Cafeteria Plans: Background and Basics

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Overview

A cafeteria plan is a critical component of every employer sponsored health and welfare plan. It is a funding vehicle created under § 125 of the Internal Revenue Code (Code) that allows employees to salary reduce to pay for certain qualified benefits on a pre-tax or tax favored basis. Without a cafeteria plan in place employees are taxed on the value of benefits they receive and the wages used to pay for benefits. The tax advantage offered through a cafeteria plan, however, comes with certain rules to keep the cafeteria plan a "qualified" funding vehicle. Those rules and other compliance considerations are discussed below.

Plan Documents

A cafeteria plan under Code § 125 allows employees to pay for certain qualified benefits on a pre-tax basis through payroll deductions. A cafeteria plan must be maintained pursuant to its own written plan document. A cafeteria plan document must contain all of the following information:

- Description of available benefits;
- Participation rules;
- Election and election change rules and procedures;
- Information on contributions;
- Plan year;
- If the plan includes flexible spending arrangements (H-FSA or DCAP), the plan's provisions complying with additional requirements for those FSAs;
- If the plan includes an HSA, information on eligibility and any employer contributions; and
- If the plan includes a grace period, the plan's grace period provisions.

Importantly, a cafeteria plan is not an ERISA welfare benefit plan, so no specific disclosure requirements apply to cafeteria plans themselves. Any ERISA benefits paid for with pre-tax dollars through a cafeteria plan (e.g., medical premiums or a health flexible spending account) are subject to ERISA, which means that ERISA's rules apply to these benefits. Most notably, the requirement to create and maintain a summary plan description (SPD) or wrap SPD. Also, the impact of the cafeteria plan rules, like irrevocable elections, on ERISA benefits funded through the cafeteria plan should be disclosed in the SPD or Wrap SPD for ERISA plan(s). For more information see our Alliant Insight ERISA Plan Documents and 5500s.

Qualified Benefits

A cafeteria plan must offer employees a choice between income and other non-taxable qualified benefits. Under Code § 125 the term "qualified benefit" means any benefit which is not includible in

the gross income of the employee by reason of an express exclusion under the Code.[1] Cafeteria plan qualified benefits[2] include:

- Coverage under an accident or health plan—Code § 106;
    - Includes medical, dental, and vision premiums, AD&D, and H-FSAs
    - Includes short-term disability (STD) and long-term disability (LTD) policies but how benefits are taxed depends on whether premiums are paid with pre-tax dollars
- Benefits under a dependent care assistance program—Code § 129;
- Group term life insurance coverage—Code § 79;
    - Does not include life insurance coverage on the life of an employee's spouse or dependent
- Adoption assistance—Code § 137;
- 401(k) plan cash or deferred arrangement—Code § 125(d)(2)(B);
    - Employees must have the option of receiving the 401(k) contribution amount in cash
- Health savings accounts (HSAs)—Code § 223

Who Can Participate

Cafeteria Plan rules expressly require that all participants are employees. In almost all cases, employees will consist of common-law employees. For more information on common law employee status see our Alliant Insight, Common Law Employee Status and its Importance under the ACA.

Self-employed individuals are not considered employees and cannot participate in a cafeteria plan. Self-employed individuals include a sole proprietor, a partner in a partnership, and a director serving on a corporation's board of directors who does not otherwise provide services to the corporation as an employee, and non-employee members of LLCs. Any individual who is a more-than-2% shareholder of an S corporation also cannot participate in a cafeteria plan. One exception to the exclusion of shareholders is shareholders in a Subchapter C corporation because they can have employee status and are, therefore, not precluded from participating in a cafeteria plan (unlike a more-than-2% shareholder in a Subchapter S corporation),

Irrevocable Elections and Status Change Events

A cafeteria plan must provide that participant elections are irrevocable for the period of coverage (generally the plan year). The period of coverage in a cafeteria plan is typically the 12-month plan year. However, it may also be a shorter period for an initial plan year, for a short plan year (often when trying to change plan year) or with respect to a new employee's initial election. If the irrevocable coverage rule is not honored the cafeteria plan will not be qualified under Code §125 and benefits become taxable.

Cafeteria plan election change regulations do, however, create certain permissible exceptions to this irrevocability requirement. Under these rules if a participant experiences certain status change events and timely comes forward to request a change to their benefits, he or she may generally make an

[1] There are certain Code based income exclusions that can be provided on a tax favored basis, just not as part of the cafeteria plan. Those include, but are not limited to, § 127 educational assistance programs and § 132 transit and other fringe benefit programs.

[2] Some additional qualified benefits that are seldom offered are not listed here.

election change. Status change or election change events are broken down into the following 15 categories.

1. Change in Status (6 categories of events)
    - Marriage/Divorce
    - Change in # of dependents (by way of birth, adoption, or death)
    - Change in employment status if it impacts eligibility
    - Change in dependent status (becomes eligible or ceases to satisfy eligibility req.)
    - Change in residence that impacts eligibility under the plan
    - Commencement or termination of adoption
2. Cost Changes with Automatic Increase/Decreases in Elective Contributions (for example, a slight change in premium during the plan year)
3. Significant Cost Change
    - Allows participants to make a mid-year corresponding and prospective election change (broader than item 2 and may include add/drop due to a significant cost change)
4. Significant Coverage Curtailment
5. Addition or Significant Improvement of Benefit Package Option
6. Change in Coverage Under Another Employer Plan
7. Loss of Group Health Coverage Sponsored by Governmental or Educational Institution
8. HIPAA Special Enrollment Rights
    - acquiring a dependent through marriage, birth, adoption or placement for adoption
    - loss of other group health plan coverage or insurance
    - eligibility for a CHIP premium assistance subsidy
    - loss of Medicaid or CHIP coverage
9. Exchange Open or Special Enrollment Period
10. A reduction in hours to below 30 per week, even if the change in status doesn't impact plan eligibility, as long as the employee and other dependents who lose coverage intend to enroll in other MEC (employee can drop coverage to enroll in Exchange or other MEC plan)
11. COBRA Qualifying Events
12. Judgments, Decrees, or Orders (such as child support orders, including Qualified Medical Child Support Orders "QMSCOs").
13. Medicare or Medicaid Entitlement
14. FMLA Leaves of Absences
15. Changes in pre-tax HSA Contributions (changes can be made on a monthly basis)

The list of status change or election change events must also be analyzed under the consistency rule. Generally, this rule requires that an election change must be on account of and correspond with a status change or election change event. For example, under the consistency rule if an employee chooses not to enroll her spouse during open enrollment the fact that her spouse later got a new job that offered benefits would not allow the employee to add the spouse to the employee's plan even though this is a change of coverage under another employer plan. However, the employee could drop her coverage to enroll in the plan her spouse became newly eligible for under the consistency rule.

Lastly, the cost and coverage election change events (items 2-7 above) and the two newer election change events (items 9-10 above) expressly do not allow changes to H-FSA elections. An example in the Cafeteria Plan regulations also indicates that a H-FSA change cannot be made with a change in residence. HIPAA special enrollment rights (item 8 above) generally do not apply to excepted benefits,

which include dental, vision, and H-FSA coverage. HSA elections can also be changed on an at least monthly basis (see discussion below). For additional information on status change or election change events see our Alliant Insight, Cafeteria Plan Mid-Year Election Change Rules.

Effective Date of Elections and Election Changes

Elections and election changes are effective on a prospective basis. There are, however, exceptions for new hires and for the acquisition of a dependent child through birth, adoption or placement for adoption. Under a special rule allowing retroactive coverage for new hires, a cafeteria plan may give new employees a window of up to 30 days after their hire date to make elections between cash and qualified benefits. Elections made during this window can be effective as of the employee's hire date on a retroactive basis even though salary reductions to pay for elected benefits must be taken from compensation that is not yet currently available when the election is made. Similarly, HIPAA portability rules require group health plans (other than excepted benefits) to provide coverage on a retroactive basis when there is a special enrollment right due to birth, adoption, or placement for adoption of a child. The cafeteria plan regulations accommodate that HIPAA requirement by allowing elections and coverage to be retroactive.

IRS regulations do not specify exactly how long a participant has after a permitted election change event to request a change of election. However, election requests that are too far removed from the event could be challenged as not being "on account of" the event under the consistency rules. Consequently, most employers require that employees submit their election change requests within a narrow window after the event occurs (30 days is most commonly used). The cafeteria plan document should address when new elections must be made for new hires or after a participant experiences an event justifying a midyear change in election.

Correcting Mistakes

Although the permitted election change regulations do not address mistakes, IRS officials have consistently commented that an election may be corrected without violating the irrevocable coverage rule when there is clear and convincing evidence that a mistake has been made. An employer's administrative or clerical mistake in recording an election can easily be undone. Employee mistakes, however, are more difficult to adjudicate. With an employee's alleged mistake there are two approaches for determining whether there is clear and convincing evidence of an employee mistake, an impossibility standard and a facts and circumstances standard. Under the impossibility standard, a correction is allowed if it can be established that it was impossible for the employee to benefit from the mistaken election. The clearest example of a mistake under the impossibility standard is when an employee with no dependent children makes a dependent care FSA or DCAP election instead of a health-FSA election. Under the facts and circumstances standard, errors can be corrected if the plan administrator can reasonably ascertain, based on facts and circumstances, that a mistake has actually occurred. This is a more subjective standards and can consider factors including, the employee's past elections and benefit usage, plausible evidence of a clerical mistake (e.g., $5,000 input on the system could have been $500 or $50, but not likely $1,390) and how much time passed since the first payroll date reflecting the mistaken election.

H-FSAs

An H-FSA is a self-insured medical reimbursement plan that can reimburse otherwise unreimbursed Code § 213(d) medical expenses of an employee or their dependents. It is subject to the Code, HIPAA,

ERISA and COBRA. The ACA also added a salary reduction election limit of $2,500 (indexed annually) that applies on a per employer basis and must be prorated for short plan years. Although this limit does not include employer contributions, to retain excepted benefit status employer contributions cannot exceed the greater of $500 or a match of the employee's election.

Two foundational rules for H-FSAs are the "uniform coverage rule" and "use-it-or-lose-it" rule. The uniform coverage rule requires that the maximum amount of reimbursement from an H-FSA must be available at all times during the period of coverage regardless of the amount of the employee's contributions. This does create some financial exposure for employers because an employee could make a calendar year H-FSA election of $2,500 and spend that full amount in January and then terminate employment having only salary reduced a small percentage of their $2,500 election. Employers are expressly precluded from seeking repayment in such cases.

The use-it-or-lose-it rule acts as a counterpoint to the uniform coverage rule. Under the use-it-or lose-it rule any amount remaining in an H-FSA at the end of the coverage period is forfeited. This risk of loss for the employee can be mitigated by employers that choose to implement any of the following designs:

- A run out – provides additional time after the end of a plan year to submit expenses incurred during the coverage period or plan year
- A grace period – allows participants to access unused FSA amounts after the end of a plan year to reimburse expenses incurred for up to 2 ½ months after the end of the plan year (cannot be used with a carryover)
- A carryover – allows H- FSAs to offer carryovers of unused balances of up to $550 (not shown as indexed) remaining at the end of a plan year to be used for qualified medical expenses incurred in subsequent plan years (cannot be used with a grace period)

As noted above H-FSAs are also subject to COBRA but have a limited COBRA obligation. COBRA only needs to be offered to under spent accounts and then only for the duration of the plan year (plus any grace period). In determining whether an account is underspent, we look at the total COBRA premium that would be paid for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period (PY) as compared to the balance remaining in the account. This significantly limits the COBRA obligation and thus limits administrative costs.

Carryovers complicate the limited COBRA obligation in two ways. First, in determining whether an account is underspent we must include any carryover amounts in the balance but when we compare the balance to the COBRA premium that would be paid for the remainder of the coverage period we only base the COBRA premium on the current year's salary reduction election. This means that many more accounts will be underspent and more COBRA offers made. Second, if a carryover is available to active employees it must be available to COBRA QBs on the same terms. This can extend the COBRA coverage period past the end of the plan year. To address these issues employer can limit carryovers to employees that make an H-FSA election in the subsequent year and limit the carryover duration to one year.

DCAPs

A DCAP is an employer sponsored flexible spending arrangement that allows employees to exclude up to $5,000 from gross income for amounts paid for dependent care $2,500 if married filing separately ($10,500 for the 2021 calendar year only). Reimbursements are for care of a qualifying child age 12 or

under or a spouse or other tax dependent (as defined generally in Code § 152) who is physically or mentally incapable of self-care. The expense must also be incurred to enable the employee (and spouse if applicable) to be gainfully employed. Overnight camps and school expenses do not qualify but care before school and after care generally does. Importantly, DCAP income exclusion limits apply on a calendar year or tax year basis which can be challenging for non-calendar year plans. For example, if a DCAP is operated on a July 1–June 30 plan year, an employee may incur expenses equal to the maximum DCAP limit during the second half of one plan year (e.g., between January and June) and then exceed the limit during the first half of the following plan year (e.g., between July and December).

Because a DCAP does not provide medical care it is not subject to ERISA, HIPAA, or COBRA. It is, however, subject to rules under both sections 129 and 125 of the Code. The notable exception to the 125 rules is that DCAPs are not subject to the uniform coverage rule, which means that employees can only be reimbursed for expenses up to amounts that have actually been withheld from wages. Status change or election change rules are also applied more liberally. For example, any change to day care provider or work status of a spouse would allow an election change. Use-it-or-lose it rules do apply.

Any DCAP reimbursements will offset amounts available under the federal Dependent Care Tax Credit. This generally means that employees must choose whether to participate in a DCAP or claim the Dependent Care Tax Credit. Whether participating in a DCAP on a salary reduction basis or claiming the Dependent Care Tax Credit results in the greatest tax benefits can depend on several factors unique to the individual, such as tax filing status, number of dependents, and tax bracket.

HSAs

HSAs are individually owned trust or custodial accounts that can reimburse Code § 213(d) medical expenses of an employee or their dependents on a tax favored basis. Non-medical distributions are also available but are subject to a 10% penalty. To be eligible to contribute to an HSA an individual must be covered only by a qualified high deductible health plan and have no coverage that pays claims below the deductible. HDHP/HSA offerings are now a common component of group health plans. However, absent extreme employer involvement, HSAs are not part of an employer's group health plan, they don't provide medical care, and are not subject to HIPAA, ERISA or COBRA.

When employers make contributions to employee accounts, those contributions are subject to strict "comparability rules." Those rules require that employer contributions must generally be the same amount or same percentage of HDHP deductible (e.g. comparable). If the comparability rules are not adhered to employers are subject to an excise tax of 35% of all of its HSA contributions for the calendar year. However, the strict and complex "comparability rules" can be avoided when an HSA is offered through a cafeteria plan (if salary reduction contributions are allowed, then the HSA is generally considered to be offered through a cafeteria plan, as long as the plan document contains language permitting this option.) In that case, the plan only needs to be concerned with passing section 125 non-discrimination testing, which is seldom an issue under most HSA funding strategies (see discussion below).

Lastly, because HSA eligibility can change monthly the cafeteria plan rules require plans to allow election changes to HSA salary reductions on an at least monthly basis. For more information on HSAs and Comparability rules see our Alliant Insights, HSA Comparability Rules and Implementing an HDHP HSA Benefit Option or our HSA FAQ.

Non-discrimination Rules

As mentioned above cafeteria plans are subject to non-discrimination rules and annual testing is generally required. In addition, several of the component benefits funded through a cafeteria plan are subject to their own nondiscrimination frameworks. For example, an H-FSA is theoretically subjected to section 105(h) nondiscrimination testing. DCAPs are subject to a suite of testing, including the More-Than-5% Owners Concentration Test and 55% Average Benefits Test,[3] which often create problems because higher paid individuals tend to take greater advantage of DCAP offerings. As a result the DCAP elections of these groups are often capped at amounts below the IRS limit. The basic cafeteria plan nondiscrimination rules are discussed below.

- Eligibility Test: (1) The cafeteria plan may not impose a service requirement of longer than three years, (2) any classifications among employees must be reasonable based on objective business criteria like specified job categories, nature of compensation (i.e., salaried or hourly), geographic location, or similar bona fide business criteria, and (2) enough non highly compensated employees/participants (non-HCPs) must participate in the plan relative to participation by highly compensated employees/participants (HCPs) (safe harbor percentage).
- Contributions and Benefits Test: (1) The same qualified benefits and same employer contributions must be available for *similarly situated* participants at the same cost, and (2) the aggregate qualified benefits elected by the HCPs divided by the aggregate compensation of the HCP group must be equal or less than the aggregate qualified benefits elected by the non-HCPs divided by the aggregate compensation of the non-HCP group (HCP ratio ≤ non HCP ratio). Note that a percentage of compensation approach may also be permissible. [4]
- Key employee Concentration Test: Nontaxable benefits provided to key employees cannot exceed 25% of the total of all such benefits provided for all employees under the plan.

If a cafeteria plan fails any of the nondiscrimination tests, then the HCPs and Keys, as applicable, will lose the favorable tax treatment of benefits under the cafeteria plan. Non-HCPs and non-Keys are not affected by a plan's failure to pass the nondiscrimination tests. Note that some or all of the required testing is performed by section 125 administrators on behalf of plans.

Conclusion

A cafeteria plan is a critical component of every employer sponsored health and welfare plan. Without a cafeteria plan and plan document employees cannot salary reduce to pay for most benefits on a pre-tax or tax favored basis. Failing to implement a cafeteria plan or administer it so that it retains its qualified status also creates complex double taxation for employees. Working with a good section 125 administrator to create a cafeteria plan document, conduct basic cafeteria plan nondiscrimination

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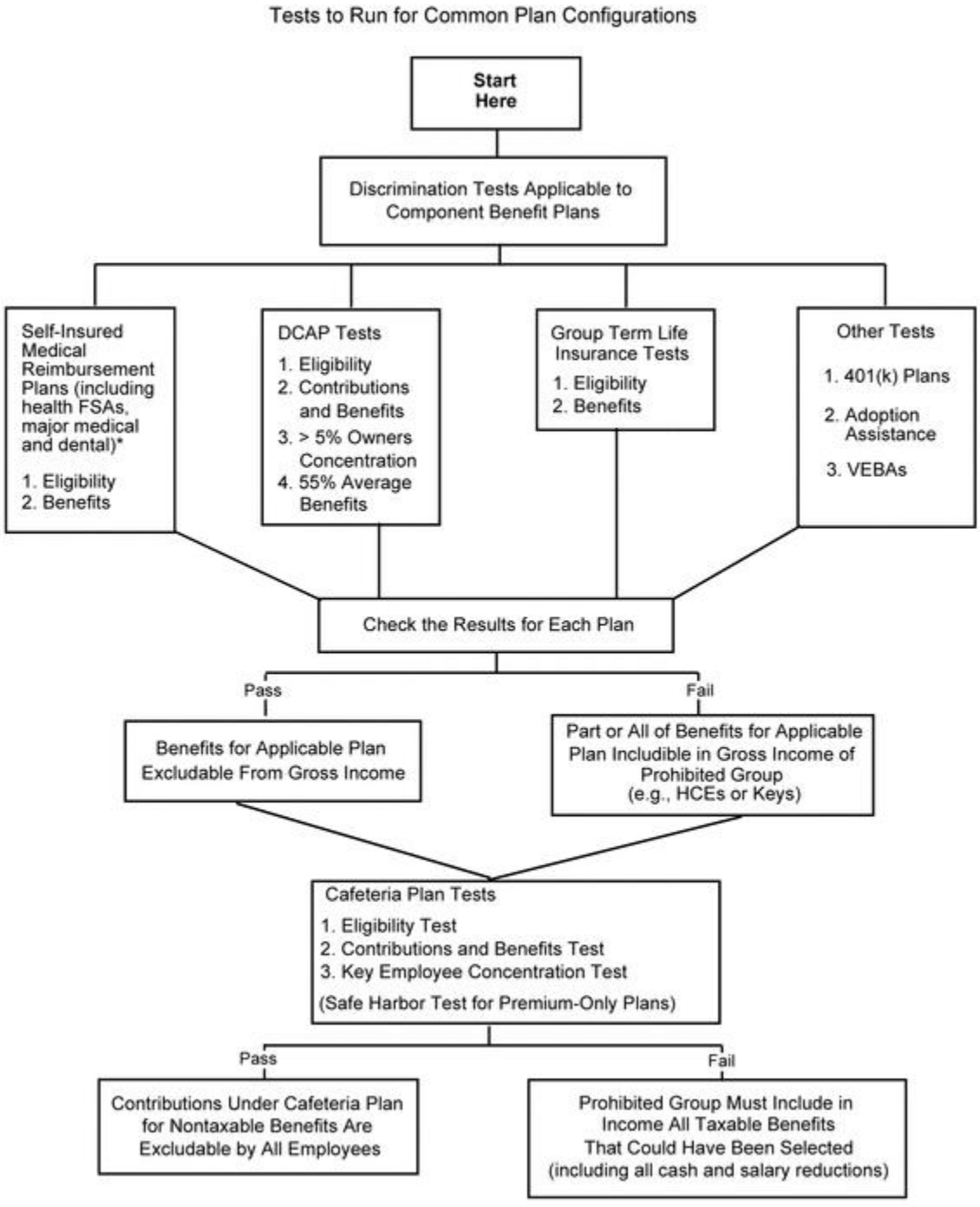
[3] The more-Than-5% Owners Concentration Test provides that not more than 25% of the amounts paid or incurred by the employer for dependent care for a plan year may be provided to shareholders or owners (or their spouses or dependents) who own more than 5% in the stock, capital, or profits interest in the employer. The 55% Average Benefits Test provides that the average DCAP benefits provided to the non-HCEs under all plans of the employer must be at least 55% of the average benefits provided to HCEs under all plans of the employer.

[4] The prohibited group for these first two tests includes: officers, more-than-5% shareholders, highly compensated individuals (414(q)) income threshold (or the top-paid group election at 20% highest paid), and spouses or dependents of such individuals.

testing and following basic rules to keep the cafeteria plan a “qualified” funding vehicle are critical steps all employers should follow.



* These nondiscrimination rules will also apply to certain insured group health plans after the government issues regulations or other guidance on how the rules apply to insured plans. See subsection D.