the IRS by November 5, 2007. A hearing is also scheduled for November 15, 2007; an outline of topics for the hearing must be received by October 25, 2007.

Detailed Overview

What follows is an overview of the clarifications and changes set forth in the New Proposed Regs. The overview is organized to correspond with each new section of the New Proposed Regs. To assist in both initial and subsequent reviews, the sections of the New Proposed Regs and this article cover the topics in the table below.

Section	Topic
1.125-1	General operating rules such as written plan document requirements, definition of qualified benefits and permitted taxable benefits, definition of non-qualified benefits and consequences of failing to satisfy the cafeteria plan operating requirements.
1.125-2	General election rules such as timing of initial and annual elections and form (e.g., electronic). [Remember, the -2 proposed regulations do not address permissible election changes. Permissible election changes are addressed in the final 1.125-4 cafeteria plan regulations]
1.125-5	General flexible spending arrangement operating rules such as the use-it or lose-it rule, uniform coverage rule, HSA compatible FSAs and Qualified HSA Distributions.
1.125-6	Substantiation rules (including benefit card administration requirements) for qualified benefits — in particular FSAs.
1.125-7	Nondiscrimination rules for cafeteria plans such as the eligibility test, the contributions and benefits test and the key employee concentration test.

A. 1.125-1 – General Operating Rules

1.125-1 of the New Proposed Regs sets forth general operating rules for establishing and maintaining a cafeteria plan, such as written plan document requirements, rules for amending plans, the types of taxable and non-taxable benefits that may be offered through a cafeteria plan and the consequences of failing to properly adopt a cafeteria plan. Although much of the operating rules remain unchanged, the New Proposed Regs clarify the scope of "permitted taxable benefits and qualified benefits (including but not limited to individual health insurance and COBRA premium), expand the written cafeteria plan document requirements and define crucial terms such as "plan year," "dependent" and "employee."

1. Permitted Taxable Benefits

The New Proposed Regs reiterate the fundamental concept set forth in the Old Proposed Regs that cafeteria plans must provide a choice of at least one qualified benefit and at least one "permitted taxable benefit," which is defined as "cash" and certain other taxable benefits treated as cash. The New Proposed Regs clarify that "cash" includes not only cash compensation (i.e., your regular salary) but also any of the following:

- Annual leave
- Sick leave
- Paid time off
- Severance pay

Consistent with prior guidance, the New Proposed Regs further clarify that "cash" does not include any distribution from a Code Section 401(a) trust (i.e., any qualified retirement or defined contribution plan payment). Thus, a pre-tax "pension reduction" arrangement is generally not allowable.

The New Proposed Regs define "other taxable benefits" to include property and "qualified" benefits purchased with after-tax dollars.

The New Proposed Regs also clarify that non-qualified benefits such as educational assistance, dependent life and transportation expense reimbursement may not be offered through a cafeteria plan, even if paid for with after-tax contributions.

2. Qualified Benefits

A cafeteria plan may only provide a choice between permitted taxable benefits and one or more "qualified benefits." For the most part, the list of qualified benefits remains unchanged – i.e., accident or health coverage (including Health FSAs and medical, dental and disability coverage), accidental death and dismemberment coverage, dependent care assistance programs and adoption assistance. Nonetheless, the New Proposed Regs provide the following clarifications with respect to qualified benefits:

- Group term life insurance that offers a "permanent" benefit (as defined in Treas. Reg. 1.79-0) is *not* a qualified benefit; and
- Premiums for an employee's COBRA coverage under the health plan of the employer sponsoring the cafeteria plan or the health plan of another employer can be a qualified benefit.

The New Proposed Regs imply that a spouse's COBRA coverage can not be paid for through the employee's employer's cafeteria plan by specifically restricting COBRA coverage to that of the employee.

The New Proposed Regs also indicate that health savings accounts (HSAs) (but not Archer medical savings accounts (MSAs)) are "qualified benefits" (despite the deferred compensation prohibition) – reflecting the changes made to Code Section 125 by the Medicare Prescription Drug Improvement and Modernization Act of 2003.

3. Definition of Dependent

The New Proposed Regs clarify that "dependent" is generally defined for purposes of Code Section 125 as set forth in Code Section 152; however, the definition is modified to conform to any different definition in the underlying Code sections relative to the qualified benefits offered under the cafeteria plan such as Code Section 105 (for health care). This helps clarify, for example, that pre-tax treatment for the expanded health care class of eligible dependents is permissible.

Note, the -4 final change in status regulations continue to refer to Code Section 152 without modifications that conform to the definition in the underlying Code sections for qualified benefits.

4. Elections Between Benefits

The New Proposed Regs state that Section 125 is the exclusive means by which an employer can offer employees a choice between taxable and nontaxable benefits without the election itself resulting in taxation to employees (i.e., it is the exclusive constructive receipt safe harbor). Also, the New Proposed Regs reiterate the concept set forth in Rev. Rul. 2002-27 that a plan providing a choice between only qualified benefits or only taxable benefits is not a cafeteria plan.

We note that despite the claims set forth in the New Proposed Regs that a cafeteria plan is the exclusive means by which constructive receipt may be avoided, pre-tax compensation reductions are permitted under a qualified transportation plan (adopted in accordance with Section 132) as well.

5. Written Plan Document Requirements

The new Proposed Regs generally restate the content requirements previously set forth in the Old Proposed Regs – i.e., the plan must include: (i) a specific description of all benefits provided under the plan and their coverage periods; (ii) the rules governing participation; (iii) the procedures governing elections under the plan; (iv) the manner in which employer contributions are made under the plan; (v) the maximum amount of employer contributions; and (vi) the plan year. Not unlike the rule set forth in the Old Proposed Regs, the New Proposed Regs indicate that the cafeteria plan need not be self contained in describing benefits, but rather can incorporate by reference benefits offered under separate plans.

The New Proposed Regs make a number of clarifications regarding the written plan document. First, the New Proposed Regs clarify that the written plan document must contain provisions relating to certain optional provisions, such as the ordering rule for paid time off (PTO), the grace period, Qualified HSA Distributions and FSA rules, if adopted by or offered through the plan.

The New Proposed Regs also clarify that the written plan document must be adopted and effective before the first day of the cafeteria plan year to which it relates. Also, amendments to cafeteria plans may be made at any time, including during the plan year, so long as the amendments meet the following two requirements:

- The amendments are in writing; and
- They are effective for periods after the later of the effective date or the adoption date (i.e., no retroactive amendments).

Most importantly, the New Proposed Regs clarify that the plan is disqualified if the plan sponsor fails to comply with the written terms of the plan.

The New Proposed Regs clarify that actions that might otherwise be permissible under the cafeteria plan rules but are not consistent with the written terms of the plan will disqualify the plan. Thus, allowing a participant to make a Health FSA election of $5,000 when the maximum set forth in the plan is $3,000 could disqualify the plan.

6. Definition of Plan Year

The New Proposed Regs specifically define the "plan year" as a 12-month period (the Old Proposed Regs did not specifically define the plan year). The New Proposed Regs also clarify that the plan year is generally the "coverage period" during which benefits are offered and different coverage periods within a single cafeteria plan are permissible (although we are not sure how this affects discrimination testing). In addition, a plan year cannot be a short plan year and/or it cannot be changed unless there is a "valid business purpose." It is not a "valid business purpose" if the reason for the change is to circumvent the cafeteria plan rules (e.g., the election change rules). The New Proposed Regs provide the following examples of a valid business purpose:

- Mid-year establishment of a plan with a calendar plan year (i.e., initial plan year); and
- Changing plan years corresponding to a change in insurance policies that results in a different policy year.

7. Grace Period

The New Proposed Regs generally restate the rules regarding grace periods set forth in Notice 2005-42. The New Proposed Regs further clarify that the plan sponsor has the following options with respect to the grace period (some of which were set forth in Notice 2005-86):

- The grace period rules apply to all qualified benefits other than paid time off (PTO) and 401(k) plans; however, the plan sponsor may choose which qualified benefits to which the plan's grace period applies. For example, the plan sponsor may adopt a grace period for Health FSA but not Dependent Care FSA.
- Plan sponsors may limit the amount of unused contributions that can be used during a grace period. However, the limit cannot be based on a percentage of the amount of unused benefits or contributions remaining at the end of the prior plan year.

- The grace period can not be longer than two months and 15 days after the end of the plan year, but may be shorter.
- The plan sponsor may wait until the end of the grace period to allocate grace period expenses to the prior year contributions or current year contributions (i.e., re-characterization of expenses after close of a plan year to accommodate claims submitted during a run-out period may be permitted to maximize benefits).

8. Run-Out Period

The New Proposed Regs specifically permit a run-out period and clarify that it must be uniform for all participants; however, the New Proposed Regs do not establish a specified time period. Thus, employer/plan sponsors continue to have discretion concerning the length of the run-out period.

9. Definition of Employee

The New Proposed Regs restate the age old rule that the cafeteria plan is only available to common law employees (and former employees) but provide the following clarifications:

- Leased employees described in Code Section 414(n) are employees for cafeteria plan purposes.
- Full-time life insurance salesman described in Code Section 7701(a)(20) are employees for cafeteria plan purposes.
- Individuals who are both employees and also provide services as an independent contractor or director ("dual status individual") may participate with respect to compensation received solely as an employee.

This "dual-status individual" rule does not apply to partners and more than two percent shareholders. The New Proposed Regs further clarify that an individual who is a partner or more than two percent shareholder of an S Corporation (or deemed to be a partner or more than two percent shareholder through the attribution rules) who later becomes an employee during the year is considered a self-employed individual for the entire year.

- More than two percent shareholders of an S Corporation are considered self employed (and thus, can't participate in the cafeteria plan). Moreover, an employee spouse/dependent of the more than two percent shareholder is considered self employed in accordance with the Code Section 318 attribution rules.

The regulations further clarify that dependents of an employee may not be given the opportunity to elect or purchase benefits offered by the plan; however, they may benefit from coverage elected by the employee.

10. Coverage for Non-Dependents

The New Proposed Regs clarify that an employee with accident and health coverage offered under a cafeteria plan may purchase accident health coverage under that plan for a non-dependent (e.g., a domestic partner) to the extent that the fair market value of the coverage is included in the employee's income.

Note: A common approach among plan sponsors who permit coverage for non-dependents is to allow the employee to pay for such coverage on a pre-tax basis but impute the value of the income in the employee's gross income. It has not been clear in the past if this approach was permissible or whether the coverage for the non-dependent had to be paid first with after tax contributions. The New Proposed Regs appear to permit payment with pre-tax salary reductions with subsequent imputation of the fair market value of coverage in the employee's income.

11. Taxation of Group Term Life Insurance in Excess of $50,000

One of the few new provisions (i.e., a provision not brought forward from the Old Proposed Regs or formal/informal guidance) in the New Proposed Regs changes the manner in which group term life insurance in excess of $50,000 is taxed. The prior rule, established by Notice 89-110, required employees to include in income the greater of the pre-tax salary reduction for such coverage or the applicable Table I rate. The new rule under the New Proposed Regs indicates that the salary reduction is tax free in all circumstances. Instead, the amount included in income is the Table I rate for pre-tax coverage in excess of $50,000, even if the salary reduction is greater.

12. Individual Health Insurance Premiums

Consistent with Rev. Rul. 61-146, the New Proposed Regs allow tax free reimbursement of an employee's "substantiated" individual health insurance premiums to the extent that the individual health insurance policy is a qualified benefit. The New Proposed Regs further clarify the payment methods:

- Direct reimbursement to employee of employee's "substantiated" health insurance premium;

Rev. Rul. 61-146 allowed direct reimbursement to the employee for individual insurance policy premiums only upon receipt of proof of payment of the premium. The New Proposed Regs require the premiums to be substantiated in accordance with the rules set forth in -6 of the New Proposed Regs (the "expense incurred" rule discussed in more detail below). It isn't clear whether the New Proposed Regs permit reimbursement only upon receipt of proof that the premium is due or whether proof of payment is still required. We think proof of payment is required. Additional clarification from IRS would be helpful.

- Check issued to employee in name of carrier; and
- Check issued to employee in name of both carrier and employee.

Note: The New Proposed Regs seem to only allow reimbursement of premiums for policies maintained (i.e., owned) by the employee and not individual coverage of an employee's spouse or dependents.

13. Prohibition Against Deferred Compensation

The New Proposed Regs restate the rules set forth in the Old Proposed Regs regarding deferred compensation. More specifically, with certain exceptions (e.g., for grace period benefits and as described below), neither contributions nor benefits can carry over from one plan year to the next regardless of how the contributions or benefits are paid in a future year. The New Proposed Regs further clarify that the following accident and health insurance benefits and features do not result in deferred compensation for purposes of the cafeteria plan rules:

- Credit towards the deductible in one year for expenses incurred in a subsequent year (i.e., "carry over deductible");
- Reasonable lifetime maximum limit on benefits;
- Level premiums;
- Premium waiver during disability;
- Guaranteed policy renewability of coverage, without further evidence of insurability (but not guaranty of the amount of premium upon renewal);
- Coverage for a specified accidental injury;
- Coverage for a specified disease or illness, including payments at initial diagnosis of the specified disease or illness and progressive payments of a set amount per month following the initial diagnosis (sometimes referred to as progressive diagnosis payments); and
- Payment of a fixed amount per day (or other period) of hospitalization.

The above mentioned benefits are permitted only to the extent the following conditions are satisfied:

- No part of any benefit is used in one plan year to purchase a benefit in a subsequent plan year.
- Except for premium waivers for disability coverage, the policies remain in force only so long as premiums are timely paid on a current basis and, irrespective of the amount of premiums paid in prior plan years, if the current premiums are not paid, all coverage for new diseases or illnesses lapses.
- There is no investment fund or cash value to rely upon for payment of premiums.
- No part of any premium is held in a separate account for any participant or beneficiary, or otherwise segregated from the assets of the insurance company.

The New Proposed Regs also clarify that long term disability benefits paid across several years is permissible.

The New Proposed Regs allow Health FSAs to pay for orthodontia services that will be provided over multiple years and durable medical equipment that has a useful life beyond the current plan year. See the discussion on -5 below for more detail.

14. Limited Exception for Premiums Taken from Pay in Last Month of Plan Year

The New Proposed Regs formally approve a common practice – using contributions from the last month of the plan to pay for coverage provided in the first month of the next plan year. The formal approval of this practice is specifically limited, however, to an advance payment of one month for accident and health coverage and must be applied uniformly to all participants.

It is interesting to note that the New Proposed Regs specifically indicate that the grace period rules, which allow prior year contributions to be used for benefits provided up to two and one-half months following the end of the plan year, apply to all qualified benefits. Thus, adoption of the grace period rule would seem to eliminate the need for this specific carveout from the deferred compensation rule. Additional clarification from the IRS is needed.

15. Mandatory Two-Year Election Lock for Dental and Vision

The New Proposed Regs clarify that a two-year "election lock" for dental and/or vision benefits is permissible provided that no salary reductions from one year are used to pay premiums for the second year and the premiums are paid no less frequently than annually.

Presumably, the new rule allowing salary reductions from the last month of one plan year to pay for coverage in the first month of the next plan year would apply in this situation despite the general prohibition against using premiums from one year to pay for coverage in the subsequent year.

16. Non-Qualified Benefits

The New Proposed Regs restate the prior list of non-qualified benefits (e.g., Section 117 scholarships, Section 119 employer meals; Section 127 educational assistance and Section 132 fringe benefits, such as qualified transportation benefits). The New Proposed Regs also clarify that non-qualified benefits may not be offered through a cafeteria plan, even if paid for with after-tax contribution. Non-qualified benefits include the following:

- Long term care services. However, the New Proposed Regs clarify prior informal guidance that long term care services (and long term care insurance) may be purchased though an HSA funded with pre-tax salary reductions made through the cafeteria plan.

The New Proposed Regs seem to indicate that all long term care services, not just "qualified" long term services as defined in Code Section 106 are non-qualified. If intended, this change could have an impact on the scope of expenses reimbursable from a Health FSA. See the discussion in -5 on qualified medical expenses for a more detailed discussion.

- Group term life insurance on the life of anyone other than the employee (i.e., dependent life is not a permissible benefit, even if after tax).
- HRAs (as defined in Notice 2002-45).
- Contributions to Archer MSAs.
- Section 403(b) elective deferrals.

17. Employer Contributions

The New Proposed regulations make the following clarifications with respect to "employer" contributions made through the cafeteria plans (including but not limited to salary reductions):

- Cafeteria plans may require employees to make contributions for qualified benefits with pre-tax salary reductions (i.e., after-tax funding does not have to be offered as an option); and
- Salary reductions may be used to pay administrative expenses of the plan and such payments are excluded from income.

This is great news for Health FSA administrators who wish to take the administrative fee from the employee's Health FSA account.

18. Failure to Follow Operational Rules

The New Proposed Regs clarify that failure to follow the terms of the plan and/or the rules of Code Section 125 results in disqualification of the entire plan. Any of the following may result in an operational failure:

- Paying or reimbursing expenses for qualified benefits incurred before the later of the adoption date or effective date of the cafeteria plan, before the beginning of a period of coverage or before the later of the date of adoption or effective date of a plan amendment adding a new benefit;
- Offering benefits other than permitted taxable benefits and qualified benefits;
- Operating to defer compensation (except as otherwise permitted);
- Failing to comply with FSA rules of operation such as the uniform coverage rule, forfeitures and expense reimbursement;
- Failing to comply with the use-it or lose-it rule (including grace period rule);
- Allowing employees to revoke elections or make new elections, except as provided in the -4 regs or in these New Proposed Regs; and
- Failing to comply with the substantiation requirements of -6.

It is very interesting to note that an FSA operational failure appears to disqualify the entire plan. Therefore, if a plan reimburses inappropriate expenses, not only might such expenses be included in income, but all salary reductions for other benefits may be taxable as well.

The New Proposed Regs further clarify that the amount included in income is the greatest amount that could have been received as a taxable benefit.

B. 1.125-2 – General Election Rules

1.125-2 of the New Proposed Regs provides general rules for making and changing cafeteria plan elections, including the timing and appropriate methods of making and/or changing elections. Generally, the rules are similar to those set forth in the Old Proposed Regs; however, there are a few noteworthy clarifications and changes (e.g., the limited retroactive election for new employees).

1. Timing of Elections

The New Proposed Regs clarify that an election must be made before the earlier of the date that taxable benefits are currently available or the first day of the plan year (or other coverage period). A benefit is currently available under the New Proposed Regs if it has been paid to the employee or, the employee is able to currently receive the taxable benefit at the employee's discretion. Moreover, the New Proposed Regs clarify that this determination is made without regard to whether the taxable benefit has been constructively received for purposes of Code Section 451; which is similar to language in the regulations governing 401(k) elections. Thus, it seems that the revised language suggests that an election can be made on or before the first pay date occurring during the coverage period (as opposed to prior to the first day of the pay period). On the other hand, the New Proposed Regs also suggest that the election must be made before the coverage period begins (the period during which the benefits are provided). Thus, the New Proposed Regs seem to offer conflicting principles. Additional clarification from IRS on this issue would be helpful.

2. Election Changes (generally)

The New Proposed Regs clarify that only the employee may make or change an election.

Does this prohibition also apply to properly authorized representatives – e.g., an employee's spouse acting under a duly authorized power of attorney? Likely not, but additional clarification from IRS would provide additional comfort.

3. Automatic and Default Elections

The New Proposed Regs incorporate the "automatic election" rules from Rev. Rul. 2002-27 regarding default elections – e.g., provided adequate notice and an opportunity to opt-out is provided. In addition, the New Proposed Regs specifically accommodate so-called "evergreen" or "rolling" elections.

4. HSA Elections

The New Proposed Regs incorporate guidance from Notice 2004-50 indicating that an HSA election made under the cafeteria plan may be changed for any reason (i.e., the -4 restictions are not applicable) so long as the election is prospective. More importantly, the New Proposed Regs clarify that employees must be allowed to change pre-tax HSA elections no less frequently than on a monthly basis.

5. Limited Retroactive Election for New Employees

The New Proposed Regs clarify that a cafeteria plan may allow new employees (other than former employees who are hired within 30 days of terminating employment) 30 days after their date of hire to make elections for coverage effective on the date of hire. All salary reductions for such retroactive coverage must come from compensation that is not yet currently available (see above for a discussion regarding when compensation is deemed to be currently available).

C. 1.125-5 – Flexible Spending Arrangement Rules

For the most part, the New Proposed Regs restate the FSA operating rules previously set forth in Section 1.125-2 of the Old Proposed Regs. Thus, for example, the New Proposed Regs restate the use-it or lose-it rule applicable to all FSAs and the uniform coverage requirement applicable to Health FSAs.

1. Non-Application of Uniform Coverage Rule to Adoption Expenses or Dependent Care FSA Benefits

The New Proposed Regs clarify that the uniform coverage rule otherwise applicable to Health FSAs does not apply to adoption expense reimbursement plans (as is the case with Dependent Care FSA benefits).

2. Periods of Coverage

The New Proposed Regs restate the rule set forth in the Old Proposed Regs that the period of coverage for an FSA is 12 months. However, the New Proposed Regs clarify that each FSA (i.e., Health, Dependent Care and Adoption) may have a separate period of coverage. It should be noted, however, that operating such benefits on a separate (especially a non-calendar) plan year can create administrative difficulties.

3. Limited Eligibility and Expenses

Plan sponsors are specifically permitted to limit participation in the Health FSA to employees who participate in one or more specified employer provided accident and health plans. Also, the New Proposed Regs clarify that Health FSAs may limit reimbursement to specific medical expenses (e.g., vision or dental expenses).

The New Proposed Regs further clarify that cross reimbursement between FSA accounts is not permitted (e.g., Health FSA funds cannot be used to pay Dependent Care FSA expenses).

4. Orthodontia and Durable Medical Equipment

The New Proposed Regs clarify that a Health FSA may reimburse a participant for orthodontia services before the services are provided, but only to the extent the employee has actually made the payments in advance of the services in order to receive the services. It does not violate the prohibition against deferred compensation if some of the services are provided in a subsequent year. Note, however, that the New Proposed Regs do not indicate whether or not some portion of the services must be performed in the year in which the payment is made. For example, if Bob pays $3,000 in 2009 but all of the services are performed in 2010, can Bob be reimbursed with 2009 contributions? We think not, although this issue is not specifically addressed.

Previous informal guidance suggested that advance payments for pre-natal care would be treated similar to advance payments for orthodontia expenses. However, the New Proposed Regs do not specifically address pre-natal expenses.

Likewise, it is not deferred compensation to reimburse durable medical equipment that has a useful life beyond the plan year in which it is purchased.

5. Long Term Care Insurance Services

The New Proposed Regs clarify that Health FSAs may not reimburse "long term care" services. Under Section 106(c), Health FSAs are prohibited from reimbursing "qualified long term care services" (as defined by Code Section 7702) but long term care services that are not qualified (as defined in Code Section 7702) are not specifically prohibited.

Did the IRS intend to preclude reimbursement of long term care services and long term care services that are not "qualified"?

6. HSA Compatible FSAs

In Rev. Rul. 2004-45, the IRS recognized that Health FSA coverage would not adversely impact HSA eligibility if the FSA is restricted to expenses incurred after the statutorily imposed minimum deductible for an HSA is satisfied. The New Proposed Regs clarify that expenses incurred BEFORE the annual High Deductible Health Plan (HDHP) deductible is satisfied are not reimbursable regardless of whether the expenses are applied to the HDHP deductible or not. This is the rule even if the post-deductible Health FSA is not tied to the HDHP deductible. To accommodate this limitation, sponsors of post-deductible Health FSAs must require substantiation from an independent third party that the HDHP deductible has been satisfied before expenses may be reimbursed under the post-deductible FSA.

The above rule seems to require that the HDHP deductible be satisfied (not just the HSA statutory minimum) and creates an additional substantiation requirement whereby administrators of post-deductible FSAs must now ensure that expenses were incurred after the HDHP deductible has been satisfied.

Consistent with Rev. Rul. 2004-45, the New Proposed Regs also recognize limited purpose (vision, dental, preventive care) FSAs and combined post-deductible limited purpose FSAs.

7. Qualified HSA Distributions

The New Proposed Regs generally incorporate the rules and concepts set forth in Notice 2007-22 regarding Qualified HSA Distributions (transfers of unused Health FSA contributions to an HSA) with one significant difference. The New Proposed Regs do not specifically limit Qualified HSA Distribution to the end of the plan year and only for plans with a grace period (as was the case in Notice 2007-22). This leaves open the possibility of mid-year tax free Qualified HSA Distributions for HSA compatible FSAs (i.e., limited purpose or post-deductible FSAs) to the extent that the Health FSA is amended (in accordance with the New Proposed Regs) on or before the first day of the month in which the Qualified HSA Distribution is made to be a limited purpose Health FSA for all participants. If the plan is not amended to be limited purpose for all participants, the individuals for whom the Qualified HSA Distribution was made would not be an eligible individual as defined in Code Section 223 and would be subject to adverse tax consequences as a result of making the Qualified HSA Distribution.

The New Proposed Regs continue to assert that an individual is covered under an FSA, even if there is a zero balance, if the coverage period has not expired. Thus, if the Heath FSA is not amended to be a limited purpose or post-deductible Health FSA, the individual making the Qualified HSA Distribution would not be an eligible individual under the Code Section 223 rules.

8. Forfeitures

The New Proposed Regs clarify that employers may either retain forfeitures (subject to ERISA's exclusive benefit rule, if applicable) or, alternatively, use them only in one of the following ways:

- Reduce salary reduction amounts for the immediately following plan year on a reasonable and uniform basis. An example in the regs indicates that the salary reduction decrease would be provided only to those who made the contributions giving rise to the forfeiture (i.e., if the forfeiture arises from 2009 contributions, then the decrease in salary reduction contributions in 2010 would apply to those 2009 participants who elect to participate in 2010).

The New Proposed Regs do not clarify whether "immediately following plan year" means the plan year following the plan year in which the contributions giving rise to the forfeitures were made or the plan year following the plan year in which the forfeitures were determined (which would be the second plan year following the plan year in which the contributions giving rise to the forfeitures were made). An example in the regs suggests that it is the plan year following the plan year in which the contributions giving rise to the forfeitures were made. Additional clarification from the IRS is needed.

- Return to the employees on a reasonable and uniform basis.

The Old Proposed Regs specifically referenced cash dividends or refunds as a viable option. The New Proposed Regs do not specifically mention cash dividends or refunds – in fact, the New Proposed Regs do not specifically indicate that the forfeitures can be returned to the participants in cash; however, it is presumed that "forfeitures returned to employees" includes cash dividends or refunds. Additional guidance from IRS is needed.

- Use to offset reasonable administrative expenses.

The IRS has informally indicated that using forfeitures to increase the reimbursement amount in the following year is a viable option as well. The New Proposed Regs do not identify this as one of the viable options in the text of the regulation; however, an example in this section seems to indicate that using the forfeitures to increase a participant's reimbursement maximum is also permitted.

D. 1.125-6 – Substantiation

1.125-6 of the New Proposed Regs addresses the substantiation requirements for qualified benefits offered under a cafeteria plan. Much of the rules reflect guidance previously issued – especially with respect to debit cards issued in conjunction with Health FSAs and Dependent Care FSAs – with a few subtle clarifications.

1. Dependent Care Expenses

The New Proposed Regs confirm that advance reimbursements are not permitted. The regs further clarify that Dependent Care FSAs may offer a spend down option following cessation of participation/ termination of employment.

2. Substantiation (generally)

The New Proposed Regs clarify that the substantiation from the independent third party provider must identify the service or product. Thus, for example, submitting a grocery receipt that merely states that it is for an "OTC" would presumably not pass muster.

Note: The IRS has informally indicated that a receipt showing that the product was a prescription drug is sufficient even if the receipt doesn't identify what the drug is. Presumably this is still the case since prescription drugs are, by definition, medicines. Additional clarification is needed.

It is interesting to note that the general substantiation rules set forth in the New Proposed Regs do not specifically require participant certification, except in the case of Explanation of Benefits (EOB) rollover (discussed below). We believe this was an oversight by the IRS. Additional clarification from IRS is needed.

3. Explanation of Benefits Rollover

The New Proposed Regs clarify that additional substantiation is not needed to the extent the employer is provided with an EOB from an independent third party indicating the date of the medical care and the employee's responsibility for payment. In addition, the employee must certify that the expense has not been reimbursed and they will not seek reimbursement.

This is the only time a participant certification is mentioned in the New Proposed Regs. Requiring after-the-fact participant certification in the case of an EOB rollover creates administrative difficulties that obliterate the advantages provided by the EOB rollover. However, the verb tense in the EOB provision – i.e., the employee certifies that the expense "has not been reimbursed" – is troublesome. Presumably, the participant certification for an EOB rollover arrangement can be provided in advance. Additional clarification is needed.

4. Loans

In determining whether, under all the facts and circumstances, 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.

5. Debit Cards

The New Proposed Regs essentially incorporate the rules and concepts set forth in Rev. Rul. 2003-43, Notice 2006-69 and Notice 2007-2 regarding a plan's use of electronic payment cards. [For an extensive discussion of these requirements, see our July 2007 advisory: Health Benefit Cards: New Rules for 2008 and Beyond.]

One noteworthy change is that the New Proposed Regs indicate that the card need only be turned off when participation ceases (as opposed to when employment terminates as set forth in Rev. Rul. 2003-43). This appears to leave the door open for use of electronic payments by former employees on COBRA. Also noteworthy is the requirement that a plan using Merchant Category C filtered cards employ "all" of the pay and chase procedures specified in Rev. Rul 2003-43. The New Proposed Regs also seem to require a specified order for "pay and chase" (contrary to informal IRS guidance).

The New Proposed Regs still do not resolve a number of outstanding issues related to benefit card administration, including the following:

- Is an offset permitted with respect to expenses incurred in a subsequent year?
- If unsubstantiated claims are required to be included in income, is a W-2 or 1099 required?

E. 1.125-7 – Nondiscrimination Rules

The New Proposed Regs provide much needed clarifications on the methods of conducting the nondiscrimination tests under Code Section 125. Revised definitions of "highly compensated individual" and "key employee" are provided and a new safe harbor is provided for premium only plans (as defined in the New Proposed Regs).

1. Definition of Highly Compensated Individual

The New Proposed Regs clarify that an individual is "highly compensated" as determined generally by Code Section 414(q) (the compensation threshold); however, a spouse or dependent of a highly compensated individual is also included. Also, unlike Code Section 414(q), the New Proposed Regs indicate that the determination is made based on compensation earned in the prior year *or current year, in the case of first year of employment*. Thus, there is no pass on testing for new hires,

2. Definition of Key Employee

The New Proposed Regs reflect the requirements of the statute by specifically applying the rules under Code Section 416(i) to determine a "key employee"; however, unlike the definition of "key employee" under Code Section 416(i), the New Proposed Regs indicate that the determination is made based on compensation and/or status during the preceding plan year (Code Section 416(i) looks to current plan year).

3. Eligibility Test

The New Proposed Regs confirm that the reasonable classification/safe harbor test set forth in Code Section 410(b) is the appropriate method of conducting the cafeteria plan eligibility test. The New Proposed Regs also restate the rule from the statute that the cafeteria plan may not impose a waiting period of longer than three years.

The New Proposed Regs also clarify the scope of employees who may be excluded from testing. For purposes of the safe and unsafe harbor percentage tests (elements of the Code Section 410(b) test), the following individuals are excluded from participating:

- If a three year waiting period is imposed, employees who otherwise meet the requirements of eligibility but do not have three years of employment may be excluded. If the waiting period is less than three years, all employees who have less than three years of employment must be included. For this purpose a year of employment is determined using the qualified plan rule set forth in Reg. 1.410(a)-7. A disaggregation concept applies allowing testing of employees with more than and less than three years of employment separately for purposes of the eligibility and contributions tests.
- Union employees (other than key employees) to the extent cafeteria plan benefits were the subject of good faith bargaining.

Note: Presumably, it appears that union employees may be excluded from testing even if they are allowed to participate in the plan.

- Employees who are non-resident aliens and receive no earned U.S. source income.
- Employees participating in the cafeteria plan pursuant to COBRA continuation provisions.

In an unusual twist, examples in the New Proposed Regs relating to the eligibility test seem to blend eligibility and contributions and benefits testing concepts. For example, a plan fails the eligibility test, according to the examples, if the highly compensated employees are required to make fewer salary reductions for accident and health coverage than non-highly compensated employees, even if every employee is equally eligible to participate. Will disaggregation (discussed below) allow benefit differences? Additional clarification from the IRS is needed.

4. Contributions and Benefits Test

The New Proposed Regs restate many of the requirements set forth in the Old Proposed Regs. For example, the New Proposed Regs restate the rule that 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. Moreover, the New Proposed Regs restate the rule that a cafeteria plan must satisfy this test with respect to both benefit availability and benefit utilization. Thus, a plan must give each similarly situated participant a uniform opportunity to elect qualified benefits, and the actual election of qualified benefits through the plan must not be disproportionate by highly compensated participants (while other participants elect permitted taxable benefits). Fortunately, the New Proposed Regs provided an objective test for determining if qualified benefits are disproportionately elected by highly compensated participants. Qualified benefits are disproportionately selected by highly compensated participants if the aggregate qualified benefits elected by such participants, measured as a percentage of compensation, exceed

the aggregate qualified benefits selected by non-highly compensated participants, measured as a percentage of compensation.

Note: The New Proposed Regs do not identify the method for determining the value of the qualified benefits selected by the two groups. Presumably it would be the fair market value of such benefits but this is not specifically stated.

In addition, the plan must give each "similarly situated participant" a uniform election with respect to employer contributions and the actual election with respect to employer contributions for qualified benefits must not be disproportionate by highly compensated participants. "Similarly situated" may be determined by taking into account reasonable differences in plan benefits such as geographical location or level of coverage (single or family). The same "disproportionate" test discussed above with respect to the overall election of qualified benefits applies to the election of employer contributions.

5. Safe Harbor Test for Premium Only Plans

The New Proposed Regs provide a safe harbor test for "premium only plans." A premium only plan is defined in the -1 section as a cafeteria plan that offers as its sole benefit an election between cash and payment of the employee's share of employer provided accident and health insurance premium (i.e., that is excludible from income by virtue of Code Section 106). Under the safe harbor, such a plan satisfies the contributions and benefits test if the plan passes the eligibility test.

Presumably, even though a Health FSA is an accident or health plan, a cafeteria plan with a Health FSA could not qualify as a "premium only plan." Read literally, the safe harbor would apply to a cafeteria plan through which the only benefit is a Health FSA or individual accident and health insurance coverage, since both are excluded from income by virtue of Code Section 106. Additional clarification from IRS is needed regarding the scope of this safe harbor (e.g., it is possible that the IRS only intended to apply this safe harbor to cafeteria plans through which the sole benefit is a traditional group health plan).

6. Disaggregation/Aggregation

The New Proposed Regs describe specific rules regarding permissible disaggregation of plans and aggregation of plans. For example, if a plan allows employees with less than three years of employment to participate, then the plan may treat employees with less than three years of employment as one plan and those with three or more years of employment as a separate plan. In addition, multiple plans may be aggregated and tested as a single plan. In either case, the "plan" must satisfy both the eligibility test and the contributions and benefits test.

7. Time Period for Testing

The New Proposed Regs clarify that testing **must** be performed on the last day of the plan year. Moreover, the test must take into account all non-excludable employees and former employees who were employees on any day during the plan year.

Note: Is testing only at the beginning of the year sufficient? It appears as though plan sponsors will have an obligation to show that the plan passed on the last day of the plan year, which means that plan sponsors will have to test both at the beginning of the year to determine adjustments and on the last day of the plan year.

No guidance was provided regarding permissible adjustments during the year to pass the applicable tests.

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