CHAPTER 4

Cafeteria Plans: Recent Developments and Unresolved Issues

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SYNOPSIS

§ 4.01 Introduction
§ 4.02 Permissible Benefits
[1] Cosmetic Surgery Expenses and the Limits of the "Cash Equivalence" Rule
[2] Fringe Benefits Under Code § 132
[3] Dependent Care Benefits
[4] Deferred Compensation Issues
[a] Overlapping Plans
[b] Return of Premium Riders
[5] Group Term Life Insurance Under a Cafeteria Plan
[6] Long-Term Disability Benefits
§ 4.03 Issues Relating to Changes in Elections
[1] Changes in Law
[2] Change in Plan Design
[3] Job Transfers
[4] Paid Leaves of Absence
[5] Loss of Dependency Status
[6] Period of Coverage After a Change in Election
§ 4.04 Implications of Flexible Spending Account Definition Outside of § 125
§ 4.05 Premium Only Reimbursement Arrangements
§ 4.06 "Nontaxable-Only" or "Benefit-Only" Plans
§ 4.07 Labor Department Issues

[1] Flexible Spending Accounts and the ERISA Trust Requirements
[2] Bonding Requirements
[3] Annual Report Requirements
§ 4.08 COBRA and Cafeteria Plans
[1] General
[2] Premium Amount
[3] Monthly Premiums
[4] Scope of the Employer Risk Under COBRA—Do COBRA Beneficiaries Get Independent Elections?
[5] Prior Claims and FSAs Under COBRA
[6] Alternative Coverage

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§ 4.01 INTRODUCTION

The popularity of cafeteria plans continues to grow as the legislative and regulatory attacks on cafeteria plans have receded. This does not mean that cafeteria plans have been unaffected by change. For example, the 1990 budget legislation made a number of changes affecting cafeteria plans. While there have been no major developments in the last year in terms of new regulations—with all of the cafeteria plan regulations still in proposed form—the Internal Revenue Service has issued a couple of important private rulings bearing on flexible benefit plans. Perhaps a testimony to the uncertainty surrounding the proposed regulations, the Internal Revenue Service also has ceased issuing any private letter rulings involving any aspect of a cafeteria plan.[1] This paper will discuss the recent developments affecting cafeteria plans, and will also address a number of key issues that remain unresolved.

§ 4.02 PERMISSIBLE BENEFITS

Cafeteria plans are restricted in the types of benefits that they may offer.[2] Under the 1989 proposed regulations, certain non-

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[1] Rev. Proc. 91-10, 1991-5 I.R.B. 6; Rev. Proc. 91-4, 1991-4 I.R.B. 19; Rev. Proc. 91-3, 1991-1 I.R.B. 52.

[2] For a more detailed discussion of the basic rules on the types of benefits that may be offered under a cafeteria plan, see "Recent Developments Affecting Cafeteria Plans," Forty-Eighth New York University Institute on Federal Taxation (1990), Annual Conference on Employee Benefits and Executive Compensation, Chapter 5.

cash taxable benefits may be offered under a cafeteria plan provided the employer treats those benefits as cash for reporting and withholding purposes.[3] This is often referred to as the "cash equivalence" rule. Cafeteria plans may not offer deferred compensation benefits and the regulations offer an expansive definition of deferred compensation.[4] Cafeteria plans also may not include certain types of tax-free benefits, including fringe benefits under § 132.[5]

[1] Cosmetic Surgery Expenses and the Limits of the "Cash Equivalence" Rule

While the "cash equivalence" rule of the proposed regulations permits plans to offer taxable benefits other than cash, the change in the tax treatment of cosmetic surgery expenses points up the limits of the rule. The 1990 Budget Reconciliation Act modified Code § 213 to exclude certain cosmetic surgery expenses from the definition of "medical care." Although the "cash equivalence" rule generally applies to cafeteria plans, it does not apply to "flexible spending accounts" (FSAs), which are prohibited from reimbursing any expenses other than those deductible under Code § 213. The rationale for this FSA limitation is clear; if the FSA could reimburse any kind of health-related expenses, the "use it or lose it" rule easily could be circumvented. Nonetheless, the Conference Committee Report to the 1990 Budget Reconciliation Act implies that a health FSA can reimburse *taxable* cosmetic surgery expenses in 1991,[6] and many plan sponsors are relying on the Conference Report to allow such reimbursements with respect to salary reduction elections made before January 1, 1991.

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[3] Prop. Treas. Reg. § 1.125–2 (A-4(b)).

[4] Prop. Treas. Reg. § 1.125–1 (A-7); Prop. Treas. Reg. § 1.125–2 (A-5).

[5] Prop. Treas. Reg. § 1.125–2 (A-4(d)).

[6] The Conference Committee Report states that "In addition, the conference agreement clarifies that if expenses for cosmetic surgery are not deductible under this provision, then amounts paid for insurance coverage for such expenses are not deductible under § 213 and reimbursement for such expenses is not excludable from the gross income of an individual under a health plan provided by an employer (including under a flexible spending arrangement)." H. Rept. 101–964, 101st Cong., 2d Sess. 1033.

[2] Fringe Benefits Under Code § 132

Code § 125 provides that neither qualified scholarships under Code § 117 nor fringe benefits under Code § 132 may be offered under a cafeteria plan. The proposed regulations apply this restriction literally and provide that these benefits may not be offered under a cafeteria plan even if purchased with after-tax employee contributions.[7] An example of the strict interpretation of this rule is found in the treatment of dependent life insurance. In Notice 89-100,[8] the Service clarified that up to $2,000 of group term life insurance coverage on the life of a spouse or child is a tax-free fringe benefit under Code § 132. Notice 89-110 also provided that effective January 1, 1989 and extending through plan years ending on or before December 31, 1991, dependent life insurance may be included in a cafeteria plan as long as it is treated as "cash" under the "cash equivalence" rule. This is so even if the dependent life insurance is $2,000 or less and would qualify for the § 132 exclusion if offered outside the cafeteria plan. Reiterating the position taken in the proposed cafeteria plan regulations, Notice 89-110 provides that dependent life insurance may not be offered under a cafeteria plan on an after-tax basis. Of course, employers can avoid the problem by merely offering the dependent life benefit on an after-tax basis outside the legal confines of the cafeteria plan.

Another interesting example of the application of the § 132 prohibition is found in the Internal Revenue Service's withdrawal of the 1989 private letter ruling dealing with outplacement services.[9] This ruling held that outplacement services do not qualify for exclusion from income as a working condition fringe benefit. The ruling stirred controversy and the Service withdrew the ruling pending further study.[10] In withdrawing the ruling, however, the Service noted that employees described in the private ruling would have been taxed under the particular program no matter how § 132 is determined to apply. This is because the employees were given a choice between cash and the outplacement benefit and the § 125 relief from the constructive

[7] Prop. Treas. Reg. § 1.125-2 (A-4(d)).

[8] Notice 89-110, 1989-2 C.B. 447.

[9] Private Letter Ruling 8913008 (December 2, 1988).

[10] Private Letter Ruling 9040025 (July 6, 1990).

receipt of income doctrine is unavailable if Code § 132 covers the outplacement benefit.

[3] Dependent Care Benefits

The Budget Reconciliation Act of 1990 made a minor change affecting dependent care benefits. The Act added a supplemental earned income credit for taxpayers with children under one year of age. If a taxpayer elects to take a child into account under this supplemental earned income credit, however, the child ceases to be a qualifying individual under Code § 21.[11] This rule prevents a taxpayer who claims the supplemental credit from treating that same child (but not other children) as a "qualifying individual" for purposes of the dependent care credit. Since the income exclusion of Code § 129 cross-references to Code § 21 when defining "dependent care assistance," this rule also applies to cafeteria plans offering dependent care reimbursements. To deal with this, employees should be required to certify on the dependent care reimbursement account claims form that the reimbursed expenses are attributable to the care of "qualifying individuals" with respect to whom the supplemental earned income tax credit will not be claimed for the year of reimbursement.

[4] Deferred Compensation Issues

A cafeteria plan may not provide any deferred compensation other than Code § 401(k) deferrals. The proposed regulations interpret this restriction broadly and provide that the use of one plan year's contribution to purchase benefits in a subsequent plan year is treated as prohibited deferred compensation.[12]

[a] *Overlapping Plans*

The deferred compensation prohibition raises a number of interesting problems. For example, what if an arrangement outside the cafeteria plan provides coverage that is identical to the coverage within the cafeteria plan and the arrangement outside the cafeteria plan provides coverage extending beyond the end of the cafeteria plan year. For example, some employers have adopted so-called medical savings accounts that are employer-funded and

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[11] Code § 32(b)(1)(D).

[12] Prop. Treas. Reg. § 1.125–2 (A-5(a)).

are not covered by § 125.[13] These accounts reimburse employees for certain medical expenses and carry over the unused company contributions from year to year. If the employer also maintains a salary reduction FSA under Code § 125 and the FSA reimburses the same kinds of medical expenses as the medical savings account, is there a risk that nonelective company-funded account will be combined with the § 125 FSA so that the carryover of the unused amounts in the medical savings account jeopardizes the qualification of the Code § 125 FSA?

With the expansive definition of deferred compensation, the overlapping coverage of the two programs could prove fatal to the cafeteria plan. The regulations broadly provide that a cafeteria plan may not "operate in a manner that enables participants to defer the receipt of compensation."[14] As an example of this rule, the regulations include a special ordering rule for vacation days whereby the participant is deemed to use nonelective days before the elective days for purposes of determining whether unused vacation days can be carried over to a future year.[15] It appears that the special rule for vacation days is not limited to vacation pay benefits, but rather demonstrates a general principle that could be extended to any kind of benefit that is found both inside and outside a cafeteria plan. This same principle could be applied where there is an FSA and a medical savings account if the employee can seek reimbursement from either account for a given expense; the Service could argue that reimbursements must first be sought from the non-§ 125 medical savings account so as to minimize the possibilities of a carryover.

The coordination of benefits inside and outside a cafeteria plan points up a fundamental problem of defining the boundaries of a cafeteria plan. The law has to allow some leeway for employers to declare what is inside and outside the plan and the mere overlap of benefits cannot cause plan disqualification. For

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[13] Even though these arrangements are outside of § 125, there is a question of whether they qualify as "flexible spending accounts" under the § 125 proposed regulations. As noted later in this article (see the text accompanying footnote 30), the definition of "flexible spending account" is derived from the "insurance" requirement in §§ 105 and 106. Thus, the restrictions imposed by the "flexible spending account" definition are not limited to accounts under § 125.

[14] Prop. Treas. Reg. § 1.125-1 (A-7); Prop. Treas. Reg. § 1.125-2 (A-5(a)).

[15] Prop. Treas. Reg. § 1.125-1 (A-7); Prop. Treas. Reg. § 1.125-2 (A-5(a)).

example, many employers offer salary reduction or bonus reduction nonqualified deferred compensation arrangements and the employer has to be free to offer this benefit outside of the cafeteria plan without having it linked with the cafeteria plan just because it also involves salary reduction.

[b] *Return of Premium Riders*

Another example of a benefit that poses deferred compensation concerns is a return of premium rider that might be offered with an insured medical plan. Under such a rider, the participant receives a return of premiums after a stated period of time, such as twenty years, to the extent that medical claims have been less than premiums paid. The Service has privately ruled that a return of premium rider associated with a medical plan does not qualify as § 106 benefit,[16] so this kind of benefit could only be offered under a cafeteria plan on an after-tax basis. Nonetheless, since such a benefit provides future cash based on the utilization of the medical insurance, it appears that the benefit also provides an impermissible deferred compensation benefit. Whether the benefit could be offered in a companion plan that is separate from the cafeteria plan turns on the scope of the deferred compensation prohibition; because of the coordination of the return of premium feature with the benefits under the cafeteria plan, the arrangement may "operate" so as to "enable" the deferral of compensation under the cafeteria plan even if it is not part of the cafeteria plan.

[5] Group Term Life Insurance Under a Cafeteria Plan

If employees are offered optional group term life insurance coverage under Code § 79 and the employer-provided coverage does not exceed $50,000, it makes sense for the employee to purchase the optional coverage on a pre-tax basis under a cafeteria plan up to the $50,000 tax-free limit. Even if the coverage exceeds $50,000, many employers allow employees to purchase the coverage on a pre-tax basis under a cafeteria plan to take advantage of the § 79 Table I rates. The Table I rates would prove advantageous if employees pay more for the optional coverage than would be imputed under § 79 using the Table I rates. The Ser-

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[16] Private Letter Ruling 9022059 (March 6, 1990).

vice has taken issue with this ploy and, in Notice 89-110 dealing with the taxation of dependent life insurance, pronounced that employees who purchase group term life insurance under a cafeteria plan should be taxed at the greater of the employee's pre-tax contributions or the Table I table cost.[17] Apparently, the Service's position is that the "cash equivalence" rule applies in this case and that "full value" of the taxable benefit that must be reported and withheld upon under the "cash equivalence" rule is the actual cost of the insurance and not the Table I cost. The Service's argument is tenuous and many employers have ignored this aspect of Notice 89-110.

[6] Long-Term Disability Benefits

If an employee is allowed to purchase long-term disability coverage on either a pre-tax or a post-tax basis under a cafeteria plan, the tax treatment of the disability benefits is affected. If the disability coverage is employer-provided, the disability benefit is taxable; if the disability coverage is employee-provided, the disability benefit is tax-free.

Often overlooked when employers offer a pre-tax disability option are the § 105 regulations spelling out how the employer and employee-paid portions of long-term disability coverage are determined. Under the regulations, the employer-provided portion of the coverage is calculated by adding the employer and employee contributions for the prior three years and applying a ratio test.[18] Unless the pre-tax and post-tax benefits are treated as being provided under separate plans for § 105 and 106 purposes, the employee pre- and post-tax contributions should be combined with the result that every participant would be deemed to have a benefit that is partly employer-provided and partly employee-funded. Few plan documents are carefully crafted to deal with this issue.

§ 4.03 ISSUES RELATING TO CHANGES IN ELECTIONS

The proposed regulations require that elections under a cafeteria plan must be irrevocable once the period of coverage has be-

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[17] Notice 89-110, 1989-2 C.B. 447.

[18] Prop. Treas. Reg. § 1.105-1(e).

gun.[19] A cafeteria plan may allow changes in a participant's election "on account of and consistent with a change in family status."[20] Benefit election changes are "consistent" with family status changes only if the election changes are necessary and appropriate as a result of the family status changes.[21] The regulations list a number of events that qualify as family status changes, but the list is not intended to be exclusive; changes in election based on similar events may also be permissible.[22]

The limits of the family status rule continue to pose an interpretative problem for employers. A number of very common situations are not addressed in the regulation and it is difficult to find a common philosophical thread to the events listed in the proposed regulation.

[1] Changes in Law

The elimination of cosmetic surgery expenses as deductible medical expenses in the 1990 Budget Act points up the strict nature of the change in election rules. For example, many participants in cafeteria plans made irrevocable elections in 1990 for the 1991 plan year in contemplation of a cosmetic surgery expenses in 1991. The 1990 Budget Reconciliation Act eliminated cosmetic surgery expenses from the definition of "medical care" and fairness would seem to dictate that participants be allowed to change their elections, particularly if there is any question whether taxable reimbursements can be made from the FSA. The proposed regulations, however, expressly rule out election changes because of changes in law. The same problem was presented with dependent care expenses when overnight camp expenses were eliminated from § 129 in 1987 and when the age of qualified children dropped from under age 15 to under age 23 in 1988.[23]

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[19] Prop. Treas. Reg. § 1.125-1 (A-8); 1.125-2 (A-6(a)).

[20] Prop. Treas. Reg. § 1.125-1 (A-8); 1.125-2 (A-6(c)).

[21] Prop. Treas. Reg. § 1.125-1 (A-8); 1.125-2 (A-6(c)).

[22] Prop. Treas. Reg. § 1.125-2 (A-6(c)).

[23] Prop. Treas. Reg. § 1.125-2 (A-6(a)).

[2] Change in Plan Design

Employers frequently redesign their plans in the middle of a plan year and want to offer employees new elections under a cafeteria plan without having to change the original plan year. For example, the employer may have an FSA and, in the middle of the FSA plan year, the employer adopts a full-flex plan offering multiple benefit levels. Can the employer offer new FSA elections because of the mid-year plan redesign? Surprisingly, the proposed regulations do not address this issue; moreover, what little can be gleaned from the examples in the proposed regulations is not helpful to the case. New elections would be allowable if the employer changes to the plan year of the FSA when the new plan is offered, since the proposed regulations clearly permit short plan years either in the initial year of the plan or in any subsequent year.[24] It is unclear, however, whether the short plan year rule contemplates back-to-back short years.

The proposed regulations also include a rule allowing election revocations when there is a significant change in the coverage under a health plan, but only where the health coverage is provided by an independent, third-party provider.[25] There have been informal indications from the Service that this provision does not apply where the employer self-insures a plan and the change in coverage results from the employer's actions. Since a change in plan design is nothing more than a large-scale change in coverage dictated by the employer, this rule presents a serious obstacle.

In spite of the proposed regulations, employers commonly allow election changes when a plan is redesigned. Some have argued that short plan years are recognized when a plan is started and that the short plan years also should be recognized when a plan is terminated. When the employer starts out with an FSA and adds a full flex plan in mid-year that also includes an FSA, the argument is that the first FSA terminated and a new cafeteria plan started with an initial short plan year. While the legal

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[24] Prop. Treas. Reg. § 1.125–2 (A-7(b)(3)); Prop. Treas. Reg. § 1.125–1 (A-17, 18). Although a portion of the 1989 proposed regulation allowing short plan years to be other than the initial plan year is limited to "flexible spending accounts," the rule should apply to all forms of cafeteria plans.

[25] Prop. Treas. Reg. § 1.125–2 (A-6(b)).

support for election changes when a plan is redesigned is murky, some practical comfort can be gained if employees were unaware of any impending plan termination (and the consequent short plan year) when the original elections for the year were made. After all, the cafeteria plan election restrictions were designed to prevent participants from making salary reduction elections shortly before a covered expense was incurred and there could not have been any such manipulation if employees were unaware that the original plan would be terminated when they made their first elections.

[3] Job Transfers

Another common problem involves employees who transfer jobs and whose benefits change because of the job transfer. For example, the employee may transfer out of one HMO area and move into another HMO area. Can election changes be made in this instance?

This is another area where employers commonly allow cafeteria plan election changes, even though the proposed regulations do not specifically cover this situation. The proposed regulations allow election revocations when the health plan provided by an independent third-party provider is significantly curtailed or ceases during a period of coverage and this rule might be stretched to cover employee transfers.[26] The regulation is drafted broadly enough to permit an employee to revoke an election where coverage is eliminated not because of an insurer (e.g., bankruptcy) but because of the employee's own actions (e.g., loss of coverage caused by moving out of an HMO service area). The "third-party provider" requirement of the proposed regulations suggests, however, that the rule may not have been intended to reach so broadly.

[4] Paid Leaves of Absence

The proposed regulations allow election changes when an employee takes an unpaid leave of absence, but the regulations do not address the question of paid leaves of absence.[27] Many employers faced this problem with reservists who were called up

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[26] Prop. Treas. Reg. § 1.125–2 (A-6(b)).

[27] Prop. Treas. Reg. § 1.125–2 (A-6(c)); Prop. Treas. Reg. § 1.125–1 (A-8).

during the Desert Storm action where the employer continued to pay the reservists the difference between the reservists' prior pay and their military pay.

The apparent distinction between paid and unpaid leave under the proposed regulations could be explained as an attempt to limit election changes to cases where the individual's pay changes significantly. This would be consistent with the rule allowing election changes when an employee changes from full-time to part-time employment.[28] An employee who is paid some amount by his employer during the period of military absence may have received less pay from the employer but may have received the same overall salary when taking into account the military pay. The proposed regulations, however, allow election changes when an employee goes from full-time to part-time status as well as when an employee goes on an unpaid leave regardless of the participants' amount of outside income. Accordingly, in determining whether there has been a change in status it seems appropriate to look only at the employer-employee relationship which would make the fact that the employee was receiving pay from elsewhere irrelevant to whether a change in status has occurred.

[5] Loss of Dependency Status

There are a number of situations where a dependent of an employee ceases to eligible for coverage in the middle of the plan year. For example, many plans exclude dependents once they graduate from college, turn 21, or when the dependent marries. Likewise, under the dependent care exclusion of Code § 129, a child is no longer a qualifying dependent once the child attains age 13. The proposed regulations fail to address these situations, but a good argument can be made for allowing election changes in these situations. The regulations allow an election change when a dependent dies, and the reason for the loss off dependency status should not matter. Also, it can be argued that any event which is considered to be a family status change when it happens to a spouse, such as marriage or a change of employment status, should also be an event permitting an employee could change an election when it happens to a dependent. Some

[28] Prop. Treas. Reg. § 1.125–2 (A-6(c)).

advisors are troubled by allowing election changes in these instances because of the predictability of the events, but predictability is not the sole criteria involved under the family status change rules. For example, the birth of a child is perfectly predictable even if a cafeteria plan election is made after conception.

[6] Period of Coverage After a Change in Election

If an employee changes an election under a flexible spending account because of a change in family status, a question arises as to how the FSA coverage rules work in this situation. For example, if an employee elects to contribute $100 a month to a calendar year FSA in return for coverage of $1,200, and the employee incurs and is reimbursed a $600 expense in January, what happens if the employee has a change in family status and reduces the monthly contributions to $50 per month for the last 10 months of the plan year. If the employee incurs another $600 expense in March, it is unclear whether the employee is entitled to a reimbursement of $600 in March, some lesser amount, or zero. There are numerous ways to analyze this situation, ranging from bifurcating the coverage periods to keeping a single coverage period and determining the amount of coverage by annualizing the total expected premium payments for the year.[29] Although there have been informal indications that the Service might take the position that separate coverage periods are created when an election is changed, so that the employer's risk of loss increases with an election change, it is difficult to see this approach withstanding scrutiny. At this point, it is impossible to say that any of the commonly used coverage methods is more reasonable than another, even though the various methodologies can significantly affect the amount payable to any particular employee. The key point is that the employer must adopt a rule and explain it to participants. Many plan documents and summaries are silent on this point and should be reviewed.

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[29] For a more complete discussion of some of these methods see, footnote 2, above, "Recent Developments Affecting Cafeteria Plans," § 5.04[3][b].

§ 4.04 IMPLICATIONS OF FLEXIBLE SPENDING ACCOUNT DEFINITION OUTSIDE OF § 125

Many employers are considering replacing their defined benefit retiree health plans with defined contribution retiree health plans. Also, as noted previously, many employers have adopted non-elective, employer-funded defined contribution arrangements for active employees. These various defined contribution arrangements typically allow a participant to receive reimbursement for any medical expenses, including insurance coverage, and also carry over the unused account balances from year-to-year.[30]

According to the proposed regulations, these defined contribution accounts may not qualify for tax-free treatment under Code §§ 105 and 106 because the period of coverage extends beyond 12 months. The proposed cafeteria plan regulations include a definition of "flexible spending account," the scope of which is not limited to cafeteria plans. As with the original "use it or lose it" rule that appeared in the 1984 proposed cafeteria plan regulations, the FSA rules are derived from the "insurance" requirement in §§ 105 and 106[31] and apply to elective and nonelective plans. Defined contribution medical plans can avoid the restriction imposed by the FSA definition if the arrangement only reimburses insurance premiums for insurance coverage that satisfies the "five times premium" rule of the proposed regulation. If the arrangement allows both premiums and direct medical costs to be reimbursed, a chicken and egg problem is presented. Is the arrangement is an FSA so that premiums cannot be reimbursed? Or, assuming that an insurance premium can be reimbursed that would provide sufficient coverage to satisfy the "five time rules," does the arrangement falls outside of the FSA definition. It is difficult to make this latter argument without undermining the entire FSA definition, however.

An interesting question posed by the FSA definition is whether the employer can avoid FSA classification by linking the FSA to the employer's main health benefits. For example,

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[30] The IRS issued at least one favorable private letter ruling on such an arrangement in PLR 8637082 (June 17, 1986). The issue was placed on the no-rulings list in Rev. Proc. 87–46, 1987–2 C.B. 684.

[31] Prop. Treas. Reg. § 1.125–1 (A-13).

assume that the employer offers a conventional Blue Cross medical plan and that the employer also offers a conventional spending account that is funded by salary reduction contributions under Code § 125. If the participation in the spending account is limited to employees who also participate in the Blue Cross arrangement, can the amount of coverage available under the Blue Cross arrangement be added to the coverage available under the spending account in order to satisfy the "five times" premium rule and avoid FSA treatment of the spending account? Would it matter if the spending account can be used to reimburse only the deductibles and copays under the Blue Cross arrangement?

§ 4.05 PREMIUM ONLY REIMBURSEMENT ARRANGEMENTS

Many employers adopted cafeteria plans for the sole purpose of allowing employees to pay employee premiums for health insurance on a pre-tax basis. In order to avoid the administrative difficulties of offering both a pre- and post-tax employee contribution option, many employers limit employees to pre-tax contributions. The arrangement qualifies as a cafeteria plan because the employees have a choice between receiving their regular salary (i.e., cash) and receiving a tax-free medical benefit. With the addition of the new health insurance tax credit that was imputed in the Budget Reconciliation Act of 1990, however, these employers will have to consider adding an after-tax election for the purchase of health insurance since the new health insurance tax credit is only applicable to amounts paid by an employee for health insurance on an after-tax basis.[32] As a result, some employees who qualify for the credit may be able to save more in taxes by participating in a medical plan on an after-tax basis and claiming the health insurance credit rather than participating on a pre-tax basis through a cafeteria plan. Of course, nothing requires the employer to offer the best possible tax savings to employees, so that many employers may forego adding an after-tax feature. Either way, prior employee communications should be reviewed to be sure that any statements about tax savings associated with pre-tax elections are still accurate in light of the new tax credit.

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[32] Code § 32(b)(2).

§ 4.06 "NONTAXABLE-ONLY" OR "BENEFIT-ONLY" PLANS

Prior to the adoption of § 125, a number of employers adopted flexible compensation plans offering employees a choice among various nontaxable benefits. These plans, which are frequently referred to as "American Can" plans because of one of the pioneering employers in this area, were thought to be without federal tax implications because the optional benefits were all tax-free.[33] For instance, these plans frequently include such things as disability benefits, medical benefits, dental benefits, and contributions to the employers' savings plan.

In a recent private letter ruling, the Service held that including a qualified retirement plan within a "nontaxable-only" plan causes the participants to be taxed on any current benefits elected under the plan.[34] The ruling involved employees covered by both a multiemployer pension plan and a multiemployer health plan. Since many employees received duplicate medical coverage under their spouse's medical plans, the plan trustees proposed allowing participants with other medical coverage to opt out of the health plan and to have additional employer contributions made to their retirement plan instead. The ruling holds that employees who could have elected out of the health plan and who did not do so would be taxed currently on the theory that they were assigning future pension income in return for a current health benefit.

The private ruling is significant because of its reliance on the "assignment of income" doctrine to find current taxation. In the classic case, the "assignment of income" doctrine has been used to prevent the assignment of income from one taxpayer to another. In the late 1970s, the Service toyed with the formulation of a "dominion and control" doctrine of taxation that was to be applied to various elective compensation arrangements, including deferred compensation plans.[35] This "dominion and control" theory apparently was derived from the "assignment of income"

[33] In PLR 7922011 (February 8, 1979), the Service concluded that an American Can-style "benefits only" plan was not a "cafeteria plan" under the special transition rule for cafeteria plans in § 2006 of ERISA.

[34] PLR 9104050 (November 1, 1990).

[35] General Counsel's Memorandum 37014 (February 25, 1977).

doctrine and was rumored to be the basis for the Service's 1978 proposed regulations dealing with elective deferred compensation plans. From all indications, however, the Service had given up on this approach when Congress effectively overturned the Service's proposed deferred compensation regulations in the Revenue Act of 1978.[36]

If the assignment of income theory applies to "nontaxable-only" plans, then the assignment of income theory also poses a problem for conventional cafeteria plans. While § 125 is worded broadly enough to protect against taxation under any theory of tax law, conventional wisdom was that § 125 was enacted to protect against the risk of taxation under the constructive receipt of income doctrine. Indeed, the proposed cafeteria plan regulations make repeated references to the constructive receipt doctrine and there is no indication in the proposed regulations that the Service ever though that cafeteria plans might be at risk under the assignment of income doctrine.[37] If the Service is serious in applying the assignment of income doctrine to questions of compensation arrangements involving some element of employee choice, the implications of the ruling are quite troublesome and would put at risk all kinds of negotiated compensation packages.

§ 4.07 LABOR DEPARTMENT ISSUES

[1] Flexible Spending Accounts and the ERISA Trust Requirements

In March 1988, the Labor Department published regulations taking the position that employees' salary reduction contributions must be held in trust under Title I of ERISA.[38] In July 1988, the Labor Department announced that it would not enforce the trust requirement for cafeteria plans pending the development of a possible class exemption.[39] Two such exemption re-

[36] Revenue Act of 1978 § 132(a). In PLRs 8202002 (July 30, 1980) and 8243001 (July 30, 1982), the Service held that the assignment of income doctrine does not apply in determining an elective deferred compensation arrangement.

[37] Prop. Treas. Reg. § 1.125-1 (A-8, 9 and 10).

[38] 29 C.F.R. § 2510.3-102.

[39] ERISA Technical Release 88-1, BNA Pension Reporter, Vol. 15, No. 33, p. 1458.

quests were filed in the summer of 1988 and at this time the exemption requests are still under consideration.

[2] Bonding Requirements

ERISA § 412 requires that every person who "handles" funds or other property of a plan must be bonded. The bond must protect to the plan against loss by reason of acts of fraud or dishonesty by the covered person and the amount of the bond is required to be ten percent of the amount of funds handled (with a $1,000 minimum bond and a $500,000 maximum).

While many employers have blanket bonds already covering FSAs, these accounts often are administered by third parties who should be bonded with respect to the FSA. The bonding regulations include a very broad definition of the plan "funds" and this definition is not synonymous with the definition of "plan assets." Accordingly, the question of whether a FSA involves "funds of the plan" does not turn on whether the salary reduction contribution or "plan assets" are unaffected by the Labor Department's enforcement moratorium of the trust requirement for FSAs. The bonding regulations exempt plans that pay benefits solely from the assets of the employer, but an arrangement falls outside the exemption if there is a separate FSA checking account against which benefit checks are written.[40] Even if a third party administrator writes checks against a separate checking account of the employer, the mere existence of the salary reduction contributions to the FSAs may be enough to make the FSA non-exempt under the bonding rules.[41] Also, a third party administrator is considered to be handling funds or other property of a plan if the administrator has authority to determine benefit claims, sign checks, or to actually disburse funds.[42]

[3] Annual Report Requirements

The annual reporting obligation for cafeteria plans stems from two separate legal requirements. First, if the cafeteria plan is covered by ERISA, the plan sponsor is required to file an annual

[40] 29 C.F.R. § 2580.412-2(d); § 2580.412-5.

[41] 29 C.F.R. § 2580.412-2(c); § 2580.412-5.

[42] 29 C.F.R. § 2580.412-6(b).

report using the Form 5500 series unless an exemption applies.[43] Under the Labor Department regulations, welfare plans with fewer than 100 participants are not required annual reports if the plan is (1) fully insured, (2) unfunded, or (3) a combination of the two.[44] The second basis for filing an annual report for a cafeteria plan is Code § 6039D. Code § 6039D requires cafeteria plans to file a Form 5500 each year although only certain items have to be completed on the form. IRS Notice 90–24 clarified that cafeteria plans filing under Code § 6039D do not have to file the more detailed information required by the 1986 Tax Reform Act until further notice.[45] The 1986 Act would have required more detailed information regarding plan coverage and the number of highly-compensated participants.

Many plan sponsors seem to be under the misimpression that multiple ERISA plans are formed when a cafeteria plan is adopted and that, accordingly, multiple 5500 Forms have to be filed for the arrangement. For instance, if the employer adopts a cafeteria plan to allow the payment of pre-tax premiums, many employers believe that they have two ERISA plans—the underlining medical plan and a separate cafeteria plan. The confusion apparently stems from the description of the cafeteria plan in Code § 125 as a "separate written plan," which suggests that the cafeteria plan is somehow different than the plan from which the underlining benefits are delivered. While the employer is free to treat this kind of arrangement as two ERISA plans, the employer could design the arrangement as a single ERISA plan and reduce the burden of ERISA reporting and disclosure.

The same point applies to flexible spending accounts. For example, assume that the employer offers a health FSA and a separate insured health package. The employer could treat this either as a single plan with dual features or as two separate ERISA plans. The arrangement could be treated as a single plan even if the insured covered is nonelective or does not involve the payment of premiums on a pre-tax basis.

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[43] Employee Retirement Income Security Act of 1974, as amended (ERISA), Act §§ 103(a)(1)(A), 104(a)(3).

[44] 29 CFR § 1520.104–20.

[45] Internal Revenue Service Notice 90–54, 1990–44 I.R.B. 13.

§ 4.08 COBRA AND CAFETERIA PLANS

[1] General

The COBRA regulations makes it clear that an FSA is a group health plan for COBRA purposes.[46] This means that a participant in a health FSA who separates from service should be given a COBRA election as to the FSA.

[2] Premium Amount

If an employee was contributing $100 a month to a health FSA, the COBRA premium may not be $102 a month. Rather, as with any other self-insured arrangement, the premium may have to be calculated by an actuarilly-based estimate of future costs or by an adjustment of past cost for inflation. If based on plan costs, the prior years FSA cost would not include amounts forfeited to the employer.

[3] Monthly Premiums

The COBRA regulations provides that qualified beneficiaries must be allowed to pay COBRA premiums on a monthly basis.[47] This means that an employer's risk under an FSA may multiply if qualified beneficiaries can obtain the maximum amount of coverage and then drop the COBRA FSA. It is unclear whether employers can force COBRA beneficiaries to continue coverage if active employees are prohibited from making any election changes, *i.e.*, the employer does not allow any change in status elections.

[4] Scope of the Employer Risk Under COBRA—Do COBRA Beneficiaries Get Independent Elections?

The COBRA regulations provide that each qualified beneficiary can make their own COBRA election. It is unclear how this rule applies to a family coverage by an FSA.[48] For example, assume that an employee with a spouse and a child elects a $1,200 FSA and that the employee terminates employment with-

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[46] Prop. Treas. Reg. § 1.162–26 (A-14).

[47] Prop. Treas. Reg. § 1.162–26 (A-46).

[48] Prop. Treas. Reg. § 1.162–26 (A-37).

out having any covered expenses to submit. Does the former employee get an election to continue a $1,200 FSA or does each qualified beneficiary have the right to elect a $1,200 FSA? One example in the COBRA regulations suggests that the election may involve a single family FSA.[49] Even if there is one family FSA during the original year of termination, it is not clear whether the answer changes in the next open enrollment.

While the answers are not clear in COBRA cases caused by termination of employment, it is clear that the divorce situation does expand the employer's risk. For example, if the employee had elected a $1,200 FSA for the family's expenses and the employee divorces the spouse, the spouse and the child would be able to elect separate FSA coverage.

[5] Prior Claims and FSAs Under COBRA

The COBRA regulations explain how plan deductibles and plan limits apply to COBRA coverage and provide that COBRA coverage is limited to the remaining coverage in effect under the plans on the date the qualifying event occurs.[50] The same rule applies to FSAs. For example, assume an employee with $1,200 of FSA coverage already has received $400 in reimbursements at the time of divorce and would be limited to $800 in coverage for the rest of the year. The COBRA beneficiaries electing FSA continuation would be limited to $800 in coverage for the rest of the year. It is unclear how you determine how much is remaining in these cases. For example, is it based on claims incurred on the date of the divorce or claims actually submitted before that date? If the remaining coverage is determined based on claims incurred on the COBRA date, a practical problem is posed since most plans permit FSA claims to be submitted for reimbursement well after the end of the plan year.

[6] Alternative Coverage

The COBRA regulations provide that an employee can elect to forego COBRA coverage in favor of other employer-paid health coverage.[51] Some employers are using the unused

[49] Prop. Treas. Reg. § 1.162–26 (A-28, example (g)).
[50] Prop. Treas. Reg. § 1.162–26 (A-28, A-29).
[51] Prop. Treas. Reg. § 1.162–26 (A-17(c), Example 4).

amounts in an employee's FSA as an alternative to COBRA. For example, assume the employee elects $1,200 of FSA coverage ($100 a month salary reduction) and the employer terminates at the end of June after paying $600 in monthly "premiums." Assume that the employee has incurred no reimbursable expenses at the time of termination and that the period of coverage could otherwise end if the employee stops making monthly contributions. The employer offers to provide $600 in coverage for the rest of the year (the employee's unused amount) in lieu of COBRA. It is not clear that this approach satisfies the cafeteria plan regulations. It could be viewed as violating the basic "use it or lose it" rule of the 1984 proposed regulations.[52] It might also violate the uniform coverage rule in the 1989 proposed regulations.[53] This rule provides that "the maximum of reimbursement at any particular time during the period of coverage cannot relate to the extent to which the participant has paid the required premiums for coverage under the health FSA for the coverage period."

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[52] Prop. Treas. Reg. § 1.125–1 (A-17).

[53] Prop. Treas. Reg. § 1.125–2 (A-7(b)(2)).