

INTRODUCTION TO CAFETERIA PLANS

Internal Revenue Service
Office of Chief Counsel

Cafeteria Plans

Plan Requirements

Employee

Deferred compensation

Qualified Benefits

Cash Requirement

Salary Reduction

Election Requirements

- a. Health Insurance Portability and Accountability Act of 1996 (HIPAA) special enrollment rights
- b. Changes in status
- c. Judgment, decree or order
- d. Entitlement to Medicare or Medicaid
- e. Changes in contributions to 401(k) plans
- f. Significant cost or coverage changes
- g. Family and Medical Leave Act (FMLA)

Flexible Spending Arrangements

- a. Health FSAs
- b. Dependent Care Assistance FSAs

Reporting and Filing Requirements

Contacts

[Click for Revocation of
Election Rules](#)

Cafeteria Plans

Section 125 of the Internal Revenue Code makes it possible for employers to offer their employees a choice between cash and a variety of nontaxable benefits without the application of the constructive receipt rules with respect to income recognition by the employees.

See, §125(a), §1.125-1, Q&A-1, §1.125-2, Q&A-2.

Section 125 was enacted in 1978 and amended in 1980, 1984, 1986, 1988 and 1996. Proposed regulations were issued on May 7, 1984 and were amended on December 31, 1984. Additional regulations were proposed on March 7, 1989, December 21, 1995, and November 7, 1998 (temporary regulations). The temporary regulations were converted to final and proposed regulations on March 23, 2000. These were then finalized on January 10, 2001. Regulation § 1.125-3 was finalized on October 16, 2001.

Plan Requirements

A cafeteria plan is a written benefit plan maintained by an employer for the benefit of its employees. The plan must allow employees to choose between two or more benefits consisting of cash (or a taxable benefit which is treated as cash) and certain "qualified benefits."

See, §125(d), §1.125-1, Q&A-2, §1.125-2, Q&A-3.

The written plan must include the following provisions:

1. A specific description of each benefit available under the plan and the period of coverage.
2. The rules governing which employees are eligible to participate in the plan.
3. The procedures for making elections under the plan, including when elections may be made, the rules governing irrevocability of elections and the periods for which elections are effective.
4. The manner in which employer contributions may be made such as by salary reduction agreement between the employer and employee, by nonelective employer contributions or by both.
5. The maximum amount of employer contributions available to any participant. To meet this requirement, the plan must describe the maximum amount of elective contributions available to any employee either by stating the maximum dollar amount or maximum percentage of compensation that may be contributed as elective contributions or by stating the method for determining the maximum amount or percentage of elective contributions that an employee may make.
6. The plan year.

See, §1.125-1, Q&A-3, §1.125-2, Q&A-3.

Employee

The term "employee" includes both present and former employees, but not self-employed individuals described in section 401(c). Thus, sole proprietors, partners in a partnership and 2% or greater shareholders in an S-corporation are ineligible to participate in a cafeteria plan. In addition, the plan may not be established primarily for the benefit of former employees.

A spouse or other beneficiary of a plan participant may receive benefits under a cafeteria plan; however, only the plan participant may make the election of benefits under the plan.

See, §125(d)(1)(A), §1.125-1, Q&A-4.

Deferred Compensation

A cafeteria plan may not offer any benefit which defers the receipt of compensation (other than a section 401(k) plan). Therefore, the plan may not permit participants to use one plan year's contributions to purchase benefits in a subsequent plan year, or to carryover unused benefits from year to year.

See, §125(d)(2), §1.125-1, Q&A-7, §1.125-2, Q&A-5.

Qualified Benefits

A qualified benefit is a benefit that does not defer compensation and which is excludable from an employee's gross income under a specific provision of the Code. Qualified benefits include the following:

- a. Employer-provided accident or health coverage under sections 105 and 106. This includes health, medical, hospitalization coverage, disability insurance and coverage under an accidental death and dismemberment policy. It also includes reimbursement for health care expenses under a health flexible spending arrangement (FSA). Individually owned accident or health insurance policies may be offered under a cafeteria plan provided that the employer requires an accounting to insure that the health insurance is in force and is being paid by the employees. See, Rev. Rul. 61-146, 1961-2 C.B. 25. Moreover, the plan may not reimburse the health insurance premiums under a health FSA.
- b. Employer-provided group-term life insurance coverage which is either excludable from income under section 79 or includible in income solely because the benefit exceeds the dollar limit of section 79 (\$50,000). Only the first \$50,000 of coverage is nontaxable. Dependent group term life insurance may not be included in a cafeteria plan if the benefit is eligible for exclusion under section 132. See, Notice 89-110, 1989-2 C.B. 447.
- c. Employer-provided dependent care assistance under section 129.
- d. Employer-provided adoption assistance under section 137.
- e. A 401(k) plan or purchase of retiree group term life insurance by participants employed by certain educational institutions described in section 170(b)(1)(A)(ii).

The following benefits are not qualified benefits and not permitted in a cafeteria plan:

- a. Contributions to medical savings accounts under section 106(b);
- b. Qualified scholarships under section 117;

- c. Educational assistance programs under section 127;
- d. Certain fringe benefits under section 132; and
- e. Qualified long-term care insurance under section 7702B.

See, §125(f), §1.125-1, Q&A-5, §1.125-2, Q&A-4.

Cash Requirement

A cafeteria plan must offer a cash option (this is usually in the form of a salary reduction agreement). Cash benefits include not only cash, but also benefits which may be purchased with after-tax dollars, or the value of which is generally treated as taxable compensation to the employee.

See, §125(d)(1)(B), §1.125-1, Q&A-5, §1.125-2, Q&A-(b) and (c), and Q&A-5(c).

Qualified scholarships under section 117, and employer provided fringe benefits under section 132 may not be included in a cafeteria plan even if purchased with after-tax contributions.

See, §1.125-2, Q&A-4(d).

Salary Reduction

Employer contributions to the cafeteria plan are usually made pursuant to salary reduction agreements between the employer and the employee in which the employee agrees to contribute a portion of his or her salary on a pre-tax basis to pay for the qualified benefits.

Salary reduction contributions are not actually or constructively received by the participant. Therefore, those contributions are not considered wages for federal income tax purposes. In addition, those sums generally are not subject to FICA and FUTA. A salary reduction agreement is sufficient to satisfy the "cash" requirement of a cafeteria plan. Thus, a cafeteria plan need only offer a choice between one qualified benefit and salary reduction.

See, §§3121(a)(5)(G) and 3306(b)(5)(G), §1.125-1, Q&A-6, 14 and 16.

Election Requirements

For participants to avoid constructive receipt of taxable benefits, the plan must offer an election, and participants must elect the amounts and types of benefits to be received prior to the beginning of the plan year. If salary reduction is permitted to pay for the benefits chosen, the salary reduction amount must be elected prior to the beginning of the plan year.

Generally, the plan may not permit participants to elect their benefit coverage, benefit reimbursement, or salary reduction for less than 12 months. However, this does not prohibit new employees from electing benefits for a part of the cafeteria plan year.

See, §125(d)(2), §1.125-1, Q&A-6, 8, and 15, §1.125-2, Q&A-6.

Revocation of Elections

After a participant has elected and begun to receive benefits under the plan, the plan may not allow the participant to revoke the benefit election during the period of coverage unless the revocation is due to one of the following events:

a. Health Insurance Portability and Accountability Act of 1996 (HIPAA) special enrollment rights.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to permit individuals to be enrolled for coverage following the loss of other health coverage, or if a person becomes the spouse or dependent of an employee through birth, marriage, adoption or placement for adoption. If a participant has a right to enroll in an employer's group health plan or to add coverage for a family member under HIPAA, the participant can revoke an existing election and make a new election under the cafeteria plan that conforms with the special enrollment right.

See, §1.125-4T(b), §9801 (f), §54.9801-6T.

b. Changes in status.

Under the change in status rules, a plan may permit participants to revoke an election and make a new election with respect to accident and health coverage, dependent care expenses, group-term life insurance, or adoption assistance if,

- (1) a change in status occurs and
- (2) the election change is "consistent" with the change in status.

Change in status events are:

- Changes in legal marital status;
- Changes in number of dependents;
- Changes in employment status;
- Cases where the dependent satisfies or ceases to satisfy the requirements for eligibility;
- Changes in residence, and
- For purposes of adoption assistance, the commencement or termination of an adoption proceeding.

An election change is "consistent" if that change is "on account of" and "corresponds with" a change in status event that affects eligibility for coverage. In the case of accident or health coverage (such as a health FSA), if a change in status results in an increase or decrease in the number of an employee's family members or dependents who may benefit from coverage under the plan, the eligibility requirement is satisfied. Election changes must be on a prospective basis only.

See, §1.125-4(c).

c. Judgment, decree or order.

A plan may permit a participant to revoke and change an election if a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires accident and health coverage for a participant's child, and that coverage is actually obtained.

See, §1.125-4(d).

d. Entitlement to Medicare or Medicaid.

A plan may permit a participant to revoke an election for accident or health coverage if the participant, spouse or dependent becomes entitled to Medicare or Medicaid.

See, §1.125-4(e).

e. Changes in contributions to 401(k) plans.

A plan may permit an employee to modify or revoke elections in accordance with sections 401(k) and 401(m) and the regulations thereunder.

See, §1.125-4(h).

f. Significant cost or coverage changes. (These rules do not apply to health flexible spending arrangements).

1. Cost changes: If the cost under a health plan increases or decreases during the plan year, the plan may automatically increase or decrease all affected participant contributions for such health plan. In the alternative, if the cost significantly increases or decreases, the plan may permit participants to either make a corresponding change in their premium payments, commence participation (in the case of a premium decrease) or revoke their elections and, in lieu thereof, to receive coverage under another health plan with similar coverage. If cost significantly increases and there is no similar coverage, participants may drop coverage.

2. Coverage changes: If the coverage provided ceases or is significantly curtailed, the plan may permit participants to revoke their elections of the health plan and, in lieu thereof, to receive prospective coverage under another health plan with similar coverage. A significant curtailment is defined as an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally. If a significant curtailment amounts to a loss of coverage and no similar coverage is available, participants may drop coverage. A loss of coverage means a complete loss of coverage and includes the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation. In addition, the cafeteria plan has discretion to treat other similar events as a loss of coverage.

See, §1.125-4(f).

g. Family and Medical Leave Act (FMLA).

A plan must allow a participant who takes unpaid FMLA leave to revoke an existing election for health plan coverage for the remainder of the coverage period (notwithstanding any contrary rules stated in the cafeteria plan document). A participant who takes FMLA leave may revoke elections for non-health benefits only under the same rules that apply to participants taking non-FMLA leave. In either case, the participant may choose to be reinstated in the plan upon return from FMLA leave on the same terms and conditions as prior to taking FMLA leave.

See, §1.125-3, Q&A-1 and Q&A-7.

Flexible Spending Arrangements (FSA)

An FSA is an arrangement that provides coverage under which specified, incurred expenses may be reimbursed and the maximum amount of reimbursement available to a participant for a period of coverage is usually equal to the participant's contributions. Like all qualified benefits, FSA coverage must meet all of the rules under the relevant Code section (e.g., sections 105, 106 and 129) in order to be excludable from gross income. The two most common types of FSAs are health FSAs and dependent care assistance FSAs.

See, §1.125-1, Q&A-16, §1.125-2, Q&A-7(c)

a. Health FSAs.

A health FSA must qualify as an accident or health plan (i.e., it must exhibit the risk-shifting and risk distribution characteristics of insurance). Thus, a health FSA must provide "uniform coverage" throughout the coverage period. This means that the

maximum amount of reimbursement (i.e., the annual election) must be available to the participant at all times. For example, if an employee elects salary reduction of \$100 per month for a health FSA, the employee's annual election of \$1200 must be available to the employee for reimbursement at any time during the plan year (properly reduced for prior reimbursements) without regard to the employee's actual contributions to the plan at that time. The plan may not accelerate the payment schedule based upon the claims that the employee has made.

Reimbursements under a health FSA must be paid specifically to reimburse the participant for medical expenses not covered by health insurance. 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 taxable benefit, without regard to whether the participant incurs medical expenses during the period of coverage. Reimbursements are permissible for medical expenses as defined in section 213 of the Code with the exception of premiums for other health plan coverage (e.g., major medical policies).

A health FSA cannot operate in a manner that enables participants to receive coverage only for periods during which they expect to incur medical expenses. Consequently, the period of coverage under a health FSA generally must be 12 months or the entire length of a short plan year.

The participant must substantiate all claims for reimbursement under a health FSA. Thus, the participant must provide both a written statement that the expense has not been reimbursed (or is not reimbursable) under any other health plan coverage and verifying the date and the amount incurred for the expense.

Reimbursements may only be made for claims incurred during the period of coverage. Expenses are treated as having been incurred when the participant is provided with the medical care that precipitates the expense, not when the participant is billed or pays for the care.

FSAs are subject to a use-or-lose rule. Amounts unused by the participant at the end of the plan year are forfeited. If this was not the case, the FSAs would be a mechanism for deferring compensation.

See, §1.125-1, Q&A-17, §1.125-2, Q&A-7 (a) and (b)(1) through (7).

b. Dependent Care Assistance FSAs.

The same rules that apply to health FSAs also apply to dependent care FSAs except that coverage does not have to be uniform during the coverage period. Thus, a participant is only entitled to reimbursement of amounts actually contributed to the plan and available in the participant's account at any given time.

See, §1.125-1, Q&A-18, §1.125-2, Q&A-7(b)(8).

Reporting and Filing Requirements

The filing of an information return (Form 5500 series with Schedule F) has been suspended effective April 22, 2002.

See Notice 2002-24, 2002-16 I.R.B. 785

Contacts

For additional information, contact any of the following persons in
CC:TEGE:EB:HW at (202)622-6080;

Harry Beker
Felix Zech
Shoshanna Chaiton