Cafeteria Plan Regulations

October 4, 2007

On August 3, 2007, the IRS released new proposed regulations on cafeteria plans under Section 125 of the Internal Revenue Code. These new regulations will replace prior sets of proposed regulations issued between 1984 and 2000. In reviewing the regulations, it appears that little has changed in the law, but that there may be additional clarification and/or examples to aid in interpretation. This is a high level review of the regulations. Specific questions may be directed to Ann Poland in the Indianapolis Office.

When are the new regulations effective?

The rules take effect for plan years beginning on or after January 1, 2009; however, the new regulations should be used when determining good faith compliance until that time.

What do the regulations address about Cafeteria Plans?

- The regulations provide guidance as to what would cause a cafeteria plan to fail.
- They provide a definition of a cafeteria plan and state that participants must be permitted to choose among at least one permitted taxable benefit (i.e., cash or salary reduction, payment for annual leave, sick leave, or other paid time off, severance pay, etc.) and at least one qualified benefit. The "qualified benefits" permitted to be offered in an IRS Section 125 cafeteria plan are group term life insurance, medical, accident, and disability benefits; group legal services; and dependent care assistance.
    - Participants must be employees – this now includes common law employees, leased employees, and full-time life insurance salesmen, as well as former employees.
- A cafeteria plan must not provide for deferral of compensation (unless specifically permitted under the law).
- The **plan year must be 12 consecutive months** and must be set out in the written plan document. A short plan year (or change in plan year) is permitted only for a valid business purpose.
- The maximum contribution amount for **Dependent Care FSAs** remains $5,000.
- The allowance of the **2-1/2 month grace period** remains allowable in the regulations for one or more qualified benefits (i.e., Dependent Care, Health FSA) but cannot apply to paid time off or contributions to a 401(k) plan.

What do the regulations address specifically in regard to Flexible Spending Arrangements (FSA)?

- There are three types of FSAs:
    - Dependent Care Assistance
    - Adoption Assistance
    - Medical Care Reimbursements (Health FSA)

What is specific to Health FSAs that has changed or what made clearer through the regulations?

This document is not intended as legal or tax advice. This information is a high level summary of the new IRS regulations in relation to Cafeteria Plan.

- Enrollment in a Health FSA may be limited to those employees who participate in the health plan.
- The uniform rule (maximum amount of reimbursement must be available at all times during the period of coverage) only applies to the Health FSA.

What can be done with forfeited contributions under use-it-or-lose-it rules?

- The employer sponsoring the plan may:
  - Retain the forfeitures
  - Use forfeitures to defray expenses of administering the plan
  - Allocate forfeitures among employees contributing through salary reduction on a reasonable and uniform basis

What are the rules of substantiation of requests for reimbursement of qualified expenses?

- The new rules provide that 100% of all expenses must be substantiated.
- All expenses must be substantiated by information from a third party (describing the service or product, date of service or sale and the amount) that is independent of the employee and employee's dependents.
  - This may be done through an automatic rollover of information between the health plan and the FSA. Substantiation may be satisfied through the information provided on an EOB (ie for co-pays or other patient responsibilities) or other type of information sharing between the two plans. This alleviates the need for the participant to submit any additional information.
- Debit cards:
  - Employee must agree in writing in advance that
    - he/she will not use the debit card for any medical expense that has already been reimbursed
    - he/she will not seek reimbursement under any other health plan for any expense paid for with a debit card
    - he/she will acquire and retain sufficient documentation of any expense paid with the debit card
  - Card must be automatically cancelled when the employee ceases to participate.
  - Must be limits on the use of the debit card to specific health care providers and stores as noted within the regulations.
  - There must be correction procedures for improper payments.
- The regulations still allow for claims substantiation for copayment matches, certain recurring medical expenses and real-time substantiation.

What is addressed in relation to nondiscrimination testing? (NOTE: For more specific information relating to the Nondiscrimination Rules, see Focus Article 2006-5)

- Highly compensated individuals (HCI) are defined (no apparent change from prior rules)
  - The new regulations state that the spouse or dependent of an HCI is also considered an HCI in determining nondiscrimination levels.
- Nondiscrimination testing must be performed as of the last day of the plan year.