Guide for Designing a Compliant Cafeteria Plan

January 2020

Benefits & Human Resources Consulting

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SECTION 1 – INTRODUCTION

This cafeteria plan guide was created to provide a basic, but practical, summary of the major cafeteria plan compliance rules as of January 1, 2020. It provides information on:

- Types of cafeteria plans
- Qualified individuals and qualified benefits
- Election rules
- Nondiscrimination requirements
- Special rules for certain component plans such as flexible spending accounts.

We also include a few general comments on consulting issues such as carrier rules or employer administrative concerns.

We include examples of potential problems to avoid when designing a cafeteria plan at the end of each section.

What this guide does **NOT** do:

- It does not include consulting advice such as what type of cafeteria plan to implement, what components (e.g., medical, life insurance, FSA) to include, how to set employee contributions, or how to communicate the plan or resolve administrative issues.
- It does not include a discussion of other federal (or state) laws that impact the component benefit plans (e.g., medical, dental, disability, vacation) offered under a cafeteria plan. Although this guide includes a few comments about other laws, it does not address compliance concerns under other federal laws such as ADA, ADEA, COBRA, FMLA, HIPAA, the ACA etc. (While we do include some tips related to a few of these laws as they intersect with cafeteria plans, a comprehensive look is beyond the scope of this guide.)
- It does not cover adoption assistance plans, 401(k), or disability plans (except for a comment on the tax impact of disability plans).

This guide is intended to provide a basic, working knowledge of HRA plan rules. It is not an exhaustive discussion of all of the IRS or other rules or nuances. It is intended to be a starting point.

SECTION 2 – TYPES OF CAFETERIA PLANS

Cafeteria plans have different types of designs ranging from a plan with only an opt-out bonus to a plan that provides flex credits with a menu of benefits and options that employees may purchase. But all cafeteria plans, regardless of the level of complexity, have one thing in common – they must all satisfy the cafeteria plan rules under Section 125 of the Internal Revenue Code (IRC).

Below is the basic definition of a cafeteria plan from the IRC followed by examples of different types of cafeteria plans.

A. Basic Definition

Section 125 of the IRC defines a cafeteria plan as follows:

"The term "cafeteria plan" means a written plan under which –

(A) All participants are employees; and

(B) The participants may choose among 2 or more benefits consisting of cash and qualified benefits."

In the August 2007 proposed regulations, the IRS stated that plans could offer a taxable benefit other than cash – for example long term disability (LTD) insurance purchased with after-tax dollars.[1] In order for the plan to be a cafeteria plan, the employee must be given a choice between at least one taxable qualified benefit (e.g., almost always cash) and one non-taxable qualified benefit (e.g., major medical coverage). A choice between two non-taxable benefits such as the choice between a PPO and an HMO with contributions under both on an after-tax basis may be a flexible benefits plan, but it is not a cafeteria plan as defined by the IRC. It is the choice between the nontaxable major medical plan and taxable cash that makes it a cafeteria plan

One key requirement is that a cafeteria plan must be a written plan. Verbal agreements and informal arrangements are not sufficient. Unless the plan is in writing, it is not a "qualified" cafeteria plan. If the cafeteria plan is determined to be nonqualified (e.g., during an IRS audit), the result will be additional taxable income for all employees participating in the cafeteria plan. The additional taxable income will be based on the maximum taxable benefit the employee could have selected regardless of the employee's actual election. For example, if the plan consists of pre-tax contributions for medical coverage and the plan does not satisfy the written plan requirement, all employee contributions will be after-tax rather than pre-tax (i.e., there is no cafeteria

[1] Some employers offer LTD on an after-tax basis because of the tax treatment. In general, if an employee pays the LTD premium on a pre-tax basis, any LTD benefits payable in the future would be taxable as income. If, however, the employee pays the full LTD premium with after-tax dollars, then an LTD benefit received in the future would not be taxable.

plan.) Thus, the employees would be taxed as if they had not made pre-tax contributions.

Other key elements in tax code definition - such as who may participate and what "qualified benefits" may be included - will be discussed in subsequent sections.

B. Types of Cafeteria Plans

Although every cafeteria plan must satisfy the IRC definition, there are several different types of plan designs. Following is a short description of the most common types:

Opt-Out Bonus Plan

This is the simplest type of cafeteria plan. It involves a choice between a qualified non-taxable benefit such as major medical coverage or a cash payment. Here's an example.

Employee Choice of:
PPO Medical coverage
$1,500 cash bonus *(taxable)*

Tip: *A small business that is owned by a sole proprietor has only a few employees. The owner, as a sole proprietor (not an employee), cannot pay premiums on a pre-tax basis. Only a few employees elect coverage and pay very modest contributions for the coverage. The owner decides to provide health coverage on an after-tax basis to avoid the time and expense needed to establish and maintain a cafeteria plan. However, at a later date, a new employee who does not need major medical coverage asks for a larger salary instead and the owner agrees. This small employer has just unintentionally created a cafeteria plan.*

In Notice 2015-87, the IRS stated that when an employer offers its employees an unconditional opt-out bonus (that is, an offer of a bonus conditioned solely on the employee declining coverage under an employer's health plan and not on an employee satisfying any other meaningful requirement related to the provision of health care to the employee, such as the requirement to provide proof of coverage provided by a spouse's employer), then the IRS will consider the opt-out bonus as an additional charge for the coverage for determining its affordability for application of the ACA employer mandate penalty. According to the IRS, if the employee has the option of receiving additional salary for foregoing coverage, then it would be appropriate to view the situation as the employee being charged the amount of the additional salary (the opt-out bonus) if he or

she accepts coverage. This is important because affordability for the employer mandate is based upon the amount employee must pay for self-only coverage.

For plan years that start on or after January 1, 2017, a conditional opt-out bonus will not affect the affordability calculation only if the payment of the opt-out bonus is conditioned on all of the following requirements:

(1) The employee must decline to enroll in the employer-sponsored coverage;
(2) The employee must provide reasonable evidence that the employee and all other individuals for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year or years that begin or end in or with the employer's plan year to which the opt-out arrangement applies ("employee's expected tax family") have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the opt-out arrangement applies. Reasonable evidence of alternative coverage can include the employee's attestation that the employee and all other members of the employee's expected tax family, if any, have or will have minimum essential coverage, or any other reasonable evidence;
(3) The arrangement must also provide that any opt-out payment cannot be made if the employer knows or has reason to know that the employee or any other member of the employee's expected tax family does not have (or will not have) the required alternative coverage; and
(4) The opt-out arrangement must also require that the evidence of other coverage be provided no less frequently than every plan year to which the eligible opt-out arrangement applies, and that the evidence be provided no earlier than a reasonable period before the commencement of the period of coverage to which the eligible opt-out arrangement applies.

Assuming all the above requirements are met, a conditional opt-out payment may be excluded from the employee's required contribution for the remainder of the plan year, even if the alternative coverage subsequently terminates for the employee or any other member of the employee's expected tax family.

If the employee's required employee contribution for self-only coverage (regardless of whether the employee elects self-only coverage or family coverage) exceeds 9.78 percent for 2020 (indexed in future years) of the employee's household income for the taxable year, or fails to satisfy any of the three affordability safe harbors introduced by the IRS, then the employer sponsored coverage is deemed unaffordable and the employer may face an Employer Shared Responsibility penalty.

Premium Only Plan

Premium only plans are sometimes called POP plans (or premium conversion or salary reduction plans). These plans involve pre-tax payment of an employee's contributions toward the cost of coverage. For example:

Employee Choice of:

PPO Medical coverage in exchange for a salary reduction of $50 per month

OR

No coverage and no salary reduction

Some employers permit employees to choose between pre-tax and after-tax contributions (except where contributions must be after-tax). Providing a choice may be more prevalent under plans that require substantial employee contributions because of the potential impact on Social Security. For example, an employee who earns $30,000 per year pays a contribution of $6,000 per year for family coverage. If she elects coverage, she will have taxable income of $24,000, but she will also have FICA wages of $24,000. A reduction in FICA wages – especially if continued over a long period of time – could have some impact on the employee's Social Security benefits.

Some employers do not give employees a choice between pre-tax and after-tax in order to simplify administration – for example, by limiting the amount of categories that payroll must set up for deductions and display on paystubs.

Tip: In order to qualify as a "premium only plan" as defined by the IRS, the only benefit that can be in the plan is pre-tax contributions (salary reductions) for health and disability benefits. If the cafeteria plan includes any other benefits such as an opt-out bonus or a flexible spending account, it no longer satisfies the IRS definition of a premium only plan. The difference may seem to be insignificant, but it is not insignificant for nondiscrimination purposes. A "premium only plan" as defined by the IRS only needs to pass an eligibility nondiscrimination test. All other cafeteria plans are required to pass the eligibility, the benefits or contributions, and the key employee tests.

Under certain circumstances, employers with pre-tax only plans will be covering individuals who are not the employee's tax dependent – such as an older child (e.g., age 28) or a domestic partner. Although coverage for these individuals must be post tax, IRS rules permit an employer to take employee salary reduction amounts on a pre-tax basis if the full cost of coverage is included as taxable income on the employee's Form W-2. For example, if the cost of coverage for an older child is $5,000 for the year

and the employee contribution is $1,000, the employer may either charge the employee $1,000 on an after-tax basis and add $4,000 of taxable income to the employee's Form W-2 or may charge the employee $1,000 as a salary reduction amount and add $5,000 of taxable income to the employee's Form W-2.

Flexible Spending Account(s)

Many employers establish Flexible Spending Account (FSA) plans to give employees a way to pay for certain expenses on a pre-tax, rather than after-tax, basis. Employers may offer accounts for health care expenses, dependent care (e.g., child care) and/or adoption expenses. The majority of employers who offer FSAs include both health care and dependent care accounts. Few employers offer only a health FSA; most offer an FSA and pre-tax contributions. Here's an example of a plan that includes pre-tax contributions plus health and dependent care flexible spending accounts.

Plan	Salary Reduction Amount
Medical/Rx	$50/month for single coverage $100/month for family coverage
Health FSA	Employee chooses amount up to $2,750 for 2020 (annual)
Dependent Care FSA	Employee chooses amount up to $5,000 (annual)

Most FSAs are funded solely via salary reductions. In some cases an employer may provide funds in the form of a "seed," flexible credits or matching amounts. For example an employer might credit $100 to the account of all eligible employees (seed), give employees credits to spend on benefits with unused credits deposited into an FSA (flexible credits), or provide a 50% match on participant salary reduction amounts so that an employee who elects a salary reduction amount of $1,200 for the year would also receive $600 in his/her account from the employer (match) for a total of $1,800.

Under IRS guidance issued in September 2013, health FSAs must qualify as HIPAA "excepted benefits" under HIPAA. In order to qualify, a health FSA must satisfy two rules:

(1) The total amount available to the employee may not exceed 2 x the employee's salary reduction amount OR the employee's salary reduction amount plus $500 if that amount is larger; and
(2) The employer must also offer other health coverage that is not a HIPAA excepted benefit to all of the classes of employees who are eligible for the health FSA.

Example #1 – An employee elects $1,200. His total amount available when employer contributions are added can't be more than $2,400 (2x the $1,200 salary reduction amount).

Example #2 – An employee elects $400. Her total amount available when employer contributions are added can't be more than $900 ($400 + $500 which is greater than 2 x her salary reduction amount).

Tip: An employer can't offer a major medical plan and health FSA to full-time employees, but only an FSA to part-time employees since the plan would not satisfy rule #2 above. The employer could either offer major medical and a health FSA to both full and part-time employees, or the employer could limit the health FSA to full-time employees. (More detailed information on this issue is contained in Section 5.)

More Complex Cafeteria Plans

Three types of designs that are more complicated in terms of design, administration, and communications are: Core with Buy-up Options, Choice Model with "Net Pricing," and Flex Credit plans. Although these can be premium only plans, in the vast majority of cases they include other benefits such as an FSA, pre-tax employee group term life insurance, and/or an opt-out bonus. Which of these types of plans an employer selects and how the options are structured may have a significant impact on the affordability and potential penalties under the ACA's Employer Shared Responsibility Mandate.

Core with Buy-up Options

Under these plans the participant is given a core level of coverage and permitted to buy a more expensive level of coverage by paying the difference in cost via salary reduction. Here's an example:

Core Benefit(s)	Buy-up Options
Employee Life Insurance = 1x salary	Employee Life Insurance = 2 x salary Employee Life Insurance = 3 x salary
$2,000 Deductible PPO	$1,000 Deductible PPO
No Dental Coverage	Employee Dental Coverage

A less common variation is a Core with Buy-down Option where an employee is given a more expensive level of coverage and then permitted to select a less expensive option and receive some or all of the premium savings. The employee may then use those savings to purchase more coverage under another benefit plan or take as taxable cash. An example of a core with buy down is a plan where the employer provides employee life insurance equal to 2 x salary and the employee is permitted to select 1 x salary instead. The employer would then pay the employee (add to his paycheck) the difference between the premium for the 2 x salary and the 1 x salary level of coverage. These plans were more prevalent in the past.

Choice Model with "Net Pricing"

These plans give employees a choice of options for several types of coverage such as medical, dental, life and disability. The employer determines what benefit levels employees may select and the amount of the employee's contribution for each benefit level.

Here's an example showing just employee coverage:

Coverage	Options	Example of Contributions
Employee Life Insurance	1, 2, or 3 x salary	Rate per $1,000 of coverage at attained age in 5 year brackets
Long Term Disability	No coverage	$0
	60% of salary	Rate per $100 of covered payroll.
Medical/Rx	No coverage	$0
	$1,000 Deductible PPO	$100 per month
	$2,000 Deductible PPO	$50 per month
	HMO	$120 per month
Dental	No coverage	$0
	PPO Dental	$10 per month
	Dental HMO	$15 per month
Health FSA	Employee choice up to $2,700 in 2019	Funded with salary reduction amounts.

Coverage	Options	Example of Contributions
Dependent Care FSA	Employee choice up to $5,000	Funded with salary reduction amounts.

Flexible Credit Plans

These are the most complex type of plan design. They generally have the same type of benefit options as the choice model with net pricing, but they use a different method for setting employee contributions. Under these plans the employee is given a set amount of flex credits to spend on a menu of benefit options where each option has a separate price tag. These programs are virtually always more expensive to design, communicate, and administer because the amount of credits provided and prices charged are virtually never the same for all employees.

Tip: Although credits and price tags are not the same for all employees, the values used must comply with applicable laws. For example, an employer is not permitted to give highly compensated employees more credits than non-highly compensated employees because doing so would violate the nondiscrimination requirement. Similarly, other federal laws such as the HMO nondiscrimination requirement and Age Discrimination in Employment Act also apply.

Employers have implemented these types of plans for a number of reasons. One reason was to use the credits and price tags as a way to gradually add contributions to a previously noncontributory program. During the first year of the plan the employer might give employees sufficient credits to purchase the most expensive medical plan. Employees could then select a less expensive medical plan and have the option to: take the credits in cash, put the excess credits into an FSA, or purchase more life insurance. During the second year, the employer might provide credits sufficient to purchase the less expensive medical option so that employees would be required to make a contribution for the more expensive medical option. The employer has introduced the idea of contributions in the second year, but the employee still has access to medical coverage at no cost. In the third year, the employer provides credits, but the credits by themselves are not sufficient and the employee must make some contribution toward the cost of medical coverage under all of the options.

A second reason was to encourage employees to think in terms of an overall benefits “budget” by permitting benefit trade-offs. For example, an employee who selects a less expensive medical option could use his credits to purchase a more expensive dental plan or additional life insurance. Or, if the plan includes vacation sale, an employee could sell vacation days and use the credits from the days sold to purchase a more expensive medical option.

Many employers would like to use a defined contribution approach to health and welfare benefits similar to defined contribution retirement plans. They want to be able to give employees a set amount of money to use to purchase benefits and get out of the business of purchasing coverage for employees. Even those who prefer to maintain a role in selecting benefit options for employees to purchase would like manage increases in cost – not be tied to escalating health care costs.

The opening of the Marketplaces, which eliminated the problem of the inability of some individuals to purchase individual health insurance in the past, sparked employer interest in the defined contribution approach to medical coverage. Initially, some anticipated giving employees a set amount of money to purchase individual health insurance policies in Marketplaces. IRS guidance in September 2013 eliminated this approach, which it describes as Employer Payment Plans (EPPs). In that guidance, the IRS states that EPPs, health reimbursement arrangements, and similar types of plans used to purchase individual health insurance[2] (inside or outside a Marketplace) do not comply with the ACA's requirements (which could trigger a $100 per day ($36,500 per year) per person excise tax). Flex credit pricing could be used under a group plan or policy, but cannot be used in conjunction with the purchase of individual health insurance policies in a public Marketplace. Moreover, pursuant to IRS Notice 2015-87, an employer may only use flex credits to reduce an employee's contribution (for purposes of measuring affordability) if all three of the following criteria are met:

(1) The credits may be used to pay for minimum essential coverage;
(2) The credits cannot be cashed out; and
(3) The credits may be used exclusively for medical care expenses (as defined under Internal Revenue Code Section 213).

As a result of this guidance, employer contributions in the form of flex credits that are made available to an employee to pay for non-medical benefits, such as dependent care or group term life insurance, will not be deemed to reduce the required employee contributions and depending on the amount of credits may make the employee's required contribution unaffordable. Similarly, employer flex credits that are available to pay for health care but also could be received as cash will not reduce the employee's required contribution for affordability purposes.

A comprehensive discussion of why and how credits and prices vary for different employees, is a consulting issue and outside the scope of this guide. A few questions and two quick examples for specific benefits may provide a glimpse of the potential difficulties involved in pricing.

Questions

[2] Final regulations issued in 2019 now permit the use of HRAs to purchase individual health insurance. See our Technical Bulletin, *Final HRA Regulations*, for more information.

- Since the cost of life insurance varies by age, how does the employer determine what credits to give employees at different ages? What prices will be charged by the insurance carrier?
- The cost of disability coverage such as LTD insurance typically varies based on earnings (and sometimes age). What credits should employees at different income levels receive? How does the insurance carrier determine the rate(s) it will charge?
- Insurance premiums for health coverage vary based on the number of individuals covered. How does an employer determine credits and price tags for employees with no dependents and those with dependents? How will credits and price tags vary if the employee has 1 dependent, 2, 3, 4, 5 or more dependents? How to line these up with the insurance carrier's premium rates?

Example # 1

Life insurance premiums for coverage that is a multiple of salary, such as a choice of 1, 2 or 3 x salary, will vary based on three factors: the employee's age, the employee's salary and the employee's election. Giving each employee the same amount of dollars to spend on life insurance will probably create some unintended (and undesirable) consequences. If an equal dollar amount is provided, a 20 year old employee may have enough money to purchase life insurance of 6 x salary, a 40 year old may only be able to buy 2 x salary, and a 60 year old may not have enough to purchase 1 x salary. In order to eliminate this problem, employers often vary the credits provided to each employee based on the premium rates. For example, an employer might give each employee sufficient credits to purchase life insurance equal to 2 x salary. The result would be different credits for each employee based on the employee's age and salary.

Example #2

Last year an employer offered PPO medical that cost $13,000 for family coverage. The employer charged employees $300 per month for family coverage. The employer's net cost was $9,400 ($13,000 minus $3,600 contributions). This year the employer decides to use credits and price tags and gives married employees $9,400 in credits. Employee #1 did not take any medical coverage last year because she was covered under her husband's plan. This year she makes the same election as last year – she waives coverage under the plan because she has coverage under her husband's plan – except that this year she gets $9,400. This employee will be very happy. The employer may not be as happy because the cost for this employee went from $0 to $9,400. A similar problem may arise if the plan if employees with low or no claims take the credits and waive coverage while employees with high claims continue to enroll in the plan.

Because these designs virtually always use individualized credits and price tags, they require additional communication and personalized enrollment forms which adds to the cost of administering the program particularly in the first year of the program. Employers that want to use flex pricing may need the assistance of an actuary in pricing the plan to avoid unintended results. Developing credit pricing is complicated and mistakes in pricing can be costly. The employer will also need to ensure that their pricing strategy does not violate other federal laws – e.g., ACA's, ADA's, and GINA's wellness rules, age discrimination, and HMO nondiscrimination requirements.

"Simple" Cafeteria Plans

These are a type of cafeteria plan created by the ACA. Unfortunately, the IRS has not yet issued any regulations on these plans so the information we have is limited to the statutory requirements.[3] In general:

- Only employers with an average of 100 or fewer employees during either of the preceding two years may establish a simple cafeteria plan.
- All employees with at least 1,000 hours of service during the preceding plan year (certain employees may be excluded[4]) must be eligible to participate.
- All eligible employees must be able to select any benefit option available under the plan.
- The same terms and conditions under the plan must apply to all eligible employees.
- All eligible employees who are not key employees or highly compensated[5] must receive employer contributions that are a uniform percentage and are at least (a) 2% of the employee's compensation for the plan year, or (b) the lesser of 6% of the employee's compensation for the plan year or twice the employee's salary reductions.

Employers are permitted to make contributions in addition to those that are required. If the employer uses the matching contribution method, however, it cannot make matching contributions for key or highly compensated employees at a rate that is greater than the rate for non-key and non-highly compensated employees.

As long as these eligibility, contribution, and participation requirements are satisfied, the cafeteria plan will be treated as meeting the nondiscrimination rules. Additional rules will apply and careful attention must be paid to the design of the health FSA to ensure that it

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3 In the fall of 2010 when asked if regulations might be available by the end of 2010, a Treasury representative indicated that regulations would not be available by the end of 2010 and added that when the regulators looked at these "simple" plans they realized that they are not simple.

4 Generally, these are employees under age 21, with less than one year of service, and/or collectively bargained employees.

5 See the Appendix for a definition of "key" and "highly compensated" employees for this purpose.

does not fail to qualify as an excepted benefit which could trigger ACA penalties. All of the other cafeteria plan rules apply.

Tip: Designing a "simple" cafeteria plan may be difficult given the absence of IRS guidance. In addition, some of the requirements such as the 1,000 hour eligibility requirement may be problematic for many employers.

C. Potential Problems

Understanding the basic definition of a cafeteria plan and the types of plans can help to avoid problems. Following are some examples of potential problems to avoid:

(1) **Creating a cafeteria plan unintentionally.** An employer who wants to give an employee – any employee – a choice between additional salary and a nontaxable benefit, such as health coverage, can only do so through a cafeteria plan. The "Tip" on page 3 is one example. Another example is a hospital that wants to create two classes for nursing staff employees – with and without benefits at different rates of pay. For example, the hospital might want to offer each newly hired nurse the choice of either $30 per hour with benefits or $35 per hour without benefits. This is a cafeteria plan even if the employer doesn't realize it.

(2) **Maintaining a health FSA that is not a HIPAA excepted benefit**. Pursuant to the IRS guidance issued on September 13, 2013, a health FSA that is not an excepted benefit will be subject to the requirements of the ACA, but will not be able to satisfy two of those requirements: (1) the prohibition against annual or lifetime dollar maximums on essential health benefits; and (2) for non-grandfathered plans the requirement to reimburse specified preventive care services at 100%. Three scenarios that may have been common in the past will create a problem going forward.

a. First, being more generous and allowing employees who are ineligible for the employer's medical plan to establish a health FSA. One common arrangement was to offer medical coverage to full-time employees, but make the FSA available to both full-time and part-time employees. An FSA with this design is not an excepted benefit. Although it was not an excepted benefit prior to the ACA, the primary downside was that the health FSA could not limit COBRA continuation to the end of the plan year. Instead, it was required to provide the full 18, 29, or 36 months of COBRA continuation coverage. Unfortunately, ACA failures carry a much higher penalty – $100 per day ($36,500 per year) per affected employee.
b. Second, health FSA plan designs that include seed money, wellness credits, flex credits that are not cashable, or employer matches will need to be monitored to ensure that they qualify as excepted benefits.

An employer matching contribution should not create a problem as long as the match does not exceed 100% since the rule permits an election up to 2 x the salary reduction amount. Employers may want to limit the amount of seed money or credits added to an FSA election. Dollar amounts up to $500 present no problem. Amounts greater than $500 will be permissible only to the extent that the employee's salary reduction election exceeds $500. Large employer contributions – such as $3,000 – are not permitted since the employee salary reduction amount is limited to $2,750 (for 2020).

c. Third, a plan that uses credit pricing that limits or does not permit cash out of unused credits could unintentionally create a health FSA that is not a HIPAA excepted benefit. For example, the employer gives employees sufficient credits so that an employee who purchases the least expensive medical option will have $600 in unused credits that may be used to purchase other benefits such as pre-tax LTD insurance or a more expensive dental plan. The employee may also put the unused credits in an FSA, but can't take the unused credits as cash. If an employee puts just $600 unused credits in a health FSA (i.e., elects $0 salary reduction for the FSA), the FSA is no longer a HIPAA excepted benefit because the maximum amount available to this employee – $600 is more than the permitted amount. This problem does not arise if the employee is permitted to take the $600 in unused credits as taxable cash because the IRS views cashable credits as salary reduction amounts.

(3) **Offering employees an unconditional opt-out bonus.** An offer of an unconditional opt-out bonus (that is, an offer of a bonus conditioned solely on the employee declining coverage under the employer's health plan) is viewed by the IRS as an additional charge for the employee's coverage for purposes of determining the affordability of the coverage. According to the IRS, if the employee has the option of receiving additional salary for foregoing coverage, then it would be appropriate to view the situation as the employee being charged the amount of the additional salary (the opt-out bonus) if he or she accepts coverage. For example, if an employer offers employees group health coverage through a Section 125 cafeteria plan, requiring employees who elect self-only coverage to contribute $200 per month toward the cost of that coverage, and offers an additional $100 per month in taxable wages to each employee who declines the coverage, the offer of $100 in additional compensation has the economic effect of increasing the employee's contribution for the coverage. In this case, the employee contribution for the group health plan effectively would be $300 ($200 + $100) per month, because an employee electing coverage under the health plan must forgo $100 per month in compensation in addition to the $200 per month in salary reduction.

(4) **Failing to meet the stricter flex credit rules introduced by 2015-87.** While many employers that have implemented a defined contribution methodology have decided against adopting a pure defined contribution approach, those that adopt a pure defined contribution approach in the future will likely face penalty exposure under the Employer Mandate due to the stricter flex credit rules introduced by Notice 2015-87. In this notice, the IRS clarified that an employer may not use flex credits to "reduce" an employee's contribution (the employee's share of the premium) in the affordability calculation, unless certain criteria are met. If an employer is unable to reduce or subtract out the flex credits from an employee's contribution, then it will likely mean that that the employer-sponsored coverage will be deemed "unaffordable," and thus, more likely that the employer will be subject to penalties. According to the IRS, an employer may only use flex credits to reduce an employee's contribution (for purposes of measuring affordability) if all three of the following criteria are met:

a. The credits may be used to pay for minimum essential coverage; and
b. The credits cannot be cashed out; and
c. The credits may be used exclusively for medical care expenses (as defined under Internal Revenue Code Section 213).

For example, assume an employer offers flex credits in the amount of $600 per year under a Section 125 plan. An employee electing self-only coverage under the health plan is required to contribute $200 per month toward the cost of coverage. The credits cannot be cashed out; however, the $600 in flex credits can be used for benefits not related to health care (such as dependent care or group life insurance). In this scenario, the flex credits can be used for items other than medical care, so the "exclusive" requirement (requirement #3 above) is not satisfied. And as a result, none of the flex credit amount ($600) can be used to reduce the employee's required contribution amount ($200) in the affordability calculation. With respect to this example, if the flex credits can be used to reduce the employee's required contribution amount, then the health coverage would be more affordable ($200 minus $50 = $150). Under those circumstances, the employee would be considered to contribute $150 (rather than $200) towards his/her health coverage. However, this is only the case if all three of the criteria outlined in 2015-87 are met. By contrast, if the flex credits cannot be used to reduce the employee's required contribution amount ($200 with nothing subtracted = $200), then the health plan might not be affordable for that particular employee. In short, requiring the employee to use the flex credits to reduce the employee's required health coverage contribution or for health benefits helps the employer pass the affordability test with regard to the particular employee, and makes a penalty less likely.

SECTION 3 – QUALIFIED INDIVIDUALS AND QUALIFIED BENEFITS

Cafeteria plans may only be offered to qualified individuals and may only include qualified benefits. **Following this rule closely is important because permitting non-qualified individuals to participate or including non-qualified benefits under the cafeteria plan jeopardizes the status of the entire plan.** If the cafeteria plan is determined to be nonqualified (e.g., during an IRS audit), the result will be additional taxable income for **all** employees participating in the cafeteria plan. The additional taxable income will be based on the maximum taxable benefit the employee could have selected regardless of the employee's actual election. If the cafeteria plan is a premium only plan, the result would be that all contributions would be after-tax rather than pre-tax. If the cafeteria plan includes an opt-out bonus, all employees would be taxed on the value of the opt-out bonus, including those who did not receive the opt-out bonus.

A. Qualified Individuals

All types of employers may establish cafeteria plans – private sector (for profit and nonprofit), governmental, and church employers. Private employers may include sole proprietorships, corporations (Subchapter C or Subchapter S), partnerships, limited liability corporations (LLCs), and limited liability partnerships (LLPs). Although all of these employers may establish a cafeteria plan, only common law employees of these employers – sometimes called Form W-2 employees – may participate in a cafeteria plan. Former employees may also participate, but the cafeteria plan may not be established primarily for the benefit of former employees.

Tip: Although retirees may be included in a cafeteria plan, they rarely are. The primary reason is probably the fact that there is no way for retirees to pay any required contributions or contribute to an FSA on a pre-tax basis. They do not have salary (or wages) that can be reduced and any funds deducted from a pension check must be after-tax.

Individuals Who May Not Participate

Self-employed individuals such as sole proprietors, partners, and 2% shareholders in a subchapter S corporation are not eligible. Other individuals such as independent contractors and non-employee directors are also ineligible. There is, however, a special rule for individuals who are both employees and directors of the employer. Generally, these individuals may participate, but only to the extent that they are common law employees. For example, an employee who is also a director has W-2 wages of $50,000 and director fees of $3,000. She would be able to participate in the cafeteria plan and would be treated as an employee with $50,000 of compensation.

Individuals who are partners in a limited liability partnership (LLP) are generally ineligible to participate. A few who are also employees and are not entitled to

guaranteed payments may be eligible to participate, but only to the extent of their compensation as employees. Individuals who are members of a limited liability corporation (LLC) are generally not eligible to participate in a cafeteria plan.

The rules for participation by individuals who may be considered self-employed are complex. For example, determining ownership for a Subchapter S corporation includes using "attribution" rules under Internal Revenue Code Section 318. Under IRC Section 318 certain individuals such as the spouse, children, parents, and grandparents are deemed to have the same ownership as the shareholder. As a result, the spouse of a 2% owner in a subchapter S corporation cannot participate in a cafeteria plan even if she is a full-time employee with $50,000 in W-2 wages because she is also deemed to be a 2% shareholder. Employers that include self-employed individuals (and employee family members of self-employed individuals) should discuss their specific situation with legal counsel to determine who may and may not participate in a cafeteria plan.

A Professional Employer Organization (PEO) may establish a cafeteria plan for its employees. Each client employer of the PEO may establish a cafeteria plan for its employees. It is not clear if the PEO may establish a cafeteria plan for the employees of its employer clients. PEOs and their client employers should seek legal advice on this issue.

B. Qualified Benefits

Cafeteria plans are permitted to include only certain types of benefits called "qualified benefits." Qualified benefits are:

- Group accidental or health coverage – insured or self-insured. **Individual medical insurance policies are no longer a qualified benefit** (they were qualified prior to 2013);
- Prepaid vision, dental, or drug plans as long as the plans include an element or risk or prepaid medical services;
- Flexible spending accounts – health, dependent care, and adoption;
- Group term life insurance covering employees – including amounts in excess of $50,000 (amounts over $50,000 create imputed income which is taxable);
- Disability coverage such as short term or long term disability;
- Accidental death and dismemberment insurance;
- Employer provided adoption assistance benefits;
- Health savings accounts;
- Contributions to a 401(k) plan;
- Vacation buy/sell and Paid Time Off (PTO); and
- Certain contributions for post-retirement group life insurance in a plan maintained by an educational institution.

Although most benefits offered under a cafeteria plan are pre-tax or non-taxable, coverage does not have to be non-taxable to be a qualified benefit. Taxable benefits that may be included under a cafeteria plan are coverage for dependents who do not qualify as tax dependents, such as domestic partners or a child over age 26, and benefits that are purchased with after-tax dollars. For example, many employers charge contributions for LTD insurance on an after-tax rather than pre-tax basis because of the tax treatment (i.e., if LTD premiums are paid pre-tax any benefits received would be subject to federal income tax, but if the full premium is paid by the employee on an after-tax basis, LTD benefits received would not be taxable).

Finally, under certain circumstances premiums for COBRA coverage may be a qualified benefit. If the participant has sufficient compensation that can be reduced and the coverage is for the participant, participant's spouse, or participant's tax dependent, the coverage can be paid pre-tax under the cafeteria plan. Examples would include an employee paying COBRA premiums from severance pay or an employee paying COBRA premium for his 28-year-old child who is also the employee's tax dependent.

C. Nonqualified Benefits

Nonqualified benefits may NOT be included under a cafeteria plan. Many of these benefits may be offered at the same time as cafeteria plan is offered, but must be outside the cafeteria plan. Nonqualified benefits are any benefits that are not on the IRS list of qualified benefits and include:

- Health reimbursement arrangements (HRAs) including Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) – directly or indirectly. A high deductible major medical plan provided in conjunction with the HRA will usually be a qualified benefit;
- Individual medical insurance (inside or outside a Marketplace);
- Archer Medical Savings Accounts (MSAs);
- Group term life insurance covering anyone other than the employee – e.g., spouse and children;
- Life insurance other than group term life subject to IRC Section 79 – e.g., whole life, universal life, group universal, split-dollar life insurance;
- Transportation assistance plans (note: although these plans may be pre-tax, they must be separate from the cafeteria plan);
- Group legal, auto, and homeowners;
- Education assistance/tuition assistance programs;
- Scholarships;
- Long Term Care; and
- Elective deferrals to any pension/retirement plan other than a 401(k) – e.g., 403(b) plans.

D. Potential Problems

Adhering to the rules applicable to qualified individuals and qualified benefits is critical because permitting a non-qualified individual to participate or including a non-qualified benefit disqualifies a cafeteria plan. Unfortunately, unlike pension plans, there is currently no mechanism for IRS review of a cafeteria plan to ensure that the plan design is compliant. If there is a problem, it will almost always be discovered after the fact and cannot be corrected to avoid the adverse tax results. A cafeteria plan that is disqualified is, in essence, not a cafeteria plan from the start.

The following are some examples of plan provisions that would disqualify a cafeteria plan.

Ineligible Individuals

(1) **Permitting non-employees, such as independent contractors or partners, to participate in a cafeteria plan.**
(2) **Permitting an employee who has a dual role as an employee and a director to participate to an extent that exceeds his/her status as an employee.** For example, the cafeteria plan is open to all employees and annual contributions of $3,000 are required for health insurance. If the director employee's Form W-2 earnings are $2,000, his $3,000 contribution cannot be paid on a pre-tax basis. *(Note: There may also be issues under other laws such as state wage laws.)*
(3) **Permitting the spouse of a 2% shareholder to participate when the spouse is a full-time employee and has $50,000 of Form W-2 earnings for the year.** Under ownership attribution rules, the spouse of a 2% owner is also deemed to be a 2% owner and ineligible to participate.

Ineligible Benefits

(1) **Including individual medical insurance under the cafeteria plan.** Individual medical insurance that is not a HIPAA excepted benefit is NOT a qualified benefit. Note: Under guidance issued on September 13, 2013, the IRS made it clear that individual medical insurance policies may not be part of a cafeteria plan and further that arrangements where an employer pays the premium or reimburses the employee for the premium (called employer payment plans) are also prohibited.[6] The penalty for not following the cafeteria plan rules is additional taxable income based on constructive receipt. *The penalty for failing to follow the ACA requirements is $100 per day ($36,500 per year) per affected employee.*

[6] Final regulations issued in 2019 now permit the use of HRAs to purchase individual health insurance. See our Technical Bulletin, *Final HRA Regulations*, for more information..

(2) **Structuring a health reimbursement arrangement (HRA or QSEHRA) in a way that makes it indirectly funded through the cafeteria plan. IRS regulations provide the following examples:**

a. An employer offers group health plan coverage along with an HRA. The cost for family health coverage is $4,500. An employee who elects a $2,500 salary reduction amount gets $1,000 added to his HRA. An employee who elects a $3,500 salary reduction amount gets $2,000 added to her HRA. This design is impermissible since the cafeteria plan is indirectly funding the HRA.
b. An employer credits $1,000 to each participating employee's HRA. The employee contribution for health coverage is $500. The employer gives the employee a choice of paying the $500 via salary reduction or by deducting the premium from the HRA. This design is impermissible since it the HRA is indirectly funded by the cafeteria plan.
c. An employer transfers unused FSA amounts to the HRA after the end of the plan year. Transferring amounts that will be forfeited from an FSA results in the HRA being funded indirectly with salary reduction amounts which is not permitted.

(3) **Offering nonqualified benefits along with qualified benefits and not making it clear in the enrollment materials, the SPD (or benefits book), and plan document that the nonqualified benefits are outside the cafeteria plan.** Nonqualified benefits may be offered at the same time as the cafeteria plan – such as group universal life insurance, dependent life insurance, and transportation assistance – but must be outside the cafeteria plan.

(4) **An employer with a flex credit plan permits employees to use flex credits to pay for a number of benefits including dependent life insurance.** Dependent life insurance is not a qualified benefit and may not be included in a cafeteria plan – even on an after-tax basis. Plans that involve credits such as flex or wellness credits may not permit employees to use those credits to purchase any benefits that are not qualified benefits for a cafeteria plan. Employers may communicate these benefits at the same time as the cafeteria plan benefits and may use a common enrollment period. However, these benefits must be after-tax, and the plan communication materials and documents must indicate that these benefits are not part of the cafeteria plan.

SECTION 4 –ELECTION RULES

Cafeteria plan elections are governed by final regulations issued by the Internal Revenue Service in 2001. The IRS rules govern initial elections as well as annual and mid-year changes in those elections. Adhering to the IRS cafeteria plan election rules is critical. Although a mistake or two in administering the program may not create a problem, consistently ignoring or not enforcing the rules could jeopardize the qualified status of the cafeteria plan. This section begins with a review of IRS rules that apply to all elections, followed by a quick look at types of elections, then a summary of rules governing mid-year election changes, and ends with a description of potential problems.

The IRS rules govern the pre-/after-tax element of the employee's benefits selection – such as a choice of medical insurance or cash. Other federal laws – such as HIPAA and QMCSO requirements under ERISA – also have enrollment rules that don't apply to the cafeteria plan, but do affect the benefit plans that are part of the cafeteria plan. For example, HIPAA requires plans to provide special enrollment rights upon the occurrence of certain events such as marriage. HIPAA rules govern only the offer of medical coverage. IRS rules govern the choice between paying for the coverage on a pre- or after-tax basis. Group health plans are required to provide HIPAA special enrollment rights, but there is no requirement that the coverage be provided on a pre-tax basis (although almost all plans do allow for payment on a pre-tax basis).

The IRS 2001 change-in-status regulations include one example that illustrates the IRS's view of the cafeteria plan election rules. They include an example in which an employee has a choice between coverage under a PPO at a cost of $100 per month or an HMO at $140 per month. Mid-year, the employee wants to change from the PPO to the HMO even though he had no change in status that would permit a new election. In the example, the IRS states that while the employee may change his election from the PPO to the HMO he may not change his salary reduction election of $100. He may, however, select the HMO and pay the additional $40 per month on an after-tax basis. (Of course, an employer that wants to permit this change would want to be sure that the insurance carrier also agrees to avoid unintentional self-insurance.)

Tip: Although the IRS would permit this change, the HMO and PPO might have different opinions. The PPO may be willing to permit the employee to terminate coverage during the year. The HMO may not be willing to permit the employee to join mid-year. Employers permitting mid-year changes will want to make sure that both the IRS and carrier rules are satisfied. While not included in the IRS example, the reverse situation does not have such an easy solution. If the individual had purchased HMO coverage at a cost of $140 per month and wanted to change to the PPO at $100 per month (without a change in status that would permit that election), he could be able to change coverage to the PPO, but must continue to pay $140 per month.

Tip: The IRS election rules only apply to cafeteria plans and benefits offered under those cafeteria plans. The IRS rules do not apply to coverage provided outside a cafeteria plan. For example, if employees are permitted to purchase supplemental life insurance solely on an after-tax basis outside of the cafeteria plan, the only election restrictions that apply would be those imposed by the insurance carrier and the employer.

A. General Requirements

In general, cafeteria plan elections may only be **made by participants**, must be in writing, must be made before the period of coverage begins, and must be irrevocable during the period of coverage with certain limited exceptions. Individuals such as spouses who are covered under one of the component benefits offered through the cafeteria plan (such as health insurance) are not permitted to make elections; only participants (i.e., employees) may make elections. Some of those individuals, such as alternate recipients under Qualified Medical Child Support Orders (QMCSOs), may enroll and make elections under one of the component benefit plans such as medical, but they cannot make cafeteria plan elections.

All cafeteria plan elections must be **in writing** – they may be made electronically as long as the IRS rules for electronic elections are followed. In general, the IRS rules provide that the participant must be effectively able to access the electronic system that will be used to make elections and that the system: (1) must be reasonably designed to preclude any other individual from making the election; (2) provide the participant with a reasonable opportunity to review; confirm, modify, or rescind the election before the election is effective; and (3) provide a written confirmation of the election within a reasonable period of time. The confirmation may be provided either electronically or via a paper document. Participants who do not have the ability to effectively access the electronic system must be provided with another method – usually paper enrollment.

IRS rules require cafeteria plan elections to be **prospective** – made before the period of coverage begins – with two exceptions: (1) HIPAA special enrollments in the event of birth or adoption (including placement for adoption) may be retroactive to the date of birth or adoption if made on a timely basis; and (2) elections by newly hired employees during a 30-day window. Employers are permitted to make these two types of elections retroactive on a pre-tax basis.

Elections must be **irrevocable** – the election must remain unchanged during the period of coverage except in specified circumstances where IRS rules permit a change mid-year. The period of coverage is generally the full plan year except for newly eligible employees for whom it will be from the date of eligibility to the end of the plan year. Although IRS rules do not specify the length of time an employee may be given to make his initial cafeteria plan election, employers should limit the amount of time an employee has to complete the election process for several reasons: (1) carrier contracts virtually

always have a maximum time period for enrollment – usually 30 or 31 days; (2) it increases the administrative burden on the HR department since it extends the period of time they may need to track down the employee's form; and (3) while not explicitly stated in the regulations, gaining eligibility for the cafeteria plan year is a mid-year change in status – the employee has changed from ineligible to eligible. As a result, the "on account of" rule used for other mid-year elections would probably apply. Employers will want to coordinate the length of the initial enrollment period with their insurance contracts (including stop loss) and generally should not use a time frame greater than 60 days.

IRS rules generally do not permit periods of coverage that exceed 12 months. Separate dental and vision plans are an exception where the IRS has informally indicated that a longer time frame, such as two years, may be permitted. IRS rules generally do not permit periods of coverage that are less than 12 months. There are a few exceptions:

- A new cafeteria plan where the first plan year will be less than 12 months. For example, an employer with calendar year life, medical, and dental plans adopts a cafeteria plan on July 1. In order to align the cafeteria plan year with the plan year of the benefits that are components of the cafeteria plan, the employer uses July 1 through December 31 for its first cafeteria plan year. For the second and subsequent cafeteria plan years the employer uses January 1 through December 31.
- An employee first becomes eligible to enroll in the cafeteria plan on August 1. If the cafeteria plan uses a calendar year, her first election will be for the period August 1 through December 31.

Special Rule for Rehired Employees

A special rule applies to employees who terminate employment and are later rehired. If the rehire is less than 30 calendar days after the date of termination and the employee has not experienced another change in status (e.g., marriage, divorce) during that time period, the employer has two options: (1) reinstate the employee with the elections he had before he terminated employment for the rest of the plan year, or (2) make the employee wait until the earlier of the beginning of the next plan year or a change in status that would permit a new election. If the employee experiences a change in status that would permit a new election under both the IRS and the cafeteria plan's rules, he may make a new election subject to those rules. If the date of rehire is more than 30 calendar days after the date of termination the employer has three options: (1) reinstate the employee with his previous election; (2) permit the employee to make a new election; or (3) make the employee wait until the earlier of the next plan year or a change in status that would permit a new election.

Tip: Employers will want to coordinate their cafeteria plan rules with insurance carrier(s) rules to avoid discrepancies that may lead to unintentional self-insurance. Employers will also want to be mindful of differences among carrier

rules where more than one carrier is involved (e.g., life, disability, medical, vision, and dental carriers) both to avoid discrepancies and to reduce the administrative burden on HR. There are almost certainly differences in insurance carrier requirements based on type of coverage. For example, life and disability insurance virtually always include requirements, such as actively-at-work, and may also involve evidence of good health or pre-existing condition limitations – something that health plans (other than HIPAA excepted benefits) cannot do. Multiple sets of rules are more likely to result in problems in misunderstandings and mistakes. Similarly employers may want to coordinate the duration of election periods with all of the involved insurance contracts. For example, an employer with multiple carriers and election periods of 30, 31, and 45 days depending on the carrier may want to negotiate to use a 45-day period for all carriers and its cafeteria plan. A common time frame is easier to communicate and administer and reduces the risk of mistakes.

Tip: Employers that are creating or modifying election rules will also want to remember that the rules they select will also apply to COBRA qualified beneficiaries, alternate recipients under a QMCSO, and employees on FMLA.

B. Types of Elections

Currently there are four general types of elections:

- *Affirmative* – the employee makes specific selections. This is the only type of election that can be made for HIPAA special enrollments and election changes mid-year. The initial election is almost always affirmative. Some employers – especially those with more complex plans – require an affirmative election at open enrollment.
- *Negative* – the employer automatically enrolls the employee in a particular option and the employee must make a different election or may "opt-out" if she doesn't want the coverage. For example, the employer might automatically enroll newly eligible employees for employee-only coverage under the medical plan. An employee may choose to opt-out by signing a required form.
- *Default* – a specific selection is assigned if the employee does not make a selection. It is most often used for open enrollment. It can be used for initial enrollment (e.g., if the employee does not complete the election process, he has no coverage), but is probably less prevalent. The most common default election at open enrollment is continuation of the coverage already in effect with one exception. Most employers use a $0 election for FSAs as the default.
- *Evergreen* – after the employee makes an initial election, that election continues unchanged until the employee affirmatively changes it. This is generally used by employers that have a very limited cafeteria plan – for example, the cafeteria plan is limited to an opt-out bonus or just pre-tax contributions.

IRS rules permit evergreen elections so that employers with uncomplicated plans (e.g., pre-tax contributions for medical only) do not need to collect new enrollment forms each year. However, in order to use an evergreen election the employer must communicate with all eligible employees (whether enrolled or not) each year and give them a reasonable opportunity to change their election. As long as the communication is made and employees are permitted to make changes during an annual "enrollment period," the employer is not required to obtain new enrollment forms.

C. Timeframes for Elections

IRS regulations do not include any specific time frame for making elections or for election changes; instead they require that the new election be "on account of" the change in status that makes the new election permissible. HIPAA requires a minimum of 30 days for special enrollments, and enrollments based on loss of Medicaid or SCHIP eligibility (or gain of premium assistance under those programs) must be for at least 60 days. Most employers will use a time period between 30 and 60 days. Election periods greater than 60 days are not recommended because there is a risk that the new election will not be viewed as satisfying the "on account of" rule. Employers should also remember that the time period provided to active employees must also be available to COBRA qualified beneficiaries. More importantly, insurance carriers (or stop loss carriers) may not be willing to use longer time periods.

Employers are permitted to use longer periods – such as 45 or 60 days – but should obtain carrier agreement. Employers may also want to consider the administrative impact of time frames longer than 30 days and differing periods for different carriers or lines of coverage. Increased flexibility often causes increased complexity, which is accompanied by more paperwork and may pose a greater risk of errors. (As noted above, plans must offer HIPAA special enrollments. Employers are permitted, but not required, to allow employees to make the change on a pre-tax basis. Virtually all employers permit a pre-tax election.)

Tip: Most employers will want to limit this time period to no more than 60 days. Although there is nothing in the law or regulations that would prohibit a longer time frame, there are two potential problems. First, the longer the time frame, the greater than likelihood that the election could be challenged as not being made "on account of" the change in status. Second, even if the current medical or stop loss carrier is willing to use a period longer than 60 days, will the employer remember to check with the new medical or stop loss carrier if there is a change in a subsequent year?

D. Critical ACA Requirement

The ACA requires applicable large employers to "offer" coverage that provides minimum value and is affordable or face penalties. In order for an applicable large employer to

satisfy the requirement to make an "offer" of coverage, one of the following requirements must be satisfied:

- The employee must have an effective opportunity to elect to enroll in the coverage at least once with respect to the plan year, or
- The employee has an effective opportunity to decline to enroll if:
  - The coverage offered does not provide minimum value, or
  - The coverage requires an employee contribution for any calendar month of more than 9.78% in 2020 (and indexed in future years) of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year divided by 12.

Whether an employee has an effective opportunity to enroll or to decline to enroll is determined based on all the relevant facts and circumstances, including adequacy of notice of the availability of the offer of coverage, the period of time during which acceptance of the offer of coverage may be made, and any other conditions on the offer. An employee's election of coverage from a prior year that continues for the following plan year, unless the employee affirmatively elects to opt out of the plan, constitutes an offer of coverage for purposes of the employer mandate. Moreover, if an applicable large employer does not offer coverage to a full-time employee for any day of a calendar month, the employer is treated as not having offered coverage during that entire month, subject to two exemptions. First, an employee is treated as having been offered coverage for the entire calendar month in which his or her employment terminates if the employee would have been offered coverage for the entire month if they had not terminated employment. Second, an employer is considered to have offered coverage for a calendar month if the employee's start date is other than is on a date other than the first day of the calendar month.

Tip: Employers that currently use evergreen elections and want to avoid ACA penalties for failure to "offer" medical coverage on an annual basis must obtain a signed coverage waiver every year from employees who have elected no medical coverage.

E. Election Changes during a Period of Coverage (Mid-Year Election Changes)

The IRS rules do not REQUIRE employers to permit ANY election changes during the year. Under IRS rules, employers are free to restrict all enrollments to initial and annual open enrollment. However, the IRS rules only govern the taxable/non-taxable choice, not the underlying health and welfare benefits choice. Other laws, such as HIPAA, have their own requirements that affect the underlying health and welfare benefit plans. Virtually all employers that sponsor cafeteria plans permit an initial enrollment with annual open enrollment and HIPAA special enrollment. Similar to initial

and annual open enrollment, elections must be made in writing and may be made electronically as long as the IRS rules are followed. Unlike other enrollments, mid-year election changes must be affirmative; they can't be default or evergreen.

Employers may permit mid-year election changes under certain circumstances. IRS rules covering when an election change may be made generally fall into one of three categories: (1) a change in status; (2) cost or coverage changes; and (3) other laws or court orders. Each is described briefly below.

Election changes under health plans are also subject to a consistency rule. In general, the consistency rule requires that the individual's change in status (i.e., cost, coverage, court order, other law) must cause an individual to either gain or lose eligibility for coverage and that the election change must correspond with the change in status. For example, in the event of divorce it would be consistent for the employee to drop coverage for the now ex-spouse; it would not be consistent to drop coverage for the employee. The spouse has lost eligibility under the health plan, the employee has not. The rules for other types of coverage such as life and disability insurance are more flexible. For example, in the event of marriage, the employee could either increase or decrease her life insurance coverage.

Change in Status

Before beginning a discussion of the change in status regulations, it may be helpful to repeat some basic concepts that are too often overlooked:

- The IRS change-in-status rules represent a maximum, NOT a minimum (with the exception of HSA changes). Plans may use a less liberal set of rules. ***Plans may NOT use more liberal rules.***
- A change in status ***is <u>not</u> an open enrollment.*** The rules permit certain changes based on the nature of the status change and include a consistency rule. A change in status does not give the employee an opportunity to do what he can do at open enrollment each year (i.e., change any and all of his benefit selections).
- Carrier rules and employer administrative concerns are also important. Breaking a carrier rule may not lead to cafeteria plan disqualification, but it may expose the employer sponsoring the plan to unintentional self-insurance. Ignoring employer administrative concerns and limitations may complicate administration of the plan and can lead to increased potential for mistakes.

The 2001 regulations list five categories of change in status; no other categories of status changes are permitted. Those five categories are:

(1) **Change in legal marital status –** marriage, divorce, legal separation (only in states that recognize legal separation), death of one of the spouses.
(2) **Change in the number of dependents –** birth, adoption, placement for adoption, death.

(3) **Change in employment status –** termination or commencement of employment, beginning or returning from an unpaid leave of absence, or a change in worksite. The change may be in the employment status of the employee, spouse, or dependent, but the change must affect the individual's eligibility.
(4) **Dependent satisfies or ceases to satisfy dependent eligibility requirements –** a child reaches the limiting age.
(5) **Change in residence –** moving outside the service area of a network plan such as an HMO.

Marketplace Enrollment Periods

Cafeteria plans may permit employees to revoke coverage under the employer's medical plan during a Marketplace's annual open enrollment period or in the event the employee becomes eligible for a Marketplace special enrollment. Marketplace special enrollments are similar to HIPAA special enrollments, but include several additional events such as: becoming a citizen, becoming eligible for premium tax credits, or gaining access to new Qualified Health Plans (QHP) as the result of a permanent move. Coverage may be dropped, but not added, and corresponding changes are required (i.e., if the employee drops coverage in the employer's plan, he must enroll in a QHP). Coverage under the QHP must begin the day after coverage under the employer's medical plan ends. (See also IRS Notice 2104-55.)

No change is permitted in an employee's health FSA election.

Reduction in Hours below 30 per Week

In certain circumstances, a cafeteria plan may permit an employee to revoke an election related to medical coverage under the employer's plan if, due to a change in employment, the employee's hours are reduced below 30 per week. Specifically, the employee may revoke medical coverage under the employer's plan if:

- the employee was reasonably expected to average at least 30 hours of service per week and, due to a change in employment status, the employee's hours are reduced so that the employee is expected to average fewer than 30 hours of service per week; and
- the revocation corresponds to the employee's intended enrollment in another plan that provides minimum essential coverage (that is effective no later than the first day of the second month following the month in which the original coverage is revoked).

Note that the reduction in hours need not change the employee's eligibility for coverage.

Enrollment in other minimum essential coverage could include enrollment in another plan by the same employer, another employer's plan, or a Qualified Health Plan through

a Marketplace (if, due to the reduction in hours, the employee is eligible for a special enrollment period to enroll in a QHP and revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee in a QHP through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. See "Marketplace Enrollment Periods" above).

If an employer's cafeteria plan and underlying medical plan permit an election change when hours are reduced below 30 per week, the employee's salary reduction agreement may be changed, coverage may be dropped, but not added, and corresponding changes are required (i.e., the employee must enroll in minimum essential coverage under another medical plan). Coverage under the other medical plan must begin no later than the first day of the second month following the month that includes the date that coverage under the employer's medical plan ends. (See also IRS Notice 2104-55.)

No change is permitted in an employee's health FSA election.

Change in Cost or Coverage

The change in cost or coverage rules permit certain new elections. The rules do not result in an "open enrollment" with the employee able to make a selection from any available option; only certain changes are permitted. *No changes are permitted under a health FSA based on a change in cost or coverage under another plan such as the employer's or spouse's employer's major medical plan.*

Types of changes and permitted elections are:

Change in Cost: If there is an insignificant increase or decrease in costs, the plan may permit an automatic change in employee contributions (the plan document and employee communications should have appropriate language). If there is a significant increase in the cost, the employee may be permitted to either keep the same option and pay the increased cost or select a less expensive option from the same type of coverage. For example, an employer offers three medical options – high, medium and low cost – and the premiums increase for all three options. An employee in the medium option could pay more and stay in the medium option or change to the low cost option. He would not be permitted to switch to the high cost option. If there is a significant decrease in cost, employees already enrolled would be permitted to remain enrolled and pay less. Employees not enrolled may be given an opportunity to enroll.

Change in Coverage – Significant Decrease without "Loss" of Coverage: If there is a significant curtailment of coverage without the "loss" of coverage, the employee may be permitted to select another option. For example, an employer offers a PPO with a $600 deductible and an HMO option. Mid-year the employer increases the deductible

under the PPO plan from $600 to $1,200. Under IRS rules, the employee may be permitted to change from the PPO to the HMO option.

Change in Coverage – Significant Decrease that Constitutes a "Loss" of Coverage: If there is a significant curtailment of coverage that constitutes a loss of coverage, the employee may be permitted to select another option. An example would be the elimination of a benefit option from the employer's program – e.g., the employee offers a choice of PPO 1, PPO 2, and an HMO. If the employer terminates the contract with PPO 2, employees enrolled in PPO 2 would be permitted to change to PPO 1 or the HMO. While employees enrolled in the PPO 2 make a new election, other employees – those enrolled in PPO 1 or the HMO and those not enrolled in medical – may not make an election change. Another example could be a substantial change in the number of network providers under a network-based plan – such as a 50% decrease in the number of acute care hospitals in the network. Although regulations do not define "significant" decrease, the loss of a single provider would not qualify.

Change in Coverage – Significant Improvement or Addition of a New Option: If there is a significant improvement in a benefit plan or the addition of a new option, employees may be permitted to select the improved option (or the new option), but may not make other changes. For example, an employer that currently offers a $1,000 deductible PPO and a $1,500 deductible PPO adds a third PPO that has a $500 deductible. Employees not enrolled may enroll in the new $500 deductible PPO. Employees enrolled in the $1,000 and $1,500 deductible PPOs may change to the $500 PPO, but not make any other change.

If an employer currently offers only medical coverage and decides mid-year to offer dental, all employees may elect dental coverage, but may not make changes in medical coverage or other benefits.

Change in Coverage under another Employer's Plan: Cafeteria plans may permit employees to make a new election if there is a change in coverage under a plan provided by another employer. The other employer could be the spouse's employer or a dependent's employer. The employee's new election must be on account of the change in the other employer's plan and correspond with that change. For example, the employee's plan is calendar year while the spouse's employer uses a July 1 through June 30 plan year. On July 1, the spouse's plan increases the deductible from $1,000 to $2,000. The employee who is covered under the spouse's plan wants to drop that coverage and enroll in the employee's plan, which has a $1,500 deductible. The employee may make a change to drop coverage under the spouse's plan and enroll in his employer's plan. He may not enroll in his employer's plan and keep coverage under the spouse's plan since corresponding changes are required.

The intent of this rule is to permit employees and spouses (or dependents) to make election changes during another plan's open enrollment. Without this rule an employee would only be able to make changes during annual enrollment and would need to either

drop coverage under the spouse's plan on July 1 and have no coverage for six months, or keep coverage under the spouse's plan for an additional year – with double coverage for six months.

Dependent Care FSA Cost or Coverage Changes: Employees may be permitted to change their dependent care FSA elections as the result of a change in the cost or coverage of dependent care. Although the IRS rules are liberal in this area, the change in cost rule is not available if the dependent care provider is related to the employee (e.g., if the care provider is a grandparent).

Other La ws or Court Orders

HIPAA: HIPAA requires a health plan to provide a special enrollment opportunity in the event of marriage, birth, adoption (including placement), loss of other coverage, loss of eligibility for Medicaid or SCHIP, and becoming eligible for premium assistance under Medicaid or SCHIP. A minimum of 60 days is required for changes related to Medicaid or SCHIP; for all other events a minimum of 30 days is required.

Tip: Loss of eligibility for Medicaid or SCHIP permits an employee to enroll in an employer's plan. Gaining eligibility for Medicaid or SCHIP premium assistance also enables an employee to enroll in an employer's plan. However, gaining eligibility for premium assistance under Medicaid or SCHIP does NOT permit an employee to drop coverage under an employer's plan.

Judgments, Decrees or Orders: Generally, employees are permitted to make changes to comply with court orders or judgments. For example, if a divorce decree requires the employee to cover her children under her employer's plan, she may make a new election to enroll those children while her ex-spouse may be able to drop coverage for the children. Note: An employee whose ex-spouse is required to cover the children under a Qualified Medical Child Support Order may not drop coverage until he confirms that his ex-spouse is covering the children.

Entitlement to Medicare or Medicaid or Loss of Eligibility: If the individual becomes covered under Medicare or Medicaid (not just eligible for coverage), he may drop or reduce coverage under the employer's plan. Loss of eligibility for coverage under Medicare or Medicaid would make an employee able to enroll in her employer's plan. The individual must lose eligibility; losing coverage for another reason, such as for not paying any required premium, is not sufficient.

Family and Medical Leave Act (FMLA) Leave: When an employee begins an unpaid FMLA leave, she may drop health coverage (including a health FSA) during the leave and will be permitted to reinstate coverage when she returns from leave. During unpaid FMLA leave, plans may permit employees choosing to continue coverage to select from three methods of payment: pre-pay, pay-as-you-go, and catch-up. Pre-pay and catch-up may be pre-tax, whereas pay-as-you-go must be after-tax. Plans must permit pay-as-

you go. No other changes are permitted unless there is another event that would permit the employee to make a new election, such as the birth of a child.

No election change is permitted during a paid FMLA leave unless there is another event that would permit the employee to make a new election, such as the birth of a child. Note: "Paid" leave is any period during which the employee receives compensation, including a period during which the employee receives short term or long term disability insurance payments, not just wages.

Because health FSAs are health plans, the FMLA rules regarding health plans apply. In general, election changes for a health FSA are **not** permitted during a **paid** leave. Employees may be permitted to cancel health coverage during an **unpaid** FMLA leave. Employers may require employees to continue health coverage during an unpaid leave with no contributions paid during the leave, and the employer may generally recover the contributions after the employee returns from the unpaid leave so long as the employer has provided advance notice that it will recoup the missed payments after leave ends. More detailed rules apply. No other election changes are permitted (e.g., canceling non-health coverage during a paid leave or changing the election amount) unless there is another change in status that would permit a change, such as the birth of a child.

Health Savings Account (HSA) Contributions: Employees must be permitted to change their HSA elections on a monthly basis. The ability to make changes during the plan year is necessary since an employee's HSA eligibility is determined on the first day of each calendar month.

F. Potential Problems

IRS change in status rules are not the only requirements that will affect when, how, and what new elections may be permitted. Insurance carriers virtually always have limitations included in their contracts, and employer administrative concerns may also limit options. Following is a partial list of potential problem areas. The first set represents some general problems; the second set includes specific situations that have surfaced in the past.

General Problems

(1) **Failing to include a default election in the plan.** Without a default election, HR must track down every employee's election. Without a completed election from the employee, the employer will be forced to make an election on the employee's behalf which may be challenged later – by the employee, an insurance carrier, or a judge.
(2) **Treating status changes as open enrollments and permitting employees to choose any option.** IRS restrictions on new elections and carrier rules will limit the options available.

(3) **Following IRS rules for new elections mid-year based on permitted status changes, but not coordinating with insurance carriers (including stop loss carriers).** This could result in unintended self-insuring (or self-insuring without stop loss protection).
(4) **Not following carrier rules for election changes at annual enrollment.** While the IRS may permit a new election to increase life insurance or disability coverage at annual enrollment, the insurance carrier may have additional rules. Life and disability insurance changes may still be subject to underwriting requirements such as actively-at-work and evidence of good health.
(5) **Believing that the IRS rules are a minimum requirement and giving employees all of the IRS options plus additional status changes that are not permitted** (e.g., pregnancy or a change in income). IRS rules are the maximum permissible; employers may be less, but not more, liberal. (The one exception involves HSA contribution changes.)
(6) **Using too many sets of enrollment rules.** An employer with life, disability, medical, dental, and vision plans and separate carriers for each line of coverage may want to negotiate with carriers to use one or two sets of enrollment rules instead of four or five. Employers may use more than one set of rules as long as all of the rules comply with IRS requirements. The greater the number of rules the greater the chance for error. Multiple sets are also harder to communicate effectively, and difficulties may also arise when the employer changes carriers.
(7) **Permitting changes when there is a significant change in cost under another employer's plan (usually the employee's spouse's employer's plan) without defining what is "significant."** The employer may consider a 25% increase as "significant" while the employee views a 5% increase as "significant." Trying to reconcile this mid-year could lead to problems. If this happens consistently and the employer permits election changes based on the employee's definition of "significant," the plan could be viewed as violating the election rules. The solution is to define and communicate what the employer will treat as "significant" before the coverage period begins.
(8) **Permitting changes when there is a significant change in coverage under another employer's plan without defining "significant" change up front.** Similar to cost changes in #6 above, the employer will want to define what is "significant" before employees make elections to avoid misunderstandings mid-year.
(9) **Adopting the most liberal set of change rules that the current carrier will permit without considering what rules other carriers use.** If an employer selects the most flexible rules possible and changes a carrier in the future and the next carrier is not willing to use all of the employer's status change rules, the employer may find itself in a position where it needs to change the rules to be less liberal. The disadvantage is that the revision of the rules could be

perceived as a “take-away” by employees; a result that can be avoided by selecting a set of rules that many different carriers are willing to use.

G. Examples of Specific Problems

(1) **Permitting employees to make a change in their FSA elections when there is a significant change in the coverage or coverage under another plan.** For example:

a. The employer adds a new dental plan. An employee who previously elected $1,200 for his health FSA wants to decrease his FSA election to $600. He had elected $1,200 at the beginning of the year to cover dental expenses he expected to incur during the year. Under IRS rules, he may not change his FSA election under these circumstances.
b. The employer increases the deductible under the medical plan from $600 to $1,200. An employee who had enrolled in the health FSA with a $600 election now wants to enroll to increase her election to $1,200. Under IRS rules, she may not change her election.

(2) **Being more liberal than required for HIPAA special enrollments.** Two examples:

a. An employee with one child – Ann – is not enrolled in the health plan. The employee marries, and his new spouse has two children. HIPAA rules require a special enrollment for the employee, new spouse, and two new stepchildren. Ann does not have a HIPAA special enrollment right. IRS rules would permit the employee to enroll Ann based upon the tagalong rule; however, the insurance carrier’s contract may not permit the employee to add coverage for Ann until annual enrollment. (It’s also unlikely that the carrier would agree to this change.)
b. An employee waived coverage, but did not sign a form stating that other coverage was the reason for the waiver. Two months later in the middle of the year, the employee loses other coverage. If the plan required the written statement, this employee does not have a HIPAA special enrollment right when the other coverage is lost. The employer may permit the employee to enroll – the IRS rules do not require a written statement only the loss of coverage. However, many insurance contracts will require the written statement. Employers that want to eliminate the written statement requirement should obtain written agreement from their insurance carriers.

3. **Permitting new elections based on events that are not permitted by the IRS rules.** Common examples:

    a. An employee just learns that his wife is pregnant and wants to enroll her in the medical plan and increase his health FSA election. Neither election change is permitted. Pregnancy is not included on the IRS change in status list; the change in status will occur when the baby is born.
    b. An employee has just gotten a raise and can afford to purchase a more expensive option because he has more income. A change in earnings is not a change in status that would permit a new election.
    c. An employee who was working 40 hours per week reduces his hours to 30 per week and makes less money. He's still eligible for the same plan at the same cost, but wants to change to a less expensive option. A change in earnings is not a change in status that would permit a new election. (Note: A reduction in hours below 30, as a result of a change in employment status, can be treated as a change in status that would permit an employee to enroll in a Marketplace plan) that provides minimum essential coverage. The employer's cafeteria plan must include this event.)

(4) **The employee provides a copy of a divorce decree that requires the employee to provide health insurance coverage for her ex-spouse.** The employee wants to keep her ex-spouse covered under the plan. Although the divorce decree may require the employee to provide health coverage for her ex-spouse, that coverage cannot be provided on a pre-tax basis unless the ex-spouse is the employee's tax dependent (which is highly unlikely). The employee may be able to satisfy the requirements of the divorce decree by paying the ex-spouse's COBRA premiums on an after-tax basis. The employee may also be able to purchase an individual policy through a Marketplace in order to satisfy the requirements of the divorce decree.

(5) **An employee elects to increase her supplemental life insurance coverage from 1 x salary to 2 x salary in December for a January 1 effective date. The coverage is paid for on a pre-tax basis. Under the insurance carrier's contract, she must provide evidence of good health and be approved** before the increased amount becomes effective. The employer changes the employee's payroll deduction effective January 1 to reflect the higher amount of coverage. The insurance carrier receives her medical information and, based on that information on February 20, declines to increase her life insurance amount; the employee's supplemental life remains at 1 x salary. The employer's plan document should have a provision that automatically adjusts the employee's contribution under these circumstances since the employee would not be permitted to change her

election. *Note: A better practice might be to delay taking the increased deduction until the insurance carrier has approved the increased amount. The employer would also need a provision in the plan document that would automatically adjust the employee's contributions so that the employer could collect contributions beginning on the date the increased coverage is effective.*

(6) **An employee wants to cancel her dental coverage and stop paying $10 per month for the coverage in the middle of the year.** She points to a provision in the insurance carrier's contract that states that coverage may be dropped at any time on a prospective basis. The employee may cancel her dental coverage. However, **she may not cancel her cafeteria plan election** unless she has a change in status that would permit that change under the IRS and the employer's cafeteria plan's rules. In the absence of a change in status, she may cancel dental coverage, but must continue to pay for it.

(7) **An employer with a calendar year plan year has several employees who want to make changes on July 1 based on events that the employees perceive as good reasons for making a change, but which are not on the IRS list of status changes that would permit a new election** (e.g., the employer determines raises for most employees in July). The employer wants to change the plan year so that employees may make changes. The employer would have one plan year from January 1 through June 30 followed by a plan year of July 1 through December 31. IRS regulations permit an employer to change its cafeteria plan year only for a valid business purpose. Changing a plan year to circumvent IRS election rules does not qualify as a valid business purpose.

(8) **A single mother with modest income becomes eligible for SCHIP coverage for her child in the middle of the year on April 1.** She would like to change from employee + child coverage to employee-only coverage and enroll her child in SCHIP on April 1. Although losing eligibility for SCHIP is a status change that would permit the employee to enroll her child in the employer's plan, gaining eligibility for SCHIP does not permit her to drop coverage for her child under the employer's plan.

(9) **An employee with a modest income becomes eligible for SCHIP coverage for his child on May 1.** He wants to change from employee plus child coverage to employee-only coverage on May 1. The employer's cafeteria plan is on a calendar year basis. Since the IRS rules do not permit this change, the employee wants to arrange with the employer to quit on April 30 and be rehired on May 1 so that he may make a new election as a new employee. Although termination of employment and a later rehire may enable the employee to make a new election, he cannot be given a new election when the termination and rehire has been pre-arranged (the IRS final regulations included this as one of the examples).

(10) **A married employee with family coverage reaches age 65 and wants to drop coverage and take Medicare.** However, since his wife is only age

63, employee wants her coverage to continue. Under the IRS rules, this would be permissible. However, virtually all insurance contracts require the employee to be covered in order to cover the employee's spouse or dependents (at least under contracts covering active employees; retiree contracts have different rules). This employee must either continue coverage for both himself and his wife or drop coverage for both himself and his wife.

SECTION 5 –SPECIAL RULES FOR CERTAIN BENEFITS

The rules described in the previous sections apply to all cafeteria plans. There are additional rules that may apply to some component benefits that are included in a cafeteria plan. In this section we summarize the special rules applicable to several types of benefits that are component components of cafeteria plans. Several of the most common component benefits are:

- Short and Long Term Disability
- Health Flexible Spending Accounts (FSAs)
- Dependent Care Flexible Spending Accounts (DCAPs)
- Health Savings Accounts
- Vacation Buy/Sell Programs
- Group Term Life Insurance.

A brief summary of important additional rules applicable to these benefits follows.

Tip: It is important to follow the additional rules for these component benefits. In some cases, not following the rules could jeopardize the favorable tax treatment of the particular benefit. Although a single mistake might not jeopardize the favorable tax treatment of a particular benefit, a consistent disregard for the rules might.

These plans also have common legal requirements such as the need for written plan documents. In addition, many health FSAs and Group Term Life programs will be subject to ERISA requirements. This guide focuses on cafeteria plan requirements.

A. Short and Long Term Disability

There are no additional special rules for short or long term disability plans, but how premiums are paid affects the tax status of any benefits that are received. If the premium is paid by the employer or paid by the employee on a pre-tax basis, any disability benefits paid will be taxable income to the employee. If, on the other hand, the employee pays the premium on an after-tax basis or if the employer pays the premium but includes the amount of premium paid on the employee's Form W-2 as taxable compensation, any disability benefits paid would not be taxable. If the premiums are split with the employer paying some portion and the employee paying the rest, there is a special formula that involves 3-year averaging that must be used to determine what portion of any disability benefits paid is taxable.

B. Health Flexible Spending Accounts

A health FSA must meet the following criteria in order to be considered a HIPAA excepted benefit (and thus not run afoul of ACA limitations on annual dollar limits and preventive service coverage requirements): (1) the maximum annual benefit payable for

an employee under the health FSA must not exceed twice the employee's salary reduction election under the FSA for the year (or, if greater, the amount of the employee's salary reduction under the health FSA for the year plus $500); and (2) the employer must offer other health coverage to the employee that is not limited to "excepted benefits." Prior to the September 2013 ACA guidance on health FSAs and annual dollar limits and preventive services benefits, the disadvantage of not being an "excepted benefit" was primarily that COBRA could not be limited to the end of the plan year. Instead, if the health FSA was not an excepted benefit, COBRA had to be offered for the full 18, 29, or 36 months. ***However, the ACA raised the stakes by adding a $100 per day ($36,500 per year) per person excise tax for a health FSA that is not an excepted benefit.***

There are two design elements that have been common in the past that may cause an FSA to fail to be an "excepted benefit." First, the health FSA maximum exceeds the 2 x the salary reduction amount or if greater the salary deduction amount plus $500 limitation. This is most likely to occur if the employer provides "seed" money into the account, assigns non-cashable credits such as wellness credits to the health FSA, or permits the employee to assign non-cashable flex credits to the health FSA. Cashable credits (i.e., the amount the employee may choose to receive as credits in the form of taxable cash) are treated as salary reduction amounts, which are subject to a $2,750 limit for 2020 (indexed in future years) under the ACA. Second, the FSA is made available to employees who are not eligible for the employer's major medical plan. For example, in the past some employers would permit part-time employees to enroll in the health FSA, but not the major medical plan. Unfortunately, this design makes the FSA fail to satisfy the requirements to be an excepted benefit.

Tip: Wellness rewards that are "credited" to the employee's health FSA may not be called "credits," but they often function in the same way as non-cashable flex credits – i.e., the amount credited is not available to the employee as cash. If the dollar amount of wellness credits allocated to an employee's health FSA goes over the salary reduction + $500 or 2 x salary reduction maximums, the health FSA will no longer be a HIPAA excepted benefit and may be subject to the ACA's $100 per day per person excise tax.

In addition to the cafeteria plan rules and application of the Section 105(h) nondiscrimination requirements (outlined in Section 6), health FSAs are subject to a number of special design restrictions and operational rules.

Design Restrictions

Key design restrictions are the general health care reimbursement rules, limitation on salary reduction contributions, the uniform benefit rule, and a modified use-or-lose rule.

Under the general health reimbursement rules, only qualified health care expenses may be reimbursed by a health FSA. Qualified expenses are generally deductible expenses

(with some exceptions such as insurance premiums which may not be reimbursed from an FSA) for the employee, the employee's spouse, the employee's child (natural, adopted, step, or foster) until the end of the year in which the child reaches age 26, and the employee's tax dependents. Nonqualified health expenses such as cosmetic surgery may not be reimbursed. FSAs may cover all eligible expenses or be limited to only certain types of expenses such as dental and vision expenses. Expenses for an individual who is not the employee, employee's spouse or employee's child, and is not the employee's tax dependent may not be reimbursed. Examples of individuals whose expenses are not eligible are an employee's older child (e.g., age 28) or the employee's domestic partner unless the domestic partner is the employee's tax dependent. Expenses for a domestic partner's children unless adopted by the employee are rarely reimbursable because the domestic partner's child will generally not satisfy the rules to be the employee's qualifying child or qualifying relative under Internal Revenue Code Section 152. IRS Publication 502 contains more detailed information about deductible expenses and qualified individuals.

Under the ACA salary reduction rule, the maximum amount that an employee may contribute to a health FSA is $2,750 per year for 2020 (indexes in future years). This cap does not include employer contributions to the employee's health FSA.

Under the uniform benefit rule, the employee's full annual health FSA election must be available at all times during the plan year. For example, if the employee's election is $2,400 and the employee incurs eligible health expenses of $2,400 during the first month of the plan year, the entire $2,400 must be paid even though the employee's salary reduction amount has only been $200 by the end of the first month.

Prior to 2007, if the amount of claims reimbursed for claims incurred during the plan year was less than the employee's annual election amount, the excess had to be forfeited – the "use-or-lose" rule. Claims could be submitted and reimbursed after the end of the plan year, but the expenses had to be incurred (i.e., health care services received) during the plan year. In 2007, the IRS permitted the addition of a limited grace period – up to 2 ½ months – during which an employee could incur expenses that could be reimbursed from the prior year's health FSA amount. Plan sponsors are free to choose a shorter grace period or no grace period at all. For example, a calendar year cafeteria plan has a 2 ½ month grace period. An employee who elected $1,200 but had incurred claims of only $1,000 during the 2019 calendar year could be reimbursed for up to $200 of expenses incurred during the period January 1, 2020 through March 15, 2020 from her 2019 health FSA. If the employee only incurred $100 of eligible expenses during that period, the remaining $100 would be forfeited.

In October 2013, the IRS issued new guidance that permits a carryover amount of up to $500 for any given year. Under the new rule, an unused amount that previously would have been forfeited at the end of the plan year can be carried forward and used at any time during the next plan year. Unlike the grace period, the employee has 12 months

rather than 2 ½ months to incur eligible expenses. Similar to the grace period, plan sponsors may select a lower (but not higher) carryover amount or no carryover at all. However, plan sponsors must choose either a grace period or a carryover provision; a health FSA may not have both.

Tip: A grace period or carry over provision in a health FSA may affect an employee's ability to establish or contribute to an HSA in the following plan year. See Health Savings Accounts later in this section for more information.

Operational Rules

Key operational rules include the claims substantiation requirement, special rules that apply to an employee on an unpaid FMLA leave, and a requirement to offer COBRA continuation coverage.

Claims Substantiation

First, the health FSA may generally only reimburse expenses incurred during the plan year. If an employee enrolls in a health FSA on January 1, 2020, the plan cannot reimburse expenses from November 2019. Second, health FSAs must substantiate all health care expenses that employees submit for reimbursement before the expenses may be reimbursed. The claims administrator must obtain information from an independent third party describing the service or product, the date of the service or sale, and the amount. The participant must also certify that the expense was not reimbursed, and will not be reimbursed, from any other health plan. All expenses must be substantiated, not just a representative sample, limited number of claims, or claims above a certain dollar amount.

There are also specific rules that apply to FSAs using debit cards for claim reimbursement. Among the permissible substantiation methods for debit card expenses are copayment matches, recurring expenses, and real-time substantiation. In general, the FSA debit card rules limit the places where debit cards may be used and what expenses may be covered for automatic adjudication. For example, an FSA debit card can be used for a copayment at a doctor's office. An FSA debit card can also be used at a pharmacy to pay a $25 copayment for a prescription refill. FSA debit cards may be used to pay for other health care services when the care is received as long as the claim is substantiated after reimbursement has been made. There are specific steps that must be followed to recover amounts paid if the expense is not substantiated.

Health FSAs and F MLA Leave

Two rules apply to employees who choose to cancel health FSA enrollment during an unpaid FMLA leave. First, if an employee cancels his health FSA, any expenses incurred during the leave cannot be reimbursed. Second, an employee must be permitted to reinstate his FSA election when he returns from leave and must be given

the choice to either restore the original maximum or take a pro-rata reduced maximum. For example, if an employee elected $1,200 for the plan year and cancels health FSA participation during a 2 month FMLA leave, she must be permitted to retain the $1,200 maximum (and have higher salary reduction amounts after returning to work) or reduce to $1,000 (10/12 x $1,200).

Tip: Employees may want to continue health FSA participation during an unpaid FMLA leave in order to be eligible to receive reimbursement for expenses incurred during the leave. For example, an employee having a baby may want to be able to obtain reimbursement for the deductible or coinsurance for her hospital stay. She may continue participation by paying contributions on an after-tax basis during the leave, or to the extent permitted by the plan she may pre-pay before the leave begins, or if the plan permits she may make catch-up contributions after she returns from leave on a pre-tax basis.

COBRA

Health FSAs must offer continuation coverage to qualified beneficiaries if there is a qualifying event and the employer is subject to federal COBRA continuation. If a health FSA allows carryovers of unused amounts for non-COBRA beneficiaries, it must also allow carryovers by similarly situated COBRA beneficiaries, subject to the same terms. However, the health FSA is not required to allow a COBRA beneficiary to elect additional salary reduction amounts or to have access to any employer contributions to the health FSA during the carryover period. Any health FSA carryover amount is included in determining the amount that a qualified beneficiary may receive during the remainder of the plan year of a qualifying event. The maximum cost of COBRA continuation coverage on a health FSA (that is,102% of the applicable premium) does not include unused amounts carried over from prior years. The applicable premium is based solely on the sum of the employee's salary reduction election for the year plus any non-elective employer contribution. However, a health FSA may limit carryovers of unused amounts (subject to the $500 limit) to individuals who have elected to participate in the health FSA in the next year, even if continued participation requires a minimum salary reduction election to the health FSA for that next year. Moreover, the health FSA may limit carryovers of unused amounts to a maximum period (subject to the $500 limit), such as one year. The IRS does not specifically indicate if the requirement to enroll in the upcoming plan year may be applied only to employees or if it may be applied to both employees and COBRA qualified beneficiaries. The guidance states that if the plan permits carryovers for non-COBRA beneficiaries, then it must permit carryovers for COBRA beneficiaries "subject to the same terms applicable with respect to non-COBRA beneficiaries." This statement would seem to imply that COBRA qualified beneficiaries must also satisfy any minimum contribution requirement, which would make COBRA less attractive, because the qualified beneficiaries must generally pay 102% of the premium payments on an after-tax basis. Clarification on this point would be welcome.

Since a health FSA that is not a HIPAA excepted benefit will violate the ACA and subject the plan sponsor to a potential penalty of $100 per person per day, virtually all health FSAs will be HIPAA excepted benefits going forward.

C. Dependent Care Flexible Spending Accounts

Most employers that offer a dependent care assistance program do so through an FSA. An employee can use a dependent care FSA (DCAP) to be reimbursed for employment-related expenses that allow the employee and his or her spouse to be gainfully employed. Typical dependent care expenses are those incurred to have a babysitter or day-care provider take care of an employee's child under the age of 13, while both parents are working, or taking care of a spouse or other tax dependent who is incapable of self-care. Most employees pay the cost of a DCAP via salary reduction. Some employers may make matching contributions that the employee can apply toward expenses. Under plans that use flex credits, employees may be able to apply flex credits toward the DCAP.

There is a statutory limit on the amount of expenses that can be paid under a DCAP. The limit is calculated on a calendar-year basis (not the plan year) and is equal to the smallest of the following amounts:

- $5,000 (if the employee is married and filing a joint return or is a single parent);
- $2,500 (if the employee is married but filing separately);
- The employee's earned income; or
- The spouse's earned income (if the employee is married at the end of the taxable year).

If a spouse is not gainfully employed because he or she is a full-time student or is incapable of self-care, then the spouse will be deemed to have an income of $250 per month for one qualifying individual or $500 per month for two or more qualifying individuals. These dollar limits are set by the statute and are not indexed each year.[7]

Amounts unused by the end of the plan year must be forfeited under the "use-or-lose" rule. Unlike health FSAs, which may permit a carryover of up to $500, unused amounts from a DCAP cannot be carried forward to the next plan year. The plan may, however, include a grace period of up to 2 ½ months. Further, unlike a health FSA (in which the entire year's election is immediately available), only the amount actually taken out in salary reduction is required to be available for reimbursement.

DCAPS are also subject to nondiscrimination requirements. Section 6 contains a summary of those requirements.

[7] Certain individuals may be able to take a dependent day care credit on their income tax forms. The dollar maximums for the tax credit are different than the FSA maximums.

Eligible Expenses

Expenses are employment-related if they satisfy two tests. First, the employee must incur the expense to allow the employee, and the employee's spouse, to be "gainfully employed." Second, the expenses must be for the care of one or more "qualifying individuals."

Whether expenses are incurred to allow someone to be gainfully employed generally is determined on a daily basis, although there are limited exceptions for certain short, temporary absences from work and part-time employment. Expenses can also be reimbursed if they are incurred while someone is looking for work or in order to be self-employed. Generally, a married employee can only be reimbursed for expenses if his or her spouse is also working or looking for work. A spouse is also considered to be gainfully employed, however, for any month that he or she is a full-time student or is mentally or physically incapable of self-care.

Expenses must be for the care of a qualifying individual. Generally, a qualifying individual is either: (a) a child of the employee who is under age 13 and is the employee's tax dependent; or (b) a spouse or tax dependent that is physically or mentally incapable of self-care. A qualifying individual must have the same principal place of abode as the employee for more than half the year. A special rule for children of divorced or separated parents treats a child who is under age 13 or physically or mentally incapable of self-care as a qualifying individual with respect to the custodial parent even when the noncustodial parent can claim the child as a tax dependent or pays for the child's care.

Tip: The care must be for the employee's child. Care for the employee's domestic partner's child would not be a qualifying expense even if the care is needed to enable the employee and domestic partner to work.

The care provided must be for the qualifying individual's well-being and protection. Generally, amounts paid for education, food, and clothing are not expenses paid for care. But, if an expense for care also covers other services that are incidental to and inseparably a part of the care, then the entire amount is considered to be for care. For example, bills from a day-care center that provides meals in addition to child care would be reimbursable if the cost of the food could not be separated from the cost of care.

Some expenses are not reimbursable. For example, expenses for services provided outside an employee's home by a dependent care center that does not comply with applicable state and local law cannot be reimbursed. A plan may not reimburse dependent care payments made to: (a) an employee's child who is under age 19; (b) someone for whom the employee (or the employee's spouse) can claim a dependency exemption; (c) the employee's spouse; or (d) the child's parent (if the child is under age 13). Any payments for care outside the employee's household of a qualifying individual who is incapable of self-care (other than a child of the employee who is under age 13)

generally cannot be reimbursed unless the qualifying individual regularly spends at least eight hours each day in the employee's household.

Tip: Expenses for kindergarten and overnight camps may not be reimbursed by a DCAP.

D. Substantiation of DCAP Expenses

Cafeteria plans are required to substantiate all expenses that employees incur for dependent care under a DCAP during the plan year before those expenses may be reimbursed. All expenses must be substantiated, not just a representative sample, limited number of claims, or claims above a certain dollar amount.

An employer may use a debit card program under the DCAP to provide reimbursement. However, dependent care expenses may not be reimbursed before the expenses are incurred. If a dependent care provider requires payment before the dependent care services are provided, those expenses cannot be reimbursed at the time of payment. The employee must pay the expense and seek reimbursement after the care has been provided.

E. Health Savings Accounts[8]

Health savings accounts may be included under a cafeteria plan and are subject to all of the cafeteria plan rules with one major exception. An employee's HSA election may not be irrevocable for the entire plan year. Instead, employees must be permitted to change HSA elections at least monthly on a prospective basis for any reason.

Eligible expenses under a health savings account are different from health plans and health FSAs. Health plans, including health FSAs, may reimburse expenses on a tax-free basis for the employee's natural, adopted, step, or foster child until the end of the calendar year in which the child attains age 26 – even if the child is not the employee's tax dependent. Although the ACA modified the definition of a "dependent" child for health plans, it did **not** modify the definition for health savings accounts. As a result, only expenses from the employee, employee's spouse, and employee's tax dependents are qualified expenses under an HSA. In order to reimburse on a tax-free basis, the employee's child must be either a "qualifying child" or a "qualifying relative" as defined in Internal Revenue Code Section 152.

Tip: Expenses of the employee's domestic partner's child(ren) generally are not qualified expenses since the child would almost never be the employee's tax dependent (i.e., qualifying child or qualifying relative).

8 Our HSA Design Guide provides more detailed information about the rules applicable to HSAs.

FSA and HSA Eligibility

Individuals that are "covered" under a health FSA are not also eligible to contribute to an HSA during the same plan year unless the FSA is an HSA-compatible FSA, such as a limited purpose FSA that only reimburses dental and vision expenses or an FSA that only reimburses expenses that exceed the statutory deductible for a qualified High Deductible Health Plan (for 2020, $1,400 for self-only coverage and $2,800 for family coverage). Individuals who are covered under a health FSA with a grace period may have a delay in their ability to establish or contribute to an HSA in the following plan year. For example, if an individual participated in a health FSA in 2019 that had a grace period of 2 ½ months, he would be able to incur health expenses until March 15, 2020 and have those reimbursed from his 2019 health FSA. Because he has "coverage" under the health FSA during the period January 1, 2020 through March 15, 2020, he would not be HSA eligible until April 1, 2020, and his maximum HSA contribution for 2020 would be based on 9 months rather than 12 months. There is one exception to this rule – when an employee has a $0 balance on a cash basis in his FSA on the last day of the plan year. In our example, if the employee had a $0 cash balance in his FSA on December 31, 2019, he may contribute to an HSA on January 1, 2020. The $0 cash balance means that the FSA has already reimbursed him for the maximum amount. Claims that have not been submitted or that have been submitted, but not yet paid, cannot be taken into consideration. If the employee has a balance of $100 on December 26 and submits reimbursable claims of $150 on December 29, but those claims are not processed and paid until January 2, he does not have the requisite $0 cash balance on December 31, and he will not be HSA eligible until April 1.

The IRS issued guidance in October 2013 permitting up to $500 to be carried over from one plan year to the next. Individuals who are covered (i.e., whose expenses could be reimbursed by a health FSA that is not HSA-compatible) are not eligible to establish or contribute to an HSA, even if they are covered by the general purpose FSA solely due to a carryover of unused amount from the previous year. This ban on contributions to an HSA applies to the entire plan year, even for months in the plan year when the health FSA no longer has funds available to pay or reimburse health expenses. For example, if an employee under a calendar year FSA had a balance of $100 on December 31, 2018 that carried forward to 2019, she is not eligible to establish or contribute to an HSA for all of calendar year 2019 even if she exhausted the $100 carry over in January 2019.

Plan sponsors may, however, elect to have any unused amounts in the general purpose health FSA carried over to an HSA-compatible FSA. There is no requirement that amounts from a general purpose FSA go to another general purpose FSA; however, any unused amounts cannot be carried over to a non-health FSA or another type of cafeteria plan benefit. Employees that elect to have unused amounts carried over to an HSA-compatible FSA, such as an FSA that reimburses only dental and vision expenses, are permitted to contribute to an HSA during the following year. The election to carry over to the HSA-compatible FSA must be made before the end of the plan year from

which funds are to be carried over. The plan document and employee communications must contain applicable language.

A cafeteria plan is permitted to allow employees that participate in a general purpose health FSA with a carryover to decline or waive the carryover prior to the beginning of the following plan year. These individuals would then be permitted to contribute to an HSA for the following year (assuming the employee is otherwise HSA eligible).

Employers may also be written to automatically enroll employees in an HSA-compatible FSA and carry over unused amounts from the general purpose FSA (up to $500) if the employee elects to enroll in a high-deductible health plan with an HSA for the upcoming year.

Tip: Individuals who are "covered" under a health FSA are not limited to the employee who enrolled. Almost all health FSAs permit reimbursement of qualified expenses from the employee, employee's spouse, or the employee's child to the end of the year in which the child reaches age 26 and the employee's tax dependents. All of these individuals will be HSA ineligible even if the individual attempts to "waive coverage" by agreeing in writing not to submit claims. In order to be HSA eligible, these individuals must be not "covered" under the plan (i.e., under the terms of the health FSA, their expenses are not eligible for reimbursement).

F. Vacation Buy/Sell Plans

Vacation buy/sell plans that permit purchase or sale of days (or partial days) may be included under a cafeteria plan.[9] Inclusion of vacation purchase or sale may be more common under plans using flex credits because employees may be able to use credits to purchase more time off or can sell days and receive credits that may be used to pay contributions or purchase more or more expensive benefits. Employees may be permitted to purchase or sell additional days via salary reduction, but only future, unearned vacation days can be bought or sold under a cafeteria plan. Generally, an employee makes an election to purchase or sell a specified number of days for the next year during open enrollment. The employee selling days is usually permitted to either take the dollar value of the days sold and apply it to non-taxable benefits or take the amount as taxable cash. If an employee elects to use the dollar value of days sold to purchase non-taxable benefits, such as by making contributions to a health and/or dependent care FSA, the dollar amount spent on non-taxable benefits will not be taxed as income as long as the IRS rules are followed.

[9] A vacation plan arrangement that permits employees to cash out accrued vacation days that is **not** part of a cafeteria plan would trigger taxable income for all employees – including those who do not elect cash outs. An arrangement that permits carry over, but no cash out, does not generate taxable income until the year in which the vacation is taken.

Under IRS regulations, purchased vacation days are called “elective days.” Regulations prohibit the carry forward of unused elective days and require that elective days be used **last**. For example, an employer gives all employees 10 vacation days each calendar year and permits employees to purchase up to 5 additional days. One employee purchases an additional 5 days. She now has 15 vacation days (10 non-elective and 5 elective). If she takes 12 vacation days she will have used 10 non-elective and 2 elective days. The remaining 3 elective days must either be cashed out before the end of the year or forfeited at the end of the year. There is no grace period for unused elective days.

Note: This guide only covers federal rules for vacation days purchased or sold under a cafeteria plan. It does not cover arrangements outside of a cafeteria plan. Nor does it include any state laws such as payroll laws that may place restrictions on these plans.

G. Group Term Life Insurance

Group term life insurance on employees that is subject to Internal Revenue Code Section 79 is the only type of life insurance that may be included in a cafeteria plan. Insurance on individuals other than the employee (or former employee) such as coverage for a spouse or child may not be provided under a cafeteria plan. Other types of life insurance such as group universal life and split dollar insurance may not be offered under a cafeteria plan.

Tip: Employers are not required to conduct a separate enrollment just for dependent or group universal life insurance. However, contributions must be after-tax, and all cafeteria plan documents and enrollment materials must make it clear that the group universal and/or dependent life insurance is not part of the cafeteria plan.

Imputed Income

Many employers provide some level of basic life insurance to employees, such as a flat dollar amount or a multiple of compensation and permit employees to purchase additional amounts of group term life insurance. As an example, an employer might provide employees with basic group term life insurance coverage of 1 x compensation and permit employees to purchase supplemental coverage of 1, 2, or 3 x compensation. If employees purchase supplemental coverage on a pre-tax basis, the supplemental coverage is considered to be employer-provided and amounts over $50,000 (all amounts – basic plus supplemental combined) create imputed income. If, for example, an employee earning $30,000 selects supplemental coverage of 2 x compensation, her total coverage would be $90,000 ($30,000 basic plus $60,000 supplemental) and imputed income must be calculated on $40,000 ($90,000 minus the $50,000 exclusion amount).

Offering supplemental coverage on a pre-tax basis may be advantageous to some employees, particularly if the employer-provided basic life insurance is a modest amount. For example, if the basic life insurance is $10,000, an employee earning $20,000 per year could purchase up to 2 x compensation on a pre-tax basis with no imputed income since his basic and supplemental life insurance would not exceed the $50,000 exclusion amount. An employee earning $40,000 per year could purchase 1 x compensation with no imputed income. The disadvantage of pre-tax payment of premiums is that for employees who select higher amounts (and/or earn more) the employer may need to explain why the coverage the employee paid the full premium for is now "employer-paid" and generates taxable income for the employee. For example, if an employer provides basic coverage of $10,000 and an employee earning $50,000 purchases 3 x compensation coverage, his total life insurance coverage will be $160,000 ($10,000 basic plus $150,000 supplemental). If he pays for $150,000 of coverage on a pre-tax basis and he will have imputed income calculated on the value of $110,000 of coverage ($160,000 total minus the $50,000 exclusion amount).

If, on the other hand, the employee pays the full premium cost for his coverage on an after-tax basis, then only the basic employer paid coverage would be subject to imputed income. In the example above, the employee would not have any amount subject to imputed income because his $10,000 basic amount is less than the $50,000 exclusion and he has paid for the additional life insurance coverage with after-tax dollars. There is one exception to this rule – when the premium rates charged employees "straddle" IRS Table I rates. The rates "straddle" Table I if one employee pays more than the Table I rate and another employee pays less than the Table I rate. For example, the Table I rates at ages 40 and 50 are $0.10 and $0.23 respectively. If the insurance carrier's premium rates are $0.09 at age 40 and $0.25 at age 50, the premium rates are straddling the Table I rates since a 40 year old employee will be paying less than the Table I cost and a 50 year old employee will be paying more than the Table I cost. The result is that all amounts of supplemental life insurance are treated as employer-provided. The amount of imputed income may be small since the employee's after-tax contribution would be subtracted from the Table I cost to determine the amount of imputed income. For example, if the 40 year old has $100,000 of coverage ($50,000 basic plus $50,000 supplemental), his imputed income would be calculated using $50,000 and the Table I rate of $0.10 or $10 per month ($120 per year). However, his after-tax contributions may be subtracted so that the amount that shows on his Form W-2 will be $12 per year ($10 per month Table I cost minus his contributions of $9 per month). Many employers that offer supplemental coverage on an after-tax basis do so in order to avoid generating imputed income for employee-paid life insurance.

Tip: If the cost of coverage will be paid 100% by employees on an after-tax basis it is important to make sure that the insurance carrier's premium rates do not straddle Table I. Insurance companies determine premium rates based on actuarial calculations; they may not take Table I into consideration when setting those rates. It will be up to the employer to monitor how the insurance carrier's

rates compare to the IRS rates. Charging employee premiums on an after-tax basis using premium rates that do not straddle Table I avoids the need to impute income for coverage where employees are paying the full premium cost.

H. Potential Problems

Following is a short description of a number of potential problems organized by type of special plan. These are just samples of some common problems we have seen.

Health FSA

(1) **An employer seeds FSA accounts with wellness credits of $300 for single employees and $600 for married employees.** This arrangement will exceed the maximum amount permitted for the FSA to be a HIPAA excepted benefit if any employee who receives $600 in credits selects a salary reduction amount less than $100.

(2) **An employer limits eligibility for its major medical plan to full-time employees defined as those working 30 hours or more.** Part-time employees working at least 20 hours per week are permitted to enroll in the employer's health FSA. This FSA is not a HIPAA excepted benefit. (Current guidance does not indicate if the $100 per day would apply only to the part-time employees or to all employees under the FSA.)

(3) **Employees have FSA debit cards that may be swiped to pay health care expenses when received.** The store where an employee swipes his card has a pharmacy, but it also sells other items such as clothing and groceries. The $95 dollar amount swiped does not match the $20/$40 drug copays under the plan. The plan requires after-the-fact claim substantiation which the employee doesn't provide. The employer doesn't follow up and request repayment of the $95. Since the employee didn't provide the needed substantiation, the employer adds $95 to the employee's Form W-2 as taxable income. This employer has not satisfied the claim substantiation rules since it did not attempt to recover the $95 by following the required steps.

(4) **An employee enrolls herself, her domestic partner, and her domestic partner's daughter (whom the employee has not adopted) in the employer's major medical plan and makes a $1,000 salary reduction election for a health FSA.** Mid-year, the domestic partner's daughter has a minor illness that results in several doctor's office visits and two prescriptions. Since the amounts are small and below the major medical plan's deductible, the employee submits the expenses for reimbursement under the health FSA. Unfortunately, unless the child is also the employee's tax dependent, the FSA cannot reimburse her expenses. In virtually all cases, the child will be a qualifying child of the domestic partner rather than the employee. Nor will the child be the employee's qualifying relative because one of the requirements for being a qualifying relative of the employee is that child cannot be someone

else's qualifying child. Note: The major medical plan can pay expenses for the domestic partner's daughter as long as the premium for major medical coverage for the child is included on the employee's Form W-2 as taxable income.

Dependent Care FSA

(1) **A dependent care provider requires payment of the $300 per week on Monday morning at the beginning of each week.** The employee must pay the provider each Monday for care that is to be provided during that week. The employee requests reimbursement on Monday afternoon for the expense for the upcoming week and the employer agrees. The employer has violated the claim reimbursement rules since the plan is not permitted to reimburse expenses until after the care has been provided, even if the employee is required to pay upfront.

(2) **An employee enrolls in the Dependent Care FSA to get reimbursed pre-tax for dependent care expenses so she and her domestic partner can both work full-time.** The child is the domestic partner's child and the employee has not adopted the child. It is unlikely that this child's expenses would be qualified except in very limited circumstances. The child is not the employee's "qualifying child" since he is not the employee's child and is unlikely to be the employee's qualifying relative since once of the requirements for qualifying relative is that the individual not be someone else's qualifying child. In this case the child would be the qualifying child of the domestic partner. The plan would almost certainly not be permitted to pay these expenses.

(3) **An employee and spouse are divorced, and under the divorce settlement, the spouse has custody of the child. The employee is required to pay the cost of dependent care and may include the child as a tax dependent on his federal income tax form.** The employee wants to use the dependent care FSA to pay dependent care expenses on a pre-tax basis. Unfortunately, the employee's dependent care FSA may not reimburse these expenses because the employee does not have custody of the child. Because the employee does not have custody, the dependent expenses are not required to enable the employee to work (they are incurred to enable the ex-spouse to work). Neither can the ex-spouse seek reimbursement through a dependent care FSA through his/her employer because the ex-spouse is not paying the cost of the care.

Health Savings Account

(1) **An employee enrolled in a calendar year cafeteria plan wants to stop his pre-tax HSA election prospectively on July 1.** His wife changed from full-time to part-time so they have a lower income and want to increase the

employee's take-home pay by eliminating the HSA deduction. The employer refuses to let the employee make a new election because he has not experienced a status change. Although the employee has not experienced a change in status that would permit a new cafeteria plan election, employees must be permitted to make monthly changes in their HSA elections under the IRS rules. This employee must be permitted to change his pre-tax HSA election as of July 1.

(2) **An employer provides wellness credits of $300 for single employees and $600 for married employees if the spouse also participates in the wellness program.** The employer does not want to give taxable cash and understands that putting more than $500 into a health FSA could create a problem. The employer decides to deposit the funds into an employee's HSA account on a pre-tax basis. Although the employer may place funds into an employee's HSA account, there are potential problems if the employee does not have an HSA or if the employee is HSA ineligible (e.g., because the employee is covered under her spouse's general purpose health FSA).

(3) **An employee who covers his 25-year-old son under the employer's medical plan wants to pay medical expenses for his son that were not reimbursed under the employer's major medical plan from his HSA on a pre-tax basis.** Unless the son satisfies the requirements to be the employee's tax dependent as a "qualifying relative," reimbursement of medical expenses from the employee's HSA will be a non-qualified distribution subject to federal income tax and a 20% penalty. *(In contrast, the son's expenses are eligible expenses under both the major medical plan and under the employee's health FSA.)*

(4) **The employer amends its calendar year health FSA to add a $500 carryover amount.** In year 1, an employee enrolls in the health FSA and elects $1,200. At the end of the year she has $200 remaining that is carried forward to year 2 since she did not waive the carryover before the beginning of year 2. She signs up for a high deductible health plan for year 2. She incurs $200 of expenses and submits a claim in February of year 2 and has a zero balance in her FSA on March 1 of year 2. She wants to contribute to an HSA starting on March 1. Unfortunately, based on current IRS guidance she will not be eligible to contribute to an HSA until year 3.

Vacation Buy/Sell Plan

(1) **An employer provides employees with 10 days of paid vacation each year. Any unused vacation days at the end of the year carry forward to the next year.** Because some employees would like to have more vacation time, the employer implements a vacation purchase option under its cafeteria plan and permits employees to buy an additional 1, 2, or 3 days. One employee purchases an additional 2 days for a total of 12 days. The employee is unable to use all 12 days during the year because of a

scheduling problem. The employee uses 9 days and wants to carry forward 3 days to the next year. Under IRS rules elective days are used last and must be either paid out before the end of the year or forfeited. This employee may only carry forward 1 non-elective day. The 2 non-elective days must either be cashed out before the end of the year or forfeited.

Group Term Life Insurance

(1) **An employer provides basic life insurance equal to 1 times compensation and permits employees to buy additional coverage of 1 or 2 times compensation on a pre-tax basis.** For this additional coverage, 100% of the premium is paid by the employee on a pre-tax basis. Because employees paid the full premium, the employer does not include the additional life insurance amounts when it calculates Section 79 imputed income. Although employees paid the full cost of the coverage, because premiums were paid on a pre-tax basis, the amounts are considered to be employer-provided and must be included when calculating imputed income.

SECTION 6 –NONDISCRIMINATION REQUIREMENTS

Cafeteria plans are not permitted to discriminate in favor of highly compensated or key employees. Highly compensated employees are generally officers, shareholders with more than 5% ownership, and employees earning more than a specified dollar amount - $125,000 in 2019 and $130,000 in 2020 - and the spouse or tax dependent of one of these individuals. Key employees are generally officers with annual compensation in excess of a specified dollar amount $180,000 in 2019 and $185,000 in 2020, a 5% owner, and a 1% owner with annual compensation from the employer of more than $150,000.

Plans are prohibited from discriminating with respect to eligibility to participate, contributions and benefits, and "utilization." Utilization in this context refers to benefit elections, not claims paid. More detailed definitions of highly compensated and key employees are contained in the Appendix.

The penalty for failing the nondiscrimination requirements is NOT disqualification of the entire cafeteria plan. Although the cafeteria plan does not lose qualified status, highly compensated, key employers and/or key employees may lose some or all of the tax benefits of the cafeteria plan. The impact depends on which rule is not satisfied. Non-key and non-highly compensated employees are unaffected.

A. Cafeteria Plan Nondiscrimination Rules

There are several general nondiscrimination rules that are applicable to all cafeteria plans. First, the controlled group rules under Internal Revenue Code Sections 414 (b), (c), and (m) apply. In determining whether a cafeteria plan is discriminatory in regard to contributions or benefits (or in regard to coverage); all employees who are employed by a commonly controlled group of businesses are treated as if they were employed by a single employer. For this purpose, the single-employer aggregation rule also applies to affiliated service groups. Second, nondiscrimination testing must be performed as of the last day of the plan year, taking into account all non-excludable employees who were employees on any day during the plan year. Third, there is a special rule for union plans. A cafeteria plan maintained under an agreement that is found to be a collective bargaining agreement between employee representatives and one or more employers is not discriminatory (i.e., a union only plan).

Cafeteria plans that are limited to pre-tax contributions for health and disability benefits are required to satisfy two nondiscrimination requirements: (1) the plan does not discriminate in terms of eligibility to participate, and (2) is nondiscriminatory in operation. An example included in the 2007 proposed regulations seems to suggest that the eligibility test includes a benefits component. In the example, all employees are able to elect the same salary reduction amount or same percentage of the premium for self-only coverage or family coverage. Only cafeteria plans that are limited to pre-tax

contributions for health and/or pre-tax contributions for disability benefits may use this method. All other cafeteria plans must satisfy four nondiscrimination requirements: (1) eligibility to participate, (2) contributions and benefits, (3) key employee concentration test, and (4) nondiscrimination in operation. A short description of each of these requirements follows.

Caution: Cafeteria plans that include opt-out bonuses, pre-tax life insurance, or FSAs are required to satisfy all four requirements. Even though a cafeteria plan that includes just an opt-out bonus (i.e., a plan gives employees a choice between $1,500 in cash or medical coverage with no other benefits such as pre-tax contributions for coverage or an FSA) which is the least complicated type of cafeteria plan, it must satisfy all four nondiscrimination requirements.

"Simple" cafeteria plans are new plans that were created by the ACA. They have specific, less flexible rules that must be followed and are generally considered to satisfy the nondiscrimination tests as long as the plan satisfies the Simple cafeteria plan requirements with respect to employer size, eligibility, contributions, and benefits rules. They are only available to employers with 100 or fewer employees. Unfortunately, the Internal Revenue Service has not yet issued any guidance with respect to Simple cafeteria plans.

B. Open Issues

There are still a number of open questions about the nondiscrimination rules and testing process.

- The 2007 regulations do not provide any guidance on the question of when and how plans might be aggregated for nondiscrimination testing.
- No regulations have been provided for Simple cafeteria plans leaving many open questions such as what employees must be counted to determine if the employer has 100 or fewer employees.
- Nondiscrimination rules for fully insured health plans have not yet been issued. This requirement has been delayed pending release of regulations.
- How to determine what is the controlled group when the employer is a nonfederal government entity is unanswered.

There are also open issues under Internal Revenue Code Sections 105(h) (governing self-insured health plans) and 129 (covering dependent care FSA plans).

C. Eligibility

A cafeteria plan must not discriminate in favor of highly compensated individuals as to eligibility to participate. A cafeteria plan does not discriminate in favor of highly compensated individuals if: (1) the plan benefits a group of employees who qualify under a reasonable classification established by the employer (e.g., all full-time

employees), and (2) a comparison of the percentage of highly compensated and the percentage of non-highly compensated eligible employees satisfies the safe/unsafe harbor percentage test.

Excludable Employees

Certain employees are excluded when performing the eligibility test:

- Employees (except key employees) covered by a collectively bargained plan where cafeteria plan benefits were the subject of collective bargaining;
- Employees who are nonresident aliens and receive no earned income; and
- Employees participating in the cafeteria plan under a COBRA continuation provision.

Tip: Only the above categories of employees are excluded when performing the cafeteria plan eligibility test. Employees such as temporary, seasonal, leased, and part-time must be included. In addition, employees who have not yet satisfied the cafeteria plan's service requirement must also be included.

The chart below contains the safe/unsafe harbor values for selected levels of non-highly compensated individual concentration (the complete chart is contained in the Appendix). An example of a safe/unsafe harbor calculation is provided below.

Concentration of non- highly compensated individuals	Safe Harbor Percentage	Unsafe Harbor Percentage
Up to 60%	50.00	40.00
65	46.25	36.25
70	42.50	32.50
75	38.75	28.75
80	35.00	25.00
85	31.25	21.25
90	27.50	20.00
95	23.75	20.00

A plan at or above the safe harbor percentage passes the eligibility test. A plan that falls at or below the unsafe harbor percentage fails the eligibility test. A plan that has a

percentage between the safe and unsafe harbor percentages may be able to pass depending on facts and circumstances.

The general rule for the safe harbor percentage is: (1) if 50% or more of non-excludable non-HCIs are eligible, then the plan passes; (2) if fewer than 20% of non-excludable non-HCIs are eligible, then the plan fails; and (3) if the testing shows that the concentration is between the 20% and 50% Safe Harbor percentages, then the plan may pass depending on: (a) the concentration of non-HCIs; and (b) the comparison of percentage of eligible non-HCIs to percentage of eligible HCIs . There are six steps to conducting the safe harbor percentage test:

D. Safe Harbor Percentage Numeric Test - Six Steps:

1. Determine the number of non-excludable employees
2. Determine the Non-HCI concentration percentage
3. Determine the percentage of non-HCI eligible to participate
4. Determine the percentage of HCI eligible to participate
5. Find the ratio of non-HCI to HCI percentages [Step (3) ÷ Step (4)]
6. Compare to safe/unsafe harbors in 410(b) chart shown above

Example: Assume that all full-time employees are eligible to participate in the cafeteria plan, that part-time and seasonal employees are not eligible to participate, and that the plan does not have a service requirement. Also assume the following.

Number of Non-HCI Employees

- 950 Full-time (30 hrs)
- 300 Part-time (20 hrs)
- 50 Seasonal (3 mos)
- **1,300 Total**

Number of Highly Compensated Individuals

- 29 Officers
- 1 Five percent shareholder
- 65 Earning > $120k

- 5 Spouses/deps of HCIs (who work part-time)
- **100 Total**

Step 1: Determination of number of non-excludable employees:

Non-HCIs = 1,300

- 950 Full-time
- 300 Part-time
- 50 Seasonal
- Excludable = 0
- Non-excludable = **1,300**

Step 2: Determination of the non-HCI concentration percentage:

- Non-excludable HCIs = 100
- Non-excludable non-HCIs = 1,300
- Total non-excludable = 1,400
- Concentration percentage =1,300 non-excludable non-HCIs ÷ 1,400 total non-excludable = **93%**

Step 3: Determination of the percentage of non-HCIs eligible to participate:

- 1,300 non-excludable non-HCIs
- 350 ineligible (300 PT + 50 Seasonal)
- 950 eligible
- Percentage eligible = 950/1,300 = **73.1%**

Step 4: Determination of the percentage of HCIs eligible to participate:

- 100 non-excludable HCIs
- 5 ineligible (PT. spouses, dependents)
- 95 eligible

- Percentage eligible = 95/100 = **95%**

Step 5: Find the ratio of non-HCI to HCI percentages [Step (3) ÷ Step (4)]

- % age non-HCIs = 73.1 (from Step 3)
- % age HCIs = 95 (from Step 4)
- Ratio = 73.1% ÷ 95% = **76.9%**

Step 6: Compare to safe/unsafe harbors in 410(b) chart shown

- Safe harbor = 25.25
- Unsafe harbor = 20.0

*This plan's ratio percentage = **76.9%; plan passes***

Tip: Eligibility failures are probably less common than other failures, but may be more difficult to correct. Generally in order to "fix" an eligibility problem, the employer must change cafeteria plan eligibility so that fewer highly compensated employees are eligible or broaden eligibility so that more non-highly compensated employees are eligible to participate. In some cases the employer may need to do both.

E. Benefits and Contributions Tests

A cafeteria plan does not discriminate as to benefits and contributions if statutory nontaxable benefits and total benefits (or employer contributions allocable to nontaxable benefits and total contributions) do not discriminate in favor of highly compensated participants. A cafeteria plan must satisfy this requirement with respect to both benefit availability and benefit selection. Thus, a plan must give each similarly situated participant a uniform opportunity to elect taxable and nontaxable benefits, and the actual election of non-taxable benefits through the plan must not be disproportionate by highly compensated participants (while other participants elect taxable benefits). Non-taxable benefits are disproportionately elected by highly compensated participants if the aggregate non-taxable benefits elected by highly compensated participants, measured as a percentage of the aggregate compensation of highly compensated participants, exceeds the aggregate non-taxable benefits elected by non-highly compensated participants measured as a percentage of the aggregate compensation of non-highly compensated participants.

Example: Employer C's cafeteria plan satisfies the eligibility test described above. Highly compensated participants in the cafeteria plan elect aggregate nontaxable benefits (e.g., major medical coverage or health FSA benefits rather than taxable

benefits such as cash) equaling 5 % of aggregate compensation; non-highly compensated participants elect aggregate non-taxable benefits equaling 10 % of aggregate compensation. Total benefits selected by highly compensated employees and non-highly compensated employers are 7% and 12% of compensation respectively. Employer C's cafeteria plan passes the contributions and benefits tests.

Tip: IRS regulations refer to a "utilization" test. However, their concern is with elections (i.e., contributions) made by highly compensated and non-highly compensated employees – not claims paid.

There may be times when an employer has a business reason for providing a benefit to an executive, but not to all employees. For example, the company is hiring a new CEO, and the CEO had a specific type of medical expense covered at his previous employer that the new employer's plan does not cover. The employer wants to provide the benefit to the new CEO, but only to the new CEO and only because it's something he had at his prior job. Providing the benefit for just the CEO under the cafeteria plan would cause the cafeteria plan to fail the non-discriminatory benefits test. If the plan is self-insured, it would also cause a failure under Internal Revenue Code Section 105(h). If the plan is fully insured, it will be discriminatory under the ACA once guidance is issued. The first two scenarios generate taxable income for the CEO. The last will create a $100 per day per impacted individual excise tax on the employer once guidance is issued. Under this type of circumstance, an employer may want to simply give the new CEO additional taxable cash that the employee may use to cover the expense. Taxable cash is usually an option when an employer wants to provide a benefit that is discriminatory.

Alternative Benefits and Contributions Testing

Following is an alternative test that may be used for benefits and contributions. Based on the language in Section 125(g)(2), this test is a safe harbor test that is available only to cafeteria plans that include major medical benefits (excluding dental coverage and health FSAs). The plan will not be discriminatory if:

- Contributions on behalf of each participant include an amount that equals either 100% of the cost of medical benefit coverage under the plan to the majority of highly compensated participants who are similarly situated (for example, who have the same size family), or is at least equal to 75% of the cost of the most expensive medical benefit coverage elected by any similarly situated participant; and
- Contributions or benefits in excess of those above bear a uniform relationship to compensation.

F. Key Employee Concentration Test

No more than 25% of the non-taxable benefits (e.g., major medical coverage or health FSA benefits rather than taxable benefits such as cash) may be provided to key employees.

G. In Operation

In addition to not discriminating as to either benefit availability or benefit selection, a cafeteria plan must not discriminate in favor of highly compensated participants in actual operation. For example, a plan may be discriminatory in actual operation if the duration of the plan (or of a particular nontaxable benefit offered through the plan) is for a period during which only highly compensated participants utilize the plan (or the benefit).

H. Additional Nondiscrimination Rules for Certain Component Plans

Some of the component benefits plans that are included in a cafeteria plan are subject to additional nondiscrimination requirements. Additional rules applicable to health and dependent care Flexible Spending Accounts (FSAs) and Group Term Life Insurance are summarized below.

Health FSAs

All self-insured health plans – including health FSAs – are subject to the nondiscrimination requirements under Internal Revenue Code Section 105(h). Similar to the cafeteria plan rules, these plans may not discriminate in favor of highly compensated employees; however, there are differences between these rules and the cafeteria plan rules.

First, Section 105(h) has a different definition of “highly compensated” employee. The Section 105(h) definition of highly compensated is the 5 highest paid officers, 10% shareholders, ***and the 25% highest paid of all non-excludable employees.*** Excludable employees are generally employees who: have not completed an applicable service requirement, have not attained age 25, are part-time, are seasonal, or are covered by a collective bargaining agreement. However, these employees may be excluded ***only*** if they are not eligible to participate under the plan. For example, if the health plan’s service requirement is two months, only employees with fewer than two months of service are excludable. (Note: Employees in this example with less than two months of service may be excludable under IRC Section 105(h), but they would not be excludable when performing the eligibility test under IRC Section 125.)

A second major difference is the nondiscriminatory eligibility requirement. The cafeteria plan requirement is based on the employee’s eligibility. The self-insured health test is

based on employees "benefitting" under the plan – in other words, employees actually enrolled. Section 105(h) permits the plan sponsor to use one of three tests:

1. 70% test – at least 70% of all non-excludable employees are enrolled;
2. 80% test – at least 70% of all non-excludable employees are eligible and 80% of those eligible are enrolled – generally a minimum of 56% (70% x 80%); or
3. The safe/unsafe harbor test that is used for cafeteria plan eligibility. ***However, when running the safe/unsafe harbor test, the IRC Section 105(h) definition of highly compensated must be used, not the Section 125 definition.***

Health FSAs that are funded solely via salary reduction almost never pass the 70% or 80% tests, but many will be able to satisfy the safe harbor/unsafe harbor test.

There is also a requirement that in order to be nondiscriminatory, the same benefits must be available to all eligible employees. This requirement is generally not a problem for flexible spending accounts limited to salary reduction amounts where all employees are permitted to make a salary reduction election up to a specified dollar maximum. Plans that include employer seed money, matching contributions, or credits such as wellness or flex may not create a problem if the same seed, matches, and credits are provided to all eligible employees.

Dependent Care FSAs

Dependent care FSAs are subject to the nondiscrimination requirements under Internal Revenue Code Section 129. Under Section 129, these plans may not discriminate in favor of highly compensated employees or 5% shareholders. However, there are differences between these rules and the cafeteria plan rules. First, the definition of highly compensated is different from the cafeteria plan definition under Section 125. Under Section 129, highly compensated includes an employee who earns more than a specified dollar amount ($130,000 in 2020) or who owns more than 5% of the stock of the employer. Officers are not included (unless they earn over the applicable dollar amount or own more than 5% of the stock). Spouses and tax dependents of these individuals are not included in the definition of highly compensated (as they are under Section 125), but must be included when testing because Section 129 prohibits discrimination in favor of highly compensated individuals and their spouses and dependents.

Section 129 has four tests: an eligibility test, a benefits availability test, a "concentration" test, and an average benefits test. The eligibility test is the safe/unsafe harbor test used under Section 125 (but with the Section 129 definition of highly compensated). The benefits availability test requires all benefits available to highly compensated employees also to be available to non-highly compensated employees. The 25% "concentration" test is similar to Section 125 in that it limits benefits to 25%, but the limitation is for 5% shareholders (and their spouses and tax dependents) rather than key employees.

Section 129 also contains a utilization (i.e., benefits selection) test in the form of an average benefits test. Under this test the average benefit provided to non-highly compensated employees must be at least 55% of the average benefit provided to highly compensated employees. Unlike the benefits test under Section 125, the comparison is not based on benefits selected by participants. Instead it is based on benefits selected by all non-excludable employees. When performing the 55% average benefits test, any non-excludable employee who has not elected dependent care benefits is included with a benefit of $0. This includes employees who do not have any qualified dependents. As a result, this is the most difficult test for plans to pass. However, the plan may exclude the following classes of employees: (1) employees under age 21 if the plan excludes them from participation; (2) employees with less than one year of service if the plan excludes them from participation, and (3) union employees if dependent care benefits were the subject of good faith bargaining and the union employees are not eligible for dependent care benefits. For the purpose of the 55% average benefits test only, employees whose compensation from the employer is less than $25,000 may be excluded even if they are eligible to participate.

The nondiscrimination requirements under Section 129 are essentially "all-or-nothing." Under a cafeteria plan, failure of a nondiscrimination requirement means that some (or all) benefits become taxable to highly compensated and/or key employees. Under Section 129, if the plan fails any of the nondiscrimination requirements, all benefits for all highly compensated employees and 5% shareholders become taxable. Non-highly compensated employees are not affected.

Tip: Because of the all-or-nothing results of failing nondiscrimination tests for dependent care benefits, many employers perform estimated testing within a few months after open enrollment. If the estimated testing shows that the plan is likely to fail when actual testing is performed after the end of the year, the employer may be able to make changes such as reducing benefits for highly compensated and/or 5% shareholders so that the plan will be able to pass the tests. The plan sponsor must determine what/how reductions will be made. For example, based on estimated testing, the plan sponsor may determine that the plan will pass if benefits for highly compensated employees are reduced to $3,000 and reduce all highly compensated elections that are more than $3,000 to $3,000. Or, the plan sponsor could reduce all highly compensated employee elections by a specified percentage such as 20%. The plan document must contain the necessary language to permit reductions by the plan sponsor (not new elections by highly compensated employees) and the method that will be used. Early testing is recommended because it makes it more likely that the plan sponsor will have sufficient time to make changes that may be needed to pass. No changes can be made once the plan year has ended.

Tip: The 55% average benefits test is the only test where cafeteria plans are permitted to use separate lines of business rules. Internal Revenue Code Section

414(r) contains the separate lines of business rules that are detailed and used primarily for pension plans.

Group Term Life Insurance

Section 79 of the Internal Revenue Code generally prohibits discrimination in favor of key employees. If a cafeteria plan satisfies the nondiscriminatory eligibility requirements, then group term life offered under the cafeteria plan is deemed to satisfy the Section 79 nondiscriminatory eligibility requirement. (Outside of a cafeteria plan, a group term life plan must satisfy either a 70% or an 85% test.) Benefits available to key employees must also be available to non-key employees. Under this benefits test, either a flat dollar amount for all employees or the same percentage of compensation for all employees satisfies a safe harbor test for benefits. For plans that do not have a uniform percentage of compensation or a single flat dollar amount, the determination of whether benefits are discriminatory may be made using “classes” of benefits. As long as each “class” of benefits has no more than 15% key employees, the class passes. Section 79 regulations include the following example.

An employer provides group term life insurance to 500 employees – 10 key and 490 non-key employees. The 10 key employees and 90 non-key employees have coverage equal to 2 x compensation. The remaining 400 non-key employees have coverage of 1 x compensation. This plan passes because each benefit “class” (i.e., the class that equals 1 x compensation and the class that equals 2 x compensation) is tested separately, and no more than 15% of the employees in every class are key employees. In other words, in each class of benefits, 85% or more of the employees are non-key employees. If there were a third class (e.g., a class that receives 3 x compensation) and only one key employee, is in that class, the plan would fail.

Tip: If a group term life insurance plan is discriminatory, all key employees lose the $50,000 exclusion and must calculate imputed income on their total life insurance coverage amount using the greater of Table I or actual premium rates. This applies to all key employees, not just the key employees who receive the discriminatory benefit. Non-key employees are not affected.

I. Potential Problems

Many common problems fall all into one of two categories – design issues and testing errors. Following are a list of several potential problems.

Design Issues

(1) **Not taking into consideration the fact that differences in eligibility or benefits and contributions that are common business categories could lead to a discriminatory plan. For example:**

a. Having a different service requirement for full-time and part-time employees, or salaried and hourly employees (or management/non-management or similar classes) whereby highly compensated employees have a shorter service requirement.
b. Having different contributions for full-time and part-time or salaried and hourly employees, whereby highly compensated employees pay less for the same coverage as non-highly compensated employees.
c. Having different benefits based on location – such as a $1,000 deductible PPO in Alabama but a $2,000 deductible PPO in New Jersey.
d. Having different contributions based on tenure, whereby highly compensated employees who are longer tenured pay less for benefits than non-highly compensated employees with shorter tenure.

(2) **Forgetting to consider the controlled group when designing a plan.** Often there is a higher concentration of highly compensated employees in a headquarters location. For example, assume an employer is headquartered in one state and has plants in two other states with different plans for each location. So if the plan of benefits for the headquarters location also happens to be more generous than other locations, the headquarters plan may be discriminatory. Assume that the employer's headquarters is in State A. In State A the employer has 100 employees of whom 20 are non-highly compensated. The employer also has a plant in State B with 1,000 employees of whom 980 are non-highly compensated. The employer offers a $500 deductible PPO in State A with employees paying $25 per month for single coverage and a $2,000 deductible PPO in State B with employees paying $100 per month for single coverage. When testing, the employer must include census data from both locations. So when the employer tests the $500 PPO plan, the employees in State A must be included in the census data as ineligible with $0 benefits. When State A's plan is tested 80% of the highly compensated (80 eligible/100 total) will be eligible, compared to 2% of the non-highly compensated (20 eligible/1,000 total). This plan fails the eligibility test.

(3) **Forgetting the "in operation" requirement.** This may involve an additional benefit in one of the component plans such as major medical. If the employer adds a benefit mid-year just in time for a highly compensated executive to use the benefit and then terminates it shortly thereafter, it may fail the "in operation" rule. It may also create other problems such as a discrimination problem under Section 105(h) if the major medical plan is self-insured (and eventually under the ACA when the nondiscrimination requirements for fully insured plans become effective).

(4) **Not monitoring the plan during the year to determine the likelihood of the plan's passing or failing.** It may be possible to make changes during the year to head off a problem. Unlike pension plans, there is no way to "fix" a

nondiscriminatory cafeteria plan after the plan year has ended. If the plan fails, highly compensated and/or key employees will have taxable income.

(5) **Not including language in the cafeteria plan document that permits the plan sponsor to make adjustments such as reducing elections** for highly compensated, key employees, and/or 5% shareholders to "fix" discrimination issues.

Testing Errors

Following are examples of potential problems that may arise when performing nondiscrimination testing.

(1) **Not testing on a controlled group basis.** This is more likely to present a problem for employers with multiple locations or more complex business structures that involve subsidiaries and entities where the employer has a substantial, but less than 100%, ownership interest in a business.

Tip: Employers with pension plans generally already have someone in finance who knows what entities are in the controlled group. In addition, employers that are subject to ACA reporting requirements under Section 6056 must list members of their controlled group members when they complete Form 1094-C.

(2) **Excluding from testing employees who cannot be excluded (i.e., part-time employees, seasonal employees, temporary employees, and leased employees).**

(3) **Performing nondiscriminatory testing with incomplete census data. Although it may not be possible to obtain "perfect" census data, the data used needs to be as complete as practicable.** Using data such as renewal census data is not appropriate since it will virtually always exclude groups of employees who are not eligible making it impossible to perform the eligibility test correctly. In addition, testing requires inclusion of all employees employed during the year, not just employees who are eligible for coverage prior to renewal.

(4) **Not identifying key and highly compensated employees correctly. For example, it is not appropriate to treat just employees earning more than $125,000 in 2019 ($130,000 in 2020) as highly compensated; there may be employees earning less those amounts** who are highly compensated based on officer status, ownership, or their relationship to a highly compensated employee (e.g., a spouse of an officer who is also an employee). In addition, who is highly compensated varies based on the plan being tested – for example it's generally the 25% highest paid non-excludable employees for self-insured health benefits such as a health FSA.

(5) **Not performing all of the cafeteria plan tests and, if applicable, the tests for components such as the self-insured medical tests for a health FSA.**

One plan that employers frequently overlook is group term life insurance that is included under the cafeteria plan; however, some employers consciously keep their group term life plan outside the cafeteria plan. Others may forget to include long-term disability (LTD) if it is part of the cafeteria plan.

(6) **Testing only some components of the cafeteria plan such as FSAs without testing the entire cafeteria plan.** It is possible to test components separately. However, pre-tax contributions and FSAs can be tested as separate plans as long as each separate component is tested using the controlled group and each separate component passes all of the tests. Any component that fails the tests would generate taxable income for highly compensated and/or key employees.

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SECTION 7 –APPENDIX

A. Qualified and Non-Qualified Benefits

Qualified Benefits	Non-Qualified Benefits
Accident or health coverage including: • Group medical insurance (HMO, PPO, POS) • Self-insured medical, including health FSA • Group dental, vision, hearing benefits – insured or self-insured	Archer Medical Savings Accounts (Archer MSAs)
Accidental Death & Dismemberment Insurance	Educational Assistance Benefits
Adoption Assistance Benefits	Group Homeowners
COBRA Coverage (under limited circumstances – e.g., employee may pay COBRA premium for child that is his/her tax dependent)	Group Legal
Dependent Care Assistance	Group Term Life Insurance covering spouse or dependents
Disability Coverage – Long or Short Term	Group Universal Life Insurance or any other cash value life insurance such as split dollar life insurance
Discount/referral Plans – only if the arrangement includes an element or risk or prepaid health services	Health Reimbursement Arrangements (HRAs) including Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)
Fixed Indemnity or Hospital Indemnity	Individual Health Policies that do not qualify as HIPAA excepted benefits.
Group Term Life Insurance on Employee	Individual Life Insurance Policies – term or cash-value
Health Savings Accounts (HSAs)	Long term care insurance
Individual Health Policies with Limited Benefits such as Cancer or Dread Disease Insurance if HIPAA excepted	Scholarships
Medicare Supplement or Medicare Premium Reimbursement – only for retirees due to MSP rules	Transportation Assistance (may be pre-tax, but must be outside a cafeteria plan)

Qualified Benefits	Non-Qualified Benefits
Prepaid Vision, Dental or Prescription Drug plans – must have an element of risk or provide prepaid services	Any pension other than 401(k), such as 403(b) contributions
Vacation Purchase/Sale (including PTO)	
401(k) Plan Contributions – yes, but only if the employee has the option of received the 401(k) contribution in cash	

NOTES:

1. *The taxation of disability benefits received depends on whether the coverage was purchased using pre-tax or after-tax dollars.*
2. *Employee group term life insurance amounts purchased with pre-tax dollars and amounts over $50,000 create imputed income.*
3. *Policies with a return of premium feature may not be included under a cafeteria plan.*

B. Nondiscrimination Testing Definitions

Several terms used in the nondiscrimination rules have specific definitions. Following is a more detailed definition of each of these terms.

OFFICER

Whether an individual is an officer is determined based on all the facts and circumstances, including the source of the individual's authority, the term for which he or she is elected or appointed, and the nature and extent of his or her duties. Generally, the term "officer" means an administrative executive who is in regular and continued service. The term implies continuity of service and excludes individuals performing services in connection with a special and single transaction. An individual who merely has the title of an officer, but not the authority of an officer, is not an officer. Similarly, an individual without the title of an officer, but who has the authority of an officer, is an officer. Sole proprietorships, partnerships, associations, trusts, and labor organizations also may have officers.

Note: There does not appear to be any exception for governmental employers.

COMPENSATION

Compensation includes the employee's wages, salaries, fees for professional services, and other amounts received for personal services rendered in the course of employment with the employer to the extent that the amounts are includible in gross income. It includes commissions, compensation on the basis of a percentage of profits, tips, bonuses, and reimbursements or other expense allowance under a nonaccountable plan(see Treasury Regulations Section 1.62-2(c)). It also includes:

- Elective deferrals to retirement plans such as 401(k), 403(b), 408(p), and 457 plans;
- Pre-tax contributions under a cafeteria plan (including HSA amounts if pre-tax);
- Salary reduction amounts under an FSA (health or dependent care);
- Compensation reduction amounts under a qualified transportation plan; and
- Imputed income amounts for taxable benefits such as health insurance for a non-tax dependent

Compensation does not include employer contributions (other than salary reduction amounts) for qualified benefits such as health insurance and pension plans to the extent that such contributions are not includable on the employee's Form W-2 as taxable income even though amounts paid for employer-sponsored medical benefits must now be included in Box 12 under the ACA. The amount reported for medical care in Box 12 is not counted as compensation unless it is taxable. For example, an employer's contribution toward the cost of medical insurance for the employee, the employee's spouse, children (to age 26), and the employee's tax dependents would not be included.

Amounts an employer paid for coverage for a non-tax dependent such as a domestic partner would be taxable and included in the employee's compensation.

HIGHLY COMPENSATED INDIVIDUAL (HCI)

Highly compensated individual is defined under Internal Revenue Code Section 125 in general as an individual who is:

1. An officer;
2. A shareholder owning more than 5% of the voting power or value of all classes of stock of the employer;
3. An employee who earns more than $125,000* (2019) $130,000 (2020); or
4. A "Spouse" or dependent of an individual who is described in 1, 2 or 3 above.

"Officer" means an employee who was an officer in the ***prior plan year (current year if the employee's first year of employment).***

"Spouse" means the lawful spouse of the employee. It does not include domestic or civil union partner.

> **Employers are permitted to limit the number of employees who are considered "highly compensated" based on earnings greater than $120,000 (2018) $125,000 (2019) to the "top paid group" which is generally the top 20% of all of the employer's employees based on compensation (IRC Section 414(q)(3)).* ***However, an employer that elects to use this rule must satisfy certain requirements such as by following specific rules that specify how to calculate the top 20%. The employer must also use the same rule for all qualified plans - health & welfare and retirement plans.***

KEY EMPLOYEE (KEY) – IRC Section 416(i)

"Key employee" is defined in Internal Revenue Code Section 416(i). The term "key employee" means an employee who, at any time during the preceding plan year, is:

- An officer of the employer having an annual compensation greater than $180,000 in 2019 ($185,000 for 2020);
- A 5% owner of the employer,* or
- A 1% owner of the employer having an annual compensation from the employer of more than $150,000.*

In general, no more than 50 employees (or, if lesser, the greater of 3 or 10% of the employees) shall be treated as officers. Detailed rules on how to determine the number of officers are contained in IRC Section 416(i) and regulations.

**Certain aggregation rules may apply.*

Notes:

- *Governmental do not have key employees.*
- *Not-for-profits do not have owners.*
- *Compensation is actual (not annualized) compensation from the preceding plan year. Alternatively compensation may be based on the employee's From W-2 compensation for the calendar year ending with or within the plan year.*

HIGHLY COMPENSATED EMPLOYEES – IRC SECTION 105(h)

"Highly compensated employee" is defined under Internal Revenue Code Section 105(h) as an individual who is:

- One of the 5 highest paid officers,
- A shareholder who owns more than 10% of the value of the stock of the employer, or
- Among the highest paid 25% of all non-excludable employees.

Excludable employees are generally employees who have not completed an applicable service requirement, employees who are under age 25, and part-time and seasonal employees who are not eligible to participate in the plan. In addition, union employees who are not eligible are excludable if accident and health benefits were the subject of good faith collective bargaining.

THE FOLLOWING DEFINITIONS ARE USED ONLY FOR DEPENDENT CARE FSAS.

5% OWNER – IRC Section 129

Internal Revenue Code Section 129 defines "principal shareholders or owners" as employees who are shareholders or owners - or their spouses or dependents (on any day of the year) - each of whom owns more than 5% of the stock or of the capital or profits interest in the employer. Certain attribution rules apply.

"Spouse" means the lawful spouse of the employee. It does not include a domestic or civil union partner.

Note: Governmental, church, and not-for-profit plans do not have shareholders or owners.

HIGHLY COMPENSATED INDIVIDUAL DEPENDENT CARE (HCID) - IRC Section 129

"Highly compensated individual" is defined under Internal Revenue Code Section 129 as an individual who is highly compensated as defined in Internal Revenue Code Section 414(q), which in general is:

- A shareholder owning more than 5% of the voting power or value of all classes of stock of the employer during the current or preceding year; or
- Employees who earn more than $125,000 (2019) $130,000 (2020); or
- The spouse or dependent of (1) or (2).*

While these individuals are not defined as "highly compensated" in IRC Section 129, they must be included because Section 129 prohibits discrimination in favor of "highly compensated" individuals and <u>their spouses and dependents.</u>

Employers are permitted to limit the number of employees who are considered "highly compensated" based on earnings greater than $125,000 (2019) $130,000 (2020) to the "top paid group" which is generally the top 20% of all of the employer's employees based on compensation (IRC Section 414(q)(3)). **However, an employer that elects to use this rule must satisfy certain requirements such as following specific rules that specify how to calculate the top 20%. The employer must also use the same rule for all qualified plans - health & welfare and retirement plans.**

Compensation for determining "highly compensated" status is based on compensation actually paid, rather than annualized compensation (i.e., if testing is performed for a plan that uses a calendar year an employee hired on July 1 with a $140,000 salary would be included using the $70,000 he/she actually received during July 1- December 31 of that plan year). Non-calendar year plans may elect to use calendar year compensation rather than plan year compensation to make this determination. For

example, a plan with an April 1, 2019 – March 31, 2020 plan year may use calendar year 2019 compensation. In this case, the employer must use the 2019 value for compensation.

Notes:

- *Governmental, church, and not-for-profit employers do not have owners.*
- *Governmental and not-for-profits will have officers.*
- *Church plans may or may not have officers.*

The definition of Highly Compensated Individual for the dependent day care FSA differs from the definition used under IRC Section 125 in three ways: (1) it does not include officers; (2) attribution rules apply when determining 5% shareholders; and (3) compensation is based on the prior year with no adjustment for newly hired employees.

C. Nondiscriminatory Classification Table

IRC Section 410(b)

Non-HCI Concentration Percentage	Safe Harbor	Unsafe Harbor	Non-HCI Concentration Percentage	Safe Harbor	Unsafe Harbor
0 – 60	50.00	40.00	80	35.00	25.00
61	49.25	39.25	81	34.25	24.25
62	48.50	38.50	82	33.50	23.50
63	47.75	37.75	83	32.75	22.75
64	47.00	37.00	84	32.00	22.00
65	46.25	36.25	85	31.25	21.25
66	45.50	35.50	86	30.50	20.50
67	44.75	34.75	87	29.75	20.00
68	44.00	34.00	88	29.00	20.00
69	43.25	33.25	89	28.25	20.00
70	42.50	32.50	90	27.50	20.00
71	41.75	31.75	91	26.75	20.00
72	41.00	31.00	92	26.00	20.00
73	40.25	30.25	93	25.25	20.00
74	39.50	29.50	94	24.50	20.00
75	38.75	28.75	95	23.75	20.00
76	38.00	28.00	96	23.00	20.00
77	37.25	27.25	97	22.25	20.00
78	36.50	26.50	98	21.50	20.00
79	35.75	25.75	99	20.75	20.00

Plans at or above the safe harbor percentage pass the eligibility test.

Plan below the unsafe harbor fail the eligibility test.

Plans below the safe harbor, but at or above the unsafe harbor may be able to pass the eligibility test based on facts & circumstances.

D. Cafeteria Plans Election Change Matrix

Cafeteria plan elections must generally be made before a period of coverage begins and remain unchanged during the period of coverage. The period of coverage is usually the 12-month cafeteria plan year, but may be a shorter period of time for a newly eligible employee or a new cafeteria plan. Cafeteria plans may not have a plan year that exceeds 12 months in length. Election changes must be permitted annually with the exception of separate dental and vision plans. In informal guidance, the IRS has indicated that two year elections may be used for separate dental and vision plans.

Cafeteria plan election rules are a MAXIMUM – not a floor. Cafeteria plans may be more restrictive, but not more expansive. Technically, a cafeteria plan may be written to prohibit any mid-year election change except for Health Savings Account (HSA) elections. Although other laws, such as HIPAA, require health plans to permit certain election changes such as adding coverage for a new spouse following a marriage, an employer could require the change to be made on an after-tax basis. As a practical matter, virtually all cafeteria plans permit HIPAA special enrollment changes to be made on a pre-tax basis. Cafeteria plans must permit election changes at least monthly for HSA elections.

Carrier rules may be similar to IRS rules, but they are not identical. Group health insurance contracts almost universally permit employees to enroll themselves and/or family members when:

- They first become eligible;
- At annual enrollment;
- For HIPAA special enrollment *(not required for HIPAA-excepted benefits such as separate dental, vision, or health FSAs*); and
- To comply with a Qualified Medical Child Support Order (QMCSO).

Beyond those events, employers should check their insurance contracts to determine which events will permit an employee to enroll. Carrier rules for disenrollment are almost always more liberal. For example, an insurance contract may permit an employee to drop coverage at any time. While the carrier contract may permit disenrollment under the insurance contract, the IRS rules may not permit a change in the salary reduction amount. Employers need to keep both IRS and carrier rules (as well as any internal administrative concerns the employer may have) in mind when establishing, modifying or using election change rules. Not adhering to the IRS rules could jeopardize the status of the cafeteria plan whereas not adhering to carrier rules could result in unintended self-insurance. In general, the HIPAA special enrollment rules are binding on the employer's group health plan and the insurance company under an insured plan. Other rules such as continuation during an FMLA leave and QMCSO rules are binding on the employer and employer's group health plan, but not the insurance company. However, in situations where an employer is required to provide certain

coverage – such as a QMCSO – virtually all carriers will voluntarily follow the minimum requirements of those rules. Not as many are willing to be more liberal with respect to those rules or to permit all of the changes that the IRS will permit. Stop loss carriers are not required to provide HIPAA special enrollment because stop loss insurance is virtually never classified under state insurance law as health insurance. Some examples of situations where a carrier's underwriting rules may be more restrictive than the IRS (i.e., the IRS will permit a new election, the carrier will not):

- An employee with a child who is not enrolled in the employer's plan gets married and acquires a stepchild. The employee, new spouse and new stepchild have a HIPAA special enrollment right. The employee's previously eligible child does not. The IRS rules would permit the employee to enroll the previously eligible child; many carrier contracts will not.
- An employee and spouse covered under an HMO get divorced and the employee wants to both drop coverage for the now ex-spouse and change to the PPO. The employee would almost always be required to drop HMO coverage for the ex-spouse who is no longer eligible, but the PPO carrier may not be willing to permit the employee to enroll in the PPO instead.
- An employee becoming eligible for Medicare upon reaching age 65 may want to enroll in Medicare and drop the employer's coverage for himself, but keep his 63-year-old spouse on the employer's plan. Under IRS rules, the employee who enrolls in Medicare could drop coverage for himself (but not his spouse). However, insurance contracts (including stop loss) almost never permit enrollment of a dependent when the employee is not enrolled. (There are some exceptions under retiree health plans and in situations involving a surviving spouse.)
- IRS rules permit a re-hired employee to be treated as a new employee with new elections if the employee's rehire date is more than 30 days after his termination date. Many carrier contracts have a definition of rehire that uses a 3- or 6-month time frame and as a result the insurance contract may only permit reinstatement of prior coverage.
- An employee wants to make a change in her coverage based on changes in her husband's employer's plan (or during her husband's employer's open enrollment). IRS rules would permit corresponding changes, but many carrier contracts will not.

A mid-year election change is NOT an open enrollment. An employee experiencing one of the permitted events may be permitted to make certain changes as the result of the event, but only certain changes. For example, if an employer adds or improves a dental plan mid-year, the employee may be able to enroll in the new or improved dental plan, but would not be permitted to make any changes to his medical election or his health FSA.

Before permitting an employee to make an election change during the plan year, the employer should ask the following questions:

- **Is the requested change permitted by IRS?** Is the event experienced by the employee included in the IRS list of events that would permit a new election? Does the event apply to the particular benefit the employee is asking to change (e.g., medical coverage or health FSA)?
- **Does the election change satisfy the consistency rule?** Generally, the event must affect eligibility for the benefit. For example, if an employee with two person major medical coverage is divorced, the now ex-spouse is no longer eligible for health coverage under the plan, and the employee may be permitted to change from two person to single coverage. It would not be consistent for the employee to drop all coverage since his eligibility has not changed -- only his ex-spouse's eligibility has changed.
- **Does the cafeteria plan document permit the requested change?** Does the plan impose any limitations on the election change that can be made for the event? Does the plan allow an employee to elect to commence benefits midyear when the employee was not previously in any of the cafeteria plan benefits?
- **Does the plan document or insurance policy governing the applicable benefit allow the requested election change?** For example, does the medical carrier (or stop loss carrier) permit an employee to enroll under their contract mid-year if it's during the spouse's employer's open enrollment period?
- **Has there been proper documentation?** Has the participant provided a signed or electronic certification that the event occurred and that the change is consistent with the event? If coverage is being dropped because of a change in status that results in a gain in eligibility under another plan, has the participant provided any certification that coverage has been or will be obtained under the other plan? Is there any reason to believe that any certification is not correct?
- **Does the election change comply with time limits outlined in the plan?** Is the request for a prospective change? Or is it a permitted retroactive election change for a HIPAA special enrollment for birth, adoption, or placement for adoption?

A matrix outlining permitted election changes under IRS rules is contained in several charts on the following pages. Chart #1 contains change in status rules that apply to all health plans, including health FSAs. Chart #2 shows change in cost or coverage rules which apply to health plans other than health FSAs. Chart #3 shows the rules that apply to Dependent Care FSAs. For all charts, the term "spouse" includes same-sex spouses whose marriage is recognized by the federal government. The children of federally recognized same-spouses will have the same enrollment rights as the children of opposite-sex spouses.

Following the charts are sections which address the rules for life insurance and disability insurance and domestic/civil union partners and their children. ***Note: This***

document does not include any of the rules for adoption assistance or 401(k) plans.

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Chart #1: Election Changes for Healthcare Plans (including health FSA)

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
HIPAA Special Enrollments(not required for HIPAA excepted benefits)					
Marriage	• Enrollment of employee • Enrollment of new spouse • Enrollment of newly eligible dependents • Drop of coverage for dependents if enrolling in spouse's plan • Drop of coverage for employee if enrolling in spouse's plan	Required	• Enrollment in FSA • Increase in dollar election • Decrease in dollar election (if newly eligible under spouse's plan) • Drop in coverage (if newly eligible under spouse's plan)	HIPAA special enrollment rights apply to the employee, new spouse, and newly eligible dependents, but not previously eligible dependents. Entering into a domestic partnership is not a marriage and does not create a HIPAA special enrollment right. However, see increase in dependents on page 16 and the rules for domestic partners on page 16.	☐ Yes ☐ No
Birth, adoption, or placement for adoption	• Enrollment of employee • Enrollment of spouse • Enrollment of newly born/adopted/placed child	Required	• Enroll in FSA • Increase in dollar election	HIPAA special enrollment rights do not apply to previously eligible dependents. Children born/adopted/placed with a domestic partner have HIPAA special enrollment rights (as will the employee), but not the domestic partner. Coverage must be retroactive to the date of birth/adoption.	☐ Yes ☐ No

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Loss of coverage under spouse's plan (For example: • Divorce/legal separation • Death • Spouse's termination of employment • Spouse's change in employment status)	• Enrollment of employee • Enrollment of individual losing coverage (may be subject to waiver restrictions)	Required	• Enrollment in FSA • Increase in dollar election	HIPAA special enrollment is available to the employee and other individuals who lose eligibility under the spouse's plan An employer is permitted to limit special enrollment rights to individuals who actually were enrolled in another plan at the time of the coverage waiver. To enforce this provision, the plan may require a written statement from an employee who is waiving coverage that the other coverage is the reason for the waiver. If the employer uses and communicates this requirement and the employee does not provide it, the plan is not required to offer a HIPAA special enrollment if the other coverage is lost.	☐ Yes ☐ No

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Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Loss of coverage under another employment based group health plan (e.g., 26-year old employee loses coverage under parent's plan, domestic partnership ends, or employee's 22-year old child terminates employment)	• Enrollment of employee • Enrollment of individual losing coverage (may be subject to waiver restrictions)	Required	• Enrollment in FSA • Increase in dollar election	HIPAA special enrollment based on the loss of other coverage is available to the employee and other individuals who are eligible under the plan, including domestic and civil union partners and their children. An employer is permitted to limit special enrollment rights to individuals who actually were enrolled in another plan at the time of the coverage waiver. To enforce this provision, the plan may require a written statement from an employee who is waiving coverage that the other coverage is the reason for the waiver. If the employer uses and communicates this requirement and the employee does not provide it, the plan is not required to offer a HIPAA special enrollment if the other coverage is lost.	☐ Yes ☐ No
Loss of eligibility for individual health insurance (e.g., insurer drops individual product line, drops specific plan design such as PPO, drops out of individual market, or stops offering a	• Enrollment of employee • Enrollment of individual losing coverage (may be subject to waiver restrictions)	Required	• Enrollment in FSA • Increase in dollar election	HIPAA special enrollment based on the loss of other coverage is available to the employee and other individuals who are eligible under the plan, including domestic and civil union partners and their children. An employer is permitted to limit special enrollment rights to individuals who actually were enrolled in another plan at the time of the coverage waiver. To enforce this provision, the	☐ Yes ☐ No

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
product the end of the year)				plan may require a written statement from an employee who is waiving coverage that the other coverage is the reason for the waiver. If the employer uses and communicates this requirement and the employee does not provide it, the plan is not required to offer a HIPAA special enrollment if the other coverage is lost. Loss of coverage for reasons such as failure to pay premium or fraud does not create a special enrollment right.	
Exhaustion of COBRA coverage at end of 18, 29, or 36 months	• Enrollment of employee • Enrollment of individual losing coverage (may be subject to waiver restrictions)	Required	• Enrollment in FSA • Increase in dollar election	HIPAA special enrollment based on the loss of other coverage is available to the employee and other individuals who are eligible under the plan, including domestic and civil union partners and their children. The HIPAA special enrollment right is only available as the result of exhaustion of the maximum COBRA duration. Voluntary termination does not give the individual special enrollment rights even if the individual is losing free COBRA coverage. For example, if a former employer does not charge for COBRA for three months after a layoff, there is no special enrollment with a	☐ Yes ☐ No

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
				new employer at the end of that three-month period.	
Loss of Medicaid eligibility	• Enrollment of employee • Enrollment of individual losing coverage	Required	Unclear whether permitted	Employees must be given at least 60 days to exercise special enrollment rights and be permitted to change coverage options.	☐ Yes ☐ No
Loss of SCHIP eligibility	• Enrollment of employee • Enrollment of individual losing coverage	Required	Unclear whether permitted	Employees must be given at least 60 days to exercise special enrollment rights and be permitted to change coverage options.	☐ Yes ☐ No
Gain Medicaid premium assistance	• Enrollment of employee • Enrollment of dependent	Required	Unclear whether permitted	Employees must be given at least 60 days to exercise special enrollment rights and be permitted to change coverage options. If already enrolled, employee may be able to reduce salary reduction election to reflect lower employer contribution.	☐ Yes ☐ No
Gain SCHIP premium assistance	• Enrollment of employee • Enrollment of dependent	Required	Unclear whether permitted	Employees must be given at least 60 days to exercise special enrollment rights and be permitted to change coverage options. If already enrolled may be able to reduce salary reduction election to reflect lower employer contribution.	☐ Yes ☐ No

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Event	Permitted Changes to Salary Reduction Agreement to Reflect: Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA	Comments	Event Applies to the Plan
Status Changes – these are the only categories of status changes that are permitted					
Divorce, annulment, legal separation, and/or death of spouse	• Drop of coverage for spouse losing eligibility • Drop of coverage for stepchildren losing eligibility	Yes	• Decrease dollar election • End of enrollment	Legal separation and annulment are events permitting a change only in states that recognize them. In the event of divorce, the employee's children do not lose eligibility under parents' plans, but the employee's stepchildren would generally lose eligibility. An employee enrolled in the spouse's group health plan who loses coverage under the spouse's plan may be eligible for a HIPAA special enrollment – see page 16.	☐ Yes ☐ No
Increase in the number of dependents other than birth, adoption, or placement for adoption	• Enrollment of newly eligible dependent(s)	No	• Enrollment • Increase in dollar election	Newly eligible dependent and other dependents that previously were not covered (under the tag-along rule) may be enrolled under IRS rules.	☐ Yes ☐ No
Decrease in number of dependents (For example: • Death • Loss of eligibility under the plan –	• Drop of coverage for dependent losing eligibility	No	• Decrease in dollar election • End of enrollment	If the event causing loss is a COBRA qualifying event and the child is the employee's dependent, the employee may make a change in the salary reduction amount to pay for COBRA coverage pre-tax.	☐ Yes ☐ No

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Event	Permitted Changes to Salary Reduction Agreement to Reflect: Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA	Comments	Event Applies to the Plan
e.g., child reaches age 26)					
Gain in eligibility due to employee's change in employment status • Class (e.g., salaried to hourly) • Hours (e.g., part-time to full-time) • Union (e.g., non-union to union)	• Enrollment of newly eligible employee after allowing new plans to be selected	Select from newly available options	• Enrollment if newly eligible	May only change election where eligibility for a benefit/plan affected (i.e., if different medical options for salaried and hourly or different contributions, make new elections). If eligibility has not changed (i.e., same FSA plan for salaried and hourly), no FSA change permitted.	☐ Yes ☐ No
Loss of eligibility due to employee's change in employment status • Termination • Strike/lock out • Class (e.g., hourly to salaried) • Hours (e.g., full-time to part-time) • Union (e.g., union to non-union)	• Cancellation of coverage	No (see comments)	• End of enrollment	However, if the change in employment status results in eligibility for a new or different plan (or new coverage option), then employee can select the new or different plan.	☐ Yes ☐ No
Reduction in hours of service, where	• Revocation of coverage	No	• No change permitted	The employee must be in a position that was expected to average at least 30 hours of	☐ Yes ☐ No

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
employee expected to average less than 30 hours per week				service per week and there was a change so that the employee will reasonably be expected to average less than 30 hours of service per week. Eligibility for the employer's health plan need not be affected by the change in the expected hours of service. The cancellation of coverage under the employer's health coverage corresponds to the intended enrollment of the employee (and any related individuals) in another plan that provides minimum essential coverage. Coverage under the new plan must be effective no later than the first day of the second month following the month that the employer coverage is cancelled. Employer may rely on a reasonable representation of an employee and related individual who have enrolled or intent to enroll in another plan.	
Employee seeks to enroll in a QHP when the employee is eligible for a Marketplace Special Enrollment	• Revocation of coverage	No	• No change permitted	An employee seeking to revoke his election to enroll in a Marketplace QHP may do so if the employee is eligible for Marketplace Special Enrollment period. The revocation of the election for employer coverage must correspond to the intended enrollment of the employee (and any related individuals) in a	☐ Yes ☐ No

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
				QHP through the Marketplace. Coverage under the Marketplace QHP must be effective no later than the day immediately following the last day the original coverage was revoked. For additional insight, on Marketplace Special enrollment, please refer to the following link - https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/	
Employee seeks to enroll in a QHP during the Marketplace's annual open enrollment	• Revocation of coverage	No	• No change permitted	The revocation of the election for employer coverage must correspond to the intended enrollment of the employee (and any related individuals) in a QHP through the Marketplace. Coverage under the Marketplace QHP must be effective no later than the day immediately following the last day the original coverage was revoked.	☐ Yes ☐ No

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Rehire employee within 30 days of termination[10]	• Reinstatement of old election • Denial of reinstatement until the next plan year	No	• Reinstatement of prior coverage • Denial of reinstatement until the next plan year	If another event occurs that permits a change (which must be specified in the plan), then rehired employee may be able to make new selections.	☐ Yes ☐ No
Rehire employee 30 or more days after termination	• Enrollment employee, allowing new plan selections • Reinstatement of previous election • Denial of reinstatement until the next plan year	Yes	• Enrollment • Reinstatement • Denial of reinstatement until the next plan year	After 30 days, rehired employees are treated as new employees under the cafeteria plan election rules.	☐ Yes ☐ No

[10] The ACA's Employer Shared Responsibility requirement includes rules about counting hours for rehired employees. In general, employers must count hours for rehired employees unless the employee is rehired after a break in service of at least 13 weeks (26 weeks for an academic employee). An employer that denies reinstatement for rehired employees could be faced with an Employer Shared Responsibility penalty if an employee who is not reinstated to health insurance is determined to be a full-time employee under the ACA's rules and receives a premium tax credit and/or cost sharing reduction under a QHP purchased in a Marketplace.

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Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Gain in eligibility under another plan because spouse or dependent commences employment	• Drop of coverage employee if enrolls in the other plan • Drop of coverage for spouse, dependent, and/or other family members enrolling in the other plan	No	• Decrease in dollar election • End of enrollment	Corresponding changes required. Employee may not drop coverage unless employee (and/or family members) actually enrolls in the other plan.	☐ Yes ☐ No
Dependent gains eligibility under employer's plan (e.g., 27-year old child who is a dependent becomes a full-time student)	• Enrollment of newly eligible dependent	No	• Enrollment • Increase in dollar election		☐ Yes ☐ No
Change in residence that causes employee to gain eligibility (e.g., employee moves into an HMO's service area)	• Enrollment of newly eligible employee and dependents	No	• No change allowed	Previously eligible dependents may be added under the tag-along rule in addition to newly eligible spouse and dependents. Employee may only enroll in the plan he/she is newly eligible for. No other changes permitted.	☐ Yes ☐ No
Change in residence that causes employee to lose eligibility	• Drop of coverage if moving out of network area	Yes	• No change allowed	HIPAA special enrollment rights may also apply due to a loss in coverage. See loss of coverage on page 16.	☐ Yes ☐ No

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Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
(e.g., employee moves out of an HMO's service area)	• Change to another similar option				
Change in residence that causes dependent to gain eligibility	• Addition of newly eligible dependent	No	• No changes permitted		☐ Yes ☐ No
Change in residence that causes dependent to lose eligibility	• Drop of coverage for dependent that loses eligibility	No	• No changes permitted	HIPAA special enrollment rights may also apply due to a loss of coverage. See loss of coverage on page 16.	☐ Yes ☐ No
Commencement of paid leave of absence with loss of eligibility	• Cancellation of coverage (reinstate on return)	No	• End of enrollment	May cancel coverage only if eligibility lost; otherwise no change permitted. Paid leave includes periods when an employee is receiving replacement income such as salary continuation, short term disability, and long term disability benefits.	☐ Yes ☐ No
Commencement of paid leave of absence without loss of eligibility.	• No change	No	• No changes permitted	Because there is no loss of eligibility, no changes are permitted.	☐ Yes ☐ No
Commencement of unpaid leave of absence (non-FMLA) with loss of eligibility	• Cancellation of coverage (reinstate on return)	No	• End of enrollment	May cancel coverage if eligibility lost, otherwise no changes permitted.	☐ Yes ☐ No

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Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Return after paid leave of absence (gain eligibility)	• Reinstatement of previous coverage	No	• Reinstatement with blended dollar election • Enroll with new dollar amount (short period)	May reinstate if eligibility was lost upon commencement of leave. FSA may reinstate with blended dollar election or new short period.	☐ Yes ☐ No
Return after unpaid leave of absence (non-FMLA) (gain eligibility)	• Reinstatement of previous coverage	No	• Reinstatement if eligibility was lost • Enroll with new dollar amount (short period)	May reinstate if eligibility was lost upon commencement of leave. FSA may reinstate with new dollar amount – short period.	☐ Yes ☐ No
Government Programs/Legal					
Judgment, decree, QMCSO, NMSN, or other legal proceeding	• Adherence to court order	Must adhere to court order	• Adherence to court order	Under QMCSO or NMSN, a plan must enroll child (and employee if necessary) in the plan option specified in the Order or Notice.	☐ Yes ☐ No
Eligibility for Medicare	• No change permitted	No	• No change permitted	No change based on eligibility for Medicare.	☐ Yes ☐ No

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Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Entitlement to Medicare	• Drop of coverage for affected individual	No	• Decrease in dollar amount • End of enrollment	Requires actual enrollment in Medicare, not just gain in eligibility.	☐ Yes ☐ No
Loss of Medicare Eligibility	• Enrollment of affected individual	Yes	• Enrollment • Increase in dollar election	Not a common event. Could occur if individual entitled to Medicare on the basis of disability or ESRD after a specified recovery period. Could allow employee to add coverage of family members as well under tag-along rule.	☐ Yes ☐ No
Gain eligibility for Medicaid (not gain of premium assistance)	• Drop coverage for affected individual	No	• No change permitted	Gain of Medicaid with premium tax assistance is a HIPAA special enrollment, see page 6.	☐ Yes ☐ No
Gain eligibility for SCHIP (not gain of premium assistance)	• No change permitted	No	• No change permitted	Gaining eligibility for SCHIP premium assistance is a HIPAA special enrollment, see page 6.	☐ Yes ☐ No
Gain eligibility for premium tax credits in Marketplace	• No change permitted	No	• No change permitted	Under current regulations, this is not a status change that would permit an election change.	☐ Yes ☐ No
Drop Medicare Coverage (not loss of eligibility)	• No change permitted	No	• No change permitted	This is not a change in status that would permit a new election unless there is a loss of eligibility for Medicare. Voluntarily terminating coverage by discontinuing premium payments is not a loss of eligibility.	☐ Yes ☐ No
Lose eligibility for premium tax credits in Marketplace	• No change permitted	No	• No change permitted	Under current regulations, this is not a status change that would permit an election change.	☐ Yes ☐ No

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Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Commencement of paid FMLA leave of absence	• Continuation of existing election	No	• Continuation of existing election	Unless another event occurs, such as birth of a child, employees may not make any changes during a paid FMLA leave. Paid leave includes periods when an employee is receiving replacement income such as salary continuation, short term disability, and long term disability benefits.	☐ Yes ☐ No
Commencement of unpaid FMLA leave of absence	• Continuation existing coverage • Cancellation of coverage (reinstate on return)	No	• End of enrollment	If coverage is cancelled, the employee must be permitted to reinstate coverage upon return from unpaid FMLA leave.	☐ Yes ☐ No
Return after paid FMLA leave of absence	• Continuation of coverage • Reinstatement of previous coverage	No	• Continuation of coverage • Reinstatement of previous coverage • Election of a pro-rata reduction in dollar election	No change permitted after returning from a paid leave unless another event which would permit a change occurs.	☐ Yes ☐ No

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Return after unpaid FMLA leave of absence	• Continuation of coverage • Reinstatement of previous coverage	No	• Reinstatement with prior dollar election • Election of a pro-rata reduction in dollar election	Employer may require an employee to be reinstated to his or her election upon return from leave if employees who return from a non-FMLA leave are required to be reinstated in their elections. Employee may make new election only if another event, such as birth of a child, would permit a new election. For health FSA, employee has the choice to reinstate prior election or pro-rated reduction. For example, an employee with a two-month unpaid FMLA and a $1,200 election amount could continue the $1,200 or $1,000 election (10/12 x $1,200).	☐ Yes ☐ No

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Chart #2: Election Changes for Healthcare Plans Except Health FSA

No Health FSA Changes are Permitted Based on Cost or Coverage Change

Event	Permitted Change(s) to Reflect:	Ability Change to Coverage Option	Comments	Event Applies to the Plan
Change in Cost				
Insignificant increase	• Automatic increase in cost	No	A cost increase may be the result of employee action (e.g., switching from full-time to part-time while remaining eligible for plan coverage) or employer action (e.g., a change in the amount of contributions required from employees). The plan document must require the automatic election change in the event of an insignificant cost change.	☐ Yes ☐ No
Insignificant decrease	• Automatic decrease in cost	No	A cost decrease may be the result of employee action or employer action. The plan document must require the automatic election change in the event of an insignificant cost change.	☐ Yes ☐ No
Significant increase	• Payment of increased costs • Election of another similar, less expensive plan • Drop of coverage if similar plan is not available	Yes, but limited	The IRS has not provided guidance on what is a "significant" change in coverage. Employers must look at the facts and circumstances to determine if the increase is significant. Not an "open" enrollment. Only specified changes permitted. For example, if medical cost increased employee may select less expensive medical. The employee may not make other changes such as drop dental coverage.	☐ Yes ☐ No

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Event	Permitted Change(s) to Reflect:	Ability Change to Coverage Option	Comments	Event Applies to the Plan
Significant decrease	• Enrollment • Payment of decreased cost • Enrollment in a more expensive option	Yes, but limited	The IRS has not provided guidance on what is a "significant" change in coverage. Employers must look at the facts and circumstances to determine if the decrease is significant. Not an "open" enrollment. Only specified changes permitted. For example, if medical cost decreases employee may select a more expensive medical option. The employee may not make other changes such as add dental coverage.	☐ Yes ☐ No
Change in Coverage				
Plan coverage improvement (e.g., addition of a new option under the plan)	• Enrollment • Election of improved plan option	Yes, but limited	Employees may enroll in the option even if they did not previously enroll in another plan option. May enroll dependent(s) not previously covered. Employees enrolled in an existing option may change to the new option. Not an open enrollment. No other changes permitted. For example, if a new option is added to the medical plan, employees may not make changes to other health coverage such as dental or vision.	☐ Yes ☐ No
New plan	• Enrollment in new plan	Yes, but limited	May enroll employees and dependents in the new plan. Not an open enrollment. No other changes permitted. For example, if an employer offers dental for the first time, employees may enroll in the dental plan, but may not make changes in other plans such as a new medical plan election.	☐ Yes ☐ No

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Event	Permitted Change(s) to Reflect:	Ability Change to Coverage Option	Comments	Event Applies to the Plan
Significant coverage curtailment without loss of coverage	• Revocation of election • Election of coverage, on a prospective basis, that provides similar coverage	Yes, but limited	A significant curtailment in coverage is defined as an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally. This includes: a significant increase in employees' plan deductibles, copayments, or out-of-pocket cost-sharing limits. Might involve substantial changes to providers in a network (e.g., 1/3 of the hospitals leave the network), but would not be available for situations such as the loss of a single physician even if that physician is the employee's primary care physician.	☐ Yes ☐ No
Significant coverage curtailment with loss of coverage	• Election of a similar plan • Drop coverage, but only if a similar plan is not available	Yes, but limited	Curtailment must apply overall and be considered a virtual loss of coverage. This includes: elimination of a benefits option or an HMO ceasing to be available in the coverage area. It could also include reduction in benefits for a specific condition or treatment that participant in undergoing.	☐ Yes ☐ No
Another employer's open enrollment	• Drop coverage due to enrollment in spouse's plan • Enrollment due to drop of coverage in spouse's plan	Yes, but limited	Usually this is related to a spouse's open enrollment. Corresponding changes required (e.g., enrollment in spouse's plan if dropping employer's plan). Other employer's plan must be a cafeteria plan and have a different plan year.	☐ Yes ☐ No

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Chart #3: Election Changes for Dependent Care FSAs

Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Change in dependent care provider (e.g., change in residence affects available care providers)	• Enrollment in DCAP • Increase in dollar election • Decrease in dollar election • End of enrollment in DCAP	Consistency rule applies (e.g., employee may change salary reduction to reflect enrollment if a new provider becomes available or the end of enrollment if losing existing provider). Election change is permitted even if provider switches from day care center to relative.	☐ Yes ☐ No
Change in the cost of day care	• Increase in dollar election • Decrease in dollar election	Election change is permitted only if the provider is not related to the employee.	☐ Yes ☐ No
Change in the number of hours of dependent care and care costs	• Increase in dollar election • Decrease in dollar election	Consistency rule would apply (e.g., an employee could increase an election if she increased her work hours and needed more hours of day care for her child).	☐ Yes ☐ No
Marriage	• Enrollment in DCAP • Increase in dollar election • Decrease in dollar election • End of enrollment in DCAP	Enrolling or increasing the dollar election can occur to accommodate newly qualified dependents. Ending enrollment may be needed if new spouse is not employed.	☐ Yes ☐ No

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Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Divorce, annulment, or legal separation	• Enrollment in DCAP • Increase in dollar election • Decrease in dollar election • End of enrollment in DCAP	Enrolling or increasing the dollar election can occur to accommodate newly qualified dependents. For example, employees' ex-spouse begins employment and can no longer provide care while the employee works.	☐ Yes ☐ No
Birth or adoption	• Enrollment in DCAP • Increase in dollar election	An increase in the dollar election can occur to accommodate newly eligible dependents.	☐ Yes ☐ No
Child attains the age of 13	• Decrease in dollar election • End of enrollment in DCAP	Child ceases to be a qualified dependent on his/her 13th birthday. After age 13, the child must be physically or mentally incapable of self-support to be a qualified dependent. A decrease in dollar election is permitted to account for a dependent losing eligibility. May end enrollment if no more eligible dependents.	☐ Yes ☐ No
Child over the age of 13 becomes disabled	• Enrollment in DCAP • Increase in dollar election	After age 13, the child must be physically or mentally incapable of self-support to be a qualified dependent.	☐ Yes ☐ No
Previously disabled child over the age of 13 recovers from the disability	• End of enrollment in DCAP • Decrease in dollar election	A decrease in dollar election is permitted to account for a dependent losing eligibility. May end enrollment if no more eligible dependents.	☐ Yes ☐ No

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Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Change in employment status that causes the employee to gain eligibility (e.g., part-time to full-time)	• Enrollment in DCAP • Increase in dollar election	Employee may gain eligibility for dependent care or may have increased need (e.g., such as a change from part-time to full-time).	☐ Yes ☐ No
Change in employment status or termination that causes an employee to lose eligibility (e.g., unpaid leave, strike, lock out, layoff)	• End of enrollment in DCAP • Decrease in dollar election	Employee will have no qualified expenses during a leave of absence (paid or unpaid).	☐ Yes ☐ No
Begin FMLA or other leave (paid or unpaid)	• Decrease in dollar election • End of enrollment in DCAP	Employee will have no qualified expenses during a leave of absence (paid or unpaid).	☐ Yes ☐ No
Return from FMLA or other leave (paid or unpaid)	• Reinstatement of coverage		☐ Yes ☐ No
Return from strike, lock out, or layoff	• Reinstatement of coverage		☐ Yes ☐ No

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Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Rehire employee within 30 days	• Reinstatement of prior election • Denial of reinstatement until the next plan year		☐ Yes ☐ No
Rehire employee after 30 days or more	• Selection of new election • Reinstatement of prior election • Denial of reinstatement until the next plan year		☐ Yes ☐ No
Commencement of employment by spouse	• Enrollment in DDCAP • Increase in dollar election	Enrolling or increasing the dollar election can occur to accommodate newly qualified dependents.	☐ Yes ☐ No
Loss of eligibility under another plan due to spouse's termination or change in employment status	• Enrollment in DCAP • Increase in dollar election	Employee may choose to enroll if coverage was provided under the spouse's dependent care FSA.	☐ Yes ☐ No

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Election Changes for Life and Disability Insurance

Most changes in status permit changes, even when eligibility is not affected, to reflect the following: enrollment of employee, increase in coverage, decrease in coverage, or end of enrollment. For example, in the event of marriage, an employee may either increase or decrease her life insurance coverage. In the event of a divorce, she may either increase or decrease her life insurance. However, when an employee is rehired within 30 days, the only permitted changes are to reflect: reinstatement of the prior election or to denial of reinstatement until the next plan year. When an employee is rehired after 30 days, the following changes are permitted: selection of new plans, reinstatement of a prior election, or denial of reinstatement until the next plan year.

Note: Life or disability insurance that is provided on an after-tax basis outside the cafeteria plan is not subject to the IRS election change rules. Carrier rules will apply.

Rules for Domestic/Civil Union Partners and their Children

In general, the rules for a domestic/civil union partner depend on whether the domestic/civil union partner is the employee's tax dependent. If the domestic/civil union partner is the employee's tax dependent, then the rules for dependents included in Charts #1, #2, and #3 above would apply. If the domestic/civil union partner is not the employee's tax dependent, then coverage for the domestic/civil union partner must be paid for on an after-tax basis.

The children of a domestic/civil union partner are almost never the employee's tax dependent. The tax code definition of a tax dependent includes a qualifying child and a qualifying relative. A domestic/civil union partner's child would be the domestic partner's qualifying child, not the employee's qualifying child. One of the requirements for being a qualifying relative is that the individual not be another person's qualifying child. As a result, unless the employee has legally adopted the domestic/civil union partner's child, the child will not be the employee's tax dependent.

HIPAA special enrollment rights do not apply upon entering a domestic/civil union partnership. Special enrollment rights would be available based on the birth, adoption or placement for adoption of a child by the employee's domestic/civil union partner. In the event of birth/adoption/placement by the employee's domestic partner, the child(ren) and employee, but not the domestic/civil union partner, would have a special enrollment right. HIPAA special enrollment rights do apply to dependents that are defined as dependents under the terms of the plan that lose other coverage (health insurance or coverage under an employer's health plan) – including domestic/civil union partners and their children even those that are not the employee's tax dependents.

For domestic/civil union partners who are not the employee's tax dependent (and their children), no cafeteria plan changes are permitted. However, where there is a change in eligibility for coverage, corresponding election changes are virtually always permitted in the component benefit plans offered under the cafeteria plan, but the changes must be made on an after-tax basis.