April 29, 2008

Hon. Douglas H. Shulman
Commissioner
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, DC 20224

Re: Comments Concerning Proposed Regulations Under Section 125

Dear Commissioner Shulman:

Enclosed are comments concerning proposed regulations under section 125 of the Internal Revenue Code. These comments represent the views of the American Bar Association Section of Taxation. They have not been approved by the Board of Governors or the House of Delegates of the American Bar Association and should not be construed as representing the policy of the American Bar Association.

Sincerely,

Stanley L. Blend
Chair, Section of Taxation

Enclosure

cc: Hon. Donald L. Korb, Chief Counsel, Internal Revenue Service
    Hon. Eric Solomon, Assistant Secretary (Tax Policy), Department of the Treasury
    Michael J. Desmond, Tax Legislative Counsel, Department of the Treasury
These comments (“Comments”) are submitted on behalf of the American Bar Association Section of Taxation (the “Section”) and have not been approved by the House of Delegates or Board of Governors of the American Bar Association. Accordingly, the Comments should not be construed as representing the position of the American Bar Association.

Principal responsibility for preparing these Comments was exercised by Mark L. Stember. Substantive contributions were made by Andy R. Anderson, Alden Bianchi, Julie Burbank and Nancy K. Campbell. These Comments were reviewed by David A. Mustone, Chair of the Section’s Employee Benefits Committee (“Committee”) and John L. Utz, Vice Chair of the Committee; by the Quality Assurance Group of the Committee, which is chaired by Thomas R. Hoecker and whose members are former chairs of the Committee; by Roberta Casper Watson on behalf of the Section’s Committee on Government Submissions; and by Priscilla E. Ryan, Council Director for the Committee.

Although the members of the Section of Taxation who participated in preparing these Comments have clients who might be affected by the federal income tax principles addressed by these Comments or have advised clients on the application of such principles, no such member (or the firm or organization to which such member belongs) has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these Comments.

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April 29, 2008
EXECUTIVE SUMMARY

These Comments respond to the request for comments made by the Internal Revenue Service (the “Service”) and the U.S. Department of Treasury (the “Treasury”) in the notice of proposed rulemaking under section 125 published in the Federal Register¹ on August 6, 2007 (the “Proposed Regulations”).² The Proposed Regulations address general rules and operating procedures for cafeteria plans and flexible spending arrangements. The Section commends the Service and the Treasury for their efforts to address the tax policy and administration issues arising in connection with these plans and arrangements.

Following is a brief summary of our recommendations with respect to these rules:


A. The provisions in Proposed Regulation section 1.125-1(a)(3)(C), when finalized, expressly permit an employee to pay COBRA premiums for his or her spouse or dependents within the meaning of Proposed Regulation section 1.125-1(a)(4) (“section 152 dependents”) on a pre-tax basis through a cafeteria plan.

B. The final Regulations clarify Example 3 in Proposed Regulation section 1.125-1(b)(4)(iii) to confirm that a plan that provides that unused flex-credits are automatically applied to provide non-taxable qualified benefits, such as by transferring unused flex-credits to a health FSA, is not a cafeteria plan.

C. The provisions in Proposed Regulation section 1.125-1(c)(1), when finalized:

(a) provide that (1) different benefits can be offered to different groups of employees within the same cafeteria plan and (2) the uniformity requirement applies strictly to the cafeteria plan itself and not to any of the benefits that may be elected under the cafeteria plan (e.g., medical, dental, vision, etc.), and

(b) permit an employer explicitly to designate the written cafeteria plan document (or the multiple documents that comprise the written cafeteria plan document) as the plan document for a single plan or two or more plans.

D. The final Regulations align the timing rule for plan amendments and the addition of new benefits with the year-end amendment rule for tax-qualified plans.

E. With respect to the operational failures addressed in Proposed Regulation section 1.125-1(c)(7)(i).


² Unless otherwise indicated, all references to “sections” are to the Internal Revenue Code of 1986, as amended (the “Code”) and all references to Regulations are to the regulations promulgated by Treasury under the Code.
The final Regulations provide that where a state agency has control over any administrative aspects of a third-party employer’s cafeteria plan, the tax impact of any operational failure caused or committed by the state agency be limited to the individual participant(s) who were the subject of the operational error.

The final Regulations establish the following tiered correction process:

1. Allow self-correction (without any reporting or filing obligations) for any non-egregious error identified and corrected before the end of the calendar year in which it occurred;

2. Establish a self-correction program for non-egregious errors that are not identified and corrected before year-end under which specified errors are corrected (generally without the requirement to issue amended W-2s for all participants) and reported as appropriate; and

3. Establish a limited process similar to the voluntary correction program under the Employee Plans Compliance Resolution System\(^3\) to apply for approval of a proposed correction for non-egregious errors that cannot be corrected under the proposed self-correction programs.

The provisions in Proposed Regulation section 1.125-1(d)(3), when finalized, clarify that (a) an employer may terminate a cafeteria plan mid-year for any reason, as long as a primary purpose of the termination is not to circumvent the rules of section 125 and (b) a participant coverage under a flexible spending arrangement (“FSA”) can be pro-rated in the case of any short plan year (including one which is the result of a plan termination).

The final Regulations provide that an individual who is a bona fide employee of a C corporation be treated as eligible to participate in that corporation’s cafeteria plan even though the individual may also be a partner or a 2-percent shareholder of an S corporation that is treated as a single employer with the C corporation.

The provisions of Proposed Regulation section 1.125-1(p)(5), when finalized, be revised to provide that salary reduction amounts from the last two months of a plan year may be applied to pay for coverage in the immediately following plan year. In the alternative, we recommend that final Regulations provide an exception to the one-month rule to the extent necessary to comply with any applicable state or local law involving health coverage mandates.

The final Regulations provide that nonqualified benefits and qualified benefits can be addressed in the same plan document, as long as the cafeteria plan portion of

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the document provides that the nonqualified benefits are not part of the cafeteria plan for section 125 purposes.

II. Proposed Regulation section 1.125-2 – General Election Rules

The special 30-day rule under Proposed Regulation section 1.125-2(d), when finalized, also be applied to employees who are newly eligible for coverage due to a merger or acquisition involving their employer with an unrelated employer.

III. Proposed Regulation section 1.125-5 – General FSA Rules

A. The use-or-lose rule not apply to adoption assistance FSAs for participants who are attempting a foreign adoption and the amounts contributed automatically roll over to the next year while the foreign adoption proceeding is on-going (in which case the rolled-over amounts may only be used for reimbursement of the foreign adoption).

B. The provisions of Proposed Regulation section 1.125-5(k)(3)(i), when finalized:

(a) permit advance reimbursement for any situation in which a participant has received a bill for orthodontia service and has paid for such services; and

(b) permit reimbursement of any section 213(d) expense that is paid in advance of an extended course of treatment or other covered services being provided to the participant or his or her spouse or section 152 dependent.

IV. Proposed Regulation section 1.125-6.

A. The provisions of Proposed Regulation section 1.125-6(a), when finalized, provide that if an employee is retroactively enrolled as permitted under Proposed Regulation section 1.125-2(d), any expense incurred prior to the date of actual enrollment, but on or after the effective date of coverage, may be reimbursed.

B. The provisions of Proposed Regulation section 1.125-6(a)(4)(iv), when finalized:

(a) provide that a participant may elect dependent care FSA coverage for periods of less than 12 months where the participant’s election correlates to and covers an entire seasonal work cycle that is less than 12 months; and

(b) include an example confirming that a non-refundable fee for child care paid during one period of coverage (e.g., December 2007) can be reimbursed in a subsequent year if (a) the child care is provided in a subsequent period of coverage (e.g., January 2008) and (b) the individual is a participant in the dependent care FSA for that subsequent period.
C. The final Regulations clarify:

(a) whether the participant certification requirement applies to (1) the reimbursement of all health FSA claims, including those which are substantiated by means other than an explanation of benefits provided by an insurance company and (2) dependent care FSAs.

(b) that advance participant certification is permissible.

D. The provisions of Proposed Regulation section 1.125-6(d)(4), when finalized, provide that debit card use by former employees, including those with COBRA coverage, is permitted as long as the former employee continues to be a plan participant.

E. The provisions of Proposed Regulation section 1.125-6(d)(7), when finalized:

(a) clarify that the correction procedures may be followed in any order, and on a participant-by-participant basis, as long as treating the unrecovered amount as business indebtedness is applied last; and

(b) permit an offset of eligible expenses incurred within 2 ½ months after the end of the plan year regardless of whether the plan has adopted the 2 ½ month grace period rule under Proposed Regulation section 1.125-1(e).

V. Proposed Regulation section 1.125-7 – Nondiscrimination Rules

A. The provisions of Proposed Regulation section 1.125-7(b)(1), when finalized:

(a) provide that as long as an employee’s pre-tax premiums (or flex-credits) required to purchase the underlying benefits are identical for all eligible participants, and the flex-credits (if any) associated with the underlying plans are also identical, a cafeteria plan that offers medical benefits of “unequal value” passes the eligibility test (as long as the plan otherwise satisfies the general eligibility requirements under the Proposed Regulations).

(b) Example 4, when finalized, be revised to read “Accident and health plans of unequal value for equal salary reduction amounts.”

B. The provisions of Proposed Regulation section 1.125-7(c)(2), when finalized, provide that employers can satisfy the contributions and benefits nondiscrimination rule by either satisfying the benefit availability test or the utilization test (and not both).

C. The final Regulations replace the term “nonhighly compensated employees” in the examples under Proposed Regulation section 1.125-7(d)(2) with the term “non-key employees.”
D. The provisions of Proposed Regulation section 1.125-7(f)(2), when finalized:
   (a) allow a premium-only plan (“POP”) to provide different levels of employee pre-tax premiums for different health plan coverages, as long as each option available under the POP separately satisfies the requirements of Proposed Regulation section 1.125-7(f)(1).
   (b) clarify that a cafeteria plan that meets the POP safe harbor is deemed to satisfy all of the nondiscrimination rules described in Proposed Regulation section 1.125-7, including the eligibility test under Proposed Regulation section 1.125-7(b), the general test for benefits and contributions under Proposed Regulation section 1.125-7(c), the key employee nondiscrimination test in Proposed Regulation section 1.125-7(d), the actual operation nondiscrimination test in Proposed Regulation section 1.125-7(k), and the anti-abuse rule in Proposed Regulation section 1.125-7(l).

E. The provisions of Proposed Regulation section 1.125-7(g), when finalized, permit disaggregation to be done to the same extent that aggregation is allowed under Proposed Regulation section 1.125-7(h).

F. The provisions of Proposed Regulation section 1.125-7(j)(1), when finalized:
   (a) include a transition rule, similar to the transition rule in section 410(b)(6)(C) for tax-qualified plans, for cafeteria plan nondiscrimination testing which would extend to the last day of the first plan year beginning after the date of the corporate event; and
   (b) permit a plan to perform nondiscrimination testing as of an alternate testing date to the same extent permitted for testing tax-qualified plans under Treasury Regulation section 1.410(b)-8.

VI. Comments on Application to Multiple Employer Plans.

The final Regulations:
   (a) permit multiple employer cafeteria plans in which unrelated employers could participate;
   (b) provide that the plan is disaggregated on an employer-by-employer basis for nondiscrimination testing purposes;
   (c) provide that each employer in the plan separately bear the obligations and benefits for its employee group under the plan, with certain adjustments permitted in the case of business transactions and for employees transferring among participating employers; and
(d) permit such plans to choose whether employees receive credit for service with other participating employers for purposes of eligibility or any other applicable plan purpose.
DISCUSSION

I. Proposed Regulation section 1.125-1


1. Issue

Section 1.125-1(a)(3)(C) of the Proposed Regulations provides that “[p]remiums for COBRA continuation coverage (if excludable under section 106) under the accident and health plan of the employer sponsoring the cafeteria plan or premiums for COBRA continuation coverage of an employee of the employer sponsoring the cafeteria plan under an accident and health plan sponsored by a different employer” are qualified benefits. By referencing only the employee, it appears that COBRA premiums (under either the employer’s or a different employer’s plan) for spouses and dependents may not be paid on a pre-tax basis through a cafeteria plan.

2. Recommendation

We recommend that the provisions in Proposed Regulation section 1.125-1(a)(3)(C), when finalized, expressly permit an employee to pay the COBRA premiums for his or her spouse or dependents within the meaning of Proposed Regulation section 1.125-1(a)(4) (“section 152 dependents”) on a pre-tax basis through a cafeteria plan.

3. Explanation

Some employers who have a waiting period for health coverage allow new employees to pay for COBRA coverage through the new employer’s cafeteria plan until the employee enrolls in the new employer’s health plan. The Proposed Regulations would allow such an employee to pay for his or her COBRA coverage through the cafeteria plan sponsored by the employee’s new employer, but apparently not for COBRA coverage for his or her spouse or dependents. Similarly, the Proposed Regulations would allow an employee to pay for his or her COBRA coverage upon a reduction of hours or termination of employment through the cafeteria plan from severance or other pay, but apparently not the COBRA premiums for the employee’s spouse or section 152 dependents. In addition, it appears that the Proposed Regulations would also bar an employee from paying for the COBRA coverage of the employee’s section 152 dependents under the employer’s health plan through a cafeteria plan (e.g., a child that ages out of the employer’s health plan but still qualifies as a section 152 dependent). We are not aware of any legal basis for treating spouses and section 152 dependents differently from the employee for this purpose. Thus, if an employee is able to pay for regular health coverage for his or her spouse and tax dependents
through a cafeteria plan, there appears to be no legal or policy justification for not allowing an employee to do so for COBRA coverage.

B. Proposed Regulation section 1.125-1(b)(4)(iii) – Flex-Credits and Other Medical Coverage.

1. Issues

Example 3 of Proposed Regulation section 1.125-1(b)(4)(iii) addresses a plan that offers employees an election between employer flex-credits and qualified benefits, but the plan does not allow employees to elect to receive unused employer flex-credits in cash. The example concludes that the plan is not a cafeteria plan because participants do not have a choice between taxable and nontaxable benefits.

2. Recommendations

We recommend that Example 3 be clarified to confirm that a plan that provides that unused flex-credits are automatically applied to provide non-taxable qualified benefits, such as by transferring unused flex-credits to a health FSA, is not a cafeteria plan.

3. Explanation

Many employers provide that an employee’s unused flex-credits are automatically transferred to a health FSA. This plan design is often used in those states, such as New Jersey, that do not follow the tax treatment provided under section 125. In these states, employee contributions or premiums for health coverage must, for state tax purposes, be paid with after-tax dollars. Because flex-credits are employer contributions, they can be transferred to a health FSA and be used by an employee to pay for health coverage without triggering taxation in states with laws similar to the New Jersey law. Thus, to avoid this treatment, unused flex-credits are automatically transferred to a health FSA. Such a transfer is no different substantively than the situation presented in Example 3. Therefore, we believe that such an arrangement would be treated the same.

C. Proposed Regulation section 1.125-1(c)(1) – Uniformity and Writing Requirements.

1. Issues

(a) Proposed Regulation section 1.125-1(c)(1) provides that the “terms of the plan must apply uniformly to all participants.” This provision prohibits an employer from offering different benefits to different groups of employees (e.g., salaried and hourly employees) within a single cafeteria plan. However, the Proposed Regulations separately allow an employer to offer different benefits to different groups of employees as long as it adopts a separate cafeteria plan for each group and each plan satisfies the nondiscrimination tests in Proposed Regulation section 1.125-7.
(b) Section 1.125-1(c)(1), which generally requires that a cafeteria plan document contain certain specified information, provides that the “document may be comprised of multiple documents.” It is unclear, however, whether an employer can document its sponsorship of multiple cafeteria plans via a single document.

2. Recommendations

We recommend that the provisions of Proposed Regulation section 1.125-1(c)(1), when finalized:

(a) provide that (1) different benefits can be offered to different groups of employees within the same cafeteria plan and (2) the uniformity requirement apply strictly to the cafeteria plan itself, and not to any of the benefits that may be elected under the cafeteria plan (e.g., medical, dental, vision, etc.), and

(b) permit an employer explicitly to designate the written cafeteria plan document (or the multiple documents that comprise the written cafeteria plan document) as the plan document for a single plan or two or more plans.

3. Explanation

(a) Uniformity

Many employers offer different benefits to different groups of employees. For example, some medical options may be offered to salaried employees, while different medical options may be offered to hourly employees. In addition, certain medical options may only be available to those employees within a certain geographical area (e.g., local HMO options). In general, tax-qualified retirement and savings plans (which are generally subject to similar statutory coverage and benefit requirements) are not required to provide uniform benefits to all participants as long as the plan can be restructured into component plans each of which satisfies the coverage rules in section 410(b).4 We believe that there is no tax policy reason not to apply a similar rule to cafeteria plans, rather than require an employer to maintain separate cafeteria plans to accomplish this. In our view, requiring employers to maintain separate plans where the applicable discrimination rules are otherwise met would elevate form over substance.

(b) Writing Requirement

Depending on an employer’s business operations and structure, an employer may wish to sponsor two or more separate cafeteria plans for

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4 See Reg. § 1.401(a)(4)-9(c).
various groups of employees. For example, an employer, as well as an union representing some of the employer’s employees, may find it desirable to have a separate cafeteria plan for the employees covered by an collective bargaining agreement with the union. In addition, it is possible that employers may also wish to sponsor two or more cafeteria plans to limit the adverse tax impact of an operational failure. We believe that there is no policy or legal basis for barring employers from using one plan document for multiple plans as long as the document clearly identifies the plans involved. This will enable employers to maintain separate plans without the need for maintaining otherwise duplicative documentation.

D. Proposed Regulation section 1.125-1(c)(5) – Plan Amendments.

1. Issue

Proposed Regulation section 1.125-1(c)(5) provides that

"Any amendment to the cafeteria plan must be in writing. A cafeteria plan is permitted to be amended at any time during a plan year. However, the amendment is only permitted to be effective for periods after the later of the adoption date or effective date of the amendment. For an amendment adding a new benefit, the cafeteria plan must pay or reimburse only those expenses for new benefits incurred after the later of the amendment’s adoption date or effective date.”

This requirement is more restrictive than the amendment timing rules that apply to tax-qualified plans, under which amendments documenting design changes generally can be retroactive as long as the amendment is adopted by the end of the plan year in which the change is made.5

2. Recommendation

We recommend that final Regulations align the timing rule for plan amendments and the addition of new benefits with the year-end amendment rule for tax-qualified plans.

3. Explanation

We understand and share the Service’s concern regarding a retroactive adoption of a cafeteria plan and agree that, as a legal matter, a new cafeteria plan can only be put into effect once it is adopted. This is similar to the rule for new section 401(k) plans, under which such a plan must be adopted before salary deferrals can commence.6 However, once a cafeteria plan has been adopted, we believe that

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the same concerns do not apply to documenting changes and adding new benefits. Thus, as is the case for tax-qualified plans, it would be helpful if an existing cafeteria plan could be retroactively amended in these circumstances as long as the amendments are executed prior to the end of the plan year in which the change or new benefit goes into effect and are consistent with the plan’s operations. There does not appear to be any statutory or policy reason for imposing a harsher rule on cafeteria plans for discretionary amendments than that for tax-qualified plans. For example, both a section 401(k) plan and cafeteria plan allow for pre-tax deductions from employees’ taxable wages. Yet, if the Proposed Regulations remain unchanged, an employer could, depending on the circumstances, retroactively amend its section 401(k) plan by plan year-end to document changes or new features, but could not do so under its cafeteria plan.

E. Proposed Regulation section 1.125-1(c)(7)(i) – Operational Failures.

1. Issues

   (a) Proposed Regulation section 1.125-1(c)(7)(i) provides that “if the cafeteria plan fails to operate according to its written plan or otherwise fails to operate in compliance with section 125 and the regulations, the plan is not a cafeteria plan and employees’ elections between taxable and nontaxable benefits result in gross income to the employees.” However, there are circumstances in which an employer may not have operational control over certain aspects of a cafeteria plan due to state or local regulation (e.g., a Massachusetts Connector-only cafeteria plan).

   (b) In addition, treating the entire arrangement as failing to constitute a cafeteria plan, and the resulting taxation on all eligible participants, imposes, in our view, an unnecessarily severe penalty for non-egregious operational or documentary errors.

2. Recommendations

   We recommend as follows:

   (a) Where a state agency has control over any administrative aspects of a third-party employer’s cafeteria plan, the tax impact of any operational failure caused or committed by the state agency be limited to the individual participant(s) who were the subject of the operational error.

   (b) The following tiered correction process be established:

      (1) Allow self-correction (without any reporting or filing obligations) for any non-egregious operational or documentary error identified and corrected before the end of the calendar year in which it occurred;
(2) Establish a self-correction program for non-egregious operational or documentary errors that are not identified and corrected before year-end under which specified errors are corrected (generally without the requirement to issue amended W-2s for all participants) and reported as appropriate; and

(3) Establish a limited process similar to the voluntary correction program (VCP) under the Employee Plans Compliance Resolution System (“EPCRS”)\(^7\) to apply for approval of a proposed correction for errors that cannot be corrected under the proposed self-correction programs.

3. **Explanation**

(a) **Errors resulting from state agency control**

In order for an employer to avoid a potentially significant state surcharge, Massachusetts requires that employees who are not eligible for employer-sponsored group health coverage must be given the opportunity to purchase individual health insurance through the Massachusetts Connector. To allow this purchase to be made on a pre-tax basis, an employer is required to make a cafeteria plan available to virtually all of its employees working in Massachusetts.\(^8\) However, an employee’s purchase of individual insurance through the Connector is controlled by the Connector. The Connector (and not the employer) decides when an employee can change his or her election for coverage through the Connector. Further, the Connector (and not the employer) decides whether an individual can be covered as an employee’s spouse or dependent. Under the Proposed Regulations, an operational failure caused or committed by the Connector would have an adverse tax impact on all cafeteria plan participants and the employer even though the employer could not have prevented the error.

(b) **Proposed corrections program**

In general, we recommend that a three-tiered correction program be established to allow employers to correct non-egregious or documentary errors without treating the entire arrangement as failing to constitute a cafeteria plan. Akin to sections 409A and 401, the complex regulatory scheme of section 125 will provide numerous opportunities for innocent errors, both documentary and administrative. In addition, as opposed to qualified retirement plans, many employers (particularly small employers) operate their cafeteria plans without the regular advice of knowledgeable professionals.

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\(^8\) See Commonwealth of Massachusetts Regulations section 956 CMR 4.00.
advisors and consultants. While employers should not be allowed to ignore the law, we believe that compliance would be facilitated by allowing employers to correct minor documentary and administrative errors in a timely fashion. The negative impact of disqualification, particularly for the rank and file participants, greatly outweighs any benefit of rigid compliance with the new regulatory requirements. Of course, in order for any correction under our proposed program to be effective, we would expect that the employer also would be required to establish reasonable procedures to ensure that the error does not reoccur.

The first tier, which would allow self-correction of any non-egregious operational or documentary errors to be done “with no strings attached” in the year in which the error occurred, is similar to corrections currently allowed under the section 409A correction program for errors corrected in the same year.\(^9\) We believe that the Service has the general authority, under established practice for benefit plans generally and general tax principles, to allow section 125 errors to be “rescinded” by the end of the year in which they occur without negative tax implications for any plan participants. Allowing correction of an error in the same year by rescission will encourage greater vigilance and prompt, on-going compliance with section 125.

We envision the second tier as being akin (but not with the same limited timeframe) to section III of the section 409A correction program under which certain section 409A errors occurring in prior years can be corrected. What we recommend here is that plan sponsors be permitted to correct non-egregious errors occurring in prior years without disqualifying the plan for all participants. Instead, we recommend that the Service only require that corrected Forms W-2 reflecting the cafeteria plan amounts includable in income for those years be issued to those participants who benefited from the error. For example, where impermissible mid-year election changes were permitted, the employer would only issue corrected Forms W-2 to the participants who were permitted to make those changes. In our view, allowing plan sponsors to self-correct non-egregious errors occurring in past years without fully disqualifying the plan would be fair and equitable, facilitate consistent administration of section 125 and promote the uniform application of the tax laws.

The third tier would involve the establishment of a voluntary correction program similar to the EPCRS VCP program. We recognize that given the Service’s limited resources, it may not be possible to establish a program of this sort in the near term. However, we encourage the Service to allocate what resources it can to implementing such a program (even if

it is initially limited in scope to more common errors), as such a procedure would be instrumental in developing uniform methods of correction.

We believe that the Service currently has sufficient authority to establish the second and third tier programs. Section 7121 is sufficiently broad to permit the Service to establish a correction procedure pursuant to which an employer may correct errors and the corresponding tax liabilities of plan participants can be addressed. In addition, section 1101 of the Pension Protection Act of 2006\(^\text{10}\) generally authorizes the Service to establish correction programs for “other employee plans” (without any limitations), which we believe would extend to cafeteria plans. Therefore, section 1101 could also serve as authority for the establishment of a correction program for plans subject to section 125.

F. Proposed Regulation section 1.125-1(d)(3) – Short Plan Year.

1. Issue

Proposed Regulation section 1.125-1(d)(3) provides that “a short plan year of less than twelve consecutive months is permitted for a valid business purpose.” The accompanying examples in the Proposed Regulations provide two examples of a valid business purpose: (i) Establishing a calendar year plan mid-year; and (ii) changing plan years to coincide with a change in health insurance carrier.

2. Recommendation

We recommend that the provisions of Proposed Regulation section 1.125-1(d)(3), when finalized, clarify that (a) an employer may terminate a cafeteria plan mid-year for any reason, as long as a primary purpose of the termination is not to circumvent the rules of section 125 and (b) an FSA participant’s coverage amounts can be pro-rated in the case of any short plan year (including one which is the result of a plan termination).

3. Explanation

In our view, an employer is not required to have a valid business purpose to terminate a cafeteria plan. In general, employers are free to terminate any benefit program they maintain for any reason and there is nothing in section 125 that requires a different result for cafeteria plans. It would be helpful to clarify that a cafeteria plan termination is not subject to the valid business purpose requirement for short plan years. However, to ensure that plan terminations are not used to avoid compliance with the short plan year rules, it would be appropriate to provide that a plan termination will not pass muster where a primary purpose of the termination is to circumvent the section 125 rules.

In addition, there continues to be some uncertainty as to how to calculate FSA participants’ coverage amounts in the context of a short plan year. For example, if a participant elects a $5,000 annual coverage amount and the plan is terminated mid-year on June 30th, the participant would have a coverage amount of $5,000 up to June 30th. However, it is unclear whether the participant would still have a $5,000 coverage amount after June 30th for claims incurred on or before June 30th, or whether the coverage amount could be pro-rated to $2,500 to account for the short plan year.

We recommend that the annual coverage amount for FSA participants be prorated in the event of a short plan year (including one that results from a plan termination). This is the most logical approach given that the period for contribution is reduced commensurately. At the same time, we believe that participants in a healthcare FSA will not be unfairly disadvantaged by this rule. Thus, if the pro-ration results in a deficit for a participant’s account (e.g., the participant has already received reimbursements of $3,000 on June 30th), it appears that the uniform coverage rule would prevent the plan sponsor from accelerating payment of the deficit by the participant. Instead, the employer would need to handle this situation similar to how it would handle excess reimbursements for a terminated employee.


1. Issue

Proposed Regulation section 1.125-1(g)(2)(iii) provides that “if an individual is an employee of an employer and also provides services to that employer as an independent contractor or director (for example, an individual is both a director and an employee of a C corporation), the individual is eligible to participate in that employer’s cafeteria plan solely in his or her capacity as an employee.” However, this section also provides that this rule does not apply to partners or to 2-percent shareholders of an S corporation. For example, an individual who is both an employee of a C corporation and a partner in an LLC (which is taxed as a partnership) would not be eligible to participate in the C corporation’s cafeteria plan where the two entities are treated as single employer under Proposed Regulation section 1.125-1(g)(5).

2. Recommendation

We recommend that final Regulations provide that an individual who is a bona fide employee of a C corporation be treated as eligible to participate in that corporation’s cafeteria plan even though the individual may also be a partner or a 2-percent shareholder of an S-corporation that is treated as a single employer with the C corporation.
3. **Explanation**

We submit that there is no need to treat partners (or 2-percent shareholders of S corporations who are deemed partners under section 1372(a)) of a related entity differently from independent contractors where the employment with the C corporation is bona fide. First of all, while the treatment of 2 percent S corporation shareholders is addressed in section 1372(a), all that is required under section 1372(a) is that these individuals be treated as “partners” for fringe benefit purposes. Thus, this section does not bar their participation in a cafeteria plan in any circumstances. At the same time, there are myriad situations where such individuals are employed as a common law employee by the related C corporation for valid business reasons. And, where the employment relationship with the C corporation is bona fide, partners (and deemed partners) of related entities are on the same footing as independent contractors. We recognize that there could situations in which the employment of a partner (or deemed partner) by the C corporation might be done solely to circumvent the exclusions. However, such abuse is also possible in the independent contractor context. In any event, we believe that the proposed requirement that the employment arrangement be bona fide would minimize the potential for that, as it would exclude any employment arrangement that is done solely to circumvent the limitations of section 125.

H. **Proposed Regulation section 1.125-1(p)(5) – Salary Reduction between Plan Years.**

1. **Issue**

Proposed Regulation section 1.125-1(p)(5) provides that “salary reduction amounts from the last month of one plan year of a cafeteria plan may be applied to pay accident and health insurance premiums for insurance during the first month of the immediately following plan year, if done on a uniform and consistent basis with respect to all participants (based on the usual payroll interval for each group of participants).” A major drawback to this rule is that the Massachusetts Connector has put into place administrative procedures that could potentially require an employer to pay premiums more than one month in advance. In addition, employers with multiple divisions, payroll systems and health options (including HMOs) may, due to the interplay of its various payroll systems and plan options, sometimes be unable to apply employee premium payments within one month of deduction.

2. **Recommendation**

We recommend that the provisions of Proposed Regulation section 1.125-1(p)(5), when finalized, provide that salary reduction amounts from the last two months of a plan year may be applied to pay for coverage in the immediately following plan year. In the alternative, we recommend that final Regulations provide an exception to the one month rule to the extent necessary to comply with any applicable state or local law involving health coverage mandates.
3. **Explanation**

Large employers who have a geographically diverse employee workforce sometimes utilize multiple payroll systems. Also, many such employers sponsor various local HMOs in addition to various self-insured health options. Due to the interplay of multiple options and payroll systems, the employer may not always be able to ensure that the deducted premium payments will be applied by the close of the following month. We believe that expanding the provisions of Proposed Regulation section 1.125-1(p)(5) to permit salary reductions from the last two months of a year to pay for coverage in the following year would provide a reasonable accommodation for employers in these circumstances. In our view, it would minimize the need for employers to make wholesale changes to payroll systems without compromising the overall aim of the Proposed Regulations.

The Massachusetts Connector rules also present a problem here. In this regard, the Terms and Conditions for employers found on the website describe the timing of payments for insurance purchased through the Massachusetts Connector as follows:

> With respect to Commonwealth Choice Members, the Connector shall send the Employer a monthly premium invoice 45 calendar days prior to the applicable coverage month... The amount due is due to the Connector by the 10th of the calendar month following the month in which the invoice is sent.  

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For example, pursuant to this procedure, an employer may receive an invoice on November 17, 2007, and will be required to send payment by December 10, 2007, for coverage that will be provided in January 2008. Given the timing of the invoice and payment, it is likely that payment will include salary reduction amounts withheld in November 2007, which is more than one month before January 2008. The proposed exception is needed to ensure that any cafeteria plans in which employees subject to this rule participate are not deemed noncompliant solely because of the operation of state or local law. At the same time, because employers have no control over this timing, we believe that the proposed exception would not be subject to manipulation or other abuse.

I. **Proposed Regulation section 1.125-1(q)(2) – Nonqualified Benefits.**

1. **Issue**

Proposed Regulation section 1.125-1(q)(2) provides that a cafeteria plan may not offer nonqualified benefits under a cafeteria plan “regardless of whether any such benefit is purchased with after-tax employee contributions or on any other basis.”

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Thus, it appears that under the Proposed Regulations, the inclusion of such benefits in a cafeteria plan document would cause the plan to fail to be a cafeteria plan.

2. **Recommendation**

We recommend that the final Regulations provide that nonqualified benefits and qualified benefits can be addressed in the same plan document, as long as the cafeteria plan portion of the document provides that the nonqualified benefits are not part of the cafeteria plan for section 125 purposes.

3. **Explanation**

To simplify the employee election process, employers often offer nonqualified benefits using the same annual cycle and eligibility, election, and enrollment rules as are used for qualified benefits, even though the former benefits are not actually offered through the cafeteria plan. For example, this is typically done for group term life insurance for spouses and dependents, universal life policies with cash value accumulation features, and increasingly long term care insurance. Our proposal would allow employers to continue this practice without unduly complicating the established employee election process. It would also avoid the time and expense of adopting and maintaining duplicative plan documentation for any nonqualified benefits. At the same time, we believe this proposal would not give rise to any compliance concerns as the employer must still carefully document that the nonqualified benefits are not part of the cafeteria plan to avoid the risk of disqualification.

II. **Proposed Regulation section 1.125-2**

Proposed Regulation section 1.125-2(d) – Optional Election Period for New Employees.

1. **Issue**

In general, the Proposed Regulations provide that an election of benefits under a cafeteria plan must be applied prospectively. However, Proposed Regulation section 1.125-2(d) provides an exception for new employees for elections made within 30 days of their date of hire by allowing those elections to be applied retroactively to the date of hire. However, this section also provides that the salary reduction amounts used to pay for the coverage must be deducted from compensation not yet currently available on the date of the election.

2. **Recommendation**

We recommend that final Regulations also apply the special 30-day rule to employees who are newly eligible for coverage due to a merger or acquisition with an unrelated employer.
3. **Explanation**

It would be helpful to apply the 30-day rule to new employees who are acquired through a merger or acquisition with an unrelated employer. Although these employees might not be considered newly hired (except in the case of an asset acquisition), they would, for all intents and purposes, become newly eligible in circumstances identical to that for the newly hired. Thus, employees acquired as a result of a stock sale may be offered new benefits and required to make new benefit elections in the same way and at the same time as newly hired employees. Therefore, we believe that it would be appropriate to extend the special 30-day rule to employees who become newly eligible under a cafeteria plan due to a merger or acquisition.

### III. Proposed Regulation section 1.125-5

#### A. Proposed Regulation section 1.125-5(c) – Application of Use-or-Lose Rule to Adoption Assistance FSAs

1. **Issue**

   Proposed Regulation section 1.125-5(c) provides that the use-or-lose rule applies to FSAs, which include adoption assistance flexible spending accounts (FSAs). However, the use-or-lose rule could adversely impact participants who adopt a foreign born child because the participant would only have qualified adoption expenses if and when the adoption becomes final.

2. **Recommendation**

   We recommend that (a) the use-or-lose rule not apply to adoption assistance FSAs for participants who are attempting a foreign adoption and (b) the amounts contributed automatically roll over to the next year while the foreign adoption proceeding is on-going (in which case the rolled-over amounts may only be used for reimbursement of the foreign adoption).

3. **Explanation**

   Section 23(e) and Revenue Procedure 2005-31\(^{12}\) provide that an adoption assistance FSA participant will only have qualified adoption expenses if the foreign adoption becomes final, and if it does become final, all adoption expenses paid or incurred in any previous taxable year are treated as paid or incurred in the taxable year in which the foreign adoption becomes final. Thus, an adoption assistance FSA may not reimburse any expenses for failed foreign adoptions. This rule does not apply to domestic adoptions, and for domestic adoptions an adoption assistance FSA can reimburse qualifying adoption expenses even if the adoption is never finalized.

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This rule is a substantial hardship on those FSA participants who elect adoption assistance FSA benefits under the reasonable belief that a foreign adoption will be finalized. However, if the adoption is finalized in a subsequent year, the use-or-lose rule provides that the FSA contributions for the prior year must be forfeited. The result would be the same if the foreign adoption fails to materialize and never becomes final.

This result is undesirable because of the dramatic differences between domestic and foreign adoptions. An employee who is planning a domestic adoption may budget his or her expenses, plan ahead, and make an adoption assistance FSA election with the knowledge and reasonable belief that the employee will be able to utilize the funds in the FSA account to pay for the often substantial expenses that will be incurred in a domestic adoption. However, an employee who is planning a foreign adoption must do so without the benefit of making a meaningful adoption assistance FSA election. Due to the operation of the use or lose rule and the section 23(e), an employee who is planning a foreign adoption must make an FSA election with the thought that he or she may never be able to use the funds in the FSA account. Most employees in this situation will simply choose not to participate in the FSA, and many employers may unduly restrict adoption assistance FSA plans only to domestic adoptions out of concern for employees who may misunderstand this rule.


1. Issues

(a) Proposed Regulation section 1.125-5(k)(3)(i) provides that a health FSA may reimburse participants for orthodontia services before the services are provided but only to the extent that the employee has actually made the payments “in order to receive the services.” This language appears to provide that advance reimbursement is only allowed if the advance payments are required. Thus, if the dental provider does not require advance payment for services, but merely permits advance payment, the FSA could not reimburse that amount in advance of the services being provided.

(b) Proposed Regulation section 1.125-5(k)(3)(i) does not allow advance reimbursement of other expenses before the services are provided. Depending on the rules of the particular health care provider, certain other expenses are typically required to be paid in advance of the services being provided. Expenses that fall into this category include pre-natal expenses, child delivery expenses (hospital and the physician charges), surgical expenses and other long term dental treatments (such as root canal treatments).
2. **Recommendations**

We recommend that the provisions of Proposed Regulation section 1.125-5(k)(3)(i), when finalized:

(a) permit advance reimbursement for any situation in which the participant has received a bill for the orthodontia service and has paid for such services; and

(b) permit reimbursement of any section 213(d) expense that is paid in advance of an extended course of treatment or other covered services being provided to the participant or his or her spouse or section 152 dependent.

3. **Explanation**

(a) **Orthodontia Expenses.**

In general, whether an advance payment is “required” or is “permitted” is often a point of negotiation between the FSA participant and the provider. Thus, even if a provider only “permits” advance payment, a FSA participant could always ask the provider to “require” the advance payment in his or her situation in order to receive reimbursement, something which most providers would be willing to do. Consequently, we believe the above rule creates unneeded complexity for claims administrators and effectively elevates form over substance. Therefore, we recommend that the Service simplify this reimbursement rule and allow advance reimbursements of orthodontia expenses regardless whether advance payment is required.

(b) **Other Services.**

Many health care providers require expenses to be paid in advance of the services being provided. For example, an obstetrician may calculate the total pre-natal charges for the 9-month course of treatment, plus delivery expenses, and then estimate what the individual’s health plan will pay based on the terms of the plan (e.g., 80% co-insurance). The obstetrician then may require the individual to pay the balance at the beginning of the 9-month course of treatment, which for many individuals would span two plan years. For example, assuming the total course of treatment, including delivery, is $10,000 and the plan is estimated to pay $8,000, the obstetrician may require the individual to pay the $2,000 up front rather than as services are rendered.

In addition, if advance payment is not required at the beginning of the treatment, a provider may request that advance payment be made in December for any remaining services that would be rendered in the following calendar year (e.g., a provider may require this due to the
operation of a large deductible for the next calendar year). For example, if
the individual has a high deductible health plan or otherwise has a high
deductible on his/her medical coverage, such as $1,500, the physician
knows that any claims submitted in the first quarter of the year will be
subject to the deductible and the physician will not receive payment from
the medical coverage. This would typically be the case if the services are
not subject to a co-pay or the physician is out of network. In this situation,
many physicians will ask for payment up-front at year-end for services
rendered in the first half of the following year.

The prohibition on advance payment in these circumstances could create
problems for FSA participants who have planned to use their FSA funds in
a certain plan year based on their knowledge of their provider’s payment
terms. At the same time, given that the participant would be required to
pay the expense to be eligible for advance reimbursement, we believe that
allowing advance payment for other services would be no more
susceptible to abuse than the advance payment currently permitted under
the Proposed Regulations for orthodontia expenses.

IV. Proposed Regulation section 1.125-6

A. Proposed Regulation section 1.125-6(a) – Timing of When an Expense is Incurred.

1. Issue

Proposed Regulation section 1.125-6(a) provides that a “cafeteria plan may pay or
reimburse only those substantiated expenses for qualified benefits incurred on or
after the later of the effective date of the cafeteria plan and the date the employee
is enrolled in the plan.” At the same time, Proposed Regulation section 1.125-
2(d) allows new hires to make a cafeteria plan election within 30 days of hire,
with the effective date of that election being retroactive to the date of hire.

2. Recommendation

We recommend that the provisions of Proposed Regulation section 1.125-6(a),
when finalized, provide that if an employee is retroactively enrolled as permitted
under Proposed Regulation section 1.125-2(d), any expense incurred prior to the
date of actual enrollment, but on or after the effective date of coverage, may be
reimbursed.

3. Explanation

It would be helpful to clarify that the rule in Proposed Regulation section 1.125-
6(a) does not override or otherwise conflict with Proposed Regulation section
1.125-2(d).
B. Proposed Regulation section 1.125-6(a)(4) – Reimbursements of Dependent Care Expenses.

1. Issues

(a) Proposed Regulation section 1.125-6(a)(4)(iii) provides that, in order to satisfy section 129, a “plan may not operate in a manner that enables employees to purchase dependent care assistance only for periods during which the employees expect to receive dependent care assistance.” This section also provides that if the coverage period is 12 months (except in the case of a short plan year) and the plan does not permit an employee to elect specific amounts of coverage, reimbursement or salary reduction for less than 12 months, the plan will be deemed to meet this requirement. This implies that salary reductions lasting less than 12 months, except in the case of a short plan year, may violate section 129.

(b) Examples 1 and 2 in Proposed Regulation section 1.125-6(a)(4)(iv) address the reimbursement of non-refundable registration fees for child care. Under the examples, such a fee is not eligible for reimbursement unless and until the child care is provided. The examples, however, do not expressly address the situation where the non-refundable fee is paid prior to the period of coverage during which the child care is first provided.

2. Recommendations

We recommend that:

(a) the provisions of Proposed Regulation section 1.125-6(a)(4)(iv), when finalized, provide that a participant may elect dependent care FSA coverage for periods of less than 12 months where the participant’s election correlates to and covers an entire seasonal work cycle that is less than 12 months; and

(b) An example be added in the final Regulations confirming that a non-refundable fee for child care paid during one period of coverage (e.g., December 2007) can be reimbursed in a subsequent year if (a) the child care is provided in a subsequent period of coverage (e.g., January 2008) and (b) the individual is a participant in the dependent care FSA for that subsequent period.

3. Explanation

(a) Seasonal Work Cycle

It is common practice for certain seasonal employers, such as public schools, to allow salary reductions for dependent care assistance to be prorated during the relevant season (regardless of whether employees are on a seasonal or 12-month pay cycle). Thus, for example, assuming monthly
paychecks and an election of $5,000 for dependent care assistance, it is common practice for many public schools to withhold, in keeping with the 9-month school year, one-ninth of $5,000 from each paycheck. It appears that Proposed Regulation section 1.125-6(a)(4)(iii) was intended to curtail elections that correlate to a specific incurred expense – not to prohibit elections that correlate to a bona fide seasonal work cycle. It would be helpful to have confirmation that the correlation of elections to such a work cycle would be permissible.

(b) **Non-refundable Child Care Fees**

Because non-refundable registration and like fees do not qualify as eligible expenses until the dependent care services are actually provided, we believe that it would be consistent to allow reimbursement of non-refundable fees paid in the prior year to be made in the year in which the services are first provided.


1. **Issues**

   (a) Prior proposed regulations under section 125 required a participant in a health FSA to certify that medical expenses had not been reimbursed and would not be reimbursed under any other health plan in order to be entitled to reimbursement for such expenses.\(^{13}\) The prior proposed regulations also provided analogous rules for dependent care assistance provided under section 129.\(^{14}\) Under the Proposed Regulations, participant certification is only addressed in section 1.125-6(b)(3)(ii), which only applies to substantiation of health claims using an explanation of benefits provided by an insurance company (and “EOB”). There is no similar provision for dependent care FSA claims.

   (b) The Proposed Regulations do not address whether the required participant certification may be made before an expense is incurred.

2. **Recommendations**

   We recommend that final Regulations clarify:

   (a) whether the participant certification requirement applies to (1) the reimbursement of all health FSA claims, including those which are substantiated by means other than an explanation of benefits provided by an insurance company and (2) dependent care FSAs.


that advance participant certification is permissible.

3. **Explanation**

(a) **Scope of Certification Requirement**

It is unclear whether participant certification is required for all health FSA and dependent care FSA claims or is limited to the EOB situation described in Proposed Regulation section 1.125-6(b)(3)(ii). Presumably, the former is intended. Therefore, we suggest that the final Regulations make clear that this requirement generally applies to all health FSA and dependent care FSA claims. This could be done by including the participant certification requirement in a more general provision.

(b) **Advance Certification**

In general, most plans require participants enrolling in health FSAs and dependent care FSAs to certify, at the time of enrollment (and before any expenses are incurred) that they have no other coverage and will not submit any claim for reimbursement under any other plan. In our view, there does not appear to be any policy reason for not allowing advance certification for all purposes under a health FSA. This is allowed elsewhere under the Proposed Regulations, as section 1.125-6(d)(1) provides that debit card users are required to agree in writing before receiving the debit card (and before expenses are incurred) that the user will not seek reimbursement under any other health plan for any expenses which are paid with a debit card. Because debit card users are allowed to make this certification in advance, there is no reason not to allow a general certification to be made during annual enrollment (and before any expenses are incurred) by those participants who do not have access to (or otherwise use) a debit card.

D. **Proposed Regulation section 1.125-6(d)(4) – Debit Cards.**

1. **Issue**

Proposed Regulation section 1.125-6(d)(4) provides that where a health FSA pays or reimburses medical expenses through a debit card, the debit card must be “automatically cancelled when the employee ceases to participate in the health FSA.” This language indicates that debit cards may be used as long as an employee participates in the plan. However, this does not address the use of a debit card by a former employee, who continues to be a plan participant (e.g., though the end of the month in which the employee terminates) or who elects COBRA continuation coverage.
2. **Recommendation**

We recommend that the provisions of Proposed Regulation section 1.125-6(d)(4), when finalized, provide that debit card use by former employees, including those with COBRA coverage, is permitted as long as the former employee continues to be a plan participant.

3. **Explanation**

It appears that under prior Service rulings use of debit cards was restricted to active employees.\(^\text{15}\) We believe that from both a policy and compliance standpoint there is no need automatically to terminate a participant’s use of a debit card once he or she terminates employment. To the extent that a former employee remains a health FSA participant (either through operation of the plan document or by electing COBRA continuation coverage), the former employee would continue to be eligible to receive reimbursement for subsequently incurred claims. All reimbursement methods should be available to such participants, including reimbursement through the use of a debit card. Indeed, prohibiting the use of a debit card by a COBRA continuee may be inconsistent with COBRA’s equal coverage requirement, under which the COBRA continuee is required to receive the same coverage that was in effect prior to the qualifying event.\(^\text{16}\)

E. **Proposed Regulation section 1.125-6(d)(7) – Improper Payments Using a Debit Card.**

1. **Issues**

   (a) Proposed Regulation section 1.125-6(d)(7) describes the procedures an employer must follow for any improper debit card payments and the order in which they must be followed. Because the prior guidance on these “pay and chase” procedures did not directly discuss the order in which the procedures should be followed,\(^\text{17}\) employers and third party administrators reasonably believed that the procedures could be followed in any order as long as treating the payment as a general employer indebtedness was used as a last resort. In this regard, third party administrators have generally determined that offsetting otherwise eligible expenses as permitted by Proposed Regulation section 1.125-6(d)(7)(iv) provides for an immediate plan recovery of an improper payment and works more effectively than cancelling the debit card, demanding repayment, or withholding the improper charge from the employee’s pay as required by Proposed Regulation section 1.125-6(d)(7)(i), (ii), and (iii). Yet, offsetting benefits


\(^\text{16}\) See Reg. § 54.4980B-5.

before first attempting the other methods may not be permitted under the Proposed Regulations.

(b) Proposed Regulation section 1.125-6(d)(7)(iv), which addresses the offset of improper debit card payments, implies that an offset may only occur during the same plan year.

2. **Recommendations**

We recommend that the provisions of Proposed Regulation section 1.125-6(d)(7), when finalized:

(a) clarify that the correction procedures may be followed in any order, and on a participant-by-participant basis, as long as treating the unrecovered amount as business indebtedness is applied last;

(b) permit an offset of eligible expenses incurred within 2½ months after the end of the plan year regardless of whether the plan has adopted the 2 ½ month grace period rule under Proposed Regulation section 1.125-1(e).

3. **Explanation**

(a) In general, employers and third party administrators endeavor to collect improper payments as quickly and efficiently as possible. To be able to accomplish this, it would be helpful if they had the flexibility to employ the methods listed in Proposed Regulation section 1.125-6(d)(7)(i) through (iv) in any order. This would include following a different order on a participant-by-participant basis because what works best may vary from participant to participant. At the same time, we believe that permitting this flexibility would not create any policy or compliance concerns, as the correction procedures still must be followed (albeit in a different order than provided in the regulations).

(b) Allowing offsets of eligible expenses incurred within the first 2½ months of the subsequent plan year would provide additional flexibility and ease the administrative burden involved in dealing with impermissible charges made at year-end (while avoiding any potential deferred compensation issues). Thus, for example, if an unsubstantiated expense is incurred in December 2007, an offset of any eligible expenses incurred up until March 15, 2008 could be done. At the same time, it would be helpful if this was allowed regardless of whether the plan has formally adopted the grace period rule in Proposed Regulation section 1.125-1(e), as there does not appear to be any need to require such adoption in order to permit offsets to be made after year-end.
V. Proposed Regulation section 1.125-7

A. Proposed Regulation section 1.125-7(b) – Equal Benefits.

1. Issues

   (a) Based on Examples 3 and 4, it appears that Proposed Regulation section 1.125-7(b) contains a broad eligibility rule which could be violated where an employer offers underlying health plans of “unequal value,” even if the opportunity to contribute to both plans through the cafeteria plan is identical.\(^\text{18}\)

   (b) It also appears that Example 4 of Proposed Regulation section 1.125-7(b)(iv) is mislabeled.

2. Recommendations

   We recommend that:

   (a) the provisions of Proposed Regulation section 1.125-7(b)(1), when finalized, provide that as long as the employee pre-tax premiums (or flex-credits) required to purchase the underlying benefits are identical for all eligible participants, and the flex-credits (if any) associated with the underlying plans are also identical, a cafeteria plan that offers medical benefits of “unequal value” would pass the eligibility test (as long as the plan otherwise satisfies the general eligibility requirements under the Proposed Regulations).

   (b) the title of Example 4 in the final Regulations be revised to read “Accident and health plans of unequal value for equal salary reduction amounts.”

3. Explanation

   (a) Health Plans of Unequal Value

   Section 125 governs the ability of a participant to choose from an array of benefits (and cash), without being taxed under the assignment of income or the constructive receipt rules. In our view, the nondiscrimination rules in Proposed Regulation section 1.125-7(b) do not apply to the individual benefits offered under the plan, as other sections of the Code address whether the offered benefits are discriminatory (e.g., section 105(h)). Instead, the section 125 nondiscrimination rules are simply designed to ensure that the opportunity to choose among benefits (or cash) is offered in a nondiscriminatory way.

\(^\text{18}\) See Prop. Reg. § 1.125-7(b)(iv), Examples 3 and 4.
Consequently, we believe that the section 125 eligibility requirements are not violated where the unequal benefits are offered as long as (i) the array of benefits from which participants may choose is the same for all participants, (ii) any employee contribution (or employer flex-credit) required for coverage for a particular benefit and coverage level is the same for all participants, (iii) the flex-credits (if any) made available to participants is identical for the applicable benefit and coverage level, and (iv) the array is made available to a nondiscriminatory classification of employees. For example, assume a cafeteria plan has two medical options, one that provides rich benefits with a low deductible and another one that provides fewer benefits with a high deductible. Assume further that the required employee contribution for each option and coverage level is the same for all participants. If these two medical options are both available to a nondiscriminatory classification as required under Proposed Regulation section 1.125-7(b)(1), we believe that even though unequal benefits are offered, the plan would not violate the eligibility rules because each option is offered on the same terms. In these circumstances, the underlying value of the two medical options would be irrelevant for eligibility purposes. Because an employer could accomplish this by establishing separate plans, it does not, in our view, make sense to prohibit the employer from doing so in one plan.

(b) Example 4 Fix

Example 4 involves equal, and not unequal, salary reduction amounts. We recommend that the heading be revised accordingly.

B. Proposed Regulation section 1.125-7(c)(2) – Utilization Test.

1. Issue

Section 125 provides that a cafeteria plan shall not discriminate in favor of highly compensated individuals as to either eligibility to participate or contributions and benefits. Proposed Regulation section 1.125-7(c)(2) provides that to satisfy the contributions and benefits nondiscrimination rule, the plan must satisfy both benefit availability and benefit utilization test. On its face, section 125 does not contain a utilization requirement.

2. Recommendation

We recommend that the provisions of Proposed Regulation section 1.125-7(c)(2), when finalized, provide that employers can satisfy the contributions and benefits nondiscrimination rule by either satisfying the benefit availability test or the utilization test (and not both).
3. **Explanation**

While section 125 does not expressly provide a utilization test, some have read the legislative history as requiring such. Relevant in this regard are the Senate and the House of Representatives Reports for the Revenue Act of 1978\(^\text{19}\). Specifically, the Senate Report provides the following:

> The bill provides that a cafeteria plan must not discriminate as to contributions or benefits in favor of highly compensated employees. A plan will not be discriminatory if total benefits and nontaxable benefits attributable to highly compensated employees, measured as a percentage of compensation, are not significantly greater than total benefits and nontaxable benefits attributable to other employees (measured on the same basis), provided the plan is not otherwise discriminatory under the standards of the bill.\(^\text{20}\)

In the same general vein, the House Report provides the following:

> Of course, the Committee intends that a cafeteria plan will not be considered to be discriminatory where the other contributions or benefits provided (or total contributions or benefits in the case of a plan which does not provide health benefits) for a highly compensated employee are a lower percentage of that employee's compensation than the plan provides for employees who are not highly compensated.\(^\text{21}\)

We read these reports as providing, at best, that the utilization rule is simply one way, and not the only way, that a cafeteria plan can satisfy the contributions and benefits tests. Thus, we recommend that the Service structure the utilization test as an alternative means for satisfying the contributions and benefits nondiscrimination rule.

Relevant here is the fact that employers today have only limited control over which employees elect to receive cafeteria plan benefits and to what extent that they do so. Unlike the situation for section 401(k) plans, where a working spouse can participate only in his or her employer’s 401(k) plan, medical coverage for a two-wage earner family is typically purchased under the plan of one or the other spouse’s employer, not both. Moreover, which plan is selected will turn on the offered coverage, the providers that participate in the networks and cost. In these circumstances, an employer’s only choice to ensure compliance (short of excluding the highly compensated) would be to subsidize or enrich the benefits to encourage greater participation -- a route which is uncertain to work and which the employer may not be able to do due to market, competitive or other factors.

\(^{19}\) Pub. L. 95-600.


Thus, the inclusion of a mandatory utilization test could cause otherwise appropriately designed cafeteria plans to fail to comply due to factors beyond the employer’s control and, thereby, unfairly disadvantage tax-wise all employees who participate in the plan. In contrast, this is not a problem for tax-qualified plans. Although these plans are subject to a similar statutory contributions and benefits nondiscrimination rule, the Service has not interpreted that language as requiring that a utilization test be applied to those plans.

In sum, the Proposed Regulations could have the effect of penalizing employers whose benefit offerings are less favorable than other employers in the same locale. It serves no meaningful policy objective to penalize employers that offer a uniform set of benefits to all their employees at the same cost, simply because a greater percentage of low paid employees opt for coverage under the plan of the spouse’s employer (or elsewhere) than do highly compensated employees.

C. Proposed Regulation section 1.125-7(d)(2) – Key Employee Concentration Test.
   1. Issue

   Both examples in Proposed Regulation section 1.125-7(d)(2) refer to “key employees” and “nonhighly compensated employees,” rather than “key employees” and “non-key employees.”

   2. Recommendation

   We recommend that final Regulations replace the term to “nonhighly compensated employees” in the examples under Proposed Regulation section 1.125-7(d)(2) with the term “non-key employees.”

   3. Explanation

   To ensure that there is no confusion as to the employee groups involved in applying the key employee concentration test, we recommend that the above clarification be made.

D. Proposed Regulation section 1.125-7(f)(2) – Safe Harbor Test Example.
   1. Issues

   (a) The employee cost under premium-only plans (“POP”) can vary from option to option offered under the plan. It is unclear whether POPs that require different premiums for different health plan options satisfy the safe harbor under Proposed Regulation section 1.125-7(f)(2).

   (b) Paragraph (ii) of the Example in Proposed Regulation section 1.125-7(f)(2) provides that the safe harbor provides an exemption from section 125(b) and (c). However, the text of Proposed Regulation section 1.125-
7(f)(1) provides for an exemption for all of the “nondiscrimination rules” in Proposed Regulation section 1.125-7.

2. **Recommendations**

We recommend that the provision of Proposed Regulation section 1.125-7(f)(2), when finalized:

(a) allow a POP to provide different levels of employee pre-tax premiums for different health plan coverages, as long as each option available under the POP separately satisfies the requirements of Proposed Regulation section 1.125-7(f)(1); and

(b) clarify that a cafeteria plan that meets the POP safe harbor is deemed to satisfy all of the nondiscrimination rules described in Proposed Regulation section 1.125-7, including the eligibility test under Proposed Regulation section 1.125-7(b), the general test for benefits and contributions under Proposed Regulation section 1.125-7(c), the key employee nondiscrimination test in Proposed Regulation section 1.125-7(d), the actual operation nondiscrimination test in Proposed Regulation section 1.125-7(k), and the anti-abuse rule in Proposed Regulation section 1.125-7(l).

3. **Explanation**

(a) **POPs**

We believe that where each health option under the POP satisfies the rules of Proposed Regulation section 1.125-7(f)(1) (i.e., satisfies the safe harbor percentage test of Proposed Regulation section 1.125-7(b)(3)), it does not matter that the employee cost for each health option differs. To conclude otherwise would in our view exalt form over substance, as employers could simply circumvent this by setting up a separate plan for each option and thereby satisfy the rule by that route. We recommend that Proposed Regulations be revised to avoid such a result.

(b) **Example**

It would be helpful if the Example specifically identified the Proposed Regulation section 1.125-7 requirements from which the POP is exempt.

E. **Proposed Regulation section 1.125-7(g) – Permissive Disaggregation.**

1. **Issue**

Proposed Regulation section 1.125-7(g) adopts a very limited form of permissive disaggregation.
2. **Recommendation**

We recommend that the provisions of Proposed Regulation section 1.125-7(g), when finalized, permit disaggregation to be done to the same extent that aggregation is allowed under Proposed Regulation section 1.125-7(h).

3. **Explanation**

The combination of a narrow permissive disaggregation rule with a broad aggregation rule will lead many employers to divide their plans into several separate plans to provide the maximum flexibility possible for testing -- an exercise which, as explained above as to other aspects of the Proposed Regulations, would, in our view, unnecessarily elevate form over substance.

F. Proposed Regulation section 1.125-7(j)(1) – Time to Perform Testing.

1. **Issues**

   (a) Proposed Regulation section 1.125-7(j)(1) provides that “[n]ondiscrimination testing must be performed as of the last day of the plan year, taking into account all non-excludable employees (or former employees) who were employees on any day during the plan year.” This methodology could be problematic for employers who acquire or dispose of an affiliate (or the assets of a business) during a plan year.

   (b) Testing as of year-end and including all employees at any point in the year could create unnecessary administrative burdens on plans and eliminate the flexibility to correct errors during the plan year.

2. **Recommendations**

We recommend that the provisions of Proposed Regulation section 1.125-7(j)(1), when finalized:

   (a) include a transition rule, similar to the transition rule in section 410(b)(6)(C) for tax-qualified plans, for cafeteria plan nondiscrimination testing which would extend to the last day of the first plan year beginning after the date of the corporate event; and

   (b) permit a plan to perform nondiscrimination testing as of an alternate testing date to the same extent permitted for testing tax-qualified plans under Treasury Regulation section 1.410(b)-8.
3. **Explanation**

(a) **Transition period for corporate transactions**

For tax qualified plans, section 410(b)(6)(C) generally provides that the coverage requirements are deemed to be met for a short period of time after a corporate event (provided certain requirements are met). This rule is a recognition that it is often extremely difficult to assess and change benefits in a compliant manner as of the closing of a transaction. We believe that it would be equally beneficial to apply a comparable rule under section 125. While there is no comparable rule to section 410(b)(6)(C) for section 125 plans, we submit that the Service would be within its power under section 7805 to provide similar short-term “deemed compliance” rules to allow for an orderly transition and, thereby avoid unexpected compliance issues for the employers and the participants. This could be accomplished by providing that a cafeteria plan that satisfied the nondiscrimination rules immediately prior to a corporate event will be deemed to satisfy the nondiscrimination rules after the corporate event for the transition period, provided that the cafeteria plan is not materially modified.

(b) **Testing Period**

We believe that for the following reasons, it would facilitate compliance if, as is the case for tax qualified plans, cafeteria plans can have an alternate testing date (provided plan participation as of that date is reasonably representative of the population for the whole plan year). First, this system works well for qualified retirement plans. Second, there is, in our view, nothing to suggest that allowing such would be any more susceptible to manipulation or misuse than on the tax qualified plan-side. Third, allowing testing during the year would provide ample time to make any necessary corrections during the remainder of the year should a problem be found and, at the same time, avoids the unnecessary expense of repeating a test at year-end where the plan passed under the initial test and there are no significant changes in the plan population during the year. Finally, given that a substantial portion of plans operate on the calendar year, it may be more difficult to obtain sufficient help from consultants and other advisers to perform the needed tests in a timely manner if the year-end rule is retained.

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22 *See Reg. § 1.410(b)-8(a)*, which allows a daily, quarterly or annual testing option.
VI. **Comments on Application to Multiple Employer Plans.**

1. **Issue**

   Whether multiple unrelated employers (other than members of a controlled group described in section 125(g)(4)) may sponsor a single cafeteria plan consistent with section 125.

2. **Recommendation**

   We recommend that final Regulations:

   (a) permit multiple employer cafeteria plans in which unrelated employers could participate;

   (b) provide that the plan is disaggregated on an employer-by-employer basis for nondiscrimination testing purposes;

   (c) provide that each employer in the plan separately bear the obligations and benefits for its employee group under the plan, with certain adjustments permitted in the case of business transactions and for employees transferring among participating employers; and

   (d) permit such plans to choose whether employees receive credit for service with other participating employers for purposes of eligibility or any other applicable plan purpose.

3. **Explanation**

   We are aware of at least three situations in which participation in a multiple employer cafeteria plan could be beneficial for both employers and employees. Those situations are as follows:

   A. **Business transactions** in which a group of employees are transferred from one employer or one controlled group to another and the parties to the transaction wish to permit the employees to remain in the pre-transaction cafeteria plan on a transitional basis for a designated period of time.

   B. **Employers** (i) who have a degree of affiliation through common ownership (such as participation in a joint venture), franchise affiliation or a similar business connection (but are not members of a controlled group) and (ii) whose employees move from employer to another. In these circumstances, having access to a single plan could be a cost effective way to provide a uniform benefits package, facilitate the pooling of resources and promote parity among related businesses and consistency with the use of a corporate or business brand (e.g., by a franchise operation or hotel chain in which separate locations are generally separately owned).
C. Small affiliated employers (whose affiliation does not rise to the level of a controlled group) may be better able to bear the expense of establishing and operating a cafeteria plan if they are able to share costs through use of a multiple employer plan.

In each of these circumstances, the availability of a multiple employer cafeteria plan would enable the employers to provide cafeteria plan benefits on a more efficient and cost effective basis. Although some separate recordkeeping, testing and other administration would be required for each employer, substantial cost savings should be obtainable through use of a single plan document, uniform disclosure materials, and the sharing of systems and other administrative expenses. Moreover, a multiple employee plan arrangement would facilitate the tracking and provision of benefits to employees who transfer from one employer to another by allowing an employee’s participation in any FSAs or other components of the plan to continue without interruption. At the same time, we believe that requiring discrimination testing to be done on an employer-by-employer would be sufficient to prevent any abuse or manipulation of the tax advantages of a cafeteria plan.

We also recommend that each employer participating in a multiple employer cafeteria plan bear the risks and benefits of its own arrangement within the plan, with two exceptions noted below. What this means is that if there are forfeitures from the FSAs maintained for employees of one employer, the forfeitures would be retained by that employer or applied for the benefit of that employer’s employees in the manner otherwise permitted under the regulations (and would not be used for the benefit of employees of other participating employers). Similarly, if there are cost overruns under a health FSA, e.g., because one or more employees receive a large reimbursement early in the year and then terminate employment, the employer involved would bear that expense.

The two exceptions we recommend are as follows: First, in the event that the plan provides, or all of the adopting employers agree, that all forfeitures for a year shall be applied to defray expenses, it should be permissible to apply all forfeitures to defray expenses of operating the plan without any need to allocate either expenses or forfeitures among the employers. Second, in connection with a business transaction or the transfer of employees among the participating employers, it ought to be permissible for the plan to provide that the FSA accounts of affected employees carry over from employer to employer (with such monetary adjustments between employers as may be provided under the plan or agreed to by them).