CHAPTER 5

Recent Developments Affecting Cafeteria Plans

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§ 5.01 INTRODUCTION

The Internal Revenue Service has published cafeteria plan regulations on four occasions. The original "use it or lose it" proposed regulations were issued in 1984.[1] Additional regulations were issued in 1984 describing the transition relief provided in the Deficit Reduction Act of 1984 (DEFRA).[2] A temporary regulation describing the benefits that can be offered under a cafeteria plan was published in 1986.[3] The most recent set of regulations, which are the focus of this article, was published in 1989 in conjunction with the Proposed Section 89 regulations.[4] While the 1989 regulations focused heavily on flexible spending accounts, the regulations also provided guidance on the types of benefits that may be offered under a cafeteria plan and election changes under a plan.

§ 5.02 PERMISSIBLE BENEFITS

The proposed regulations expand the types of benefits that may be offered under a cafeteria plan. The regulations also expand the scope of the deferred compensation prohibition as it relates to insurance premium reimbursements in 1989.

[1] Accidental Death and Dismemberment ("AD&D")

In a long-awaited clarification, the Proposed Sections 89 and 125 regulations provide that accidental death and dismemberment benefits and business travel accident insurance are tax-free under Section 106, thereby clarifying that these benefits may be offered under a cafeteria plan.[5] A 1989 private letter ruling held that accidental death and dismemberment coverage on the life of the employee's dependents also qualifies as a tax-free benefit.[6]

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[1] Prop. Treas. Reg. § 1.125–1 (A–1 through A–21).

[2] Prop. Treas. Reg. § 1.125–1 (A–22 through A–29).

[3] Temp. Treas. Reg. § 1.125–2T.

[4] Prop. Treas. Reg. § 1.125–2 (A–1).

[5] Prop. Treas. Reg. § 1.89(a)–1 (A–1(f)); Prop. Treas. Reg. § 1.125–2 (A–4(a)(2)).

[6] PLR 8949030 (September 8, 1989).

[2] Taxable In-Kind Benefits

In 1984, Section 125 was amended to limit the kinds of non-cash taxable benefits that can be offered under a cafeteria plan to (1) group-term life insurance over $50,000, (2) dependent life insurance, (3) vacation pay benefits, and (4) group legal benefits that exceed the Section 120 dollar limit effective in 1988.[7] The 1986 temporary regulations expanded this list by permitting after-tax employee contributions to be used to buy benefits that would have been tax-free if purchased with employer contributions.[8] Many employers continued to offer nonqualifying taxable benefits under their flexible benefits arrangements, but structured the arrangement so that the nonqualifying benefit was offered outside the cafeteria plan, but this solution just added to the paperwork.

The restrictions on taxable benefits proved to be a nuisance for cafeteria plans. For instance, if a cafeteria plan reimbursed a dependent care benefit that failed to satisfy the Section 129(d) requirements (i.e., if the employer failed to provide the January 31 statement of expenses to employees), the cafeteria plan faced disqualification for offering a taxable benefit other than cash.

The 1989 proposed regulations permit in-kind taxable benefits to be offered under a cafeteria plan if the employer treats the benefit as cash for income tax and notification purposes.[9] Accordingly, employers may offer group auto insurance under a cafeteria plan as long as employees are properly taxed on the value of the coverage. Taxable in-kind benefits may not be offered under the cafeteria plan, however, if the taxable benefit includes a deferred compensation element.[10] Examples of benefits providing a deferred compensation element include long-term care insurance and life insurance with a cash-surrender feature. For this reason, any employer offering group universal life insurance (GULP) to employees will have to offer this benefit outside of a cafeteria plan because of the side-fund associated with the insurance.

Neither qualified scholarships described in Section 117 nor fringe benefits described in Section 132 may be offered under a

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[7] IRC § 125.

[8] Temp. Treas. Reg. § 1.125–2T (A–1).

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

[10] Prop. Treas. Reg. § 1.125–2 (A–5).

cafeteria plan according to the new regulations even if they are purchased with after-tax employee contributions.[11] The rationale for this limitation is elusive.

An interesting sidelight to the proposed "cash equivalence" rule is the interplay of this rule with Section 401(k). The final Section 401(k) regulations took the position that real cash (not a taxable benefit treated as cash) must be available for an arrangement to qualify as a cash or deferred arrangement under Section 401(k).[12] Accordingly, if an employer offers a choice between a $100 tax-free medical benefit, a $100 taxable group auto insurance benefit and a $100 contribution to qualified profit sharing plan, the deferred compensation arrangement is not considered a Section 401(k) option. Since the only type of deferred compensation that may be offered under a cafeteria plan is a 401(k) option (with certain exceptions including those noted below in the discussion of 401(k) plans), the whole arrangement also would fail Section 125.

[3] Dependent Life Insurance

The 1986 cafeteria plan regulations made it clear that group-term life insurance for a participant's spouse and dependents could be offered under a cafeteria plan,[13] although it was unclear whether the benefit only could be offered only on a taxable basis. The proposed fringe benefit regulations issued in 1989 modified the prior regulations under Section 61 and stated that dependent life insurance coverage is taxable, even if the cost is *de minimis.*[14] The Internal Revenue Service backed away from this position in IRS Notice 89–110, issued late in 1989. IRS Notice 89–110 modified the fringe benefit regulations, with the result that up to $2,000 of dependent life insurance coverage again qualifies as a tax-free benefit.[15]

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

[12] Treas. Reg. § 1.401(k)–1(e)(1).

[13] Temp. Treas. Reg. § 1.125–2T (A–1(a)).

[14] Treas. Reg. § 1.132–6(e)(2).

[15] Notice 89–110, 1989–49 I.R.B. 17 (December 4, 1989); the Notice postpones the effective date of Treas. Reg. § 132–6(e)(2) and clarifies Treas. Reg. § 1.61–2(d)(2)(ii)(b).

[a] *Background*

In addition to holding that dependent life insurance does not qualify as a tax-free *de minimis* fringe benefit under IRC Section 132, the fringe benefit regulations also stated that the amount of income is measured under the Section 79 tables.[16] This position posed a major problem for most employers. Since the relevant age for determining the amount of income is the dependent's age and not the employee's age, few employers possessed the necessary information to impute income properly. The proper treatment employee-pay-all programs also was unclear in cases where the employees pay less than the Section 79 table rate. On a more positive note, however, the fringe benefit regulations allowed cafeteria plans to offer dependent life insurance as long as the "cash equivalence" rule of the proposed cafeteria plan regulations was satisfied.

[b] *Notice 89–110*

Notice 89–110 provides that up to $2,000 of group term life insurance coverage on the life of a spouse or child will be a tax-free fringe benefit under Section 132. In determining whether employer-provided dependent life insurance above $2,000 is a tax-free *de minimis* fringe benefit, only the excess of the cost of the insurance over the employee's after-tax payments for the insurance is taken into account. For example, if there is $5,000 of dependent life coverage and the employee pays for $3,000 of the coverage, the $2,000 employer-provided coverage is treated as tax-free. Of course, as with the original Section 61 regulation,[17] if the employer-provided coverage exceeds the *de minimis* threshold, all of the coverage is taxable. If, for example, the employer-provided coverage is $10,000, the entire $10,000 of coverage is taxed—even if $2,000 of coverage would have qualified as a *de minimis* fringe benefit.

[c] *Employee Pay-All Plans*

The Notice provides that employer-provided dependent group-term insurance is not includable in income to the extent that the

[16] Treas. Reg. § 1.61–2(d)(2)(ii)(b); Treas. Reg. § 1.132–6(e)(2).

[17] Treas. Reg. § 1.61–2(d)(2).

employee pays for the coverage on an after-tax basis. The Notice also provides that the cost of the insurance is determined under the IRC Section 79 tables. The Notice, however, fails to clearly address the key question of when coverage is deemed to be employer-provided. Under the IRC Section 79 regulations, a policy is considered to be "carried directly or indirectly by the employer" even when there are no employer contributions as long as one employee is charged less than his Section 79 cost and another employee is charged more than his Section 79 cost.[18] In other words, if all employees pay less than the Section 79 table rates and there are no employer contributions, the difference between the Section 79 table rates and the employee contributions is not viewed as an employer-provided benefit. It is unclear whether the Section 79 approach will be used to determine whether a dependent life benefit is employer-provided.

[d] *Amount of Income*

Notice 89-110 provides no relief in determining the amount of income if income must be imputed. Many had suggested that the IRS adopt some rule of thumb that could be used to determine the ages of children and/or spouses, but the Service failed to do so.

[e] *Effect on Cafeteria Plans*

Notice 89-110 provides 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 Section 132 exclusion if offered outside the cafeteria plan. In other words, dependent life insurance which may be tax-free outside a cafeteria plan is taxable under Notice 89-110 solely because it is offered as part of a cafeteria plan. For plan years ending after 1991, moreover, the Notice provides that dependent life insurance may not be offered under a cafeteria plan even on an after-tax basis. As before, employers can avoid technical disqualification of the cafeteria plan by offering the dependent life benefit on an after-tax basis outside the cafeteria plan.

[18] Treas. Reg. § 1.79-0.

[f] *FICA Implications*

Many employers provide dependent coverage in excess of $2,000 and these employers will have to decide whether to be aggressive and take the position that employer-provided coverage in excess of $2,000 also qualifies as a *de minimis* fringe benefit. Any decisions in this area should be evaluated carefully, however, since the employer has an income and FICA tax withholding responsibility for any taxable coverage—while the income tax withholding provisions provide an exclusion for any group-term life insurance coverage on the life of the *employee* (even if it is taxable), there is no similar exclusion for dependent life insurance.[19]

[4] Group-Term Life Insurance Under a Cafeteria Plan

[a] *Pre-Tax Advantage*

Previously, there were a number of advantages gained by allowing employees to purchases optional group-term life insurance coverage on a pre-tax basis.

First, prior to 1988, a FICA tax advantage was gained because employer-provided group term life insurance coverage was excluded from FICA tax even if it was included in income under Section 79. This rule was changed in 1987, however, so that any taxable Section 79 coverage is now treated as wages for FICA tax purposes.[20]

Income tax and FUTA savings could also be achieved if in certain situations employee contributions were pre-tax. For example, if the employer-provided group term coverage is less than $50,000 and employees can purchase additional insurance, it makes sense for the employee to purchase coverage up to the $50,000 limit on a pre-tax basis. If the employee is purchasing coverage over the $50,000 tax-free limit, it also made sense to pay the premiums on a pre-tax basis if the cost to the employee exceeds the Section 79 Table I cost. Here, it was thought that the employee was taxed only on the Section 79 Table I cost of the coverage rather than on the full amount of the payment.[21]

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[19] Code §§ 3401(a)(14); 3121(a)(2)(C).

[20] Code § 3121(a)(2)(C).

[21] Treas. Reg. 1.79–3(d)(2).

[b] *Notice 89–110*

Notice 89–110 changes the answer for coverage over the $50,000 limit of Section 79. It notes as follows:

> "As is true of employer-provided group term life insurance on the life of the employee in excess of the dollar limit of Section 79 that is offered under a cafeteria plan, the total amount includible in the gross income of an employee who receives[dependent life] insurance under a cafeteria plan is *the greater* of the employee's contributions toward the purchase of the insurance or the cost (determined under § 1.79–3(d)(2) of the regulations) of the insurance." (Emphasis added.)

Apparently, the Service has concluded that the taxable group term life coverage must satisfy the "cash equivalence" rule of the proposed regulations in order to be offered under the plan. As noted previously, the "cash equivalence" rule provides that taxable benefits may be offered under a cafeteria plan only if employees are properly taxed on the "full value" of the taxable benefit and the Service's view is that the "full value" of taxable group term coverage is the actual cost of the insurance, if *actual cost* is greater than the Section 79 Table I cost.

It is difficult to find support for the Service's conclusion under the existing regulations. Taxable Section 79 insurance has always been treated as a permissible cafeteria plan benefit, even before the "cash equivalence" rule was proposed. Indeed, the 1989 proposed regulations themselves list taxable Section 79 insurance as a permissible cafeteria plan benefit, totally apart from the "cash equivalence" rule.[22]

[5] Deferred Compensation

[a] *Deferred Welfare Benefits*

A plan is not a cafeteria plan if it provides for deferred compensation.[23] Under IRC Section 125, the use of a contribution from one plan year to purchase benefits in a subsequent plan year is treated as prohibited "deferred compensation." The same is true

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[22] Prop. Treas. Reg. § 1.125–2(A–4(a)(2)(ii) and (b)).

[23] Code § 125(c)(2)(A); Prop. Treas. Reg. § 1.125(A–5).

if a benefit is carried over from one plan year to the next. The regulations specifically state that "a cafeteria plan operates to permit the deferral of compensation if the plan permits participants to use contributions for one plan year to purchase a benefit that will be provided in a subsequent plan year."[24]

The 1989 proposed regulations make it clear that certain deferred welfare benefits may also be treated as deferred compensation. They give as examples of such benefits: (1) "life, health, disability, or long-term care insurance coverage with a savings or investment feature, such as whole life insurance" and (2) a flexible spending arrangement that reimburses participants for premium payments for accident or health coverage extending beyond the end of the plan year.[25] Other arrangements potentially covered by this rule include: (3) prepaid orthodontic services covering a period of years and (4) prepaid obstetrical services covering a pregnancy lasting into a subsequent plan year.

The proposed rules are effective for plan years beginning after December 31, 1988.[26] Many plans may have violated this rule in 1989 plan year by reimbursing improper insurance premiums prior to the publication date of the regulations. This result was apparently not intended, but it has not been corrected to date.

[b] *Vacation Pay Exception*

The carryover of unused elective vacation days to the next plan year is prohibited deferred compensation. Unused elective vacation days can be cashed out provided the days are cashed out before the earlier of the last day of the cafeteria plan year or the last day of the employee's taxable year to which the elective contributions relate.[27]

Unused *nonelective* vacation days earned during a plan year may be carried over to the following year without disqualifying the cafeteria plan. However, elective vacation days are treated as used only *after* nonelective vacation days have been used.[28]

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

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

[26] Prop. Treas. Reg. § 1.125–2 (A–1).

[27] Prop. Treas. Reg. § 1.125–2 (A–5(c)(3)).

[28] Prop. Treas. Reg. § 1.125–2, A–5(c)(2).

The vacation rules continue to pose a practical problem for any employer wanting to permit vacation selling. For example, if the employer allowed vacation carryovers prior to the adoption of a cafeteria plan, and still wants to allow vacation selling, the ordering rule will result in the loss of carryover days in some instances. Assume that an employee had ten carryover weeks of vacation before the cafeteria plan was adopted, and that he gets three weeks vacation each year. Since the employee can sell the three vacation weeks, all three become "elective" weeks. If the employee only takes one week of vacation, the ordering rule treats him as having used one of the ten carryover weeks. The employee then has nine carryover weeks left and the three unused weeks from the current year cannot be carried over.

[c] *Section 401(k) and 401(m) Exception*

The prohibition against deferred compensation does not apply to contributions to a trust under a stock-bonus or profit-sharing plan that includes a qualified cash or deferred arrangement (a 401(k) plan) or contributions subject to IRC Section 401(m).[29] The clarification dealing with IRC Section 401(m) was most helpful, since the statute does not refer to these kinds of contributions. The statute and the prior regulations dealt with elective contributions under IRC Section 401(k) and there was a concern that employer contributions matching elective contributions might disqualify the cafeteria plan. Similarly, there was a concern that any elective contributions that are re-characterized as after-tax employee contributions might disqualify the cafeteria plans.

Some employers with full-flex plans have explored the possibility of forcing unused "cashable credits" into to a Section 401(k) plan rather than having these amounts paid in cash out to the participant. If the participant does not have the option of taking the amount in cash, however, the contribution is not an "elective contribution" and the arrangement is not a Section 401(k) arrangement.

[e] *Exception for Retired Lives Reserve*

Effective in 1989, certain educational institutions (i.e., organiza-

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[29] Code § 125(c)(2)(B).

tions "which normally maintain . . . a regular faculty and curriculum and normally [have] a regularly enrolled body of pupils or students in attendance at the place where its educational activities are carried on") may offer a cafeteria plan which includes as a benefit retired lives reserves. Amounts paid under the plan for electing employees can be credited to individual employee accounts so that postretirement life insurance coverage will be fully paid up upon retirement.[30]

[6] Administrative Expenses

A frequently asked question is whether administrative expenses can be paid out of flexible spending account without violating the "qualified benefit" restriction. In discussing what can be done with unused flexible spending account amounts (so called experience gains) the proposed regulations provide that account balances exceeding total claims and reasonable administrative costs can be rebated to participants in various ways.[31] The implication is that reasonable administrative expenses can be paid out of an FSA without violating the "qualified benefit" rule.

§ 5.03 CHANGES IN ELECTIONS DURING THE PLAN YEAR

[1] Election Restrictions

A plan is not a cafeteria plan unless it offers participants an election among qualifying benefits. The proposed regulations require that the election must be irrevocable once the period of benefit coverage has begun.[32]

Despite the general rule, a plan may under limited circumstances permit a participant to revoke an election and, in some cases, to make a new election. Under none of these circumstances, however, is a plan *required* to allow participants to make any election revocations. The proposed regulations expand the circumstances under which participants in a cafeteria plan may change their elections during the plan year, but retain the general

[30] Code § 125(e)(2)(C).

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

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

proposition of the earlier proposed regulations that once an election has been made, it generally may not be revoked during the period of coverage. Before embracing the new, more liberal list of events which may justify an election change, employers should carefully consider the new coverage rules for FSAs.

[2] Cost Change of Health Plan Provided by Third Party

If the cost of a health plan under a cafeteria plan increases or decreases during a plan year, the cafeteria plan may automatically change participants' premium contributions (regardless of whether they are salary reductions or after-tax contributions) to take into account the change in cost.[33] Any automatic changes must be made on a "reasonable and consistent basis," and may only be made if the plan provides that changes in the plan's cost require a corresponding change in employees' premium payments.

Alternatively, if the premium cost increases "significantly," the plan may allow participants either to increase their premium payments or to revoke their elections and instead receive prospective coverage under a similar plan.[34] The regulations do not attempt to define what constitutes a "significant" increase in cost. Nor do they explain what constitutes a "similar" plan. The regulations do not address what happens if the administrator determines that no similar plan exists; it is unclear whether the participants may simply revoke their elections and *not* receive prospective coverage at all. If a similar plan does exist, the regulations seem to require that the participant receive coverage under the similar plan and not revoke altogether.

Only where the health plan is provided by an independent third-party may a cafeteria plan allow election changes because the cost of the plan changes. Thus, it appears that participants may not make such election changes if employer self-insures the plan.

[3] Change in Health Plan Coverage Provided by Third Party

If the coverage under a health plan provided by an independent third party is eliminated or "significantly" cut back during a period of coverage, a cafeteria plan may allow participants to revoke their

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[33] Prop. Treas. Reg. § 1.125–2 (A–6(b)(1)).

[34] Prop. Treas. Reg. § 1.125–2 (A–6(b)(1)).

elections under the health plan and instead receive prospective coverage under another plan with similar coverage.[35] There are no standards as to what might constitute a "significant" cutback or a "similar" plan. If there is a similar plan, participants apparently may not simply revoke coverage without making a new election.

The regulation is drafted broadly enough to permit an employee to revoke an election where coverage is eliminated not because of the 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 suggests, however, that the rule may not have been intended to reach so broadly.

[4] Changes in Family Status

A participant may be allowed to revoke a benefit election and make a new election for the rest of the period of coverage on account of a change in family status, provided that the revocation and new election are consistent with the change. As provided under the 1984 regulations, the following events are examples of a change in family status: marriage; divorce; death of spouse or dependent; birth or adoption of a child of the employee; or termination of spouse's employment.[36]

The new proposed regulations offer additional examples:[37] commencement of spouse's employment; the employee's or spouse's change from part-time to full-time, or full-time to part-time status; the employee's or spouse's taking an unpaid leave of absence; or a significant change in the employee's or spouse's health coverage "attributable to" the spouse's employment.

It is unclear when a change is "attributable to" a spouse employment. The phrase "attributable to" employment must mean something more than termination or commencement of employment because those events are covered by a separate example. That the phrase means something less than any voluntary change in the spouse's employer-provided coverage can be gleaned by the separate "opt-in" rule that was tied to the "sworn statement" rules

[35] Prop. Treas. Reg. § 1.125–2 (A–6(b)(2)).
[36] Prop. Treas. Reg. § 1.125–1 (A–8).
[37] Prop. Treas. Reg. § 1.125–2 (A–6(c)).

of the Section 89 requirements.[38] A change in health benefits available to the employee or spouse may be considered "attributable to" the spouse's employment where the spouse transfers to a new job location within the company, or where the spouse's employer eliminates coverage for employees or their families.

The regulations do not address whether events similar to the specific examples listed above, but not explicitly included, might be considered a change in family status. Legal separation, for example, should arguably be treated the same as divorce in allowing a participant to make an election change. Similarly, events that are considered changes in family status when they happen to a spouse, such as marriage or a change in employment status, may also be events permitting an employee to change an election when they happen to a dependent, (e.g., a dependent's marriage may cause the dependent to lose coverage under the parent's medical policy).

Unfortunately, the regulations fail to address other common situations involving potential election changes, and the lack of a clear principle in the regulations makes it difficult to deal with these cases. A common problem is whether new elections can be given if a plan is redesigned in mid-year. For instance, assume that the employer had a "premium-only" salary reduction medical arrangement and that the employer wants to adopt a full-flex cafeteria plan in the middle of the "premium-only" plan year. Since the regulations apparently limit the "change in health plan coverage" rule to situations involving a third-party provider, the implication is that coverage changes due to employer redesign of a plan might not qualify as an election change event. Also, while the regulations allow a plan to have a short plan year (discussed in § 5.04[8], below.) it is not clear that the regulations countenance back-to-back short plan years. The election change restrictions were intended to prevent anti-selection against the fisc, however, and it is difficult to see the potential for significant abuse when the plan redesign is bona-fide.

The new proposed regulations retain the "consistency" requirements found in the 1984 proposed regulations, but they provide

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[38] Prop. Treas. Reg. § 1.89(a)–1 (A–3(c)(6)); Prop. Treas. Reg. § 1.125–2 (A–6(a)).

employers no guidelines for determining whether a revocation and a new election are consistent with a change in family status.[39] Changes are consistent "only if the election changes are necessary or appropriate as a result of the family status changes."

Any events that a plan might consider a change in family status, and the standards for determining whether revocations and new elections are consistent with that change, should be set forth in the plan rather than administered on a case-by-case basis.

[5] Separation From Service

A cafeteria plan may allow an employee who separates from service to either revoke his benefit elections and terminate coverage for the rest of the plan year following termination or to continue contributions to the plan and receive coverage throughout the plan year.[40] If the employee chooses revocation, the plan must prohibit the employee from making a "new" election should he become reemployed during the same plan year. Alternatively, the plan may require the terminated employee to continue to make contributions to the plan and, of course, the employee would receive coverage throughout the plan year. The scope of the "new" election restrictions for rehired participants is unclear. For example, is it permissible for the participant to come back into the cafeteria plan at the same rate of pre-tax contributions, or must the employee be limited to after-tax contributions because any pre-tax election is considered to be a "new" election? There have been informal indications from the Service that the employee must be brought back into the plan on an after-tax basis in this case. The Service apparently is concerned that a separation and rehire could be arranged in order to permit election changes. If this is true for separations, however, it should also be true for leaves of absence and conversions from part-time to full-time. Nonetheless, the regulations do not apply the same restriction in these other situations.

Unlike other changes in family status, separation from service does not entitle an employee to modify his benefit elections, only to revoke them and drop out of the plan altogether. Thus, a

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

[40] Treas. Reg. § 1.125–2 (A–6(d)).

COBRA-covered employee need only be given a choice whether to continue to receive his existing benefits.

[6] Cessation of Required Contributions

The plan may provide that if an employee fails to make payments required for a particular benefit, the plan will cease providing the benefit to the employee.[41] As with separation from service revocations, the plan must prohibit the employee from making a new benefit election for the rest of the plan year.

This provision is one of the more ambiguous provisions of the proposed cafeteria plan regulations. If interpreted broadly, it would allow any participant to opt out of a plan at will, thus undermining the general prohibition on revocation of benefit elections. More likely, however, it is intended to address a situation where an employee discontinues making contributions even though the plan does not permit an election revocation.

Practically speaking, most contributions to cafeteria plans are made through payroll withholdings over which an employee is powerless. A number of states, however, prohibit mandatory withholding.[42] This rule permits an employer to cease coverage for a participant who, midway through the plan year, asserts his state law rights (if any) to have the employer cease making wage withholdings for the plan. If such state laws can be asserted by participants, the requirement of immediate full coverage under an FSA becomes more difficult for employers. This provision recognizes the fact that, no matter how ironclad an election may be for tax purposes, other factors make it revocable as a practical matter, and the plan will not be disqualified as a result.

[7] Election Changes Permitted by a Qualified CODA

A cafeteria plan that includes a qualified cash or deferred arrangement under Section 401(k) may permit a participant to make changes or revocations in 401(k) elections that are otherwise permitted under Section 401(k).[43] As Section 401(k) has no res-

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[41] Treas. Reg. § 1.125–2 (A–6(e)).

[42] McKinney's Consolidated Laws of New York (Annotated), Book 30, Labor Laws, § 193(1)(b).

[43] Treas. Reg. § 1.125–2 (A–6(f)).

trictions on election changes during a plan year, the effect of this provision is that where Section 401(k) and Section 125 is more restrictive with respect to election changes for the cash or deferred arrangement than Section 401(k), the cafeteria plan may be as generous with respect to 410(k) elections as Section 401(k) permits. Similarly, where a plan permits after-tax contributions under Section 401(m), Section 401(m) trumps Section 125 with respect to after-tax contribution election changes.

[8] Changes to Comply With Nondiscrimination Rules

Mid-year election cutbacks for highly compensated employees and key employees are permissible, provided they are imposed in a nondiscretionary manner and are not used to circumvent the "use it or lose it" rule.[44]

[9] Changes in the Law

Effective for plan years beginning after December 31, 1988, the regulations provide that a change in the tax status of a benefit will not justify a change in election.[45] This issue has come up in the context of dependent care benefits; overnight camp expenses were eliminated from Section 129 in 1987 and the age of qualified children dropped from under age 15 to under age 13 in 1988.

§ 5.04 SPECIAL RULES FOR FLEXIBLE SPENDING ACCOUNTS

[1] FSA Defined

The new rules define an FSA as a benefit program that limits the maximum amount of reimbursement "reasonably available" to a participant for a period of coverage to an amount that is not "substantially in excess of the total employer and employee contributions to his account." A maximum amount of reimbursement is not substantially in excess of the total annual premium if it

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[44] This principle does not appear in the regulations but appears in the legislative history of the 1988 technical corrections. Technical and Miscellaneous Revenue Act of 1988, H. Rept. 100–1104 (100th Cong. 2d Sess.) 51; General Explanation of the Tax Reform Act of 1986 (H.R. 3838, 99th Cong.; Pub. Law 99–514), 811.

[45] Treas. Reg. § 1.125–2 (A–6(a)).

is no more than five times the premium.[46] Thus, an arrangement under which an employee could be reimbursed for $1,000 in medical expenses in return for a premium of only $100 would not be an FSA, because the maximum reimbursement would be ten times the premium.

Some health plans not commonly thought of as FSAs may be swept in under this definition. For example, a cafeteria plan offers a choice between Plan A, a high-option indemnity plan costing $2,000, and Plan B, a low-option indemnity plan costing $1,400. The only differences between Plan A and Plan B are that (1) Plan A has no deducible and Plan B has a $500 deductible and (2) Plan A covers 100 percent of all claims and Plan B covers only 80 percent of the first $10,000 in expenses. For the $600 additional premium, a Plan A participant may receive at most $2,500 in additional reimbursements, an amount which is less than 5 times the premium. Is Plan A in part an FSA? Any benefit with a premium that is high relative to the maximum reimbursements (dental plans, vision plans) may be an FSA under the proposed regulations. For the most part, categorizing an indemnity plan as an FSA may have no practical effect under the Section 125 rules.

While the preceding example might seem of academic importance only, it does point up an interpretative dilemma for the Service. If the Service were to conclude that the various benefit options in a full-flex plan are not FSAs, employers might take advantage of the rule. For example, if the employer has a real FSA and limits FSA participants to employees who are also covered in the employers basic medical plan, the employer could argue that the FSA is part of the basic medical plan and falls outside the "5 times the premium" rule.

[2] Risk-Shifting and Uniform Coverage

The general approach of the new rules is to make medical FSAs look more like true insurance by shifting additional risk to employers. This is accomplished by requiring an employer to reimburse an employee even if the amount in the employee's account is not sufficient to cover the expense involved. This approach requires an employer to assume the risk that an employee

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[46] Treas. Reg. § 1.125–2 (A–7(c)).

might submit large claims early in the plan year, and then revoke his election on account of a change in family status or termination of employment before building up a correspondingly large salary reduction account balance. As noted previously, a participant's right to revoke his election is created by the plan provisions; a plan is not required to permit election changes on separation from service or upon a change in family status.

At the heart of the new rules is the requirement that the maximum amount of reimbursement (i.e., the total for the entire period of coverage) must be "available" *at all times* during the period of coverage.[47] Thus, the maximum amount available at the particular time cannot be limited or keyed to the amount that a participant has in his account at that time. For example, an employee who elects to contribute $100 per month to a calendar year FSA, and is entitled as a result to $1200 in reimbursements for the year, must be reimbursed the full $1,200 in January if he incurs a qualified medical expense of at least that amount at that time.

[3] Uniform Coverage and Changes in Coverage

As previously noted, the regulations indicate that the level of coverage may be changed prospectively during a period of coverage in the event of separation from service or a change in family status if the plan permits a change in election (but not in the event of significant cost or coverage changes, which do not apply to FSAs).

[a] *Separation From Service*

A plan may permit an employee to revoke his election upon separation from service, but an employee who revokes his election upon separation from service may only be given the option to drop out of the FSA completely, and may not be allowed to change his benefit elections at that time. An employee who chooses to drop out of the FSA and make no more contributions to it cannot be reimbursed for expenses incurred after that date. Accordingly, an employee who is contributing $100 per month to an FSA and receiving $1,200 in coverage who then separates from service must either (1) continue to pay $100 per month to the FSA (in which case the $1,200 coverage will continue) or, if the Plan permits, (2)

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[47] Treas. Reg. § 1.125-2 (A-7(b)(2)).

stop payments to the FSA (in which case the coverage for post-separation expenses will cease).

[b] *Other Changes in Status*

Coverage under an FSA may change prospectively in the event of a change in family status. The regulations fail to explain, however, how the reimbursements are credited against reimbursements that occur after the change.

Two examples will point up the problem.

> **Example 1:** Assume that an employee in a calendar year FSA starts out with a $1,200 FSA election, with monthly salary reduction amounts of $100. After two months, the employee changes his election and drops to a $50 monthly contribution for the last ten months of the year. The employee incurs a $600 medical expense in January and another $600 expense in March. How much must the employee be reimbursed?

> **Example 2:** Assume the same facts as above, but assume that the employee has a $1,200 expense in January and a $600 expense in March.

There are at least six ways to analyze these examples:

[i] *Split Coverage Periods, Cumulative Coverage*

The situation can be split into separate coverage periods. The first two months' coverage is $1,200 ($100 × 12 months anticipated coverage) and the coverage for the last ten months is $500 ($50 × 10 months anticipated coverage). In Example 1, the employee would receive a full reimbursement for the $600 expense in January and only $500 for the $600 expense in march. In Example 2, however, the employee would receive a $1,200 reimbursement in January and a $500 reimbursement for the $600 expense in March—for a total of $1,800! A hybrid of this method looks at the annual premiums for the entire year in establishing the coverage amount after the change in elections. Under this approach, the coverage for the latter part of the year is $700 ((2 × $100) plus (10 × $50)).

[ii] *Annualized Split Coverage Period, Cumulative Coverage*

Under this approach, the coverage amount for the first two

months is $1,200 and the coverage amount for the last is computed as if the $50 contribution had been in effect for the entire year. This means that the coverage amount for the last ten months is $600 ($50 × 12). In Example 1, the employee would receive $600 for the January expense and $600 for the March expense. In Example 2, the employee would receive $1,200 for the January expense and $600 for the March expense, for a total of $1,800.

[iii] *Split Coverage Period, Subject to Yearly Maximum*

Under this approach, the coverage periods remain separate, so that the expenses must be matched against the particular coverage in effect. The difference is that the maximum coverage for the year is limited to the highest rate of coverage in effect during the year. The coverage amount for the first two months is $1,200 and the coverage for the last ten months remains at $500. The yearly maximum is determined by reference to the $1,200 coverage. Under this analysis, the employee in Example 1 would receive $600 for the January expense and $500 for the March expense. In Example 2, however, the employee would receive $1,200 for the January expense and zero for the March expenses because the yearly maximum of $1,200 was met. (Of course, if this is the correct analysis and if the plan permits, the employee in Example 2 would have reduced the contributions to zero in March rather than $50 because the additional contributions buy no additional benefits.)

[iv] *Annualized Split Coverage Periods, Subject to a Yearly Maximum*

This approach is the same as the Approach 3, except that the coverage for the last ten months is computed as if the $50 contribution were in effect for the full year. This gives $600 in coverage for the last ten months ($50 × 12 = $600). This is subject to a $1,200 maximum for the year, however. Under Example 1, the employee would receive a $600 reimbursement for the January expense and $600 reimbursement for the March expense. In Example 2, the employee would be reimbursed for the $1,200 January expense and not at all for the March expense.

[v] *Layering of Coverage, First Reimbursements Attributed to the Short Period of Coverage*

This approach looks at the monthly premium that was common for the year and treats this as one coverage period. The short period picks up the difference. In Examples 1 and 2, the employee had at least $50 in contributions for the entire 12 months. This gives a 12-month period of coverage of $600. A second period of coverage is also calculated for January and February when the contributions were at $100. The second period of coverage for January and February is also $600, calculated as if there were a second $50 monthly premium being paid that was expected to continue for the year. If the $600 expense in January is attributed to the January-February short period of coverage, this means that the employee receives a $600 reimbursement for the January expense and another $600 expenses out of the 12-month period of coverage (which was also $600). In Example 2, the employee would receive a $1,200 reimbursement for the January expense and zero for the March expense.

[vi] *Layering of Coverage, First Reimbursements Attributed to the 12-Month Period of Coverage*

This is the same as Approach 5, except that the first expenses are applied against the year-long coverage period. This gives a dramatically different answer in Example 1. Here, the employee would receive a $600 reimbursement for the January expense, but a zero reimbursement for the March expense. In Example 2, the employee would receive the full $1,200 reimbursement for the January expense, but zero for the March expense.

[vii] *Conclusions*

There has been informal indications that Approaches [i] and [ii] have some support within the IRS. If either approach is adopted by the IRS, employers will have to consider whether to allow any election changes in an FSA in mid-year—whether a participant is increasing or decreasing an election change the amount of total coverage for the year increases because of the election change. Until the IRS comes out with a formal position on this subject, however, it is difficult to say that any interpretation is unreasonable.

[4] Strategies to Reduce Employer Risk

[a] *Delay Payment of Claims*

The regulations do not allow reimbursement to be delayed until late in the year when participants' account balances are highest, because reimbursement is not considered "available" at all times during the period of coverage unless it is paid at least monthly, or when the total amount of the claims to be submitted is at least a specified, reasonable minimum amount (e.g., $50).[48]

[b] *Paying the Premium Upfront*

Requiring participants to pay for coverage in advance, e.g., in semi-annual or even annual installments, does *not* eliminate the risk that an employee will incur a large reimbursable expense early in the plan year and then quit, unless an employer requires continued contributions notwithstanding a separation from service. The regulations provide that, when an employee is permitted to revoke existing benefit and salary-reduction elections upon separation from service, the employer must *refund* any amounts the employee previously paid for coverage, to the extent it relate to the remaining period of coverage, *regardless* of the amount of the employee's claims or reimbursements as of such date.[49] For example, if an employee pays $1,200 into a (calendar year) FSA form his first paycheck for the year, incurs and is reimbursed for a $1,200 medical expense in January, then quits and is permitted to revoke his elections on February 1, the new regulations require the employer to refund 11/12ths of the contribution (i.e., $1,100), for a net loss of $1,100.

[c] *Reduce the Dollar Limit on the FSA*

Many employers reduced their medical FSA limit to $2,000 because of the effective availability rule under Section 89 proposed regulations. This is also an effective risk containment strategy.

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[48] Treas. Reg. § 1.125–2 (A–7(b)(2)).

[49] Treas. Reg. § 1.125–2 (A–7(b)(2)).

[d] *Limit Reimbursements*

An employer could limit reimbursement for predictable expenses (or largely discretionary expenses, such as eyeglasses).

[e] *Risk Charges*

The plan could vary the "premiums" charged to reimburse different types of expenses based on the risks involved.

[f] *Election Restrictions*

Another possibility would be to eliminate or restrict election changes that can be made during the year. Participants could be allowed to increase elections but not allowed to decrease elections.

[g] *Final Paycheck*

A frequently mentioned idea is to withhold amounts from an employee's final paycheck. This is permissible only if all terminating employees are subject to the same rule; the regulations prohibit basing the paying schedule for premiums on the amount of claims incurred. In effect, withholding remaining premiums from an employee's paycheck is simply eliminating the rule which permits revocation on termination of employment. The acceleration of premium may violate the COBRA continuation rules under IRC Section 4980B because the "terms" of the plan change upon termination of employment.

[h] *Restrict Eligibility*

Since former employees are the class of participants who are most likely to cause losses for the employer, employers might want to extend the eligibility period for participation in the FSA. An employee can impose up to a three-year eligibility requirement.[50] The application of the nondiscrimination tests must be carefully

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[50] The 1989 proposed regulation permits so-called FSA experience gains to be allocated in certain ways for the benefit of participants. *See* § 5.04[7] infra. The regulations do to rule out the possibility of having the forfeitures revert to the employer. The reversion to the employee could be a problem if the Labor Department eventually enforces the trust requirement as applied to salary reduction contributions.

considered.[51]

[i] *Limit Participants*

Some employers have considered excluding from future participation any employee who creates a loss under the FSA. It is unclear whether this approach is permissible.

[j] *Use Forfeitures to Offset Risk*

Forfeitures remaining in the plan at year end may, to some extent, blunt the effect of this new rule, as forfeitures may be used inside the plan to offset losses created by the new rule.[52]

[k] *Limit Benefits to Reimbursements*

Some FSAs permit the participant to have the FSA pay the service provider directly from the FSA for services rendered. Participants find this desirable because it avoids the cash-flow problem of paying a bill and then seeking reimbursement from the plan. The employer could require that the expense be paid in cash (and not with a credit card) before the employer will reimburse the expense. This might inhibit certain employees from making large claims against the employer.

[5] Prohibited Reimbursements

The new regulations also prohibit, for the first time, medical FSAs from reimbursing participants for the cost of other health coverage.[53] By "other health coverage," the regulations mean coverage under another health plan or policy besides the FSA itself, including premiums paid for health coverage under pans maintained by the employer of the employee's spouse or dependent, or premiums on individual policies for the employee or his spouse or dependent. While this rule has a 1990 effective date, the provision in the new regulations that treats insurance coverage

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[51] Code § 125(g)(3).

[52] The three-year maximum eligibility requirement specified in § 125(g)(3) appears only to be an entry date rule and does not appear to permit the employer to ignore the waiting period for employees for purposes of the coverage nondiscrimination rest.

[53] Prop. Treas. Reg. § 1.125–2 (A–7(b)(4)).

lasting into the succeeding plan year as prohibited deferred compensation is effective in 1989, and may also disqualify FSAs that reimburse employees for the cost of individual health insurance policies.

This rule does *not*, however, affect the status of "premium-conversion" or "premium-only" plans: the regulations specifically provide that this rule does not prevent premiums for current health plan coverage from being paid on a salary reduction basis "through the ordinary operation of the cafeteria plan," i.e., outside of an FSA.[54]

[6] Claims Substantiation

Effective for plan years beginning after 1989, a health FSA may reimburse an employee for his medical expenses *only* if the participant provides (1) a "written statement from an independent third party stating that the medical expense has been incurred and the amount of such expense," and (2) "a written statement that the medical expense has not been reimbursed or is not reimbursable under any other health plan coverage."[55] This rule clearly disqualifies so-called "advance reimbursement" arrangements whereby some employers were permitting employees to receive FSA reimbursements without proof of payment. It may also affect other FSAs, since it seems to require participants to submit an actual bill from the service-provider, rather than just proof of payment, such as a cancelled check. This rule also seems to eliminate the reimbursement of transportation costs in cases where the participant used his own car to obtain medical or dependent care services.

[7] Account Forfeitures

Under current law, amounts contributed to an FSA that are not used to provide health benefits may not be returned directly or indirectly to the employees who suffered the forfeitures. This is known as the "use it or lose it" rule. The new regulations clarify that unused amounts may be applied to administrative costs for the year, used to reduce required premiums for the following year or

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[54] Prop. Treas. Reg. § 1.125–2 (A–7(b)(4); Prop. Treas. Reg. § 1.125–2 (A–7(f), Example 1).

[55] Prop. Treas. Reg. § 1.125–2 (A–7(b)(5)).

returned to participants as dividends or premium refunds.[56] To take advantage of this rule, however, refunds must be allocated among participants on a "reasonable and uniform basis" that is not related to "individual claims experience." The regulations state that, under this rule, it would be permissible to allocate of refunds based on different coverage levels under an FSA received by each participant (or different salary reduction elections).

[8] Short Plan Years

Before the new proposed regulations were issued, there was no guidance as to the circumstances in which a plan could have a short plan year, other than as the initial plan year.[57] With respect to FSAs, the regulations confirm the general position that a plan may have a short plan year either as its first year *or* as a transition year to effect a change in plan year.[58] For example, if a plan with a calendar plan year (January 1–December 31) changes to a fiscal plan year (e.g., September 1–August 31), the regulations allow the transition period from January 1 to September 1 to be a short plan year. The regulations further provide that where the plan has a short plan year, the entire short plan year is a "period of coverage." Because participants may make new elections for each period of overage, they may change elections with respect to a short plan year.

A question raised by the new regulations regarding short plan years is whether the rule is limited to FSAs. The short plan year discussion is included in the Question and Answer on flexible spending accounts. The absence of any rules on short plan year elsewhere in the regulations, however, probably does not mean that short plan years are prohibited for non-FSAs.

[9] Dependent Care

The new regulations state that, effective for plan years beginning after December 31, 1989, analogous rules to the rules described above (except the new risk-shifting requirement) apply to depend-

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[56] Prop. Treas. Reg. § 1.125–2 (A–7(b)(7)).
[57] Prop. Treas. Reg. § 1.125–1 (A–17, A–18).
[58] Prop. Treas. Reg. § 1.125–2 (A–7(b)(3)).

ent care assistance provided under IRC Section 129.[59]

[10] Implications of FSA Definition Outside Section 125

The definition of FSA has significant implications outside of the cafeteria plan area. For example, one device that has been popularized in recent years is a "medical savings account" for retirees.[60] The arrangement is a defined contribution account funded completely by the employer (i.e., not on a salary reduction basis). Contributions may be based on years of service or on a combination of age and service. If the arrangement *only* reimburses insurance premiums for insurance coverage that will satisfy the "5 times premium" rule, the arrangement presumably is not considered an FSA.[61] If the arrangement is limited to the reimbursement of direct medical costs, it will fail the "5 times premium" rule and will constitute an FSA. If it is an FSA, the carryover of the unspent amount would violate the 12-month coverage rule.[62] If the arrangement allows permits both premiums and direct medical costs to be reimbursed, a chicken or egg problem is posed. Is the arrangement an FSA so that premiums cannot be reimbursed? Or, assuming that an insurance premium can be reimbursed that would provide sufficient coverage to pass the "5 times rule, does the arrangement fall outside of the FSA? It is difficult to make the latter argument without undermining the entire FSA definition. In any event, the FSA definition poses a problem for many defined contribution medical plans.

§ 5.05 COBRA AND CAFETERIA PLANS

[1] General

The COBRA regulations makes it clear that an FSA is a group health plan for COBRA purposes.[63] This means that a participant

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[59] Prop. Treas. Reg. § 1.125–2 (A–7(b)(8)).

[60] 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.

[61] *See,* PLR 9022059 (March 6, 1990).

[62] Prop. Treas. Reg. § 1.125–2 (A–7(b)(3)).

[63] Treas. Reg. § 1.162–26 (A–14)

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 should probably be calculated by an actuarially-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.[64] 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.[65] For example, assume that an employee with a spouse and a child elects a $1,200 FSA and that the employee terminates employment without 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.[66] Even if their is one family FSA during the

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[64] Treas. Reg. § 1.162–26 (A–46).

[65] Treas. Reg. § 1.162–26 (A–37).

[66] Treas. Reg. § 1.162–26 (A–28, example (g)).

original year of termination, it is not clear whether the answer change 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.[67] 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.[68] Some employers are using the unused 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

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[67] Treas. Reg. § 1.162–26 (A–28, A–29).

[68] Treas. Reg. § 1.162–26 (A–17(c), Example 4).

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.[69] It might also violate the uniform coverage rule in the 1989 proposed regulations.[70] 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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[69] Prop. Treas. Reg. § 1.125–1 (A–17).

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