DEPARTMENT OF THE TREASURY
Internal Revenue Service
AGENCY: Internal Revenue Service, Treasury.

26 CFR Part 1
Benefits Provided Under Certain Employee Benefit Plans

[EE-130-86]

54 FR 9460

March 7, 1989

List of Subjects in 26 CFR 1.61-1 Through 1.281-1

Deductions, Exemptions, Income taxes, Taxable income.

Proposed Amendments to the Regulations

The proposed amendments to 26 CFR Part 1 are as follows:

Par. 3. Proposed § 1.125-1 as published in the Federal Register on May 7, 1984 *(49 FR 19321)*, and amended on December 31, 1984 *(49 FR 50733)*, is amended by adding a new Q&A-30 at the end, to read as follows:

§ 1.125-1 Questions and Answers relating to cafeteria plans.

* * * * *

Q-30: Are there additional rules for cafeteria plans?

A-30: Yes. Additional rules for cafeteria plans are contained in § 1.125-2 and take effect as set forth in Q&A-1 of § 1.125-2. To the extent that § 1.125-2 and this § 1.125-1 are inconsistent, § 1.125-2 supersedes this § 1.125-1.

Par. 4. New § 1.125-2 is added to read as follows:

§ 1.125-2 Miscellaneous cafeteria plan questions and answers.

The following is a list of the questions addressed in this section.

Q-1: What are the effective dates of these cafeteria plan rules?

Q-2: What does section 125 of the Code provide?

Q-3: What is a cafeteria plan under section 125?

Q-4: What benefits constitute qualified benefits and what benefits constitute cash under a cafeteria plan?

Q-5: May a cafeteria plan include a benefit that defers the receipt of compensation?

Q-6: In what circumstances may participants revoke existing elections and make new elections under a cafeteria plan?

Q-7: How do the rules governing the tax-favored treatment of employer-provided benefits apply to plans that are flexible spending arrangements?

Q-1: What are the effective dates of these cafeteria plan rules?

A-1: Q&A-1 through Q&A-6 of this § 1.125-2 apply to plan years of cafeteria plans as set forth in Q&A-10 of § 1.89(a)-1 (regarding the effective date of section 89). Q&A-7 of this § 1.125-2 (relating to flexible spending arrangements) applies to plan years beginning after December 31, 1989.

Q-2: What does section 125 of the Code provide?

A-2: In general, an employee who has an election among nontaxable benefits and taxable benefits (including cash) must include in gross income any taxable benefits that the employee could have actually received pursuant to the employee's election. The amount of these benefits is included in the employee's income in the year in which the employee would have actually received the taxable benefits if the employee had elected such benefits. This generally is the result even if the employee's election between the nontaxable benefits and taxable benefits is made prior to the year in which the employee would have actually received the taxable benefits. However, section 125 provides that cash (including certain taxable benefits) provided under a nondiscriminatory cafeteria plan will not be included in a participant's gross income merely because the participant has the opportunity, before the cash becomes currently available to the participant, to choose among cash and the nontaxable benefits under the cafeteria plan

Q-3: What is a cafeteria plan under section 125?

A-3: A cafeteria plan is a plan maintained by an employer for the benefit of its employees that satisfies the requirements of section 89(k), under which all participants are employees, and under which each participant has the opportunity to choose among cash and qualified benefits. Additionally, a cafeteria plan satisfies the written plan document requirement of clause (v) of Q&A-3 of § 1.125-1 only if the plan describes the maximum amount of elective contributions available to any employee under the plan either by stating the maximum dollar amount or maximum percentage of compensation that may be contributed as elective contributions under the plan by employees or by stating the method for determining the maximum amount or percentage of elective contributions that employees may make under the plan. The meaning of "elective contributions" under a cafeteria plan is the same as the meaning of "salary reduction contributions" under a cafeteria plan. See also paragraph (a)(2) of Q&A-8 of § 1.89(a)-1.

Q-4: What benefits constitute qualified benefits and what benefits constitute cash under a cafeteria plan?

A-4: (a) Qualified benefits -- (1) In general. A benefit is a qualified benefit under a cafeteria plan if the benefit does not defer the receipt of compensation and the benefit is not includable in an employee's gross income by reason of an express provision of Chapter 1 of the Code. In the case of insurance-type benefits, such as benefits provided under accident or health plans (sections 106 and 105) and group-term life insurance plans (section 79), the benefit is the coverage under the plan.

(2) Items that constitute qualified benefits -- (i) Accident or health plans. Coverage under an accident or health plan is a qualified benefit to the extent that such coverage is excludable from income under section 106. Thus, for example, coverage under a long-term disability plan and coverage under an accidental death and dismemberment policy may be qualified benefits.

(ii) Group-term life insurance. Group-term life insurance coverage that is excludable from gross income under section 79 and group-term life insurance coverage that is includable in gross income solely because the death benefit payable thereunder is in excess of the dollar limit of section 79 are qualified benefits.

(iii) Certain discriminatory benefits. Accident or health plan coverage, group-term life insurance coverage, and benefits under a dependent care assistance program do not fail to be qualified benefits under a cafeteria plan merely because they are includable in gross income solely because of section 89 or any other applicable nondiscrimination requirement (e.g., section 129(d)).

(iv) Certain dependent care assistance benefits. Benefits under a dependent care assistance program that would have been excludable from gross income under section 129 but for the elimination of overnight camp expenses from dependent care assistance under such section (effective January 1, 1988) or the reduction of the age limit on children qualifying as dependents under such section (effective January 1, 1989) do not fail to be qualified benefits merely because such changes in law cause such benefits to be taxable. However, the preceding sentence applies only if the benefits are provided under a program that otherwise qualifies as a dependent care assistance program under section 129, are taxable to the employee upon receipt, and are provided by the December 31 next following the effective date of the applicable change in law. After such date, such benefits will not constitute qualified benefits but may be treated as cash pursuant to paragraph (b) of this Q&A-4.

(b) Currently taxable benefits treated as cash. In general, a benefit is treated as cash if such benefit does not defer the receipt of compensation and an employee who receives such benefit purchases such benefit with after-tax employee contributions or is treated, for all purposes under the Code (including, for example, reporting and withholding purposes), as receiving, at the time that such benefit is received, cash compensation equal to the full value of such benefit at such time and then purchasing such benefit with after-tax employee contributions. Thus, for example, long-term disability coverage is treated as cash if the cafeteria plan provides that an employee may purchase the coverage under the plan with after-tax employee contributions, or provides that the employee receiving such coverage is treated as having received cash compensation equal to the value of the coverage and then as having purchased the coverage with after-tax employee contributions. Any taxable benefit that is not described in paragraph (a) of this Q&A-4 and is not treated as cash under this paragraph (b) may not be included in a cafeteria plan.

(c) Qualified cash or deferred arrangements. Elective contributions to a qualified cash or deferred arrangement (section 401(k)) are permitted under a cafeteria plan. In addition, after-tax employee contributions under a qualified plan subject to section 401(m) are permitted under a cafeteria plan. The right to make such contributions will not cause a plan to fail to be a cafeteria plan merely because, under the qualified plan, employer matching contributions are made with respect to elective or after-tax employee contributions.

(d) Benefits that do not constitute qualified benefits or cash. Benefits of the type described in section 117 or 132 do not constitute qualified benefits or cash and thus may not be included in a cafeteria plan regardless of whether any such benefit is purchased with after-tax employee contributions or on any other basis. Thus, for example, health diagnostic or examination plans are qualified benefits under a cafeteria plan because such plans are accident or health plans that are eligible for the exclusion under section 106 and are not, in any case, eligible for the exclusion under section 132.

Q-5: May a cafeteria plan include a benefit that defers the receipt of compensation?

A-5: (a) In general. A cafeteria plan may not include any plan that offers a benefit that defers the receipt of compensation. In addition, a cafeteria plan may not operate in a manner that enables employees to defer compensation. For example, a plan that permits employees to carry over unused elective contributions or plan benefits (e.g., accident or health plan coverage) from one plan year to another operates to defer compensation. This is the case regardless of how the contributions or benefits are used by the employee in the subsequent plan year (e.g., whether they are automatically or electively converted into another taxable or nontaxable benefit in the subsequent plan year or used to provide additional benefits of the same type). Similarly, a cafeteria plan operates to permit the deferral of compensation if the plan permits participants to use contributions for one plan year to purchase a benefit that will be provided in a subsequent plan year (e.g., life, health, disability, or long-term care insurance coverage with a savings or investment feature, such as whole life insurance). For example, a cafeteria plan operates to permit the deferral of compensation if the cafeteria plan includes a health plan that is a flexible spending arrangement (as defined in Q&A-7 of this section) and such health plan may reimburse participants' premium payments for other accident or health coverage extending beyond the end of the plan year. See Q&A-7 of this section for the treatment of experience gains under a health plan that is a flexible spending arrangement.

(b) Exceptions. A plan does not fail to be a cafeteria plan merely because the plan permits participants to make elective contributions under a qualified cash or deferred arrangement under section 401(k) or permits participants employed by certain educational institutions to purchase retiree group-term life insurance. Similarly, a cafeteria plan does not include a benefit that defers the receipt of compensation merely because the cafeteria plan provides the opportunity to make after-tax employee contributions subject to section 401(m) under a qualified plan. In addition, a cafeteria plan will not be treated as including a benefit that defers the receipt of compensation merely because, under

the qualified plan, employer matching contributions (as defined in section 401(m)(4)(A)) are made with respect to such elective contributions or after-tax employee contributions. Finally, reasonable premium rebates or policy dividends paid with respect to benefits provided under a cafeteria plan do not constitute impermissible deferred compensation if such rebates or dividends are paid before the close of the 12-month period immediately following the plan year to which such rebates and dividends relate.

(c) Treatment of paid vacation days under a cafeteria plan -- (1) In general. A cafeteria plan may include elective, paid vacation days by permitting participants to receive either additional or fewer paid vacation days than the employer otherwise provides to the employees on a nonelective basis, if the inclusion of elective vacation days under the plan does not operate to permit the deferral of compensation.

(2) Ordering of elective and nonelective vacation days. In determining whether a plan that provides for paid vacation days operates to permit the deferral of compensation, and thus fails to be a cafeteria plan, a participant is deemed to use nonelective vacation days (i.e., the vacation days with respect to which the employee had no election) before elective vacation days.

(3) Cashing out unused elective vacation days. A plan does not operate to permit the deferral of compensation merely because the plan permits a participant who has not used all elective, paid vacation days for a plan year to receive in cash the value of such unused days in exchange for such days if the participant receives the cash on or before the earlier of the last day of the plan year of the cafeteria plan or the last day of the employee's taxable year to which the elective contributions used to purchase the unused days relate.

(4) Examples. The following examples illustrate the rules of this paragraph (c):

Example 1. Assume that an employer provides an employee with 2 weeks of paid vacation for each calendar year and maintains a calendar year cafeteria plan that permits the employee to "purchase," with elective contributions, an additional week of paid vacation. Assume further that Employee A, with a calendar tax year, purchases 1 additional week of vacation. If Employee A uses only 2 weeks of vacation during the year, the employee is treated as having used the 2 nonelective weeks and as having retained the 1 elective week. If the 1 remaining week (i.e., the elective week) may be carried over to the next year (or the value thereof used for any other purpose in the next year), the plan operates to permit the deferral of compensation and thus is not a cafeteria plan. However, the cafeteria plan may permit the employee to receive the value of the unused elective vacation week in cash before the end of the applicable calendar year.

Example 2. The facts are the same as set forth in Example 1, except that Employee A uses only 1 week of vacation during the year. Thus, Employee A is treated as having used 1 nonelective week and as having retained 1 nonelective week as well as 1 elective week of vacation. Because the nonelective vacation days are not part of the cafeteria plan (i.e., the employer or plan does not permit participants to exchange regular vacation days for other benefits), Employee A may be permitted to carry over the 1 nonelective week of vacation to the next year. In addition, under the terms of the cafeteria plan, Employee A must either forfeit the remaining elective vacation week or receive in cash the value of such unused days before the end of the applicable calendar year.

Q-6: In what circumstances may participants revoke existing elections and make new elections under a cafeteria plan?

A-6: (a) In general. A plan is not a cafeteria plan unless the plan requires that participants make elections among the benefits offered under the plan. In general, an election will not be deemed to have been made if, after a participant has elected and begun to receive a benefit under the plan, the participant is permitted to revoke the election during the period of coverage under the plan, even if the revocation relates only to the remaining portion of the coverage period with respect to the benefit and even if the revocation is in response to a change in the tax treatment of such benefit. However, in the circumstances specified in paragraphs (b) through (g) of this Q&A-6, notwithstanding Q&A-8 of § 1.125-1, the terms of a cafeteria plan may permit a participant to revoke an existing election and, in some cases, to make a new election with respect to the remaining portion of the period of coverage. If a new election is permitted under this Q&A-6, then such new election must be consistent with the reason that such change was permitted. In addition, a cafeteria plan may permit an election change to the extent required under paragraph (c)(6) of Q&A-3 of § 1.89(a)-1. Such election changes will not cause taxable benefits offered under the cafeteria plan to be treated as currently available

to employees. See Q&A-7 of this section for certain additional limits on election changes that relate to certain flexible spending arrangements.

(b) Significant cost or coverage changes -- (1) Cost changes. If the cost of a health plan provided by an independent, third party provider under a cafeteria plan increases or decreases during a plan year and under the terms of the cafeteria plan, employees are required to make a corresponding change in their premium payments, the cafeteria plan may, on a reasonable and consistent basis, automatically increase or decrease, as the case may be, all affected participants' elective contributions or after-tax employee contributions for such health plan. Alternatively, if the premium amount significantly increases, a cafeteria plan may permit participants either to make a corresponding change in their premium payments or to revoke their elections and, in lieu thereof, to receive on a prospective basis, coverage under another health plan with similar coverage. No elective adjustments of participants' contributions or revocations of participants' elections other than those provided for in the preceding sentence may be permitted under a cafeteria plan on account of changes in the cost of a health plan.

(2) Coverage changes. If the coverage under a health plan provided by an independent, third-party provider is significantly curtailed or ceases during a period of coverage, a cafeteria plan may permit all affected participants to revoke their elections of the health plan and, in lieu thereof, to receive on a prospective basis coverage under another health plan with similar coverage.

(c) Certain changes in family status. A cafeteria plan may permit a participant to revoke a benefit election during a period of coverage and to make a new election for the remaining portion of the period if the revocation and new election are both on account of a change in family status and are consistent with such change in family status. For purposes of this paragraph (d), examples of changes in family status for which a benefit election change may be permitted include the marriage or divorce of the employee, the death of the employee's spouse or a dependent, the birth or adoption of a child of the employee, the termination of employment (or the commencement of employment) of the employee's spouse, the switching from part-time to full-time employment status or from full-time to part-time status by the employee or the employee's spouse, and the taking of an unpaid leave of absence by the employee or the employee's spouse. Election changes are also permitted where there has been a significant change in the health coverage of the employee or spouse attributable to the spouse's employment. Benefit election changes are consistent with family status changes only if the election changes are necessary or appropriate as a result of the family status changes.

(d) Separation from service. A cafeteria plan may permit an employee who separates from the service of the employer during a period of coverage to revoke existing benefit elections and terminate the receipt of benefits for the remaining portion of the coverage period. However, in such case, the plan must prohibit the employee, if the employee should return to service for the employer, from making new benefit elections for the remaining portion of the period of coverage.

(e) Cessation of required contributions. A cafeteria plan may provide that a benefit will cease to be provided to an employee if the employee fails to make the required premium payments with respect to the benefit (e.g., employee ceases to make premium payments for health plan coverage after a separation from service). However, in such case, the plan must prohibit the employee from making a new benefit election for the remaining portion of the period of coverage.

(f) Elective contributions under a qualified cash or deferred arrangement. A cafeteria plan may permit a participant who has elected to make elective contributions under a qualified cash or deferred arrangement (within the meaning of section 401(k)) to modify or revoke the election as permitted under section 401(k). Similarly, a cafeteria plan may permit a participant who has elected to make after-tax employee contributions subject to section 401(m) to modify or revoke the election as permitted under section 401(m). Thus, for example, a cafeteria plan may include a benefit option providing for elective contributions under a qualified cash or deferred arrangement which requires that, as a condition of a hardship distribution, the employee receiving the distribution cease making elective contributions under the arrangement for a specified period.

Q-7: How do the rules governing the tax-favored treatment of employer-provided benefits apply to plans that are flexible spending arrangements?

A-7: (a) In general. Health plans that are flexible spending arrangements as defined in paragraph (c) of this Q&A-7 (health FSAs) must conform to the generally applicable rules under sections 105 and 106 in order for the coverage and reimbursements under such plans to qualify for tax-favored treatment under such sections. Thus, health FSAs must qualify as accident or health plans. This means that, in general, while the health coverage under the FSA need not be provided through a commercial insurance contract, health FSAs must exhibit the risk-shifting and risk-distribution characteristics of insurance. Similarly, reimbursements under health FSAs must be paid specifically to reimburse the participant for medical expenses incurred previously during the period of coverage. Furthermore, a health FSA cannot operate under a cafeteria plan in a manner that enables participants to receive coverage only for periods for which the participants expect to incur medical expenses if such periods constitute less than a plan year. A reimbursement is not paid specifically to reimburse the participant for medical expenses if the participant is entitled to these amounts, in the form of cash or any other taxable or nontaxable benefit (including health coverage for an additional period), without regard to whether or not the employee incurs medical expenses during the period of coverage. A health FSA will not qualify for tax-favored treatment under sections 105 and 106 of the Code if the effect of the reimbursement arrangement eliminates all, or substantially all, risk of loss to the employer maintaining the plan or other insurer. These rules apply with respect to a health plan without regard to whether the plan is provided through a cafeteria plan. See Q&A-17 of § 1.125-1.

(b) Special requirements -- (1) In general. A health FSA must satisfy the requirements set forth in this paragraph (b) in order for the employer-provided health coverage provided through the health FSA to qualify for the exclusion from income under section 106 and for the reimbursements and other benefits pursuant to the health FSA coverage to qualify for the exclusion from income under section 105.

(2) Uniform coverage throughout coverage period. The maximum amount of reimbursement under a health FSA must be available at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage). Thus, the maximum amount of reimbursement at any particular time during the period of coverage cannot relate to the extent to which the participant has paid the required premiums for coverage under the health FSA for the coverage period. Similarly, the payment schedule for the required premiums for coverage under a health FSA may not be based on the rate or amount of covered claims incurred during the coverage period. Reimbursement will be deemed to be available at all times if it is paid at least monthly or when the total amount of the claims to be submitted is at least a specified, reasonable minimum amount (e.g., $50). If the employee revokes existing elections, the employer must reimburse the employee for any amount previously paid for coverage or benefits relating to the period after the date of the employee's separation from service regardless of the employee's claims or reimbursements as of such date. The following examples illustrate the rules of this paragraph (b)(2):

Example 1. Assume that an employee elects coverage under a health FSA providing coverage of up to $300 in medical expenses and the annual premium for a calendar year of coverage is $300. Assume also that the employee is permitted to pay the $300 premium through salary reduction of $25 per month throughout the coverage period. The employee must be eligible to receive the maximum amount of reimbursement of $300 at all times throughout the coverage period (reduced by prior reimbursements). Thus, if the employee incurs $250 of medical expenses in January, the full $250 must be available for reimbursement even though the employee has made only one premium payment. If the employee incurs another $50 in health expenses in February, the remaining $50 of the $300 maximum must be available for reimbursement. The employer or plan may not provide for an acceleration of the required premium payments based on the employee's incurred claims and reimbursements.

Example 2. Assume that an employee elects coverage under a health FSA with a maximum reimbursement limit of $500 for a calendar year of coverage and is required to pay the $450 premium for such coverage in two equal $225 installments, one at the beginning of the period of coverage and the second installment by the beginning of the sixth month of coverage. Assume further that the employee incurs a $400 medical expense in February and the FSA makes a $400 reimbursement to the employee in March. The employee does not incur any additional medical expenses before the end of June, at which time the employee separates from service. If the employee fails to make the second premium installment, the employee's coverage under the FSA may be terminated as of the end of June so that medical expenses incurred after June are not covered. If the employee pays the second premium installment, the employee's coverage under the FSA must continue, so that additional medical expenses (up to the remaining $100) incurred before the end of December are covered.

(3) Twelve-month period of coverage. The period of coverage under a health FSA must be 12 months or, in the case of a short first plan year or a short plan year of a cafeteria plan where the plan year is being changed, the entire short plan year. Election changes to increase or decrease the level of coverage under a health FSA during the 12-month period of coverage are not permitted with respect to health FSAs. However, a cafeteria plan may permit participants to make health FSA election changes for the remaining portion of the 12-month period of coverage on account of and consistent with certain family status changes. See Q&A-6 of this section. In addition, a cafeteria plan may provide that the period of coverage under a health FSA terminates if the employee ceases to make required premium payments; however, such employee may not be permitted to make a new health FSA benefit election for the remaining portion of the original coverage period. Also, a cafeteria plan may permit an employee who separates from the service of the employer during a period of coverage to revoke existing benefit elections and terminate receipt of benefits, including coverage under the health FSA. For the application of the health care continuation rules of section 4980B of the Code to health FSAs, see the regulations under section 4980B or its predecessor section 162(k) of the Code. The requirements of this paragraph (b)(3) are illustrated by the following example:

Example. Assume that an employee has elected a $300 calendar year health FSA, with monthly premium payments of $25 during the 12-month period of coverage. Such employee separates from service for the employer at the end of June and ceases to make additional premium payments. The cafeteria plan may provide that the FSA's period of coverage does not extend beyond June if the employee does not continue to make the required premium payments. However, if the employee makes the total premium payment for the 12-month period of coverage, the cafeteria plan may not terminate the FSA's period of coverage merely because the employee separated from service before the end of the coverage period.

(4) Prohibited reimbursement. A health FSA can only reimburse medical expenses as defined in section 213. Thus, for example, a health FSA cannot reimburse dependent care expenses. In addition, a health FSA may not treat participants' premium payments for other health coverage as reimbursable expenses. Thus, for example, a health FSA may not reimburse participants for premiums paid for other health plan coverage, including premiums paid for health coverage under a plan maintained by the employer of the employee's spouse or dependent. (See also Q&A-5 of this section with respect to whether the reimbursement of other premiums constitutes impermissible deferred compensation.) This paragraph (b)(4) does not prevent premiums for current health plan coverage (including coverage under a health FSA) from being paid on a salary reduction basis through the ordinary operation of the cafeteria plan.

(5) Claims substantiation. A health FSA may reimburse a medical expense only if the participant provides a written statement from an independent third party stating that the medical expense has been incurred and the amount of such expense and the participant provides a written statement that the medical expense has not been reimbursed or is not reimbursable under, any other health plan coverage. Thus, for example, as with any other flexible spending arrangement, a health FSA cannot make advance reimbursements of future or projected expenses. In determining whether, under all the facts and circumstances, employees are being reimbursed for inadequately substantiated claims, special scrutiny will be given to other arrangements such as employer-to-employee loans that are related to the employee premium payments or actual or projected employee claims.

(6) Claims incurred. Medical expenses reimbursed under a health FSA must be incurred during the participant's period of coverage under the FSA. Expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care. Also, expenses are not treated as incurred during a period of FSA coverage if such expenses are incurred before the later of the date the health FSA is first in existence or the participant first becomes enrolled under the health FSA.

(7) FSA experience gains. If a health FSA has an experience gain with respect to a year of coverage, the excess of the premiums paid (e.g., employer contributions, including salary reduction contributions and after-tax employee contributions) and income (if any) of the FSA over the FSA's total claims reimbursements and reasonable administrative costs for the year may be used to reduce required premiums for the following year or may be returned to the premium payers (the participants for premiums paid by salary reduction or employee contributions) as dividends or premium refunds. Such experience gains must be allocated among premium payers on a reasonable and uniform basis. It is permissible to allocate such amounts based on the different coverage levels under the FSA received by the premium payers. However, in no case may the experience gains be allocated among premium payers based (directly or indirectly) on their individual claims experience. The requirements of this paragraph (b)(7) are illustrated in the following example:

Example. Assume that an employer maintains a cafeteria plan under which its 1.200 employees may elect one of several different annual coverage levels under a health FSA in $100 increments from $500 to $2,000. For a plan year, 1,000 employees elect levels of coverage under the health FSA. For such year, the FSA has an experience gain of $5,000 (i.e., premium payments for the year exceed reimbursed claims plus administrative costs by $5,000). The $5,000 may be allocated to all premium payers for the year, as a premium refund, on a per capita basis weighted to reflect the participants' elected levels of coverage. Alternatively, the $5,000 may be used to reduce the required premiums under the health FSA for all eligible employees for the next plan year (e.g., a $500 health FSA for the next year might be priced at $480) or to reimburse claims incurred above the elective limit in such year as long as such reimbursements are made in a nondiscriminatory manner.

(8) Dependent care assistance. Analogous rules to this paragraph (b), with the exception of paragraph (b)(2) relating to uniform coverage throughout the coverage period, are applicable to dependent care assistance provided under section 129. See Q&A-18 of § 1.125-1.

(c) Definition of flexible spending arrangement. A flexible spending arrangement (FSA) generally is a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if such maximum amount is less than 500 percent of the premium. A single FSA may provide participants with different levels of coverage and maximum amounts of reimbursement. However, for purposes of section 89, each different level of coverage under a FSA is a separate plan.

(d) Effective date. This Q&A-7 is effective for plan years beginning after December 31, 1989.

(e) Authority to issue additional requirements. The Commissioner, in revenue rulings, notices and other publications of general applicability, may make any modification to, or issue such additional requirements for the application of, the rules contained in this Q&A-7 as may be necessary to insure proper compliance with the intent of such rules.

(f) Example. The provisions of paragraph (c) of this Q&A-7 are illustrated by the following example:

Example 1. Assume that an employer with 1,000 employees maintains a cafeteria plan under which the employees may elect among several benefit options, including insured health plans and HMOs. The plan provides that the required premiums or contributions for the benefits are to be made by salary reduction. Even though the plan may characterize employees' premium payments and other contributions as flexible spending contributions or credits, the operation of a cafeteria plan to permit employees' contributions to be made on a salary reduction basis does not, standing alone, cause the plan (or any benefit thereunder) to be treated as a flexible spending arrangement.

Example 2. Assume that an employer with 1,000 employees maintains a cafeteria plan under which the employees may elect, among other benefits, a level of coverage under an arrangement that will reimburse medical expenses incurred during a year up to the specified amount elected by the employee. The maximum amount of reimbursement that can be deducted for a year is $5,000.

Each employee's premium for such coverage is equal to the maximum reimbursement amount selected by the employee. Such an arrangement is a health FSA.

Lawrence B. Gibbs,

Commissioner of Internal Revenue.

[FR Doc. 89-5136 Filed 3-2-89; 8:45 am]

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to benefits provided under certain employee benefit plans under sections 89 and 125 of the Internal Revenue Code of 1986. The regulations reflect changes made by the Revenue Act of 1978, the Tax Reform Act of 1984, the Tax Reform Act of 1986, and the Technical and Miscellaneous Revenue Act of 1988. The regulations provide the public with guidance on the nondiscrimination and qualification requirements for certain employee benefit plans and affect sponsors of, and participants in, a variety of types of plans, including accident and health plans, group-term life insurance, and dependent care assistance programs.

DATES: Written comments and requests for a public hearing must be delivered or mailed on or before May 8, 1989. The amendments are generally proposed to apply to plan years beginning after December 31, 1988.

ADDRESS: Send comments and requests for a public hearing to: Commissioner of Internal Revenue, Attention: CC:CORP:T:R (EE-130-86), Washington, DC 20224.
FOR FURTHER INFORMATION CONTACT: Felix Zech or David Munroe of the Office of the Assistant Chief Counsel, Employee Benefits and Exempt Organizations, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224 (Attention: CC:CORP:T:R (EE-!30-86)) ((202) 535-3818) (not a toll-free number).

TEXT: SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collections of information contained in this notice of proposed rulemaking have been submitted to the Office of Management and Budget for review in accordance with the Paperwork Reduction Act of 1980 *(44 U.S.C. 3504*(h)). Comments on the collections of information should be sent to the Office of Management and Budget, Paperwork Reduction Project, Washington, DC 20503, with copies to the Internal Revenue Service, Attention: IRS Reports Clearance Officer TR:FP, Washington. DC 20224.

The collections of information in these regulations are in §§ 1.89(a)-1 and 1.89(k)-1. Certain of this information is required by the Internal Revenue Service to memorialize the method of testing used by the employer in determining whether it meets the requirements of section 89(a) and correctly reports an employee's wages on the Form W-2. Additional requirements include the preparation of a written plan document, a notice relating to benefits (both required under section 89(k)). The likely respondents/recordkeepers are employers who provide welfare benefit programs to their employees.

These estimates are an approximation of the average time expected to be necessary for a collection of information. They are based on such information as is available to the Internal Revenue Service. Individual recordkeepers may require more or less time, depending on their particular circumstances.

The burden estimates represent an estimation of the actual time for recordkeeping, learning about the law, computations and testings.

The estimated total annual reporting and/or recordkeeping burden: 9,000,000 hours. With respect to learning about the law, testing and making any written elections, the estimated annual burden per respondent/recordkeeper varies from l hour to 40 hours, depending on individual circumstances, with an estimated average of 10 hours. The estimated number of respondents and/or recordkeepers: 750,000. With respect to physically preparing the written plan, notice and statement relating to employees, the estimated annual burden per respondent/recordkeeper varies from 30 minutes to 4 hours, depending on individual circumstances, with an estimated average of 2 hours. The estimated number of respondents and/or recordkeepers: 750,000. Estimated annual frequency of response (for reporting requirements only): as necessary.

Background

This document contains proposed additions to the Income Tax Regulations (26 CFR Part 1) under sections 89 and 125 of the InternaI Revenue Code of 1986 (Code). The additions with respect to section 89 are proposed to conform the regulations to section 1151 of the Tax Reform Act of 1986 (TRA '86) (100 Stat. 2494), and section 3021 of the Technical and Miscellaneous Revenue Act of 1988 (TAMRA '88) (102 Stat. 3625). The additions with respect to section 125 are proposed pursuant to section 134 of the Revenue Act of 1978 (92 Stat. 2763), section 101 of the Technical Corrections Act of 1979 (92 Stat. 2227), section 226 of the Miscellaneous Revenue Act of 1980 (94 Stat. 3525), section 531(b)(4) of the Tax Reform Act of 1984 (96 Stat. 494), section 1l51 of the Tax Reform Act of 1986 (TRA '86) (100 Stat. 2494), and section 1O11B of the Technical and Miscellaneous Revenue Act of 1988 (TAMRA '88) (!02 Stat. 3485).

Section 89 was intended, in part, to discourage employers from offering health plans and other welfare benefits that disproportionately favor highly compensated employees either as to coverage or extent of benefits. A principal objective of this legislation was to extend health coverage for employees not now covered. The sanction for failing to meet nondiscrimination criteria outlined in the statute and this implementing rule is the taxation of the excess value of highly compensated employees' benefits.

To help provide an improved basis for evaluation of the specific content and effect of the statute and these regulations, comments are invited on changes in plan provisions, the numbers and types of employee eligible for plans affected by these regulations, and employee participation rates that may be associated with one or more changes proposed in these regulations. Information indicating the effect on particular groups of employees identified by wage leve1s, occupations, industries or other characteristics would be especially useful. Comments also are invited on the expected effect on costs to employers and health providers which result from particular requirements.

Explanation of Rules

The proposed regulations include guidance in three general areas. First, they provide information with respect to miscellaneous matters relating to the nondiscrimination rules of section 89(a). Second, the proposed regulations contain detailed guidance with respect to the qualification requirements of section 89(k). Finally, the proposed regulations include questions and answers relating to section l25 (cafeteria plans) and supplementing the existing proposed regulations contained at § 1.125-1 *(49 FR 19321)*. The proposed regulations include a variety of special rules to facilitate the application of and compliance with sections 89 and 125, particularly for plan years beginning in 1989.

1. In General

These proposed regulations constitute the issuance of comprehensive section 89 rules on which taxpayers may rely. Nevertheless, until the later of January 1, 1990, or the beginning of the second testing year beginning after December 31, 1988, if an employer reasonably and in good faith complies with the requirements of section 89 (including the legislative history thereto), the employer will be treated as having satisfied section 89. After this transition period, this standard of compliance will not apply to the extent that these proposed regulations address issues under section 89. Whether compliance is reasonable and in good faith is to be determined on the basis of all the facts and circumstances, including whether the employer makes a reasonable and good faith effort to collect and analyze the necessary data and information, and whether the employer consistently resolves unclear issues in its favor.

These questions and answers do not provide comprehensive guidance on certain issues. For example, no guidance is provided on the special multiemployer plan rules adopted in TAMRA '88. In addition, this guidance does not address the separate line of business rules of section 414(r) or the extent to which additional employer disaggregation is available under section 89. In addition, the proposed regulations generally do not address the application of section 89 to group-term life insurance. These matters will be addressed in future guidance.

The proposed regulations also do not address certain issues with regard to the application of section 89 to former employees and with regard to who is an excludable employee under section 89(h). Nevertheless, under the excludable employee rules, if any employee included in a collective bargaining unit receives any employer-provided benefit, no

employee in that collective bargaining unit may be treated as an excludable employee merely because the employee is a member of the collective bargaining unit. This is the case without regard to the fact that the employer-provided benefit is in the form of an employer contribution under a collective bargaining agreement to a multiemployer plan. See section 1151(k) of TRA '86 and paragraph (a)(2) of Question and Answer (Q&A) 10 of the proposed regulation for the effective date of section 89 for certain collectively bargained plans.

The proposed regulations provide that, in general, section 414(n) applies to employee benefit plans covered by section 89 in the same manner as it applies to qualified plans covered by section 401(a). They also include a delegation to the Commissioner to provide guidance in the form of revenue rulings, notices or other publications of general applicability on the extent to which the differing nature of these types of plans require different rules. The Service invites comments on the manner in which the leased employee rules apply to plans covered by section 89 and, in particular, on the extent to which different rules are appropriate.

The proposed regulations also clarify that plans are not exempt from section 89 merely because they are maintained by the federal government, state or local governments, or employee organizations. In addition, plans maintained by tax-exempt entities are subject to the requirements of section 89, with the exception that a plan maintained exclusively for church employees by an entity described in section 3121(w) is not required to satisfy the requirements of section 89.

If the public wishes to comment on the content and timing of additional guidance that may be required to implement the law, the Service will consider these comments in developing further guidance. In particular, the Service invites comments regarding the exclusion of certain classes of employees for purposes of applying the nondiscrimination rules of section 89 (e.g., prisoners incarcerated in federal or state institutions or clients in sheltered workshops maintained by charitable entities) similar to the exclusion provided in the safe harbors in Notice 89-23, l*989-8 I.R.B. 25*.

2. Nondiscrimination Requirements

Section 89(a) is generally applicable to accident and health plans within the meaning of sections 105 and 106 (health plans) and group-term life insurance plans within the meaning of section 79. In addition, an employer may elect to treat certain other plans as subject to section 89(a). The term "benefit" appears throughout the proposed regulations. Unless indicated otherwise, the term "benefit" in connection with the nondiscrimination requirements of section 89(a) means the value of the coverage provided under the plan in the case of insurance type plans and, in the case of noninsurance type plans, the value of the payments, reimbursements, services and products provided under the plan. The proposed regulation contained at § 1.89(a)-1 includes questions and answers relating to nondiscrimination rules for purposes of section 89.

Q&A-1 of § 1.89(a)-1 sets forth in general terms the nondiscrimination tests applicable under section 89(a). In general, an employer has two approaches to nondiscrimination testing under section 89. Under the first approach, an employer's employee benefit plan satisfies section 89(a) only if (i) at least 50 percent of the employees eligible to participate in a plan are nonhighly compensated employees (the 50 percent eligibility test); (ii) at least 90 percent of the nonhighly compensated employees are eligible to participate in the plan or plans of the same type that, on an aggregate basis, are at least 50 percent as valuable as the combined value of the plans of the same type that are available to any highly compensated employee (the 90 percent/50 percent eligibility test); and (iii) the average benefit received by nonhighly compensated employees under all plans of the same type is at least 75 percent of the average benefit received by highly compensated employees under such plans (the 75 percent benefits test).

Under the second approach, an employer's employee benefit plan satisfies section 89(a) only if it benefits at least 80 percent of the employer's nonhighly compensated employees (the 80 percent coverage test). An employer may elect to test its health and group-term life insurance plans (and determine excess benefits, if any) under the 80 percent coverage test notwithstanding the fact that the first approach would produce different amounts of excess benefits.

Under either of the two approaches, a plan fails to satisfy section 89(a) if the plan contains any provision that by its terms, operation or otherwise discriminates in favor of highly compensated employees (the nondiscriminatory provisions test).

For 1989 and 1990, an employer may decide to adopt an alternative to the 75 percent benefits test for its health plans. Under this alternative, set forth in Q&A-2, an employer must treat as includible in gross income (i.e., as discriminatory excess benefits) all employer-provided coverage under its health plans with respect to certain highly compensated employees. Also, if an employer adopts this alternative for 1989, the employer may use a modified version of the 90 percent/50 percent eligibility test under which at least 80 percent of the nonhighly compensated employees must be eligible to participate in plans of the same type that, on an aggregate basis, are at least 66 percent as valuable as the aggregate value of the plans of the same type available to any highly compensated employee. For testing years ending in 1990, this modified version of the 90 percent/50 percent eligibility test is not available and the class of highly compensated employees who are considered to receive taxable employer-provided health coverage under the alternative to the 75 percent benefits test is broadened.

Q&A-2 also provides a permanent alternative to the general nondiscrimination tests for certain large employers whose employees are substantially all nonhighly compensated employees. Under this alternative, an employer's health plans satisfy section 89(a) if the employer employs at least 5,000 individuals; at least 90 percent of the full-time active employees are nonhighly compensated employees; less than 0.75 percent of all active employees have compensation in excess of twice the section 414(q)(1)(C) amount ($50,000 indexed); at least 80 percent of those employees eligible to participate in each plan are nonhighly compensated employees and 80 percent of the nonhighly compensated employees have available to them under all health plans a health benefit that is at least 80 percent as valuable as the largest such benefits available to any highly compensated employee; and at least 66 percent of all nonhighly compensated employees receive core health benefits that are at least 66 percent as valuable as the largest such benefit available to any highly compensated employee. In addition, the nondiscriminatory provisions test must be satisfied. This alternative is only available to determine if any employer's health plan or plans are discriminatory: it is not available to determine the amount of excess benefits.

Core health coverage generally means comprehensive major medical and hospitalization coverage. Dental, vision and health coverages provided under flexible spending arrangements (see paragraph (c) of Q&A-7 of proposed § 1.125-2) are not core health benefits. Note that the definition of "core health coverage" under section 89 is not necessarily the same as the definition of "core coverage" under section 4980B (COBRA continuation coverage) and, therefore, no inference should be drawn from these proposed regulations with respect to the meaning of such term under section 4980B.

Q&A-3 details the treatment of family and other coverage under section 89 and the extent to which such coverages may be tested separately from employee-only coverage. Included in Q&A-3 is guidance relating to the use of sworn statements when employee-only coverage is to be tested separately. The proposed regulations state that a sworn statement need not be notarized but, for testing years commencing on or after January 1, 1990, a sworn statement must be made under penalty of perjury. An example of a sworn statement is provided.

Q&A-4 sets forth rules relating to health plan comparability and health plan aggregation for the purposes of the 50 percent eligibility test and the 80 percent coverage tests. These rules were changed extensively by TAMRA '88. The comparability rules in the proposed regulations generally enable health plans that fail the 50 percent eligibility test or the 80 percent coverage test on an individual basis to satisfy such tests on a group basis.

Q&A-5 and Q&A-6 of the proposed regulation set forth the method for nondiscrimination testing. Q&A-5 states that testing for compliance with the nondiscrimination requirements of section 89(a) is done by reference to the employees employed on, and benefits provided for, a single day (the testing day), and such results are then annualized for the entire testing year with adjustments to reflect certain benefit changes during the testing year (both before and after the testing day). In general, the facts on the testing day must be adjusted to reflect benefit changes due to changes in plan terms and, in the case of highly compensated employees, changes in elections by such employees. lf the terms of available plans change during an open season, benefit changes that occur due to elections during that open season are considered changes due to changes in plan terms. The proposed regulation contains a transition rule for 1989 that generally allows benefit changes prior to July 1, 1989 to be disregarded.

The employer must designate a uniform 12-month testing period for all its plans of the same type. In certain circumstances, an employer may elect a short testing year. To the extent that the employer elects to test plans of different types together for purposes of certain nondiscrimination tests, all these plans must be tested on a uniform testing year. Thus, if an employer tests its group-term life insurance plans with its dependent care assistance programs

for purposes of the 75 percent benefits test, all such plans and programs must be tested on the same 12-month period. The same rule applies where the employer aggregates its health plans with its group-term life insurance plans to enable its group-term life insurance plans to satisfy the requirements of the 75 percent benefits test.

As set forth in Q&A-6, the first testing year of an employer with respect to plans of the same type generally must begin on the first day of the first plan year that any plan of that type is subject to section 89. Also, the employer may use an earlier testing year, including the calendar year, for 1989. Thus, for testing years beginning in 1989, the employer is required to test all its plans of the same type together even though not all of such plans are subject to the requirements of section 89 for the entire testing year. In these circumstances, the proposed regulation requires an employer to test all benefits under the plans as if they were subject to section 89 for the entire testing year. However, in determining any excess benefits under the plans, Q&A-6 contains rules under which an employer may prorate the amount of any excess to reflect the extent to which coverage is subject to section 89.

Q&A-7 sets forth rules relating to valuing coverage under a health plan. These rules apply until the Service publishes valuation procedures under section 89(g)(3)(B). Q&A-7 provides that an employer may use any reasonable method for valuing a health plan and specifies that the cost of the health plan is a reasonable method of valuation. Specifically, in valuing coverage an employer is permitted to use the cost of the applicable premium under section 4980B(f)(4) for continuation coverage under a group health plan and is permitted to adjust the premium for differences related to geographic locale, the demographics of the participant population, and utilization. No inference should be drawn from Q&A-7 concerning the method that may be used to determine the applicable premium under section 4980B(f)(4).

The proposed regulation clarifies that cost containment features may be disregarded under a reasonable method of valuation. Similarly, the fact that a delivery system used by a plan is different from a delivery system used by another plan should not affect the values of such plans. Thus, the fact that one plan is provided through a health maintenance organization and another through a traditional indemnity program should not cause the value of the plans to differ as long as the coverage under both plans is substantially similar.

The method of valuing health plans used by an employer for purposes of section 89 must be applied consistently for all the employer's health plans, except that the employer may use the cost method described in section 89(g)(3)(E) for multiemployer plans.

When determining the amount of excess benefits under section 89(b), an employer is required to use the cost method used for determining the applicable premium under section 4980B(f)(4), even if that was not the valuation method the employer used for testing purposes. This method must be used for calculating both the highly and nonhighly compensated employees' employer-provided benefits when excess benefits for highly compensated employees are determined. The only permissible adjustment to this method is for differences in the premium due to utilization.

Q&A-7 also sets forth the method of valuing coverage under flexible spending arrangements that provide health benefits. See Q&A-7 of § 1.125-2 of the proposed regulation for the definition of a flexible spending arrangement. Such coverage is to be valued on the basis of its cost (in general, the premium required for the health coverage under the arrangement). As is the case with any valuation method, the fact that a premium is not paid does not affect the value of the coverage so long as the coverage is provided.

Q&A-8 of the proposed regulation contains an explanation of the treatment of salary reduction contributions under the nondiscrimination tests of section 89. Salary reduction contributions generally are defined as elective, pre-tax contributions under a cafeteria plan. TAMRA '88 contains a provision allowing, in certain cases, salary reduction contributions to be taken into account as employer contributions in performing the 90 percent/50 percent eligibility test. In addition to this provision, the proposed regulation describes circumstances in which certain salary reduction contributions by highly compensated employees must be taken into account as employer contributions and circumstances in which certain salary reduction contributions by nonhighly compensated employees must be treated as after-tax employee contributions. This mandatory treatment of salary reduction contributions applies to testing years beginning after 1989.

Q&A-9 sets forth the method by which excess benefits provided under a discriminatory employee benefit plan are to be calculated.

Q&A-10 contains guidance relating to the effective dates of the nondiscrimination and qualification requirements. Generally, the requirements apply to plans for plan years that commence on or after January 1, 1989. With respect to health plans, a special rule applies if the designated plan year of such a plan begins later in calendar year 1989 than the plan year for such health plan began in 1988.

Section 89 provides a later effective date that may apply with respect to collectively bargained plans. In the case of a plan maintained pursuant to a collective bargaining agreement ratified before March l, 1986, the rules under section 89 do not apply to employees covered by such agreement in years beginning before the earlier of January 1, 1991, or the date on which the last collective bargaining agreement relating to the plan expires (determined without regard to any extension thereof after February 28, 1986). Thus, such a collectively bargained plan is not subject to section 89 before the date determined under the preceding sentence, and collectively bargained employees under such a plan may be treated as excludable employees until such date for purposes of applying section 89 to those other plans of the same type of the employer that are subject to section 89. The proposed regulation provides that the employer may elect to take all such otherwise excludable collectively bargained employees under a plan into account and, in so doing, to accelerate the effective date with respect to the collectively bargained plan for purposes of the nondiscrimination tests.

3. Qualification Requirements Under Section 89(k)

Unless statutory employee benefit plans and certain other plans meet the requirements of section 89(k) employer-provided benefits received under such plans are includible in an employee's gross income, notwithstanding the fact that the employer-provided benefits are otherwise excludable under the Code. The term "benefit" for purposes of the section 89(k) qualification requirements, in contrast to the definition of the term "benefit" for purposes of the nondiscrimination tests, means the value of the payments, reimbursements, services and products provided under the plan.

In order to meet the requirements of section 89(k), a plan must be in writing, legally enforceable, maintained for the exclusive benefit of employees, and established with the intent that it will be maintained for an indefinite period of time. In addition, an employer must provide those who are eligible to participate in the plan with reasonable notice of benefits available under the plan.

Section 89(k) applies to statutory employee benefit plans and certain other types of plans maintained by an employer. Section 89(k) generally applies to the following types of plans, regardless of whether such plans are subject to nondiscrimination testing under section 89(a): Accident and health plans; group-term life insurance plans; dependent care assistance programs; qualified tuition reduction programs; cafeteria plans; fringe benefit programs providing no-additional-cost services, qualified employee discounts, or employer-operated eating facilities, the benefits from which are otherwise excludable from the gross income of the beneficiary; and plans to which section 505 applies. The list of specific kinds of plans contained in the proposed regulation that are of a type to which section 89(k) applies is not intended to be exhaustive.

The proposed regulation contains several special rules with respect to accident or health plans. In general, an accident or health plan is not subject to section 89(k) unless the employer-provided benefits under the plan are (or are intended to be) excludable from gross income under section 105(b) or (c). Thus, for example, sick pay and disability plans are generally not subject to the rules of section 89(k).

Because coverages under accidental death and dismemberment (AD&D plans) plans and business travel accidental death plans are eligible for the exclusion under section 106, benefits provided pursuant to such coverages are excludable under sections 101 and 105(c). Thus, such plans are subject to the provisions of section 89(k). The coverages and benefits under these plans, like other accident or health plans the coverage of which is excludable (or of a kind that is excludable) under section 106, may not be excluded under section 132. If a death benefit under an AD&D plan is not conditioned on the accidental death of the employee, that benefit is not part of an AD&D plan.

The proposed regulation states that a plan that is a part of an organization described in section 501(c)(9) or 501(c)(17) must meet the requirements of section 89(k) and that, to the extent that the plan provides benefits of the type provided by statutory employee benefit plans, such benefits must be considered in nondiscrimination testing under section 89. If a plan does not meet the requirements of section 89(k), the related organization is not exempt from tax under section

501(a). Section 89 applies to the plan that is part of a voluntary employees' beneficiary association (VEBA) even if the VEBA is a collectively bargained VEBA as described in section 505(a)(2).

Section 89(k)(1)(A) provides that a plan must be in writing. The proposed regulation provides that all of the material terms of a plan must be oontained in a single written document. However, the document may incorporate material terms by reference to other documents rather than setting forth such terms in full. The proposed regulation also clarifies that a single written document may satisfy the writing requirement for several plans. Similarly, material terms contained in one document related to several plans may be incorporated in each of the single written documents for such plans. These rules have been included to give employers the flexibility to group their plans in written documents in various ways so long as all of the coverage is in fact in writing.

Both the proposed regulation and section 89 require that an employer's elections with respect to nondiscrimination testing be in writing. If any such election is not in writing it is waived. For example, if no testing year is designated in writing with regard to any health plan, all health plans must be tested on the calendar year. The nondiscrimination testing e1ections are not required to be in the single written document. Consequently, the failure to make an election in writing does not cause a plan to fail to meet the writing requirement.

The proposed regulation provides that a plan must be in writing prior to the first day on which coverage or benefits are available under the plan. There is a transition rule under which a plan is not required to meet the writing requirement of section 89(k) before the later of the beginning of the first day of the second plan year beginning after December 31, 1988, and the end of the 12-month period beginning on the first day of the first plan year that the plan is subject to section 89.

Section 89(k)(1)(B) provides that a plan must be legally enforceable. The intent of this provision is to ensure that the employer cannot exercise excessive discretion. Therefore, the proposed regulation provides that, in general, the conditions required for an employee to participate in or obtain a benefit under a plan must be definitely determinable and the employee must be able to compel the coverage or payment of benefits described in the plan. Except in certain circumstances, a plan fails the enforceability requirement if coverage or a benefit available under the plan is subject to the discretion of the employer, either in operation or under the terms of the plan. Nevertheless, the proposed regulation permits employer discretion relating to certain administrative acts. In addition, an employer generally may expand coverage on a retroactive basis if the employer memorializes such expansion in writing, provides notice of such expansion, and meets the permanence requirements of section 89(k) with regard to the expanded coverage. The fact that such limited employer discretion does not violate the enforceability requirement of section 89(k) does not mean that, under certain circumstances, such employer discretion would not cause the plan to fail the nondiscrimination tests of section 89, in particular the nondiscriminatory provisions test of section 89(d)(1)(C).

The proposed regulation contemplates that many cost containment features existing in the health care industry today do not violate the enforceability requirements of section 89(k). For example, a managed care program that allows an insurer to grant a benefit not otherwise available under the plan in lieu of a benefit described in the plan does not violate the enforceability requirement if the patient, the employer and the insurance company consent to such alternative, a physician recommends or concurs with such alternative, and the plan describes the possibility of such alternative as well as the general criteria under which such alternative is available and may be selected. Similarly, health benefits may be conditioned on a medical opinion of a physician.

The proposed regulation contains a transition rule with regard to the enforceability rules of section 89(k). A plan is not required to satisfy the enforceability rules outlined in the proposed regulation before the first day of the second plan year that the plan is subject to section 89.

Section 89(k)(1)(C) provides that employees must be provided reasonable notification of benefits available in a plan. The purpose of this requirement is to inform an individual who is eligible to participate in the plan of its essential features. Therefore, the proposed regulation requires that individuals eligible for coverage or benefits under a plan be provided with a summary explanation of these features, including directions concerning the method by which individuals may receive more information. Such notice must be given to an individual prior to the initial availability of coverage or benefits to such individual.

The proposed regulation states that the employer must provide the notice. ln the case of a multiemployer plan, the plan administrator must provide the notice. Nevertheless, the notice requirements are satisfied if an insurance company or other health care insurer or provider (e.g., a health maintenance organization) provides the notice.

The proposed regulation provides a transition rule for the notice requirement for plan years commencing in 1989. Under this rule, an employer is not required to provide notice to employees for any such plan year until July 1, 1989. Thus, for example, an employer is first required to provide notice under section 89(k) with respect to a calendar year plan by July 1, 1989. Similarly, with respect to a plan that uses a September 1 through August 30 plan year, notice under section 89(k) is first required by September 1, 1989. The delay in the notice to employees under this rule does not preclude the transitional relief providing for a delay in the requirement that a plan be in writing.

The reporting, notification and written plan requirements under this regulation are in addition to, and not in lieu of, reporting, disclosure, notification and written plan requirements which may otherwise apply under Title I of the Employee Retirement Income Security Act of 1974 or any other law.

Section 89(k)(1)(D) provides that a plan must be maintained for the exclusive benefit of employees. The purpose of the exclusive benefit requirement is to preclude an employer from extending its plan to individuals who have no current or prior employment-type relationship with the employer. The proposed regulation provides, in general, that a plan must be maintained for the exclusive benefit of those employees who are described in the plan as eligible to participate. A plan may fail this requirement by its terms or through its operation.

The proposed regulation provides rules concerning who may participate under a plan. In general, only individuals who are or who are treated as employees (or former employees) of the employer or who otherwise perform services for the employer may participate under a plan of the employer. The proposed regulation does not have any effect on any other existing or future eligibility rule concerning who may participate in a plan. Thus, for example, a self-employed individual described in section 401(c)(1) cannot be a participant in a cafeteria plan even though such individual is treated as an employee for purposes of section 89(k).

There is a transition rule relating to the applicability of the exclusive benefit requirement. The proposed regulation provides that an employer is not required to meet the exclusive benefit requirement until the first day of the second plan year that the plan is subject to section 89.

Section 89(k)(1)(E) requires that a plan must be established with the intention that it will be maintained for an indefinite period of time. The proposed regulation focuses on the operation of the plan, as opposed to the plan terms, in determining whether the plan was intended to be maintained for an indefinite period of time. Accordingly, if a plan is materially amended or terminated and the coverage has been in effect for at least a consecutive 12-month period, the requirement of section 89(k)(1)(E) is satisfied, regardless of any terms of the plan which may provide that the employer has the right to change or terminate the plan. However, if a plan is materially amended or terminated before the coverage has been in effect for a consecutive 12-month period, the plan is considered to have been established with the intent of being temporary, unless the employer can demonstrate that there is a substantial business purpose for such termination or amendment.

The proposed regulation contains several rules relating to the sanction under section 89(k). In general, the proposed regulation provides that if a plan fails to satisfy the qualification requirements of section 89(k), the value of the employer-provided benefits received (rather than the value of the coverage provided), is not excludable from gross income. Thus, for example, the exclusions provided in sections 101 and 105 are generally not available with respect to benefits provided under an accident or health plan. All employees who receive benefits are subject to this sanction without regard to whether they are highly compensated employees within the meaning of section 414(q).

The proposed regulation contains a rule that allows correction of failures to comply with section 89(k) in certain circumstances. If there is a de minimis failure to comply with certain requirements, the employer may correct the failure within 90 days of its occurrence. If the employer timely corrects the failure, the plan does not fail section 89(k) merely because of such failure. A failure is not de minimis under this rule if correction requires the amendment of the plan document to reduce coverage on a retroactive basis to conform the document to the operation of the plan.

The proposed regulation clarifies the definition of a plan with respect to the sanction under section 89(k). In the case of a health plan, to the extent that the coverage providing the benefit taxable by reason of section 89(k) may reasonably be separated from other plan coverage, the proposed regulation permits the failed portion of the plan to be treated as a separate plan.

The proposed regulation provides for a limitation on the amount that must be included in the income of an employee as a result of section 89(k). The limitation is the sum of the following (dollar amounts are indexed in accordance with section 414(q)(1)(C)): 10 percent of the first $50,000 of the employee's compensation; 25 percent for amounts of such compensation in excess of $50,000 and up to $100,000; 75 percent for amounts of such compensation in excess of $100,000 and up to $150,000; and 100 percent of compensation in excess of $150,000. In addition, the Commissioner, through revenue rulings, notices or other publication of general applicability, is authorized to adjust the amounts of the sanction where such adjustment is appropriate and is not inconsistent with the purposes of section 89(k). Section 213 governs whether the amount includible in income as a result of section 89(k) is deductible.

If the sanction under section 89(k) is imposed with regard to a benefit under coverage that is determined under section 89(a) to discriminate in favor of a highly compensated employee, the proposed regulation provides for the coordination of the two sanctions. In general, the higher of the two taxable amounts must be included in the gross income of the highly compensated employee.

4. Miscellaneous Matters Relating to Section 125

Proposed § 1.125-2 contains seven questions and answers that supplement and, in part, update the questions and answers contained in proposed regulations under § 1.125-1 that were published on May 7, 1984 *(49 FR 19321)*, and amended on December 31, 1984 *(49 FR 50733)*. Q&A-1 of proposed § 1.125-2 provides that Q&A-2 through Q&A-6 of that section are generally effective in accordance with the effective date provisions of section 89 (generally plan years commencing after December 31, 1988). In addition, Q&A-1 provides that Q&A-7 of proposed § 1.125-2 (relating to flexible spending arrangements subject to sections 106 and 105) applies to plan years beginning after December 31, 1989.

Many of the questions and answers under § 1.125-2 clarify previously proposed § 1.125-1 as well as § 1.125-2T of the Temporary Regulations published on February 4, 1986 *(51 FR 4318)*. To the extent the provisions of proposed § 1.125-2 clarify the provisions of proposed §§ 1.125-1 or 1.125-2T and are less restrictive, the Service will apply them as if contained in those regulations. However, consistent with the statement in the preamble to the May 7, 1984 Notice of Proposed Rulemaking, to the extent that the provisions of proposed § 1.125-2 clarify the provisions of proposed §§ 1.125-1 and 1.125-2T and are more restrictive, the Service will apply them only as set forth in Q&A-1 of proposed § 1.125-2.

Q&A-2 and Q&A-3 of the proposed regulation under § 1.125-2 restate the general requirements of section 125. Q&A-4 sets forth what benefits are treated as qualified benefits and what benefits constitute cash under a cafeteria plan. For example, Q&A-4 provides that a benefit that is taxable because it is determined to be an excess benefit under section 89(b) or because the plan fails to satisfy section 89(k) remains a qualified benefit under section 125. As a result of this provision a cafeteria plan may provide such taxable benefits.

The proposed regulation provides further guidance with regard to the rule that a cafeteria plan may not operate to defer compensation. Thus, under Q&A-5, to the extent that a benefit carries over to the following plan year, such benefit may not be offered under a cafeteria plan. For example, life or health insurance with a savings or investment feature (e.g., so-called whole-life or whole-health insurance) may not be offered in a cafeteria plan. Q&A-5 also contains a rule to determine the extent to which the inclusion of elective vacation days under a cafeteria plan operates to permit the deferral of compensation.

A cafeteria plan may permit employees to make elective contributions under a qualified cash or deferred arrangement described in section 401(k). Similarly, a cafeteria plan does not impermissibly allow the deferral of compensation merely because, as an option under the plan, employees may make after-tax employee contributions under a qualified plan that is subject to section 401(m). Finally, the deferred compensation prohibition does not prevent an employer from

providing employer matching contributions subject to section 401(m) with respect to elective contributions under section 401(k) or after-tax employee contributions subject to section 401(m).

Q&A-6 clarifies and expands the rule contained in proposed § 1.125-1 concerning when an employee may revoke a benefit election and make a new election under a cafeteria plan. In general, Q&A-6 provides that a plan may allow such a revocation and subsequent election in the following circumstances: When a third-party health care insurer or provider significantly increases the cost to the employee of coverage or significantly curtails or ceases coverage; when the participant has a change in family status; or when the participant has separated from service. In addition, a cafeteria plan may provide that a benefit ceases if the participant has ceased making required premium payments. Finally, a cafeteria plan may allow a revocation or modification with respect to elective contributions subject to section 401(k) and after-tax employee contributions subject to section 401(m), to the extent such modification or revocation is permitted under section 401(k) or 401(m).

Q&A-7 contains special rules applicable to health plans that are flexible spending arrangements (FSAs). These rules are intended to protect the integrity of the distinction between the taxable treatment of personal medical expenses (subject to the rules of section 213) and the more favorable tax treatment of employer-provided health plan coverage and benefits under section 106 or 105, including benefits received under employee-purchased accident or health coverage under section 104.

In general, if a health plan has a low maximum limitation on benefits and the amount of the premium for coverage is the same or similar to this limitation on benefits, there is a significant concern that the plan operates primarily to exclude from income amounts paid for personal medical expenses that would otherwise only be deductible under section 213 to the extent that they exceed 7.5 percent of adjusted gross income. This concern is greater if, with respect to such plan, there is no person, such as an employer or insurance company, who bears a risk of experience loss with respect to the health plan and thus has an interest in regulating the arrangement to minimize adverse selection and substantiate claimed expenses. In order to limit the extent to which health FSAs effectively operate to exclude amounts paid for personal medical expenses, Q&A-7 applies requirements to health FSAs that are similar to the requirements that an independent health insurer with a meaningful risk of loss would apply to protect against adverse selection and the inappropriate reimbursement of expenses. Thus, the requirements in the proposed regulation are consistent with those features that are commonly associated with arrangements that exhibit the basic risk-shifting and risk-spreading characteristics of insurance.

Q&A-7 clarifies that an employee's salary reduction contributions under a health FSA are payments of a premium by the employee for health coverage with respect to which the maximum reimbursement amount is the same or similar to the amount of the required premium. Therefore, health FSAs are bona fide plans and are not separate, employee-by-employee, health expense reimbursement accounts that operate in a manner similar to employee-funded, defined contribution plans. The maximum amount of reimbursement available under a health FSA at any particular time with respect to an individual cannot be based on the amount of premium that the individual has paid as of such time. Rather, the maximum reimbursement amount must be uniform throughout the coverage period. In addition, health FSAs cannot reimburse employees for premiums for other health coverage. Finally, because there is no party directly involved in an FSA with an interest in assuring that claims are bona fide, the proposed regulation imposes certain claims substantiation requirements for FSAs.

Under the proposed regulation, experience gains under health FSAs (i.e., premiums in excess of claims paid plus expenses) may be treated as gains under bona fide health plans. Thus, such gains may be available to pay reasonable and bona fide dividends or premium refunds to the premium payers. Similarly, experience gains may be used to reduce required premiums for coverage in future years. For example, experience gains for one year may be used in a second year to permit the health FSA to charge all eligible employees only a $490 premium for coverage with a $500 reimbursement maximum. In no case, however, may the treatment of experience gains under a health FSA have the effect, directly or indirectly, of reimbursing employees based on their individual claims.

Reliance on These Proposed Regulations

Taxpayers may rely on these proposed regulations for guidance pending the issuance of final regulations. Because these proposed regulations are generally effective for years beginning after December 31, 1988, the Service will apply

these proposed regulations in issuing rulings and in examining returns with respect to taxpayers and plans after that date. If future regulations are more restrictive than these proposed regulations, such regulations will be applied without retroactive effect.

Special Analyses

The Commissioner of Internal Revenue has determined that this proposed rule is not a major rule as defined in Executive Order 12291 and that a regulatory impact analysis is therefore not required. Although this document is a notice of proposed rulemaking which solicits public comments, the Internal Revenue Service has concluded that the regulations proposed herein are interpretative and that the notice and public procedure requirements of *5 U.S.C. 553* do not apply. Accordingly, the proposed regulations do not constitute regulations subject to the Regulatory Flexibility Act (5 U.S.C. Chapter 6).

Comments and Requests for Public Hearing

Before adopting these proposed regulations, consideration will be given to any written comments that are submitted (preferably eight copies) to the Commissioner of Internal Revenue. All comments will be available for public inspection and copying. A public hearing will be held upon written request to the Commissioner by any person who has submitted written comments. If a public hearing is held, notice of the time and place will be published in the Federal Register.

Drafting Information

The principal authors of the proposed regulations are Felix Zech, David Munroe, and Steven Miller of the Office of the Assistant Chief Counsel (Employee Benefits and Exempt Organizations). However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing the proposed regulations on matters of both substance and style.

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