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In the
Supreme Court of Ohio

CLAUDIA BERNARD, Appellant, v. UNEMPLOYMENT COMPENSATION REVIEW COMMISSION [Ohio Department of Job and Family Services], *et al.*, Appellees.	:	Case No. 2012-0717 On Appeal from the Miami County Court of Appeals, Second Appellate District Court of Appeals Case No. 11 CA 00016

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INTRODUCTION

Claudia Bernard asked her employer to help her cope with the expenses of her diabetes. Her employer complied by setting up a health flexible-spending arrangement that allowed Bernard to shelter $10,800 from federal income taxation. One result of this favorable tax treatment was that the $10,800 was not subject to unemployment taxes and therefore not part of her wages for calculating unemployment-compensation benefits.

Now Bernard wants to treat that $10,800 as part of her taxable salary for purposes of calculating her unemployment benefits. She wants both the benefit of the tax sheltering she already enjoyed and the benefit of treating that same money as taxable so that she can collect unemployment benefits (if she ultimately satisfies other prerequisites).

Ohio statutes (and the federal statutes to which they point) foreclose Bernard's argument. Sensibly, Ohio and federal statutes largely treat taxable wages consistently—if some portion of wages is exempt from income tax, it is not part of an employee's wage base for unemployment benefits. Because Bernard enjoyed tax savings through the employer-sponsored health flexible-spending arrangement, she cannot later treat those dollars as taxable for purposes of increasing her taxable wage for purposes of unemployment-compensation benefits.

The Second District correctly affirmed the common pleas court's decision denying benefits, which had affirmed consistent administrative decisions also denying benefits. The Second District, though, made the case more complicated than it need be. The court resorted to an interpretive canon that defers to administrative readings of statutes. But the relevant statutes need no interpretation. Still, if interpretation is needed, deference to the ODJFS reading of the statute is appropriate. ODJFS has consistently read the statute for nearly 20 years, and the IRS has similarly interpreted its own statutes for at least that long.

STATEMENT OF THE CASE AND FACTS

Claudia Bernard worked for the Wakeman Educational Foundation, an entity named after the long-time Director of Education at the Cincinnati Zoo. Wakeman runs programs for adults and children aimed at connecting them with "our environment." *See* http://www.wakemanfoundation.org/home/mission.html (Nov. 15, 2012).

Bernard last worked at Wakeman in 2009. For that year, she earned $17,320, but chose to divert $10,800 into a health flexible-spending arrangement. App. Op. ¶ 3 (Appx. A). Bernard desired this expansive pre-tax benefit because she is a Type 1 diabetic and has "a lot of medical expenses." Hear. Tr. at 10, Br. of Bernard in Common Pleas, Ex. 1 at 1. According to Wakeman, it indulged this request, despite a $4,000 cost to set up the program. Br. of Wakeman in 2d Dist. at 6. By depositing the $10,800 in this way, Bernard avoided any federal income tax liability on more than half her earnings.

Bernard lost her job at the end of 2009 and she applied for unemployment benefits. App. Op. at ¶ 2. The Ohio Department of Job and Family Services denied benefits because Bernard had not made enough money to qualify. Her average weekly wage, calculated from the $6,520 she chose to designate as take-home pay, fell below the then-applicable $213 weekly minimum to qualify for benefits under R.C. 4141.01. Bernard appealed, and the Unemployment Compensation Review Commission affirmed because "flexible spending account payments are not considered wages." Appx. C at 2. On further appeal, the Miami County Common Pleas Court affirmed, concluding that the administrative application of the statute was reasonable "when one realizes [Bernard] wanted the money directed in this fashion." Appx. B at 4. The Second District, over a dissent by Judge Fain, affirmed after examining several federal authorities regarding the tax treatment of health flexible-spending arrangements.

STANDARD OF REVIEW

By statute, a court reviewing agency action involving unemployment compensation "shall affirm" the Unemployment Compensation Review Commission's decision unless it is "unlawful, unreasonable, or against the manifest weight of the evidence." R.C. 4141.282(H). "This limited standard of review applies to all appellate courts," which "may not reverse the commission's decision simply because reasonable minds might reach different conclusions." *Williams v. Ohio Dep't of Job & Family Servs.*, 129 Ohio St. 3d 332, 2011-Ohio-2897 ¶ 20 (citation and internal quotation marks omitted). This Court independently resolves questions of law. *Univ. Hosp., Univ. of Cincinnati Coll. of Med. v. State Employment Relations Bd.*, 63 Ohio St. 3d 339, 343 (1992).

ARGUMENT

Appellee's Proposition of law:

> *Remuneration placed in a tax-advantaged medical flexible-spending arrangement is not part of an employee's "average weekly wage" for purposes of determining eligibility for unemployment-compensation payments.*

Bernard makes this case far more complicated than it is. Ohio statutes governing eligibility for unemployment compensation exclude that part of an employee's compensation that she places in tax-advantaged flexible-spending arrangements. The choice to avoid income tax liability means that those dollars are also not counted towards the minimum earnings necessary for an applicant to be considered for unemployment compensation (there are other qualifications as well). The statute is straightforward and no interpretation—including the agency-deference or liberal-construction canons—is needed.

The Court of Appeals, though it reached the right result, also made this case harder than it is. Ohio Revised Code 4141.01(H)(1)(a) unambiguously excludes compensation placed in tax-advantaged flexible-spending arrangements. There is thus no need to "defer" to the

administrative interpretation of ODJFS. App. Op. ¶ 1. And there is certainly no occasion—as the dissent would have held—to resort to the liberal-construction canon in R.C. 4141.46. The statute is plain; the only task for this Court (like the courts and administrative bodies below) is to apply the plain text. That text compels affirming the Second District.

A. Compensation excluded from income tax in a flexible-spending arrangement is not "remuneration" for purposes of unemployment-compensation benefits.

Although the conclusion is plain that money placed in tax-advantaged flexible-spending arrangements is not counted when calculating unemployment-compensation benefits, reaching that conclusion requires a few steps.

1. Under R.C. 4141.01(R)(1), an employee is eligible for unemployment compensation in Ohio only if she "is unemployed," had been employed at least 20 weeks in the relevant timeframe, and had "been paid remuneration at an average weekly wage" 27.5% or more of the statewide average weekly wage. The only element relevant here is whether Bernard's "remuneration" in 2009 met the 27.5% threshold. That threshold for 2009 was $213. *See* App. Op. at ¶ 3. Bernard made $333 per week if her deposits to the tax-advantaged health spending arrangement are included in her "remuneration" and $125 per week if they are not.

2. Under R.C. 4141.01(H)(1)(a), remuneration excludes "payments" listed in Internal Revenue Code Section 3306(b), a portion of the Federal Unemployment Tax Act.

3. Section 3306(b) of the Internal Revenue Code excludes from wages payments to an employee "under a cafeteria plan." 26 U.S.C. 3306(b)(5)(G). A cafeteria plan is a fringe benefit that lets an employee choose between cash (or equivalents) and "qualified" benefits. *See, e.g.*, 2010-20 Internal Revenue Bulletin at 683 (Notice 2010-38) (May 17, 2010) (Appx. D). A qualified benefit is one otherwise excludable from taxation under another portion of the Internal Revenue Code, and includes "health plans" and "health flexible spending arrangements (health

FSAs)." *Id*; *see also* FAQs for government entities regarding Cafeteria Plans http://www.irs.gov/Government-Entities/Federal,-State-&-Local-Governments/FAQs-for-government-entities-regarding-Cafeteria-Plans ("Generally, qualified benefits under a cafeteria plan are not subject to FICA, FUTA, Medicare tax, or income tax withholding.") (last visited Nov. 15, 2012) (Appx. E); IRS Chief Counsel Advice 200117038 at 5 (Jan. 16, 2001) (same) (Appx. F).

Thus a payment "under a cafeteria plan" is not automatically excludable or includable merely because it is in a cafeteria plan. The code section defining cafeteria plans is designed to prevent tax consequences that would otherwise follow from selecting a tax-favored benefit instead of cash because—without the provisions of Section 125—that choice alone would make the benefit taxable under the doctrine of constructive receipt (the idea that the *option* to receive cash makes an otherwise tax-free benefit taxable).

4. A payment "under a cafeteria plan" is tax exempt if it "is not includible in the gross income of the employee by reason of an express provision" of the Internal Revenue Code. 26 U.S.C. 125(f). To determine whether a payment "under a cafeteria plan" is tax exempt under federal law, and therefore excludable from remuneration under Ohio unemployment compensation law, we need to look to other parts of the Internal Revenue Code. The relevant provision is 26 U.S.C. 105(b), which excludes from income amounts "paid, directly or indirectly, to the taxpayer to reimburse [her] for expenses incurred . . . [for] medical care."

5. A flexible-spending arrangement to reimburse out-of-pocket medical expenses is tax exempt under 26 U.S.C. 105(b), and there is abundant authority so holding. *See, e.g.*, Proposed Treas. Reg. 1.125-1(a)(3)(B), 72 FR 43938, 43946 (qualified benefits include "self-insured medical reimbursement plans (such as health FSAs") (Appx. G); 72 FR 43938, 43940

(Aug. 6, 2007) ("Examples of [tax-exempt] qualified benefits include . . . health flexible spending arrangements") (Appx. G); IRS Bulletin 2007-39 (Sept. 24, 2007) (same); IRS Pub. 969 (2011) (Appx. H) ("You do not pay federal income tax . . . on the salary you contribute . . . to the FSA."); 2010-20 Internal Revenue Bulletin 682 (April 27, 2010) ("reimbursements under an employer-provided accident and health plan for employees . . . are excluded from wages") (Appx. D).

A salary-reduction plan like the one Wakeman set up for Bernard is tax exempt, and there is no serious dispute on that point. Bernard thus owed no federal income tax on the money she set aside to reimburse her for out-of-pocket medical expenses.

Reversing the statutory chain we just traveled in steps 1-5 shows again that Bernard's flexible-spending-account payments are not part of her remuneration for purposes of unemployment-compensation eligibility.

5. Health flexible-spending account payments are exempt from federal income taxation. 26 U.S.C. 105(b).

4. This income-tax exemption means that medical flexible-spending accounts are "qualified" (tax exempt) for purposes of the cafeteria-plan statute. 26 U.S.C. 125(f).

3. Qualified benefits paid under a cafeteria plan are exempt from federal unemployment taxes. 26 U.S.C. 3306(b)(5)(G).

2. Payments exempt from federal unemployment taxes are not "remuneration" under Ohio unemployment law. R.C. 4141.01(H)(1)(a).

1. Bernard's $10,800 in available flexible-spending reimbursements for medical expenses is not remuneration for benefits purposes.

The question presented by this appeal is also answered more directly by authorities addressing whether health flexible-spending arrangements are exempt from federal unemployment taxes. For years, the IRS has issued private letter rulings addressing the precise question of whether payments from health flexible-spending arrangements are taxed under the Federal Unemployment Tax Act (FUTA). They are not. "No portion of any of the amounts available under the . . . medical expense reimbursement program will be includable in 'wages' for purposes of . . . FUTA [Federal Unemployment Tax Act] taxes, except to the extent that the amounts are received by the employee in cash or to the extent that the benefit is includable in the gross income of the employee." Private Letter Ruling 9034078 (May 31, 1990) (Appx. I); *see also* Private Letter Ruling 9034025 (May 24, 1990) (same) (Appx. J); Private Letter Ruling 8917081 (Feb. 2, 1989) ("amounts paid to, or on behalf of, a participant or the participant's dependents or beneficiaries under the Plan are not 'wages'" for the purposes of federal employment taxes) (describing flexible-spending arrangement) (Appx. K); Joint Committee on Taxation, *Description of the Taxpayer Assistance and Simplification Act of 2008* (JCX 26-08) at 17-18 (April 8, 2008) ("Health FSAs typically are funded on a salary reduction basis, meaning that employees are given the option to reduce current compensation and instead have the compensation used to reimburse the employee for medical expenses. . . . [T]he compensation that is forgone is not includible in gross income or wages for employment tax purposes and reimbursements for medical care from the health FSA are excludable from gross income and wages.") (Appx. L).

Although the private letter rulings are not binding authority, they are part of the consistent treatment by the Internal Revenue Service of the exact arrangement Bernard requested from Wakeman. These authorities confirm what the statutes say—payments from health

flexible-spending arrangements are not wages. That resolves this case and means affirming the Second District.

The result compelled by the plain text of state and federal statutes makes equitable sense as well. Bernard chose to shield more than half of her income from federal income taxation (and federal FICA taxes). Bernard reaped substantial tax savings from that decision. But now she wants to *include* the same money she sheltered from federal taxes as part of her salary so that she might qualify for unemployment payments. The problem with this reasoning—as an Oregon court pointed out—is that, "by virtue of [her] election of benefits and salary reduction agreement . . . [her] pretax contribution to the cafeteria plan was withheld from [her] salary with [her] permission." *Lee v. Employment Dep't*, 190 P.3d 453, 455 (Or. Ct. App. 2008), *rev. denied*, 200 P.3d 146 (Or.). Or, as the trial court chided, Bernard "wish[es] to have [her] cake and eat it too." Appx. B at 4 n.6.

All of this shows that it is no answer—as Bernard suggests—to say that the payments from her flexible-spending arrangement "would be treated as wages, but for the [cafeteria] plan." App. Br. at 12. A health flexible-spending arrangement is a type of insurance plan excluded from gross income under 26 U.S.C. 105(b) without regard to a cafeteria plan. *See, e.g.*, 2004-33 Internal Revenue Bulletin at 205 (Notice 2004-50) (Aug. 16, 2004) (FSA regulations "are generally imposed so that health FSAs operate in a manner similar to 'insurance-type' accident or health plans under section 105 [of the Internal Revenue Code]) (Appx. M); Adam Chodorow, *Charitable FSAs: A Proposal to Combine Healthcare and Charitable Giving Tax Provisions*, 2011 B.Y.U.L. Rev. 1041, 1050 (2011) ("to the IRS, FSAs are a form of employer-provided health insurance").

"But for" the cafeteria plan, the flexible-spending arrangement would still enjoy this tax exemption because the arrangement is a type of medical insurance that is—like most medical insurance plans—tax exempt under the Internal Revenue Code. 26 U.S.C. 105(b). The language Bernard cites here and labels the "but for" clause is nothing more than a reminder that cafeteria plans do not change the tax status of employee fringe benefits. When a cafeteria plan offers a choice between cash or other non-qualified benefits (taxable) and a medical-insurance plan or other qualified benefits (non-taxable), the plan itself does not alter the tax status of those benefits.

The language in 26 U.S.C. 3306(b)(5)(G) that payments "under a cafeteria plan" are not wages if the payment would not be treated as wages "without regard" to the plan simply reiterates that a cafeteria plan does not change the taxable status of a benefit merely because it is within that plan. The "without regard" clause does not ask, "What would be the tax status of the cash if the employee did not select a qualified benefit?" Instead it asks, "Would this benefit be taxable if not part of a cafeteria plan?" *See, e.g.*, 49 FR 19321 (May 7, 1984) ("if a benefit that is taxable. . . when offered separately is offered under a cafeteria plan, the benefit will continue to be a taxable [one], . . . [S]uch [benefits] must be included in the participant's gross income for income and employment tax purposes *without regard* to whether the plan satisfies section 125") (emphasis added) (Appx. N). For health flexible-spending arrangements, the benefit is not taxable, whether in a cafeteria plan or not. Bernard offers no authorities supporting—or even suggesting—her "but for" reading of the statute.

Bernard structured her compensation to treat most of her salary as tax-free, non-wage compensation. That choice shielded the money from federal taxes, but also excluded it from counting as wages for calculating unemployment payments.

B. Because employers pay no unemployment tax on health flexible-spending contributions, those contributions are not wages for calculating unemployment benefits.

Excluding wages from the eligibility side of the ledger mirrors the way Ohio law treats employer contributions on the other side. R.C. 4141.01(G) defines "wages" for purposes of employer contributions into the unemployment compensation accounts that in turn fund payments to former employees. Wages are defined as remuneration, R.C. 4141.01(G)(1), which in turn is defined to exclude payments exempted from federal unemployment taxation. R.C. 4141.01(H)(1)(a). Thus, flexible-spending payments like Bernard's are not "subject to contribution" by the employer. R.C. 4141.01(G)(1); *see also* O.A.C. 4141-9-02 (employer contributions "shall be paid on the wages defined in division (G) of section 4141.01"). Guided by the statute and the Internal Revenue Service, ODJFS (and its predecessor) have treated as non-taxable all benefits under cafeteria plans (other than cash). *See* Tax Policy Memo. 95-07 (June 27, 1995) (Appx. O).

Employers do not contribute to the unemployment-compensation fund from money sheltered in health flexible-spending arrangements; employees therefore cannot count that money as part of their remuneration for benefits purposes. The federal tax treatment of amounts placed in health flexible-spending arrangements "virtually compels the conclusion that it be treated similarly for unemployment compensation purposes." *Shepherd v. Wearever-Proctor Silex, Inc.*, 75 Ohio App. 3d 414, 418 (4th Dist. 1991) (internal quotation marks and citation omitted). "Fundamentally, amounts that are withheld from wages under a cafeteria plan are not amounts on which employers pay . . . unemployment taxes. To be consistent with that principle, the amounts that are withheld from wages under a cafeteria plan also should not be included in the calculation of wages for payment of unemployment benefits." *Lee*, 190 P.3d at 455 n.1; *see also American Family Mut. Ins. Co. v. U. S.*, 815 F. Supp. 1206, 1210 (D. Wis. 1992) ("What these

provisions mean is that . . . [the] obligation to pay employment taxes on benefits paid to employees is determined by whether its employees can exclude such payments as benefits paid pursuant to a qualified medical reimbursement plan under § 105") (referring to FICA tax exemption). Bernard made the initial choice to seek tax-favored treatment of $10,800 of her compensation. That choice triggered several tax and benefit consequences. Bernard paid no federal income taxes on that money. She paid no Social Security or Medicare taxes. Her employer paid no unemployment taxes. And—consistent with those tax exemptions—the money is not part of Bernard's wages for purposes of unemployment-compensation benefits.

Ohio is hardly alone in consistently treating the tax and benefits sides of the ledger. In addition to Oregon (as shown by the *Lee* decision), several other states also exclude cafeteria-plan benefits when calculating unemployment-compensation benefits. *See, e.g.*, Cal. Unemployment Insurance Code § 938(d); Mississippi Department of Employment Security, Employer FAQs (http://www.mdes.ms.gov/Home/FAQ/employerServices.html#4_1) (Nov. 15, 2012); Alaska Dept. of Labor and Workforce Development, Alaska Unemployment Tax Handbook, at 20 (http://www.labor.state.ak.us/estax/taxbook.pdf) (Nov. 15, 2012); Florida Dept. of Revenue, Employer Guide to Unemployment Tax, at 11 (available at http://dor.myflorida.com/dor/forms/2012/uct800002.pdf) (Nov. 15, 2012).

Ohio—by pointing to federal tax law—has opted for consistency in the tax and compensation treatment of health flexible-spending arrangements. That consistent treatment means affirming the Second District's decision.

C. The text dictates the result here, but any interpretative deference would favor ODJFS, not Bernard.

Because R.C. 4141.01(H)(1)(a) "is unambiguous," the task is not to interpret the statute, but to apply it. *Estate of Heintzelman v. Air Experts, Inc.*, 126 Ohio St. 3d 138, 2010-Ohio-3264 ¶ 17. No interpretive canon is necessary to illuminate the statute or to resolve this case. Bernard is thus wrong to insist that "courts must interpret statutes . . . with deference to the affected party and against the state agency" that administers the statute. App. Br. at 9. Instead, if any canon is appropriate here, the courts must "give due deference" to ODJFS's "administrative interpretation." *State ex rel. McLean v. Indus. Comm'n*, 25 Ohio St. 3d 90, 92 (1986).

Ignoring administrative deference, Bernard views R.C. 4141.46 as a trump. *See* App. Br. at 10. But this Court does not treat 4141.46 (or any other liberal-construction canon) that way. After all, liberal construction does not mean an automatic win for the party opposing the agency. The rule has limits. Liberal construction plays no role when interpreting an unambiguous provision. *See Lake Hosp. Sys. v. Ohio Ins. Guar. Assn.*, 69 Ohio St. 3d 521, 525 (1994). Nor does liberal construction allow a court or agency to read into a statute a meaning that "cannot reasonably be implied" by the language. *See Johnson v. Bur. of Emp. Services*, 48 Ohio St. 3d 67, 70 (1990).

Judge Fain's dissent does not engage this analysis and—like Bernard—treats 4141.46 as the beginning and end of the inquiry. He starts with the mistaken premise that R.C. 4141.01(H)(1)(a) is "anything but clear and unambiguous." App. Op. at ¶ 15. That alone undermines his conclusion in favor of Bernard because the language of the statutes is straightforward. But the dissent makes other missteps as well.

The dissent veers off course when it addresses a purported "conflict" between the canons of administrative deference and liberal construction. *Id.* at ¶ 18. If those canons conflict, and if

that conflict must always tip in favor of 4141.46, no deference to ODJFS or the Bureau of Workers' Compensation (its statute contains a similar liberal-construction directive) would be possible. But that is not the law. *See, e.g.*, *Swallow v. Indus. Comm'n*, 36 Ohio St. 3d 55, 55 (1988) (per curiam) (deferring to Bureau); *State ex rel. McLean*, 25 Ohio St. 3d 90 (same). Nor do administrative deference and liberal construction necessarily conflict. If a statute's implementation is not delegated to an agency, if no agency has relevant expertise, or if the agency has not interpreted the statute, then liberal construction may fill the gap. Otherwise, administrative deference controls. *See Swallow*, 36 Ohio St. 3d 55.

The dissent also loses its way because, even assuming it rightly relied on the liberal-construction canon, it cites no text for the idea that the income at issue here is "remuneration" for unemployment-compensation purposes. That is, the dissent offers no text that it *interpreted* with the aid of R.C. 4141.46 to conclude that Bernard should be eligible for unemployment compensation benefits.

The dissent and Bernard are wrong because, if any interpretive canon applies, deference to administrative interpretation is the appropriate guide to resolving any ambiguity in the statutes. When interpreting statutes, courts "must give due deference to an administrative interpretation formulated by an agency which has accumulated substantial expertise, and to which the legislature has delegated the responsibility of implementing the legislative command." *McLean*, 25 Ohio St. 3d 90, 92; *see also Nw. Ohio Bldg. & Constr. Trades Council v. Conrad*, 92 Ohio St. 3d 282, 287-88 (2001); *Swallow*, 36 Ohio St. 3d at 57 (per curiam); *Jones Metal Prods. Co. v. Walker*, 29 Ohio St. 2d 173, 181 (1972). These two elements—administrative expertise and legislative delegation—trigger a court's duty to defer. Because both delegation

and expertise are present here—if any interpretive canon is appropriate—this Court should defer to ODJFS's reasonable interpretation of R.C. 4141.01(H)(1)(a).

Legislative delegation to ODJFS and the agency's expertise over unemployment calculations are evident throughout the statutes. The Director of ODJFS is empowered to "adopt rules with respect to the collection . . . of the unemployment . . . fund," R.C. 4141.13(C), and to "determine the contribution rate upon employers." R.C. 4141.13(I). The Director is also entrusted to "determine" if the unemployment compensation fund is "below the minimum safe level." R.C. 4141.01(G)(2). All of these duties speak to the Director's delegated responsibilities and expertise, and show why the Director's interpretation of R.C. 4141.01(H)(1)(a) is entitled to deference—if any deference is needed.

The directive in R.C. 4141.46 to construe chapter 4141 "liberally" does not undermine this administrative deference. The uniform tax treatment of medical flexible-spending arrangements and the corresponding match between inflow and outflow in the unemployment accounts is a matter committed to the expertise of the ODJFS Director. Because the meaning of "wages" is part of the Director's core expertise and a key task the General Assembly delegated to the Director, deference to the Director's interpretation is warranted. The liberal construction directive in 4141.46 does not undercut that conclusion because it "does not necessarily equate with giving an individual claimant what he thinks is best in his particular situation." *Swallow* 36 Ohio St. 3d at 57. And any "tension" between 4141.46 and deference to ODJFS should be resolved in favor of the deference owed ODJFS. *See id.*

In contrast, liberal construction may play a role when addressing undefined terms in Chapter 4141 that are outside the Director's delegated powers and outside his expertise. *See, e.g.*, *Bowman v. Administrator, Ohio Bureau of Employment Services*, 30 Ohio St. 3d 87, 90

(1987) (applying R.C. 4141.46 to liberally interpret "postmark," a term not "defined in any relevant statute or rule"). Unlike the meaning of "postmark," the meaning of "wages" is core to both the legislative delegation to ODJFS and ODJFS's expertise regarding unemployment compensation. The liberal-construction directive is not needed.

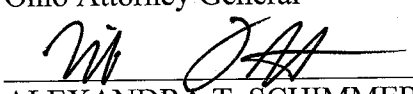
ODJFS has consistently applied R.C. 4141.01(H)(1)(a) to exclude qualified cafeteria plan benefits from state unemployment-compensation taxes. *See* Tax Policy Memo. 95-07 (June 27, 1995). That is a straightforward application of the language that unemployment "wages" exclude payments "under" a cafeteria plan. But if any interpretation is needed, the Court should defer to ODJFS (not Bernard), read the statute to exclude the flexible-spending amounts, and affirm the Second District.

CONCLUSION

The Court should affirm the Second District's judgment.

Respectfully submitted,

MICHAEL DEWINE (0009181)
Ohio Attorney General



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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing Brief of Appellee Ohio Department of Job and Family Services was served by U.S. mail this 19th day of November 2012 upon the following counsel:

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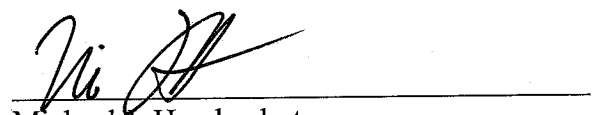

Michael J. Hendershot

APPENDIX A

[Cite as *Bernard v. Unemp. Comp. Rev. Comm.*, 2012-Ohio-958.]

IN THE COURT OF APPEALS OF OHIO
SECOND APPELLATE DISTRICT
MIAMI COUNTY

CLAUDIA BERNARD	:	Appellate Case No. 2011-CA-16
Plaintiff-Appellant	:	Trial Court Case No. 11-72
v.	:	
UNEMPLOYMENT COMPENSATION REVIEW COMMISSION, et al.	:	(Civil Appeal from Common Pleas Court)
Defendant-Appellants	:	

. . . . . .

OPINION

Rendered on the 9th day of March, 2011.

. . . . . .

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W. ROGER FRY, Atty. Reg. #0009819, and WILLIAM H. FRY, Atty. Reg. #0079108, Rendigs, Fry, Kiely & Dennis, LLP, One West Fourth Street, Suite 900, Cincinnati, Ohio 45202-3688
Attorneys for Defendant-Appellee, Wakeman Educational Foundation

. . . . . .

HALL, J.

{¶ 1} The issue presented here is whether the amount of pretax pay that an employee elects to place in a flexible spending account (FSA) for qualifying medical expenses constitutes "remuneration" under Ohio's unemployment compensation law. It is the Ohio Department of Job and Family Services's (ODJFS) position that it does not. Because the ODJFS is the agency charged with implementing and administering this law and because its interpretation is reasonable, we defer to it and affirm.

I.

{¶ 2} Appellant Claudia Bernard worked as a caretaker for The Barry and Patricia Wakeman Educational Foundation until she was discharged in late 2009. In January 2010, Bernard applied to the ODJFS for unemployment benefits based on her employment with the Foundation during 2009. The ODJFS denied Bernard's application on the basis she was not eligible. Bernard appealed, and the ODJFS affirmed its decision.

{¶ 3} Bernard then appealed the ODJFS's decision to the Unemployment Compensation Review Commission (UCRC), which is independent of the ODJFS and reviews its unemployment compensation decisions. After a hearing, a UCRC hearing officer affirmed the ODJFS's decision. For a benefits application to be valid, Ohio's unemployment compensation law requires that the applicant be currently unemployed, that the applicant was employed during at least 20 weeks within the applicant's base period, and that the applicant's average weekly wage during those weeks was at least 27.5% of the statewide average weekly wage during the same period. *See* R.C. 4141.01(R)(1). The hearing officer determined that

Bernard's average weekly wage during her base period (January 1, 2009 to December 31, 2009) did not meet the statutorily required minimum. Bernard's average weekly wage needed to be at least $213, but the officer determined that it was only $125. "Average weekly wage" is defined by the unemployment compensation law as "the amount obtained by dividing an individual's total remuneration for all qualifying weeks during the base period by the number of such qualifying weeks." R.C. 4141.01(O)(2). The law's definition of "remuneration" is "all compensation for personal services, including commissions and bonuses and the cash value of all compensation in any medium other than cash." R.C. 4141.01(H)(1). The hearing officer found that, in 2009, Bernard received $17,320 in compensation. Of that amount, she received $6,520 in cash, and she elected to place $900 each month ($10,800 total) in a flexible spending account for medical expenses, under a cafeteria plan set up for her by the Foundation.

{¶ 4} Cafeteria plans "are benefit plans under which all participants are employees who can choose from among cash and certain qualified benefits." Pub. 15-A, Employer's Supplemental Tax Guide (Revised January 2001). Such plans are governed by section 125 of the Internal Revenue Code. "Flexible spending accounts (FSAs) are employer-established benefit plans that reimburse employees for specified expenses as they are incurred. * * * FSAs and cafeteria plans are closely related, but not all cafeteria plans have FSAs and not all FSAs are part of cafeteria plans. FSA reimbursements funded through salary reduction agreements (the most common arrangement) are exempt from income and employment taxes under cafeteria plan provisions because employees have a choice between cash (their regular salary) and a nontaxable benefit." Report for Congress by the Congressional Review Service, Tax

Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation, at 6 (Feb. 3, 2010). The plan set up for Bernard by the Foundation was intended to qualify as a section 125 cafeteria plan. Bernard paid for this benefit with pretax pay–the Foundation contributed nothing. So instead of receiving $900 each month in cash, this amount was put into the FSA. The benefit to Bernard of this arrangement was that she did not need to pay federal income or employment taxes on FSA amounts, nor did she pay taxes on the payments that she received from the FSA as reimbursements for qualified medical expenses.

{¶ 5} The hearing officer determined that Bernard's total remuneration in 2009 was the $6,520 in cash compensation. The officer determined that the amount that went into the FSA was not "remuneration." The Ohio unemployment compensation law expressly excludes from the definition of remuneration "payments as provided in divisions (b)(2) to (b)(16) of section 3306 of the 'Federal Unemployment Tax Act,' 84 Stat. 713, 26 U.S.C.A. 3301 to 3311, as amended.'" R.C. 4141.01(H)(1)(a). Division (b) of section 3306 defines "wages" as "all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash." But, certain remuneration is expressly excluded from the definition. It is some of these (those in (b)(2) to (b)(16)) to which the Ohio law is referring. Pertinent among them is the one described in division (b)(5)(G), which excludes "any payment made to, or on behalf of, an employee or his beneficiary * * * under a cafeteria plan (within the meaning of section 125) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received."

{¶ 6} With the amount that went into Bernard's FSA, her average weekly wage in 2009 was roughly $333, well over the required statutory minimum of $213. But without that amount, the average drops to $125, rendering her application invalid. So Bernard asked for review of her application by the full UCRC, but the UCRC declined to do so. Having exhausted her administrative remedies, Bernard appealed the hearing officer's decision to the Miami County Court of Common Pleas, arguing that the FSA amounts are "remuneration" under Ohio's unemployment compensation law. In July 2011, after a hearing, the trial court affirmed the hearing officer's decision.

{¶ 7} Bernard's appeal of the decision is now before this Court. The primary issue raised in the sole assignment of error is one of statutory construction: whether the amount that went into her FSA is "remuneration." We review not the trial court's decision but the UCRC's. *See Tzangeos, Plakas, & Mannos v. Ohio Bur. of Emp. Serv.*, 73 Ohio St.3d 694, 697, 1995-Ohio-206, citing R.C. 4141.282(H). We may reverse its decision "only if it is unlawful, unreasonable, or against the manifest weight of the evidence." *Id.* Here, though, because no material facts are disputed by the parties and the issue presented is a question of law, our review focuses on the lawfulness of the UCRC's interpretation of the Ohio unemployment compensation law. *See Fegatelli v. Ohio Bur. of Emp. Serv.*, 146 Ohio App.3d 275, 277 (2001).

II.

{¶ 8} Appellant's argument concerns section 3306(b)(5)(G) of the Federal Unemployment Tax Act (FUTA). Specifically, the argument centers on the first qualification

to payments made under a cafeteria plan–"if such payment would not be treated as wages without regard to such plan." Appellant asserts that if the $900 had not gone into the FSA each month, it would have gone into her pocket as "wages," that is, "remuneration for employment," 26 U.S.C. 3306(b). This is not necessarily true. Division (b)(5)(G) describes payments "made to, or on behalf of, an employee or his beneficiary," section (b)(5), "*under* a cafeteria plan," (emphasis added) section (b)(5)(G). In other words, these are payments made *from* a cafeteria plan to an employee (or on behalf of the employee to his beneficiary) not payments *to* a cafeteria plan. This becomes clear when other subdivisions under division (b)(5) are considered that describe payments made not only "under" but "under or to." *See, e.g.*, Section 3306(b)(5)(B); 3306(b)(5)(D) ("under or to an annuity contract"); *see*, also, Section 3306(b)(5)(C) (describing payments, similar to division (b)(5)(G), "under a simplified employee pension"). While it is true that if Bernard had not elected to put $900 each month into the FSA, she would have received it as cash compensation, it is not technically correct to say that the payments Bernard received from the FSA were compensation. The payments that Bernard received from the FSA were to reimburse her for medical expenses.

{¶ 9} Still, it may reasonably be argued that reimbursements were, in essence, compensation–after all, it was Bernard's pay that went into the FSA each month. The question, then, is whether the exclusion of such amounts from the definition of "remuneration" was what the legislature intended. *See Proctor v. Kardassilaris*, 115 Ohio St.3d 71, 2007-Ohio-4838, at ¶12 ("When analyzing a statute, our primary goal is to apply the legislative intent manifested in the words of the statute."). When discerning the legislative intent of a law found within a legislative scheme, a court may rely on the expertise of the state

agency to which the legislature has delegated the scheme's enforcement. *Elyria Foundry Co. v. Pub. Util. Comm.*, 118 Ohio St.3d 269, 2008-Ohio-2230, at ¶13. Furthermore, a reviewing court should "give due deference to the director's 'reasonable interpretation of the legislative scheme' governing his agency." *Sandusky Dock Corp. v. Jones*, 106 Ohio St.3d 274, 2005-Ohio-4982, at ¶8, quoting *Northwestern Ohio Bldg. & Constr. Trades Council v. Conrad*, 92 Ohio St.3d 282, 287 (2001); *McLean*, at 92 ("It is well-settled that courts, when interpreting statutes, must give due deference to an administrative interpretation formulated by an agency."), quoted in *Maitland v. Ford Motor Co.*, 103 Ohio St.3d 463, 2004-Ohio-5717, at ¶26. The legislature has placed the responsibility to oversee and administer Ohio's unemployment compensation system with the ODJFS. *See* 2010 Ohio Atty.Gen.Ops. No. 2010-029. And its interpretation of "remuneration" under this legislative scheme is reasonable.

{¶ 10} The Internal Revenue Service (IRS) interprets section 3306(b)(5)(G) as excluding the amounts that an employee elects to place in an FSA for medical expenses under an employer's section 125 cafeteria plan. Neither the employer nor the employee pays FUTA taxes on such amounts–in fact, these amounts are subject to no employment taxes or income taxes. In Private Letter Rulings, the IRS has analyzed the federal tax consequences of an employer's providing a medical reimbursement benefit to employees through a section 125 cafeteria plan under which each employee would elect to reduce her salary to pay for the benefit. The IRS has concluded that generally, in addition to not being subject to federal income tax, none of the amounts by which an employee elects to reduce her compensation to pay for the medical expense reimbursement benefit, or the amounts available under the plan,

are "wages" for purposes of FUTA taxes. PLR 90-34-078 (Aug. 24, 1990); PLR 89-17-081 (April 28, 1989) (concluding that, "with respect to the federal employment taxes, provided the benefits under the Plan meet the requirements of [certain] sections * * * of the Code, amounts paid to, or on behalf of, a participant or the participant's dependents or beneficiaries under the Plan are not 'wages' for purposes of either section 3121 [the Federal Insurance Contribution Act (FICA)] or section 3306 of the Code." The IRS has expressed the same view in a Chief Counsel Advice memorandum: "Generally, qualified benefits under a cafeteria plan are not subject to FICA, FUTA, Medicare tax, or income tax withholding." C.C.A. 2001-17-038 (April 27, 2001). "Employers may also offer flexible spending accounts to employees under a cafeteria plan that provides coverage under which specified, incurred expenses may be reimbursed. These include health flexible spending accounts for expenses not reimbursed under any other health plan." *Id.* The memo explains that "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." *Id.* Citing section 3121(a)(5)(G) and 3306(b)(5)(G), the memo also says that "those sums generally are not subject to FICA and FUTA." *Id.* Finally, two IRS tax guides say the same. *See* Pub. 15-A, Employer's Supplemental Tax Guide (Revised January 2001) ("Generally, qualified benefits under a cafeteria plan are not subject to social security, Medicare, and FUTA taxes, or income tax withholding."); IRS Pub. 969 (January 14, 2011) ("You contribute to your FSA by electing an amount to be voluntarily

withheld from your pay by your employer. This is sometimes called a salary reduction agreement. * * * You do not pay federal income tax or employment taxes on the salary you contribute * * * to the FSA.").

{¶ 11} According to the IRS, then, an employee's contributions to an FSA are not subject to federal unemployment compensation taxes. Nor are they subject to Ohio unemployment compensation taxes. Under the Ohio unemployment compensation law, an employer's tax liability is based on its average annual payroll. *See* R.C. 4141.25. The law defines "annual payroll," in part, as "the total amount of wages subject to contributions." R.C. 4141.01(J). And it defines "wages," in part, as "remuneration paid to an employee * * * with respect to employment." R.C. 4141.01(G)(1). As discussed above, Ohio excludes from the definition of "remuneration" payments under section 3306(b)(2)-(16). *See* R.C. 4141.01(H)(1)(a). Therefore, since section 3306(b)(5)(G) excludes an employee's FSA contributions from unemployment compensation taxes, they are also excluded from Ohio unemployment compensation taxes. This means that neither the federal or the state unemployment compensation system sets aside money to compensate unemployed individuals for their FSA contributions. It makes logical sense that if money placed in the cafeteria plan is not subject to unemployment tax, then that amount should not be considered for calculating whether the employee is eligible for unemployment benefits.

{¶ 12} Because the ODJFS's interpretation of Ohio's unemployment compensation law is reasonable, we defer to it. We hold that the UCRC's decision, and the decision of the trial court which is based on the same interpretation, is not unlawful or unreasonable.

{¶ 13} The sole assignment of error is overruled.

{¶ 14} The UCRC's decision is affirmed.

. . . . . .

GRADY, P.J., concurs.

FAIN, J., dissenting:

{¶ 15} Judge Hall's opinion for the court lays out the intricacies of the interpretation of the statute with reference to the circumstances of this case with admirable skill, and I cannot usefully add to that exposition. It is apparent, though, that the proper interpretation of the statutory definition of remuneration as it applies to the flexible spending account in this case is anything but clear and unambiguous.

{¶ 16} The principle that a court should give deference to an administrative agency's interpretation of the legislative enactment that it is charged to administer is a general principle of statutory interpretation employed by courts. *Northwestern Ohio Bldg. & Constr. Trades Council v. Conrad*, 92 Ohio St.3d 282, 287, 2001-Ohio-190, 750 N.E.2d 130. This principle finds statutory support in R.C. 1.49(F).

{¶ 17} The principle that Ohio's Unemployment Compensation Law shall be construed liberally in favor of the applicant is a specific rule of construction set forth in the Unemployment Compensation Law, itself, at R.C. 4141.46. *Vespremi v. Giles*, 68 Ohio App.2d 91, 93, 427 N.E.2d 30 (1st Dist. 1980).

{¶ 18} It is another principle of statutory construction that a special or local provision shall prevail as an exception to a general provision, where the two provisions are in conflict. This principle is codified at R.C. 1.51.

{¶ 19} Given the specific legislative commandment, in R.C. 4141.46, that the Ohio Unemployment Compensation Law should be liberally construed in favor of applicants for compensation, I would construe the statute in Bernard's favor and find her eligible to receive benefits. She earned the moneys that were paid into a flexible spending account for her benefit, through her labor in her employer's behalf. To me, interpreting those moneys as remuneration for purposes of determining her eligibility does not unduly stretch the bounds of the requisite liberal construction of the statute; in my view, that interpretation lies within a reasonable, liberal construction of the statute in her favor.

{¶ 20} I would reverse the judgment of the trial court and remand with appropriate instructions.

. . . . . .

Copies mailed to:

Robert L. Guehl
Michael DeWine
Robin A. Jarvis
W. Roger Fry
William H. Fry
Hon. Robert J. Lindeman

APPENDIX B

FILED
MIAMI COUNTY
COMMON PLEAS COURT
2011 JUL -1 A 8:52
JAN A. HOFFINGER
CLERK OF COURTS

IN THE COMMON PLEAS COURT
OF MIAMI COUNTY, OHIO
GENERAL DIVISION

CLAUDIA BERNARD	:	CASE NO. 11-72
Appellant,	:	Judge Robert J. Lindeman
VS.	:	
UNEMPLOYMENT COMPENSATION REVIEW COMMISSION, et al.	:	JUDGMENT ENTRY
Appellees.	:	

This matter comes on for consideration pursuant to Loc.R. 14, upon the appeal filed by Claudia Bernard pursuant to O.R.C. 4141.282.

The Court has considered the certified transcript of the proceedings in this case, filed by the Ohio Unemployment Compensation Review Commission, on March 10, 2011 with the Clerk of Courts.

The Court has also considered the memorandums filed by counsel.

BACKGROUND

The plaintiff-appellant filed her Notice of Administrative Appeal from the Unemployment Compensation Review Commission (UCRC) on January 27, 2011, alleging, in paragraph 7, that:

> "The decision of the hearing officer and the UCRC was unlawful, unreasonable, or against the manifest weight of the evidence, in that (the Plaintiff) earned an average weekly wage of at least $213.00 in covered employment in at least 20 qualifying weeks within the base period."

The base period in this case was January 1, 2009 to December 31, 2009. The appellant received $2,000.00 during the first four months as an independent contractor (but the

hearing officer found she was an employee); the appellant received $3,520.00 during the remaining part of the year as a W-2 employee and a $1,000.00 check in December which the officer found to be a Christmas bonus. Thus it was determined the appellant had $6,520.00 in remuneration during the base period. The parties are in agreement on this.

The appellant's employer also deposited $900.00 per month into a medical flex-spending account (FSA) during the base period, at the appellant's election. This totaled $10,800.00 for the base period.

Thus the issue in this case can be succinctly framed:

> "Are the FSA payments made during the base period considered wages for unemployment compensation benefit purposes?"

If they are, then the appellant qualifies for benefits. However, the UCRC found they do not qualify and the appellant was found ineligible for benefits.

ANALYSIS

The burden of persuasion is upon the appellant to establish she is entitled to benefits.[1]

But the issue before the Court in this case appears to be legal rather than factual. The 2009 W-2 issued to the appellant by her employer indicated total wages at $3,520.00 and (in box 14) indicated, other, $10,800.00, Health FSA 125.

Thus, the appellant elected to have $10,800.00 of her earnings transferred to a health savings account instead of receiving the $10,800.00 as income, in 2009.

Generally, courts will give due deference to administrative interpretations formulated by an agency which has accumulated substantial expertise in the subject area and to

---

[1] *Silkert v. Ohio Dept. of Jobs & Family Serv.* , 184 Ohio App.3d 78, 2009-Ohio-4399.

which the General Assembly has delegated responsibility of implementing legislative command, including the agency's interpretation of its own rules.[2]

As noted by the appellee, the entire Unemployment Compensation Act is funded by an excise tax on employers. This is based upon the gross wages paid to employees each quarter. To be a viable safety net for eligible workers, the Act needs to maintain a stream of income consistent with its obligations to pay. To that end, the legislature has defined wages to mean remuneration paid to an employee* * * .[3]

The legislature defined remuneration to mean all compensation for personal services[4] * * * provided that remuneration does not include: (a) payments as provided in divisions (b)(2) to (b)16 of Section 3306 of the Federal Unemployment Tax Act, 84 Stat. 703, 26 U.S.C.A. 3301 to 3311 as amended.[5]

Section 3306 states that wages do not include payments under a cafeteria plan if the payments are not treated as wages.

For purposes of the excise tax payable by the employer, Health FSA diversions are not considered wages.

---

[2]*State ex rel. McLean v. Ind. Comm.* (1986), 25 Ohio St.3d 90;
Swallow v. Indus. Comm. of Ohio (1988), 36 Ohio St.3d 55;
Joudah v. Ohio Dept. Of Human Serv. (1994), 94 Ohio App.3d 614;
Opus III-VII Corp. v. Ohio St. Bd. of Pharmacy (1996), 109 Ohio App.3d 102;
State ex rel. DeMuth v. St. Bd. of Education (1996), 113 Ohio App.3d 430.;
Clark v. St. Bd. of Reg. for Prof. Eng. (1997), 121 Ohio App.3d 278;
City of Warren v. Warren Mun-Civil Serv. Comm, 150 Ohio App.3d 719, 2002-Ohio-6928;
City of Salem v. Koncelik, 164 Ohio App.3d 597, 2005-Ohio-5537.

[3]O.R.C. 4141.01(G)(1).

[4]O.R.C. 4141.01(H)(1).

[5]O.R.C. 4141.01(H)(1)(a).

When one realizes the appellant wanted the money directed in this fashion, and both she and the employer benefitted from not having to report the money as a wage under box 1 of her W-2 form,[6] the appellee's interpretation of not considering the $10,800.00 as wages for unemployment purposes seems quite reasonable.

The Court finds the UCRC interpretation is reasonable and appropriate under the circumstances.

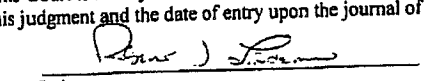
The Court finds the evidence in this case supports the conclusion the appellant did not earn an average weekly wage of at least $213.00 for the year 2009 and the decision finding her unqualified for benefits is not unreasonable, unlawful or against the manifest weight of the evidence.

The decision of the UCRC is affirmed. Costs from the deposit.

ROBERT J. LINDEMAN, JUDGE

cc: Robert L. Guehl
Robin A. Jarvis
W. Roger Fry/William H. Fry

Pursuant to Civ.R. 58(B), the Clerk of this Court is hereby directed to serve upon all parties not in default for failure to appear, notice of this judgment and the date of entry upon the journal of its filing.



Judge

[6]In addition to the employer not having to pay unemployment compensation tax on this amount, the appellant was able to use it without having to pay federal income tax on the amount. Now it appears the Appellant and her employer wish to have their cake and eat it too. (English idiomatic proverb.)

APPENDIX C

State of Ohio
Unemployment Compensation Review Commission
P.O. Box 182299
Columbus, Ohio 43218-2299

Docket No: H2010-111-0088

DECISION

In re claim of:
Claudia J. Bernard - APPELLANT

Claimant Representative:
Guehl Law Office

Employer:
The Barry and Patricia Wakeman Educational Foundation
UCO No.: 1492069002

Employer Representative:
Rendigs Fry Kiely & Dennis

CASE HISTORY

The claimant, Claudia J. Bernard, filed an Application for Determination of Benefit Rights for a benefit year beginning January 10, 2010.

On April 8, 2010, the Director issued a Redetermination in which he held that the Ohio Department of Job and Family Services has DISALLOWED the claimant's application for unemployment compensation benefits dated January 12, 2010. The claimant did not have at least twenty qualifying weeks of employment that was subject to an unemployment compensation law or did not earn an average weekly wage of at least $213 before taxes during the base period January 1, 2009 to December 31, 2009, as required by Section 4141.01(R)(1) of the Ohio Revised Code.

On April 15, 2010, the claimant filed an appeal from the Redetermination.

On April 20, 2010, the Ohio Department of Job and Family Services transferred jurisdiction to the Unemployment Compensation Review Commission.

On October 25, 2010, a hearing was held before Hearing Officer Phillip Wright Jr. by telephone. The claimant appeared and testified. Robert Guehl, Esq. represented the claimant. Roger Fry, Esq. represented the employer with no witnesses.

FINDINGS OF FACT

During the base period January 1, 2009 through December 31, 2009, the claimant was employed by The Barry and Patricia Wakeman Educational Foundation. The claimant received a tax form 1099 for her compensation from the employer from January 1, 2009 through April 30, 2009. She received a form W-2 for

Appx. C

EXHIBIT App. 1

PENGAD 800-631-6989

her compensation from the employer from May 1, 2009 through December 31, 2009. The claimant was an employee for the employer at all times during the base period because the employer had the right to direct and control the claimant's activities and duties during that time. The claimant was not totally unemployed in any weeks during the base period in question. The claimant's total wages for the base period in question were $6,520.00. As a benefit of employment, the claimant received $900.00 per month, for each month during the base period in question, in a flexible spending account for medical expenses. The flexible spending account payments are not considered wages.

ISSUE

Did the claimant file a valid application on January 12, 2010?

LAW

An individual does not qualify for a valid application for determination of benefit rights if the individual did not work in 20 qualifying weeks of covered employment in the individual's base period and if the individual does not average at least $213.00 for all qualifying weeks. *4141.01 (R) O.R.C.*

REASONING

The claimant worked in at least 20 qualifying weeks of covered employment during the base period in question. However, her average weekly wage for the base period in question is $125.00. The flexible spending account payments are not considered wages. Unfortunately, the claimant did not earn an average weekly wage of at least $213.00 for the base period in question, and therefore, she did not file a valid application.

DECISION

The Director's Redetermination, issued April 8, 2010, is affirmed. The claimant did not earn an average weekly wage of at least $213.00 for the base period in question, and therefore, she did not file a valid application.

This decision rules on only those issues set forth above.

Phillip Wright Jr., Hearing Officer

PW
OJI Determination #: 219804351

APPEAL RIGHTS

This decision was mailed on December 3, 2010.

A Request for Review before the U.C. Review Commission may be filed by any interested party within twenty-one calendar days after this decision is mailed. Said twenty-one day period is calculated to end on December 27, 2010.

The Request for Review must be in writing and signed by the appealing party or an authorized representative. The request should set forth the reasons why the appellant disagrees with the Hearing Officer's decision. You may file your Request for Review by mailing it to the U.C. Review Commission, P.O. Box 182299, Columbus, Ohio 43218-2299, or by faxing it to (614) 387-3694.

This decision was sent to the following:

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APPENDIX D

Part III. Administrative, Procedural, and Miscellaneous

Tax Treatment of Health Care Benefits Provided With Respect to Children Under Age 27

Notice 2010–38

I. PURPOSE

This notice provides guidance on the tax treatment of health coverage for children up to age 27 under the Affordable Care Act. (In this notice, the "Affordable Care Act" refers to the Patient Protection and Affordable Care Act, Public Law No. 111–148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111–152 (HCERA), signed into law by the President on March 23 and 30, 2010, respectively.)

The Affordable Care Act requires group health plans and health insurance issuers that provide dependent coverage of children to continue to make such coverage available for an adult child until age 26. The Affordable Care Act also amends the Internal Revenue Code (Code) to give certain favorable tax treatment to coverage for adult children. This notice addresses a number of questions regarding the tax treatment of such coverage.

Specifically, this notice provides guidance on the Affordable Care Act's amendment of § 105(b) of the Code, effective March 30, 2010, to extend the general exclusion from gross income for reimbursements for medical care under an employer-provided accident or health plan to any employee's child who has not attained age 27 as of the end of the taxable year. (See § 1004(d) of HCERA.) The Affordable Care Act also makes parallel amendments, effective March 30, 2010, to § 401(h) for retiree health accounts in pension plans, to § 501(c)(9) for voluntary employees' beneficiary associations (VEBAs), and to § 162(l) for deductions by self-employed individuals for medical care insurance. (See § 1004(d) of HCERA.)

The Affordable Care Act amended the Public Health Service Act (PHS Act) to add § 2714, which requires group health plans and health insurance issuers that provide dependent coverage of children to continue to make such coverage available for an adult child until age 26. (See § 1001 of PPACA.) Section 2714 of the PHS Act is incorporated into § 9815 of the Code by § 1562(f) of PPACA. In certain respects, the rules of § 2714 of the PHS Act extending coverage to an adult child do not parallel the gross income exclusion rules provided by the Affordable Care Act's amendments of §§ 105(b), 401(h), 501(c)(9), and 162(l) of the Code. For example, § 2714 of the PHS Act applies to children under age 26 and is effective for the first plan year beginning on or after September 23, 2010, while, as noted above, the amendments to the Code addressed in this notice apply to children who have not attained age 27 as of the end of the taxable year and are effective March 30, 2010.

II. EXCLUSION OF EMPLOYER-PROVIDED MEDICAL CARE REIMBURSEMENTS FOR EMPLOYEE'S CHILD UNDER AGE 27

Section 105(b) generally excludes from an employee's gross income employer-provided reimbursements made directly or indirectly to the employee for the medical care of the employee, employee's spouse or employee's dependents (as defined in § 152 (determined without regard to § 152(b)(1), (b)(2) or (d)(1)(B)). As amended by the Affordable Care Act, the exclusion from gross income under § 105(b) is extended to employer-provided reimbursements for expenses incurred by the employee for the medical care of the employee's child (within the meaning of § 152(f)(1)) who has not attained age 27 as of the end of the taxable year. (The Affordable Care Act does not alter the existing definitions of spouse or dependent for purposes of § 105(b).) Under § 152(f)(1), a child is an individual who is the son, daughter, stepson, or stepdaughter of the employee, and a child includes both a legally adopted individual of the employee and an individual who is lawfully placed with the employee for legal adoption by the employee. Under § 152(f)(1), a child also includes an "eligible foster child," defined as an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

As amended by the Affordable Care Act, the exclusion from gross income under § 105(b) applies with respect to an employee's child who has not attained age 27 as of the end of the taxable year, including a child of the employee who is not the employee's dependent within the meaning of § 152(a). Thus, the age limit, residency, support, and other tests described in § 152(c) do not apply with respect to such a child for purposes of § 105(b).

The exclusion applies only for reimbursements for medical care of individuals who are not age 27 or older at any time during the taxable year. For purposes of §§ 105(b) and 106, the taxable year is the employee's taxable year; employers may assume that an employee's taxable year is the calendar year; a child attains age 27 on the 27th anniversary of the date the child was born (for example, a child born on April 10, 1983 attained age 27 on April 10, 2010); and employers may rely on the employee's representation as to the child's date of birth.

III. EXCLUSION OF EMPLOYER-PROVIDED ACCIDENT OR HEALTH COVERAGE FOR EMPLOYEE'S CHILD UNDER AGE 27

Section 106 excludes from an employee's gross income coverage under an employer-provided accident or health plan. The regulations under § 106 provide that the exclusion applies to employer-provided coverage for an employee and the employee's spouse or dependents (as defined in § 152, determined without regard to § 152(b)(1), (b)(2) or (d)(1)(B)). See Prop. Treas. Reg. § 1.106–1. Prior to the Affordable Care Act, the exclusion for employer-provided accident or health plan coverage under § 106 paralleled the exclusion for reimbursements under § 105(b). There is no indication that Congress intended to provide a broader exclusion in § 105(b) than in § 106. Accordingly, IRS and Treasury intend to amend the regulations under § 106, retroactively to March 30, 2010, to provide that coverage for an employee's child under age 27 is excluded from gross income. Thus, on and after March 30, 2010, both coverage under an

employer-provided accident or health plan and amounts paid or reimbursed under such a plan for medical care expenses of an employee, an employee's spouse, an employee's dependents (as defined in § 152, determined without regard to § 152(b)(1), (b)(2) or (d)(1)(B)), or an employee's child (as defined in § 152(f)(1)) who has not attained age 27 as of the end of the employee's taxable year are excluded from the employee's gross income.

The following examples illustrate this rule. In these examples, any reference to a "dependent" means a dependent as defined in § 152, determined without regard to § 152(b)(1), (b)(2) or (d)(1)(B). Also, in these examples, it is assumed that none of the individuals are disabled.

Example (1). (i) Employer X provides health care coverage for its employees and their spouses and dependents and for any employee's child (as defined in § 152(f)(1)) who has not attained age 26. For the 2010 taxable year, Employer X provides coverage to Employee A and to A's son, C. C will attain age 26 on November 15, 2010. During the 2010 taxable year, C is not a full-time student. C has never worked for Employer X. C is not a dependent of A because prior to the close of the 2010 taxable year C had attained age 19 (and was also not a student who had not attained age 24).

(ii) C is a child of A within the meaning of § 152(f)(1). Accordingly, and because C will not attain age 27 during the 2010 taxable year, the health care coverage and reimbursements provided to him under the terms of Employer X's plan are excludible from A's gross income under §§ 106 and 105(b) for the period on and after March 30, 2010 through November 15, 2010 (when C attains age 26 and loses coverage under the terms of the plan).

Example (2). (i) Employer Y provides health care coverage for its employees and their spouses and dependents and for any employee's child (as defined in § 152(f)(1)) who has not attained age 27 as of the end of the taxable year. For the 2010 taxable year, Employer Y provides health care coverage to Employee E and to E's son, G. G will not attain age 27 until after the end of the 2010 taxable year. During the 2010 taxable year, G earns $50,000 per year, and does not live with E. G has never worked for Employer Y. G is not eligible for health care coverage from his own employer. G is not a dependent of E because G does not live with E and E does not provide more than one half of his support.

(ii) G is a child of E within the meaning of § 152(f)(1). Accordingly, and because G will not attain age 27 during the 2010 taxable year, the health care coverage and reimbursements for G under Employer Y's plan are excludible from E's gross income under §§ 106 and 105(b) for the period on and after March 30, 2010 through the end of the 2010 taxable year.

Example (3). (i) Same facts as *Example (2)*, except that G's employer offers health care coverage, but G has decided not to participate in his employer's plan.

(ii) G is a child of E within the meaning of § 152(f)(1). Accordingly, and because G will not attain age 27 during the 2010 taxable year, the health care coverage and reimbursements for G under Employer Y's plan are excludible from E's gross income under §§ 106 and 105(b) for the period on and after March 30, 2010 through the end of the 2010 taxable year.

Example (4). (i) Same facts as *Example (3)*, except that G is married to H, and neither G nor H is a dependent of E. G and H have decided not to participate in the health care coverage offered by G's employer, and Employer Y provides health care coverage to G and H.

(ii) G is a child of E within the meaning of § 152(f)(1). Accordingly, and because G will not attain age 27 during the 2010 taxable year, the health care coverage and reimbursements for G under Employer Y's plan are excludible from E's gross income under §§ 106 and 105(b) for the period on and after March 30, 2010 through the end of the 2010 taxable year. The fair market value of the coverage for H is includible in E's gross income for the 2010 taxable year.

Example (5). (i) Employer Z provides health care coverage for its employees and their spouses and dependents. Effective May 1, 2010, Employer Z amends the health plan to provide coverage for any employee's child (as defined in § 152(f)(1)) who has not attained age 26. Employer Z provides coverage to Employee F and to F's son, K, for the 2010 taxable year. K will attain age 22 in 2010. During the 2010 taxable year, F provides more than one half of K's support. K lives with F and graduates from college on May 15, 2010 and thereafter is not a student. K has never worked for Employer Z. Prior to K's graduation from college, K is a dependent of F. Following graduation from college, K is no longer a dependent of F.

(ii) For the 2010 taxable year, the health care coverage and reimbursements provided to K under the terms of Employer Z's plan are excludible from F's gross income under §§ 106 and 105(b). For the period through May 15, 2010, the reimbursements and coverage are excludible because K was a dependent of F. For the period on and after March 30, 2010, the coverage is excludible because K is a child of F within the meaning of § 152(f)(1) and because K will not attain age 27 during the 2010 taxable year. (Thus, for the period from March 30 through May 15, 2010, there are two bases for the exclusion.)

IV. CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH REIMBURSEMENT ARRANGEMENTS

Section 125 allows employees to elect between cash and certain qualified benefits, including accident or health plans (described in § 106) and health flexible spending arrangements (health FSAs) (described in § 105(b)). Section 125(f) defines "qualified benefit" as any benefit which, with the application of § 125(a), is not includible in the gross income of the employee by reason of an express provision of chapter 1 of the Code (other than §§ 106(b) (which applies to Archer MSAs), 117, 127, or 132). Accordingly, the exclusion of coverage and reimbursements from an employee's gross income under §§ 106 and 105(b) for an employee's child who has not attained age 27 as of the end of the employee's taxable year carries forward automatically to the definition of qualified benefits for § 125 cafeteria plans, including health FSAs. Thus, a benefit will not fail to be a qualified benefit under a cafeteria plan (including a health FSA) merely because it provides coverage or reimbursements that are excludible under §§ 106 and 105(b) for a child who has not attained age 27 as of the end of the employee's taxable year.

A cafeteria plan may permit an employee to revoke an election during a period of coverage and to make a new election only in limited circumstances, such as a change in status event. See Treas. Reg. § 1.125–4(c). A change in status event includes changes in the number of an employee's dependents. The regulations under § 1.125–4(c) currently do not permit election changes for children under age 27 who are not the employee's dependents. IRS and Treasury intend to amend the regulations under § 1.125–4, effective retroactively to March 30, 2010, to include change in status events affecting nondependent children under age 27, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

In general, a health reimbursement arrangement (HRA) is an arrangement that is paid for solely by an employer (and not through a § 125 cafeteria plan) which reimburses an employee for medical care expenses up to a maximum dollar amount for a coverage period. Notice 2002–45, 2002–2 C.B. 93. The same rules that apply to an employee's child under age 27 for purposes of §§ 106 and 105(b) apply to an HRA.

V. FICA, FUTA, RRTA, AND INCOME TAX WITHHOLDING TREATMENT

Coverage and reimbursements under an employer-provided accident and health plan for employees generally and their dependents (or a class or classes

of employees and their dependents) are excluded from wages for Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA) tax purposes under §§ 3121(a)(2) and 3306(b)(2), respectively. For these purposes, a child of the employee is a dependent. Treas. Reg. §§ 31.3121(a)(2)–1(c) and 31.3306(b)(2)–1(c). No age limit, residency, support, or other test applies for these purposes. Thus, coverage and reimbursements under a plan for employees and their dependents that are provided for an employee's child under age 27 are not wages for FICA or FUTA purposes. For this purpose, child has the same meaning as in § 152(f)(1), as discussed in the first paragraph in Section II of this notice. A similar exclusion applies for Railroad Retirement Tax Act (RRTA) tax purposes under § 3231(e)(1)(i) and Treas. Reg. § 31.3231(e)–1(a)(1).

Such coverage and reimbursements are also exempt from income tax withholding. See Rev. Rul. 56–632, 1956–2 C.B. 101.

VI. VEBAS, SECTION 401(h) ACCOUNTS, AND SECTION 162(l) DEDUCTIONS

A VEBA is a tax-exempt entity described in § 501(c)(9) providing for the payment of life, sick, accident, or other benefits to members of the VEBA or their dependents or designated beneficiaries. The regulations provide that, for purposes of § 501(c)(9), "dependent" means the member's spouse; any child of the member or the member's spouse who is a minor or a student (within the meaning of § 151(e)(4) (now § 152(f)(2)); any other minor child residing with the member; and any other individual who an association, relying on information furnished to it by a member, in good faith believes is a person described in § 152(a). Treas. Reg. § 1.501(c)(9)–3. As amended by the Affordable Care Act, § 501(c)(9) provides that, for purposes of providing for the payment of sick and accident benefits to members of the VEBA and their dependents, the term dependent includes any individual who is a member's child (as defined in § 152(f)(1)) and who has not attained age 27 as of the end of the calendar year.

Section 401(h) provides that a pension or annuity plan can establish and maintain a separate account to provide for the payment of benefits for sickness, accident, hospitalization, and medical expenses of retired employees, their spouses and their dependents if certain enumerated conditions are met ("401(h) Account"). The regulations provide that, for purposes of § 401(h) and § 1.401–14, the term "dependent" shall have the same meaning as that assigned to it by § 152. Treas. Reg. § 1.401–14(b)(4)(i). As amended by the Affordable Care Act, § 401(h) provides that the term dependent includes any individual who is a retired employee's child (within the meaning of § 152(f)(1)) and who has not attained age 27 as of the end of the calendar year.

Section 162(l) generally allows a self-employed individual to deduct, in computing adjusted gross income, amounts paid during the taxable year for insurance that constitutes medical care for the taxpayer, his or her spouse, and dependents, if certain requirements are satisfied. As amended by the Affordable Care Act, § 162(l) covers medical insurance for any child (within the meaning of § 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

VII. TRANSITION RULE FOR CAFETERIA PLAN AMENDMENTS

Cafeteria plans may need to be amended to include employees' children who have not attained age 27 as of the end of the taxable year. Pursuant to § 1.125–1(c) of the proposed regulations, cafeteria plan amendments may be effective only prospectively. Notwithstanding this general rule, as of March 30, 2010, employers may permit employees to immediately make pre-tax salary reduction contributions for accident or health benefits under a cafeteria plan (including a health FSA) for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals. However, a retroactive amendment to a cafeteria plan to cover children under age 27 must be made no later than December 31, 2010, and must be effective retroactively to the first date in 2010 when employees are permitted to make pre-tax salary reduction contributions to cover children under age 27 (but in no event before March 30, 2010).

VIII. EFFECT ON OTHER DOCUMENTS

IRS and Treasury intend to amend the regulations at §§ 1.105–1, 1.105–2, 1.106–1, 1.125–1, 1.125–4, 1.125–5, and 1.401–14 to include children (as defined in § 152(f)(1)) who are under age 27. Additionally, IRS and Treasury intend to amend the regulations at § 1.501(c)(9)–3 to include children (as defined in § 152(f)(1)) who are under age 27, with respect to sick and accident benefits. Taxpayers may rely on this notice pending the issuance of the amended regulations.

IX. EFFECTIVE DATES

The changes relating to §§ 105(b), 106, 501(c)(9), 401(h) and 162(l) are effective on March 30, 2010.

DRAFTING INFORMATION

The principal author of this notice is Karen Levin of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Ms. Levin at (202) 622–6080 (not a toll-free call).

APPENDIX E

Federal, State, & Local Gov'ts Topics

- About FSLG
- FSLG Newsletter
- FSLG Customer Services
- Educational Products
- FSLG Fact Sheets
- FSLG FAQs
- FSLG Toolkit
- FSLG Work Plan
- **Federal, State, & Local Gov'ts Home**

FAQs for government entities regarding Cafeteria Plans

These frequently asked questions and answers are provided for general information only and should not be cited as any type of legal authority. They are designed to provide the user with information required to respond to general inquiries. Due to the uniqueness and complexities of Federal tax law, it is imperative to ensure a full understanding of the specific question presented, and to perform the requisite research to ensure a correct response is provided.
The freely available Adobe Acrobat Reader software is required to view, print, and search the questions and answers listed below.

Appx. E

1. What is a cafeteria plan?
2. Who may receive benefits under a cafeteria plan?
3. Is there a filing requirement for a town that maintains a cafeteria plan?
4. How does a cafeteria plan work?
5. What is a flexible spending arrangement?
6. A town has a cafeteria plan (section 125 plan), which offers dependent care assistance. The benefits received by an employee exceed $5,000. How is this benefit reported on Form W-2?
7. What remuneration under a cafeteria plan is not subject to social security, Medicare, FUTA, or income tax withholding?
8. Can a cafeteria plan make advance reimbursements for medical expenses?
9. A town has a cafeteria plan which offers health care benefits to domestic partners. Does a domestic partner and his or her child qualify to be covered under the health plan?

What is a cafeteria plan?
A cafeteria plan is a separate written plan maintained by an employer for employees that meets the specific requirements of and regulations of section 125 of the Internal Revenue Code. It provides participants an opportunity to receive certain benefits on a pretax basis. Participants in a cafeteria plan must be permitted to choose among at least one taxable benefit (such as cash) and one qualified benefit.

A qualified benefit is a benefit that does not defer compensation and is excludable from an employee's gross income under a specific provision of the Code, without being subject to the principles of constructive receipt. Qualified benefits include:

- Accident and health benefits (but not Archer medical savings accounts or long-term care insurance);
- Adoption assistance;
- Dependent care assistance;
- Group-term life insurance coverage;
- Health savings accounts, including distributions to pay long-term care services.

The written plan must specifically describe all benefits and establish rules for eligibility and elections.

A section 125 plan is the only means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice causing the benefits to become taxable. A plan offering only a choice between taxable benefits is not a section 125 plan.

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Who may receive benefits under a cafeteria plan?
The plan may make benefits available to employees, their spouses and dependents. It may also include coverage of former employees, but cannot exist primarily for them. See the questions below for treatment of benefits made available to individuals who are not spouses or dependents of the employee.

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Is there a filing requirement for a cafeteria plan?

Generally, no. If you only have a cafeteria plan, you are not required to file Form 5500 or Schedule F. However, if you have a welfare benefit plan, you may be required under Department of Labor regulations to file a return for that plan. Please see the Form 5500 Instructions or contact the U.S. Department of Labor for more information. Assistance is also available from our Customer Account Services office.

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How does a cafeteria plan work?

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. See Sections 3121(a)(5)(G) and 3306(b)(5)(G) of the Internal Revenue Code.
The above discussion provides only the most basic rules governing a cafeteria plan. For a complete understanding of the rules, see the Proposed Regulations under Code section 125.

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What is a flexible spending arrangement?
A flexible spending arrangement (FSA) is a form of cafeteria plan benefit, funded by salary reduction, that reimburses employees for expenses incurred for certain qualified benefits. An FSA may be offered for dependent care assistance, adoption assistance, and medical care reimbursements. The benefits are subject to an annual maximum and are subject to an annual "use -or-lose" rule. The maximum amount of reimbursement which is reasonably available to a participant for such coverage must be less than 500 percent of the value of the coverage. In the case of an insured plan, the maximum amount reasonably available must be determined on the basis of the underlying coverage. An FSA cannot provide a cumulative benefit to the employee beyond the plan year.

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A town has a cafeteria plan (section 125 plan), which offers dependent care assistance. The benefits received by an employee exceed $5,000. How is this benefit reported on Form W-2?

An employee can generally exclude from gross income up to $5,000 of benefits received under a dependent care assistance program each year. The limit is reduced to $2,500 for married employees filing separate returns. The exclusion cannot be more than the earned income of either the employee or the employee's spouse. The total dependent care benefits the employer paid to the employee or incurred on the employee's behalf (including amounts from a section 125 plan) should be reported in Box 10 of Form W-2. Any amount over $5,000 should be included in Boxes 1, 3, and 5, as "wages," "social security wages" and "Medicare wages." See Publication 535 and Publication 15-A for additional information.

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What remuneration under a cafeteria plan is not subject to FICA, FUTA, Medicare tax or income tax withholding?
Generally, qualified benefits under a cafeteria plan are not subject to FICA, FUTA, Medicare tax, or income tax withholding. However, group-term life insurance that exceeds $50,000 of coverage is subject to social security and Medicare taxes, but not FUTA tax or income tax withholding, even when provided as a qualified benefit in a cafeteria plan. Adoption assistance benefits provided in a cafeteria plan are subject to social security, Medicare, and FUTA taxes, but not income tax withholding. If an employee elects to receive cash instead of any qualified benefit, it is treated as wages subject to all employment taxes. For more information, see Publication 535, Chapter 5 or Publication 15-A .

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Can a cafeteria plan make advance reimbursements for medical expenses?
No. Employees can only be reimbursed for allowable, documented expenses incurred during the plan year, after the expenses have been substantiated.

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A town has a cafeteria plan which offers health care benefits to domestic partners. Does a domestic partner and his or her child qualify to be covered under the health plan?
Cafeteria plans can offer health insurance to employees, their spouses and their dependents. The domestic partner and dependents in this case may not be participants in a cafeteria plan because they are not employees, but the plan may provide benefits to them. For example, a domestic partner may not be given the opportunity to select or purchase benefits offered by the plan, but the domestic partner may benefit from the employee's selection of family medical insurance coverage or of coverage under a dependent care assistance program.

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Page Last Reviewed or Updated: 2012-08-01

APPENDIX F

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

OFFICE OF
CHIEF COUNSEL

Number: **200117038**
Release Date: 4/27/2001
UIL: 79.03-00, 79.04-00, 457.01-00, 408.00-00, 125.00-00, 106.00-00, 403.00-00, 3121.16-00, 3121.17-00

CC:TEGE:EOEG:ET2:EEdwards
SPR-112397-00
January 16, 2001

MEMORANDUM FOR ROBERT WESTHOVEN

FROM: Jerry Holmes
TEGE:EOEG:ET2

SUBJECT: Additional Questions: State and Local Governments

This is in partial response to your document transmitting 65 questions dealing with employment tax issues of state and local governments. These responses were prepared by other branches in TEGE.

Question #8: A municipality has a group-term life insurance plan. The employer pays for the cost of insurance coverage under $50,000. The employee may purchase additional insurance which may exceed $50,000. Is any part of the premium taxable?

Answer: An employer can provide up to $50,000 of group-term life insurance coverage tax-free. The employee is taxed on the cost of coverage in excess of $50,000 (reduced by any amounts paid by the employee toward the cost of the coverage), but only if the insurance is "provided under a policy carried directly or indirectly by the employer." The cost of the insurance must be computed using the premiums prescribed in Table I of the Internal Revenue Code (Code) section 79 regulations. To determine the amount to be included in an employee's income, total the coverage provided under all policies "carried directly or indirectly by the employer" and reduce that coverage by $50,000. Next, go to Table I to determine the cost of the insurance and then reduce that cost by any premium amounts paid by the employee.

A policy is carried directly or indirectly by the employer under two circumstances: (1) if the employer pays any cost of the life insurance; or (2) if the employer arranges for the premium payments and the premiums paid by at least one employee subsidize those paid by at least one other employee. The test for determining whether some employees are subsidizing other employees is found in section 1.79-0 of the regulations. Under that test, there is employee subsidization if at least one employee is charged less than the cost of his or her insurance (as determined under Table I) and at least one other employee is charged more than the cost of his or her insurance (as determined under Table I). This is sometimes referred to as the straddle rule. That is,

if the premiums charged the employees "straddle" the Table I premium rates, the insurance is "carried directly or indirectly by the employer." Each policy must be tested separately to determine if it is carried directly or indirectly by the employer. As a general rule, all insurance coverage provided by the same insurance company (or any of its subsidiaries) is considered one policy.

Thus, the question cannot be answered without knowing whether the employer-paid coverage and the employee-paid coverage are purchased from the same or different insurance companies. If the insurance is purchased from different insurers, the employer-paid coverage is "carried directly or indirectly by the employer" because it is financed by you. The optional insurance, even though it is paid for entirely by employee after-tax dollars, must also be included in the calculations for group-term insurance if the premiums charged to the employees "straddle" the Table I rates. If the premiums charged to employees for the optional insurance do not "straddle" the Table I rates, only the cost of the employer-paid coverage is subject to inclusion in income–and because you do not pay for more than $50,000 of coverage, no amounts would be taxable.

If you use the same insurer (or a subsidiary) to purchase both the employer-paid coverage and the optional coverage paid by the employees, as a general rule you must test both types of coverage as one policy. Because insurance provided under that policy is partially financed by the employer, it is "carried directly or indirectly by the employer," and the two coverages must be combined to determine the amount, if any, to be included in an employee's income. Note, however, that the regulations provide an exception to the rule that all coverage from the same insurer must be tested as one policy. For most group-term insurance, the exception is met only if the premiums are properly allocated among the coverages and the employer elects to treat the coverages as separate policies. To determine if premiums are properly allocated, the IRS often looks at whether the premiums are developed using separate mortality or claims experience, and whether credits and dividends are properly allocated between the coverages. If you meet the exception, you can test the employer-paid coverages separately, as if they were purchased from different insurance companies.

Question #15: Are the employer and employee contributions to a section 457 plan taxable for social security and Medicare?

Answer: Section 3121(v)(2)(A) of the Code provides that any amount deferred under a nonqualified deferred compensation plan shall be taken into account for purposes of social security and Medicare as of the later of (i) when the services are performed, or (ii) when there is no substantial risk of forfeiture of the rights to the amount.

Section 3121(a)(5)(E) of the Code provides that wages do not include any payment made to, or on behalf of, an employee or his beneficiary under, or to, an exempt governmental deferred compensation plan (as defined in section 3121(v)(3)).

However, section 3121(v)(3) of the Code provides that the term "exempt governmental deferred compensation plan" does not include any plan to which section 457(a) or section 457(e)(1) applies. Thus, contributions to an eligible state deferred compensation plan are not excludable from the definition of the term "wages" for purposes of the FICA taxes.

Both the employer and employee contributions to a 457 plan are taxable for social security and Medicare.

Question #27: A State Retirement Plan pays for life insurance for the employee's spouse and children in the amount of $5,000. Is this coverage taxable as income to the employee?

Answer: The cost of employer-provided group-term life insurance on the life of an employee's spouse or dependent is not taxable to the employee if the face amount of the coverage does not exceed $2,000. This coverage is deemed to be a de minimis fringe benefit. Amounts with a higher face amount may also be a de minimis fringe benefit. IRS Notice 98-110 requires that in determining whether coverage higher than $2,000 is a de minimis fringe benefit, only the excess (if any) of the cost of such insurance over the amount paid for the insurance by the employee on an after-tax basis shall be taken into account.

If the face amount exceeds $2,000 (or is not otherwise a de minimis fringe benefit described in Notice 89-110), the entire cost of the insurance, including the cost of the first $2,000, is included in the employee's income. The cost of the insurance must be computed using the premiums prescribed in the Uniform Premium Table (Table I) found in the Code section 79 regulations. Any premium amounts paid by the employee on an after-tax basis reduce the amount included in the employee's income.

Question #59: The employees of a town are covered by the State Retirement life insurance. This insurance coverage, combined with the town's other life insurance, is in an amount greater than $50,000 for each employee. Are these policies combined to figure the taxable income over $50,000?

Answer: The statute excluding from income the cost of up to $50,000 of group-term life insurance coverage on the life of an employee does not apply to insurance provided under a life insurance contract purchased as part of a qualified retirement plan. Different rules of taxation apply to such insurance. Whether the life insurance is provided under the retirement plan depends on the provisions of the plan.

Assuming that the life insurance provided through the state is not purchased as part of the provisions of a retirement plan, the insurance provided through the city and that provided through the state are generally combined to determine the amount to be included in an employee's income. But refer to the discussion in Question #8

(concerning whether a policy is carried directly or indirectly by the employer) if one or both of the insurance coverages are paid for entirely by the employees.

Question #16: Please explain a SEP-IRA. Can a town offer its employees a SEP-IRA?

Answer: Yes, a town can offer its employees a SEP-IRA (simplified employee pension). Under a SEP, you make the contributions to an individual retirement arrangement established by or for each eligible employee. SEP-IRAs are owned and controlled by the employees, and you make contributions to a financial institution where the SEP-IRAs are maintained. A SEP-IRA is set up for, at a minimum, each eligible employee.
An eligible employee is an individual who has: 1) reached age 21; 2) worked for you in at least 3 of the last 5 years; and 3) received at least $450 in compensation from you during the calendar year 2000.

Note: you can establish less restrictive participation requirements than those listed but not more restrictive ones.

There are three basic steps in setting up a SEP:

1) You must execute a formal written agreement to provide benefits to all employees who are eligible.
2) You must give each eligible employee certain information about the SEP, and
3) An IRA account must be established by or for each eligible employee.

The SEP rules permit you to contribute a limited amount of money each year to each employee's SEP-IRA. You do not have to make contributions every year. But if you make contributions, they must be based on a written allocation formula and must not discriminate in favor of highly compensated employees. When you contribute, you must contribute to the SEP-IRAs of all participants who actually performed personal services during the year for which the contributions are made, even employees who died or terminated employment before the contributions were made.

Contributions cannot be more than the smaller of I5% of the employee's compensation or $30,000. Do not include SEP contributions as wages on an employee's Form W-2. Your contributions to a SEP, to any other qualified defined contribution plan, and benefits under any other qualified defined benefit plan cannot exceed certain limits set forth in Code section 415.

Publication 560 discusses Simplified Employee Pension plans in detail.

This publication discusses what type of plan to set up, as well as how to set up a plan. It also tells how much you can contribute to a plan, how to treat distributions, and how to report information about the plan to the Internal Revenue Service and your employees.

You can also call the Employee Plans Taxpayer Assistance telephone service between the hours of I:30 PM and 3:30 PM, Eastern Time, Monday through Thursday at (202) 622-6074/6075. (These are not toll-free numbers.)

Question #50: A municipality offers employees not participating in the state retirement system the option of a matching IRA up to $1,000. Employees must show proof of contribution through bank documentation. The municipality then sends a check directly to the bank for contribution to the employee's IRA. Is this contribution taxable?

Answer: Yes. This arrangement is an IRA described in Code section 408(c). Employer contributions to IRAs are treated as payment of compensation to the employee. They are includible in the employee's gross income in the taxable year for which the amount was contributed. Section 219(f)(5). The total amount of the employee's contribution and the employer's contribution cannot exceed $2,000, or the amount of compensation includible in the employee's gross income for the taxable year if the employee's compensation is less than $2,000.

Question #35: Is there a filing requirement for a town that maintains a cafeteria plan?

Answer: Yes, state and governmental agencies are required to file Form 5500, Annual Return/Report of Employee Benefit Plan, for Internal Revenue Code section 125 cafeteria plans. This is true even though state agencies are exempt under the Employee Retirement Income Security Act of I974 (ERISA) from filing Form 5500 for pension benefit and welfare benefit plans such as 401(k) plans and health insurance plans.

Question #44: A town has a cafeteria plan (section 125 plan), which offers dependent care assistance. The benefits received by an employee exceed $5,000. How is this benefit reported on Form W-2?

Answer: An employee can generally exclude from gross income up to $5,000 of benefits received under a dependent care assistance program each year. The limit is reduced to $2,500 for married employees filing separate returns. The exclusion cannot be more than the earned income of either the employee or the employee's spouse. The total dependent care benefits the employer paid to the employee or incurred on the employee's behalf (including amounts from a section 125 plan) should be reported in Box 10 of Form W-2. Any amount over $5,000 should be included in Boxes 1, 3, and 5, as "wages," "social security wages" and Medicare wages. See Publications 535 and 15-A for additional information.

Question #45: What remuneration under a cafeteria plan is not subject to FICA, FUTA, Medicare tax or income tax withholding?

Answer: Generally, qualified benefits under a cafeteria plan are not subject to FICA, FUTA, Medicare tax, or income tax withholding. However, group-term life insurance

that exceeds $50,000 of coverage is subject to social security and Medicare taxes, but not FUTA tax or income tax withholding, even when provided as a qualified benefit in a cafeteria plan. Adoption assistance benefits provided in a cafeteria plan are subject to social security, Medicare, and FUTA taxes, but not income tax withholding. If an employee elects to receive cash instead of any qualified benefit, it is treated as wages subject to all employment taxes. For more information, see Chapter 5 in Pub. 535 or Pub. 15-A.

Question #46: Please explain how the cafeteria plan works.

Answer: Code section 125 makes it possible for employers to offer their employees a choice between cash salary and a variety of nontaxable benefits (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, without being subject to the principles of constructive receipt. Qualified benefits include health care, vision and dental care, group-term life insurance, disability, adoption assistance and certain other benefits. See Sections 125(a), 125(f), 79, 105, 106, 129 and 137 of the Code.

Employers may also offer flexible spending accounts to employees under a cafeteria plan that provides coverage under which specified, incurred expenses may be reimbursed. These include health flexible spending accounts for expenses not reimbursed under any other health plan and dependent care assistance programs.

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. See Sections 3121(a)(5)(G) and 3306(b)(5)(G) of the Code.

The above discussion provides only the most basic rules governing a cafeteria plan. For a complete understanding of the rules, see the proposed and final regulations under Code section 125.

Question #65: A town has a cafeteria plan which offers health care benefits to domestic partners. Does a domestic partner and his or her child qualify to be covered under the health plan?

Answer: Cafeteria plans can offer health insurance to employees, their spouses and their dependants. The domestic partner and dependants in this case may not be participants in a cafeteria plan because they are not employees, but the plan may provide benefits to them. For example, a domestic partner may not be given the

opportunity to select or purchase benefits offered by the plan, but the domestic partner may benefit from the employee's selection of family medical insurance coverage or of coverage under a dependent care assistance program.

If the domestic partner and his or her child do not qualify as the employee's dependents, those individuals may receive coverage under the cafeteria plan on a taxable basis. This means that the fair market value of the coverage for the domestic partner and his or her child must be included in the employee's wages for purposes of income tax withholding, FICA and FUTA taxes.

Question #66: What if the employer does not have a section 125 plan, but offers health insurance coverage to a domestic partner and his or her child? Is this a taxable fringe benefit to the employee?

Answer: Employer-provided coverage under an accident or health plan for individuals other than the employee, the employee's spouse or dependents is included in the employee's gross income. Code section 106. The term "dependent" is defined in section 152(a) of the Code.

Question #49: Employee X has 34 years of service with school districts. X is a participant in the State Retirement System and contributes 7.65% of his gross salary to the plan. For the past 4 years, X has been employed as superintendent of schools of the ABC school district in the State.

1. What is the maximum amount of elective deferrals X can contribute in 2000 to a 403(b) contract purchased for X by ABC School District based on his salary of $50,000+?

   Answer: A plan that provides for salary reduction contributions must not exceed the maximum deferral limitations under section 401(a)(30) of the Code. For the 2000 year, the maximum 403(b) elective deferral limit is $10,500 plus increases permitted for l5-year employees. See Publication 571, page 4, "Increase for 15-year employees," for an explanation of how to figure the amount of the yearly increase. Also see the discussion in Answer 4 below.

2. Do either employer or employee contributions to the State Retirement System, or both, have to be included when figuring the limit on elective deferrals under the 403(b) contract?

   Answer: We have not been told the plan type of the State Retirement System, i.e., the Code section which applies to it. If the retirement plan is any of the plans described below, the annual limit on Employee X's deferrals under a 403(b) contract would have to be reduced by the total of all elective deferrals contributed for the year on behalf of X (even if by different employers) to:

- 401(k) plans to the extent excluded from X's income,
- Section 501(c)(18) plans to the extent excluded from X's income,
- SIMPLE plans, and
- 403(b) plans.

See section 401(a)(30) and page 4 of Publication 571.
If the State Retirement System is a section 457 plan, the school district should adjust the limitations accordingly.

3. When figuring the amount previously excludable what exactly do you include in this figure?

   Answer: To figure Employee X's exclusion allowance, you must know the amounts previously excludable from X's income. Page 8 of Publication 571 explains how to figure this.

4. In figuring the increase in the dollar limit of elective deferrals, can Employee X use the years in other school districts to qualify for the increase in the dollar limit for a 15-year employee?

   Answer: No. Tacking of years of service for purposes of section 402(g)(8) is not permitted in other than a 414(e) church environment.

APPENDIX G

Federal Register

Monday,
August 6, 2007

Part III

Department of the Treasury

Internal Revenue Service

26 CFR Part 1
Employee Benefits—Cafeteria Plans; Proposed Rule

Appx. G

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–142695–05]

RIN 1545–BF00

Employee Benefits—Cafeteria Plans

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Withdrawal of prior notices of proposed rulemaking, notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains new proposed regulations providing guidance on cafeteria plans. This document also withdraws the notices of proposed rulemaking relating to cafeteria plans under section 125 that were published on May 7, 1984, December 31, 1984, March 7, 1989, November 7, 1997 and March 23, 2000. In general, these proposed regulations would affect employers that sponsor a cafeteria plan, employees that participate in a cafeteria plan, and third-party cafeteria plan administrators.

DATES: Written or electronic comments must be received by November 5, 2007. Outlines of topics to be discussed at the hearing scheduled for November 15, 2007, at 10 a.m., must be received by October 25, 2007.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–142695–05), room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–142695–05), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC or sent electronically via the Federal eRulemaking Portal at *http://www.regulations.gov* (IRS REG–142695–05). The public hearing will be held at the IRS Auditorium, Internal Revenue Building, 1111 Constitution Avenue, NW., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, Mireille T. Khoury at (202) 622–6080; concerning submissions of comments, the hearing, and/or to be placed on the building access list to attend the hearing, Oluwafunmilayo Taylor of the Publications and Regulations Branch at (202) 622–7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION

Paperwork Reduction Act

The collections of information contained in this notice of proposed rulemaking have been submitted to the Office of Management and Budget for review in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collections of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collections of information should be received by October 5, 2007. Comments are specifically requested concerning:

Whether the proposed collections of information are necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How the quality, utility, and clarity of the information to be collected may be enhanced;

How the burden of complying with the proposed collections of information may be minimized, including through the application of automatic collection techniques or other forms of information technology; and

Estimates of the capital or start-up costs and costs of operation, maintenance, and purchase of service to provide information.

The collection of information in this proposed regulation is in § 1.125–2 (cafeteria plan elections); § 1.125–6(b)–(g) (substantiation of expenses), and § 1.125–7 (cafeteria plan nondiscrimination rules). This information is required to file employment tax returns and Forms W–2. The collection of information is voluntary to obtain a benefit. The likely respondents are Federal, state or local governments, business or other for-profit institutions, nonprofit institutions, and small businesses or organizations.

Estimated total annual reporting burden: 34,000,000 hours.

Estimated average annual burden per respondent: 5 hours.

Estimated annual frequency of responses: once.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

This document contains proposed Income Tax Regulations (26 CFR Part 1) under section 125 of the Internal Revenue Code (Code). On May 7, 1984, December 31, 1984, March 7, 1989, November 7, 1997, and March 23, 2000, the IRS and Treasury Department published proposed amendments to 26 CFR Part 1 under section 125 in the **Federal Register** (49 FR 19321, 49 FR 50733, 54 FR 9460, 62 FR 60196 and 65 FR 15587). These 1984, 1989, 1997 and 2000 proposed regulations are hereby withdrawn. Also, the temporary regulations under section 125 that were published on February 4, 1986 in the **Federal Register** (51 FR 4318) are being withdrawn in a separate document. The new proposed regulations that are published in this document replace those proposed regulations.

Explanation of Provisions

Overview

The new proposed regulations are organized as follows: general rules on qualified and nonqualified benefits in cafeteria plans (new proposed § 1.125–1), general rules on elections (new proposed § 1.125–2), general rules on flexible spending arrangements (new proposed § 1.125–5), general rules on substantiation of expenses for qualified benefits (new proposed § 1.125–6) and nondiscrimination rules (new proposed § 1.125–7). The new proposed regulations, new Proposed §§ 1.125–1, 1.125–2, 1.125–5, 1.125–6 and § 1.125–7, consolidate and restate Proposed § 1.125–1 (1984, 1997, 2000), § 1.125–2 (1989, 1997, 2000) and § 1.125–2T (1986). Unless otherwise indicated, references to "new proposed regulations" or "these proposed regulations" mean the proposed section 125 regulations being published in this document.

The new proposed regulations reflect changes in tax law since the prior regulations were proposed, including: the change in the definition of dependent (section 152) and the addition of the following as qualified benefits: adoption assistance (section 137), additional deferred compensation benefits described in section 125(d)(1)(B), (C) and (D), Health Savings

Accounts (HSAs) (sections 223, 125(d)(2)(D) and 4980G), and qualified HSA distributions from health FSAs (section 106(e)). Other changes include the prohibition against long-term care insurance and long-term care services (section 125(f)) and the addition of the key employee concentration test in section 125(b)(2).

The prior proposed regulations, §§ 1.125–1 and 1.125–2, provide the basic framework and requirements for cafeteria plans and elections under cafeteria plans. The prior proposed regulations also outlined the most significant rules for benefits under a health flexible spending arrangement (health FSA) offered by a cafeteria plan—the requirement that the maximum reimbursement be available at all times during the coverage period (the uniform coverage rule), the requirement of a 12-month period of coverage, the requirement that the health FSA only reimburse medical expenses, the requirement that all medical expenses be substantiated by a third party before reimbursement, the requirement that expenses be incurred during the period of coverage, and the prohibition against deferral of compensation (including the use-or-lose rule). The prior proposed regulations also provided guidelines for dependent care FSAs, and the application of section 125 to paid vacation days offered under a cafeteria plan. These remain substantially unchanged in the new proposed regulations, with certain clarifications. Finally, the prior proposed regulations included a number of Q & As addressing transitional issues relating to the enactment of section 125, as well as the application of the now-repealed section 89 (special nondiscrimination rules with respect to certain employee benefit plans). These provisions are omitted from the new proposed regulations.

I. New Proposed § 1.125–1—Qualified and Nonqualified Benefits in Cafeteria Plans Section 125 Exclusive Noninclusion Rule

Section 125 provides that, except in the case of certain discriminatory benefits, no amount shall be included in the gross income of a participant in a cafeteria plan (as defined in section 125(d)) solely because, under the plan, the participant may choose among the benefits of the plan. The new proposed regulations clarify and amplify the general rule in the prior proposed regulations that section 125 is the exclusive means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice itself resulting in inclusion in gross income by the employees. When employees may elect between taxable and nontaxable benefits, this election results in gross income to employees, unless a specific Internal Revenue Code (Code) section (such as section 125) intervenes to prevent gross income inclusion. Thus, except for an election made through a cafeteria plan that satisfies section 125 or another specific Code section (such as section 132(f)(4)), any opportunity to elect among taxable and nontaxable benefits results in inclusion of the taxable benefit regardless of what benefit is elected and when the election is made. This interpretation of section 125 is consistent with the legislative history of section 125. The legislative history begins with the interim ERISA rules for cafeteria plans:

> Under * * * ERISA, an employer contribution made before January 1, 1977, to a cafeteria plan in existence on June 27, 1974, is required to be included in an employees' gross income only to the extent that the employee actually elects taxable benefits. In the case of a plan not in existence on June 27, 1974, the employer contribution is required to be included in an employee's gross income to the extent the employee could have elected taxable benefits. S. Rep. No. 1263, 95th Cong., 2d Sess. 74 (1978), reprinted in 1978 U.S.C.C.A.N. 6837; H. R. Rep. No. 1445, 95th Cong., 2d Sess. 63 (1978); H.R. Conf. Rep. No. 1800, 95th Cong., 2d Sess. 206 (1978).

The legislative history also provides:

> [G]enerally, employer contributions under a written cafeteria plan which permits employees to elect between taxable and nontaxable benefits are excluded from the gross income of an employee to the extent that nontaxable benefits are elected. S. Rep. No. 1263, 95th Cong., 2d Sess. 75 (1978), reprinted in 1978 U.S.C.C.A.N. 6838; H. R. Rep. No. 1445, 95th Cong., 2d Sess. 63 (1978). See also H.R. Conf. Rep. No. 1800, 95th Cong., 2d Sess. 206 (1978).

The legislative history to the 1984 amendments to section 125 continues:

> The cafeteria plan rules of the Code provide that a participant in a nondiscriminatory cafeteria plan will not be treated as having received a taxable benefit offered under the plan solely because the participant has the opportunity, before the benefit becomes available, to choose among the taxable and nontaxable benefits under the plan.
>
> H.R. Conf. Rep. No. 861, 98th Cong., 2d Sess. 1173 (1984), reprinted in 1984 U.S.C.C.A.N. 1861. See also H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 295, reprinted in 1996 U.S.C.C.A.N. 2108.

The new proposed regulations provide that unless a plan satisfies the requirements of section 125 and the regulations, the plan is not a cafeteria plan. Reasons that a plan would fail to satisfy the section 125 requirements include: Offering nonqualified benefits; not offering an election between at least one permitted taxable benefit and at least one qualified benefit; deferring compensation; failing to comply with the uniform coverage rule or use-or-lose rule; allowing employees to revoke elections or make new elections during a plan year, except as provided in § 1.125–4; failing to comply with substantiation requirements; paying or reimbursing expenses incurred for qualified benefits before the effective date of the cafeteria plan or before a period of coverage; allocating experience gains (forfeitures) other than as expressly allowed in the new proposed regulations; and failing to comply with grace period rules.

Definition of a Cafeteria Plan

The new proposed regulations provide that a cafeteria plan is a separate written plan that complies with the requirements of section 125 and the regulations, that is maintained by an employer for employees and that is operated in compliance with the requirements of section 125 and the regulations. Participants in a cafeteria plan must be permitted to choose among at least one permitted taxable benefit (for example, cash, including salary reduction) and at least one qualified benefit. A plan offering only elections among nontaxable benefits is not a cafeteria plan. Also, a plan offering only elections among taxable benefits is not a cafeteria plan. See Rev. Rul. 2002–27, Situation 2 (2002–1 CB 925), see § 601.601(d)(2)(ii)(*b*). Finally, a cafeteria plan must not provide for deferral of compensation, except as specifically permitted in section 125(d)(2)(B), (C), or (D).

Written Plan

Section 125(d)(1) requires that a cafeteria plan be in writing. The cafeteria plan must be operated in accordance with the written plan terms. The new proposed regulations require that the written plan specifically describe all benefits, set forth the rules for eligibility to participate and the procedure for making elections, provide that all elections are irrevocable (except to the extent that the plan includes the optional change in status rules in § 1.125–4), and state how employer contributions may be made under the plan (for example, salary reduction or nonelective employer contributions), the maximum amount of elective contributions, and the plan year. If the plan includes a flexible spending arrangement (FSA), the written plan must include provisions complying

with the uniform coverage rule and the use-or-lose rule. Because section 125(d)(1)(A) states that a cafeteria plan is a written plan under which "all participants are employees," the new proposed regulations require that the written cafeteria plan specify that only employees may participate in the cafeteria plan. The new proposed regulations also require that all provisions of the written plan apply uniformly to all participants.

Individuals Who May Participate in a Cafeteria Plan

All participants in a cafeteria plan must be employees. See section 125(d)(1)(A). These proposed regulations provide that employees include common law employees, leased employees described in section 414(n), and full-time life insurance salesmen (as defined in section 7701(a)(20)). These proposed regulations further provide that former employees (including laid-off employees and retired employees) may participate in a plan, but a plan may not be maintained predominantly for former employees. See Rev. Rul. 82–196 (1982–2 CB 53); Rev. Rul. 85–121 (1985–2 CB 57), see § 601.601(d)(2)(ii)(*b*). All employees who are treated as employed by a single employer under section 414(b), (c) or (m) are treated as employed by a single employer for purposes of section 125. See section 125(g)(4). A participant's spouse or dependents may receive benefits through a cafeteria plan although they cannot participate in the cafeteria plan.

Self-employed individuals are not treated as employees for purposes of section 125. Accordingly, the new proposed regulations make clear that sole proprietors, partners, and directors of corporations are not employees and may not participate in a cafeteria plan. In addition, the new proposed regulations clarify that 2-percent shareholders of an S corporation are not employees for purposes of section 125. The new proposed regulations provide rules for dual status individuals and individuals moving between employee and non-employee status. A self-employed individual may, however, sponsor a cafeteria plan for his or her employees.

Election Between Taxable and Nontaxable Benefits

The new proposed regulations require that a cafeteria plan offer employees an election among only permitted taxable benefits (including cash) and qualified nontaxable benefits. See section 125(d)(1)(B). For purposes of section 125, cash means cash from current compensation (including salary reduction), payment for annual leave, sick leave, or other paid time off, severance pay, property, and certain after-tax employee contributions. Distributions from qualified retirement plans are not cash or taxable benefits for purposes of section 125. See Rev. Rul. 2003–62 (2003–1 CB 1034) (distributions to former employees from a qualified employees' trust, applied to pay health insurance premiums, are includible in former employees' gross income under section 402), see § 601.601(d)(2)(ii)(*b*).

Qualified Benefits

In general, in order for a benefit to be a qualified benefit for purposes of section 125, the benefit must be excludible from employees' gross income under a specific provision of the Code and must not defer compensation, except as specifically allowed in section 125(d)(2)(B), (C) or (D). Examples of qualified benefits include the following: group-term life insurance on the life of an employee (section 79); employer-provided accident and health plans, including health flexible spending arrangements, and accidental death and dismemberment policies (sections 106 and 105(b)); a dependent care assistance program (section 129); an adoption assistance program (section 137); contributions to a section 401(k) plan; contributions to certain plans maintained by educational organizations, and contributions to HSAs. Section 125(f), (d)(2)(B), (C), (D). See Notice 97–9 (1997–2 CB 35) (adoption assistance), see § 601.601(d)(2)(ii)(*b*); Notice 2004–2, Q & A–33 (2004–1 CB 269) (HSAs), see § 601.601(d)(2)(ii)(*b*). A cafeteria plan may also offer long-term and short-term disability coverage as a qualified benefit (see section 106). However, see paragraph (q) in § 1.125–1 for nonqualified benefits.

Group-Term Life Insurance

An employer may provide group-term life insurance through a combination of methods. Generally, under section 79(a), the cost of $50,000 or less of group-term life insurance on the life of an employee provided under a policy (or policies) carried directly or indirectly by an employer is excludible from the employee's gross income. (Special rules apply to key employees if the group-term life insurance plan does not satisfy the nondiscrimination rules in section 79(d)). However, if the group-term life insurance provided to an employee by an employer or employers exceeds $50,000 (taking into account all coverage provided both through a cafeteria plan and outside a cafeteria plan), the cost of coverage exceeding coverage of $50,000 is includible in the employee's gross income. For this purpose, the cost of group-term life insurance is shown in § 1.79–3(d)(2), Table I (Table I). The Table I cost of the excess group-term life insurance (minus all after-tax contributions by the employee for group-term life insurance coverage) is includible in each covered employee's gross income. The new proposed regulations provide that the cost of group-term life insurance on the life of an employee, that either is less than or equal to the amount excludible from gross income under section 79(a) or provides coverage in excess of that amount, but not combined with any permanent benefit, is a qualified benefit that may be offered in a cafeteria plan. The new proposed regulations also provide that the entire amount of salary reduction and employer flex-credits for group-term life insurance coverage on the life of an employee is excludible from an employee's gross income.

The rule in the new proposed regulations differs from Notice 89–110 (1989–2 CB 447), see § 601.601(d)(2)(ii)(*b*). Notice 89–110 provides that an employee includes in gross income the greater of the Table I cost of group-term life insurance coverage exceeding $50,000 or the employee's salary reduction and employer flex-credits for excess group-term life insurance coverage. The new proposed regulations provide instead that the employee includes in gross income the Table I cost of the excess coverage (minus all after-tax contributions by the employee for group-term life insurance coverage) and that the entire amount of salary reduction and employer flex-credits for group-term life insurance coverage on the life of the employee is excludible from the employee's gross income. As noted in this preamble, taxpayers may rely on the new proposed regulations for guidance pending the issuance of final regulations.

Employer-Provided Accident and Health Plan

Coverage under an employer-provided accident and health plan that satisfies the requirements of section 105(b) may be provided as a qualified benefit through a cafeteria plan and is excludible from employees' gross income. Section 106; § 1.106–1. The nondiscrimination rules under section 105(h) apply to self-insured medical reimbursement arrangements (including health FSAs).

The new proposed regulations specifically permit a cafeteria plan (but

not a health FSA) to pay or reimburse substantiated individual accident and health insurance premiums. See Rev. Rul. 61–146 (1961–2 CB 25), see § 601.601(d)(2)(ii)(*b*). In addition, a cafeteria plan may provide for payment of COBRA premiums for an employee.

For employer-provided accident and health plans and medical reimbursement plans, the definition of dependents is the definition in section 105(b) as amended by the Working Families Tax Relief Act of 2004 (WFTRA), Public Law 108–311, section 207(9) (118 Stat. 1166) (that is, a dependent as defined in section 152, determined without regard to section 152(b)(1), (b)(2), or (d)(1)(B)). See Notice 2004–79 (2004–2 CB 898), see § 601.601(d)(2)(ii)(*b*). For purposes of the exclusion from employees' gross income for accident and health plans and for medical reimbursement under sections 105(b) and 106, the spouse or dependent of a former employee (including a retired employee or a laid-off employee) or of a deceased employee is treated as a spouse or dependent. See Rev. Rul. 82–196 (1982–2 CB 53); Rev. Rul. 85–121 (1985–2 CB 57), see § 601.601(d)(2)(ii)(*b*).

Dependent Care Assistance Programs and Adoption Assistance Programs

If the requirements of section 129 are satisfied, up to $5,000 of employer-provided assistance for amounts paid or incurred by employees for dependent care is excludible from employees' gross income. The new proposed regulations outline the general requirements for providing dependent care assistance programs and adoption assistance programs under section 137 through a cafeteria plan. See Notice 97–9, section II (1997–2 CB 35), see § 601.601(d)(2)(ii)(*b*).

Cafeteria Plan Year

The new proposed regulations require that a cafeteria plan year must be 12 consecutive months and must be set out in the written cafeteria plan. A short plan year (or a change in plan year resulting in a short plan year) is permitted only for a valid business purpose. A change in plan year resulting in a short plan year, for other than a valid business purpose, is disregarded. If a principal purpose of a change in plan year is to circumvent the rules of section 125, the change in plan year is ineffective.

No Deferral of Compensation

Qualified benefits must be current benefits. In general, a cafeteria plan may not offer benefits that defer compensation or operate to defer compensation. Section 125(d)(2)(A). In general, benefits may not be carried over to a later plan year or used in one plan year to purchase benefits to be provided in a later plan year. For example, life insurance with a cash value build-up or group-term life insurance with a permanent benefit (within the meaning of § 1.79–0) defers the receipt of compensation and thus is not a qualified benefit.

The new proposed regulations clarify whether certain benefits and plan administration practices defer compensation. For example, the regulations permit an accident and health insurance policy to provide certain benefit features that apply for more than one plan year, such as reasonable lifetime limits on benefits, level premiums, premium waiver during disability, guaranteed renewability of coverage, coverage for specified accidental injury or specific diseases, and the payment of a fixed amount per day for hospitalization. But these insurance policies must not provide an investment fund or cash value to pay premiums, and no part of the premium may be held in a separate account for any beneficiary. The new proposed regulations also provide that the following benefits and practices do not defer compensation: a long-term disability policy paying benefits over more than one plan year; reasonable premium rebates or policy dividends; certain two-year lock-in vision and dental policies; certain advance payments for orthodontia; salary reduction contributions in the last month of a plan year used to pay accident and health insurance premiums for the first month of the following plan year; reimbursement of section 213(d) expenses for durable medical equipment; and allocation of experience gains (forfeitures) among participants.

Paid Time Off

Under the prior proposed regulations, permitted taxable benefits included various forms of paid leave. Since the prior proposed regulations were issued, many employers have recharacterized and combined vacation days, sick leave and personal days into a single category of "paid time off." The new proposed regulations use the term "paid time off" to refer to vacation days and other types of paid leave. The new proposed regulations contain the same ordering rule for elective and nonelective paid time off as set forth in Prop. § 1.125–1, Q & A–7 (1984). A plan offering an election solely between paid time off and taxable benefits is not a cafeteria plan.

Grace Period

The new proposed regulations allow a written cafeteria plan to provide an optional grace period immediately following the end of each plan year, extending the period for incurring expenses for qualified benefits. A grace period may apply to one or more qualified benefits (for example, health FSA or dependent care assistance program) but in no event does it apply to paid time off or contributions to section 401(k) plans. Unused benefits or contributions for one qualified benefit may only be used to reimburse expenses incurred during the grace period for that same qualified benefit. The amount of unused benefits and contributions available during the grace period may be limited by the employer. A grace period may extend to the fifteenth day of the third month after the end of the plan year (but may be for a shorter period). Benefits or contributions not used as of the end of the grace period are forfeited under the use-or-lose rule. The grace period applies to all employees who are participants (including through COBRA), as of the last day of the plan year. Grace period rules must apply uniformly to all participants. The grace period rules in these proposed regulations are based on Notice 2005–42 (2005–1 CB 1204), modified in Notice 2007–22 (2007–10 IRB 670), see § 601.601(d)(2)(ii)(*b*), amplified in Notice 2005–86 (2005–2 CB 1075), amplified in Notice 2007–22 (2007–10 IRB 670), see § 601.601(d)(2)(ii)(*b*). For eligibility to contribute to a Health Savings Account (HSA) during a grace period, see Notice 2005–86 (2005–2 CB 1075), see § 601.601(d)(2)(ii)(*b*). For Form W–2 reporting for unused dependent care assistance used for expenses incurred during a grace period, see Notice 2005–61 (2005–2 CB 607), see § 601.601(d)(2)(ii)(*b*).

Contributions to Section 401(k) Plans Through a Cafeteria Plan

A cafeteria plan may include contributions to a section 401(k) plan. Section 125(d)(2)(B). The new proposed regulations clarify the interactions between section 125 and section 401(k). Contributions to a section 401(k) plan expressed as a percentage of compensation are permitted. Pursuant to § 1.401(k)–1(a)(3)(ii), elective contributions to a section 401(k) plan may be made through automatic enrollment (that is, when the employee does not affirmatively elect cash, the employee's compensation is reduced by a fixed percentage, which is contributed to a section 401(k) plan).

Nonqualified Benefits

A cafeteria plan must not offer any of the following benefits: scholarships (section 117); employer-provided meals and lodging (section 119); educational assistance (section 127); fringe benefits (section 132); long-term care insurance. See section 125(f). Long-term care services are nonqualified benefits, H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 29, reprinted in 1996 U.S.C.C.A.N. 2109. (An HSA funded through a cafeteria plan may, however, be used to pay premiums for long-term care insurance or for long-term care services.) The new proposed regulations clarify that contributions to Archer Medical Savings Accounts (sections 220, 106(b)), group term life insurance for an employee's spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits. A plan offering any nonqualified benefit is not a cafeteria plan. A cafeteria plan may not offer a health FSA that provides for the carryover of unused benefits. See Notice 2002–45, Part I (2002–2 CB 93); Rev. Rul. 2002–41 (2002–2 CB 75), see § 601.601(d)(2)(ii)(*b*).

After-Tax Employee Contributions

The new proposed regulations allow a cafeteria plan to offer after-tax employee contributions for qualified benefits or paid time off. A cafeteria plan may only offer the taxable benefits specifically permitted in the new proposed regulations. Nonqualified benefits may not be offered through a cafeteria plan, even if paid with after-tax employee contributions.

Employer Contributions Through Salary Reduction

Employees electing a qualified benefit through salary reduction are electing to forego salary and instead to receive a benefit which is excludible from gross income because it is provided by employer contributions. Section 125 provides that the employee is treated as receiving the qualified benefit from the employer in lieu of the taxable benefit. A cafeteria plan may also impose reasonable fees to administer the cafeteria plan which may be paid through salary reduction. A cafeteria plan is not required to allow employees to pay for any qualified benefit with after-tax employee contributions.

II. New Prop. § 1.125–2—Elections in Cafeteria Plans

Making, Revoking and Changing Elections

Generally, a cafeteria plan must require employees to elect annually between taxable benefits and qualified benefits. Elections must be made before the earlier of the first day of the period of coverage or when benefits are first currently available. The determination of whether a taxable benefit is currently available does not depend on whether it has been constructively received by the employee for purposes of section 451. Annual elections generally must be irrevocable and may not be changed during the plan year. However, § 1.125–4 permits a cafeteria plan to provide for changes in elections based on certain changes in status. An employer that wishes to permit such changes in elections must incorporate the rules in § 1.125–4 in its written cafeteria plan. These proposed regulations omit the rule in Q & A–6(b) in Prop. § 1.125–2 (1989) (cessation of required contributions), because the change in status rules in § 1.125–4 superseded this provision of the 1989 proposed regulations.

If HSA contributions are made through salary reduction under a cafeteria plan, employees may prospectively elect, revoke or change salary reduction elections for HSA contributions at any time during the plan year with respect to salary that has not become currently available at the time of the election.

A cafeteria plan is permitted to include an automatic election for new employees or current employees. Rev. Rul. 2002–27 (2002–1 CB 925), see § 601.601(d)(2)(ii)(*b*). A new rule also permits a cafeteria plan to provide an optional election for new employees between cash and qualified benefits. New employees avoid gross income inclusion if they make an election within 30 days after the date of hire even if benefits provided pursuant to the election relate back to the date of hire. However, salary reduction amounts used to pay for such an election must be from compensation not yet currently available on the date of the election. Also, this special election rule for new employees does not apply to any employee who terminates employment and is rehired within 30 days after terminating employment (or who returns to employment following an unpaid leave of absence of less than 30 days).

New elections and revocations or changes in elections can be made electronically. The safe harbor for electronic elections in § 1.401(a)–21 is available. Only an employee can make an election or revoke or change his or her election. An employee's spouse or dependent may not make an election under a cafeteria plan and may not revoke or change an employee's election.

III. New Prop. § 1.125–5—Flexible Spending Arrangements

Overview

In general, a flexible spending arrangement (FSA) is a benefit designed to reimburse employees for expenses incurred for certain qualified benefits, up to a maximum amount not substantially in excess of the salary reduction and employer flex-credits allocated for the benefit. The maximum amount of reimbursement reasonably available must be less than five times the value of the coverage. Employer flex-credits are non-elective employer contributions that an employer makes available for every employee eligible to participate in the cafeteria plan, to be used at the employee's election only for one or more qualified benefits (but not as cash or other taxable benefits). The three types of FSAs are dependent care assistance, adoption assistance and medical care reimbursements (health FSA).

Uniform Coverage Rule

The new proposed regulations retain the rule that the maximum amount of reimbursement from a health FSA must be available at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements). The uniform coverage rule does not apply to FSAs for dependent care assistance or adoption assistance.

Use-or-Lose Rule

An FSA must satisfy all the requirements of section 125, including the prohibition against deferring compensation. In general, as discussed under "No deferral of compensation", in order to satisfy this requirement of section 125, all benefits and contributions must be used by the end of the plan year (or grace period, if applicable), or are forfeited. The new proposed regulations continue the use-or-lose rule.

Period of Coverage

The required period of coverage for all FSAs continues to be twelve months, with an exception for short plan years that satisfy the conditions in the new proposed regulations. The period of coverage and the plan year need not be the same. The beginning and end of a period of coverage is clarified. The new proposed regulations also clarify that FSAs for different qualified benefits need not have the same coverage period. See also "Grace period", discussed in this preamble. The new proposed

regulations also continue to provide that expenses are incurred when services are provided. Expenses incurred before or after the period of coverage may not be reimbursed.

Health FSA

A health FSA may only reimburse certain substantiated section 213(d) medical care expenses incurred by the employee, or by the employee's spouse or dependents. A health FSA may be limited to a subset of permitted section 213(d) medical expenses (for example, a health FSA is permitted to exclude reimbursement of over-the-counter drugs described in Rev. Rul. 2003–102 (2003–2 CB 559), see § 601.601(d)(2)(ii)(*b*)). Similarly, a health FSA may be an HSA-compatible limited-purpose health FSA or post-deductible health FSA. Rev. Rul. 2004–45 (2004–1 CB 971), see § 601.601(d)(2)(ii)(*b*), amplified, Notice 2005–86 (2005–2 CB 1075). A health FSA may not reimburse premiums for accident and health insurance or long-term care insurance. See section 125(f).

A health FSA must satisfy all requirements of section 105(b), §§ 1.105–1 and 1.105–2. The section 105(h) nondiscrimination rules apply to health FSAs. All medical expenses must be substantiated before expenses are reimbursed. See *Incurring and reimbursing expenses for qualified* benefits, discussed in this preamble. The new proposed regulations also clarify when medical expenses are incurred.[1] A cafeteria plan may limit enrollment in a health FSA to those employees who participate in the employer's accident and health plan.

Qualified HSA Distributions

Section 106(e), enacted in section 302 of the Health Opportunity Patient Empowerment Act of 2006, Public Law 109–432 (120 Stat. 2922 (2006)) allows "qualified HSA distributions" from health FSAs to HSAs. Section 106(e) applies to distributions between December 20, 2006 and December 31, 2011. The proposed regulations incorporate the rules on qualified HSA distributions set forth in Notice 2007–22 (2007–10 IRB 670). See § 601.601(d)(2)(ii)(b).

Dependent Care Assistance After Termination

A new optional rule permits an employer to reimburse a terminated employee's qualified dependent care expenses incurred after termination through a dependent care FSA, if all section 129 requirements are otherwise satisfied.

Experience Gains

If an employee fails to use all contributions and benefits for a plan year before the end of the plan year (and the grace period, if applicable), those unused contributions and benefits are forfeited under the use-or-lose rule. Unused amounts are also known as experience gains. The new proposed regulations retain the forfeiture allocation rules in the 1989 proposed regulations, and clarify that the employer sponsoring the cafeteria plan may retain forfeitures, use forfeitures to defray expenses of administering the plan or allocate forfeitures among employees contributing through salary reduction on a reasonable and uniform basis.

FSA Administrative Rules

Salary reduction contributions may be made at whatever interval the employer selects, including ratably over the plan year based on the employer's payroll periods or in equal installments at other regular intervals (for example, quarterly installments). These rules must apply uniformly to all participants.

IV. New Prop. § 1.125–6—Substantiation of Expenses for All Cafeteria Plans

Incurring and Reimbursing Expenses for Qualified Benefits

The new proposed regulations provide that only expenses for qualified benefits incurred after the later of the effective date or the adoption date of the cafeteria plan are permitted to be reimbursed under the cafeteria plan. Similarly, if a plan amendment adds a new qualified benefit, only expenses incurred after the later of the effective date or the adoption date are eligible for reimbursement.[2] This rule applies to all qualified benefits. Similarly, a cafeteria plan may pay or reimburse only expenses for qualified benefits incurred during a participant's period of coverage.

Substantiation and Reimbursement of Expenses for Qualified Benefits

The new proposed regulations provide, after an employee incurs an expense for a qualified benefit during the coverage period, the expense must first be substantiated before the expense may be paid or reimbursed. All expenses must be substantiated (substantiating only a limited number of total claims, or not substantiating claims below a certain dollar amount does not satisfy the requirements in the new proposed regulations). See § 1.105–2; Rul. 2003–80; Rev. Rul. 2003–43 (2002–1 CB 935), see § 601.601(d)(2)(ii)(*b*); Notice 2006–69 (2006–31 IRB 107), Notice 2007–2 (2007–2 IRB 254). FSAs for dependent care assistance and adoption assistance must follow the substantiation procedures applicable to health FSAs.

Debit Cards

The new proposed regulations incorporate previously issued guidance on substantiating, paying and reimbursing expenses for section 213(d) medical care incurred at a medical care provider when payment is made with a debit card. Rev. Rul. 2003–43 (2003–1 CB 935), amplified, Notice 2006–69 (2006–31 IRB 107), Notice 2007–2 (2007–2 IRB 254); Rev. Proc. 98–25 (1998–1 CB 689), see § 601.601(d)(2)(ii)(*b*). Among the permissible substantiation methods are copayment matches, recurring expenses, and real-time substantiation. The new proposed regulations also allow point-of-sale substantiation through matching inventory information with a list of section 213(d) medical expenses. The employer is responsible for ensuring that the inventory information approval system complies with the new regulations and with the recordkeeping requirements in section 6001. Rev. Rul. 2003–43 (2003–1 CB 935), amplified, Notice 2006–69 (2006–31 IRB 107), Notice 2007–2 (2007–2 IRB 254); Rev. Proc. 98–25 (1998–1 CB 689), see § 601.601(d)(2)(ii)(*b*). The new proposed regulations also provide rules under which an FSA may pay or reimburse dependent care expenses using debit cards.

Pursuant to prior guidance (in Notice 2006–69 (2006–31 IRB 107), amplified, Notice 2007–2 (2007–2 IRB 254)), for plan years beginning after December 31, 2006, the recordkeeping requirements described in paragraph (f) in § 1.125–6 apply (that is, responsibility of employers relying on the inventory information approval system for health

[1] See Rev. Rul. 2005–55 (2005–2 CB 284) and Rev. Rul. 2005–24 (2005–1 CB 892), see § 601.601(d)(2)(ii)(*b*) (section 105(b) exclusion only applicable to reimbursements for medical expenses incurred by employee, or by the employee's spouse or dependents); Rev. Rul. 2002–3 (2002–1 CB 316) (purported reimbursements to employees of health insurance premiums not paid by employees and therefore impermissible); Rev. Rul. 2002–80 (2002–2 CB 925), see § 601.601(d)(2)(ii)(*b*) (so-called advance reimbursements and purported loans are impermissible); Rev. Rul. 2003–43 (2003–1 CB 935), see § 601.601(d)(2)(ii)(*b*); Notice 2006–69 (2006–31 IRB 107) (substantiation requirements for debit cards), amplified in Notice 2007–2 (2007–2 IRB 254), see § 601.601(d)(2)(ii)(*b*).

[2] *See American Family Mut. Ins. Co.* v. *United States*, 815 F. Supp. 1206 (W.D. Wis. 1992); *Wollenberg* v. *United States*, 75 F. Supp.2d 1032 (D. Neb. 1999); Rev. Rul. 2002–58 (2002–2 CB 541), see § 601.601(d)(2)(ii)(*b*); Notice 97–9, section II (adoption assistance).

FSA debit cards to ensure that the system complies with the new proposed recordkeeping requirements, including Rev. Proc. 98–25 (1998–1 CB 689), Notice 2006–69 (2006–31 IRB 107), amplified, Notice 2007–2 (2007–2 IRB 254). For health FSA debit card transactions occurring on or before December 31, 2007, all supermarkets, grocery stores, discount stores and wholesale clubs that do not have a medical care merchant category code (as described in Rev. Rul. 2003–43 (2003–2 CB 935) are nevertheless deemed to be an "other medical provider" as described in Rev. Rul. 2003–43. (For a list of merchant category codes, see Rev. Proc. 2004–43 (2004–2 CB 124).) During this time period, mail-order vendors and web-based vendors that sell prescription drugs are also deemed to be an "other medical provider" as described in Rev. Rul. 2003–43. After December 31, 2008, health FSA debit cards may not be used at stores with the Drug Stores and Pharmacies merchant category code unless (1) the store participates in the inventory information approval system described in Notice 2006–69, or (2) on a store location by store location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care under section 213(d) (including nonprescription medications described in Rev. Rul. 2003–102 (2003–2 CB 559)). Notice 2006–69 (2006–31 IRB 107), amplified, Notice 2007–2 (2007–2 IRB 254).

V. New Prop. § 1.125–7—Nondiscrimination Rules

Discriminatory benefits provided to highly compensated participants and individuals and key employees are included in these employees' gross income. See section 125(b), (c). The new proposed regulations reflect changes in tax law since Prop. § 1.125–1, Q & A–9 through 13 and 19 were proposed in 1984, including the key employee concentration test, statutory nontaxable benefits (enacted in the Deficit Reduction Act of 1984 (DEFRA), Public Law 98–369, section 531(b), (98 Stat. 881(1984)), and the change in definition of dependent in WFTRA.

The new proposed regulations provide additional guidance on the cafeteria plan nondiscrimination rules, including definitions of key terms, guidance on the eligibility test and the contributions and benefits tests, descriptions of employees allowed to be excluded from testing and a safe harbor nondiscrimination test for premium-only-plans.

Specifically, the new proposed regulations define several key terms, including highly compensated individual or participant (consistent with the section 414(q) definition of highly compensated employee), officer, five percent shareholder, key employee and compensation. The new proposed regulations also provide guidance on the nondiscrimination as to eligibility requirement by incorporating some of the rules under section 410(b) (specifically the rules under § 1.410(b)–4(b) and (c) dealing with reasonable classification, the safe harbor percentage test and the unsafe harbor percentage component of the facts and circumstances test).

The new proposed regulations also provide additional guidance on the contributions and benefits test and, unlike the prior proposed regulations, the new proposed regulations provide an objective test to determine when the actual election of benefits is discriminatory. Specifically, the new proposed regulations provide that a cafeteria plan must give each similarly situated participant a uniform opportunity to elect qualified benefits, and that highly compensated participants must not actually disproportionately elect qualified benefits. Finally, the new rules provide guidance on the safe harbor for cafeteria plans providing health benefits and create a safe harbor for premium-only-plans that satisfy certain requirements.

The example in Prop. § 1.125–1, Q & A–11 (1984) is deleted because it concerns a qualified legal services plan, which is no longer a qualified benefit.

Other Issues

These proposed regulations provide guidance under section 125 (26 U.S.C. 125). Other statutes may impose additional requirements (for example, the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1000), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), (sections 9801–9803); and the continuation coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (section 4980B).

Proposed Effective Date

With the exceptions noted in the "Effect on other documents" section of this preamble and under the "Debit cards" section of the preamble, it is proposed that these regulations apply for plan years beginning on or after January 1, 2009. Taxpayers may rely on these regulations for guidance pending the issuance of final regulations. Prior published guidance on qualified benefits under sections 79, 105, 106, 129, 137 and 223 that is affected by these proposed regulations remains applicable through the effective date of the final regulations (except as modified in "Effect on other documents" section of this preamble).

Effect on Other Documents

Notice 89–110 (1989–2 CB 447), see § 601.601(d)(2)(ii)(*b*), states that where group-term life insurance provided to an employee by an employer exceeds $50,000, the employee includes in gross income the greater of the cost of group-term life insurance shown in § 1.79–3(d)(2), Table I (Table I) on the excess coverage or the employee's salary reduction and employer flex-credits for excess coverage. Notice 89–110 is modified, effective as of the date the proposed regulations are published in the **Federal Register**.

Published guidance under § 105(b) states that if any person has the right to receive cash or any other taxable or nontaxable benefit under a health FSA other than the reimbursement of section 213(d) medical expenses of the employee, employee's spouse or employee's dependents, then all distributions made from the arrangement are included in the employee's gross income, even amounts paid to reimburse medical care. See Rev. Rul. 2006–36 (2006–36 IRB 353); Rev. Rul. 2005–24 (2005–1 CB 892); Rev. Rul. 2003–102 (2003–2 CB 559); Notice 2002–45 (2002–2 CB 93); Rev. Rul. 2002–41 (2002–2 CB 75); Rev. Rul. 69–141 (1969–1 CB 48). New section 106(e) provides that a health FSA will not fail to satisfy the requirements of sections 105 or 106 merely because the plan provides for a qualified HSA distribution. Amounts rolled into an HSA may be used for purposes other than reimbursing the section 213(d) medical expenses of the employee, spouse or dependents. Accordingly, Rev. Rul. 2006–36, Rev. Rul. 2005–24, Rev. Rul. 2003–102, Notice 2002–45, Rev. Rul. 2002–41, and Rev. Rul. 69–141 are modified with respect to qualified HSA distributions described in section 106(e). See Notice 2007–22 (2007–10 IRB 670), see § 601.601(d)(2)(ii)(*b*).

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this regulation. It is hereby certified that the collection of information in this regulation will not have a significant economic impact on a substantial

number of small entities. This certification is based on the fact that the regulations will only minimally increase the burdens on small entities. The requirements under these regulations relating to maintaining a section 125 cafeteria plan are a minimal additional burden independent of the burdens encompassed under existing rules for underlying employee benefit plans, which exist whether or not the benefits are provided through a cafeteria plan. In addition, most small entities that will maintain cafeteria plans already use a third-party plan administrator to administer the cafeteria plan. The collection of information required in these regulations, which is required to comply with the existing substantiation requirements of sections 105, 106, 129 and 125, and the recordkeeping requirements of section 6001, will only minimally increase the third-party administrator's burden with respect to the cafeteria plan. Therefore, an analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Internal Revenue Code, this proposed regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. The IRS and Treasury Department specifically request comments on the clarity of the proposed rules and how they can be made easier to understand. In addition, comments are requested on the following issues:

1. Whether, consistent with section 125 of the Internal Revenue Code, multiple employers (other than members of a controlled group described in section 125(g)(4)) may sponsor a single cafeteria plan;
2. Whether salary reduction contributions may be based on employees' tips and how that would work;
3. For cafeteria plans adopting the change in status rules in § 1.125–4, when a participant has a change in status and changes his or her salary reduction amount, how should the participant's uniform coverage amount be computed after the change in status.

All comments will be available for public inspection and copying.

A public hearing has been scheduled for November 15, 2007, beginning at 10 a.m. in the Auditorium, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 30 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the **FOR FURTHER INFORMATION CONTACT** section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit written or electronic comments and an outline of the topics to be discussed and the amount of time to be devoted to each topic (a signed original and eight (8) copies) by October 25, 2007. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal author of these proposed regulations is Mireille T. Khoury, Office of Division Counsel/ Associate Chief Counsel (Tax Exempt and Government Entities), Internal Revenue Service. However, personnel from other offices of the IRS and Treasury Department participated in their development.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Withdrawal of Proposed Regulations

Accordingly, under the authority of 26 U.S.C. 7805, the notice of proposed rulemaking (EE–16–79) that was published in the **Federal Register** on Monday, May 7, 1984 (49 FR 19321), and Monday, December 31, 1984 (49 FR 50733), the notice of proposed rulemaking (EE–130–86) that was published in the **Federal Register** on Tuesday, March 7, 1989 (54 FR 9460), and Friday, November 7, 1997 (62 FR 60196) and the notice of proposed rulemaking (REG–117162–99) that was published in the **Federal Register** on Thursday, March 23, 2000 (65 FR 15587) are withdrawn.

Proposed Amendment to the Regulations

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 continues to read, in part, as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Sections 1.125–0, 1.125–1 and 1.125–2 are added to read as follows:

§ 1.125–0 Table of contents.

This section lists captions contained in §§ 1.125–1, 1.125–2, 1.125–5, 1.125–6 and § 1.125–7.

§ 1.125–1 Cafeteria plans; general rules.

(a) Definitions.
(b) General rules.
(c) Written plan requirements.
(d) Plan year requirements.
(e) Grace period.
(f) Run-out period.
(g) Employee for purpose of Section 125.
(h) After-tax employee contributions.
(i) Prohibited taxable benefits.
(j) Coordination with other rules.
(k) Group-term life insurance.
(l) COBRA premiums.
(m) Payment or reimbursement of employees' individual accident and health insurance premiums.
(n) Section 105 rules for accident and health plan offered through a cafeteria plan.
(o) Prohibition against deferred compensation.
(p) Benefits relating to more than one year.
(q) Nonqualified benefits.
(r) Employer contributions to a cafeteria plan.
(s) Effective/applicability date.

§ 1.125–2 Cafeteria plans; elections.

(a) Rules relating to making elections and revoking elections.
(b) Automatic elections.
(c) Election rules for salary reduction contributions to HSAs.
(d) Optional election for new employees.
(e) Effective/applicability date.

§ 1.125–5 Flexible spending arrangements.

(a) Definition of flexible spending arrangement.
(b) Flex-credits allowed.
(c) Use-or-lose rule.
(d) Uniform coverage rules applicable to health FSAs.
(e) Required period of coverage for a health FSA, dependent care FSA and adoption assistance FSA.
(f) Coverage on a month-by-month or expense-by-expense basis prohibited.
(g) FSA administrative practices.
(h) Qualified benefits permitted to be offered through a FSA.
(i) Section 129 rules for dependent care assistance program offered through a cafeteria plan.
(j) Section 137 rules for adoption assistance program offered through a cafeteria plan.
(k) FSAs and the rules governing the tax-favored treatment of employer-provided health benefits.
(l) Section 105(h) requirements.
(m) HSA-compatible FSAs-limited-purpose health FSAs and post-deductible health FSAs.

(n) Qualified HSA distributions.
(o) FSA experience gains or forfeitures.
(p) Effective/applicability date.

§ 1.125–6 Substantiation of expenses for all cafeteria plans.

(a) Cafeteria plan payments and reimbursements.
(b) Rules for claims substantiation for cafeteria plans.
(c) Debit cards—overview.
(d) Mandatory rules for all debit cards usable to pay or reimburse medical expenses.
(e) Substantiation of expenses incurred at medical care providers and certain other stores with Drug Stores and Pharmacies merchant category code.
(f) Inventory information approval system.
(g) Debit cards used to pay or reimburse dependent care assistance.
(h) Effective/applicability date.

§ 1.125–7 Cafeteria plan nondiscrimination rules.

(a) Definitions.
(b) Nondiscrimination as to eligibility.
(c) Nondiscrimination as to contributions and benefits.
(d) Key employees.
(e) Section 125(g)(2) safe harbor for cafeteria plans providing health benefits.
(f) Safe harbor test for premium-only-plans.
(g) Permissive disaggregation for nondiscrimination testing.
(h) Optional aggregation of plans for nondiscrimination testing.
(i) Employees of certain controlled groups.
(j) Time to perform nondiscrimination testing.
(k) Discrimination in actual operation prohibited.
(l) Anti-abuse rule.
(m) Tax treatment of benefits in a cafeteria plan.
(n) Employer contributions to employees' Health Savings Accounts.
(o) Effective/applicability date.

§ 1.125–1 Cafeteria plans; general rules.

(a) *Definitions.* The definitions set forth in this paragraph (a) apply for purposes of section 125 and the regulations.

(1) The term *cafeteria plan* means a separate written plan that complies with the requirements of section 125 and the regulations, that is maintained by an employer for the benefit of its employees and that is operated in compliance with the requirements of section 125 and the regulations. All participants in a cafeteria plan must be employees. A cafeteria plan must offer at least one permitted taxable benefit (as defined in paragraph (a)(2) of this section) and at least one qualified benefit (as defined in paragraph (a)(3) of this section). A cafeteria plan must not provide for deferral of compensation (except as specifically permitted in paragraph (o) of this section).

(2) The term *permitted taxable benefit* means cash and certain other taxable benefits treated as cash for purposes of section 125. For purposes of section 125, *cash* means cash compensation (including salary reduction), payments for annual leave, sick leave, or other paid time off and severance pay. A distribution from a trust described in section 401(a) is not cash for purposes of section 125. *Other taxable benefits treated as cash* for purposes of section 125 are:

(i) Property;

(ii) Benefits attributable to employer contributions that are currently taxable to the employee upon receipt by the employee; and

(iii) Benefits purchased with after-tax employee contributions, as described in paragraph (h) of this section.

(3) *Qualified benefit.* Except as otherwise provided in section 125(f) and paragraph (q) of this section, the term *qualified benefit* means any benefit attributable to employer contributions to the extent that such benefit is not currently taxable to the employee by reason of an express provision of the Internal Revenue Code (Code) and which does not defer compensation (except as provided in paragraph (o) of this section). The following benefits are qualified benefits that may be offered under a cafeteria plan and are excludible from employees' gross income when provided in accordance with the applicable provisions of the Code—

(A) Group-term life insurance on the life of an employee in an amount that is less than or equal to the $50,000 excludible from gross income under section 79(a), but not combined with any permanent benefit within the meaning of § 1.79–0;

(B) An accident and health plan excludible from gross income under section 105 or 106, including self-insured medical reimbursement plans (such as health FSAs described in § 1.125–5);

(C) Premiums for COBRA continuation coverage (if excludible 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;

(D) An accidental death and dismemberment insurance policy (section 106);

(E) Long-term or short-term disability coverage (section 106);

(F) Dependent care assistance program (section 129);

(G) Adoption assistance (section 137);

(H) A qualified cash or deferred arrangement that is part of a profit-sharing plan or stock bonus plan, as described in paragraph (o)(3) of this section (section 401(k));

(I) Certain plans maintained by educational organizations (section 125(d)(2)(C) and paragraph (o)(3)(iii) of this section); and

(J) Contributions to Health Savings Accounts (HSAs) (sections 223 and 125(d)(2)(D)).

(4) *Dependent.* The term *dependent* generally means a dependent as defined in section 152. However, the definition of dependent is modified to conform with the underlying Code section for the qualified benefit. For example, for purposes of a benefit under section 105, the term dependent means a dependent as defined in section 152, determined without regard to section 152(b)(1), (b)(2) or (d)(1)(B).

(5) *Premium-only-plan.* A *premium-only-plan* is a cafeteria plan that offers as its sole benefit an election between cash (for example, salary) and payment of the employee share of the employer-provided accident and health insurance premium (excludible from the employee's gross income under section 106).

(b) *General rules*—(1) *Cafeteria plans.* Section 125 is the exclusive means by which an employer can offer employees an election between taxable and nontaxable benefits without the election itself resulting in inclusion in gross income by the employees. Section 125 provides that cash (including certain taxable benefits) offered to an employee through a nondiscriminatory cafeteria plan is not includible in the employee's gross income merely because the employee has the opportunity to choose among cash and qualified benefits (within the meaning of section 125(e)) through the cafeteria plan. Section 125(a), (d)(1). However, if a plan offering an employee an election between taxable benefits (including cash) and nontaxable qualified benefits does not meet the section 125 requirements, the election between taxable and nontaxable benefits results in gross income to the employee, regardless of what benefit is elected and when the election is made. An employee who has an election among nontaxable benefits and taxable benefits (including cash) that is not through a cafeteria plan that satisfies section 125 must include in gross income the value of the taxable benefit with the greatest value that the employee could have elected to receive, even if the employee elects to receive only the nontaxable benefits offered. The amount of the taxable benefit is includible in the

employee's income in the year in which the employee would have actually received the taxable benefit if the employee had elected such benefit. This is the result even if the employee's election between the nontaxable benefits and taxable benefits is made prior to the year in which the employee would actually have received the taxable benefits. See paragraph (q) in § 1.125–1 for nonqualified benefits.

(2) *Nondiscrimination rules for qualified benefits.* Accident and health plan coverage, group-term life insurance coverage, and benefits under a dependent care assistance program or adoption assistance program do not fail to be qualified benefits under a cafeteria plan merely because they are includible in gross income because of applicable nondiscrimination requirements (for example, sections 79(d), 105(h),129(d), 137(c)(2)). See also §§ 1.105–11(k) and 1.125–7.

(3) *Examples.* The following examples illustrate the rules of paragraph (b)(1) of this section.

Example 1. Distributions from qualified pension plan used for health insurance premiums. (i) Employer A maintains a qualified section 401(a) retirement plan for employees. Employer A also provides accident and health insurance (as described in section 106) for employees and former employees, their spouses and dependents. The health insurance premiums are partially paid through a cafeteria plan. None of Employer A's employees are public safety officers. Employer A's health plan allows former employees to elect to have distributions from the qualified retirement plan applied to pay for the health insurance premiums through the cafeteria plan.

(ii) Amounts distributed from the qualified retirement plan which the former employees elect to have applied to pay health insurance premiums through the cafeteria plan are includible in their gross income. The same result occurs if distributions from the qualified retirement plan are applied directly to reimburse section 213(d) medical care expenses incurred by a former employee or his or her spouse or dependents. These distributions are includible in their income, and are not cash for purposes of section 125. The plan is not a cafeteria plan with respect to former employees.

Example 2. Severance pay used to pay COBRA premiums. Employer B maintains a cafeteria plan, which offers employees an election between cash and employer-provided accident and health insurance (excludible from employees' gross income under section 106). Employer B pays terminating employees severance pay. The cafeteria plan also allows a terminating employee to elect between receiving severance pay and using the severance pay to pay the COBRA premiums for the accident and health insurance. These provisions in the cafeteria plan are consistent with the requirements in section 125.

(4) *Election by participants*—(i) *In general.* A cafeteria plan must offer participants the opportunity to elect between at least one permitted taxable benefit and at least one qualified benefit. For example, if employees are given the opportunity to elect only among two or more nontaxable benefits, the plan is not a cafeteria plan. Similarly, a plan that only offers the election among salary, permitted taxable benefits, paid time off or other taxable benefits is not a cafeteria plan. See section 125(a), (d). See § 1.125–2 for rules on elections.

(ii) *Premium-only-plan.* A cafeteria plan may be a premium-only-plan.

(iii) *Examples.* The following examples illustrate the rules of paragraph (b)(4)(i) of this section.

Example 1. No election. Employer C covers all its employees under its accident and health plan (excludible from employees' gross income under section 106). Coverage is mandatory (that is, employees have no election between cash and the Employer C's accident and health plan). This plan is not a cafeteria plan, because the plan offers employees no election between taxable and nontaxable benefits. The accident and health coverage is excludible from employees' gross income.

Example 2. Election between cash and at least one qualified benefit. Employer D offers its employees a plan with an election between cash and an employer-provided accident and health plan (excludible from employees' gross income under section 106). If the plan also satisfies all the other requirements of section 125, the plan is a cafeteria plan because it offers an election between at least one taxable benefit and at least one nontaxable qualified benefit.

Example 3. Election between employer flex-credits and qualified benefits. Employer E offers its employees an election between an employer flex-credit (as defined in paragraph (b) in § 1.125–5) and qualified benefits. If an employee does not elect to apply the entire employer flex-credit to qualified benefits, the employee will receive no cash or other taxable benefit for the unused employer flex-credit. The plan is not a cafeteria plan because it does not offer an election between at least one taxable benefit and at least one nontaxable qualified benefit.

Example 4. No election between cash and qualified benefits for certain employees. (i) Employer F maintains a calendar year plan offering employer-provided accident and health insurance coverage which includes employee-only and family coverage options.

(ii) The plan provides for an automatic enrollment process when a new employee is hired, or during the annual election period under the plan: only employees who certify that they have other health coverage are permitted to elect to receive cash. Employees who cannot certify are covered by the accident and health insurance on a mandatory basis. Employer F does not otherwise request or collect information from employees regarding other health coverage as part of the enrollment process. If the employee has a spouse or child, the employee can elect between cash and family coverage.

(iii) When an employee is hired, the employee receives a notice explaining the plan's automatic enrollment process. The notice includes the salary reduction amounts for employee-only coverage and family coverage, procedures for certifying whether the employee has other health coverage, elections for family coverage, information on the time by which a certification or election must be made, and the period for which a certification or election will be effective. The notice is also given to each current employee before the beginning of each plan year, (except that the notice for a current employee includes a description of the employee's existing coverage, if any).

(iv) For a new employee, an election to receive cash or to have family coverage is effective if made when the employee is hired. For a current employee, an election is effective if made prior to the start of each calendar year or under any other circumstances permitted under § 1.125–4. An election for any prior year carries over to the next succeeding plan year unless changed. Certification that the employee has other health coverage must be made annually.

(v) Contributions used to purchase employer-provided accident and health coverage under section 125 are not includible in an employee's gross income if the employee can elect cash. Section 125 does not apply to the employee-only coverage of an employee who cannot certify that he or she has other health coverage and, therefore, does not have the ability to elect cash in lieu of health coverage.

(5) *No deferred compensation.* Except as provided in paragraph (o) of this section, in order for a plan to be a cafeteria plan, the qualified benefits and the permitted taxable benefits offered through the cafeteria plan must not defer compensation. For example, a cafeteria plan may not provide for retirement health benefits for current employees beyond the current plan year or group-term life insurance with a permanent benefit, as defined under § 1.79–0.

(c) *Written plan requirements*—(1) *General rule.* A cafeteria plan must contain in writing the information described in this paragraph (c), and depending on the qualified benefits offered in the plan, may also be required to contain additional information described in paragraphs (c)(2) and (c)(3) of this section. The cafeteria plan must be adopted and effective on or before the first day of the cafeteria plan year to which it relates. The terms of the plan must apply uniformly to all participants. The cafeteria plan document may be comprised of multiple documents. The written cafeteria plan must contain all of the following information—

(i) A specific description of each of the benefits available through the plan, including the periods during which the benefits are provided (the periods of coverage);

(ii) The plan's rules governing participation, and specifically requiring that all participants in the plan be employees;

(iii) The procedures governing employees' elections under the plan, including the period when elections may be made, the periods with respect to which elections are effective, and providing that elections are irrevocable, except to the extent that the optional change in status rules in § 1.125–4 are included in the cafeteria plan;

(iv) The manner in which employer contributions may be made under the plan, (for example, through an employee's salary reduction election or by nonelective employer contributions (that is, flex-credits, as defined in paragraph (b) in § 1.125–5) or both);

(v) The maximum amount of employer contributions available to any employee through the plan, by stating:

(A) The maximum amount of elective contributions (*i.e.*, salary reduction) available to any employee through the plan, expressed as a maximum dollar amount or a maximum percentage of compensation or the method for determining the maximum dollar amount; and

(B) For contributions to section 401(k) plans, the maximum amount of elective contributions available to any employee through the plan, expressed as a maximum dollar amount or maximum percentage of compensation that may be contributed as elective contributions through the plan by employees.

(vi) The plan year of the cafeteria plan;

(vii) If the plan offers paid time off, the required ordering rule for use of nonelective and elective paid time off in paragraph (o)(4) of this section;

(viii) If the plan includes flexible spending arrangements (as defined in § 1.125–5(a)), the plan's provisions complying with any additional requirements for those FSAs (for example, the uniform coverage rule and the use-or-lose rules in paragraphs (d) and (c) in § 1.125–5);

(ix) If the plan includes a grace period, the plan's provisions complying with paragraph (e) of this section; and

(x) If the plan includes distributions from a health FSA to employees' HSAs, the plan's provisions complying with paragraph (n) in § 1.125–5.

(2) *Additional requirements under sections 105(h), 129, and 137.* A written plan is required for self-insured medical reimbursement plans (§ 1.105–11(b)(1)(i)), dependent care assistance programs (section 129(d)(1)), and adoption assistance (section 137(c)). Any of these plans or programs offered through a cafeteria plan that satisfies the written plan requirement in this paragraph (c) for the benefits under these plans and programs also satisfies the written plan requirements in § 1.105–11(b)(1)(i), section 129(d)(1), and section 137(c) (whichever is applicable). Alternatively, a self-insured medical reimbursement plan, a dependent care assistance program, or an adoption assistance program is permitted to satisfy the requirements in § 1.105–11(b)(1)(i), section 129(d)(1), or section 137(c) (whichever is applicable) through a separate written plan, and not as part of the written cafeteria plan.

(3) *Additional requirements under section 401(k).* See § 1.401(k)–1(e)(7) for additional requirements that must be satisfied in the written plan if the plan offers deferrals into a section 401(k) plan.

(4) *Cross-reference allowed.* In describing the benefits available through the cafeteria plan, the written cafeteria plan need not be self-contained. For example, the written cafeteria plan may incorporate by reference benefits offered through other *separate written plans,* such as a section 401(k) plan, or coverage under a dependent care assistance program (section 129), without describing in full the benefits established through these other plans. But, for example, if the cafeteria plan offers different maximum levels of coverage for dependent care assistance programs, the descriptions in the separate written plan must specify the available maximums.

(5) *Amendments to cafeteria plan.* 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.

(6) *Failure to satisfy written plan requirements.* If there is no written cafeteria plan, or if the written plan fails to satisfy any of the requirements in this paragraph (c) (including cross-referenced requirements), the plan is not a cafeteria plan and an employee's election between taxable and nontaxable benefits results in gross income to the employee.

(7) *Operational failure—(i)* In general. 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.

(ii) *Failure to operate according to written cafeteria plan or section 125.* Examples of failures resulting in section 125 not applying to a plan include the following—

(A) Paying or reimbursing expenses for qualified benefits incurred before the later of the adoption date or effective date of the cafeteria plan, before the beginning of a period of coverage or before the later of the date of adoption or effective date of a plan amendment adding a new benefit;

(B) Offering benefits other than permitted taxable benefits and qualified benefits;

(C) Operating to defer compensation (except as permitted in paragraph (o) of this section);

(D) Failing to comply with the uniform coverage rule in paragraph (d) in § 1.125–5;

(E) Failing to comply with the use-or-lose rule in paragraph (c) in § 1.125–5;

(F) Allowing employees to revoke elections or make new elections, except as provided in § 1.125–4 and paragraph (a) in § 1.125–2;

(G) Failing to comply with the substantiation requirements of § 1.125–6;

(H) Paying or reimbursing expenses in an FSA other than expenses expressly permitted in paragraph (h) in § 1.125–5;

(I) Allocating experience gains other than as expressly permitted in paragraph (o) in § 1.125–5;

(J) Failing to comply with the grace period rules in paragraph (e) of this section; or

(K) Failing to comply with the qualified HSA distribution rules in paragraph (n) in § 1.125–5.

(d) *Plan year requirements*—(1) *Twelve consecutive months.* The plan year must be specified in the cafeteria plan. The plan year of a cafeteria plan must be twelve consecutive months, unless a short plan year is allowed under this paragraph (d). A plan year is permitted to begin on any day of any calendar month and must end on the preceding day in the immediately following year (for example, a plan year that begins on October 15, 2007, must end on October 14, 2008). A calendar year plan year is a period of twelve consecutive months beginning on January 1 and ending on December 31 of the same calendar year. A plan year

specified in the cafeteria plan is effective for the first plan year of a cafeteria plan and for all subsequent plan years, unless changed as provided in paragraph (d)(2) of this section.

(2) *Changing plan year.* The plan year is permitted to be changed only for a valid business purpose. A change in the plan year is not permitted if a principal purpose of the change in plan year is to circumvent the rules of section 125 or these regulations. If a change in plan year does not satisfy this subparagraph, the attempt to change the plan year is ineffective and the plan year of the cafeteria plan remains the same.

(3) *Short plan year.* A short plan year of less than twelve consecutive months is permitted for a valid business purpose.

(4) *Examples.* The following examples illustrate the rules in paragraph (d) of this section:

Example 1. Employer with calendar year. Employer G, with a calendar taxable year, first establishes a cafeteria plan effective July 1, 2009. The cafeteria plan specifies a calendar plan year. The first cafeteria plan year is the period beginning on July 1, 2009, and ending on December 31, 2009. Employer G has a business purpose for a short first cafeteria plan year.

Example 2. Employer changes insurance carrier. Employer H establishes a cafeteria plan effective January 1, 2009, with a calendar year plan year. The cafeteria plan offers an accident and health plan through Insurer X. In March 2010, Employer H contracts to provide accident and health insurance through another insurance company, Y. Y's accident and health insurance is offered on a July 1–June 30 benefit year. Effective July 1, 2010, Employer H amends the plan to change to a July 1–June 30 plan year. Employer H has a business purpose for changing the cafeteria plan year and for the short plan year ending June 30, 2010.

(5) *Significance of plan year.* The plan year generally is the coverage period for benefits provided through the cafeteria plan to which annual elections for these benefits apply. Benefits elected pursuant to the employee's election for a plan year generally may not be carried forward to subsequent plan years. However, see the grace period rule in paragraph (e) of this section.

(e) *Grace period*—(1) *In general.* A cafeteria plan may, at the employer's option, include a grace period of up to the fifteenth day of the third month immediately following the end of each plan year. If a cafeteria plan provides for a grace period, an employee who has unused benefits or contributions relating to a qualified benefit (for example, health flexible spending arrangement (health FSA) or dependent care assistance) from the immediately preceding plan year, and who incurs expenses for that same qualified benefit during the grace period, may be paid or reimbursed for those expenses from the unused benefits or contributions as if the expenses had been incurred in the immediately preceding plan year. A grace period is available for all qualified benefits described in paragraph (a)(3) of this section, except that the grace period does not apply to paid time off and elective contributions under a section 401(k) plan. The effect of the grace period is that the employee may have as long as 14 months and 15 days (that is, the 12 months in the current cafeteria plan year plus the grace period) to use the benefits or contributions for a plan year before those amounts are *forfeited* under the *use-or-lose* rule in paragraph (c) in § 1.125–5. If the grace period is added to a cafeteria plan through an amendment, all requirements in paragraph (c) of this section must be satisfied.

(2) *Grace period optional features.* A grace period provision may contain any or all of the following—

(i) The grace period may apply to some qualified benefits described in paragraph (a)(3) of this section, but not to others;

(ii) The grace period provision may limit the amount of unused benefits or contributions available during the grace period. The limit must be uniform and apply to all participants. However, the limit must not be based on a percentage of the amount of the unused benefits or contributions remaining at the end of the immediately prior plan year;

(iii) The last day of the grace period may be sooner than the fifteenth day of the third month immediately following the end of the plan year (that is, the grace period may be shorter than two and one half months);

(iv) The grace period provision is permitted to treat expenses for qualified benefits incurred during the grace period either as expenses incurred during the immediately preceding plan year or as expenses incurred during the current plan year (for example, the plan may first apply the unused contributions or benefits from the immediately preceding year to pay or reimburse grace period expenses and then, when the unused contributions and benefits from the prior year are exhausted, the grace period expenses may be paid from current year contributions and benefits.); and

(v) The grace period provision may permit the employer to defer the allocation of expenses described in paragraph (e)(2)(iv) of this section until after the end of the grace period.

(3) *Grace period requirements.* A grace period must satisfy the requirements in paragraph (c) of this section and all of the following requirements:

(i) The grace period provisions in the cafeteria plan (including optional provisions in paragraph (e)(2) of this section) must apply uniformly to all participants in the cafeteria plan, determined as of the last day of the plan year. Participants in the cafeteria plan through COBRA and participants who were participants as of the last day of the plan year but terminate during the grace period are participants for purposes of the grace period. See § 54.4980B–2, Q & A–8 of this chapter;

(ii) The grace period provision in the cafeteria plan must state that unused benefits or contributions relating to a particular qualified benefit may only be used to pay or reimburse expenses incurred with respect to the same qualified benefit. For example, unused amounts elected to pay or reimburse medical expenses in a health FSA may not be used to pay or reimburse dependent care expenses incurred during the grace period; and

(iii) The grace period provision in the cafeteria plan must state that to the extent any unused benefits or contributions from the immediately preceding plan year exceed the expenses for the qualified benefit incurred during the grace period, those remaining unused benefits or contributions may not be carried forward to any subsequent period (including any subsequent plan year), cannot be cashed-out and must be forfeited under the use-or-lose rule. See paragraph (c) in § 1.125–5

(4) *Examples.* The following examples illustrate the rules in this paragraph (e).

Example 1. Expenses incurred during grace period and immediately following plan year. (i) Employer I's calendar year cafeteria plan includes a grace period allowing all participants to apply unused benefits or contributions remaining at the end of the plan year to qualified benefits incurred during the grace period immediately following that plan year. The grace period for the plan year ending December 31, 2009, ends on March 15, 2010.

(ii) Employee X timely elected salary reduction of $1,000 for a health FSA for the plan year ending December 31, 2009. As of December 31, 2009, X has $200 remaining unused in his health FSA. X timely elected salary reduction for a health FSA of $1,500 for the plan year ending December 31, 2010.

(iii) During the grace period from January 1 through March 15, 2010, X incurs $300 of unreimbursed medical expenses (as defined in section 213(d)). The unused $200 from the plan year ending December 31, 2009, is applied to pay or reimburse $200 of X's $300 of medical expenses incurred during the grace period. Therefore, as of March 16, 2010, X has no unused benefits or contributions

remaining for the plan year ending December 31, 2009.

(iv) The remaining $100 of medical expenses incurred between January 1 and March 15, 2010, is paid or reimbursed from X's health FSA for the plan year ending December 31, 2010. As of March 16, 2010, X has $1,400 remaining in the health FSA for the plan year ending December 31, 2010.

Example 2. Unused benefits exceed expenses incurred during grace period. Same facts as *Example 1*, except that X incurs $150 of section 213(d) medical expenses during the grace period (January 1 through March 15, 2010). As of March 16, 2010, X has $50 of unused benefits or contributions remaining for the plan year ending December 31, 2009. The unused $50 cannot be cashed-out, converted to any other taxable or nontaxable benefit, or used in any other plan year (including the plan year ending December 31, 2009). The unused $50 is subject to the use-or-lose rule in paragraph (c) in § 1.125–5 and is forfeited. As of March 16, 2010, X has the entire $1,500 elected in the health FSA for the plan year ending December 31, 2010.

Example 3. Terminated participants. (i) Employer J's cafeteria plan includes a grace period allowing all participants to apply unused benefits or contributions remaining at the end of the plan year to qualified benefits incurred during the grace period immediately following that plan year. For the plan year ending on December 31, 2009, the grace period ends March 15, 2010.

(ii) Employees A, B, C, and D each timely elected $1,200 salary reduction for a health FSA for the plan year ending December 31, 2009. Employees A and B terminated employment on September 15, 2009. Each has $500 of unused benefits or contributions in the health FSA.

(iii) Employee A elected COBRA for the health FSA. Employee A is a participant in the cafeteria plan as of December 31, 2009, the last day of the 2009 plan year. Employee A has $500 of unused benefits or contributions available during the grace period for the 2009 plan year (ending March 15, 2010).

(iv) Employee B did not elect COBRA for the health FSA. Employee B is not a participant in the cafeteria plan as of December 31, 2009. The grace period does not apply to Employee B.

(v) Employee C has $500 of unused benefits in his health FSA as of December 31, 2009, and terminated employment on January 15, 2010. Employee C is a participant in the cafeteria plan as of December 31, 2009 and has $500 of unused benefits or contributions available during the grace period ending March 15, 2010, even though he terminated employment on January 15, 2010.

(vi) Employee D continues to work for Employer H throughout 2009 and 2010, also has $500 of unused benefits or contributions in his health FSA as of December 31, 2009, but made no health FSA election for 2010. Employee D is a participant in the cafeteria plan as of December 31, 2009 and has $500 of unused benefits or contributions available during the grace period ending March 15, 2010, even though he is not a participant in a health FSA for the 2010 plan year.

(f) *Run-out period.* A cafeteria plan is permitted to contain a run-out period as designated by the employer. A run-out period is a period after the end of the plan year (or grace period) during which a participant can submit a claim for reimbursement for a qualified benefit incurred during the plan year (or grace period). Thus, a plan is also permitted to provide a deadline on or after the end of the plan year (or grace period) for submitting a claim for reimbursement for the plan year. Any run-out period must be provided on a uniform and consistent basis with respect to all participants.

(g) *Employee for purposes of section 125*—(1) *Current employees, former employees.* The term employee includes any current or former employee (including any laid-off employee or retired employee) of the employer. See paragraph (g)(3) of this section concerning limits on participation by former employees. Specifically, the term *employee* includes the following—

(i) Common law employee;

(ii) Leased employee described in section 414(n);

(iii) Full-time life insurance salesman (as defined in section 7701(a)(20)); and

(iv) A current employee or former employee described in paragraphs (g)(1)(i) through (iii) of this section.

(2) *Self-employed individual not an employee*—(i) *In general.* The term *employee* does not include a self-employed individual or a 2-percent shareholder of an S corporation, as defined in paragraph (g)(2)(ii) of this subsection. For example, a sole proprietor, a partner in a partnership, or a director solely serving on a corporation's board of directors (and not otherwise providing services to the corporation as an employee) is not an employee for purposes of section 125, and thus is not permitted to participate in a cafeteria plan. However, a sole proprietor may sponsor a cafeteria plan covering the sole proprietor's employees (but not the sole proprietor). Similarly, a partnership or S corporation may sponsor a cafeteria plan covering employees (but not a partner or 2-percent shareholder of an S corporation).

(ii) *Two percent shareholder of an S corporation.* A 2-percent shareholder of an S corporation has the meaning set forth in section 1372(b).

(iii) *Certain dual status individuals.* 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 corp), the individual is eligible to participate in that employer's cafeteria plan solely in his or her capacity as an employee. This rule does not apply to partners or to 2-percent shareholders of an S corporation.

(iv) *Examples.* The following examples illustrate the rules in paragraphs (g)(2)(ii) and (g)(2)(iii) of this section:

Example 1. Two-percent shareholders of an S corporation. (i) Employer K, an S corporation, maintains a cafeteria plan for its employees (other than 2-percent shareholders of an S corporation). Employer K's taxable year and the plan year are the calendar year. On January 1, 2009, individual Z owns 5 percent of the outstanding stock in Employer K. Y, who owns no stock in Employer K, is married to Z. Y and Z are employees of Employer K. Z is a 2-percent shareholder in Employer K (as defined in section 1372(b)). Y is also a 2-percent shareholder in Employer K by operation of the attribution rules in section 318(a)(1)(A)(i).

(ii) On July 15, 2009, Z sells all his stock in Employer K to an unrelated third party, and ceases to be a 2-percent shareholder. Y and Z continue to work as employees of Employer K during the entire 2009 calendar year. Y and Z are ineligible to participate in Employer K's cafeteria plan for the 2009 plan year.

Example 2. Director and employee. T is an employee and also a director of Employer L, a C corp that sponsors a cafeteria plan. The cafeteria plan allows only employees of Employer L to participate in the cafeteria plan. T's annual compensation as an employee is $50,000; T is also paid $3,000 annually in director's fees. T makes a timely election to salary reduce $5,000 from his employee compensation for dependent care benefits. T makes no election with respect to his compensation as a director. T may participate in the cafeteria plan in his capacity as an employee of Employer L.

(3) *Limits on participation by former employees.* Although former employees are treated as employees, a cafeteria plan may not be established or maintained predominantly for the benefit of former employees of the employer. Such a plan is not a cafeteria plan.

(4) *No participation by the spouse or dependent of an employee*—(i) *Benefits allowed to participant's spouse or dependents but not participation.* The spouse or dependents of employees may not be participants in a cafeteria plan unless they are also employees. However, a cafeteria plan may provide benefits to spouses and dependents of participants. For example, although an employee's spouse may benefit from the employee's election of accident and health insurance coverage or of coverage through a dependent care assistance program, the spouse may not participate in a cafeteria plan (that is, the spouse may not be given the opportunity to elect or purchase benefits offered by the plan).

(ii) *Certain elections after employee's death.* An employee's spouse is not a participant in a cafeteria plan merely because the spouse has the right, upon the death of the employee, to elect among various settlement options or to elect among permissible distribution options with respect to the deceased employee's benefits through a section 401(k) plan, Health Savings Account, or certain group-term life insurance offered through the cafeteria plan. See § 54.4980B–2, Q & A 8 and § 54.4980B–4, Q & A–1 of this chapter on COBRA rights of a participant's spouse or dependents.

(5) *Employees of certain controlled groups.* All employees who are treated as employed by a single employer under section 414(b), (c), (m), or (o) are treated as employed by a single employer for purposes of section 125. Section 125(g)(4); section 414(t).

(h) *After-tax employee contributions*—(1) *Certain after-tax employee contributions treated as cash.* In addition to the cash benefits described in paragraph (a)(2) of this section, in general, a benefit is treated as cash for purposes of section 125 if the benefit does not defer compensation (except as provided in paragraph (o) of this section) and an employee who receives the benefit purchases such benefit with after-tax employee contributions or is treated, for all purposes under the Code (including, for example, reporting and withholding purposes), as receiving, at the time that the benefit is received, cash compensation equal to the full value of the benefit at that time and then purchasing the benefit with after-tax employee contributions. Thus, for example, long-term disability coverage is treated as cash for purposes of section 125 if the cafeteria plan provides that an employee may purchase the coverage through the cafeteria plan with after-tax employee contributions or provides that the employee receiving such coverage is treated as having received cash compensation equal to the value of the coverage and then as having purchased the coverage with after-tax employee contributions. Also, for example, a cafeteria plan may offer employees the opportunity to purchase, with after-tax employee contributions, group-term life insurance on the life of an employee (providing no permanent benefits), an accident and health plan, or a dependent care assistance program.

(2) *Accident and health coverage purchased for someone other than the employee's spouse or dependents with after-tax employee contributions.* If the requirements of section 106 are satisfied, employer-provided accident and health coverage for an employee and his or her spouse or dependents is excludible from the employee's gross income. The fair market value of coverage for any other individual, provided with respect to the employee, is includible in the employee's gross income. § 1.106–1; § 1.61–21(a)(4), and § 1.61–21(b)(1). A cafeteria plan is permitted to allow employees to elect accident and health coverage for an individual who is not the spouse or dependent of the employee as a taxable benefit.

(3) *Example.* The following example illustrates the rules of this paragraph (h):

Example. Accident and health plan coverage for individuals who are not a spouse or dependent of an employee. (i) Employee C participates in Employer M's cafeteria plan. Employee C timely elects salary reduction for employer-provided accident and health coverage for himself and for accident and health coverage for his former spouse. C's former spouse is not C's dependent. A former spouse is not a spouse as defined in section 152.

(ii) The fair market value of the coverage for the former spouse is $1,000. Employee C has $1,000 includible in gross income for the accident and health coverage of his former spouse, because the section 106 exclusion applies only to employer-provided accident and health coverage for the employee or the employee's spouse or dependents.

(iii) No payments or reimbursements received under the accident and health coverage result in gross income to Employee C or to the former spouse. The result is the same if the $1,000 for coverage of C's former spouse is paid from C's after-tax income outside the cafeteria plan.

(i) *Prohibited taxable benefits.* Any taxable benefit not described in paragraph (a)(2) of this section and not treated as cash for purposes of section 125 in paragraph (h) of this section is not permitted to be included in a cafeteria plan. A plan that offers taxable benefits other than the taxable benefits described in paragraph (a)(2) and (h) of this section is not a cafeteria plan.

(j) *Coordination with other rules*—(1) *In general.* If a benefit is excludible from an employee's gross income when provided separately, the benefit is excludible from gross income when provided through a cafeteria plan. Thus, a qualified benefit is excludible from gross income if both the rules under section 125 and the specific rules providing for the exclusion of the benefit from gross income are satisfied. For example, if the nondiscrimination rules for specific qualified benefits (for example, sections 79(d), 105(h), 129(d)(2), 137(c)(2)) are not satisfied, those qualified benefits are includible in gross income. Thus, if $50,000 in group-term life insurance is offered through a cafeteria plan, the nondiscrimination rules in section 79(d) must be satisfied in order to exclude the coverage from gross income.

(2) *Section 125 nondiscrimination rules.* Qualified benefits are includible in the gross income of highly compensated participants or key employees if the nondiscrimination rules of section 125 are not satisfied. See § 1.125–7.

(3) *Taxable benefits.* If a benefit that is includible in gross income when offered separately is offered through a cafeteria plan, the benefit continues to be includible in gross income.

(k) *Group-term life insurance*—(1) *In general.* In addition to offering up to $50,000 in group-term life insurance coverage excludible under section 79(a), a cafeteria plan may offer coverage in excess of that amount. The cost of coverage in excess of $50,000 in group-term life insurance coverage provided under a policy or policies carried directly or indirectly by one or more employers (taking into account all coverage provided both through a cafeteria plan and outside a cafeteria plan) is includible in an employee's gross income. Group-term life insurance combined with permanent benefits, within the meaning of § 1.79–0, is a prohibited benefit in a cafeteria plan.

(2) *Determining cost of insurance includible in employee's gross income*—(i) *In general.* If the aggregate group-term life insurance coverage on the life of the employee (under policies carried directly or indirectly by the employer) exceeds $50,000, all or a portion of the insurance is provided through a cafeteria plan, and the group-term life insurance is provided through a plan that meets the nondiscrimination rules of section 79(d), the amount includible in an employee's gross income is determined under paragraphs (k)(2)(i)(A) through (C) of this section. For each employee—

(A) The entire amount of salary reduction and employer flex-credits through a cafeteria plan for group-term life insurance coverage on the life of the employee is excludible from the employee's gross income, regardless of the amount of employer-provided group-term life insurance on the employee's life (that is, whether or not the coverage provided to the employee both through the cafeteria plan and outside the cafeteria plan exceeds $50,000);

(B) The cost of the group-term life insurance in excess of $50,000 of coverage is includible in the employee's gross income. The amount includible in the employee's income is determined

using the rules of § 1.79–3 and Table I (*Uniform Premiums for $1,000 of Group-Term Life Insurance Protection*). See subparagraph (C) of this paragraph (k)(2)(i) for determining the amount paid by the employee for purposes of reducing the Table I amount includible in income under § 1.79–3.

(C) In determining the amount paid by the employee toward the purchase of the group-term life insurance for purposes of § 1.79–3, only an employee's after-tax contributions are treated as an amount paid by the employee.

(ii) *Examples.* The rules in this paragraph (k) are illustrated by the following examples, in which the group-term life insurance coverage satisfies the nondiscrimination rules in section 79(d), provides no permanent benefits, is for a 12-month period, is the only group-term life insurance coverage provided under a policy carried directly or indirectly by the employer, and applies Table I (*Uniform Premiums for $1,000 of Group-Term Life Insurance Protection*) effective July 1, 1999:

Example 1. Excess group-term life insurance coverage provided through salary reduction in a cafeteria plan. (i) Employer N provides group-term life insurance coverage to its employees only through its cafeteria plan. Employer N's cafeteria plan allows employees to elect salary reduction for group-term life insurance. Employee B, age 42, elected salary reduction of $200 for $150,000 of group-term life insurance. None of the group-term life insurance is paid through after-tax employee contributions.

(ii) B's $200 of salary reduction for group-term life insurance is excludible from B's gross income under paragraph (k)(2)(i)(A).

(iii) B has a total of $150,000 of group-term life insurance. The group-term life insurance in excess of the dollar limitation of section 79 is $100,000 (150,000–50,000).

(iv) The Table I cost is $120 for $100,000 of group-term life insurance for an individual between ages 40 to 44. The Table I cost of $120 is reduced by zero (because B paid no portion of the group-term life insurance with after-tax employee contributions), under paragraphs (k)(2)(i)(A)–(B) of this section.

(v) The amount includible in B's gross income for the $100,000 of excess group-term life insurance is $120.

Example 2. Excess group-term life insurance coverage provided through salary reduction in a cafeteria plan where employee purchases a portion of group-term life insurance coverage with after-tax contributions. (i) Same facts as *Example 1*, except that B elected salary reduction of $100 and makes an after-tax contribution of $100 toward the purchase of group-term life insurance coverage.

(ii) B's $100 of salary reduction for group-term life insurance is excludible from B's gross income, under paragraph (k)(2)(i)(A) of this section.

(iii) B has a total of $150,000 of group-term life insurance. The group-term life insurance in excess of the dollar limitation of section 79 is $100,000 (150,000–50,000).

(iv) The Table I cost is $120 for $100,000 of group-term life insurance for an individual between ages 40 to 44, under (k)(2)(i)(B). The Table I cost of $120 is reduced by $100 (because B paid $100 for the group-term life insurance with after-tax employee contributions), under paragraphs (k)(2)(i)(B) and (k)(2)(i)(C) of this section.

(v) The amount includible in B's gross income for the $100,000 of excess group-term life insurance coverage is $20.

Example 3. Excess group-term life insurance coverage provided through salary reduction in a cafeteria plan and outside a cafeteria plan. (i) Same facts as *Example 1* except that Employer N also provides (at no cost to employees) group-term life insurance coverage equal to each employee's annual salary. Employee B's annual salary is $150,000. B has $150,000 of group-term life insurance directly from Employer N, and also $150,000 coverage through Employer N's cafeteria plan.

(ii) B's $200 of salary reduction for group-term life insurance is excludible from B's gross income, under paragraph (k)(2)(i)(A) of this section.

(iii) B has a total of $300,000 of group-term life insurance. The group-term life insurance in excess of the dollar limitation of section 79 is $250,000 (300,000–50,000).

(iv) The Table I cost is $300 for $250,000 of group-term life insurance for an individual between ages 40 to 44. The Table I cost of $300 is reduced by zero (because B paid no portion of the group-term life insurance with after-tax employee contributions), under paragraphs (k)(2)(i)(B) and (k)(2)(i)(C) of this section.

(v) The amount includible in B's gross income for the $250,000 of excess group-term life insurance is $300.

Example 4. Excess group-term life insurance coverage provided through salary reduction in a cafeteria plan and outside a cafeteria plan. (i) Same facts as *Example 3* except that Employee C's annual salary is $30,000. C has $30,000 of group-term life insurance coverage provided directly from Employer N, and elects an additional $30,000 of coverage for $40 through Employer N's cafeteria plan. C is 42 years old.

(ii) C's $40 of salary reduction for group-term life insurance is excludible from C's gross income, under paragraph (k)(2)(i)(A) of this section.

(iii) C has a total of $60,000 of group-term life insurance. The group-term life insurance in excess of the dollar limitation of section 79 is $10,000 (60,000–50,000).

(iv) The Table I cost is $12 for $10,000 of group-term life insurance for an individual between ages 40 to 44. The Table I cost of $12 is reduced by zero (because C paid no portion of the group-term life insurance with after-tax employee contributions), under paragraphs (k)(2)(i)(B) and (k)(2)(i)(C) of this section.

(v) The amount includible in C's gross income for the $10,000 of excess group-term life insurance coverage is $12.

(l) *COBRA premiums*—(1) *Paying COBRA premiums through a cafeteria plan.* Under § 1.125–4(c)(3)(iv), COBRA premiums for an employer-provided group health plan are qualified benefits if:

(i) The premiums are excludible from an employee's income under section 106; or

(ii) The premiums are for the accident and health plan of the employer sponsoring the cafeteria plan, even if the fair market value of the premiums is includible in an employee's gross income. See also paragraph (e)(2) in § 1.125–5 and § 54.4980B–2, Q & A–8 of this chapter for COBRA rules for health FSAs.

(2) *Example.* The following example illustrates the rules of this paragraph (l):

Example. COBRA premiums. (i) Employer O maintains a cafeteria plan for full-time employees, offering an election between cash and employer-provided accident and health insurance and other qualified benefits. Employees A, B, and C participate in the cafeteria plan. On July 1, 2009, Employee A has a qualifying event (as defined in § 54.4980B–4 of this chapter).

(ii) Employee A was a full-time employee and became a part-time employee and for that reason, is no longer covered by Employer O's accident and health plan. Under § 1.125–4(f)(3)(ii), Employee A changes her election to salary reduce to pay her COBRA premiums.

(iii) Employee B previously worked for another employer, quit and elected COBRA. Employee B begins work for Employer O on July 1, 2009, and becomes eligible to participate in Employer O's cafeteria plan on July 1, 2009, but will not be eligible to participate in Employer O's accident and health plan until October 1, 2009. Employee B elects to salary reduce to pay COBRA premiums for coverage under the accident and health plan sponsored by B's former employer.

(iv) Employee C and C's spouse are covered by Employer O's accident and health plan until July 1, 2009, when C's divorce from her spouse became final. C continues to be covered by the accident and health plan. On July 1, 2009, C requests to pay COBRA premiums for her former spouse (who is not C's dependent (as defined in section 152)) with after-tax employee contributions.

(v) Salary reduction elections for COBRA premiums for Employees A and B are qualified benefits for purposes of section 125 and are excludible from the gross income of Employees A and B. Employer O allows A and B to salary reduce for these COBRA premiums.

(vi) Employer O allows C to pay for COBRA premiums for C's former spouse, with after-tax employee contributions because although accident and health coverage for C's former spouse is permitted in a cafeteria plan, the premiums are includible in C's gross income.

(vii) The operation of Employer O's cafeteria plan satisfies the requirements of this paragraph (l).

(m) *Payment or reimbursement of employees' individual accident and*

health insurance premiums—(1) *In general.* The payment or reimbursement of employees' substantiated individual health insurance premiums is excludible from employees' gross income under section 106 and is a qualified benefit for purposes of section 125.

(2) *Example.* The following example illustrates the rule of this paragraph (m):

Example. Payment or reimbursement of premiums. (i) Employer P's cafeteria plan offers the following benefits for employees who are covered by an individual health insurance policy. The employee substantiates the expenses for the premiums for the policy (as required in paragraph (b)(2) in § 1.125–6) before any payments or reimbursements to the employee for premiums are made. The payments or reimbursements are made in the following ways:

(ii) The cafeteria plan reimburses each employee directly for the amount of the employee's substantiated health insurance premium;

(iii) The cafeteria plan issues the employee a check payable to the health insurance company for the amount of the employee's health insurance premium, which the employee is obligated to tender to the insurance company;

(iv) The cafeteria plan issues a check in the same manner as (iii), except that the check is payable jointly to the employee and the insurance company; or

(v) Under these circumstances, the individual health insurance policies are accident and health plans as defined in § 1.106–1. This benefit is a qualified benefit under section 125.

(n) *Section 105 rules for accident and health plan offered through a cafeteria plan*—(1) *General rule.* In order for an accident and health plan to be a qualified benefit that is excludible from gross income if elected through a cafeteria plan, the cafeteria plan must satisfy section 125 and the accident and health plan must satisfy section 105(b) and (h).

(2) *Section 105(b) requirements in general.* Section 105(b) provides an exclusion from gross income for amounts paid to an employee from an employer-funded accident and health plan specifically to reimburse the employee for certain expenses for medical care (as defined in section 213(d)) incurred by the employee or the employee's spouse or dependents during the period for which the benefit is provided to the employee (that is, when the employee is covered by the accident and health plan).

(o) *Prohibition against deferred compensation*—(1) *In general.* Any plan that offers a benefit that defers compensation (except as provided in this paragraph (o)) is not a cafeteria plan. See section 125(d)(2)(A). A plan that permits employees to carry over unused elective contributions, after-tax contributions, or plan benefits from one plan year to another (except as provided in paragraphs (e), (o)(3) and (4) and (p) of this section) defers compensation. This is the case regardless of how the contributions or benefits are used by the employee in the subsequent plan year (for example, whether they are automatically or electively converted into another taxable or nontaxable benefit in the subsequent plan year or used to provide additional benefits of the same type). Similarly, a cafeteria plan also defers compensation if the plan permits employees to use contributions for one plan year to purchase a benefit that will be provided in a subsequent plan year (for example, life, health or disability if these benefits have a savings or investment feature, such as whole life insurance). See also Q & A–5 in § 1.125–3, prohibiting deferring compensation from one cafeteria plan year to a subsequent cafeteria plan year. See paragraph (e) of this section for grace period rules. A plan does not defer compensation merely because it allocates experience gains (or forfeitures) among participants in compliance with paragraph (o) in § 1.125–5.

(2) *Effect if a plan includes a benefit that defers the receipt of compensation or a plan operates to defer compensation.* If a plan violates paragraph (o)(1) of this section, the availability of an election between taxable and nontaxable benefits under such a plan results in gross income to the employees.

(3) *Cash or deferred arrangements that may be offered in a cafeteria plan.* (i) *In general.* A cafeteria plan may offer the benefits set forth in this paragraph (o)(3), even though these benefits defer compensation.

(ii) *Elective contributions to a section 401(k) plan.* A cafeteria plan may permit a covered employee to elect to have the employer, on behalf of the employee, pay amounts as contributions to a trust that is part of a profit-sharing or stock bonus plan or rural cooperative plan (within the meaning of section 401(k)(7)), which includes a qualified cash or deferred arrangement (as defined in section 401(k)(2)). In addition, after-tax employee contributions under a qualified plan subject to section 401(m) are permitted through a cafeteria plan. The right to make such contributions does not cause a plan to fail to be a cafeteria plan merely because, under the qualified plan, employer matching contributions (as defined in section 401(m)(4)(A)) are made with respect to elective or after-tax employee contributions.

(iii) *Additional permitted deferred compensation arrangements.* A plan maintained by an educational organization described in section 170(b)(1)(A)(ii) to the extent of amounts which a covered employee may elect to have the employer pay as contributions for post-retirement group life insurance is permitted through a cafeteria plan, if—

(A) All contributions for such insurance must be made before retirement; and

(B) Such life insurance does not have a cash surrender value at any time.

(iv) *Contributions to HSAs.* Contributions to covered employees' HSAs as defined in section 223 (but not contributions to Archer MSAs).

(4) *Paid time off*—(i) *In general.* A cafeteria plan is permitted to include elective paid time off (that is, vacation days, sick days or personal days) as a permitted taxable benefit through the plan by permitting employees to receive more paid time off than the employer otherwise provides to the employees on a nonelective basis, but only if the inclusion of elective paid time off through the plan does not operate to permit the deferral of compensation. In addition, a plan that only offers the choice of cash or paid time off is not a cafeteria plan and is not subject to the rules of section 125. In order to avoid deferral of compensation, the cafeteria plan must preclude any employee from using the paid time off or receiving cash, in a subsequent plan year, for any portion of such paid time off remaining unused as of the end of the plan year. (See paragraph (o)(4)(iii) of this section for the deadline to cash out unused elective paid time off.) For example, a plan that offers employees the opportunity to purchase paid time off (or to receive cash or other benefits through the plan in lieu of paid time off) is not a cafeteria plan if employees who purchase the paid time off for a plan year are allowed to use any unused paid time off in a subsequent plan year. This is the case even though the plan does not permit the employee to convert, in any subsequent plan year, the unused paid time off into any other benefit.

(ii) *Ordering of elective and nonelective paid time off.* In determining whether a plan providing paid time off operates to permit the deferral of compensation, a cafeteria plan must provide that employees are deemed to use paid time off in the following order:

(A) *Nonelective paid time off.* Nonelective paid time off (that is, paid time off with respect to which the employee has no election) is used first;

(B) *Elective paid time off.* Elective paid time off is used after all nonelective paid time off is used.

(iii) *Cashing out or forfeiture of unused elective paid time off, in general.* The cafeteria plan must provide that all unused elective paid time off (determined as of the last day of the plan year) must either be paid in cash (within the time specified in this paragraph (o)(4)) or be forfeited. This provision must apply uniformly to all participants in the cafeteria plan.

(A) *Cash out of unused elective paid time off.* A plan does not operate to permit the deferral of compensation merely because the plan provides that an employee who has not used all elective paid time off for a plan year receives in cash the value of such unused paid time off. The employee must receive the cash on or before the last day of the cafeteria plan's plan year to which the elective contributions used to purchase the unused elective paid time off relate.

(B) *Forfeiture of unused elective paid time off.* If the cafeteria plan provides for forfeiture of unused elective paid time off, the forfeiture must be effective on the last day of the plan year to which the elective contributions relate.

(iv) *No grace period for paid time off.* The grace period described in paragraph (e) of this section does not apply to paid time off.

(v) *Examples.* The following examples illustrate the rules of this paragraph (o)(4):

Example 1. Plan cashes out unused elective paid time off on or before the last day of the plan year. (i) Employer Q provides employees with two weeks of paid time off for each calendar year. Employer Q's human resources policy (that is, outside the cafeteria plan), permits employees to carry over one nonelective week of paid time off to the next year. Employer Q maintains a calendar year cafeteria plan that permits the employee to purchase, with elective contributions, an additional week of paid time off.

(ii) For the 2009 plan year, Employee A (with a calendar tax year), timely elects to purchase one additional week of paid time off. During 2009, Employee A uses only two weeks of paid time off. Employee A is deemed to have used two weeks of nonelective paid time off and zero weeks of elective paid time off.

(iii) Pursuant to the cafeteria plan, the plan pays Employee A the value of the unused elective paid time off week in cash on December 31, 2009. Employer Q includes this amount on the 2009 Form W–2 for Employee A. This amount is included in Employee A's gross income in 2009. The cafeteria plan's terms and operations do not violate the prohibition against deferring compensation.

Example 2. Unused nonelective paid time off carried over to next plan year. (i) Same facts as *Example 1*, except that Employee A uses only one week of paid time off during the year. Pursuant to the cafeteria plan, Employee A is deemed to have used one nonelective week, and having retained one nonelective week and one elective week of paid time off. Employee A receives in cash the value of the unused elective paid time off on December 31, 2009. Employer Q includes this amount on the 2009 Form W–2 for Employee A. Employee A must report this amount as gross income in 2009.

(ii) Pursuant to Employer Q's human resources policy, Employee A is permitted to carry over the one nonelective week of paid time off to the next year. Nonelective paid time off is not part of the cafeteria plan (that is, neither Employer Q nor the cafeteria plan permit employees to exchange nonelective paid time off for other benefits).

(iii) The cafeteria plan's terms and operations do not violate the prohibition against deferring compensation.

Example 3. Forfeiture of unused elective paid time off. Same facts as *Example 2*, except that pursuant to the cafeteria plan, Employee A forfeits the remaining one week of elective paid time off. The cafeteria plan's terms and operations do not violate the prohibition against deferring compensation.

Example 4. Unused elective paid time off carried over to next plan year. Same facts as *Example 1*, except that Employee A uses only two weeks of paid time off during the 2009 plan year, and, under the terms of the cafeteria plan, Employee A is treated as having used the two nonelective weeks and as having retained the one elective week. The one remaining week (that is, the elective week) is carried over to the next plan year (or the value thereof used for any other purpose in the next plan year). The plan operates to permit deferring compensation and is not a cafeteria plan.

Example 5. Paid time off exchanged for accident and health insurance premiums. Employer R provides employees with four weeks of paid time off for a year. Employer R's calendar year cafeteria plan permits employees to exchange up to one week of paid time off to pay the employee's share of accident and health insurance premiums. For the 2009 plan year, Employee B (with a calendar tax year), timely elects to exchange one week of paid time off (valued at $769) to pay accident and health insurance premiums for 2009. The $769 is excludible from Employee B's gross income under section 106. The cafeteria plan's terms and operations do not violate the prohibition against deferring compensation.

(p) *Benefits relating to more than one year*—(1) *Benefits in an accident and health insurance policy relating to more than one year.* Consistent with section 125(d), an accident and health insurance policy may include certain benefits, as set forth in this paragraph (p)(1), without violating the prohibition against deferred compensation.

(i) *Permitted benefits.* The following features or benefits of insurance policies do not defer compensation—

(A) Credit toward the deductible for unreimbursed covered expenses incurred in prior periods;

(B) Reasonable lifetime maximum limit on benefits;

(C) Level premiums;

(D) Premium waiver during disability;

(E) Guaranteed policy renewability of coverage, without further evidence of insurability (but not guaranty of the amount of premium upon renewal);

(F) Coverage for a specified accidental injury;

(G) Coverage for a specified disease or illness, including payments at initial diagnosis of the specified disease or illness, and progressive payments of a set amount per month following the initial diagnosis (sometimes referred to as progressive diagnosis payments); and

(H) Payment of a fixed amount per day (or other period) of hospitalization.

(ii) *Requirements of permitted benefits.* All benefits described in paragraph (p)(1)(i) of this section must in addition satisfy all of the following requirements—

(A) No part of any benefit is used in one plan year to purchase a benefit in a subsequent plan year;

(B) The policies remain in force only so long as premiums are timely paid on a current basis, and, irrespective of the amount of premiums paid in prior plan years, if the current premiums are not paid, all coverage for new diseases or illnesses lapses. See paragraph (p)(1)(i)(D), allowing premium waiver during disability;

(C) There is no investment fund or cash value to rely upon for payment of premiums; and

(D) No part of any premium is held in a separate account for any participant or beneficiary, or otherwise segregated from the assets of the insurance company.

(2) *Benefits under a long-term disability policy relating to more than one year.* A long-term disability policy paying disability benefits over more than one year does not violate the prohibition against deferring compensation.

(3) *Reasonable premium rebates or policy dividends.* Reasonable premium rebates or policy dividends paid with respect to benefits provided through a cafeteria plan do not constitute impermissible deferred compensation if such rebates or dividends are paid before the close of the 12-month period immediately following the cafeteria plan year to which such rebates and dividends relate.

(4) *Mandatory two-year election for vision or dental insurance.* When a cafeteria plan offers vision or dental insurance that requires a mandatory two-year coverage period, but not longer (sometimes referred to as a "two-year lock-in"), the mandatory two-year

coverage period does not result in deferred compensation in violation of section 125(d)(2), provided both of the following requirements are satisfied—

(i) The premiums for each plan year are paid no less frequently than annually; and

(ii) In no event does a cafeteria plan use salary reduction or flex-credits relating to the first year of a two-year election to apply to vision or dental insurance for the second year of the two-year election.

(5) *Using salary reduction amounts from one plan year to pay accident and health insurance premiums for the first month of the immediately following plan year.*

(i) *In general.* 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).

(ii) *Example.* The following example illustrates the rules in this paragraph (p)(5):

Example. Salary reduction payments in December of calendar plan year to pay accident and health insurance premiums for January. Employer S maintains a calendar year cafeteria plan. The cafeteria plan offers employees a salary reduction election for accident and health insurance. The plan provides that employees' salary reduction amounts for the last pay period in December are applied to pay accident and health insurance premiums for the immediately following January. All employees are paid bi-weekly. For the plan year ending December 31, 2009, Employee C elects salary reduction of $3,250 for accident and health coverage. For the last pay period in December 2009, $125 (3,250/26) is applied to the accident and health insurance premium for January 2010. This plan provision does not violate the prohibition against deferring compensation.

(q) *Nonqualified benefits*—(1) *In general.* The following benefits are nonqualified benefits that are not permitted to be offered in a cafeteria plan—

(i) Scholarships described in section 117;

(ii) Employer-provided meals and lodging described in section 119;

(iii) Educational assistance described in section 127;

(iv) Fringe benefits described in section 132;

(v) Long-term care insurance, or any product which is advertised, marketed or offered as long-term care insurance;

(vi) Long-term care services (but see paragraph (q)(3) of this section);

(vii) Group-term life insurance on the life of any individual other than an employee (whether includible or excludible from the employee's gross income);

(viii) Health reimbursement arrangements (HRAs) that provide reimbursements up to a maximum dollar amount for a coverage period and that all or any unused amount at the end of a coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods;

(ix) Contributions to Archer MSAs (section 220); and

(x) Elective deferrals to a section 403(b) plan.

(2) *Nonqualified benefits not permitted in a cafeteria plan.* The benefits described in this paragraph (q) are not qualified benefits or taxable benefits or cash for purposes of section 125 and thus may not be offered in a cafeteria plan regardless of whether any such benefit is purchased with after-tax employee contributions or on any other basis. A plan that offers a nonqualified benefit is not a cafeteria plan. Employees' elections between taxable and nontaxable benefits through such plan result in gross income to the participants for any benefit elected. See section 125(f). See paragraph (q)(3) of this section for special rule on long-term care insurance purchased through an HSA.

(3) *Long-term care insurance or services purchased through an HSA.* Although long-term care insurance is not a qualified benefit and may not be offered in a cafeteria plan, a cafeteria plan is permitted to offer an HSA as a qualified benefit, and funds from the HSA may be used to pay eligible long-term care premiums on a qualified long-term care insurance contract or for qualified long-term care services.

(r) *Employer contributions to a cafeteria plan*—(1) *Salary reduction-in general.* The term *employer contributions* means amounts that are not currently available (after taking section 125 into account) to the employee but are specified in the cafeteria plan as amounts that an employee may use for the purpose of electing benefits through the plan. A plan may provide that employer contributions may be made, in whole or in part, pursuant to employees' elections to reduce their compensation or to forgo increases in compensation and to have such amounts contributed, as employer contributions, by the employer on their behalf. See also § 1.125–5 (flexible spending arrangements). Also, a cafeteria plan is permitted to require employees to elect to pay the employees' share of any qualified benefit through salary reduction and not with after-tax employee contributions. A cafeteria plan is also permitted to pay reasonable cafeteria plan administrative fees through salary reduction amounts, and these salary reduction amounts are excludible from an employee's gross income.

(2) *Salary reduction as employer contribution.* Salary reduction contributions are employer contributions. An employee's salary reduction election is an election to receive a contribution by the employer in lieu of salary or other compensation that is not currently available to the employee as of the effective date of the election and that does not subsequently become currently available to the employee.

(3) *Employer flex-credits.* A cafeteria plan may also provide that the employer contributions will or may be made on behalf of employees equal to (or up to) specified amounts (or specified percentages of compensation) and that such nonelective contributions are available to employees for the election of benefits through the plan.

(4) *Elective contributions to a section 401(k) plan.* See § 1.401(k)–1 for general rules relating to contributions to section 401(k) plans.

(s) *Effective/applicability date.* It is proposed that these regulations apply on and after plan years beginning on or after January 1, 2009, except that the rule in paragraph (k)(2)(i)(B) of this section is effective as of the date the proposed regulations are published in the **Federal Register**.

§ 1.125–2 Cafeteria plans; elections.

(a) *Rules relating to making and revoking elections*—(1) *Elections in general.* A plan is not a cafeteria plan unless the plan provides in writing that employees are permitted to make elections among the permitted taxable benefits and qualified benefits offered through the plan for the plan year (and grace period, if applicable). All elections must be irrevocable by the date described in paragraph (a)(2) of this section except as provided in paragraph (a)(4) of this section. An election is not irrevocable if, after the earlier of the dates specified in paragraph (a)(2) of this section, employees have the right to revoke their elections of qualified benefits and instead receive the taxable benefits for such period, without regard to whether the employees actually revoke their elections.

(2) *Timing of elections.* In order for employees to exclude qualified benefits from employees' gross income, benefit

elections in a cafeteria plan must be made before the earlier of—

(i) The date when taxable benefits are currently available; or

(ii) The first day of the plan year (or other coverage period).

(3) *Benefit currently available to an employee-in general.* Cash or another taxable benefit is currently available to the employee if it has been paid to the employee or if the employee is able currently to receive the cash or other taxable benefit at the employee's discretion. However, cash or another taxable benefit is not currently available to an employee if there is a significant limitation or restriction on the employee's right to receive the benefit currently. Similarly, a benefit is not currently available as of a date if the employee may under no circumstances receive the benefit before a particular time in the future. The determination of whether a benefit is currently available to an employee does not depend on whether it has been constructively received by the employee for purposes of section 451.

(4) *Exceptions to rule on making and revoking elections.* If a cafeteria plan incorporates the change in status rules in § 1.125–4, to the extent provided in those rules, an employee who experiences a change in status (as defined in § 1.125–4) is permitted to revoke an existing election and to make a new election with respect to the remaining portion of the period of coverage, but only with respect to cash or other taxable benefits that are not yet currently available. See paragraph (c)(1) of this section for a special rule for changing elections prospectively for HSA contributions and paragraph (r)(4) in § 1.125–1 for section 401(k) elections. Also, only an employee of the employer sponsoring a cafeteria plan is allowed to make, revoke or change elections in the employer's cafeteria plan. The employee's spouse, dependent or any other individual other than the employee may not make, revoke or change elections under the plan.

(5) *Elections not required on written paper documents.* A cafeteria plan does not fail to meet the requirements of section 125 merely because it permits employees to use electronic media for such transactions. The safe harbor in § 1.401(a)–21 applies to electronic elections, revocations and changes in elections under section 125.

(6) *Examples.* The following examples illustrate the rules in this paragraph (a):

Example 1. Election not revocable during plan year. Employer A's cafeteria plan offers each employee the opportunity to elect, for a plan year, between $5,000 cash for the plan year and a dependent care assistance program of up to $5,000 of dependent care expenses incurred by the employee during the plan year. The cafeteria plan requires employees to elect between these benefits before the beginning of the plan year. After the year has commenced, employees are prohibited from revoking their elections. The cafeteria plan allows revocation of elections based on changes in status (as described in § 1.125–4). Employees who elected the dependent care assistance program do not include the $5,000 cash in gross income. The cafeteria plan satisfies the requirements in this paragraph (a).

Example 2. Election revocable during plan year. Same facts as *Example 1* except that Employer A's cafeteria plan allows employees to revoke their elections for dependent care assistance at any time during the plan year and receive the unused amount of dependent care assistance as cash. The cafeteria plan fails to satisfy the requirements in this paragraph (a), and is not a cafeteria plan. All employees are treated as having received the $5,000 in cash even if they do not revoke their elections. The same result occurs even though the cash is not payable until the end of the plan year.

(b) *Automatic elections*—(1) *In general.* For new employees or current employees who fail to timely elect between permitted taxable benefits and qualified benefits, a cafeteria plan is permitted, but is not required, to provide default elections for one or more qualified benefits (for example, an election made for any prior year is deemed to be continued for every succeeding plan year, unless changed).

(2) *Example.* The following example illustrates the rules in this paragraph (b):

Example. Automatic elections for accident and health insurance. (i) Employer B maintains a calendar year cafeteria plan. The cafeteria plan offers accident and health insurance with an option for employee-only or family coverage. All employees are eligible to participate in the cafeteria plan immediately upon hire.

(ii) The cafeteria plan provides for an automatic enrollment process: Each new employee and each current employee is automatically enrolled in employee-only coverage under the accident and health insurance plan, and the employee's salary is reduced to pay the employee's share of the accident and health insurance premium, unless the employee affirmatively elects cash. Alternatively, if the employee has a spouse or child, the employee can elect family coverage.

(iii) When an employee is hired, the employee receives a notice explaining the automatic enrollment process and the employee's right to decline coverage and have no salary reduction. The notice includes the salary reduction amounts for employee-only coverage and family coverage, procedures for exercising the right to decline coverage, information on the time by which an election must be made, and the period for which an election is effective. The notice is also given to each current employee before the beginning of each subsequent plan year, except that the notice for a current employee includes a description of the employee's existing coverage, if any.

(iv) For a new employee, an election to receive cash or to have family coverage rather than employee-only coverage is effective if made when the employee is hired. For a current employee, an election is effective if made prior to the start of each calendar year or under any other circumstances permitted under § 1.125–4. An election made for any prior year is deemed to be continued for every succeeding plan year, unless changed.

(v) Contributions used to purchase accident and health insurance through a cafeteria plan are not includible in the gross income of the employee solely because the plan provides for automatic enrollment as a default election whereby the employee's salary is reduced each year to pay for a portion of the accident and health insurance through the plan (unless the employee affirmatively elects cash).

(c) *Election rules for salary reduction contributions to HSAs*—(1) *Prospective elections and changes in salary reduction elections allowed.* Contributions may be made to an HSA through a cafeteria plan. A cafeteria plan offering HSA contributions through salary reduction may permit employees to make prospective salary reduction elections or change or revoke salary reduction elections for HSA contributions (for example, to increase or decrease salary reduction elections for HSA contributions) at any time during the plan year, effective before salary becomes currently available. If a cafeteria plan offers HSA contributions as a qualified benefit, the plan must—

(i) Specifically describe the HSA contribution benefit;

(ii) Allow a participant to prospectively change his or her salary reduction election for HSA contributions on a monthly basis (or more frequently); and

(iii) Allow a participant who becomes ineligible to make HSA contributions to prospectively revoke his or her salary reduction election for HSA contributions.

(2) *Example.* The following example illustrates the rules in this paragraph (c):

Example. Prospective HSA salary reduction elections. (i) A cafeteria plan with a calendar plan year allows employees to make salary reduction elections for HSA contributions through the plan. The cafeteria plan permits employees to prospectively make, change or revoke salary contribution elections for HSA contributions, limited to one election, change or revocation per month.

(ii) Employee M participates in the cafeteria plan. Before salary becomes currently available to M, M makes the following elections. On January 2, 2009, M elects to contribute $100 for each pay period to an HSA, effective January 3, 2009. On

March 15, 2009, M elects to reduce the HSA contribution to $35 per pay period, effective April 1, 2009. On May 1, 2009, M elects to discontinue all HSA contributions, effective May 15, 2009. The cafeteria plan implements all of Employee M's elections,

(iii) The cafeteria plan's operation is consistent with the section 125 election, change and revocation rules for HSA contributions.

(d) *Optional election for new employees.* A cafeteria plan may provide new employees 30 days after their hire date to make elections between cash and qualified benefits. The election is effective as of the employee's hire date. However, salary reduction amounts used to pay for such an election must be from compensation not yet currently available on the date of the election. The written cafeteria plan must provide that any employee who terminates employment and is rehired within 30 days after terminating employment (or who returns to employment following an unpaid leave of absence of less than 30 days) is not a new employee eligible for the election in this paragraph (d).

(e) *Effective/applicability date.* It is proposed that these regulations apply on and after plan years beginning on or after January 1, 2009.

Par. 3. Sections 1.125–5, 1.125–6 and 1.125–7 are added to read as follows:

§ 1.125–5 Flexible spending arrangements.

(a) *Definition of flexible spending arrangement*—(1) *In general.* An FSA generally is a benefit program that provides employees with coverage which reimburses specified, incurred expenses (subject to reimbursement maximums and any other reasonable conditions). An expense for qualified benefits must not be reimbursed from the FSA unless it is incurred during a period of coverage. See paragraph (e) of this section. After an expense for a qualified benefit has been incurred, the expense must first be substantiated before the expense is reimbursed. See paragraphs (a) through (f) in § 1.125–6.

(2) *Maximum amount of reimbursement.* The maximum amount of reimbursement that is reasonably available to an employee for a period of coverage must not be substantially in excess of the total salary reduction and employer flex-credit for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total salary reduction and employer flex-credit if such maximum amount is less than 500 percent of the combined salary reduction and employer flex-credit. A single FSA may provide participants with different levels of coverage and maximum amounts of reimbursement. See paragraph (r) in § 1.125–1 and paragraphs (b) and (d) in this section for the definition of salary reduction, employer flex-credit, and uniform coverage rule.

(b) *Flex-credits allowed*—(1) *In general.* An FSA in a cafeteria plan must include an election between cash or taxable benefits (including salary reduction) and one or more qualified benefits, and may include, in addition, "employer flex-credits." For this purpose, flex-credits are non-elective employer contributions that the employer makes for every employee eligible to participate in the employer's cafeteria plan, to be used at the employee's election only for one or more qualified benefits (but not as cash or a taxable benefit). See § 1.125–1 for definitions of qualified benefits, cash and taxable benefits.

(2) *Example.* The following example illustrates the rules in this paragraph (b):

Example. Flex-credit. Contribution to health FSA for employees electing employer-provided accident and health plan. Employer A maintains a cafeteria plan offering employees an election between cash or taxable benefits and premiums for employer-provided accident and health insurance or coverage through an HMO. The plan also provides an employer contribution of $200 to the health FSA of every employee who elects accident and health insurance or HMO coverage. In addition, these employees may elect to reduce their salary to make additional contributions to their health FSAs. The benefits offered in this cafeteria plan are consistent with the requirements of section 125 and this paragraph (b).

(c) *Use-or-lose rule*—(1) *In general.* An FSA may not defer compensation. No contribution or benefit from an FSA may be carried over to any subsequent plan year or period of coverage. See paragraph (k)(3) in this section for specific exceptions. Unused benefits or contributions remaining at the end of the plan year (or at the end of a grace period, if applicable) are forfeited.

(2) *Example.* The following example illustrates the rules in this paragraph (c):

Example. Use-or-lose rule. (i) Employer B maintains a calendar year cafeteria plan, offering an election between cash and a health FSA. The cafeteria plan has no grace period.

(ii) Employee A plans to have eye surgery in 2009. For the 2009 plan year, Employee A timely elects salary reduction of $3,000 for a health FSA. During the 2009 plan year, Employee A learns that she cannot have eye surgery performed, but incurs other section 213(d) medical expenses totaling $1,200. As of December 31, 2009, she has $1,800 of unused benefits and contributions in the health FSA. Consistent with the rules in this paragraph (c), she forfeits $1,800.

(d) *Uniform coverage rules applicable to health FSAs*—(1) *Uniform coverage throughout coverage period—in general.* The maximum amount of reimbursement from a health FSA must be available at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage). Thus, the maximum amount of reimbursement at any particular time during the period of coverage cannot relate to the amount that has been contributed to the FSA at any particular time prior to the end of the plan year. Similarly, the payment schedule for the required amount for coverage under a health FSA may not be based on the rate or amount of covered claims incurred during the coverage period. Employees' salary reduction payments must not be accelerated based on employees' incurred claims and reimbursements.

(2) *Reimbursement available at all times.* Reimbursement is deemed to be available at all times if it is paid at least monthly or when the total amount of the claims to be submitted is at least a specified, reasonable minimum amount (for example, $50).

(3) *Terminated participants.* When an employee ceases to be a participant, the cafeteria plan must pay the former participant any amount the former participant previously paid for coverage or benefits to the extent the previously paid amount relates to the period from the date the employee ceases to be a participant through the end of that plan year. See paragraph (e)(2) in this section for COBRA elections for health FSAs.

(4) *Example.* The following example illustrates the rules in this paragraph (d):

Example. Uniform coverage. (i) Employer C maintains a calendar year cafeteria plan, offering an election between cash and a health FSA. The cafeteria plan prohibits accelerating employees' salary reduction payments based on employees' incurred claims and reimbursements.

(ii) For the 2009 plan year, Employee N timely elects salary reduction of $3,000 for a health FSA. Employee N pays the $3,000 salary reduction amount through salary reduction of $250 per month throughout the coverage period. Employee N is eligible to receive the maximum amount of reimbursement of $3,000 at all times throughout the coverage period (reduced by prior reimbursements).

(iii) N incurs $2,500 of section 213(d) medical expenses in January, 2009. The full $2,500 is reimbursed although Employee N has made only one salary reduction payment of $250. N incurs $500 in medical expenses in February, 2009. The remaining $500 of the $3,000 is reimbursed. After Employee N submits a claim for reimbursement and substantiates the medical expenses, the cafeteria plan reimburses N for the $2,500

and $500 medical expenses. Employer C's cafeteria plan satisfies the uniform coverage rule.

(5) *No uniform coverage rule for FSAs for dependent care assistance or adoption assistance.* The uniform coverage rule applies only to health FSAs and does not apply to FSAs for dependent care assistance or adoption assistance. See paragraphs (i) and (j) of this section for the rules for FSAs for dependent care assistance and adoption assistance.

(e) *Required period of coverage for a health FSA, dependent care FSA and adoption assistance FSA*—(1) *Twelve-month period of coverage—in general.* An FSA's period of coverage must be 12 months. However, in the case of a short plan year, the period of coverage is the entire short plan year. See paragraph (d) in § 1.125–1 for rules on plan years and changing plan years.

(2) *COBRA elections for health FSAs.* For the application of the health care continuation rules of section 4980B of the Code to health FSAs, see Q & A–2 in § 54.4980B–2 of this chapter.

(3) *Separate period of coverage permitted for each qualified benefit offered through FSA.* Dependent care assistance, adoption assistance, and a health FSA are each permitted to have a separate period of coverage, which may be different from the plan year of the cafeteria plan.

(f) *Coverage on a month-by-month or expense-by-expense basis prohibited.* In order for reimbursements from an accident and health plan to qualify for the section 105(b) exclusion, an employer-funded accident and health plan offered through a cafeteria plan may not operate in a manner that enables employees to purchase the accident and health plan coverage only for periods when employees expect to incur medical care expenses. Thus, for example, if a cafeteria plan permits employees to receive accident and health plan coverage on a month-by-month or an expense-by-expense basis, reimbursements from the accident and health plan fail to qualify for the section 105(b) exclusion. If, however, the period of coverage under an accident and health plan offered through a cafeteria plan is twelve months and the cafeteria plan does not permit an employee to elect specific amounts of coverage, reimbursement, or salary reduction for less than twelve months, the cafeteria plan does not operate to enable participants to purchase coverage only for periods during which medical care will be incurred. See § 1.125–4 and paragraph (a) in § 1.125–2 regarding the revocation of elections during a period of coverage on account of changes in family status.

(g) *FSA administrative practices*—(1) *Limiting health FSA enrollment to employees who participate in the employer's accident and health plan.* At the employer's option, a cafeteria plan is permitted to provide that only those employees who participate in one or more specified employer-provided accident and health plans may participate in a health FSA. See § 1.125–7 for nondiscrimination rules.

(2) *Interval for employees' salary reduction contributions.* The cafeteria plan is permitted to specify any interval for employees' salary reduction contributions. The interval specified in the plan must be uniform for all participants.

(h) *Qualified benefits permitted to be offered through an FSA.* Dependent care assistance (section 129), adoption assistance (section 137) and a medical reimbursement arrangement (section 105(b)) are permitted to be offered through an FSA in a cafeteria plan.

(i) *Section 129 rules for dependent care assistance program offered through a cafeteria plan*—(1) *General rule.* In order for dependent care assistance to be a qualified benefit that is excludible from gross income if elected through a cafeteria plan, the cafeteria plan must satisfy section 125 and the dependent care assistance must satisfy section 129.

(2) *Dependent care assistance in general.* Section 129(a) provides an employee with an exclusion from gross income both for an employer-funded dependent care assistance program and for amounts paid or incurred by the employer for dependent care assistance provided to the employee, if the amounts are paid or incurred through a dependent care assistance program. See paragraph (a)(4) in § 1.125–6 on when dependent care expenses are incurred.

(3) *Reimbursement exclusively for dependent care assistance.* A dependent care assistance program may not provide reimbursements other than for dependent care expenses; in particular, if an employee has dependent care expenses less than the amount specified by salary reduction, the plan may not provide other taxable or nontaxable benefits for any portion of the specified amount not used for the reimbursement of dependent care expenses. Thus, if an employee has elected coverage under the dependent care assistance program and the period of coverage has commenced, the employee must not have the right to receive amounts from the program other than as reimbursements for dependent care expenses. This is the case regardless of whether coverage under the program is purchased with contributions made at the employer's discretion, at the employee's discretion, or pursuant to a collective bargaining agreement. Arrangements formally outside of the cafeteria plan providing for the adjustment of an employee's compensation or an employee's receipt of any other benefits on the basis of the assistance or reimbursements received by the employee are considered in determining whether a dependent care benefit is a dependent care assistance program under section 129.

(j) *Section 137 rules for adoption assistance program offered through a cafeteria plan*—(1) *General rule.* In order for adoption assistance to be a qualified benefit that is excludible from gross income if elected through a cafeteria plan, the cafeteria plan must satisfy section 125 and the adoption assistance must satisfy section 137.

(2) *Adoption assistance in general.* Section 137(a) provides an employee with an exclusion from gross income for amounts paid or expenses incurred by the employer for qualified adoption expenses in connection with an employee's adoption of a child, if the amounts are paid or incurred through an adoption assistance program. Certain limits on amount of expenses and employee's income apply.

(3) *Reimbursement exclusively for adoption assistance.* Rules and requirements similar to the rules and requirements in paragraph (i)(3) of this section for dependent care assistance apply to adoption assistance.

(k) *FSAs and the rules governing the tax-favored treatment of employer-provided health benefits*—(1) *Medical expenses.* Health plans that are flexible spending arrangements, as defined in paragraph (a)(1) of this section, must conform to the generally applicable rules under sections 105 and 106 in order for the coverage and reimbursements under such plans to qualify for tax-favored treatment under such sections. Thus, health FSAs must qualify as accident and health plans. See paragraph (n) in § 1.125–1. A health FSA is only permitted to reimburse medical expenses as defined in section 213(d). Thus, for example, a health FSA is not permitted to reimburse dependent care expenses.

(2) *Limiting payment or reimbursement to certain section 213(d) medical expenses.* A health FSA is permitted to limit payment or reimbursement to only certain section 213(d) medical expenses (except health insurance, long-term care services or insurance). See paragraph (q) in § 1.125–1. For example, a health FSA in a cafeteria plan is permitted to provide in

the written plan that the plan reimburses all section 213(d) medical expenses allowed to be paid or reimbursed under a cafeteria plan except over-the-counter drugs.

(3) *Application of prohibition against deferred compensation to medical expenses*—(i) *Certain advance payments for orthodontia permitted.* A cafeteria plan is permitted, but is not required to, reimburse employees for orthodontia services before the services are provided but only to the extent that the employee has actually made the payments in advance of the orthodontia services in order to receive the services. These orthodontia services are deemed to be incurred when the employee makes the advance payment. Reimbursing advance payments does not violate the prohibition against deferring compensation.

(ii) *Example.* The following example illustrates the rules in paragraph (k)(3):

Example. Advance payment to orthodontist. Employer D sponsors a calendar year cafeteria plan which offers a health FSA. Employee K elects to salary reduce $3,000 for a health FSA for the 2009 plan year. Employee K's dependent requires orthodontic treatment. K's accident and health insurance does not cover orthodontia. The orthodontist, following the normal practice, charges $3,000, all due in 2009, for treatment, to begin in 2009 and end in 2010. K pays the $3,000 in 2009. In 2009, Employer D's cafeteria plan may reimburse $3,000 to K, without violating the prohibition against deferring compensation in section 125(d)(2).

(iii) *Reimbursements for durable medical equipment.* A health FSA in a cafeteria plan that reimburses employees for equipment (described in section 213(d)) with a useful life extending beyond the period of coverage during which the expense is incurred does not provide deferred compensation. For example, a health FSA is permitted to reimburse the cost of a wheelchair for an employee.

(4) *No reimbursement of premiums for accident and health insurance or long-term care insurance or services.* A health FSA is not permitted to treat employees' premium payments for other health coverage as reimbursable expenses. Thus, for example, a health FSA is not permitted to reimburse employees for payments for other health plan coverage, including premiums for COBRA coverage, accidental death and dismemberment insurance, long-term disability or short-term disability insurance or for health coverage under a plan maintained by the employer of the employee or the employer of the employee's spouse or dependent. Also, a health FSA is not permitted to reimburse expenses for long-term care insurance premiums or for long-term care services for the employee or employee's spouse or dependent. See paragraph (q) in § 1.125–1 for nonqualified benefits

(l) *Section 105(h) requirements.* Section 105(h) applies to health FSAs. Section 105(h) provides that the exclusion provided by section 105(b) is not available with respect to certain amounts received by a highly compensated individual (as defined in section 105(h)(5)) from a discriminatory self-insured medical reimbursement plan, which includes health FSAs. See § 1.105–11. For purposes of section 105(h), coverage by a self-insured accident and health plan offered through a cafeteria plan is an optional benefit (even if only one level and type of coverage is offered) and, for purposes of the optional benefit rule in § 1.105–11(c)(3)(i), employer contributions are treated as employee contributions to the extent that taxable benefits are offered by the plan.

(m) *HSA-compatible FSAs-limited-purpose health FSAs and post-deductible health FSAs*—(1) *In general. Limited-purpose health FSAs* and *post-deductible health FSAs* which satisfy all the requirements of section 125 are permitted to be offered through a cafeteria plan.

(2) *HSA-compatible FSAs.* Section 223(a) allows a deduction for certain contributions to a "Health Savings Account" (HSA) (as defined in section 223(d)). An *eligible individual* (as defined in section 223(c)(1)) may contribute to an HSA. An eligible individual must be covered under a "high deductible health plan" (HDHP) and not, while covered under an HDHP, under any health plan which is not an HDHP. A general purpose health FSA is not an HDHP and an individual covered by a general purpose health FSA is not eligible to contribute to an HSA. However, an individual covered by an HDHP (and who otherwise satisfies section 223(c)(1)) does not fail to be an eligible individual merely because the individual is also covered by a limited-purpose health FSA or post-deductible health FSA (as defined in this paragraph (m)) or a combination of a limited-purpose health FSA and a post-deductible health FSA.

(3) *Limited-purpose health FSA.* A limited-purpose health FSA is a health FSA described in the cafeteria plan that only pays or reimburses permitted coverage benefits (as defined in section 223(c)(2)(C)), such as vision care, dental care or preventive care (as defined for purposes of section 223(c)(2)(C)). See paragraph (k) in this section.

(4) *Post-deductible health FSA*—(i) *In general.* A post-deductible health FSA is a health FSA described in the cafeteria plan that only pays or reimburses medical expenses (as defined in section 213(d)) for preventive care or medical expenses incurred after the minimum annual HDHP deductible under section 223(c)(2)(A)(i) is satisfied. See paragraph (k) in this section. No medical expenses incurred before the annual HDHP deductible is satisfied may be reimbursed by a post-deductible FSA, regardless of whether the HDHP covers the expense or whether the deductible is later satisfied. For example, even if chiropractic care is not covered under the HDHP, expenses for chiropractic care incurred before the HDHP deductible is satisfied are not reimbursable at any time by a post-deductible health FSA.

(ii) *HDHP and health FSA deductibles.* The deductible for a post-deductible health FSA need not be the same amount as the deductible for the HDHP, but in no event may the post-deductible health FSA or other coverage provide benefits before the minimum annual HDHP deductible under section 223(c)(2)(A)(i) is satisfied (other than benefits permitted under a limited-purpose health FSA). In addition, although the deductibles of the HDHP and the other coverage may be satisfied independently by separate expenses, no benefits may be paid before the minimum annual deductible under section 223(c)(2)(A)(i) has been satisfied. An individual covered by a post-deductible health FSA (if otherwise an eligible individual) is an eligible individual for the purpose of contributing to the HSA.

(5) *Combination of limited-purpose health FSA and post-deductible health FSA.* An FSA is a combination of a limited-purpose health FSA and post-deductible health FSA if each of the benefits and reimbursements provided under the FSA are permitted under either a limited-purpose health FSA or post-deductible health FSA. For example, before the HDHP deductible is satisfied, a combination limited-purpose and post-deductible health FSA may reimburse only preventive, vision or dental expenses. A combination limited-purpose and post-deductible health FSA may also reimburse any medical expense that may otherwise be paid by an FSA (that is, no insurance premiums or long-term care benefits) that is incurred after the HDHP deductible is satisfied.

(6) *Substantiation.* The substantiation rules in this section apply to limited-purpose health FSAs and to post-deductible health FSAs. In addition to

providing third-party substantiation of medical expenses, a participant in a post-deductible health FSA must provide information from an independent third party that the HDHP deductible has been satisfied. A participant in a limited-purpose health FSA must provide information from an independent third-party that the medical expenses are for vision care, dental care or preventive care.

(7) *Plan amendments.* See paragraph (c) in § 1.125–1 on the required effective date for amendments adopting or changing limited-purpose, post-deductible or combination limited-purpose and post-deductible health FSAs.

(n) *Qualified HSA distributions*—(1) *In general.* A health FSA in a cafeteria plan is permitted to offer employees the right to elect qualified HSA distributions described in section 106(e). No qualified HSA distribution may be made in a plan year unless the employer amends the health FSA written plan with respect to all employees, effective by the last day of the plan year, to allow a qualified HSA distribution satisfying all the requirements in this paragraph (n). See also section 106(e)(5)(B). In addition, a distribution with respect to an employee is not a qualified HSA distribution unless all of the following requirements are satisfied—

(i) No qualified HSA distribution has been previously made on behalf of the employee from this health FSA;

(ii) The employee elects to have the employer make a qualified HSA distribution from the health FSA to the HSA of the employee;

(iii) The distribution does not exceed the lesser of the balance of the health FSA on—

(A) September 21, 2006; or

(B) The date of the distribution;

(iv) For purposes of this paragraph (n)(1), balances as of any date are determined on a cash basis, without taking into account expenses incurred but not reimbursed as of a date, and applying the uniform coverage rule in paragraph (d) in this section;

(v) The distribution is made no later than December 31, 2011; and

(vi) The employer makes the distribution directly to the trustee of the employee's HSA.

(2) *Taxation of qualified HSA distributions.* A qualified HSA distribution from the health FSA covering the participant to his or her HSA is a rollover to the HSA (as defined in section 223(f)(5)) and thus is generally not includible in gross income. However, if the participant is not an eligible individual (as defined in section 223(c)(1)) at any time during a testing period following the qualified HSA distribution, the amount of the distribution is includible in the participant's gross income and he or she is also subject to an additional 10 percent tax (with certain exceptions). Section 106(e)(3).

(3) *No effect on health FSA elections, coverage, use-or-lose rule.* A qualified HSA distribution does not alter an employee's irrevocable election under paragraph (a) of § 1.125–2, or constitute a change in status under § 1.125–4(a). If a qualified HSA distribution is made to an employee's HSA, even if the balance in a health FSA is reduced to zero, the employee's health FSA coverage continues to the end of the plan year. Unused benefits and contributions remaining at the end of a plan year (or at the end of a grace period, if applicable) must be forfeited.

(o) *FSA experience gains or forfeitures*—(1) *Experience gains in general.* An FSA experience gain (sometimes referred to as forfeitures in the use-or-lose rule in paragraph (c) in this section) with respect to a plan year (plus any grace period following the end of a plan year described in paragraph (e) in § 1.125–1), equals the amount of the employer contributions, including salary reduction contributions, and after-tax employee contributions to the FSA minus the FSA's total claims reimbursements for the year. Experience gains (or forfeitures) may be—

(i) Retained by the employer maintaining the cafeteria plan; or

(ii) If not retained by the employer, may be used only in one or more of the following ways—

(A) To reduce required salary reduction amounts for the immediately following plan year, on a reasonable and uniform basis, as described in paragraph (o)(2) of this section;

(B) Returned to the employees on a reasonable and uniform basis, as described in paragraph (o)(2) of this section; or

(C) To defray expenses to administer the cafeteria plan.

(2) *Allocating experience gains among employees on reasonable and uniform basis.* If not retained by the employer or used to defray expenses of administering the plan, the experience gains must be allocated among employees on a reasonable and uniform basis. It is permissible to allocate these amounts based on the different coverage levels of employees under the FSA. Experience gains allocated in compliance with this paragraph (o) are not a deferral of the receipt of compensation. However, in no case may the experience gains be allocated among employees based (directly or indirectly) on their individual claims experience. Experience gains may not be used as contributions directly or indirectly to any deferred compensation benefit plan.

(3) *Example.* The following example illustrates the rules in this paragraph (o):

Example. Allocating experience gains. (i) Employer L maintains a cafeteria plan for its 1,200 employees, who may elect one of several different annual coverage levels under a health FSA in $100 increments from $500 to $2,000.

(ii) For the 2009 plan year, 1,000 employees elect levels of coverage under the health FSA. For the 2009 plan year, the health FSA has an experience gain of $5,000.

(iii) The $5,000 may be allocated to all participants for the plan year on a per capita basis weighted to reflect the participants' elected levels of coverage.

(iv) Alternatively, the $5,000 may be used to reduce the required salary reduction amount under the health FSA for all 2009 participants (for example, a $500 health FSA for the next year is priced at $480) or to reimburse claims incurred above the elective limit in 2010 as long as such reimbursements are made on a reasonable and uniform level.

(p) *Effective/applicability date.* It is proposed that these regulations apply on and after plan years beginning on or after January 1, 2009.

§ 1.125–6 Substantiation of expenses for all cafeteria plans.

(a) *Cafeteria plan payments and reimbursements*—(1) *In general.* 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. This requirement applies to all qualified benefits offered through the cafeteria plan. See paragraph (b) of this section for substantiation rules.

(2) *Expenses incurred*—(i) *Employees' medical expenses must be incurred during the period of coverage.* In order for reimbursements to be excludible from gross income under section 105(b), the medical expenses reimbursed by an accident and health plan elected through a cafeteria plan must be incurred during the period when the participant is covered by the accident and health plan. A participant's period of coverage includes COBRA coverage. See § 54.4980B–2 of this chapter. Medical expenses incurred before the later of the effective date of the plan and the date the employee is enrolled in the plan are not incurred during the period for which the employee is covered by the plan. However, the actual reimbursement of covered medical care expenses may be made after the applicable period of coverage.

(ii) *When medical expenses are incurred.* For purposes of this rule, medical expenses are incurred when the employee (or the employee's spouse or dependents) is provided with the medical care that gives rise to the medical expenses, and not when the employee is formally billed, charged for, or pays for the medical care.

(iii) *Example.* The following example illustrates the rules in this paragraph (a)(2):

Example. Medical expenses incurred after termination. (i) Employer E maintains a cafeteria plan with a calendar year plan year. The cafeteria plan provides that participation terminates when an individual ceases to be an employee of Employer E, unless the former employee elects to continue to participate in the health FSA under the COBRA rules in § 54.4980B-2 of this chapter. Employee G timely elects to salary reduce $1,200 to participate in a health FSA for the 2009 plan year. As of June 30, 2009, Employee G has contributed $600 toward the health FSA, but incurred no medical expenses. On June 30, 2009, Employee G terminates employment and does not continue participation under COBRA. On July 15, 2009, G incurs a section 213(d) medical expense of $500.

(ii) Under the rules in paragraph (a)(2) of this section, the cafeteria plan is prohibited from reimbursing any portion of the $500 medical expense because, at the time the medical expense is incurred, G is not a participant in the cafeteria plan.

(3) *Section 105(b) requirements for reimbursement of medical expenses through a cafeteria plan*—(i) *In general.* In order for medical care reimbursements paid to an employee through a cafeteria plan to be excludible under section 105(b), the reimbursements must be paid pursuant to an employer-funded *accident and health plan,* as defined in section 105(e) and §§ 1.105–2 and 1.105–5.

(ii) *Reimbursement exclusively for section 213(d) medical expenses.* A cafeteria plan benefit through which an employee receives reimbursements of medical expenses is excludable under section 105(b) only if reimbursements from the plan are made specifically to reimburse the employee for medical expenses (as defined in section 213(d)) incurred by the employee or the employee's spouse or dependents during the period of coverage. Amounts paid to an employee as reimbursement are not paid specifically to reimburse the employee for medical expenses if the plan provides that the employee is entitled, or operates in a manner that entitles the employee, to receive the amounts, in the form of cash (for example, routine payment of salary) or any other taxable or nontaxable benefit irrespective of whether the employee (or the employee's spouse or dependents) incurs medical expenses during the period of coverage. This rule applies even if the employee will not receive such amounts until the end or after the end of the period. A plan under which employees (or their spouses and dependents) will receive reimbursement for medical expenses up to a specified amount and, if they incur no medical expenses, will receive cash or any other benefit in lieu of the reimbursements is not a benefit qualifying for the exclusion under sections 106 and 105(b). See § 1.105–2. This is the case without regard to whether the benefit was purchased with contributions made at the employer's discretion, at the employee's discretion (for example, by salary reduction election), or pursuant to a collective bargaining agreement.

(iii) *Other arrangements.* Arrangements formally outside of the cafeteria plan that adjust an employee's compensation or an employee's receipt of any other benefits on the basis of the expenses incurred or reimbursements the employee receives are considered in determining whether the reimbursements are through a plan eligible for the exclusions under sections 106 and 105(b).

(4) *Reimbursements of dependent care expenses*—(i) *Dependent care expenses must be incurred.* In order to satisfy section 129, dependent care expenses may not be reimbursed before the expenses are incurred. For purposes of this rule, dependent care expenses are incurred when the care is provided and not when the employee is formally billed, charged for, or pays for the dependent care.

(ii) *Dependent care provided during the period of coverage.* In order for dependent care assistance to be provided through a dependent care assistance program eligible for the section 129 exclusion, the care must be provided to or on behalf of the employee during the period for which the employee is covered by the program. For example, if for a plan year, an employee elects a dependent care assistance program providing for reimbursement of dependent care expenses, only reimbursements for dependent care expenses incurred during that plan year are provided from a dependent care assistance program within the scope of section 129. Also, for purposes of this rule, expenses incurred before the later of the program's effective date and the date the employee is enrolled in the program are not incurred during the period when the employee is covered by the program. Similarly, if the dependent care assistance program furnishes the dependent care in-kind (for example, through an employer-maintained child care facility), only dependent care provided during the plan year of coverage is provided through a dependent care assistance program within the meaning of section 129. See also § 1.125–5 for FSA rules.

(iii) *Period of coverage.* In order for dependent care assistance through a cafeteria plan to be provided through a dependent care assistance program eligible for the section 129 exclusion, the 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. If the period of coverage for a dependent care assistance program offered through a cafeteria plan is twelve months (or, in the case of a short plan year, at least equal to the short plan year) and the plan does not permit an employee to elect specific amounts of coverage, reimbursement, or salary reduction for less than twelve months, the plan is deemed not to operate to enable employees to purchase coverage only for periods when dependent care assistance will be received. See paragraph (a) in § 1.125–2 and § 1.125–4 regarding the revocation of elections during the period of coverage on account of changes in family status. See paragraph (e) in this section for required period of coverage for dependent care assistance.

(iv) *Examples.* The following examples illustrate the rules in paragraphs (a)(4)(i)–(iii) of this section:

Example 1. Initial non-refundable fee for child care. (i) Employer F maintains a calendar year cafeteria plan, offering employees an election between cash and qualified benefits, including dependent care assistance. Employee M has a one-year old dependent child. Employee M timely elected $5,000 of dependent care assistance for 2009. During the entire 2009 plan year, Employee M satisfies all the requirements in section 129 for dependent care assistance.

(ii) On February 1, 2009, Employee M pays an initial non-refundable fee of $500 to a licensed child care center (unrelated to Employer F or to Employee M), to reserve a space at the child care center for M's child. The child care center's monthly charges for child care are $1,200. When the child care center first begins to care for M's child, the $500 non-refundable fee is applied toward the first month's charges for child care.

(iii) On March 1, 2009, the child care center begins caring for Employee M's child, and continues to care for the child through December 31, 2009. On March 1, 2009, M pays the child care center $700 (the balance of the $1,200 in charges for child care to be provided in March 2009). On April 1, 2009, M pays the child care center $1,200 for the child care to be provided in April 2009.

(iv) Dependent care expenses are incurred when the services are provided. For dependent care services provided in March 2009, the $500 nonrefundable fee paid on February 1, 2009, and the $700 paid on March 1, 2009 may be reimbursed on or after the later of the date when substantiated or April 1, 2009. For dependent care services provided in April 2009, the $1,200 paid on April 1, 2009 may be reimbursed on or after the later of the date when substantiated or May 1, 2009.

Example 2. Non-refundable fee forfeited. Same facts as *Example 1*, except that the child care center never cared for M's child (who was instead cared for at Employer F's onsite child care facility). Because the child care center never provided child care services to Employee M's child, the $500 non-refundable fee is not reimbursable.

(v) *Optional spend-down provision.* At the employer's option, the written cafeteria plan may provide that dependent care expenses incurred after the date an employee ceases participation in the cafeteria plan (for example, after termination) and through the last day of that plan year (or grace period immediately after that plan year) may be reimbursed from unused benefits, if all of the requirements of section 129 are satisfied.

(vi) *Example.* The following example illustrates the rules in paragraph (a)(4)(v) of this section:

Example. Terminated employee's post-termination dependent care expenses. (i) For calendar year 2009, Employee X elects $5,000 salary reduction for dependent care assistance through Employer G's cafeteria plan. X works for Employer G from January 1 through June 30, 2009, when X terminates employment. As of June 30, 2009, X had paid $2,500 in salary reduction and had incurred and was reimbursed for $2,000 of dependent care expenses.

(ii) X does not work again until October 1, 2009, when X begins work for Employer H. X was employed by Employer H from October 1, 2009 through December 31, 2009. During this period, X also incurred $500 of dependent care expenses. During all the periods of employment in 2009, X satisfied all requirements in section 129 for excluding payments for dependent care assistance from gross income.

(iii) Employer G's cafeteria plan allows terminated employees to "spend down" unused salary reduction amounts for dependent care assistance, if all requirements of section 129 are satisfied. After X's claim for $500 of dependent care expenses is substantiated, Employer G's cafeteria plan reimburses X for $500 (the remaining balance) of dependent care expenses incurred during X's employment for Employer H between October 1, 2009 and December 31, 2009. Employer G's cafeteria plan and operation are consistent with section 125.

(b) *Rules for claims substantiation for cafeteria plans*—(1) *Substantiation required before reimbursing expenses for qualified benefits.* This paragraph (b) sets forth the substantiation requirements that a cafeteria plan must satisfy before paying or reimbursing any expense for a qualified benefit.

(2) *All claims must be substantiated.* As a precondition of payment or reimbursement of expenses for qualified benefits, a cafeteria plan must require substantiation in accordance with this section. Substantiating only a percentage of claims, or substantiating only claims above a certain dollar amount, fails to comply with the substantiation requirements in § 1.125–1 and this section.

(3) *Substantiation by independent third-party*—(i) *In general.* All expenses must be substantiated by information from a third-party that is independent of the employee and the employee's spouse and dependents. The independent third-party must provide information describing the service or product, the date of the service or sale, and the amount. Self-substantiation or self-certification of an expense by an employee does not satisfy the substantiation requirements of this paragraph (b). The specific requirements in sections 105(b), 129, and 137 must also be satisfied as a condition of reimbursing expenses for qualified benefits. For example, a health FSA does not satisfy the requirements of section 105(b) if it reimburses employees for expenses where the employees only submit information describing medical expenses, the amount of the expenses and the date of the expenses but fail to provide a statement from an independent third-party (either automatically or subsequent to the transaction) verifying the expenses. Under § 1.105–2, all amounts paid under a plan that permits self-substantiation or self-certification are includible in gross income, including amounts reimbursed for medical expenses, whether or not substantiated. See paragraph (m) in § 1.125–5 for additional substantiation rules for limited-purpose and post-deductible health FSAs.

(ii) *Rules for substantiation of health FSA claims using an explanation of benefits provided by an insurance company*—(A) *Written statement from an independent third-party.* If the employer is provided with information from an independent third-party (such as an "*explanation of benefits*" (*EOB*) from an insurance company) indicating the date of the section 213(d) medical care and the employee's responsibility for payment for that medical care (that is, coinsurance payments and amounts below the plan's deductible), and the employee certifies that any expense paid through the health FSA has not been reimbursed and that the employee will not seek reimbursement from any other plan covering health benefits, the claim is fully substantiated without the need for submission of a receipt by the employee or further review.

(B) *Example.* The following example illustrates the rules in this paragraph (b)(3):

Example. Explanation of benefits. (i) During the plan year ending December 31, 2009, Employee Q is a participant in the health FSA sponsored by Employer J and is enrolled in Employer J's accident and health plan.

(ii) On March 1, 2009, Q visits a physician's office for medical care as defined in section 213(d). The charge for the physician's services is $150. Under the plan, Q is responsible for 20 percent of the charge for the physician's services (that is, $30). Q has sufficient FSA coverage for the $30 claim.

(iii) Employer J has coordinated with the accident and health plan so that Employer J or its agent automatically receives an EOB from the plan indicating that Q is responsible for payment of 20 percent of the $150 charged by the physician. Because Employer J has received a statement from an independent third-party that Q has incurred a medical expense, the date the expense was incurred, and the amount of the expense, the claim is substantiated without the need for J to submit additional information regarding the expense. Employer J's FSA reimburses Q the $30 medical expense without requiring Q to submit a receipt or a statement from the physician. The substantiation rules in paragraph (b) in this section are satisfied.

(4) *Advance reimbursement of expenses for qualified benefits prohibited.* Reimbursing expenses before the expense has been incurred or before the expense is substantiated fails to satisfy the substantiation requirements in § 1.105–2, § 1.125–1 and this section.

(5) *Purported loan from employer to employee.* In determining whether, under all the facts and circumstances, employees are being reimbursed for unsubstantiated claims, special scrutiny will be given to other arrangements such as employer-to-employee loans based on actual or projected employee claims.

(6) *Debit cards.* For purposes of this section, a *debit card* is a debit card, credit card, or stored value card. See also paragraphs (c) through (g) of this section for additional rules on payments or reimbursements made through debit cards.

(c) *Debit cards–overview*—(1) *Mandatory rules for all debit cards usable to pay or reimburse medical expenses.* Paragraph (d) of this section sets forth the mandatory procedures for debit cards to substantiate section 213(d) medical expenses. These rules apply to all debit cards used to pay or

reimburse medical expenses. Paragraph (e) of this section sets forth additional substantiation rules that may be used for medical expenses incurred at medical care providers and certain stores with the Drug Stores and Pharmacies merchant category code. Paragraph (f) in this section sets forth the requirements for an inventory information approval system which must be used to substantiate medical expenses incurred at merchants or service providers that are not medical care providers or certain stores with the Drug Stores and Pharmacies merchant category code and that may be used for medical expenses incurred at all merchants.

(2) *Debit cards used for dependent care assistance.* Paragraph (g) of this section sets forth additional rules for debit cards usable for reimbursing dependent care expenses.

(3) *Additional guidance.* The Commissioner may prescribe additional guidance of general applicability, published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii)(*b*) of this chapter), to provide additional rules for debit cards.

(d) *Mandatory rules for all debit cards usable to pay or reimburse medical expenses.* A health FSA paying or reimbursing section 213(d) medical expenses through a debit card must satisfy all of the following requirements—

(1) Before any employee participating in a health FSA receives the debit card, the employee agrees in writing that he or she will only use the card to pay for medical expenses (as defined in section 213(d)) of the employee or his or her spouse or dependents, that he or she will not use the debit card for any medical expense that has already been reimbursed, that he or she will not seek reimbursement under any other health plan for any expense paid for with a debit card, and that he or she will acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the debit card.

(2) The debit card includes a statement providing that the agreements described in paragraph (d)(1) of this section are reaffirmed each time the employee uses the card.

(3) The amount available through the debit card equals the amount elected by the employee for the health FSA for the cafeteria plan year, and is reduced by amounts paid or reimbursed for section 213(d) medical expenses incurred during the plan year.

(4) The debit card is automatically cancelled when the employee ceases to participate in the health FSA.

(5) The employer limits use of the debit card to—

(i) Physicians, dentists, vision care offices, hospitals, other medical care providers (as identified by the merchant category code);

(ii) Stores with the merchant category code for Drugstores and Pharmacies if, on a location by location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care described in section 213(d); and

(iii) Stores that have implemented the inventory information approval system under paragraph (f).

(6) The employer substantiates claims based on payments to medical care providers and stores described in paragraphs (d)(5)(i) and (ii) of this section in accordance with either paragraph (e) or paragraph (f) of this section.

(7) The employer follows all of the following correction procedures for any improper payments using the debit card—

(i) Until the amount of the improper payment is recovered, the debit card must be de-activated and the employee must request payments or reimbursements of medical expenses from the health FSA through other methods (for example, by submitting receipts or invoices from a merchant or service provider showing the employee incurred a section 213(d) medical expense);

(ii) The employer demands that the employee repay the cafeteria plan an amount equal to the improper payment;

(iii) If, after the demand for repayment of improper payment (as described in paragraph (d)(7)(ii) of this section), the employee fails to repay the amount of the improper charge, the employer withholds the amount of the improper charge from the employee's pay or other compensation, to the full extent allowed by applicable law;

(iv) If any portion of the improper payment remains outstanding after attempts to recover the amount (as described in paragraph (d)(7)(ii) and (iii) of this section), the employer applies a claims substitution or offset to resolve improper payments, such as a reimbursement for a later substantiated expense claim is reduced by the amount of the improper payment. So, for example, if an employee has received an improper payment of $200 and subsequently submits a substantiated claim for $250 incurred during the same coverage period, a reimbursement for $50 is made; and

(v) If, after applying all the procedures described in paragraph (d)(7)(ii) through (iv) of this section, the employee remains indebted to the employer for improper payments, the employer, consistent with its business practice, treats the improper payment as it would any other business indebtedness.

(e) *Substantiation of expenses incurred at medical care providers and certain other stores with Drug Stores and Pharmacies merchant category code*—(1) *In general.* A health FSA paying or reimbursing section 213(d) medical expenses through a debit card is permitted to comply with the substantiation provisions of this paragraph (e), instead of complying with the provisions of paragraph (f), for medical expenses incurred at providers described in paragraph (e)(2) of this section.

(2) *Medical care providers and certain other stores with Drug Stores and Pharmacies merchant category code.* Medical expenses may be substantiated using the methods described in paragraph (e)(3) of this section if incurred at physicians, pharmacies, dentists, vision care offices, hospitals, other medical care providers (as identified by the merchant category code) and at stores with the Drug Stores and Pharmacies merchant category code, if, on a store location-by-location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care described in section 213(d).

(3) *Claims substantiation for copayment matches, certain recurring medical expenses and real-time substantiation.* If all of the requirements in this paragraph (e)(3) are satisfied, copayment matches, certain recurring medical expenses and medical expenses substantiated in real-time are substantiated without the need for submission of receipts or further review.

(i) *Matching copayments—multiples of five or fewer.* If an employer's accident or health plan covering the employee (or the employee's spouse or dependents) has copayments in specific dollar amounts, and the dollar amount of the transaction at a medical care provider equals an exact multiple of not more than five times the dollar amount of the copayment for the specific service (for example, pharmacy benefit copayment, copayment for a physician's office visit) under the accident or health plan covering the specific employee-cardholder, then the charge is fully substantiated without the need for submission of a receipt or further review.

(A) *Tiered copayments.* If a health plan has multiple copayments for the same benefit, (for example, tiered

copayments for a pharmacy benefit), exact matches of multiples or combinations of up to five copayments are similarly fully substantiated without the need for submission of a receipt or further review.

(B) *Copayment match must be exact multiple.* If the dollar amount of the transaction is not an exact multiple of the copayment (or an exact match of a multiple or combination of different copayments for a benefit in the case of multiple copayments), the transaction must be treated as conditional pending confirmation of the charge, even if the amount is less than five times the copayment.

(C) *No match for multiple of six or more times copayment.* If the dollar amount of the transaction at a medical care provider equals a multiple of six or more times the dollar amount of the copayment for the specific service, the transaction must be treated as conditional pending confirmation of the charge by the submission of additional third-party information. See paragraph (d) of this section. In the case of a plan with multiple copayments for the same benefit, if the dollar amount of the transaction exceeds five times the maximum copayment for the benefit, the transaction must also be treated as conditional pending confirmation of the charge by the submission of additional third-party information. In these cases, the employer must require that additional third-party information, such as merchant or service provider receipts, be submitted for review and substantiation, and the third-party information must satisfy the requirements in paragraph (b)(3) of this section.

(D) *Independent verification of copayment required.* The copayment schedule required under the accident or health plan must be independently verified by the employer. Statements or other representations by the employee are not sufficient. Self-substantiation or self-certification of an employee's copayment in connection with copayment matching procedures through debit cards or otherwise does not constitute substantiation. If a plan's copayment matching system relies on an employee to provide a copayment amount without verification of the amount, claims have not been substantiated, and all amounts paid from the plan are included in gross income, including amounts paid for medical care whether or not substantiated. See paragraph (b) in this section.

(4) *Certain recurring medical expenses.* Automatic payment or reimbursement satisfies the substantiation rules in this paragraph (e) for payment of recurring expenses that match expenses previously approved as to amount, medical care provider and time period (for example, for an employee who refills a prescription drug on a regular basis at the same provider and in the same amount). The payment is substantiated without the need for submission of a receipt or further review.

(5) *Real-time substantiation.* If a third party that is independent of the employee and the employee's spouse and dependents (for example, medical care provider, merchant, or pharmacy benefit manager) provides, at the time and point of sale, information to verify to the employer (including electronically by email, the internet, intranet or telephone) that the charge is for a section 213(d) medical expense, the expense is substantiated without the need for further review.

(6) *Substantiation requirements for all other medical expenses paid or reimbursed through a health FSA debit card.* All other charges to the debit card (other than substantiated copayments, recurring medical expenses or real-time substantiation, or charges substantiated through the inventory information approval system described in paragraph (f) of this section) must be treated as conditional, pending substantiation of the charge through additional independent third-party information describing the goods or services, the date of the service or sale and the amount of the transaction. All such debit card payments must be substantiated, regardless of the amount of the payment.

(f) *Inventory information approval system*—(1) *In general.* An inventory information approval system that complies with this paragraph (f) may be used to substantiate payments made using a debit card, including payments at merchants and service providers that are not described in paragraph (e)(2) of this section. Debit card transactions using this system are fully substantiated without the need for submission of a receipt by the employee or further review.

(2) *Operation of inventory information approval system.* An inventory information approval system must operate in the manner described in this paragraph (f)(2).

(i) When an employee uses the card, the payment card processor's or participating merchant's system collects information about the items purchased using the inventory control information (for example, *stock keeping units* (SKUs)). The system compares the inventory control information for the items purchased against a list of items, the purchase of which qualifies as expenses for medical care under section 213(d) (including nonprescription medications).

(ii) The section 213(d) medical expenses are totaled and the merchant's or payment card processor's system approves the use of the card only for the amount of the section 213(d) medical expenses eligible for coverage under the health FSA (taking into consideration the uniform coverage rule in paragraph (d) of § 1.125–5);

(iii) If the transaction is only partially approved, the employee is required to tender additional amounts, resulting in a split-tender transaction. For example, if, after matching inventory information, it is determined that all items purchased are section 213(d) medical expenses, the entire transaction is approved, subject to the coverage limitations of the health FSA;

(iv) If, after matching inventory information, it is determined that only some of the items purchased are section 213(d) medical expenses, the transaction is approved only as to the section 213(d) medical expenses. In this case, the merchant or service-provider must request additional payment from the employee for the items that do not satisfy the definition of medical care under section 213(d);

(v) The merchant or service-provider must also request additional payment from the employee if the employee does not have sufficient health FSA coverage to purchase the section 213(d) medical items;

(vi) Any attempt to use the card at non-participating merchants or service-providers must fail.

(3) *Employer's responsibility for ensuring inventory information approval system's compliance with § 1.105–2, § 1.125–1, § 1.125–6 and recordkeeping requirements.* An employer that uses the inventory information approval system must ensure that the inventory information approval system complies with the requirements in §§ 1.105–2, 1.125–1, and § 1.125–6 for substantiating, paying or reimbursing section 213(d) medical expenses and with the recordkeeping requirements in section 6001.

(g) *Debit cards used to pay or reimburse dependent care assistance*—(1) *In general.* An employer may use a debit card to provide benefits under its dependent care assistance program (including a dependent care assistance FSA). However, dependent care expenses may not be reimbursed before the expenses are incurred. See paragraph (a)(4) in this section. Thus, if a dependent care provider requires

payment before the dependent care services are provided, the expenses cannot be reimbursed at the time of payment through use of a debit card or otherwise.

(2) *Reimbursing dependent care assistance through a debit card.* An employer offering a dependent care assistance FSA may adopt the following method to provide reimbursements for dependent care expenses through a debit card—

(i) At the beginning of the plan year or upon enrollment in the dependent care assistance program, the employee pays initial expenses to the dependent care provider and substantiates the initial expenses by submitting to the employer or plan administrator a statement from the dependent care provider substantiating the dates and amounts for the services provided.

(ii) After the employer or plan administrator receives the substantiation (but not before the date the services are provided as indicated by the statement provided by the dependent care provider), the plan makes available through the debit card an amount equal to the lesser of—

(A) The previously incurred and substantiated expense; or

(B) The employee's total salary reduction amount to date.

(iii) The card may be used to pay for subsequently incurred dependent care expenses.

(iv) The amount available through the card may be increased in the amount of any additional dependent care expenses only after the additional expenses have been incurred.

(3) *Substantiating recurring dependent care expenses.* Card transactions that collect information matching expenses previously substantiated and approved as to dependent care provider and time period may be treated as substantiated without further review if the transaction is for an amount equal to or less than the previously substantiated expenses. Similarly, dependent care expenses previously substantiated and approved through nonelectronic methods may also be treated as substantiated without further review. In both cases, if there is an increase in previously substantiated amounts or a change in the dependent care provider, the employee must submit a statement or receipt from the dependent care provider substantiating the claimed expenses before amounts relating to the increased amounts or new providers may be added to the card.

(4) *Example.* The following example illustrates the rules in this paragraph (g):

Example. Recurring dependent care expenses. (i) Employer K sponsors a dependent care assistance FSA through its cafeteria plan. Salary reduction amounts for participating employees are made on a weekly payroll basis, which are available for dependent care coverage on a weekly basis. As a result, the amount of available dependent care coverage equals the employee's salary reduction amount minus claims previously paid from the plan. Employer K has adopted a payment card program for its dependent care FSA.

(ii) For the plan year ending December 31, 2009, Employee F is a participant in the dependent care FSA and elected $5,000 of dependent care coverage. Employer K reduces F's salary by $96.15 on a weekly basis to pay for coverage under the dependent care FSA.

(iii) At the beginning of the 2009 plan year, F is issued a debit card with a balance of zero. F's childcare provider, ABC Daycare Center, requires a $250 advance payment at the beginning of the week for dependent care services that will be provided during the week. The dependent care services provided for F by ABC qualify for reimbursement under section 129. However, because as of the beginning of the plan year, no services have yet been provided, F cannot be reimbursed for any of the amounts until the end of the first week of the plan year (that is, the week ending January 5, 2009), after the services have been provided.

(iv) F submits a claim for reimbursement that includes a statement from ABC with a description of the services, the amount of the services, and the dates of the services. Employer K increases the balance of F's payment card to $96.15 after the services have been provided (i.e., the lesser of F's salary reduction to date or the incurred dependent care expenses). F uses the card to pay ABC $96.15 on the first day of the next week (January 8, 2009) and pays ABC the remaining balance due for that week ($153.85) by check.

(v) To the extent that this card transaction and each subsequent transaction is with ABC and is for an amount equal to or less than the previously substantiated amount, the charges are fully substantiated without the need for the submission by F of a statement from the provider or further review by the employer. However, the subsequent amount is not made available on the card until the end of the week when the services have been provided. Employer K's dependent care debit card satisfies the substantiation requirements of this paragraph (g).

(h) *Effective/applicability date.* It is proposed that these regulations apply on and after plan years beginning on or after January 1, 2009. However, the effective dates for the previously issued guidance on debit cards, which is incorporated in this section, remain applicable.

§ 1.125–7 Cafeteria plan nondiscrimination rules.

(a) *Definitions*—(1) *In general.* The definitions set forth in this paragraph (a) apply for purposes of section 125(b), (c), (e) and (g) and this section.

(2) *Compensation.* The term *compensation* means compensation as defined in section 415(c)(3).

(3) *Highly compensated individual.* (i) *In general.* The term *highly compensated individual* means an individual who is—

(A) An officer;

(B) A five percent shareholder (as defined in paragraph (a)(8) of this section); or

(C) Highly compensated.

(ii) *Spouse or dependent.* A spouse or a dependent of any highly compensated individual described in (a)(3)(i) of this section is a highly compensated individual. Section 125(e).

(4) *Highly compensated participant.* The term *highly compensated participant* means a highly compensated individual who is eligible to participate in the cafeteria plan.

(5) *Nonhighly compensated individual.* The term *nonhighly compensated individual* means an individual who is not a highly compensated individual.

(6) *Nonhighly compensated participant.* The term *nonhighly compensated participant* means a participant who is not a highly compensated participant.

(7) *Officer.* The term officer means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) was an officer. Whether an individual is an *officer* is determined based on all the facts and circumstances, including the source of the individual's authority, the term for which he or she is elected or appointed, and the nature and extent of his or her duties. Generally, the term officer means an administrative executive who is in regular and continued service. The term officer implies continuity of service and excludes individuals performing services in connection with a special and single transaction. An individual who merely has the title of an officer but not the authority of an officer, is not an officer. Similarly, an individual without the title of an officer but who has the authority of an officer is an officer. Sole proprietorships, partnerships, associations, trusts and labor organizations also may have officers. See §§ 301.7701–1 through –3

(8) *Five percent shareholder.* A *five percent shareholder* is an individual who in either the preceding plan year or current plan year owns more than five percent of the voting power or value of all classes of stock of the employer, determined without attribution.

(9) *Highly compensated.* The term *highly compensated* means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation from the employer in excess of the compensation amount specified in section 414(q)(1)(B), and, if elected by the employer, was also in the top-paid group of employees (determined by reference to section 414(q)(3)) for such preceding plan year (or for the current plan year in the case of the first year of employment).

(10) *Key employee.* A *key employee* is a participant who is a key employee within the meaning of section 416(i)(1) at any time during the preceding plan year. A key employee covered by a collective bargaining agreement is a key employee.

(11) *Collectively bargained plan.* A *collectively bargained plan* is a plan or the portion of a plan maintained under an agreement which is a collective bargaining agreement between employee representatives and one or more employers, if there is evidence that cafeteria plan benefits were the subject of good faith bargaining between such employee representatives and such employer or employers.

(12) *Year of employment.* For purposes of section 125(g)(3)(B)(i), a *year of employment* is determined by reference to the elapsed time method of crediting service. See § 1.410(a)–7.

(13) *Premium-only-plan.* A premium-only-plan is described in paragraph (a)(5) in § 1.125–1.

(14) *Statutory nontaxable benefits. Statutory nontaxable benefits* are qualified benefits that are excluded from gross income (for example, an employer-provided accident and health plan excludible under section 106 or a dependent care assistance program excludible under section 129). Statutory nontaxable benefits also include group-term life insurance on the life of an employee includible in the employee's gross income solely because the coverage exceeds the limit in section 79(a).

(15) *Total benefits. Total benefits* are qualified benefits and permitted taxable benefits.

(b) *Nondiscrimination as to eligibility*—(1) *In general.* A cafeteria plan must not discriminate in favor of highly compensated individuals as to eligibility to participate for that plan year. A cafeteria plan does not discriminate in favor of highly compensated individuals if the plan benefits a group of employees who qualify under a reasonable classification established by the employer, as defined in § 1.410(b)–4(b), and the group of employees included in the classification satisfies the safe harbor percentage test or the unsafe harbor percentage component of the facts and circumstances test in § 1.410(b)–4(c). (In applying the § 1.410(b)–4 test, substitute highly compensated individual for highly compensated employee and substitute nonhighly compensated individual for nonhighly compensated employee).

(2) *Deadline for participation in cafeteria plan.* Any employee who has completed three years of employment (and who satisfies any conditions for participation in the cafeteria plan that are not related to completion of a requisite length of employment) must be permitted to elect to participate in the cafeteria plan no later than the first day of the first plan year beginning after the date the employee completed three years of employment (unless the employee separates from service before the first day of that plan year).

(3) *The safe harbor percentage test*—(i) *In general.* For purposes of the safe harbor percentage test and the unsafe harbor percentage component of the facts and circumstances test, if the cafeteria plan provides that only employees who have completed three years of employment are permitted to participate in the plan, employees who have not completed three years of employment may be excluded from consideration. However, if the cafeteria plan provides that employees are allowed to participate before completing three years of employment, all employees with less than three years of employment must be included in applying the safe harbor percentage test and the unsafe harbor percentage component of the facts and circumstances test. See paragraph (g) of this section for a permissive disaggregation rule.

(ii) *Employees excluded from consideration.* In addition, for purposes of the safe harbor percentage test and the unsafe harbor percentage component of the facts and circumstances test, the following employees are excluded from consideration—

(A) Employees (except key employees) covered by a collectively bargained plan as defined in paragraph (a)(11) of this section;

(B) Employees who are nonresident aliens and receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)); and

(C) Employees participating in the cafeteria plan under a COBRA continuation provision.

(iv) *Examples.* The following examples illustrate the rules in paragraph (b) of this section:

Example 1. Same qualified benefit for same salary reduction amount. Employer A has one employer-provided accident and health insurance plan. The cost to participants electing the accident and health plan is $10,000 per year for single coverage. All employees have the same opportunity to salary reduce $10,000 for accident and health plan. The cafeteria plan satisfies the eligibility test.

Example 2. Same qualified benefit for unequal salary reduction amounts. Same facts as *Example 1* except the cafeteria plan offers nonhighly compensated employees the election to salary reduce $10,000 to pay premiums for single coverage. The cafeteria plan provides an $8,000 employer flex-credit to highly compensated employees to pay a portion of the premium, and provides an election to them to salary reduce $2,000 to pay the balance of the premium. The cafeteria plan fails the eligibility test.

Example 3. Accident and health plans of unequal value. Employer B's cafeteria plan offers two employer-provided accident and health insurance plans: Plan X, available only to highly compensated participants, is a low-deductible plan. Plan Y, available only to nonhighly compensated participants, is a high deductible plan (as defined in section 223(c)(2)). The annual premium for single coverage under Plan X is $15,000 per year, and $8,000 per year for Plan Y. Employer B's cafeteria plan provides that highly compensated participants may elect salary reduction of $15,000 for coverage under Plan X, and that nonhighly compensated participants may elect salary reduction of $8,000 for coverage under Plan Y. The cafeteria plan fails the eligibility test.

Example 4. Accident and health plans of unequal value for unequal salary reduction amounts. Same facts as *Example 3*, except that the amount of salary reduction for highly compensated participants to elect Plan X is $8,000. The cafeteria plan fails the eligibility test.

(c) *Nondiscrimination as to contributions and benefits*—(1) *In general.* A cafeteria plan must not discriminate in favor of highly compensated participants as to contributions and benefits for a plan year.

(2) *Benefit availability and benefit election.* A cafeteria plan does not discriminate with respect to contributions and benefits if either qualified benefits and total benefits, or employer contributions allocable to statutory nontaxable benefits and employer contributions allocable to total benefits, do not discriminate in favor of highly compensated participants. A cafeteria plan must satisfy this paragraph (c) with respect to both benefit availability and benefit

utilization. Thus, a plan must give each similarly situated participant a uniform opportunity to elect qualified benefits, and the actual election of qualified benefits through the plan must not be disproportionate by highly compensated participants (while other participants elect permitted taxable benefits). Qualified benefits are disproportionately elected by highly compensated participants if the aggregate qualified benefits elected by highly compensated participants, measured as a percentage of the aggregate compensation of highly compensated participants, exceed the aggregate qualified benefits elected by nonhighly compensated participants measured as a percentage of the aggregate compensation of nonhighly compensated participants. A plan must also give each similarly situated participant a uniform election with respect to employer contributions, and the actual election with respect to employer contributions for qualified benefits through the plan must not be disproportionate by highly compensated participants (while other participants elect to receive employer contributions as permitted taxable benefits). Employer contributions are disproportionately utilized by highly compensated participants if the aggregate contributions utilized by highly compensated participants, measured as a percentage of the aggregate compensation of highly compensated participants, exceed the aggregate contributions utilized by nonhighly compensated participants measured as a percentage of the aggregate compensation of nonhighly compensated participants.

(3) *Example.* The following example illustrates the rules in paragraph (c) of this section:

Example. Contributions and benefits test. Employer C's cafeteria plan satisfies the eligibility test in paragraph (b) of this section. Highly compensated participants in the cafeteria plan elect aggregate qualified benefits equaling 5 percent of aggregate compensation; nonhighly compensated participants elect aggregate qualified benefits equaling 10 percent of aggregate compensation. Employer C's cafeteria plan passes the contribution and benefits test.

(d) *Key employees*—(1) *In general.* If for any plan year, the statutory nontaxable benefits provided to key employees exceed 25 percent of the aggregate of statutory nontaxable benefits provided for all employees through the cafeteria plan, each key employee includes in gross income an amount equaling the maximum taxable benefits that he or she could have elected for the plan year. However, see safe harbor for premium-only-plans in paragraph (f) of this section.

(2) *Example.* The following example illustrates the rules in paragraph (d) of this section:

Example. (i) *Key employee concentration test.* Employer D's cafeteria plan offers all employees an election between taxable benefits and qualified benefits. The cafeteria plan satisfies the eligibility test in paragraph (b) of this section. Employer D has two key employees and four nonhighly compensated employees. The key employees each elect $2,000 of qualified benefits. Each nonhighly compensated employee also elects $2,000 of qualified benefits. The qualified benefits are statutory nontaxable benefits.

(ii) Key employees receive $4,000 of statutory nontaxable benefits and nonhighly compensated employees receive $8,000 of statutory nontaxable benefits, for a total of $12,000. Key employees receive 33 percent of statutory nontaxable benefits (4,000/12,000). Because the cafeteria plan provides more than 25 percent of the aggregate of statutory nontaxable benefits to key employees, the plan fails the key employee concentration test.

(e) *Safe harbor for cafeteria plans providing health benefits*—(1) *In general.* A cafeteria plan that provides health benefits is not treated as discriminatory as to benefits and contributions if:

(i) Contributions under the plan on behalf of each participant include an amount which equals 100 percent of the cost of the health benefit coverage under the plan of the majority of the highly compensated participants similarly situated, or equals or exceeds 75 percent of the cost of the health benefit coverage of the participant (similarly situated) having the highest cost health benefit coverage under the plan, and

(ii) Contributions or benefits under the plan in excess of those described in paragraph (e)(1)(i) of this section bear a uniform relationship to compensation.

(2) *Similarly situated.* In determining which participants are similarly situated, reasonable differences in plan benefits may be taken into account (for example, variations in plan benefits offered to employees working in different geographical locations or to employees with family coverage versus employee-only coverage).

(3) *Health benefits.* Health benefits for purposes of this rule are limited to major medical coverage and exclude dental coverage and health FSAs.

(4) *Example.* The following example illustrates the rules in paragraph (e) of this section:

Example. (i) All 10 of Employer E's employees are eligible to elect between permitted taxable benefits and salary reduction of $8,000 per plan year for self-only coverage in the major medical health plan provided by Employer E. All 10 employees elect $8,000 salary reduction for the major medical plan.

(ii) The cafeteria plan satisfies the section 125(g)(2) safe harbor for cafeteria plans providing health benefits.

(f) *Safe harbor test for premium-only-plans*—(1) *In general.* A premium-only-plan (as defined in paragraph (a)(13) of this section) is deemed to satisfy the nondiscrimination rules in section 125(c) and this section for a plan year if, for that plan year, the plan satisfies the safe harbor percentage test for eligibility in paragraph (b)(3) of this section.

(2) *Example.* The following example illustrates the rules in paragraph (f) of this section:

Example. Premium-only-plan. (i) Employer F's cafeteria plan is a premium-only-plan (as defined in paragraph (a)(13) of this section). The written cafeteria plan offers one employer-provided accident and health plan and offers all employees the election to salary reduce same amount or same percentage of the premium for self-only or family coverage. All key employees and all highly compensated employees elect salary reduction for the accident and health plan, but only 20 percent of nonhighly compensated employees elect the accident and health plan.

(ii) The premium-only-plan satisfies the nondiscrimination rules in section 125(b) and (c) and this section.

(g) *Permissive disaggregation for nondiscrimination testing*—(1) *General rule.* If a cafeteria plan benefits employees who have not completed three years of employment, the cafeteria plan is permitted to test for nondiscrimination under this section as if the plan were two separate plans—

(i) One plan benefiting the employees who completed one day of employment but less than three years of employment; and

(ii) Another plan benefiting the employees who have completed three years of employment.

(2) *Disaggregated plans tested separately for eligibility test and contributions and benefits test.* If a cafeteria plan is disaggregated into two separate plans for purposes of nondiscrimination testing, the two separate plans must be tested separately for both the nondiscrimination as to eligibility test in paragraph (b) of this section and the nondiscrimination as to contributions and benefits test in paragraph (c) of this section.

(h) *Optional aggregation of plans for nondiscrimination testing.* An employer who sponsors more than one cafeteria plan is permitted to aggregate two or more of the cafeteria plans for purposes of nondiscrimination testing. If two or

more cafeteria plans are aggregated into a combined plan for this purpose, the combined plan must satisfy the nondiscrimination as to eligibility test in paragraph (b) of this section and the nondiscrimination as to contributions and benefits test in paragraph (c) of this section, as though the combined plan were a single plan. Thus, for example, in order to satisfy the benefit availability and benefit election requirements in paragraph (c)(2) of this section, the combined plan must give each similarly situated participant a uniform opportunity to elect qualified benefits and the actual election of qualified benefits by highly compensated participants must not be disproportionate. However, if a principal purpose of the aggregation is to manipulate the nondiscrimination testing requirements or to otherwise discriminate in favor of highly compensated individuals or participants, the plans will not be permitted to be aggregated for nondiscrimination testing.

(i) *Employees of certain controlled groups.* All employees who are treated as employed by a single employer under section 414(b), (c), (m), or (o) are treated as employed by a single employer for purposes of section 125. Section 125(g)(4); section 414(t).

(j) *Time to perform nondiscrimination testing*—(1) *In general.* Nondiscrimination 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.

(2) The following example illustrates the rules in paragraph (j) of this section:

Example. When to perform discrimination testing. (i) Employer H employs three employees and maintains a calendar year cafeteria plan. During the 2009 plan year, Employee J was an employee the entire calendar year, Employee K was an employee from May 1, through August 31, 2009, and Employee L worked from January 1, 2009 to April 15, 2009, when he retired.

(ii) Nondiscrimination testing for the 2009 plan year must be performed on December 31, 2009, taking into account employees J, K, and L's compensation in the preceding year.

(k) *Discrimination in actual operation prohibited.* In addition to not discriminating as to either benefit availability or benefit utilization, a cafeteria plan must not discriminate in favor of highly compensated participants in actual operation. For example, a plan may be discriminatory in actual operation if the duration of the plan (or of a particular nontaxable benefit offered through the plan) is for a period during which only highly compensated participants utilize the plan (or the benefit). See also the key employee concentration test in section 125(b)(2).

(l) *Anti-abuse rule*—(1) *Interpretation.* The provisions of this section must be interpreted in a reasonable manner consistent with the purpose of preventing discrimination in favor of highly compensated individuals, highly compensated participants and key employees.

(2) *Change in plan testing procedures.* A plan will not be treated as satisfying the requirements of this section if there are repeated changes to plan testing procedures or plan provisions that have the effect of manipulating the nondiscrimination testing requirements of this section, if a principal purpose of the changes was to achieve this result.

(m) *Tax treatment of benefits in a cafeteria plan*—(1) *Nondiscriminatory cafeteria plan.* A participant in a nondiscriminatory cafeteria plan (including a highly compensated participant or key employee) who elects qualified benefits is not treated as having received taxable benefits offered through the plan, and thus the qualified benefits elected by the employee are not includible in the employee's gross income merely because of the availability of taxable benefits. But see paragraph (j) in § 1.125–1 on nondiscrimination rules for sections 79(d), 105(h), 129(d), and 137(c)(2), and limitations on exclusion.

(2) *Discriminatory cafeteria plan.* A highly compensated participant or key employee participating in a discriminatory cafeteria plan must include in gross income (in the participant's taxable year within which ends the plan year with respect to which an election was or could have been made) the value of the taxable benefit with the greatest value that the employee could have elected to receive, even if the employee elects to receive only the nontaxable benefits offered.

(n) *Employer contributions to employees' Health Savings Accounts.* If an employer contributes to employees' Health Savings Accounts (HSAs) through a cafeteria plan (as defined in § 54.4980G–5 of this chapter) those contributions are subject to the nondiscrimination rules in section 125 and this section and are not subject to the comparability rules in section 4980G. See §§ 54.4980G–0 through 54.4980G–5 of this chapter.

(o) *Effective/applicability date.* It is proposed that these regulations apply on and after plan years beginning on or after January 1, 2009.

Kevin M. Brown,

Deputy Commissioner for Services and Enforcement.

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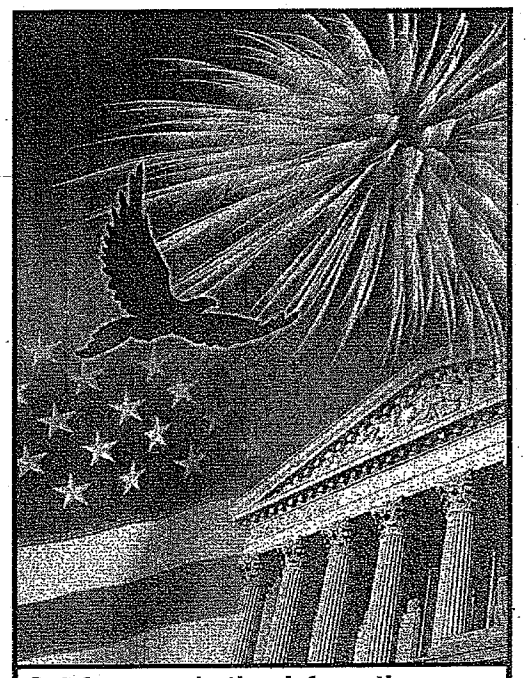
APPENDIX H

Department of the Treasury
Internal Revenue Service

Publication 969
Cat. No. 24216S

Health Savings Accounts and Other Tax-Favored Health Plans

For use in preparing
2011 Returns



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Jan 11, 2012

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What's New

Qualified medical expenses. For HSA, MSA, FSA, and HRA purposes, a medicine or drug will be a qualified medical expense only if the medicine or drug:

1. Requires a prescription,
2. Is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or
3. Is insulin.

This applies to amounts paid after 2010. However, it does not apply to amounts paid in 2011 for medicines or drugs purchased before January 1, 2011.

Additional tax increased. For HSA and MSA purposes, the additional tax on distributions not used for qualified medical expenses is increased to 20%.

Future Developments. The IRS has created a page on IRS.gov for information about Publication 969, at *www.IRS.gov/pub969*. Information about any future developments affecting Publication 969 (such as legislation enacted after we release it) will be posted on that page.

Reminder

Photographs of missing children. The Internal Revenue Service is a proud partner with the National Center for Missing and Exploited Children. Photographs of missing children selected by the Center may appear in this publication on pages that would otherwise be blank. You can help bring these children home by looking at the photographs and calling 1-800-THE-LOST (1-800-843-5678) if you recognize a child.

Introduction

Various programs are designed to give individuals tax advantages to offset health care costs. This publication explains the following programs.

- Health savings accounts (HSAs).
- Medical savings accounts (Archer MSAs and Medicare Advantage MSAs).
- Health flexible spending arrangements (FSAs).
- Health reimbursement arrangements (HRAs).

An HSA may receive contributions from an eligible individual or any other person, including an employer or a family member, on behalf of an eligible individual. Contributions, other than employer contributions, are deductible on the eligible individual's return whether or not the individual itemizes deductions. Employer contributions are not included in income. Distributions from an HSA that are used to pay qualified medical expenses are not taxed.

An Archer MSA may receive contributions from an eligible individual and his or her employer, but not both in the same year. Contributions by the individual are deductible whether or not the individual itemizes deductions. Employer contributions are not included in income. Distributions from an Archer MSA that are used to pay qualified medical expenses are not taxed.

A Medicare Advantage MSA is an Archer MSA designated by Medicare to be used solely to pay the qualified medical expenses of the account holder who is enrolled in Medicare. Contributions can only be made by Medicare. The contributions are not included in your income. Distributions from a Medicare Advantage MSA that are used to pay qualified medical expenses are not taxed.

A health FSA may receive contributions from an eligible individual. Employers may also contribute. Contributions are not includible in income. Reimbursements from an FSA that are used to pay qualified medical expenses are not taxed.

An HRA must receive contributions from the employer only. Employees may not contribute. Contributions are not includible in income. Reimbursements from an HRA that are used to pay qualified medical expenses are not taxed.

Comments and suggestions. We welcome your comments about this publication and your suggestions for future editions.

You can write to us at the following address:

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Tax questions. If you have a tax question, check the information available on IRS.gov or call 1-800-829-1040. We cannot answer tax questions sent to either of the above addresses.

Health Savings Accounts (HSAs)

A health savings account (HSA) is a tax-exempt trust or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. You must be an eligible individual to qualify for an HSA.

No permission or authorization from the IRS is necessary to establish an HSA. When you set up an HSA, you will need to work with a trustee. A qualified HSA trustee can be a bank, an insurance company, or anyone already approved by the IRS to be a trustee of individual retirement arrangements (IRAs) or Archer MSAs. The HSA can be established through a trustee that is different from your health plan provider.

Your employer may already have some information on HSA trustees in your area.

TIP *If you have an Archer MSA, you can generally roll it over into an HSA tax free. See* Rollovers, *later.*

What are the benefits of an HSA? You may enjoy several benefits from having an HSA.

- You can claim a tax deduction for contributions you, or someone other than your employer, make to your HSA even if you do not itemize your deductions on Form 1040.
- Contributions to your HSA made by your employer (including contributions made through a cafeteria plan) may be excluded from your gross income.
- The contributions remain in your account from year to year until you use them.
- The interest or other earnings on the assets in the account are tax free.

- Distributions may be tax free if you pay qualified medical expenses. See *Qualified medical expenses*, later.
- An HSA is "portable" so it stays with you if you change employers or leave the work force.

Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must meet the following requirements.

- You must be covered under a high deductible health plan (HDHP), described later, on the first day of the month.
- You have no other health coverage except what is permitted under *Other health coverage*, later.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's 2011 tax return.

Under the last-month rule, you are considered to be an eligible individual for the entire year if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers).

If you meet these requirements, you are an eligible individual even if your spouse has non-HDHP family coverage, provided your spouse's coverage does not cover you.

If another taxpayer is entitled to claim an exemption for you, you cannot claim a deduction for an HSA contribution. This is true even if the other person does not actually claim your exemption.

Each spouse who is an eligible individual who wants an HSA must open a separate HSA. You cannot have a joint HSA.

High deductible health plan (HDHP). An HDHP has:

- A higher annual deductible than typical health plans, and
- A maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that you must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

An HDHP may provide preventive care benefits without a deductible or with a deductible below the minimum annual deductible. Preventive care includes, but is not limited to, the following.

1. Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
2. Routine prenatal and well-child care.
3. Child and adult immunizations.
4. Tobacco cessation programs.
5. Obesity weight-loss programs.
6. Screening services. This includes screening services for the following:
   a. Cancer.
   b. Heart and vascular diseases.
   c. Infectious diseases.
   d. Mental health conditions.
   e. Substance abuse.
   f. Metabolic, nutritional, and endocrine conditions.
   g. Musculoskeletal disorders.
   h. Obstetric and gynecological conditions.
   i. Pediatric conditions.
   j. Vision and hearing disorders.

   For more information on screening services, see Notice 2004-23, 2004-15 I.R.B. 725 available at *www.irs.gov/irb/2004-15_IRB/ar10.html*.

The following table shows the minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2011.

	Self-only coverage	Family coverage
Minimum annual deductible	$1,200	$2,400
Maximum annual deductible and other out-of-pocket expenses*	$5,950	$11,900

* This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies.

The following table shows the minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2012.

	Self-only coverage	Family coverage
Minimum annual deductible	$1,200	$2,400
Maximum annual deductible and other out-of-pocket expenses*	$6,050	$12,100

* This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies.

Self-only HDHP coverage is an HDHP covering only an eligible individual. Family HDHP coverage is an HDHP covering an eligible individual and at least one other individual (whether or not that individual is an eligible individual).

Example. An eligible individual and his dependent child are covered under an "employee plus one" HDHP offered by the individual's employer. This is family HDHP coverage.

Family plans that do not meet the high deductible rules. There are some family plans that have deductibles for both the family as a whole and for individual family members. Under these plans, if you meet the individual deductible for one family member, you do not have to meet the higher annual deductible amount for the family. If either the deductible for the family as a whole or the deductible for an individual family member is below the minimum annual deductible for family coverage, the plan does not qualify as an HDHP.

Example. You have family health insurance coverage in 2011. The annual deductible for the family plan is $3,500. This plan also has an individual deductible of $1,500 for each family member. The plan does not qualify as an HDHP because the deductible for an individual family member is below the minimum annual deductible ($2,400) for family coverage.

Other health coverage. You (and your spouse, if you have family coverage) generally cannot have any other health coverage that is not an HDHP. However, you can still be an eligible individual even if your spouse has non-HDHP coverage provided you are not covered by that plan.

You can have additional insurance that provides benefits only for the following items.

- Liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property.
- A specific disease or illness.
- A fixed amount per day (or other period) of hospitalization.

You can also have coverage (whether provided through insurance or otherwise) for the following items.

- Accidents.
- Disability.
- Dental care.
- Vision care.
- Long-term care.

CAUTION *Plans in which substantially all of the coverage is through the above listed items are not HDHPs. For example, if your plan provides coverage substantially all of which is for a specific disease or illness, the plan is not an HDHP for purposes of establishing an HSA.*

Prescription drug plans. You can have a prescription drug plan, either as part of your HDHP or a separate plan (or rider), and qualify as an eligible individual if the plan does not provide benefits until the minimum annual deductible of the HDHP has been met. If you can receive benefits before that deductible is met, you are not an eligible individual.

Other employee health plans. An employee covered by an HDHP and a health FSA or an HRA that pays or reimburses qualified medical expenses generally cannot make contributions to an HSA. Health FSAs and HRAs are discussed later.

However, an employee can make contributions to an HSA while covered under an HDHP and one or more of the following arrangements.

- Limited-purpose health FSA or HRA. These arrangements can pay or reimburse the items listed earlier under *Other health coverage,* except long-term care. Also, these arrangements can pay or reimburse preventive care expenses because they can be paid without having to satisfy the deductible.
- Suspended HRA. Before the beginning of an HRA coverage period, you can elect to suspend the HRA. The HRA does not pay or reimburse, at any time, the medical expenses incurred during the suspension period except preventive care and items listed under *Other health coverage.* When the suspension period ends, you are no longer eligible to make contributions to an HSA.
- Post-deductible health FSA or HRA. These arrangements do not pay or reimburse any medical expenses incurred before the minimum annual deductible amount is met. The deductible for these arrangements does not have to be the same as the deductible for the HDHP, but benefits may not be provided before the minimum annual deductible amount is met.
- Retirement HRA. This arrangement pays or reimburses only those medical expenses incurred after retirement. After retirement you are no longer eligible to make contributions to an HSA.

Health FSA – grace period. Coverage during a grace period by a general purpose health FSA is allowed if the balance in the health FSA at the end of its prior year plan is zero, or a qualified HSA distribution (discussed later) of any balance remaining is made to an HSA. See *Flexible Spending Arrangements (FSAs)*, later.

Contributions to an HSA

Any eligible individual can contribute to an HSA. For an employee's HSA, the employee, the employee's employer, or both may contribute to the employee's HSA in the same year. For an HSA established by a self-employed (or unemployed) individual, the individual can contribute. Family members or any other person may also make contributions on behalf of an eligible individual.

Contributions to an HSA must be made in cash. Contributions of stock or property are not allowed.

Limit on Contributions

The amount you or any other person can contribute to your HSA depends on the type of HDHP coverage you have, your age, the date you become an eligible individual, and the date you cease to be an eligible individual. For 2011, if you have self-only HDHP coverage, you can contribute up to $3,050. If you have family HDHP coverage, you can contribute up to $6,150.

TIP *For 2012, if you have self-only HDHP coverage, you can contribute up to $3,100. If you have family HDHP coverage you can contribute up to $6,250.*

If you were, or were considered (under the last-month rule, discussed later), an eligible individual for the entire year and did not change your type of coverage, you can contribute the full amount based on your type of coverage. However, if you were not an eligible individual for the entire year or changed your coverage during the year, your contribution limit is the greater of:

1. The limitation shown on the last line of the *Line 3 Limitation Chart and Worksheet* in the Instructions for Form 8889, Health Savings Accounts (HSAs), or
2. The maximum annual HSA contribution based on your HDHP coverage (self-only or family) on the first day of the last month of your tax year.

TIP *If you had family HDHP coverage on the first day of the last month of your tax year, your contribution limit for 2011 is $6,150 even if you changed coverage during the year.*

Last-month rule. Under the last-month rule, if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered an eligible individual for the entire year. You are treated as having the same HDHP coverage for the entire year as you had on the first day of that last month.

Testing period. If contributions were made to your HSA based on you being an eligible individual for the entire year under the last-month rule, you must remain an eligible individual during the testing period. For the last-month rule, the testing period begins with the last month of your tax year and ends on the last day of the 12th month following that month. For example, December 1, 2011, through December 31, 2012.

If you fail to remain an eligible individual during the testing period, other than because of death or becoming disabled, you will have to include in income the total contributions made to your HSA that would not have been made except for the last-month rule. You include this amount in your income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. The income and additional tax are shown on Form 8889, Part III.

Example 1. Chris, age 53, becomes an eligible individual on December 1, 2011. He has family HDHP coverage on that date. Under the last-month rule, he contributes $6,150 to his HSA.

Chris fails to be an eligible individual in June 2012. Because Chris did not remain an eligible individual during the testing period (December 1, 2011, through December 31, 2012), he must include in his 2012 income the contributions made in 2011 that would not have been made except for the last-month rule. Chris uses the worksheet for line 3 in the Form 8889 instructions to determine this amount.

January	-0-
February	-0-
March	-0-
April	-0-
May	-0-
June	-0-
July	-0-
August	-0-
September	-0-
October	-0-
November	-0-
December	$6,150.00
Total for all months	$6,150.00
Limitation. Divide the total by 12	$512.50

Chris would include $5,637.50 ($6,150.00 – $512.50) in his gross income on his 2012 tax return. Also, a 10% additional tax applies to this amount.

Example 2. Erika, age 39, has self-only HDHP coverage on January 1, 2011. Erika changes to family HDHP coverage on November 1, 2011. Because Erika has family HDHP coverage on December 1, 2011, she contributes $6,150 for 2011.

Erika fails to be an eligible individual in March 2012. Because she did not remain an eligible individual during the testing period (December 1, 2011, through December 31, 2012), she must include in income the contribution made that would not have been made except for the last-month rule. Erika uses the worksheet for line 3 in the Form 8889 instructions to determine this amount.

January	$3,050.00
February	$3,050.00
March	$3,050.00
April	$3,050.00
May	$3,050.00
June	$3,050.00
July	$3,050.00
August	$3,050.00
September	$3,050.00
October	$3,050.00
November	$6,150.00
December	$6,150.00
Total for all months	$42,800.00
Limitation. Divide the total by 12	$3,566.67

Erika would include $2,583.33 ($6,150 – $3,566.67) in her gross income on her 2012 tax return. Also, a 10% additional tax applies to this amount.

Additional contribution. if you are an eligible individual who is age 55 or older at the end of your tax year, your

contribution limit is increased by $1,000. For example, if you have self-only coverage, you can contribute up to $4,050 (the contribution limit for self-only coverage ($3,050) plus the additional contribution of $1,000). However, see Enrolled in Medicare, later.

If you have more than one HSA in 2011, your total contributions to all the HSAs cannot be more than the limits discussed earlier.

Reduction of contribution limit. You must reduce the amount that can be contributed (including any additional contribution) to your HSA by the amount of any contribution made to your Archer MSA (including employer contributions) for the year. A special rule applies to married people, discussed next, if each spouse has family coverage under an HDHP.

Rules for married people. If either spouse has family HDHP coverage, both spouses are treated as having family HDHP coverage. If each spouse has family coverage under a separate plan, the contribution limit for 2011 is $6,150. You must reduce the limit on contributions, before taking into account any additional contributions, by the amount contributed to both spouse's Archer MSAs. After that reduction, the contribution limit is split equally between the spouses unless you agree on a different division.

The rules for married people apply only if both spouses are eligible individuals.

If both spouses are 55 or older and not enrolled in Medicare, each spouse's contribution limit is increased by the additional contribution. If both spouses meet the age requirement, the total contributions under family coverage cannot be more than $8,150. Each spouse must make the additional contribution to his or her own HSA.

Example. For 2011, Mr. Auburn and his wife are both eligible individuals. They each have family coverage under separate HDHPs. Mr. Auburn is 58 years old and Mrs. Auburn is 53. Mr. and Mrs. Auburn can split the family contribution limit ($6,150) equally or they can agree on a different division. If they split it equally, Mr. Auburn can contribute $4,075 to an HSA (one-half the maximum contribution for family coverage ($3,075) + $1,000 additional contribution) and Mrs. Auburn can contribute $3,075 to an HSA.

Employer contributions. You must reduce the amount you, or any other person, can contribute to your HSA by the amount of any contributions made by your employer that are excludable from your income. This includes amounts contributed to your account by your employer through a cafeteria plan.

Enrolled in Medicare. Beginning with the first month you are enrolled in Medicare, your contribution limit is zero.

Example. You turned age 65 in July 2011 and enrolled in Medicare. You had an HDHP with self-only coverage and are eligible for an additional contribution of $1,000. Your contribution limit is $2,025 ($4,050 × 6 ÷ 12).

Qualified HSA funding distribution. A qualified HSA funding distribution may be made from your traditional IRA or ROTH IRA to your HSA. This distribution cannot be made from an ongoing SEP IRA or SIMPLE IRA. For this purpose, a SEP IRA or SIMPLE IRA is ongoing if an employer contribution is made for the plan year ending with or within your tax year in which the distribution would be made.

The maximum qualified HSA funding distribution depends on the HDHP coverage (self-only or family) you have on the first day of the month in which the contribution is made and your age as of the end of the tax year. The distribution must be made directly by the trustee of the IRA to the trustee of the HSA. The distribution is not included in your income, is not deductible, and reduces the amount that can be contributed to your HSA. The qualified HSA funding distribution is shown on Form 8889, Part I, line 10 for the year in which the distribution is made.

You can make only one qualified HSA funding distribution during your lifetime. However, if you make a distribution during a month when you have self-only HDHP coverage, you can make another qualified HSA funding distribution in a later month in that tax year if you change to family HDHP coverage. The total qualified HSA funding distribution cannot be more than the contribution limit for family HDHP coverage plus any additional contribution to which you are entitled.

Example. In 2011, you are an eligible individual, age 57, with self-only HDHP coverage. You can make a qualified HSA funding distribution of $4,050 ($3,050 plus $1,000 additional contribution).

Funding distribution – testing period. You must remain an eligible individual during the testing period. For a qualified HSA funding distribution, the testing period begins with the month in which the qualified HSA funding distribution is contributed and ends on the last day of the 12th month following that month. For example, if a qualified HSA funding distribution is contributed to your HSA on August 10, 2011, your testing period begins in August 2011, and ends on August 31, 2012.

If you fail to remain an eligible individual during the testing period, other than because of death or becoming disabled, you will have to include in income the qualified HSA funding distribution. You include this amount in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. The income and the additional tax are shown on Form 8889, Part III.

Each qualified HSA funding distribution allowed has its own testing period. For example, you are an eligible individual, age 45, with self-only HDHP coverage. On June 18, 2011, you make a qualified HSA funding distribution of $3,050. On July 27, 2011, you enroll in family HDHP coverage and on August 17, 2011, you make a qualified HSA funding distribution of $3,100. Your testing period for the first distribution begins in June 2011 and ends on June 30, 2012. Your testing period for the second distribution begins in August 2011 and ends on August 31, 2012.

The testing period rule that applies under the last-month rule (discussed earlier) does not apply to amounts contributed to an HSA through a qualified HSA funding distribution. If you remain an eligible individual during the entire funding distribution testing period, then no amount of that distribution is included in income and will not be subject to the additional tax for failing to meet the last-month rule testing period.

Rollovers

A rollover contribution is not included in your income, is not deductible, and does not reduce your contribution limit.

Archer MSAs and other HSAs. You can roll over amounts from Archer MSAs and other HSAs into an HSA. You do not have to be an eligible individual to make a rollover contribution from your existing HSA to a new HSA. Rollover contributions do not need to be in cash. Rollovers are not subject to the annual contribution limits.

You must roll over the amount within 60 days after the date of receipt. You can make only one rollover contribution to an HSA during a 1-year period.

Note. If you instruct the trustee of your HSA to transfer funds directly to the trustee of another HSA, the transfer is not considered a rollover. There is no limit on the number of these transfers. Do not include the amount transferred in income, deduct it as a contribution, or include it as a distribution on Form 8889, line 14a.

Qualified HSA distribution. This is a distribution from a health FSA or an HRA that is transferred to your HSA. To be a qualified HSA distribution certain conditions must be met. See *Qualified HSA distribution* under *Flexible Spending Arrangements (FSAs)* and *Health Reimbursement Arrangements (HRAs)*, later.

Testing period. You must remain an eligible individual during the testing period. For a qualified HSA distribution, the testing period begins with the month in which the qualified HSA distribution is contributed and ends on the last day of the 12th month following that month. For example, if a qualified HSA distribution is contributed to your HSA on December 31, 2011, your testing period runs from December 2011, through December 31, 2012.

If you fail to remain an eligible individual during the testing period, other than because of death or becoming disabled, you will have to include in income the qualified HSA distribution. You include this amount in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. The income and the additional tax are shown on Form 8889, Part III.

When To Contribute

You can make contributions to your HSA for 2011 until April 17, 2012. If you fail to be an eligible individual during 2011, you can still make contributions, up until April 17, 2012, for the months you were an eligible individual.

Your employer can make contributions to your HSA between January 1, 2012, and April 17, 2012, that are allocated to 2011. Your employer must notify you and the trustee of your HSA that the contribution is for 2011. The contribution will be reported on your 2012 Form W-2.

Reporting Contributions on Your Return

Contributions made by your employer are not included in your income. Contributions to an employee's account by an employer using the amount of an employee's salary reduction through a cafeteria plan are treated as employer contributions. Generally, you can claim contributions you made and contributions made by any other person, other than your employer, on your behalf, as an adjustment to income.

Contributions by a partnership to a bona fide partner's HSA are not contributions by an employer. The contributions are treated as a distribution of money and are not included in the partner's gross income. Contributions by a partnership to a partner's HSA for services rendered are treated as guaranteed payments that are deductible by the partnership and includible in the partner's gross income. In both situations, the partner can deduct the contribution made to the partner's HSA.

Contributions by an S corporation to a 2% shareholder-employee's HSA for services rendered are treated as guaranteed payments and are deductible by the S corporation and includible in the shareholder-employee's gross income. The shareholder-employee can deduct the contribution made to the shareholder-employee's HSA.

Form 8889. Report all contributions to your HSA on Form 8889 and file it with your Form 1040 or Form 1040NR. You should include all contributions made for 2011, including those made by April 17, 2012, that are designated for 2011. Contributions made by your employer and qualified HSA funding distributions are also shown on the form.

You should receive Form 5498-SA, HSA, Archer MSA, or Medicare Advantage MSA Information, from the trustee showing the amount contributed to your HSA during the year. Your employer's contributions also will be shown in box 12 of Form W-2, Wage and Tax Statement, with code W. Follow the instructions for Form 8889. Report your HSA deduction on Form 1040 or Form 1040NR, line 25.

Excess contributions. You will have excess contributions if the contributions to your HSA for the year are greater than the limits discussed earlier. Excess contributions are not deductible. Excess contributions made by your employer are included in your gross income. If the excess contribution is not included in box 1 of Form W-2, you must report the excess as "Other income" on your tax return.

Generally, you must pay a 6% excise tax on excess contributions. See Form 5329, Additional Taxes on Qualified Plans (including IRAs) and Other Tax-Favored Accounts, to figure the excise tax. The excise tax applies to each tax year the excess contribution remains in the account.

You may withdraw some or all of the excess contributions and not pay the excise tax on the amount withdrawn if you meet the following conditions.

- You withdraw the excess contributions by the due date, including extensions, of your tax return for the year the contributions were made.
- You withdraw any income earned on the withdrawn contributions and include the earnings in "Other income" on your tax return for the year you withdraw the contributions and earnings.

If you fail to remain an eligible individual during any of the testing periods, discussed earlier, the amount you have to include in income is not an excess contribution. If you withdraw any of those amounts, the amount is treated the same as any other distribution from an HSA, discussed later.

Deducting an excess contribution in a later year. You may be able to deduct excess contributions for previous years that are still in your HSA. The excess contribution you can deduct for the current year is the lesser of the following two amounts.

- Your maximum HSA contribution limit for the year minus any amounts contributed to your HSA for the year.
- The total excess contributions in your HSA at the beginning of the year.

Amounts contributed for the year include contributions by you, your employer, and any other person. They also include any qualified HSA funding distribution made to your HSA. Any excess contribution remaining at the end of a tax year is subject to the excise tax. See Form 5329.

Distributions From an HSA

You will generally pay medical expenses during the year without being reimbursed by your HDHP until you reach the annual deductible for the plan. When you pay medical expenses during the year that are not reimbursed by your HDHP, you can ask the trustee of your HSA to send you a distribution from your HSA.

You can receive tax-free distributions from your HSA to pay or be reimbursed for qualified medical expenses you incur after you establish the HSA. If you receive distributions for other reasons, the amount you withdraw will be subject to income tax and may be subject to an additional 20% tax. You do not have to make distributions from your HSA each year.

If you are no longer an eligible individual, you can still receive tax-free distributions to pay or reimburse your qualified medical expenses.

Generally, a distribution is money you get from your health savings account. Your total distributions include amounts paid with a debit card that restricts payments to health care and amounts withdrawn from the HSA by other individuals that you have designated. The trustee will report any distribution to you and the IRS on Form 1099-SA, Distributions From an HSA, Archer MSA, or Medicare Advantage MSA.

Qualified medical expenses. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses.

Note. Non-prescription medicines (other than insulin) purchased in tax years beginning after December 31, 2010, are not considered qualified medical expenses. See *Qualified medical expenses* under *What's New*, earlier.

For HSA purposes, expenses incurred before you establish your HSA are not qualified medical expenses. State law determines when an HSA is established. An HSA that is funded by amounts rolled over from an Archer MSA or another HSA is established on the date the prior account was established.

If, under the last-month rule, you are considered to be an eligible individual for the entire year for determining the contribution amount, only those expenses incurred after you actually establish your HSA are qualified medical expenses.

Qualified medical expenses are those incurred by the following persons.

1. You and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,700 or more, or
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2011 return.

For this purpose, a child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether or not the custodial parent releases the claim to the child's exemption.

You cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the tax-free distribution from your HSA.

Insurance premiums. You cannot treat insurance premiums as qualified medical expenses unless the premiums are for:

1. Long-term care insurance.
2. Health care continuation coverage (such as coverage under COBRA).
3. Health care coverage while receiving unemployment compensation under federal or state law.
4. Medicare and other health care coverage if you were 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).

The premiums for long-term care insurance (item (1)) that you can treat as qualified medical expenses are subject to limits based on age and are adjusted annually. See *Limit on long-term care premiums you can deduct* in the instructions for Schedule A (Form 1040).

Items (2) and (3) can be for your spouse or a dependent meeting the requirement for that type of coverage. For item (4), if you, the account beneficiary, are not 65 or older, Medicare premiums for coverage of your spouse or a dependent (who is 65 or older) generally are not qualified medical expenses.

Health coverage tax credit. You cannot claim this credit for premiums that you pay with a tax-free distribution from your HSA. See Publication 502 for more information on this credit.

Deemed distributions from HSAs. The following situations result in deemed taxable distributions from your HSA.

- You engaged in any transaction prohibited by section 4975 with respect to any of your HSAs, at any time in 2011. Your account ceases to be an HSA as of January 1, 2011, and you must include the fair market value of all assets in the account as of January 1, 2011, on Form 8889, line 14a.
- You used any portion of any of your HSAs as security for a loan at any time in 2011. You must include the fair market value of the assets used as security for the loan as income on Form 1040 or Form 1040NR, line 21.

Examples of prohibited transactions include the direct or indirect:

- Sale, exchange, or leasing of property between you and the HSA,
- Lending of money between you and the HSA,
- Furnishing goods, services, or facilities between you and the HSA, and
- Transfer to or use by you, or for your benefit, of any assets of the HSA.

Any deemed distribution will not be treated as used to pay qualified medical expenses. These distributions are included in your income and are subject to the additional 20% tax, discussed later.

Recordkeeping. You must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified medical expenses had not been previously paid or reimbursed from another source, and
- The medical expenses had not been taken as an itemized deduction in any year.

Do not send these records with your tax return. Keep them with your tax records.

Reporting Distributions on Your Return

How you report your distributions depends on whether or not you use the distribution for qualified medical expenses (defined earlier).

- If you use a distribution from your HSA for qualified medical expenses, you do not pay tax on the distribution but you have to report the distribution on Form 8889. However, the distribution of an excess contribution taken out after the due date, including extensions, of your return is subject to tax even if used for qualified medical expenses. Follow the instructions for the form and file it with your Form 1040 or Form 1040NR.
- If you do not use a distribution from your HSA for qualified medical expenses, you must pay tax on the distribution. Report the amount on Form 8889 and file it with your Form 1040 or Form 1040NR. If you have a taxable HSA distribution, include it in the total on Form 1040 or Form 1040NR, line 21, and enter "HSA" and the amount on the dotted line next to line 21. You may have to pay an additional 20% tax on your taxable distribution.

HSA administration and maintenance fees withdrawn by the trustee are not reported as distributions from the HSA.

Additional tax. There is an additional 20% tax on the part of your distributions not used for qualified medical expenses. Figure the tax on Form 8889 and file it with your Form 1040 or Form 1040NR. Report the additional tax in the total on Form 1040, line 60, or Form 1040NR, line 59, and enter "HSA" and the amount on the dotted line next to that line.

Exceptions. There is no additional tax on distributions made after the date you are disabled, reach age 65, or die.

Balance in an HSA

An HSA is generally exempt from tax. You are permitted to take a distribution from your HSA at any time; however, only those amounts used exclusively to pay for qualified medical expenses are tax free. Amounts that remain at the end of the year are generally carried over to the next year (see *Excess contributions*, earlier). Earnings on amounts in an HSA are not included in your income while held in the HSA.

Death of HSA Holder

You should choose a beneficiary when you set up your HSA. What happens to that HSA when you die depends on whom you designate as the beneficiary.

Spouse is the designated beneficiary. If your spouse is the designated beneficiary of your HSA, it will be treated as your spouse's HSA after your death.

Spouse is not the designated beneficiary. If your spouse is not the designated beneficiary of your HSA:

- The account stops being an HSA, and
- The fair market value of the HSA becomes taxable to the beneficiary in the year in which you die.

If your estate is the beneficiary, the value is included on your final income tax return.

The amount taxable to a beneficiary other than the estate is reduced by any qualified medical expenses for the decedent that are paid by the beneficiary within 1 year after the date of death.

Filing Form 8889

You must file Form 8889 with your Form 1040 or Form 1040NR if you (or your spouse, if married filing a joint return) had any activity in your HSA during the year. You must file the form even if only your employer or your spouse's employer made contributions to the HSA.

If, during the tax year, you are the beneficiary of two or more HSAs or you are a beneficiary of an HSA and you have your own HSA, you must complete a separate Form 8889 for each HSA. Enter "statement" at the top of each Form 8889 and complete the form as instructed. Next, complete a controlling Form 8889 combining the amounts shown on each of the statement Forms 8889. Attach the statements to your tax return after the controlling Form 8889.

Employer Participation

This section contains the rules that employers must follow if they decide to make HSAs available to their employees. Unlike the previous discussions, "you" refers to the employer and not to the employee.

Health plan. If you want your employees to be able to have an HSA, they must have an HDHP. You can provide no additional coverage other than those exceptions listed previously under *Other health coverage*.

Contributions. You can make contributions to your employees' HSAs. You deduct the contributions on the "Employee benefit programs" line of your business income tax return for the year in which you make the contributions. If the contribution is allocated to the prior year, you still deduct it in the year in which you made the contribution. If you are filing Form 1040, Schedule C, this is Part II, line 14.

For more information on employer contributions, see Notice 2008-59, 2008-29 I.R.B. 123, questions 23 through 27, available at *www.irs.gov/irb/2008-29_IRB/ar11.html*.

Comparable contributions. If you decide to make contributions, you must make comparable contributions to all comparable participating employees' HSAs. Your contributions are comparable if they are either:

- The same amount, or
- The same percentage of the annual deductible limit under the HDHP covering the employees.

The comparability rules do not apply to contributions made through a cafeteria plan.

Comparable participating employees. Comparable participating employees:

- Are covered by your HDHP and are eligible to establish an HSA,
- Have the same category of coverage (either self-only or family coverage), and
- Have the same category of employment (part-time, full-time, or former employees).

To meet the comparability requirements for eligible employees who have not established an HSA by December 31 or have not notified you that they have an HSA, you must meet a notice requirement and a contribution requirement.

You will meet the notice requirement if by January 15 of the following calendar year you provide a written notice to all such employees. The notice must state that each eligible employee who, by the last day of February, establishes an HSA and notifies you that they have established an HSA will receive a comparable contribution to the HSA for the prior year. For a sample of the notice, see Regulation 54.498G-4 A-14(c). You will meet the contribution requirement for these employees if by April 17, 2012, you contribute comparable amounts plus reasonable interest to the employee's HSA for the prior year.

Note. For purposes of making contributions to HSAs of non-highly compensated employees, highly compensated employees shall not be treated as comparable participating employees.

Excise tax. If you made contributions to your employees' HSAs that were not comparable, you must pay an excise tax of 35% of the amount you contributed.

Employment taxes. Amounts you contribute to your employees' HSAs are generally not subject to employment taxes. You must report the contributions in box 12 of the Form W-2 you file for each employee. This includes the amounts the employee elected to contribute through a cafeteria plan. Enter code "W" in box 12.

Medical Savings Accounts (MSAs)

Archer MSAs were created to help self-employed individuals and employees of certain small employers meet the medical care costs of the account holder, the account holder's spouse, or the account holder's dependent(s).

After December 31, 2007, you cannot be treated as an eligible individual for Archer MSA purposes unless:

1. *You were an active participant for any tax year ending before January 1, 2008, or*
2. *You became an active participant for a tax year ending after December 31, 2007, by reason of coverage*

under a high deductible health plan (HDHP) of an Archer MSA participating employer.

A Medicare Advantage MSA is an Archer MSA designated by Medicare to be used solely to pay the qualified medical expenses of the account holder who is eligible for Medicare.

Archer MSAs

An Archer MSA is a tax-exempt trust or custodial account that you set up with a U.S. financial institution (such as a bank or an insurance company) in which you can save money exclusively for future medical expenses.

What are the benefits of an Archer MSA? You may enjoy several benefits from having an Archer MSA.

- You can claim a tax deduction for contributions you make even if you do not itemize your deductions on Form 1040 or Form 1040NR.
- The interest or other earnings on the assets in your Archer MSA are tax free.
- Distributions may be tax free if you pay qualified medical expenses. See *Qualified medical expenses*, later.
- The contributions remain in your Archer MSA from year to year until you use them.
- An Archer MSA is "portable" so it stays with you if you change employers or leave the work force.

Qualifying for an Archer MSA

To qualify for an Archer MSA, you must be either of the following.

- An employee (or the spouse of an employee) of a small employer (defined later) that maintains a self-only or family HDHP for you (or your spouse).
- A self-employed person (or the spouse of a self-employed person) who maintains a self-only or family HDHP.

You can have no other health or Medicare coverage except what is permitted under *Other health coverage*, later. You must be an eligible individual on the first day of a given month to get an Archer MSA deduction for that month.

CAUTION *If another taxpayer is entitled to claim an exemption for you, you cannot claim a deduction for an Archer MSA contribution. This is true even if the other person does not actually claim your exemption.*

Small employer. A small employer is generally an employer who had an average of 50 or fewer employees during either of the last 2 calendar years. The definition of small employer is modified for new employers and growing employers.

Growing employer. A small employer may begin HDHPs and Archer MSAs for his or her employees and then grow beyond 50 employees. The employer will continue to meet the requirement for small employers if he or she:

- Had 50 or fewer employees when the Archer MSAs began,
- Made a contribution that was excludable or deductible as an Archer MSA for the last year he or she had 50 or fewer employees, and
- Had an average of 200 or fewer employees each year after 1996.

Changing employers. If you change employers, your Archer MSA moves with you. However, you may not make additional contributions unless you are otherwise eligible.

High deductible health plan (HDHP). To be eligible for an Archer MSA, you must be covered under an HDHP. An HDHP has:

- A higher annual deductible than typical health plans, and
- A maximum limit on the annual out-of-pocket medical expenses that you must pay for covered expenses.

Limits. The following table shows the limits for annual deductibles and the maximum out-of-pocket expenses for HDHPs for 2011.

	Self-only coverage	Family coverage
Minimum annual deductible	$2,050	$4,100
Maximum annual deductible	$3,050	$6,150
Maximum annual out-of-pocket expenses	$4,100	$7,500

Family plans that do not meet the high deductible rules. There are some family plans that have deductibles for both the family as a whole and for individual family members. Under these plans, if you meet the individual deductible for one family member, you do not have to meet the higher annual deductible amount for the family. If either the deductible for the family as a whole or the deductible for an individual family member is below the minimum annual deductible for family coverage, the plan does not qualify as an HDHP.

Example. You have family health insurance coverage in 2011. The annual deductible for the family plan is $5,500. This plan also has an individual deductible of $2,000 for each family member. The plan does not qualify as an HDHP because the deductible for an individual family member is below the minimum annual deductible ($4,100) for family coverage.

Other health coverage. You (and your spouse, if you have family coverage) generally cannot have any other

health coverage that is not an HDHP. However, you can still be an eligible individual even if your spouse has non-HDHP coverage provided you are not covered by that plan. However, you can have additional insurance that provides benefits only for the following items.

- Liabilities incurred under workers' compensation laws, torts, or ownership or use of property.
- A specific disease or illness.
- A fixed amount per day (or other period) of hospitalization.

You can also have coverage (whether provided through insurance or otherwise) for the following items.

- Accidents.
- Disability.
- Dental care.
- Vision care.
- Long-term care.

Contributions to an MSA

Contributions to an Archer MSA must be made in cash. You cannot contribute stock or other property to an Archer MSA.

Who can contribute to my Archer MSA? If you are an employee, your employer may make contributions to your Archer MSA. (You do not pay tax on these contributions.) If your employer does not make contributions to your Archer MSA, or you are self-employed, you can make your own contributions to your Archer MSA. Both you and your employer cannot make contributions to your Archer MSA in the same year. You do not have to make contributions to your Archer MSA every year.

CAUTION *If your spouse is covered by your HDHP and an excludable amount is contributed by your spouse's employer to an Archer MSA belonging to your spouse, you cannot make contributions to your own Archer MSA that year.*

Limits

There are two limits on the amount you or your employer can contribute to your Archer MSA:

- The annual deductible limit.
- An income limit.

Annual deductible limit. You (or your employer) can contribute up to 75% of the annual deductible of your HDHP (65% if you have a self-only plan) to your Archer MSA. You must have the HDHP all year to contribute the full amount. If you do not qualify to contribute the full amount for the year, determine your annual deductible limit by using the worksheet for line 5 in the Instructions for Form 8853, Archer MSAs and Long-Term Care Insurance Contracts.

Example 1. You have an HDHP for your family all year in 2011. The annual deductible is $5,000. You can contribute up to $3,750 ($5,000 × 75%) to your Archer MSA for the year.

Example 2. You have an HDHP for your family for the entire months of July through December 2011 (6 months). The annual deductible is $5,000. You can contribute up to $1,875 ($5,000 × 75% ÷ 12 × 6) to your Archer MSA for the year.

TIP *If you and your spouse each have a family plan, you are treated as having family coverage with the lower annual deductible of the two health plans. The contribution limit is split equally between you unless you agree on a different division.*

Income limit. You cannot contribute more than you earned for the year from the employer through whom you have your HDHP.

If you are self-employed, you cannot contribute more than your net self-employment income. This is your income from self-employment minus expenses (including the deductible part of self-employment tax).

Example 1. Noah Paul earned $25,000 from ABC Company in 2011. Through ABC, he had an HDHP for his family for the entire year. The annual deductible was $5,000. He can contribute up to $3,750 to his Archer MSA (75% × $5,000). He can contribute the full amount because he earned more than $3,750 at ABC.

Example 2. Westley Lawrence is self-employed. He had an HDHP for his family for the entire year in 2011. The annual deductible was $5,000. Based on the annual deductible, the maximum contribution to his Archer MSA would have been $3,750 (75% × $5,000). However, after deducting his business expenses, Joe's net self-employment income is $2,500 for the year. Therefore, he is limited to a contribution of $2,500.

Individuals enrolled in Medicare. Beginning with the first month you are enrolled in Medicare, you cannot contribute to an Archer MSA. However, you may be eligible for a Medicare Advantage MSA, discussed later.

When To Contribute

You can make contributions to your Archer MSA for 2011 until April 17, 2012.

Reporting Contributions on Your Return

Report all contributions to your Archer MSA on Form 8853 and file it with your Form 1040 or Form 1040NR. You should include all contributions you, or your employer, made for 2011, including those made by April 17, 2012, that are designated for 2011.

You should receive Form 5498-SA, HSA, Archer MSA, or Medicare Advantage MSA Information, from the trustee

showing the amount you (or your employer) contributed during the year. Your employer's contributions should be shown in box 12 of Form W-2, Wage and Tax Statement, with code R. Follow the instructions for Form 8853 and complete the worksheet for line 5. Report your Archer MSA deduction on Form 1040, line 36, or Form 1040NR, line 35.

Excess contributions. You will have excess contributions if the contributions to your Archer MSA for the year are greater than the limits discussed earlier. Excess contributions are not deductible. Excess contributions made by your employer are included in your gross income. If the excess contribution is not included in box 1 of Form W-2, you must report the excess as "Other income" on your tax return.

Generally, you must pay a 6% excise tax on excess contributions. See Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts, to figure the excise tax. The excise tax applies to each tax year the excess contribution remains in the account.

You may withdraw some or all of the excess contributions and not pay the excise tax on the amount withdrawn if you meet the following conditions.

- You withdraw the excess contributions by the due date, including extensions, of your tax return.
- You withdraw any income earned on the withdrawn contributions and include the earnings in "Other income" on your tax return for the year you withdraw the contributions and earnings.

Deducting an excess contribution in a later year. You may be able to deduct excess contributions for previous years that are still in your Archer MSA. The excess contribution you can deduct in the current year is the lesser of the following two amounts.

- Your maximum Archer MSA contribution limit for the year minus any amounts contributed to your Archer MSA for the year.
- The total excess contributions in your Archer MSA at the beginning of the year.

Any excess contributions remaining at the end of a tax year are subject to the excise tax. See Form 5329.

Distributions From an MSA

You will generally pay medical expenses during the year without being reimbursed by your HDHP until you reach the annual deductible for the plan. When you pay medical expenses during the year that are not reimbursed by your HDHP, you can ask the trustee of your Archer MSA to send you a distribution from your Archer MSA.

You can receive tax-free distributions from your Archer MSA to pay for qualified medical expenses (discussed later). If you receive distributions for other reasons, the amount will be subject to income tax and may be subject to an additional 20% tax as well. You do not have to make withdrawals from your Archer MSA each year.

TIP *If you no longer qualify to make contributions, you can still receive tax-free distributions to pay or reimburse your qualified medical expenses.*

A distribution is money you get from your Archer MSA. The trustee will report any distribution to you and the IRS on Form 1099-SA, Distributions From an HSA, Archer MSA, or Medicare Advantage MSA.

Qualified medical expenses. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses.

Note. Non-prescription medicines (other than insulin) purchased in tax years beginning after December 31, 2010, are not considered qualified medical expenses. See *Qualified medical expenses* under *What's New*, earlier.

Qualified medical expenses are those incurred by the following persons.

1. You and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,700 or more, or
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2011 return.

TIP *For this purpose, a child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether or not the custodial parent releases the claim to the child's exemption.*

CAUTION *You cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the tax-free distribution from your Archer MSA. This is the amount on line 7 of Form 8853.*

Special rules for insurance premiums. Generally, you cannot treat insurance premiums as qualified medical expenses for Archer MSAs. You can, however, treat premiums for long-term care coverage, health care coverage while you receive unemployment benefits, or health care continuation coverage required under any federal law as qualified medical expenses for Archer MSAs.

Health coverage tax credit. You cannot claim this credit for premiums that you pay with a tax-free distribution from your Archer MSA. See Publication 502 for information on this credit.

Deemed distributions from Archer MSAs. The following situations result in deemed taxable distributions from your Archer MSA.

- You engaged in any transaction prohibited by section 4975 with respect to any of your Archer MSAs at any time in 2011. Your account ceases to be an Archer MSA as of January 1, 2011, and you must include the fair market value of all assets in the account as of January 1, 2011, on line 6a of Form 8853.
- You used any portion of any of your Archer MSAs as security for a loan at any time in 2011. You must include the fair market value of the assets used as security for the loan as income on Form 1040 or Form 1040NR, line 21.

Examples of prohibited transactions include the direct or indirect:

- Sale, exchange, or leasing of property between you and the Archer MSA,
- Lending of money between you and the Archer MSA,
- Furnishing goods, services, or facilities between you and the Archer MSA, and
- Transfer to or use by you, or for your benefit, of any assets of the Archer MSA.

Any deemed distribution will not be treated as used to pay qualified medical expenses. These distributions are included in your income and are subject to the additional 20% tax, discussed later.

RECORDS **Recordkeeping.** You must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified medical expenses had not been previously paid or reimbursed from another source, and
- The medical expenses had not been taken as an itemized deduction in any year.

Do not send these records with your tax return. Keep them with your tax records.

Reporting Distributions on Your Return

How you report your distributions depends on whether or not you use the distribution for qualified medical expenses (defined earlier).

- If you use a distribution from your Archer MSA for qualified medical expenses, you do not pay tax on the distribution but you have to report the distribution on Form 8853. Follow the instructions for the form and file it with your Form 1040 or Form 1040NR.
- If you do not use a distribution from your Archer MSA for qualified medical expenses, you must pay tax on the distribution. Report the amount on Form 8853 and file it with your Form 1040 or Form 1040NR. If you have a taxable Archer MSA distribution, include it in the total on Form 1040 or Form 1040NR, line 21, and enter "MSA" and the amount on the dotted line next to line 21. You may have to pay an additional 20% tax, discussed later, on your taxable distribution.

CAUTION *If an amount (other than a rollover) is contributed to your Archer MSA this year (by you or your employer), you also must report and pay tax on a distribution you receive from your Archer MSA this year that is used to pay medical expenses of someone who is not covered by an HDHP, or is also covered by another health plan that is not an HDHP, at the time the expenses are incurred.*

Rollovers. Generally, any distribution from an Archer MSA that you roll over into another Archer MSA or an HSA is not taxable if you complete the rollover within 60 days. An Archer MSA and an HSA can only receive one rollover contribution during a 1-year period. See the Form 8853 instructions for more information.

Additional tax. There is a 20% additional tax on the part of your distributions not used for qualified medical expenses. Figure the tax on Form 8853 and file it with your Form 1040 or Form 1040NR. Report the additional tax in the total on Form 1040, line 60, or Form 1040NR, line 59, and enter "MSA" and the amount on the dotted line next to that line.

Exceptions. There is no additional tax on distributions made after the date you are disabled, reach age 65, or die.

Balance in an Archer MSA

An Archer MSA is generally exempt from tax. You are permitted to take a distribution from your Archer MSA at any time; however, only those amounts used exclusively to pay for qualified medical expenses are tax free. Amounts that remain at the end of the year are generally carried over to the next year (see *Excess contributions*, earlier). Earnings on amounts in an Archer MSA are not included in your income while held in the Archer MSA.

Death of the Archer MSA Holder

You should choose a beneficiary when you set up your Archer MSA. What happens to that Archer MSA when you die depends on whom you designate as the beneficiary.

Spouse is the designated beneficiary. If your spouse is the designated beneficiary of your Archer MSA, it will be treated as your spouse's Archer MSA after your death.

Spouse is not the designated beneficiary. If your spouse is not the designated beneficiary of your Archer MSA:

- The account stops being an Archer MSA, and
- The fair market value of the Archer MSA becomes taxable to the beneficiary in the year in which you die.

If your estate is the beneficiary, the fair market value of the Archer MSA will be included on your final income tax return.

The amount taxable to a beneficiary other than the estate is reduced by any qualified medical expenses for the decedent that are paid by the beneficiary within 1 year after the date of death.

Filing Form 8853

You must file Form 8853 with your Form 1040 or Form 1040NR if you (or your spouse, if married filing a joint return) had any activity in your Archer MSA during the year. You must file the form even if only your employer or your spouse's employer made contributions to the Archer MSA.

If, during the tax year, you are the beneficiary of two or more Archer MSAs or you are a beneficiary of an Archer MSA and you have your own Archer MSA, you must complete a separate Form 8853 for each MSA. Enter "statement" at the top of each Form 8853 and complete the form as instructed. Next, complete a controlling Form 8853 combining the amounts shown on each of the statement Forms 8853. Attach the statements to your tax return after the controlling Form 8853.

Employer Participation

This section contains the rules that employers must follow if they decide to make Archer MSAs available to their employees. Unlike the previous discussions, "you" refers to the employer and not to the employee.

Health plan. If you want your employees to be able to have an Archer MSA, you must make an HDHP available to them. You can provide no additional coverage other than those exceptions listed previously under *Other health coverage*.

Contributions. You can make contributions to your employees' Archer MSAs. You deduct the contributions on the "Employee benefit programs" line of your business income tax return for the year in which you make the contributions. If you are filing Form 1040, Schedule C, this is Part II, line 14.

Comparable contributions. If you decide to make contributions, you must make comparable contributions to all comparable participating employees' Archer MSAs. Your contributions are comparable if they are either:

- The same amount, or
- The same percentage of the annual deductible limit under the HDHP covering the employees.

Comparable participating employees. Comparable participating employees:

- Are covered by your HDHP and are eligible to establish an Archer MSA,
- Have the same category of coverage (either self-only or family coverage), and
- Have the same category of employment (either part-time or full-time).

Excise tax. If you made contributions to your employees' Archer MSAs that were not comparable, you must pay an excise tax of 35% of the amount you contributed.

Employment taxes. Amounts you contribute to your employees' Archer MSAs are generally not subject to employment taxes. You must report the contributions in box 12 of the Form W-2 you file for each employee. Enter code "R" in box 12.

Medicare Advantage MSAs

A Medicare Advantage MSA is an Archer MSA designated by Medicare to be used solely to pay the qualified medical expenses of the account holder. To be eligible for a Medicare Advantage MSA, you must be enrolled in Medicare and have a high deductible health plan (HDHP) that meets the Medicare guidelines.

A Medicare Advantage MSA is a tax-exempt trust or custodial savings account that you set up with a financial institution (such as a bank or an insurance company) in which the Medicare program can deposit money for qualified medical expenses. The money in your account is not taxed if it is used for qualified medical expenses, and it may earn interest or dividends.

An HDHP is a special health insurance policy that has a high deductible. You choose the policy you want to use as part of your Medicare Advantage MSA plan. However, the policy must be approved by the Medicare program.

Medicare Advantage MSAs are administered through the federal Medicare program. You can get information by calling 1-800-Medicare (1-800-633-4227) or through the Internet at *www.medicare.gov*.

Note. You must file Form 8853, Archer MSAs and Long-Term Care Insurance Contracts, with your tax return if you have a Medicare Advantage MSA.

Flexible Spending Arrangements (FSAs)

A health flexible spending arrangement (FSA) allows employees to be reimbursed for medical expenses. FSAs are usually funded through voluntary salary reduction agreements with your employer. No employment or federal income taxes are deducted from your contribution. The employer may also contribute.

Note. Unlike HSAs or Archer MSAs which must be reported on Form 1040 or Form 1040NR, there are no reporting requirements for FSAs on your income tax return.

For information on the interaction between a health FSA and an HSA, see *Other employee health plans* under *Qualifying for an HSA*, earlier.

What are the benefits of an FSA? You may enjoy several benefits from having an FSA.

- Contributions made by your employer can be excluded from your gross income.
- No employment or federal income taxes are deducted from the contributions.
- Withdrawals may be tax free if you pay qualified medical expenses. See *Qualified medical expenses*, later.
- You can withdraw funds from the account to pay qualified medical expenses even if you have not yet placed the funds in the account.

Qualifying for an FSA

Health FSAs are employer-established benefit plans. These may be offered in conjunction with other employer-provided benefits as part of a cafeteria plan. Employers have complete flexibility to offer various combinations of benefits in designing their plan. You do not have to be covered under any other health care plan to participate.

Self-employed persons are not eligible for an FSA.

Certain limitations may apply if you are a highly compensated participant or a key employee.

Contributions to an FSA

You contribute to your FSA by electing an amount to be voluntarily withheld from your pay by your employer. This is sometimes called a salary reduction agreement. The employer may also contribute to your FSA if specified in the plan.

You do not pay federal income tax or employment taxes on the salary you contribute or the amounts your employer contributes to the FSA. However, contributions made by your employer to provide coverage for long-term care insurance must be included in income.

When To Contribute

At the beginning of the plan year, you must designate how much you want to contribute. Then, your employer will deduct amounts periodically (generally, every payday) in accordance with your annual election. You can change or revoke your election only if there is a change in your employment or family status that is specified by the plan.

Amount of Contribution

There is no limit on the amount of money you or your employer can contribute to the accounts; however, the plan must prescribe either a maximum dollar amount or maximum percentage of compensation that can be contributed to your health FSA.

Generally, contributed amounts that are not spent by the end of the plan year are forfeited. See *Balance in an FSA*, later. For this reason, it is important to base your contribution on an estimate of the qualifying expenses you will have during the year.

Note. For tax years beginning after 2012 your contribution to your flexible spending arrangement made through a salary reduction is limited to $2,500. Beginning in tax years after 2013 the limit will be subject to a cost-of-living adjustment.

Distributions From an FSA

Generally, distributions from a health FSA must be paid only to reimburse you for qualified medical expenses you incurred during the period of coverage. You must be able to receive the maximum amount of reimbursement (the amount you have elected to contribute for the year) at any time during the coverage period, regardless of the amount you have actually contributed. The maximum amount you can receive tax free is the total amount you elected to contribute to the health FSA for the year.

You must provide the health FSA with a written statement from an independent third party stating that the medical expense has been incurred and the amount of the expense. You must also provide a written statement that the expense has not been paid or reimbursed under any other health plan coverage. The FSA cannot make advance reimbursements of future or projected expenses.

Debit cards, credit cards, and stored value cards given to you by your employer can be used to reimburse participants in a health FSA. If the use of these cards meets certain substantiation methods, you may not have to provide additional information to the health FSA. For information on these methods, see Revenue Ruling 2003-43 on page 935 of Internal Revenue Bulletin (IRB) 2003-21 at *www.irs.gov/pub/irs-irbs/irb03-21.pdf*, Notice 2006-69, 2006-31 I.R.B.107 available at *www.irs.gov/irb/2006-31_IRB/ar10.html*, and Notice 2007-2, 2007-2 I.R.B. 254 available at *www.irs.gov/irb/2007-2_IRB/ar09.html*.

Qualified medical expenses. Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses.

Note. Non-prescription medicines (other than insulin) purchased in tax years beginning after December 31, 2010, are not considered qualified medical expenses. See *Qualified medical expenses* under *What's New*, earlier.

Qualified medical expenses are those incurred by the following persons.

1. You and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,700 or more, or

c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2011 return.

4. Your child under age 27 at the end of your tax year.

You cannot receive distributions from your FSA for the following expenses.

- Amounts paid for health insurance premiums.
- Amounts paid for long-term care coverage or expenses.
- Amounts that are covered under another health plan.

If you are covered under both a health FSA and an HRA, see Notice 2002-45, Part V, which is on page 93 of IRB 2002-28 at www.irs.gov/pub/irs-irbs/irb02-28.pdf.

CAUTION *You cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the distribution you receive from the FSA.*

Qualified HSA distribution. This is a distribution from your health FSA that is transferred to your HSA, discussed earlier. The distribution must not be more than the lesser of the balance in the health FSA on:

- September 21, 2006, or
- The date of the distribution.

If you were not covered by a health FSA on September 21, 2006, you cannot elect to make a qualified HSA distribution from the health FSA. If you were covered by a health FSA with an employer on September 21, 2006, but change employers after that date, you cannot elect to make a qualified HSA distribution from your second employer's health FSA.

The following conditions must be met to make a qualified HSA distribution.

- The plan must have been amended to allow these distributions.
- You must elect to make the rollover.
- The year-end balance in the health FSA must be frozen.
- The funds must be transferred within 2½ months after the end of the health FSA's plan year and result in a zero balance in the health FSA.
- The distribution must be contributed directly to the HSA trustee by the employer.

Only one qualified HSA distribution is allowed for each health FSA.

For more information, see Notice 2007-22, 2007-10 I.R.B. 670 available at www.irs.gov/irb/2007-10_IRB/ar10.html.

If you do not remain an eligible individual for HSA purposes during the testing period, the distribution is included in your income and is subject to a 10% additional tax. See *Qualified HSA distribution* under *Health Savings Accounts (HSAs)*, earlier.

Qualified reservist distribution. A special rule allows amounts in a health FSA to be distributed to reservists ordered or called to active duty. This rule applies to distributions made after June 17, 2008, if the plan has been amended to allow these distributions. Your employer must report the distribution as wages on your Form W-2 for the year in which the distribution is made. The distribution is subject to employment taxes and is included in your gross income.

A qualified reservist distribution is allowed if you were (because you were in the reserves) ordered or called to active duty for a period of more than 179 days or for an indefinite period, and the distribution is made during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made for the plan year that includes the date of the order or call.

Balance in an FSA

Flexible spending accounts are "use-it-or-lose-it" plans. This means that amounts in the account at the end of the plan year cannot be carried over to the next year. However, the plan can provide for a grace period of up to 2½ months after the end of the plan year. If there is a grace period, any qualified medical expenses incurred in that period can be paid from any amounts left in the account at the end of the previous year. Your employer is not permitted to refund any part of the balance to you. See *Qualified HSA distribution* and *Qualified reservist distribution*, earlier.

Employer Participation

For the health FSA to maintain tax-qualified status, employers must comply with certain requirements that apply to cafeteria plans. For example, there are restrictions for plans that cover highly compensated employees and key employees. The plans must also comply with rules applicable to other accident and health plans. Chapters 1 and 2 of Publication 15-B, Employer's Tax Guide to Fringe Benefits, explain these requirements.

Health Reimbursement Arrangements (HRAs)

A health reimbursement arrangement (HRA) must be funded solely by an employer. The contribution cannot be paid through a voluntary salary reduction agreement on the part of an employee. Employees are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. An HRA may be offered with other health plans, including FSAs.

Note. Unlike HSAs or Archer MSAs which must be reported on Form 1040 or Form 1040NR, there are no reporting requirements for HRAs on your income tax return.

For information on the interaction between an HRA and an HSA, see *Other employee health plans* under *Qualifying for an HSA*, earlier.

What are the benefits of an HRA? You may enjoy several benefits from having an HRA.

- Contributions made by your employer can be excluded from your gross income.
- Reimbursements may be tax free if you pay qualified medical expenses. See *Qualified medical expenses*, later.
- Any unused amounts in the HRA can be carried forward for reimbursements in later years.

Qualifying for an HRA

HRAs are employer-established benefit plans. These may be offered in conjunction with other employer-provided health benefits. Employers have complete flexibility to offer various combinations of benefits in designing their plan. You do not have to be covered under any other health care plan to participate.

Self-employed persons are not eligible for an HRA.

Certain limitations may apply if you are a highly compensated participant.

Contributions to an HRA

HRAs are funded solely through employer contributions and may not be funded through employee salary deferrals under a cafeteria plan. These contributions are not included in the employee's income. You do not pay federal income taxes or employment taxes on amounts your employer contributes to the HRA.

Amount of Contribution

There is no limit on the amount of money your employer can contribute to the accounts. Additionally, the maximum reimbursement amount credited under the HRA in the future may be increased or decreased by amounts not previously used. See *Balance in an HRA*, later.

Distributions From an HRA

Generally, distributions from an HRA must be paid to reimburse you for qualified medical expenses you have incurred. The expense must have been incurred on or after the date you are enrolled in the HRA.

Debit cards, credit cards, and stored value cards given to you by your employer can be used to reimburse participants in an HRA. If the use of these cards meets certain substantiation methods, you may not have to provide additional information to the HRA. For information on these methods, see Revenue Ruling 2003-43 on page 935 of Internal Revenue Bulletin (IRB) 2003-21 at *www.irs.gov/pub/irs-irbs/irb03-21.pdf*, Notice 2006-69, 2006-31 I.R.B. 107 available at *www.irs.gov/irb/2006-31_IRB/ar10.html*, and Notice 2007-2, 2007-2 I.R.B. 254 available at *www.irs.gov/irb/2007-2_IRB/ar09.html*.

If any distribution is, or can be, made for other than the reimbursement of qualified medical expenses, any distribution (including reimbursement of qualified medical expenses) made in the current tax year is included in gross income. For example, if an unused reimbursement is payable to you in cash at the end of the year, or upon termination of your employment, any distribution from the HRA is included in your income. This also applies if any unused amount upon your death is payable in cash to your beneficiary or estate, or if the HRA provides an option for you to transfer any unused reimbursement at the end of the year to a retirement plan. However, see *Qualified HSA distribution*, later.

If the plan permits amounts to be paid as medical benefits to a designated beneficiary (other than the employee's spouse or dependents), any distribution from the HRA is included in income.

Reimbursements under an HRA can be made to the following persons.

1. Current and former employees.
2. Spouses and dependents of those employees.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return,
   b. The person had gross income of $3,700 or more, or
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2011 return.
4. Your child under age 27 at the end of your tax year.
5. Spouses and dependents of deceased employees.

For this purpose, a child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether or not the custodial parent releases the claim to the child's exemption.

Qualified medical expenses. Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses.

Note. Non-prescription medicines (other than insulin) purchased in tax years beginning after December 31, 2010, are not considered qualified medical expenses. See *Qualified medical expenses* under *What's New*, earlier.

Qualified medical expenses from your HRA include the following.

- Amounts paid for health insurance premiums.
- Amounts paid for long-term care coverage.

- Amounts that are not covered under another health plan.

If you are covered under both an HRA and a health FSA, see Notice 2002-45, Part V, which is on page 93 of IRB 2002-28 at www.irs.gov/pub/irs-irbs/irb02-28.pdf.

You cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the distribution from the HRA.

Qualified HSA distribution. This is a distribution from your HRA that is transferred to your HSA, discussed earlier. The distribution must not be more than the lesser of the balance in the HRA on:

- September 21, 2006, or
- The date of the distribution.

If you were not covered by an HRA on September 21, 2006, you cannot elect to make a qualified HSA distribution from the HRA.

The following conditions must be met to make a qualified HSA distribution.

- The plan must have been amended to allow these distributions.
- You must elect to make the rollover.
- The year-end balance in the HRA must be frozen.
- The funds must be transferred within 2½ months after the end of the HRA's plan year and result in a zero balance in the HRA.
- The distribution must be contributed directly to the HSA trustee by the employer.

Only one qualified HSA distribution is allowed for each HRA.

For more information, see Notice 2007-22, 2007-10 I.R.B. 670 available at www.irs.gov/irb/2007-10_IRB/ar10.html.

If you do not remain an eligible individual for HSA purposes during the testing period, the distribution is included in your income and is subject to a 10% additional tax. See Qualified HSA distribution under *Health Savings Accounts (HSAs)*, earlier.

Balance in an HRA

Amounts that remain at the end of the year can generally be carried over to the next year. Your employer is not permitted to refund any part of the balance to you. These amounts may never be used for anything but reimbursements for qualified medical expenses. See Qualified HSA distribution, earlier.

Employer Participation

For an HRA to maintain tax-qualified status, employers must comply with certain requirements that apply to other accident and health plans. Chapters 1 and 2 of Publication 15-B, Employer's Tax Guide to Fringe Benefits, explain these requirements.

How To Get Tax Help

You can get help with unresolved tax issues, order free publications and forms, ask tax questions, and get information from the IRS in several ways. By selecting the method that is best for you, you will have quick and easy access to tax help.

Free help with your return. Free help in preparing your return is available nationwide from IRS-certified volunteers. The Volunteer Income Tax Assistance (VITA) program is designed to help low-moderate income taxpayers and the Tax Counseling for the Elderly (TCE) program is designed to assist taxpayers age 60 and older with their tax returns. Most VITA and TCE sites offer free electronic filing and all volunteers will let you know about credits and deductions you may be entitled to claim. To find the nearest VITA or TCE site, visit IRS.gov or call 1-800-906-9887 or 1-800-829-1040.

As part of the TCE program, AARP offers the Tax-Aide counseling program. To find the nearest AARP Tax-Aide site, call 1-888-227-7669 or visit AARP's website at www.aarp.org/money/taxaide.

For more information on these programs, go to IRS.gov and enter keyword "VITA" in the upper right-hand corner.

Internet. You can access the IRS website at IRS.gov 24 hours a day, 7 days a week to:

- *E-file* your return. Find out about commercial tax preparation and *e-file* services available free to eligible taxpayers.
- Check the status of your 2011 refund. Go to IRS.gov and click on *Where's My Refund*. Wait at least 72 hours after the IRS acknowledges receipt of your e-filed return, or 3 to 4 weeks after mailing a paper return. If you filed Form 8379 with your return, wait 14 weeks (11 weeks if you filed electronically). Have your 2011 tax return available so you can provide your social security number, your filing status, and the exact whole dollar amount of your refund.
- Download forms, including talking tax forms, instructions, and publications.
- Order IRS products online.
- Research your tax questions online.
- Search publications online by topic or keyword.
- Use the online Internal Revenue Code, regulations, or other official guidance.
- View Internal Revenue Bulletins (IRBs) published in the last few years.
- Figure your withholding allowances using the withholding calculator online at www.irs.gov/individuals.

- Determine if Form 6251 must be filed by using our Alternative Minimum Tax (AMT) Assistant available online at www.irs.gov/individuals.
- Sign up to receive local and national tax news by email.
- Get information on starting and operating a small business.

Phone. Many services are available by phone.

- *Ordering forms, instructions, and publications.* Call 1-800-TAX -FORM (1-800-829-3676) to order current-year forms, instructions, and publications, and prior-year forms and instructions. You should receive your order within 10 days.
- *Asking tax questions.* Call the IRS with your tax questions at 1-800-829-1040.
- *Solving problems.* You can get face-to-face help solving tax problems every business day in IRS Taxpayer Assistance Centers. An employee can explain IRS letters, request adjustments to your account, or help you set up a payment plan. Call your local Taxpayer Assistance Center for an appointment. To find the number, go to www.irs.gov/localcontacts or look in the phone book under *United States Government, Internal Revenue Service.*
- *TTY/TDD equipment.* If you have access to TTY/TDD equipment, call 1-800-829-4059 to ask tax questions or to order forms and publications.
- *TeleTax topics.* Call 1-800-829-4477 to listen to pre-recorded messages covering various tax topics.
- *Refund information.* To check the status of your 2011 refund, call 1-800-829-1954 or 1-800-829-4477 (automated refund information 24 hours a day, 7 days a week). Wait at least 72 hours after the IRS acknowledges receipt of your e-filed return, or 3 to 4 weeks after mailing a paper return. If you filed Form 8379 with your return, wait 14 weeks (11 weeks if you filed electronically). Have your 2011 tax return available so you can provide your social security number, your filing status, and the exact whole dollar amount of your refund. If you check the status of your refund and are not given the date it will be issued, please wait until the next week before checking back.
- *Other refund information.* To check the status of a prior-year refund or amended return refund, call 1-800-829-1040.

Evaluating the quality of our telephone services. To ensure IRS representatives give accurate, courteous, and professional answers, we use several methods to evaluate the quality of our telephone services. One method is for a second IRS representative to listen in on or record random telephone calls. Another is to ask some callers to complete a short survey at the end of the call.

Walk-in. Many products and services are available on a walk-in basis.

- *Products.* You can walk in to many post offices, libraries, and IRS offices to pick up certain forms, instructions, and publications. Some IRS offices, libraries, grocery stores, copy centers, city and county government offices, credit unions, and office supply stores have a collection of products available to print from a CD or photocopy from reproducible proofs. Also, some IRS offices and libraries have the Internal Revenue Code, regulations, Internal Revenue Bulletins, and Cumulative Bulletins available for research purposes.
- *Services.* You can walk in to your local Taxpayer Assistance Center every business day for personal, face-to-face tax help. An employee can explain IRS letters, request adjustments to your tax account, or help you set up a payment plan. If you need to resolve a tax problem, have questions about how the tax law applies to your individual tax return, or you are more comfortable talking with someone in person, visit your local Taxpayer Assistance Center where you can spread out your records and talk with an IRS representative face-to-face. No appointment is necessary—just walk in. If you prefer, you can call your local Center and leave a message requesting an appointment to resolve a tax account issue. A representative will call you back within 2 business days to schedule an in-person appointment at your convenience. If you have an ongoing, complex tax account problem or a special need, such as a disability, an appointment can be requested. All other issues will be handled without an appointment. To find the number of your local office, go to www.irs.gov/localcontacts or look in the phone book under *United States Government, Internal Revenue Service.*

Mail. You can send your order for forms, instructions, and publications to the address below. You should receive a response within 10 days after your request is received.

Internal Revenue Service
1201 N. Mitsubishi Motorway
Bloomington, IL 61705-6613

Taxpayer Advocate Service. The Taxpayer Advocate Service (TAS) is your voice at the IRS. Our job is to ensure that every taxpayer is treated fairly, and that you know and understand your rights. We offer free help to guide you through the often-confusing process of resolving tax problems that you haven't been able to solve on your own. Remember, the worst thing you can do is nothing at all.

TAS can help if you can't resolve your problem with the IRS and:

- Your problem is causing financial difficulties for you, your family, or your business.
- You face (or your business is facing) an immediate threat of adverse action.
- You have tried repeatedly to contact the IRS but no one has responded, or the IRS has not responded to you by the date promised.

If you qualify for our help, we'll do everything we can to get your problem resolved. You will be assigned to one advocate who will be with you at every turn. We have offices in every state, the District of Columbia, and Puerto Rico. Although TAS is independent within the IRS, our advocates know how to work with the IRS to get your problems resolved. And our services are always free.

As a taxpayer, you have rights that the IRS must abide by in its dealings with you. Our tax toolkit at *www.TaxpayerAdvocate.irs.gov* can help you understand these rights.

If you think TAS might be able to help you, call your local advocate, whose number is in your phone book and on our website at *www.irs.gov/advocate*. You can also call our toll-free number at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

TAS also handles large-scale or systemic problems that affect many taxpayers. If you know of one of these broad issues, please report it to us through our Systemic Advocacy Management System at *www.irs.gov/advocate*.

Low Income Taxpayer Clinics (LITCs). Low Income Taxpayer Clinics (LITCs) are independent from the IRS. Some clinics serve individuals whose income is below a certain level and who need to resolve a tax problem. These clinics provide professional representation before the IRS or in court on audits, appeals, tax collection disputes, and other issues for free or for a small fee. Some clinics can provide information about taxpayer rights and responsibilities in many different languages for individuals who speak English as a second language. For more information and to find a clinic near you, see the LITC page on *www.irs.gov/advocate* or IRS Publication 4134, *Low Income Taxpayer Clinic List*. This publication is also available by calling 1-800-829-3676 or at your local IRS office.

Free tax services. Publication 910, IRS Guide to Free Tax Services, is your guide to IRS services and resources. Learn about free tax information from the IRS, including publications, services, and education and assistance programs. The publication also has an index of over 100 TeleTax topics (recorded tax information) you can listen to on the telephone. The majority of the information and services listed in this publication are available to you free of charge. If there is a fee associated with a resource or service, it is listed in the publication.

Accessible versions of IRS published products are available on request in a variety of alternative formats for people with disabilities.

DVD for tax products. You can order Publication 1796, IRS Tax Products DVD, and obtain:

- Current-year forms, instructions, and publications.
- Prior-year forms, instructions, and publications.
- Tax Map: an electronic research tool and finding aid.
- Tax law frequently asked questions.
- Tax Topics from the IRS telephone response system.
- Internal Revenue Code—Title 26 of the U.S. Code.
- Links to other Internet based Tax Research materials.
- Fill-in, print, and save features for most tax forms.
- Internal Revenue Bulletins.
- Toll-free and email technical support.
- Two releases during the year.
  - The first release will ship the beginning of January 2012.
  - The final release will ship the beginning of March 2012.

Purchase the DVD from National Technical Information Service (NTIS) at *www.irs.gov/cdorders* for $30 (no handling fee) or call 1-877-233-6767 toll free to buy the DVD for $30 (plus a $6 handling fee).

APPENDIX I

This document may not be used or cited as precedent. Section 6110(j)(3) of the Internal Revenue Code.

Private Letter Ruling 9034078

PLR 9034078; 1990 PLR LEXIS 1467

May 31, 1990

[*1]

SUBJECT MATTER: Code Secs. 105, 106, 3121 and 3306

REFERENCE: Symbol: CC:EE:6-TR-31-1608-90

UI LIST:

UI No. 0105.00-00; Accident and health plans
UI No. 0106.00-00; Contribution by employer to accident and health plans
UI No. 3121.01-12; Definitions; Wages; Payment under employers' plans for retirement, disability, death, etc.
UI No. 3306.07-01; Definitions; Not employees under section 530 of 1978 Revenue Act; In general

TEXT:

This is in response to your letter dated March 27, 1990, on behalf of X, requesting rulings with respect to the federal tax consequences of providing certain benefits to employees through a plan that is intended to qualify as a cafeteria plan under *section 125 of the Internal Revenue Code* (the Code). Your ruling request with respect to *section 125 of the Code* is within the jurisdiction of the Employee Plans Technical and Actuarial Division which will respond to that request.

X has adopted the Plan to permit its employees to select among the following benefits on a pre-tax basis: health insurance coverage to the extent not provided by the employer; unreimbursed medical expense coverage; and dependent care assistance. Employees who are eligible to benefit under the Plan are all employees other than part-time [*2] students. Eligible employees enter the Plan on the date that they are hired. Each eligible employee makes an election to reduce salary to pay for the benefits selected under the Plan.

The employee may reduce salary to pay for medical premiums (medical insurance, dental insurance and vision insurance) that would otherwise be paid with after-tax contributions; to participate in a medical expense reimbursement program under which the employee is reimbursed for medical expenses not covered by the employee's medical insurance; and to participate in the dependent care assistance program under which the employee is reimbursed for dependent care expenses.

The amount of the salary reduction for any employee is limited such that the amount available for the medical insurance premiums does not exceed the amount of the premiums charged by third-party providers; the amount of the medical expense reimbursements does not exceed a maximum dollar amount established by X for each plan year; and the amount available for dependent care assistance is limited to the maximum amount permitted under *section 129(a)(2) of the Code*. Employees are not permitted to change their elections during the Plan year unless [*3] the change is on account of and consistent with a change in family status, or, in the case of health plans, if there is a significant increase in premiums.

Section 61(a) of the Code states that, unless otherwise excepted, gross income includes all compensation received for services performed including fringe benefits.

Section 106(a) of the Code provides that gross income of an employee does not include employer-provided coverage under an accident or health plan. *Section 1.106-1 of the Income Tax Regulations* further explains that the gross in-

come of an employee does not include contributions which his employer makes to an accident or health plan for compensation (through insurance or otherwise) to the employee for personal injuries or sickness incurred by him, his spouse, or his dependents.

Section 105(a) of the Code and *section 1.105-1(a) of the regulations* provide that amounts received by an employee through accident or health insurance for personal injuries or sickness shall be included in the employee's gross income to the extent amounts are (1) attributable to employer contributions not includable in the gross income of the employee, or (2) paid by the employer.

Except in **[*4]** the case of amounts attributable to (and not in excess of) deductions allowed under *section 213 of the Code* for any prior taxable year, *section 105(b) of the Code* states that gross income does not include amounts referred to in *section 105(a)* if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care (as defined in *section 213(d)*) of the taxpayer, the taxpayer's spouse or dependents (as defined in *section 152*).

Section 105(h)(6) of the Code defines a "self-insured medical reimbursement plan" as a plan of an employer to reimburse employees for expenses referred to in *section 105(b) of the Code* for which reimbursement is not provided under a policy of accident and health insurance.

The term "medical care" is defined in *section 213(d)(1) of the Code* to include amounts paid for (1) the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body, (2) for transportation primarily for and essential to such medical care, or (3) for insurance covering medical care or transportation.

Section 3121(a)(2) of the Code with respect to the Federal **[*5]** Insurance Contribution Act (FICA) and *section 3306(b)(2) of the Code* with respect to the Federal Unemployment Tax Act (FUTA), provide that the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash, except that such term shall not include the amount of any payment (including any amount paid by an employer for insurance or annuities or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees on account of medical or hospitalization expenses in connection with sickness or accident disability.

In addition, *section 3121(a)(5)(G) of the Code* with respect to FICA and *section 3306(b)(5)(G)* of the Code with respect to FUTA provide that the term "wages" shall not include "any payment made to, or on behalf of, an employee or his beneficiary ... under a cafeteria plan (within the meaning of *section 125*) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if *section 125* applied for purposes of this section) **[*6]** *section 125* would not treat any wages as constructively received." The Conference Report to the Tax Reform Act of 1986 explains: "The conference agreement clarifies that the cafeteria plan exception from the principles of constructive receipt also applies for purposes of the FICA and FUTA taxes. This clarification does not apply to elective contributions under a qualified cash or deferred arrangement that is part of a cafeteria plan." HR Rep. No. 99-841, 99th Cong., 2d Sess. II-543 (1986).

Based on the information provided, we conclude as follows:

(1) Amounts by which an employee of X, who is a participant in the Plan, elects to reduce his compensation and which amounts are allocable to the medical insurance plans and the medical expense reimbursement program are not includable in the gross income of the employee pursuant to *section 106 of the Code.*

(2) Amounts paid to or on behalf of an employee for medical care (as defined in *section 213(d)*) of the employee, the employee spouse or dependents pursuant to the medical insurance plans and the medical expense reimbursement program are not includable in the gross income of the employee pursuant to *section 105(b).*

(3) No portion of any **[*7]** of the amounts available under the Plan for the medical insurance plans and the medical expense reimbursement program will be includable in "wages" for purposes of FICA taxes and FUTA taxes, except to the extent that the amounts are received by the employee in cash or to the extent that the benefit is includable in the gross income of the employee.

(4) Finally, we note that there are no regulations under *section 129 of the Code* dealing with dependent care assistance programs. Section 17.07 of *Rev. Proc. 90-1, 1990-1 IRB 8* provides that the Service will not issue rulings pending the adoption of regulations interpreting the provisions of any act if the issues involved cannot be readily resolved before

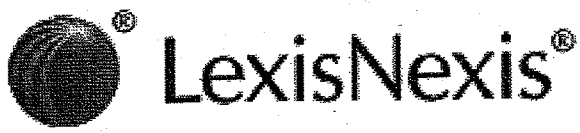
regulations are published or if warranted by the facts or circumstances of a particular case. Accordingly, no opinion is expressed as to whether the Plan contains a dependent care assistance program within the meaning of *section 129 of the Code* or as to the tax consequences of amounts paid or incurred by X with respect to the program (including the treatment of such amounts under *section 3121(a)(18)* with respect to FICA taxes and *section 3306(b)(13)* with respect to FUTA taxes).

The above **[*8]** rulings are based upon the Plan being a cafeteria plan within the meaning of *section 125 of the Code*. Moreover, the above rulings are based on the understanding that amounts by which an employee of X, who is a participant in the Plan, elects to reduce compensation and allocates such amount to the benefits under the Plan, would not be treated as constructively received under *section 125 of the Code*. However, we are not ruling, directly or indirectly, on whether the Plan constitutes a cafeteria plan within the meaning of *section 125* or on whether amounts allocable to the benefits under the Plan are constructively received. Therefore, this ruling shall not be construed as approving the Plan under *section 125* or any other provision of the Code.

No opinion is expressed concerning the federal tax consequences of the transactions described above under any provision of the Code, other than those discussed.

This ruling is directed only to the taxpayer who requested it. *Section 6110(j)(3) of the Code* provides that it may not be used or cited as precedent.

APPENDIX J



This document may not be used or cited as precedent. Section 6110(j)(3) of the Internal Revenue Code.

Private Letter Ruling 9034025

PLR 9034025; 1990 PLR LEXIS 1414

May 24, 1990

[*1]

SUBJECT MATTER: Code Secs. 3121 and 3306

REFERENCE: Symbol: CC:EE:6-TR-31-1609-90

UI LIST:

UI No. 3121.01-12; Definitions; Wages; Payment under employers' plans for retirement, disability, death, etc.
UI No. 3306.07-01; Definitions; Not employees under section 530 of 1978 Revenue Act; In general

TEXT:

This is in response to your letter date March 27, 1990, on behalf of X, requesting rulings with respect to the federal tax consequences of providing certain benefits to employees through a plan that is intended to qualify as a cafeteria plan under *section 125 of the Internal Revenue Code* (the Code). Your ruling request with respect to *section 125 of the Code* is within the jurisdiction of the Employee Plans Technical and Actuarial Division which will respond to that request.

X has adopted the Plan to permit its employees to select among the following benefits: medical coverage, dental coverage, vision coverage, and group-term life insurance coverage. All regular employees (both union and nonunion) are eligible to participate in the Plan, other than nonresident aliens and certain contract employees. Eligible employees enter the Plan after having been employed by X for two full payroll periods.

Each eligible employee makes an election [*2] among the benefits either prior to the commencement of participation in the Plan for new participants or prior to the beginning of the next Plan year for existing participants. Employees are required to elect employee-only coverage under the medical, dental, vision or group-term life insurance plans. In addition, an employee may elect between cash and providing benefit coverage for the employee's spouse or dependents. The benefits are funded through X's contributions and employee cash contributions. Employees are not permitted to change their elections during the Plan year unless the change is on account of and consistent with a change in family status.

You have requested the following rulings:

(1) Under *section 3121(a)(5)(G)*, no portion of any of the amounts available under the Plan will be includible in the wages of the employees for purposes of Chapter 21 of the Code, Federal Insurance Contributions Act, except to the extent that the employees elect to receive cash in lieu of benefits.

(2) Under *section 3306(b)(5)(G)*, no portion of any of the amounts available under the Plan will be includible in the wages of the employees for purposes of Chapter 23 of the Code, Federal Unemployment [*3] Tax Act, except to the extent that the employees elect to receive cash in lieu of benefits.

Section 3121(a)(2) of the Code with respect to the Federal Insurance Contribution Act (FICA) and *section 3306(b)(2) of the Code* with respect to the Federal Unemployment Tax Act (FUTA), provide that the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash, except that such term shall not include the amount of any payment (including any amount paid by an employer for insurance or annuities or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees on account of medical or hospitalization expenses in connection with sickness or accident disability. *Section 3121(a)(2)* further provides that the exclusion from "wages" does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee.

In addition, *section 3121(a)(5)(G) of the Code* with respect to FICA and *section 3306(b)(5)(G)* of the Code [*4] with respect to FUTA provide that the term "wages" shall not include "any payment made to, or on behalf of, an employee or his beneficiary ... under a cafeteria plan (within the meaning of *section 125*) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if *section 125* applied for purposes of this section) *section 125* would not treat any wages as constructively received." The Conference Report to the Tax Reform Act of 1986 explains: "The conference agreement clarifies that the cafeteria plan exception from the principles of constructive receipt also applies for purposes of the FICA and FUTA taxes. This clarification does not apply to elective contributions under a qualified cash or deferred arrangement that is part of a cafeteria plan." HR Rep. No. 99-841, 99th Cong., 2d Sess. II-543 (1986).

Based on the information submitted, we conclude that no portion of any of the amounts available under the Plan is includible in "wages" for [*5] purposes of FICA taxes and FUTA taxes, except to the extent that the amounts are received by the employees in cash or to the extent that the benefit is includible in the gross income of the employees.

The above ruling is based upon the Plan being a cafeteria plan within the meaning of *section 125 of the Code.* Moreover, the above ruling is based on the understanding that amounts that an employee of X allocates to the benefits under the Plan would not be treated as constructively received under *section 125 of the Code.* However, we are not ruling, directly or indirectly, on whether the Plan constitutes a cafeteria plan within the meaning of *section 125* or on whether amounts allocable to the benefits under the Plan are constructively received. Therefore, this ruling shall not be construed as approving the Plan under *section 125* or any other provision of the Code.

No opinion is expressed concerning the federal tax consequences of the transactions described above under any provision of the Code, other than those discussed.

This ruling is directed only to the taxpayer who requested it. *Section 6110(j)(3) of the Code* provides that it may not be used or cited as precedent.

APPENDIX K

This document may not be used or cited as precedent. Section 6110(j)(3) of the Internal Revenue Code.

Private Letter Ruling 8917081

PLR 8917081; 1989 PLR LEXIS 301

February 2, 1989

[*1]

SUBJECT MATTER: Code Secs. 3121 and 3306

REFERENCE: Symbol: CC:EE:6-TR-31-4252-88

UI LIST:

UI No. 3121.01-12; Definitions; Wages; Payment under employers' plans for retirement, disability, death, etc.
UI No. 3306.07-01; Definitions; Not employees under section 530 of 1978 Revenue Act; In general

TEXT:

This responds to your correspondence, dated September 15, 1988, on behalf of X, in which you request four rulings concerning the federal tax consequences of X's providing certain benefits to its employees through a plan intended to qualify as a cafeteria plan under *section 125 of the Internal Revenue Code* (the Code). We have been asked to reply to your first and fourth ruling requests with respect to dependent care benefits and federal employment taxes. your second and third ruling requests with respect to *section 125 of the Code* are within the jurisdiction of the Employee Plans Technical and Actuarial Division which has responded to those requests.

The purpose of the Plan is to provide employees of X with a choice among a premium reimbursement benefit, a medical expense reimbursement benefit, a dependent care benefit, or cash. All regular employees of X, whether full-time or part-time, are participants in the Plan. Regular employees [*2] are those who have an employment contract with X.

The Plan is funded solely through salary reduction elections. Once made, salary reductions are effective during the Plan year and are irrevocable, except where a revocation and new election are consistent with a change in family status.

Participants in the Plan may assign their salary reduction amounts among three accounts: a medical reimbursement account which is used to reimburse participants or their dependents for covered medical expenses under *sections 105* and *106 of the Code*; a premium payment account which is used to pay the cost of coverage under one or more designated group life insurance plans under *section 79 of the Code* and dental and medical insurance plans under *section 106 of the Code*; and a dependent care account which is used to reimburse participants for covered dependent care expenses under *section 129 of the Code*. Any balance remaining in any of the three accounts at the end of the Plan year remains with X.

You have requested the following rulings:

(1) The dependent care benefits described in X's Plan satisfy the requirements of *section 129 of the Code*.

(4) No federal employment taxes will be payable by participants or [*3] X on any of the Plan's non-cash benefits that are timely elected by participants.

Section 129(a)(1) of the Code provides that the gross income of an employee does not include amounts paid or incurred by the employer for dependent care assistance provided to such employee if the assistance is furnished pursuant to a program which is described in subsection (d).

Section 129(d)(1) of the Code provides that a dependent care assistance program is a plan of an employer under which the employer provides employees with dependent care assistance and which meets the requirements of paragraphs (2) through (6) and *section 89(k)*.

Section 3121(a)(2) of the Code with respect to the Federal Insurance Contribution Act (FICA) and *section 3306(b)(2) of the Code* with respect to the Federal Unemployment Tax Act (FUTA) provide that the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash, except that such term shall not include the amount of any payment (including any amount paid by an employer for insurance or annuities or into a fund, to provide for any such payment) made to, or on behalf of, an employee or **[*4]** any of his dependents under a plan established by an employer which makes provision for his employees on account of medical or hospitalization expenses in connection with sickness or accident disability, or death, except that this paragraph does not apply to a payment for group-term life insurance to the extent that such payment is includable in the gross income of the employee.

Section 3121(a)(18) of the Code with respect to FICA taxes and *section 3306(b)(13) of the Code* with respect to FUTA taxes provide that the term "wages" does not include any payment made, or benefit furnished to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under *section 129*.

In addition, the Technical and Miscellaneous Revenue Act of 1988 (TAMRA) amended *section 3121(a)(5)(G) of the Code* with respect to FICA taxes and *section 3306(b)(5)(G) of the Code* with respect to FUTA taxes to provide that the term "wages" does not include any payment made to, or on behalf of, an employee or his beneficiary "under a cafeteria plan (within the meaning of *section 125*) if such payment **[*5]** would not be treated as wages without regard to such plan and it is reasonable to believe that (if *section 125* applied for purposed of this section) *section 125* would not treat any wages as constructively received."

Section 89 of the Code sets forth certain nondiscrimination tests that must be satisfied by an employer in the provision of health and group-term life insurance benefits to its employees. If the employer fails to meet the nondiscrimination requirements of *section 89*, then certain highly compensated employees may have to include the value of a portion of such benefits in their incomes. *Section 89(k) of the Code* also imposes certain notice, writing and participant rights requirements and provides, in general, that unless those requirements are met, employer-provided benefits under plans to which *section 89* applies are includable in an employee's gross income notwithstanding the fact they are otherwise excludable under the Code.

We note that there are no regulations under *section 129 of the Code* dealing with dependent care assistance programs. Section 5.07 of *Rev. Proc. 89-1 1989-1 IRB 8, 12*, provides that the Service will not issue rulings pending the adoption of regulations (either **[*6]** temporary or final) interpreting the provisions of any act if the ruling request presents an issue that cannot be readily resolved before regulations are issued. Accordingly, we regret that we are unable to issue an opinion as to whether the Plan contains a dependent care assistance program within the meaning of *section 129 of the Code* or as to the tax consequences of amounts paid or incurred by X with respect to the program.

With respect to the federal employment taxes, provided the benefits under the Plan meet the requirements of *sections 79, 105,106* or *129* and *89 of the Code*, amounts paid to, or on behalf of, a participant or the participant's dependents or beneficiaries under the Plan are not "wages" for purposes of either *section 3121* or *section 3306 of the Code*.

The above ruling is based upon the Plan being a cafeteria plan within the meaning of *section 125 of the Code*. Moreover, the above ruling is based on the understanding that amounts by which an employee of X, who is a participant in the Plan, elects to reduce compensation and allocates such amounts to the benefits under the Plan, would not be treated as constructively received under *section 125 of the Code*. However, we are **[*7]** not ruling, directly or indirectly, on whether the Plan constitutes a cafeteria plan within the meaning of *section 125 of the Code* or on whether amounts allocable to the benefits under the Plan are constructively received. Therefore, this ruling shall not be construed as approving the Plan under *section 125* or any other provision of the Code.

No opinion is expressed concerning the federal tax consequences of the transaction described above under any provision of the Code, other than those discussed.

This ruling is directed only to the taxpayer who requested it. *Section 6110(j)(3) of the Code* provides that it may not be used or cited as precedent.

APPENDIX L

DESCRIPTION OF THE TAXPAYER ASSISTANCE AND SIMPLIFICATION ACT OF 2008

April 8, 2008

[JOINT COMMITTEE PRINT];JCX 26-08

INTRODUCTION

The House Committee on Ways & Means has scheduled a markup on April 9, 2008, of the Taxpayer Assistance and Simplification Act of 2008. This document, n1 prepared by the staff of the Joint Committee on Taxation provides a description of the Taxpayer Assistance and Simplification Act of 2008.

n1 This document may be cited as follows: Joint Committee on Taxation, *Description of the Taxpayer Assistance and Simplification Act of 2008* (JCX 26-08), April 8, 2008. This document may be cited at www.house.gov/jct.

A. Modified Standard for Imposition of Tax Return Preparer Penalties

Present Law

Taxpayer standards

Present law imposes accuracy-related penalties on a taxpayer at a rate of 20 percent of the portion of any underpayment that is attributable to any substantial understatement of income tax. In determining whether a substantial understatement exists, the amount of the understatement generally is reduced by any portion attributable to an item if (1) the treatment of the item is supported by substantial authority, or (2) facts relevant to the tax treatment of the item were adequately disclosed and there was a reasonable basis for its tax treatment.

In the case of a tax shelter item of a non-corporate taxpayer, the substantial understatement penalty does not apply if the taxpayer had substantial authority for the tax position and the taxpayer can demonstrate that he or she had a reasonable belief that the position is "more likely than not" the proper treatment. A taxpayer will be considered to have a reasonable belief that the treatment is more likely than not the proper treatment if the taxpayer relies upon the opinion of a professional advisor and the opinion is based upon the pertinent facts and authorities analyzed similar to the manner described in the substantial authority standard. n2

n2 *Treas. Reg. sec. 1.6662-4 (g)* .

Tax return preparer standards

Prior to enactment of the Small Business and Work Opportunity Tax Act of 2007, an income tax return preparer who prepared a tax return with respect to which there was an understatement of tax that was due to an undisclosed position for which there was not a realistic possibility of being sustained on its merits was liable for a $ 250 penalty. For a disclosed position, the preparer was liable only if the position was frivolous.

Legislation enacted as part of the Small Business and Work Opportunity Tax Act of 2007 broadened the scope of the preparer penalty by applying it to all tax return preparers and altered the standards of conduct a tax return preparer is required to meet in order to avoid the imposition of penalties for the preparation of a return with respect to which there is an understatement of tax. A tax return preparer now can be penalized for preparing a return on which there is an understatement of tax liability as a result of an "unreasonable position." Any position that a return preparer does not reasonably believe is more likely than not to be sustained on its merits is an "unreasonable position" unless the position is disclosed on the return and there is a reasonable basis for the position.

In general, the term "tax return preparer" is broadly defined as any person who prepares for compensation, or who employs one or more persons to prepare for compensation, any return of tax or any claim for refund of tax. n3 Preparation of a substantial portion of a return is treated as if it were the preparation of such return.

n3 Sec. 7701(a)(36)(A).

Description of Proposal

The proposal changes the standards for imposition of the tax return preparer penalty. The preparer standard for undisclosed positions is reduced to "substantial authority." The preparer standard for disclosed positions is "reasonable basis." For tax shelters and reportable transactions to which section 6662A applies (i.e., listed transactions and reportable transactions with significant avoidance or evasion purposes), a tax return preparer is required to have a reasonable belief that such a transaction was more likely than not to be sustained on its merits.

Effective Date

The proposal generally is effective with respect to returns prepared after May 25, 2007. In the case of tax shelters and reportable transactions, the proposal is effective for returns prepared for taxable years ending after the date of enactment.

B. Removal of Cellular Telephones (or Similar Telecommunications Equipment) from Listed Property

Present Law

Employer Deduction

Property, including cellular telephones and similar equipment, used in carrying on a trade or business is subject to the general rules for deducting ordinary and necessary expenses under section 162. Under these rules, a taxpayer may properly claim depreciation deductions under the applicable cost recovery rules for only the portion of the cost of the property thatis attributable to use in a trade or business. n4 Similarly, the business portion of monthly telecommunication service is generally deductible, subject to capitalization rules, as an ordinary and necessary expense of carrying on a trade or business.

n4 Sec. 212 allows deductions for ordinary and necessary expenses paid or incurred for the production or collection of income.

In the case of certain listed property, special rules apply. Listed property generally is defined as (1) any passenger automobile; (2) any other property used as a means of transportation; (3) any property of a type generally used for purposes of entertainment, recreation, or amusement; (4) any computer or peripheral equipment; (5) any cellular telephone (or other similar telecommunications equipment); n5 and (6) any other property of a type specified in Treasury regulations. n6

n5 Cellular telephones (or other similar telecommunications equipment) were added as listed property as part of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, sec. 7643 (1989).

n6 Sec. 280F(d)(4)(A).

For listed property, no deduction is allowed unless the taxpayer adequately substantiates the expense and business usage of the property. n7 Under the applicable regulations, a taxpayer must substantiate the elements of each expenditure or use of listed property, including (1) the amount (e.g., cost) of each separate expenditure and the amount of business or investment use, based on the appropriate measure (e.g., mileage for automobiles), and the total use of the property for the taxable period, (2) the date of the expenditure or use, and (3) the business purposes for the expenditure or use. n8 The level of substantiation for business or investment use of listed property varies depending on the facts and circumstances. In general, the substantiation must contain sufficient information as to each element of every business or investment use. n9

n7 Sec. 274(d)(4).

n8 Temp. Reg. sec. 1.274-5T(b)(6).

n9 Temp. Reg. sec. 1.274-5T(c)(2)(ii)(C).

With regard to the business use of listed property made available by an employer for use by an employee, the employer may generally rely on adequate records maintained, and retained, by the employee or on the employee's own statement if it is corroborated by other sufficient evidence, unless the employer knows or has reason to know that the statement, records, or other evidence are not accurate. n10

n10 Temp. Reg. sec. 1.274-5T(e)(2)(ii).

Taxation of Employee

Gross income includes all income unless a specific exclusion applies. n11 Exclusions from gross income are provided in the case of certain fringe benefits. n12 Gross income does not include the value of de minimis fringe benefits. A de minimis fringe is any property or service the value of which is(after taking into account the frequency in which similar fringes are provided by the employer to the employer's employees) so small as to make accounting for it unreasonable or administratively impracticable. An exclusion from employee gross income is also provided in the case of a working condition fringe. n13 A working condition fringe is any property or services provided to an employee of the employer to the extent that, if the employee paid for such property or services, such payment would be allowable as a deduction under section 162 or 167. n14 Treasury regulations provide that an employee may not exclude from gross income as a working condition fringe any amount of the value of the availability of listed property provided by an employer to the employee, unless the employee substantiates for the period of availability the amount of the exclusion in accordance with the substantiation requirements discussed above. n15 In general, under such requirements, in the case of listed property, the working condition fringe exception is allowed only in the case of substantiation of the employee's personal use of the property and that the employer included an appropriate amount (based on such personal use) in the employee's income. n16

n11 Sec. 61.

n12 Sec. 132.

n13 Sec. 132(a)(3).

n14 Sec. 132(d).

n15 Temp. Reg. sec. 1.274-5T(e)(1).

n16 Temp. Reg. sec. 1.274-5T(e)(2).

Cost Recovery

A taxpayer is allowed to recover through annual depreciation deductions the cost of certain property used in a trade or business or for the production of income. The amount of the depreciation deduction allowed with respect to tangible property for a taxable year is determined under the modified accelerated cost recovery system ("MACRS"). Under MACRS, different types of property generally are assigned applicable recovery periods and depreciation methods. The recovery periods applicable to most tangible personal property range from three to 25 years. The depreciation methods generally applicable to tangible personal property are the 200-percent and 150-percent declining balance methods, switching to the straight-line method for the taxable year in which the taxpayer's depreciation deduction would be maximized.

In the case of certain listed property, special depreciation rules apply. First, if for the taxable year that the property is placed in service the use of the property for trade or business purposes does not exceed 50 percent of the total use of the property, then the depreciation deduction with respect to such property is determined under the alternative depreciation system. n17 The alternative depreciation system generally requires the use of the straight-line method and a recovery period equal to the class life of the property. n18 Second, if an individual owns or leases listed property that is used by the individual in connection with the performance of services as an employee, no depreciation deduction, expensing allowance, or deduction for lease payments is available with respect to such use unless the use of the property is for the convenience of the employer and required as a condition of employment. n19

n17 Sec. 280F(b)(1). If for any taxable year after the year in which the property is placed in service the use of the property for trade or business purposes decreases to 50 percent or less of the total use of the property, then the amount of depreciation allowed in prior years in excess of the amount of depreciation that would have been allowed for such prior years under the alternative depreciation system is recaptured (i.e., included in gross income) for such taxable year.

n18 Sec. 168(g).

n19 Sec. 280F(d)(3).

Description of Proposal

The proposal removes cellular telephones (or other similar telecommunications equipment) from the definition of listed property. Thus, under the proposal, the heightened substantiation requirements that apply to listed property do not apply to cellular telephones (or other similar telecommunications equipment).

Effective Date

The proposal is effective for taxable years beginning after December 31, 2008.

C. Delayed Implementation of Government Withholding Requirement

Present law

For payments made after December 31, 2010, the Code requires withholding at a three-percent rate on certain payments to persons providing property or services made by the Government of the United States, every State, every political subdivision thereof, and every instrumentality of the foregoing (including multi-State agencies). The withholding requirement applies regardless of whether the government entity making such payment is the recipient of the property or services. Political subdivisions of States (or any instrumentality thereof) with less than $ 100 million of annual expenditures for property or services that would otherwise be subject to withholding under this provision are exempt from the withholding requirement.

Payments subject the three-percent withholding include any payment made in connection with a government voucher or certificate program which functions as a payment for property or services. For example, payments to a commodity producer under a government commodity support program are subject to the withholding requirement. The provision imposes information reporting requirements on the payments that are subject to withholding under the provision.

The three-percent withholding requirement does not apply to any payments made through a Federal, State, or local government public assistance or public welfare program for which eligibility is determined by a needs or income test. The three-percent withholding requirement also does not apply to payments of wages or to any other payment with respect to which mandatory (e.g., U.S.-source income of foreign taxpayers) or voluntary (e.g., unemployment benefits) withholding applies under present law. The provision does not exclude payments that are potentially subject to backup withholding under section 3406. If, however, payments are actually being withheld under backup withholding, withholding does not apply.

The three-percent withholding requirement also does not apply to the following: payments of interest; payments for real property; payments to tax-exempt entities or foreign governments; intra-governmental payments; payments made pursuant to a classified or confidential contract (as defined in section 6050M(e)(3)); and payments to government em-

ployees that are not otherwise excludable from the new withholding provision with respect to the employees' services as employees.

Description of Proposal

The proposal delays the effective date for the three-percent withholding requirement. Under the proposal, the requirement applies to payments made after December 31,2011.

The proposal directs the Secretary to study issues associated with the three-percent withholding requirement, including (1) the problems, if any, which are anticipated in administering and complying with such requirement, (2) the burdens, if any, that such requirements will place on small businesses (taking into account such mechanisms as may be necessary to administer such requirements), and (3) the application of such requirements to small expenditures for services and goods by governments.

The Secretary is to submit his report to the Senate Committee on Finance and House Committee on Ways and Means no later than six months after the date of enactment.

Effective Date

The proposal is effective on the date of enactment.

D. Employment Tax Treatment of Home Care Service Recipients

Present Law

In general

Employment taxes generally consist of the taxes under the Federal Insurance Contributions Act ("FICA"), the tax under the Federal Unemployment Tax Act ("FUTA"), and income taxes required to be withheld by employers from wages paid to employees ("income tax withholding"). n20

n20 Secs. 3101-3128 (FICA), 3201-3241 (the Railroad Retirement Tax Act), 3301-3311 (FUTA), and 3401-3404 (income tax withholding). Sections 3501-3510 provide additional rules.

FICA tax consists of two parts: (1) old age, survivor, and disability insurance ("OASDI"), which correlates to the Social Security program that provides monthly benefits after retirement, disability, or death; and (2) Medicare hospital insurance ("HI"). The OASDI tax rate is 6.2 percent on both the employee and employer (for a total rate of 12.4 percent). The OASDI tax rate applies to wages up to the OASDI wage base ($ 102,000 for 2008). The HI tax rate is 1.45 percent on both the employee and the employer (for a total rate of 2.9 percent). Unlike the OASDI tax, the HI tax is not limited to a specific amount of wages, but applies to all wages.

Under FUTA, employers must pay a tax of 6.2 percent of wages up to the FUTA wage base of $ 7,000. An employer may take a credit against its FUTA tax liability for its contributions to a State unemployment fund and, in certain cases, an additional credit for contributions that would have been required if the employer had been subject to a higher contribution rate under State law. For purposes of the credit, contributions means payments required by State law to be made by an employer into an unemployment fund, to the extent the payments are made by the employer without being deducted or deductible from employees' remuneration.

Employers generally are required to withhold income taxes from wages paid to employees. Withholding rates vary depending on the amount of wages paid, the length of the payroll period, and the number of withholding allowances claimed by the employee.

Wages paid to employees, and FICA and income taxes withheld from the wages, are required to be reported on employment tax returns (Forms 940 and 941) and on Form W-2. n21

n21 Secs. 6011 and 6051.

A number of special rules apply in the case of household employees. An exception from FICA exists in the case of domestic service in a private home if the cash remuneration paid during the year by the employer to the employee for

such service is less than $ 1,600 (for 2008). n22 An employer of a household employee is liable for FUTA if the employer paid wages of $ 1,000 for such service in any calendar quarter in the calendar year or the preceding calendar year. n23 An employer of a household employee is not required to withhold Federal income taxes from wages paid to household employees. n24 Household employers may report employment taxes annually on Schedule H (filed with their annual Federal income tax return) rather than quarterly on Form 941.

n22 Sec. 3121(a)(7)(B).

n23 Sec. 3306(a)(3).

n24 Sec. 3401(a)(3).

Responsibility for employment tax compliance

Employment tax responsibility generally rests with the person who is the employer of an employee under a common-law test that has been incorporated into Treasury regulations. n25 Under the regulations, an employer-employee relationship generally exists if the person for whom services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work, but also as to the details and means by which that result is accomplished. That is, an employee is subject to the will and control of the employer, not only as to what is to be done, but also as to how it is to be done. It is not necessary that the employer actually control the manner in which the services are performed, rather it is sufficient that the employer have a right to control. Whether the requisite control exists is determined on the basis of all the relevant facts and circumstances. The test of whether an employer-employee relationship exists is relevant in determining whether a worker is an employee or an independent contractor. However, the same test applies in determining whether a worker is an employee of one person or another. n26

n25 Treas. Reg. secs. 31.3121(d)-1(c)(1), 31.3306(i)-1(a), and 31.3401(c)-1.

n26 Issues relating to the classification of workers as employees or independent contractors are discussed in Joint Committee on Taxation, *Present Law and Background Relating to Worker Classification for Federal Tax Purposes* (JCX 26-07), May 2007. These issues are also discussed in Joint Committee on Taxation, *Study of the Overall State of the Federal Tax System and Recommendations for Simplification, Pursuant to Section 8022 (3)(B) of the Internal Revenue Code of 1986* (JCS 3-01), April 2001, at Vol. II, Part XV.A, at 539-550.

In some cases, a person other than the common-law employer may be liable for employment taxes. For example, if wages are paid to an employee by a person other than the employer and the payor, rather than the employer, has control of the payment of the wages, the payor is responsible for complying with the applicable employment tax requirements. n27 There are also special rules under which if a lender, surety or other person pays wages directly to an employee or group of employees, the lender, surety, or other person is responsible for employment taxes. n28 There is also a special rule under which a qualified real estate agent, or direct seller of certain consumer products, performing services is not treated as an employee with respect to the person for whom the services are performed. n29

n27 Sec. 3401(d)(1) (for purposes of income tax withholding, if the employer does not have control of the payment of wages, the person having control of the payment of such wages is treated as the employer); *Otte v. United States, 419 U.S. 43 (1974)* (the person who has the control of the payment of wages is treated as the employer for purposes of withholding the employee's share of FICA from wages); and *In re Armadillo Corporation, 561 F.2d 1382 (10th Cir. 1977),* and *In re The Laub Baking Company v. United States, 642 F.2d 196 (6th Cir. 1981)* (the person who has control of the payment of wages is the employer for purposes of the employer's share of FICA and FUTA). The mere fact that wages are paid by a person other than the employer does not necessarily mean that the payor has control of the payment of the wages. Rather, control depends on the facts and circumstances. See, e.g., *Consolidated Flooring Services v. U.S., 38 Fed. Cl. 450 (1997),* and *Winstead v. U.S., 109 F. 3d 989 (4th Cir. 1997).*

n28 Sec. 3505

n29 Sec. 3508

In addition, certain designated agents are jointly and severally liable with the employer for FICA tax and income tax withholding with respect to wages paid to the employer's employees. n30 These designated agents prepare and file employment tax returns using their own names and employer identification numbers. n31 In contrast, reporting agents (often referred to as payroll service providers) are generally not liable for the employment taxes reported on their clients' returns. Reporting agents prepare and file employment tax returns for their clients using the client's name and employer identification number.

n30 Sec. 3504. The designated payroll agent rules do not apply for FUTA purposes.

n31 The employer's name, address, and employer identification number, as well as the agent's, are provided when the agent is designated by the employer. Form 2678 is used to designate an agent.

Penalties apply in the case of failures to comply with information reporting requirements. n32 In the case of failure to file a specified information return, a penalty of $ 50 for each return (not to exceed $ 100,000) is imposed. n33

n32 Secs. 6721 - 6724.

n33 Sec. 6723.

Home-care services

Many elderly and disabled individuals receive in-home care through state and local government health and welfare programs. n34 These programs generally are funded at least in part with Federal funds. In most cases, the service recipient (i.e., the elderly or disabled individual) is the common law employer.

n34 *See* National Taxpayer Advocate 2007 Annual Report to Congress, December 31, 2007 at 355.

IRS guidance provides rules for State and local government agencies as to how they can serve as agents for disabled individuals and other welfare recipients who employ home-care service providers to assist them in their homes. n35 In general, these rules provide that the elderly or disabled individual must complete a form designating the State or local government as their agent for employment tax purposes. Under IRS guidance, unlike the general rule for designated agents, a State that furnishes home-care service providers (or a third party subagent of the State) can act as an agent on behalf of the service recipient for FUTA purposes. n36 As previously discussed, in the case of a State or local government or independent third party serving as an agent on behalf of the service recipient, the service recipient remains liable for payment of the employment taxes and for any associated penalties for noncompliance.

n35 *See* Notice 2003-70, *2003-2 C.B. 916* (providing a proposed revenue procedure). *See also,Rev. Proc. 76-6, 1970-1 C.B. 420,* as modified by*Rev. Proc. 80-4, 1980-1 C.B. 581.*

n36Notice 2003-70, *2003-2 C.B. 916.* This is not the case if the independent third party is designated as the agent directly by the employer.

Description of Proposal

The proposal provides that, in the case of amounts paid under a home care service program to a home care service provider by the fiscal administrator of such program, the fiscal administrator is solely liable for the payment of employment taxes with respect to amounts paid for services under the program. In such case, the home care service recipient is not liable for the payment of employment taxes.

A home care service program is a State or local government program which is funded in whole or part by Federal funds and under which domestic services are provided to elderly or disabled individuals in their home. A home care service program does not include any program to the extent home care service recipients make payments to the home care service providers for such in-home domestic services.

A home care service provider is an individual who provides domestic services to a home care service recipient under a home care service program. A home care service recipient is an individual receiving domestic services under a home care service program. A fiscal administrator is any person or governmental entity who pays amounts under a home care service program to home care service providers for the provision of domestic services under such program.

Employment tax returns (i.e., Forms W-2, 940 and 941) must be made under the name and employer identification number of the fiscal administrator rather than that of the common law employer, the service recipient. The fiscal administrator is required, as prescribed by the Secretary, to report to the IRS the name, address, and social security number of each home care service recipient for whom amounts are paid by such fiscal administrator under the home care services program. This is intended to assist the IRS in preventing collection action against the elderly or disabled common law employer. In the case of failure to file the required report, a penalty is imposed. n37

n37 The section 6723 present law penalties are increased under another section of the bill. Under that proposal, the penalty of $ 50 per report (not to exceed $ 100,000 per calendar year) is increased to $ 100 per report (not to exceed $ 1,500,000 per calendar year).

Under the proposal, the Secretary may prescribe regulations or other guidance as may be necessary to carry out the purposes of the provision, including rules for timing of employment tax deposits.

It is intended that the present law rules that apply in the case of household employees continue to apply under the proposal. Relevant thresholds under these rules are also determined with respect to each home care recipient. For example, it is intended that the exception from FICA for domestic service in a private home if cash remuneration paid during the year by the employer to the employee for such service is less than $ 1,600 (for 2008) would continue to apply. Similarly, FUTA would be required only if the employer paid wages of $ 1,000 for household service in any calendar quarter in the calendar year or the preceding calendar year. In addition, the present law exception from Federal income tax withholding for household employees would continue to apply.

Effective Date

The proposal is effective for amounts paid after December 31, 2008.

E. Referrals to Low-Income Taxpayer Clinics

Present Law

The Code provides that the Secretary is authorized to provide up to $ 6 million per year in matching grants to certain qualified low-income taxpayer clinics. n38 Eligible clinics are those that charge no more than a nominal fee to either represent low-income taxpayers in controversies with the IRS or provide tax information to individuals for whom English is a second language. No clinic can receive more than $ 100,000 per year.

n38 Sec. 7526.

A qualified low-income taxpayer clinic includes (1) a clinical program at an accredited law, business, or accounting school, in which students represent low-income taxpayers, or (2) an organization described in section 501(c) which either represents low-income taxpayers as described above or provides referrals to qualified representatives. A low-income taxpayer is an individual whose income does not exceed 250 percent of the poverty level, as determined in accordance with criteria established by the Director of the Office of Management and Budget ("OMB").

The Department of the Treasury prohibits its officers and employees from referring taxpayers to qualified low-income taxpayer clinics for advice and assistance.

Description of Proposal

The proposal allows officers and employees of the Department of the Treasury to refer taxpayers for advice and assistance to qualified low-income taxpayer clinics that receive funding, notwithstanding any other provision of law.

Effective Date

The proposal is effective for referrals made after the date of enactment.

F. Programs for the Benefit of Low-Income Taxpayers

Present Law

The Code provides that the Secretary is authorized to provide up to $ 6 million per year in matching grants to certain qualified low-income taxpayer clinics. n39 Eligible clinics are those that charge no more than a nominal fee to either represent low-income taxpayers in controversies with the IRS or provide tax information to individuals for whom English is a second language. No clinic can receive more than $ 100,000 per year.

n39 Sec. 7526.

A qualified low-income taxpayer clinic includes (1) a clinical program at an accredited law, business, or accounting school, in which students represent low-income taxpayers, or (2) an organization described in section 501(c) which either represents low-income taxpayers as described above or provides referrals to qualified representatives. A low-income taxpayer is an individual whose income does not exceed 250 percent of the poverty level, as determined in accordance with criteria established by the Director of the Office of Management and Budget ("OMB").

Description of Proposal

The proposal authorizes the Secretary to make $ 10 million in matching grants for volunteer income tax programs. Volunteer income tax programs are programs that provide tax return preparation and filing services to low- and moderate-income (as determined by the Secretary) taxpayers. Under the proposal, volunteer income tax programs may not charge taxpayers for return preparation services. Volunteers assisting taxpayers through such programs must meet training requirements established by the Secretary.

The authorization of $ 6 million for qualified low-income taxpayer clinics under present law also is increased to $ 10 million.

Effective Date

The proposal is effective on the date of enactment.

G. Earned Income Credit Outreach

Present Law

In general

Low and moderate-income taxpayers may be eligible for the refundable earned income credit ("EIC"). n40 Generally, the amount of the EIC is based on the presence and number of qualifying children in the taxpayer's family, as well as on adjusted gross income ("AGI") and earned income. n41 Other rules also apply.

n40 The EIC is a refundable credit, meaning that if the amount of the credit exceeds the taxpayer's Federal income tax liability, the excess is payable to the taxpayer as a direct transfer payment. Under an advance payment system, eligible taxpayers may elect to receive a portion of the credit in their paychecks, rather than waiting to claim a refund on their tax return filed by April 15 of the following year.

n41 Earned income is defined as (1) wages, salaries, tips, and other employee compensation, but only if such amounts are includible in gross income, plus (2) the amount of the taxpayer's net self-employment earnings.

Three separate schedules apply in computing the taxpayer's EIC: (1) one schedule for taxpayers with no qualifying children; (2) one schedule for taxpayers with one qualifying child; and (3) one schedule for taxpayers with more than one qualifying child. n42

n42 In general, a child is a qualifying child of a taxpayer if the child satisfies each of three tests: (1) the child has the same principal place of abode as the taxpayer for more than one-half of the taxable year; (2) the child has a specified relationship to the taxpayer; and (3) the child has not yet attained a specified age. A tie-breaking rule applies if more than one taxpayer claims a child as a qualifying child.

The EIC generally equals a specified percentage of earned income up to a maximum dollar amount. The maximum amount applies over a certain income range and then diminishes to zero over a specified phaseout range. For taxpayers with earned income (or AGI, if greater) in excess of the beginning of the phaseout range, the maximum EIC amount is reduced by the phaseout rate multiplied by the amount of earned income (or AGI, if greater) in excess of the beginning of the phaseout range. For taxpayers with earned income (or AGI, if greater) in excess of the end of the phaseout range, no credit is allowed. All income thresholds are adjusted annually for inflation.

Wage withholding

In general, the Code requires employers to withhold income tax on wages paid to employees, including wages and salaries of employees or elected officials of Federal, State, and local government units. Withholding rates vary depending on the amount of wages paid, the length of the payroll period, and the number of withholding allowances claimed by the employee. The Code also requires that employers report wage withholding information annually to the IRS and their employees (e.g., Form W-2 and Form W-3). n43

n43 Information returns, such as Form W-2, are returns within the meaning of section 6103(b)(1).

EIC outreach and assistance

Pre-tax return filing

The IRS has developed an outreach effort to inform taxpayers potentially eligible for the EIC and their employers about the EIC and how to claim the credit. One such public notice, contained inIRSNotice 797 (Rev. 12-2006), explains the EIC, its eligibility rules, and how to claim the credit. In addition, the IRS works with employers, community groups and other stakeholders to inform eligible taxpayers of the EIC. The IRS also helps taxpayers below certain income levels compute their Federal income tax liability, including the amount of EIC, if any.

Post-tax return filing

The IRS sends out notice letters addressed to taxpayers who it has identified as potentially eligible for the EIC in the immediately prior taxable year.

The notice letters are different depending on the presence of a qualifying child or children in the taxpayer's household. If the IRS identifies a taxpayer with one or more qualifying children as potentially eligible for the EIC, the notice letter informs the taxpayer that IRS records indicate that: (1) the taxpayer's income falls in the eligible range to receive the EIC; (2) the taxpayer has one or more dependents who may be an EIC qualifying child; and (3) the taxpayer did not claim the EIC for the applicable taxable year on his or her return filed with the IRS. If the IRS identifies a taxpayer without qualifying children as potentially eligible for the EIC, the notice letter informs the taxpayer that IRS records indicate that: (1) the taxpayer's income falls in the eligible range to receive the EIC and (2) the taxpayer did not claim the EIC for the applicable taxable year on his or her return filed with the IRS.

In all cases, the notice letters ask the taxpayers to completean "EIC Eligibility Check-Sheet" and, if the check-sheet indicates eligibility for the EIC, to return it to the IRS. The EIC Eligibility Check-Sheet requests the taxpayer to provide all the information necessary to determine EIC eligibility. The EIC Eligibility Check-Sheet is completed under penalty of perjury by the taxpayer (and the taxpayer's spouse in the case of a joint return). The IRS reviews the information submitted by the taxpayer and either: (1) sends any applicable refund within eight weeks (net of any other amounts the

IRS is required to collect), or (2) sends an explanation to the taxpayer stating why the taxpayer does not qualify for the EIC.

The notice letters also provide information to help eligible taxpayers correctly claim the EIC in future taxable years.

Under present law, these notice letters are sent by the IRS only to individuals who have filed a tax return for the applicable taxable year. The absence of the taxpayer's filed tax return, notwithstanding the receipt by the IRS of return information or an information return (e.g., Form W-2 indicating wage withholding on the taxpayer) from the taxpayer's employer does not trigger a notice letter to the taxpayer.

Limitations on credits and refunds

Under section 6511, a claim for credit or refund of overpayment of tax with respect to which a return must be filed must be made within the later of: (1) three years from the time the return was filed or (2) two years from the time the tax was paid. If no return was filed by the taxpayer, then the applicable time period ends two years after the tax was paid.

Description of Proposal

The proposal requires the IRS to provide annually, and to the extent possible, n44 notice to all taxpayers who have been identified based on return or return information as being potentially eligible for the EIC in any taxable year for which a claim for credit or refund is not barred by the limitation period under section 6511. Such notice must be in writing, address all open tax years, and be sent to the last known address of such taxpayers: (1) who did not file a claim for the EIC for such taxable year, and (2) who the IRS identified as potentially eligible for the EIC for such taxable year based on a return or return information (as defined in sec. 6103(b)).

n44 It is anticipated that the type of available return information and available IRS resources will affect the IRS's ability to issue the additional notice letters contemplated under this proposal.

Upon receipt of this notice letter, the taxpayer who had filed a return for the applicable taxable years would complete the applicable EIC Eligibility Check-Sheet for each of the applicable taxable years. It is anticipated that this Check-Sheet would ask for all the information relating to the taxpayer's eligibility for the EIC (e.g., earned income, AGI, presence and number of qualifying children, and taxpayer identification numbers). If eligible for the EIC, in one or more of the applicable taxable years, the taxpayer would return the EIC Eligibility Check-Sheet to the IRS for any refund (including wages withheld by the taxpayer's employer). In the case of an eligible taxpayer who had not filed a return for the applicable taxable years, the taxpayer would be instructed to file a tax return claiming the EIC with the IRS for any refund (including wages withheld by the taxpayer's employer) for each of the applicable taxable years.

Effective Date

The proposal is effective on the date of enactment.

H. Prohibition on IRS Debt Indicators for Predatory Refund Anticipation Loans

Present Law

A refund anticipation loan is a loan made by a commercial lender to a taxpayer based on the refund the taxpayer expects to receive. The loan is a private contract between the taxpayer and a commercial lender. The Code does not regulate the making of refund anticipation loans, but consumer groups, the Commissioner of the IRS, and the National Taxpayer Advocate all have raised concerns over the high interest rates and fees associated with such loans. n45

n45 See e.g., National Taxpayer Advocate, *2005 Annual Report to Congress*, Publication 2104 (Rev. 12-2005), at 162.

Certain tax practitioners that file returns electronically and financial institutions may obtain a debt indicator from the IRS for their customer taxpayers. A debt indicator facilitates the making of refund anticipation loans because it tells whether or not a taxpayer has any scheduled offsets against a claimed refund. Thus, a debt indicator reduces the lender's risk of making a refund anticipation loan because it informs the lender whether the taxpayer's refund will be paid or reduced for certain debts.

Description of Proposal

The proposal prohibits the Secretary from providing a debt indicator to any person with respect to any refund anticipation loan if the Secretary determines that the business practices of such person involve refund anticipation loans and related charges and fees that are predatory. Under the proposal, a refund anticipation loan is any loan of money or any other thing of value to a taxpayer secured by the taxpayer's anticipated receipt of a Federal tax refund. For purposes of the proposal, a debt indicator means a notification provided to a tax practitioner or financial institution pursuant to a program or procedure that a taxpayer's refund will be reduced or offset to repay debts for delinquent Federal or State taxes, student loans, child support, or other Federal agency debt.

Effective Date

The proposal is effective on the date of enactment.

I. Study on Delivery of Tax Refunds

Present Law

A large number of individual taxpayers do not have bank accounts. Because of this, these taxpayers are unable to participate fully in electronic filing, because IRS cannot electronically transmit to them their tax refunds.

Description of Proposal

The proposal requires the Secretary to conduct a study, in consultation with the National Taxpayer Advocate, of the implementation of a program to deliver tax refunds through debit cards or other electronic means. The proposal requires the Secretary to submit a report to Congress on the results of such study no later than one year after the date of enactment.

Effective Date

The proposal is effective on the date of enactment.

J. Extension of Time Limit for Return of Property for Wrongful Levy

Present Law

The IRS is authorized to return property that has been wrongfully levied upon. n46 In general, monetary proceeds from the sale of levied property upon, or an amount equal to the amount of money levied upon, may be returned within nine months of the date of the levy.

n46 Sec. 6343.

Generally, any person (other than the person against whom is assessed the tax out of which such levy arose) who claims an interest in levied property may bring a civil action for wrongful levy in a district court of the United States. n47 Generally, an action for wrongful levy must be brought within nine months from the date of levy. n48 However, if a claim for a return of property is made to the IRS, the nine-month period is extended for the shorter of a period of 12 months from the date of filing of such request or six months from the date of mailing of an IRS notice of disallowance of such request. n49

n47 Sec. 7426(a)(1).

n48 Sec. 6532.

n49 Sec. 6532(c)(2).

Description of Proposal

The proposal extends from nine months to two years the period for returning money and the monetary proceeds from the sale of property that has been wrongfully levied upon.

The proposal also extends from nine months to two years the period for bringing a civil action for wrongful levy.

Effective Date

The proposal is effective with respect to: (1) levies made after the date of enactment and (2) levies made on or before the date of enactment provided that the nine-month period has not expired as of the date of enactment.

K. Individuals Held Harmless on Improper Levy on Individual Retirement Plan

Present Law

Distributions from an individual retirement arrangement ("IRA") made on account of an IRS levy are includible in the gross income of the individual under the rules applicable to the IRA subject to the levy. Thus, in the case of a traditional IRA, the amount distributed as a result of a levy is includible in gross income except to the extent such amount represents a return of nondeductible contributions (i.e., basis). In the case of a Roth IRA, earnings on a distribution are excludable from gross income if the distribution is made: (1) after the five-taxable year period beginning with the first taxable year for which the individual made a contribution to a Roth IRA and (2) after attainment of age 59-1/2 or on account of certain other circumstances. Amounts withdrawn from an IRA due to a levy are not subject to the 10-percent early withdrawal tax, regardless of whether the amount is includible in income.

Present law provides rules under which the IRS returns amounts subject to an incorrect levy. For example, amounts withdrawn from an IRA pursuant to a levy are returned to the individual owning the IRA in the case of a wrongful levy or if the levy was not in accordance with IRS administrative procedures. In the case of a wrongful levy, the IRS is required to pay interest on the amount returned to the individual at the overpayment rate. The IRS is not required to pay interest if the levy was not in accordance with IRS administrative procedures.

Present law does not provide special rules to allow an individual to recontribute to an IRA amounts withdrawn from an IRA pursuant to a levy and later returned to the individual by the IRS (or interest thereon). Thus, if an individual wishes to contribute such returned amounts to an IRA, the contribution is subject to the normally applicable rules for IRA contributions.

Description of Proposal

Under the proposal, an individual is able to recontribute to an IRA amounts withdrawn pursuant to a levy and returned by the IRS (and any interest thereon) within 60 days of receipt by the individual, without regard to the normally applicable limits on IRA contributions and rollovers. The proposal applies to levied amounts returned to the individual because the levy (1) was wrongful or (2) is determined to be premature or otherwise not in accordance with administrative procedures. The recontribution may be made to the same IRA or to any other individuated retirement plan (other than an endowment contract) to which a rollover from the IRA levied upon is permitted. That is, the recontribution may be made to the same IRA or to an IRA of the same type.

Under the proposal, the IRS is required to pay interest on amounts returned to the individual at the overpayment rate in the case of a levy that is determined to be premature or otherwise not in accordance with administrative procedures (as well as in the case of a wrongful levy under present law). Interest paid by the IRS on the amount returned to the individual is excludable from gross income if the interest is contributed to an IRA under the provision. An amount contributed to an IRA under the provision will only be treated as interest paid by the IRS to the extent the total amount contributed under the provision exceeds the amount of the levy.

Any tax attributable to an amount distributed from an IRA by reason of a levy is abated if the amount is recontributed to an IRA pursuant to the provision.

Effective Date

The proposal is effective for levied amounts (and interest thereon) returned to individuals after the date of enactment.

L. Taxpayer Notification of Suspected Identity Theft

Present Law

Section 6103 provides that returns and return information are confidential and may not be disclosed by the Internal Revenue Service ("IRS"), other Federal employees, State employees, and certain others having access to the information except as provided in the Code. n50 The definition of "return information" is very broad and includes any information gathered by the IRS with respect to a person's liability or possible liability under the Code for any tax, penal-

ty, interest, fine, forfeiture, or other imposition or offense. n51 Thus, information gathered by the IRS in connection with an investigation of a person for a Title 26 offense, such as fraud, is the return information of the person being investigated and is subject to the confidentiality restrictions of section 6103.

n50 Sec. 6103(a).

n51 Sec. 6103(b)(2). Return information is

. a taxpayer's identity, the nature, source, or amount of his income, payments, receipts, deductions, exemptions, credits, assets, liabilities, net worth, tax liability, tax withheld, deficiencies, overassessments, or tax payments, whether the taxpayer's return was, is being, or will be examined or subject to other investigation or processing, or any other data, received by, recorded by, prepared by, furnished to, or collected by the Secretary with respect to a return or with respect to the determination of the existence, or possible existence, of liability (or the amount thereof) of any person under this title for any tax, penalty, interest, fine, forfeiture, or other imposition, or offense,

. any part of any written determination or any background file document relating to such written determination (as such terms are defined in section 6110(b)) which is not open to public inspection under section 6110,

. any advance pricing agreement entered into by a taxpayer and the Secretary and any background information related to such agreement or any application for an advance pricing agreement, and

. any closing agreement under section 7121, and any similar agreement, and any background information related to such an agreement or request for such an agreement.

Return information does not include data in a form which cannot be associated with, or otherwise identify, directly or indirectly, a particular taxpayer.

In July 2007, the IRS established the Privacy, Information Protection, and Data Security Office. Within that office is the Identity Theft and Incident Management office, which is responsible for implementing the IRS identity theft strategy and coordinating efforts within the IRS to provide assistance and consistent treatment to taxpayers who are victims of identity theft. The IRS also recently implemented a pilot program to notify IRS-identified tax fraud victims of identity theft.

Description of Proposal

The proposal provides that if, in the course of an investigation under the internal revenue laws, the Secretary determines that there was, or may have been, an unauthorized use of a taxpayer's identity or that of a dependent of the taxpayer, the Secretary shall, to the extent permitted by law, (1) as soon as practicable and without jeopardizing such investigation, notify the taxpayer of such determination, and (2) if any person is criminally charged by indictment or information with respect to such unauthorized use, notify such taxpayer as soon as practicable of such charge. Under the proposal, the IRS is not required to make such notification if disclosure would be barred by any statute (other than Title 26) or would be, for example, in violation of grand jury secrecy rules. n52 Further, notification would not be required if the IRS is unable to obtain an address or other contact information for the taxpayer. In such case notification would not be practicable because the IRS would not have the necessary information to notify that person.

n52 Persons bound by the rule of grand jury secrecy in *Fed. R. Crim. P. 6 (e)(2)* are subject to prosecution for criminal contempt under *18 U.S.C. sec. 401* for the unauthorized disclosure of grand jury information. Thus, under the proposal, a notification that was in violation of the grand jury secrecy rules would not be "permitted by law" within the meaning of the proposal.

Effective Date

The proposal applies to determinations made after the date of enactment.

M. Repeal of Private Tax Collection Contracts

Present Law

Under present law, the IRS may use private debt collection companies to locate and contact taxpayers owing outstanding tax liabilities of any type and to arrange payment of those taxes by the taxpayers.

Description of Proposal

The proposal repeals the authority for the IRS to enter into, renew, or extend any private debt collection contract.

Effective Date

The proposal generally is effective on the date of enactment, except for any contract which was entered into before July 18, 2007, and is not renewed or extended on or after March 1, 2008. The proposal also provides that any private debt collection contract which is entered into on or after July 18, 2007, and any extension or renewal of any private debt collection contract on or after March 1, 2008, shall be void.

N. Clarification of IRS Unclaimed Refund Authority

Present Law

When the IRS is unable to find a taxpayer due a refund, present law provides that the IRS may use "the press or other media" to notify the taxpayer of the refund. Section 6103 (m) allows the IRS to give the press taxpayer identity information for this purpose. Taxpayer identity includes name, mailing address, taxpayer identification number, or combination thereof. n53

n53 Sec. 6103(b)(6).

The IRS believes that the current statutory framework of "press and other media" does not permit disclosures via the Internet. The legislative history of the present-law provision does not address the meaning of "press and other media." At the time of the statute's enactment in 1976, the press (newspapers and periodicals) and other traditional media were the only means available for the IRS to distribute undelivered refund information to the public. Thus, the IRS interprets the term "other media" to exclude the Internet.

Description of Proposal

The proposal allows the IRS to use any means of "mass communication," including the Internet, to notify the taxpayer of an undelivered refund.

Effective Date

The proposal is effective on the date of enactment.

O. Prohibition on Misuse of Department of the Treasury Names and Symbols

Present Law

Section 333 of Title 31 prohibits the use, in connection with advertisements, solicitations, and other business activities, of the words, abbreviations, titles, letters, symbols, or emblems associated with the Department of the Treasury (and services, bureaus, offices, or subdivisions of the Department, including the IRS) in a manner which could reasonably be interpreted as conveying a connection with or approval by the Department of the Treasury (or one of its bureaus, offices, or subdivisions) in the absence of such connection or approval.

The provision provides for a civil penalty of not more than $ 5,000 per violation (or not more than $ 25,000 in the case of a broadcast or telecast). In addition, the provision provides a criminal penalty of not more than $ 10,000 (or not more than $ 50,000 in the case of a broadcast or telecast) or imprisonment of not more than one year, or both, in any case in which the prohibition is knowingly violated. Any determination of whether there is a violation is made without regard to the use of a disclaimer of affiliation with the Federal Government.

The IRS has issued warnings to taxpayers about Internet sites that resemble the official IRS site:

> Taxpayers may be confused by the proliferation of Internet sites that contain some form of the Internal Revenue Service name or IRS acronym with a .com, .net, .org or other designation in the address instead of .gov. Since many of these sites also bear a striking resemblance to the real IRS site, taxpayers may be misled into thinking that the site they have accessed is indeed the official IRS government site. These sites are not the official IRS Web site and have no connection to the official IRS site or to the IRS. n54

n54 Internal Revenue Service, IRS Urges Caution about Internet Sites that Resemble the Official IRS Site (IR-2007-58, March 13, 2007).

The IRS also has issued a number of warnings ongoing Internet scams. n55 The e-mails claim to be from the IRS and direct the consumer to a link (often resembling the IRS website) that requests personal and financial information. The practice is called "phishing" for information. Once the information is obtained, it could be used in identity theft and stealing a taxpayer's financial assets. Taxpayers who receive an unsolicited e-mail communication claiming to be from the IRS can forward the message to the IRS. The IRS reports it has received almost 33,000 forwarded e-mail scams. n56

n55 Internal Revenue Service, Identity Theft E-mail Scams a Growing Problem (FS-2008-9, January 2008).

n56 Id.

Description of Proposal

The proposal clarifies that "phishing," misleading websites, and other mass communications by electronic means, which could reasonably be interpreted as falsely conveying a connection to or approval by the Department of the Treasury (or its components), are subject to the civil penalty of $ 25,000 per violation and criminal penalty of $ 50,000 per violation, currently applicable to broadcasts and telecasts. The proposal reaffirms that the use of the words, abbreviations, titles, letters, symbols, or emblems associated with the Department of the Treasury (and services, bureaus, offices or subdivisions of the Department, including the IRS) in an Internet domain name is covered by *31 U.S.C. sec. 333* .

Effective Date

The proposal is effective for violations occurring after the date of enactment.

P. Health Savings Account Substantiation Requirement

Present Law

Health savings accounts

Present law section 223 provides that individuals with a high deductible health plan (and no other health plan other than a plan that provides certain permitted coverage) n57 may establish a health savings account ("HSA"). An HSA is a tax-exempt trust or custodial account. Subject to certain limitations, contributions made to an HSA by an individual are deductible above-the-line for income tax purposes and contributions made by an employer (including contributions made through a cafeteria plan through salary reduction) are excludable from income and wages. Earnings on amounts in an HSA accumulate on a tax-free basis.

n57 An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage. Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision

care, or long-term care. Effective after December 20, 2006, with respect to coverage for years beginning after December 31, 2006, certain coverage under an FSA is disregarded in determining eligibility for an HSA.

Distributions from an HSA that are for qualified medical expenses are excludable from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 10 percent. However, the additional 10-percent tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65). Under present law, the individual maintaining the HSA is responsible for determining if the distribution was made for a qualified medical expense and whether the amount should be included in income and subject to the 10-percent additional tax.

HSAs provide the opportunity to pay for current out-of-pocket medical expenses on a tax-favored basis, as well as the ability to save for future medical and nonmedical expenses on a tax-favored basis. To the extent that amounts in an HSA are not used for qualified expenses, an HSA provides tax benefits similar to an individual retirement arrangement ("IRA"). n58

n58 Other tax-favored vehicles may also be used to save for future medical expenses, but do not provide the same tax benefits. For example, funds in an IRA may be used to pay medical expenses, but distributions for medical expenses are includible in gross income to the same extent as other IRA distributions.

Qualified medical expenses generally are defined as under section 213(d) and include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for Medigap policies.

A high deductible health plan is a health plan that has a deductible that is at least $ 1,100 for self-only coverage or $ 2,200 for family coverage (for 2008) and that has an out-of-pocket expense limit that is no more than $ 5,600 in the case of self-only coverage and $ 11,200 in the case of family coverage (for 2008). n59

n59 These amounts are indexed for inflation.

For 2008, the maximum aggregate annual contribution that can be made to an HSA is $ 2,900 in the case of self-only coverage and $ 5,800 in the case of family coverage. n60 The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $ 900 in 2008, and $ 1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

n60 These amounts are the same as the maximum deductible amounts permitted under a high deductible plan for purposes of Archer medical savings accounts ("MSAs") and are indexed for inflation. In the case of individuals who are married to each other, if either spouse has family coverage, both spouses are treated as only having the family coverage with the lowest deductible and the contribution limit is divided equally between them unless they agree on a different division. Limitations based on the amount of the deductible under the high deductible plan applied to years beginning before January 1, 2007.

Health flexible spending arrangements

Health flexible spending arrangements ("FSAs") are commonly used by employers to reimburse medical expenses of their employees (and their spouses and dependents). Health FSAs typically are funded on a salary reduction basis, meaning that employees are given the option to reduce current compensation and instead have the compensation used to

reimburse the employee for medical expenses. If the health FSA meets certain requirements, the compensation that is forgone is not includible in gross income or wages for employment tax purposes and reimbursements for medical care from the health FSA are excludable from gross income and wages. Health FSAs are subject to the requirements relating to cafeteria plans generally, including a requirement that a cafeteria plan generally may not provide deferred compensation. n61 This requirement is often referred to as the "use-it-or-lose-it-rule." n62 Health FSAs are subject to certain other requirements, including rules that require that the FSA have certain characteristics similar to insurance. In addition, health FSAs are also subject to certain requirements relating to substantiation of expenses. n63

n61 Sec. 125(d)(2).

n62 This requirement has been interpreted to mean that amounts remaining in a health FSA as of the end of a plan year must be forfeited by the employee. However, Treasury guidance allows a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used.Notice 2005-42, *2005-23 I.R.B. 1204. Prop. Treas. Reg. sec. 1.125-1* .

n63 *See Prop. Treas. Reg. sec. 1.125-6* . *See also*,Notice 2002-45, *2002-2 C.B. 93, Rev. Rul. 2003-43, 2003-1 C.B. 935; Notice 2006-69, 2006-2 C.B. 107;* andNotice 2007-2, *2007-1 C.B. 254.*

Description of Proposal

The proposal provides that in the case of a health savings account distribution, in order to be a qualified medical expense, the amount must be substantiated in a manner similar to that required for health flexible spending arrangements. It is intended that substantiation is required to the trustee (or to a party designated by the trustee). As under present law, distributions from a HSA would be allowed for any purpose. Substantiated expenses would be excludable from income. Expenses not substantiated would be includible in income and subject to the 10-percent additional tax. Under the proposal, not later than January 15 of each calendar year, the HSA trustee is required to report to the account beneficiary and to the Secretary, the name, address and identifying number of the account beneficiary and the amount paid or distributed out of the HSA for the preceding year not substantiated.

Effective Date

The proposal is effective with respect to amounts paid or distributions made out of a health savings account after December 31, 2008.

Q. Increase in Information Return Penalties

Present Law

Present law imposes information reporting requirements on participants in certain transactions. Under section 6721 of the Code, any person required to file a correct information return who fails to do so on or before the prescribed filing date is subject to a penalty that varies based on when, if at all, the correct information return is filed. If a person files a correct information return after the prescribed filing date but on or before the date that is 30 days after the prescribed filing date, the amount of the penalty is $ 15 per return (the "first-tier penalty"), with a maximum penalty of $ 75,000 per calendar year. If a person files a correct information return more than 30 days after the prescribed filing date but on or before August 1, the amount of the penalty is $ 30 per return (the "second-tier penalty"), with a maximum penalty of $ 150,000 per calendar year. If a correct information return is not filed on or before August 1, of any year, the amount of the penalty is $ 50 per return (the "third-tier penalty"), with a maximum penalty of $ 250,000 per calendar year.

Special lower maximum levels for this penalty apply to small businesses. Small businesses are defined as firms having average annual gross receipts for the most recent three taxable years that do not exceed $ 5 million. The maximum penalties for small businesses are: $ 25,000 (instead of $ 75,000) if the failures are corrected on or before 30 days after the prescribed filing date; $ 50,000 (instead of $ 150,000) if the failures are corrected on or before August 1; and $ 100,000 (instead of $ 250,000) if the failures are not corrected on or before August 1.

Section 6722 of the Code also imposes penalties for failing to furnish correct payee statements to taxpayers. In addition, section 6723 imposes a penalty for failing to comply with other information reporting requirements. Under both section 6722 and section 6723, the penalty amount is $ 50 for each failure, up to a maximum of $ 100,000.

Description of Proposal

The proposal increases the penalties for failing to file correct information returns, for failing to furnish correct payee statements, and for failing to comply with other information reporting requirements. Specifically, the proposal increases the penalties for failing to file correct information returns as follows: the first-tier penalty would be increased from $ 15 to $ 25, with a maximum penalty of $ 250,000 per calendar year; the second-tier penalty would be increased from $ 30 to $ 60, with a maximum penalty of $ 500,000 per calendar year; and the third-tier penalty would be increased from $ 50 to $ 100, with a maximum penalty of $ 1,500,000 per calendar year. The maximum penalties for small businesses would be: $ 75,000 if the failures are corrected on or before 30 days after the prescribed filing date; $ 200,000 if the failures are corrected on or before August 1; and $ 500,000 if the failures are not corrected on or before August 1.

The proposal increases both the penalty for failing to furnish correct payee statements to taxpayers and the penalty for failing to comply with other information reporting requirements penalties to $ 100 for each such failure, up to a maximum of $ 1,500,000 in a calendar year.

The proposal also increases the minimum penalty for intentional disregard of the information reporting requirements to $ 250 per return.

Effective Date

The proposal is effective with respect to information returns required to be filed after December 31, 2008.

R. Increase in Penalty for Failure to File Partnership Returns

Present Law

A partnership generally is treated as a pass-through entity. Income earned by a partnership, whether distributed or not, is taxed to the partners. Distributions from the partnership generally are tax-free. The items of income, gain, loss, deduction or credit of a partnership generally are taken into account by a partner as allocated under the terms of the partnership agreement. If the agreement does not provide for an allocation, or the agreed allocation does not have substantial economic effect, then the items are to be allocated in accordance with the partners' interests in the partnership. To prevent double taxation of these items, a partner's basis in its interest is increased by its share of partnership income (including tax-exempt income), and is decreased by its share of any losses (including nondeductible losses).

Under present law, a partnership is required to file a tax return for each taxable year. The partnership's tax return is required to include the names and addresses of the individuals who would be entitled to share in the taxable income if distributed and the amount of the distributive share of each individual. In addition to applicable criminal penalties, present law imposes a civil penalty for the failure to timely file a partnership return. The penalty generally is $ 85 per partner for each month (or fraction of a month) that the failure continues, up to a maximum of 12 months.

Description of Proposal

Under the proposal, the penalty for failure to file partnership returns is increased by $ 15 per partner.

Effective Date

The proposal applies to returns required to be filed after December 31, 2008.

S. Penalty for Failure to File S Corporation Returns

Present Law

In general, an S corporation is not subject to corporate-level income tax on its items of income and loss. Instead, an S corporation passes through its items of income and loss to its shareholders. The shareholders take into account separately their shares of these items on their individual income tax returns.

Under present law, S corporations are required to file a tax return for each taxable year. The S corporation's tax return is required to include the following: the names and addresses of all persons owning stock in the corporation at any time during the taxable year; the number of shares of stock owned by each shareholder at all times during the taxable year; the amount of money and other property distributed by the corporation during the taxable year to each shareholder and the date of such distribution; each shareholder's pro rata share of each itemof the corporation for the taxable year; and such other information as the Secretary may require.

Present law imposes a monthly penalty for any failure to timely file an S corporation return or any failure to provide the information required to be shown on such a return. The penalty is $ 85 times the number of shareholders in the S corporation during any part of the taxable year for which the return was required, for each month (or a fraction of a month) during which the failure continues, up to a maximum of 12 months.

Description of Proposal

Under the proposal, the penalty for failure to file S corporation returns is increased by $ 15 per shareholder.

Effective Date

The proposal applies to returns required to be filed after December 31, 2008.

T. Modifications to Corporate Estimated Tax Payments

Present Law

In general

In general, corporations are required to make quarterly estimated tax payments of their income tax liability. For a corporation whose taxable year is a calendar year, these estimated tax payments must be made by April 15, June 15, September 15, and December 15.

Tax Increase Prevention and Reconciliation Act of 2005 ("TIPRA")

TIPRA provided the following special rules:

In case of a corporation with assets of at least $ 1 billion, the payments due in July, August, and September, 2012, shall be increased to 106.25 percent of the payment otherwise due and the next required payment shall be reduced accordingly.

In case of a corporation with assets of at least $ 1 billion, the payments due in July, August, and September, 2013, shall be increased to 100.75 percent of the payment otherwise due and the next required payment shall be reduced accordingly.

Subsequent legislation

Several public laws have been enacted since TIPRA which further increase the percentage of payments due under each of the two special rules enacted by TIPRA described above.

Description of Proposal

Under the proposal, in the case of a corporation with assets of at least $ 1 billion, the payments due in July, August, and September, 2013, the otherwise applicable payment is increased by 0.25 percent of the payment otherwise due and the next required payment shall be reduced accordingly.

Effective Date

The proposal is effective on the date of enactment.

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APPENDIX M

Part III. Administrative, Procedural, and Miscellaneous

Health Savings Accounts—Additional Qs&As

Notice 2004–50

PURPOSE

This notice provides guidance on Health Savings Accounts.

BACKGROUND

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, added section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning after December 31, 2003. Notice 2004–2, 2004–2 I.R.B. 269, provides certain basic information on HSAs in question and answer format. This notice addresses additional questions relating to HSAs.[1]

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[1] Specific issues on HSAs are also discussed in Rev. Rul. 2004–45, 2004–22 I.R.B. 971; Rev. Rul. 2004–38, 2004–15 I.R.B. 717; Rev. Proc. 2004–22, 2004–15 I.R.B. 727; Notice 2004–43, 2004–27 I.R.B. 10; Notice 2004–25, 2004–15 I.R.B. 727; Notice 2004–23, 2004–15 I.R.B. 725.

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QUESTIONS AND ANSWERS

I. Eligible individuals

Q–1. If an employer offers an employee a choice between a low-deductible health plan and a high-deductible health plan (HDHP), and the employee selects coverage only under the HDHP, is the employee an eligible individual under section 223(c)(1)?

A–1. Yes, if the employee is otherwise an eligible individual. To determine if an individual is an eligible individual, the actual health coverage selected by the individual is controlling. Thus, it does not matter that the individual could have chosen, but did not choose, a low-deductible health plan or other coverage that would have disqualified the individual from contributing to an HSA.

Q–2. May an otherwise eligible individual who is eligible for Medicare, but not enrolled in Medicare Part A or Part B, contribute to an HSA?

A–2. Yes. Section 223(b)(7) states that an individual ceases to be an eligible individual starting with the month he or she is entitled to benefits under Medicare. Under this provision, mere eligibility for Medicare does not make an individual ineligible to contribute to an HSA. Rather, the term "entitled to benefits under" Medicare means both eligibility and enrollment in Medicare. Thus, an otherwise eligible individual under section 223(c)(1) who is not actually enrolled in Medicare Part A or Part B may contribute to an HSA until the month that individual is enrolled in Medicare.

Example (1). Y, age 66, is covered under her employer's HDHP. Although Y is eligible for Medicare, Y is not actually entitled to Medicare because she did not apply for benefits under Medicare (*i.e.*, enroll in Medicare Part A or Part B). If Y is otherwise an eligible individual under section 223(c)(1), she may contribute to an HSA.

Example (2). In August 2004, X attains age 65 and applies for and begins receiving Social Security benefits. X is automatically enrolled in Medicare. As of August 1, 2004, X is no longer an eligible individual and may not contribute to an HSA.

Q–3. May an otherwise eligible individual under section 223(c)(1) who is age 65 or older and thus eligible for Medicare, but is not enrolled in Medicare Part A or Part B, make the additional catch-up contribution under section 223(b)(3) for persons age 55 or older?

A–3. Yes. See Notice 2004–2, Q&A 14, on catch-up contributions.

Q–4. Is a government retiree who is enrolled in Medicare Part B (but not Part A) an eligible individual under section 223(c)(1)?

A–4. No. Under section 223(b)(7), an individual who is enrolled in Medicare may not contribute to an HSA.

Q–5. If an otherwise eligible individual under section 223(c)(1) is eligible for medical benefits through the Department of Veterans Affairs (VA), may he or she contribute to an HSA?

A–5. An otherwise eligible individual who is eligible to receive VA medical benefits, but who has not actually received such benefits during the preceding three months, is an eligible individual under section 223(c)(1). An individual is not eligible to make HSA contributions for any month, however, if the individual has received medical benefits from the VA at any time during the previous three months.

Q–6. May an otherwise eligible individual who is covered by an HDHP and also receives health benefits under TRICARE (the health care program for active duty and retired members of the uniformed services, their families and survivors) contribute to an HSA?

A–6. No. Coverage options under TRICARE do not meet the minimum annual deductible requirements for an HDHP under section 223(c)(2). Thus, an individual covered under TRICARE is not an eligible individual and may not contribute to an HSA.

Q–7. May an otherwise eligible individual who is covered by both an HDHP and also by insurance contracts for one or more specific diseases or illnesses, such as cancer, diabetes, asthma or congestive heart failure, contribute to an HSA if the insurance provides benefits before the deductible of the HDHP is satisfied?

A–7. Yes. Section 223(c)(1)(B)(i) provides that an eligible individual covered under an HDHP may also be covered "for any benefit provided by permitted insurance." Section 223(c)(3)(B) provides that the term "permitted insurance" includes "insurance for a specified disease or illness." Therefore, an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP.

Q–8. Must coverage for "permitted insurance" described in section 223(c)(3) (liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance paying a fixed amount per day (or other period) of hospitalization), be provided under insurance contracts?

A–8. Yes. Benefits for "permitted insurance" under section 223(c)(3) must generally be provided through insurance contracts and not on a self-insured basis. However, where benefits (such as workers' compensation benefits) are provided in satisfaction of a statutory requirement and any resulting benefits for medical care are secondary or incidental to other benefits, the benefits will qualify as "permitted insurance" even if self-insured.

Q–9. May an individual who is covered by an HDHP and also has a discount card that enables the user to obtain discounts for health care services or products, contribute to an HSA?

A–9. Yes. Discount cards that entitle holders to obtain discounts for health care services or products at managed care market rates will not disqualify an individual from being an eligible individual for HSA purposes if the individual is required to pay the costs of the health care (taking into account the discount) until the deductible of the HDHP is satisfied.

Example. An employer provides its employees with a pharmacy discount card. For a fixed annual fee (paid by the employer), each employee receives a card that entitles the holder to choose any participating pharmacy. During the one-year life of the card, the card holder receives discounts of 15 percent to 50 percent off the usual and customary fees charged by the providers, with no dollar cap on the amount of discounts received during the year. The cardholder is responsible for paying the costs of any drugs (taking into account the discount) until the deductible of any other health plan covering the individual is satisfied. An employee who is otherwise eligible for an HSA will not become ineligible solely as a result of having this benefit.

Q–10. Does coverage under an Employee Assistance Program (EAP), disease management program, or wellness program make an individual ineligible to contribute to an HSA?

A–10. An individual will not fail to be an eligible individual under section 223(c)(1)(A) solely because the individual is covered under an EAP, disease man-

agement program or wellness program if the program does not provide significant benefits in the nature of medical care or treatment, and therefore, is not considered a "health plan" for purposes of section 223(c)(1). To determine whether a program provides significant benefits in the nature of medical care or treatment, screening and other preventive care services as described in Notice 2004–23 will be disregarded. See also Q&A 48 on incentives for employees who participate in these programs.

Example (1). An employer offers a program that provides employees with benefits under an EAP, regardless of enrollment in a health plan. The EAP is specifically designed to assist the employer in improving productivity by helping employees identify and resolve personal and work concerns that affect job performance and the work environment. The benefits consist primarily of free or low-cost confidential short-term counseling to identify an employee's problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem. The issues addressed during the short-term counseling include, but are not limited to, substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs. This EAP is not a "health plan" under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

Example (2). An employer maintains a disease management program that identifies employees and their family members who have, or are at risk for, certain chronic conditions. The disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan. Typical interventions include monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks. This disease management program is not a "health plan" under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

Example (3). An employer offers a wellness program for all employees regardless of participation in a health plan. The wellness program provides a wide-range of education and fitness services designed to improve the overall health of the employees and prevent illness. Typical services include education, fitness, sports, and recreation activities, stress management and health screenings. Any costs charged to the individual for participating in the services are separate from the individual's coverage under the health plan. This wellness program is not a "health plan" under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

Q–11. If an employee begins HDHP coverage mid-month, when does the employee become an eligible individual? (For example, coverage under the HDHP begins on the first day of a biweekly payroll period.)

A–11. Under section 223(b)(2), an eligible individual must have HDHP coverage as of the first day of the month. An individual with employer-provided HDHP coverage on a payroll-by-payroll basis becomes an eligible individual on the first day of the month on or following the first day of the pay period when HDHP coverage begins.

Example. An employee begins HDHP coverage on the first day of a pay period, which is August 16, 2004, and continues to be covered by the HDHP throughout 2004. For purposes of contributing to an HSA, the employee becomes an eligible individual on September 1, 2004.

II. High Deductible Health Plans (HDHPs)

Q–12. What is family HDHP coverage under section 223?

A–12. Under section 223(c)(4), the term "family coverage" means any coverage other than self-only coverage. Self-only coverage is a health plan covering only one individual; self-only HDHP coverage is an HDHP covering only one individual if that individual is an eligible individual. Family HDHP coverage is a health plan covering one eligible individual and at least one other individual (whether or not the other individual is an eligible individual).

Example. An individual, who is an eligible individual, and his dependent child are covered under an "employee plus one" HDHP offered by the individual's employer. The coverage is family HDHP coverage under section 223(c)(4).

Q–13. Can a state high-risk health insurance plan (high-risk pool) qualify as an HDHP?

A–13. Yes. If the state's high-risk pool does not pay benefits below the minimum annual deductible of an HDHP as set forth in section 223(c)(2)(A), the plan can qualify as an HDHP.

Q–14. May an HDHP impose a lifetime limit on benefits?

A–14. Yes. An HDHP may impose a reasonable lifetime limit on benefits provided under the plan. In such cases, amounts paid by the covered individual above the lifetime limit will not be treated as out-of-pocket expenses in determining the annual out-of-pocket maximum. However, a lifetime limit on benefits designed to circumvent the maximum annual out-of-pocket amount in section 223(c)(2)(A) is not reasonable.

Example. A health plan has an annual deductible that satisfies the minimum annual deductible under section 223(c)(2)(A)(i) for self-only coverage and for family coverage. After satisfying the deductible, the plan pays 100 percent of covered expenses, up to a lifetime limit of $1 million. The lifetime limit of $1 million is reasonable and the health plan is not disqualified from being an HDHP because of the lifetime limit on benefits.

Q–15. If a plan imposes an annual or lifetime limit on specific benefits, are amounts paid by covered individuals after satisfying the deductible treated as out-of-pocket expenses under section 223?

A–15. The out-of-pocket maximum in section 223(c)(2)(A) applies only to covered benefits. Plans may be designed with reasonable benefit restrictions limiting the plan's covered benefits. A restriction or exclusion on benefits is reasonable only if significant other benefits remain available under the plan in addition to the benefits subject to the restriction or exclusion.

Example (1). In 2004, a self-only health plan with a $1,000 deductible includes a $1 million lifetime limit on covered benefits. The plan provides no benefits for experimental treatments, mental health, or chiropractic care visits. Although the plan provides benefits for substance abuse treatment, it limits payments to 26 treatments per year, after the deductible is satisfied. Although the plan provides benefits for fertility treatments, it limits lifetime reimbursements to $10,000, after the deductible is satisfied. Other than these limits on covered benefits, the plan pays 80 percent of major medical expenses incurred after satisfying the deductible. When the 20 percent coinsurance paid by the covered individuals reaches $4,000, the plan pays 100 percent. Under these facts, the plan is an HDHP and no expenses incurred by a covered individual other than the deductible and the 20 percent coinsurance are treated as out-of-pocket expenses under section 223(c)(2)(A).

Example (2). In 2004, a self-only health plan with a $1,000 deductible imposes a lifetime limit on reimbursements for covered benefits of $1 million. While the plan pays 100 percent of expenses incurred for covered benefits after satisfying the deductible, the plan imposes a $10,000 annual limit on benefits for any single condition. The $10,000 annual limit under these facts is not reasonable because significant other benefits do not remain available under the plan. Under these facts, any expenses incurred by a covered individual after satisfying the deductible are treated as out-of-pocket expenses under section 223(c)(2)(A).

Q–16. If a plan limits benefits to usual, customary and reasonable (UCR) amounts, are amounts paid by covered individuals in excess of UCR included in determining the maximum out-of-pocket expenses paid?

A–16. Restricting benefits to UCR is a reasonable restriction on benefits. Thus, amounts paid by covered individuals in excess of UCR that are not paid by an HDHP are not included in determining maximum out-of-pocket expenses.

Q–17. Can a plan with no express limit on out-of-pocket expenses qualify as an HDHP?

A–17. A health plan without an express limit on out-of-pocket expenses is generally not an HDHP unless such limit is not necessary to prevent exceeding the out-of-pocket maximum.

Example (1). A plan provides self-only coverage with a $2,000 deductible and pays 100 percent of covered benefits above the deductible. Because the plan pays 100 percent of covered benefits after the deductible is satisfied, the maximum out-of-pocket expenses paid by a covered individual would never exceed the deductible. Thus, the plan does not require a specific limit on out-of-pocket expenses to insure that the covered individual will not be subject to out-of-pocket expenses in excess of the maximum set forth in section 223(c)(2)(A).

Example (2). A plan provides self-only coverage with a $2,000 deductible. The plan imposes a lifetime limit on reimbursements for covered benefits of $1 million. For expenses for covered benefits incurred above the deductible, the plan reimburses 80 percent of the UCR costs. The plan includes no express limit on out-of-pocket expenses. This plan does not qualify as a HDHP because it does not have a limit on out-of-pocket expenses.

Example (3). The same facts as Example 2, except that after the 20 percent coinsurance paid by the covered individual reaches $3,000, the plan pays 100 percent of the UCR costs until the $1 million limit is reached. For the purpose of determining the individual's out-of-pocket expenses, the plan only takes into account the 20 percent of UCR paid by the individual. This plan satisfies the out-of-pocket limit.

Q–18. A health plan which otherwise qualifies as an HDHP imposes a flat dollar penalty on a participant who fails to obtain pre-certification for a specific provider or for certain medical procedures. Is the penalty paid by the covered individual included in determining the maximum out-of-pocket expenses paid?

A–18. No. The penalty is not an out-of-pocket expense and, therefore, does not count toward the expense limits in section 223(c)(2)(A).

Q–19. A health plan which otherwise qualifies as an HDHP generally requires a 10 percent coinsurance payment after a covered individual satisfies the deductible. However, if an individual fails to get pre-certification for a specific provider, the plan requires a 20 percent coinsurance payment. Is the increased coinsurance amount included in determining the maximum out-of-pocket expenses paid?

A–19. No. Under the facts set forth, only the generally applicable 10 percent coinsurance payment is included in computing the maximum out-of-pocket expenses paid. The result is the same if the plan imposes a higher coinsurance amount for an out-of-network provider. See also Notice 2004–2, Q&A 4.

Q–20. Are cumulative embedded deductibles under family coverage subject to the out-of-pocket maximum?

A–20. Yes. An HDHP generally must limit the out-of-pocket expenses paid by the covered individuals, either by design or by its express terms.

Example (1). In 2004, a plan which otherwise qualifies as an HDHP provides family coverage with a $2,000 deductible for each family member. The plan pays 100 percent of covered benefits for each family member after that family member satisfies the $2,000 deductible. The plan contains no express limit on out-of-pocket expenses. Section 223(c)(2)(A)(ii)(II) limits the maximum out-of-pocket expenses to $10,000 for family coverage. The plan is an HDHP for any family with two to five covered individuals ($2,000 x 5 = $10,000). However, the plan is not an HDHP for a family with six or more covered individuals.

Example (2). The same facts as Example 1, except that the plan includes an umbrella deductible of $10,000. The plan reimburses 100 percent of covered benefits if the family satisfies the $10,000 in the aggregate, even if no single family member satisfies the $2,000 embedded deductible. This plan qualifies as an HDHP for the family, regardless of the number of covered individuals.

Q–21. Are amounts incurred by an individual for medical care before a health plan's deductible is satisfied included in computing the plan's out-of-pocket expenses under section 223(c)(2)(A)?

A–21. A health plan's out-of-pocket limit includes the deductible, co-payments, and other amounts, but not premiums. Notice 2004–2, Q&A 3. Amounts incurred for noncovered benefits (including amounts in excess of UCR and financial penalties) also are not counted toward the deductible or the out-of-pocket limit. If a plan does not take copayments into account in determining if the deductible is satisfied, the copayments must still be taken into account in determining if the out-of-pocket maximum is exceeded.

Example. In 2004, a health plan has a $1,000 deductible for self-only coverage. After the deductible is satisfied, the plan pays 100 percent of UCR for covered benefits. In addition, the plan pays 100 percent for preventive care, minus a $20 copayment per screening. The plan does not take into account copayments in determining if the $1,000 deductible has been satisfied. The copayments must be included in determining if the plan meets the out-of-pocket maximum. Unless the plan includes an express limit on out-of-pocket expenses taking into account the copayments, or limits the copayments to $4,000, the plan is not an HDHP.

Q–22. If an employer changes health plans mid-year, does the new health plan fail to satisfy section 223(c)(2)(A) merely because it provides a credit towards the deductible for expenses incurred during the previous health plan's short plan year and not reimbursed?

A–22. No. If the period during which expenses are incurred for purposes of satisfying the deductible is 12 months or less and the plan satisfies the requirements for an HDHP, the new plan's taking into account expenses incurred during the prior plan's short plan year (whether or not the prior plan is an HDHP) and not reimbursed, does not violate the requirements of section 223(c)(2)(A).

Example. An employer with a calendar year health plan switches from a non-HDHP plan to a new plan with the first day of coverage under the new plan of July 1. The annual deductible under the new plan satisfies the minimum annual deductible for an HDHP under section 223(c)(2)(A)(i) and counts expenses incurred under the prior plan during the first six months of the year in determining if the new plan's annual deductible is satisfied. The new plan satisfies the HDHP deductible limit under section 223(c)(2)(A).

Q–23. If an eligible individual changes coverage during the plan year from self-only HDHP coverage to family HDHP coverage, does the individual (or any other person covered under the family coverage) fail to be covered by an HDHP merely because the family HDHP coverage takes into account expenses incurred while the individual had self-only coverage?

A–23. No.

Example. An eligible individual has self-only coverage from January 1 through March 31, marries in March and from April 1 through December 31, has family coverage under a plan otherwise qualifying as an HDHP. The family coverage plan applies expenses incurred by the individual from January through March toward satisfying the family deductible. The individual does not fail to be covered by an HDHP. The family coverage satisfies the deductible limit in section 223(c)(2)(A)(i)(II). The individual's contribution to an HSA is based on three months of the self-only coverage (*i.e.*, 3/12 of the deductible for the self-only coverage) and nine months of family coverage (9/12 of the deductible for family coverage).

Q–24. How are the minimum deductible in section 223(c)(2)(A) for an

HDHP and the maximum contribution to an HSA in section 223(b) calculated when the period for satisfying a health plan's deductible is longer than 12 months?

A–24. The deductible limits in section 223(c)(2)(A) are based on 12 months. If a plan's deductible may be satisfied over a period longer than 12 months, the minimum annual deductible under section 223(c)(2)(A) must be increased to take into account the longer period in determining if the plan satisfies the HDHP deductible requirements. The adjustment will be done as follows:

(1) Multiply the minimum annual deductible in section 223(c)(2)(A)(i) (as adjusted under section 223(g)) by the number of months allowed to satisfy the deductible.

(2) Divide the amount in (1) above by 12. This is the adjusted deductible for the longer period that is used to test for compliance with section 223(c)(2)(A).

(3) Compare the amount in (2) to the plan's deductible. If the plan's deductible equals or exceeds the amount in (2), the plan satisfies the requirements for the minimum deductible in section 223(c)(2)(A). (Note that the deductible for an HDHP may not exceed the out-of-pocket maximum under section 223(c)(2)(A)(ii).)

If the plan qualifies as an HDHP, an eligible individual's maximum annual HSA contribution will be the lesser of the amounts in (1) or (2) below:

(1) Divide the plan's deductible by the number of months allowed to satisfy the deductible, and multiply this amount by 12;

(2) The statutory amount in section 223(b)(2)(A)(ii) for self-only coverage ($2,600 in 2004) or section 223(b)(2)(B)(ii) for family coverage ($5,150 in 2004), as applicable.

Example. For 2004, a health plan takes into account medical expenses incurred in the last three months of 2003 to satisfy its deductible for calendar year 2004. The plan's deductible for self-only coverage is $1,500 and covers 15 months (the last three months of 2003 and 12 months of 2004). To determine if the plan's deductible satisfies section 223(c)(2)(A) the following calculations are performed: (1) multiply $1,000, the minimum annual deductible in section 223(c)(2)(A)(i), by 15, the number of months in which expenses incurred are taken into account to satisfy the deductible, = $15,000; (2) divide $15,000 by 12 = $1,250; (3) The HDHP minimum deductible for self-only coverage for 15 months must be at least $1,250. Because the plan's deductible, $1,500, exceeds $1,250, the plan's self-only coverage satisfies the deductible rule in section 223(c)(2)(A). The maximum annual HSA contribution in 2004 for an eligible individual with self-only coverage under these facts is $1,200, the lesser of (1) ($1,500/15) X 12 = $1,200; or (2) $2,600.

Q–25. A health plan which otherwise meets the definition of an HDHP negotiates discounted prices for health care services from providers. Covered individuals receive benefits at the discounted prices, regardless of whether they have satisfied the plan's deductible. Do the discounted prices prevent the health plan from being an HDHP as defined in section 223(c)(2)?

A–25. No.

III. Preventive care

Q–26. Does a preventive care service or screening that also includes the treatment of a related condition during that procedure come within the safe harbor for preventive care in Notice 2004–23?

A–26. Yes. Although Notice 2004–23 states that preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition, in situations where it would be unreasonable or impracticable to perform another procedure to treat the condition, any treatment that is incidental or ancillary to a preventive care service or screening as described in Notice 2004–23 also falls within the safe-harbor for preventive care. For example, removal of polyps during a diagnostic colonoscopy is preventive care that can be provided before the deductible in an HDHP has been satisfied.

Q–27. To what extent do drugs or medications come within the safe-harbor for preventive care services under section 223(c)(2)(C)?

A–27. Notice 2004–23 sets out a preventive care deductible safe harbor for HDHPs under section 223(c)(2)(C). Solely for this purpose, drugs or medications are preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (*i.e.*, asymptomatic), or to prevent the reoccurrence of a disease from which a person has recovered. For example, the treatment of high cholesterol with cholesterol-lowering medications (*e.g.*, statins) to prevent heart disease or the treatment of recovered heart attack or stroke victims with Angiotensin-converting Enzyme (ACE) inhibitors to prevent a reoccurrence, constitute preventive care. In addition, drugs or medications used as part of procedures providing preventive care services specified in Notice 2004–23, including obesity weight-loss and tobacco cessation programs, are also preventive care. However, the preventive care safe harbor under section 223(c)(2)(C) does not include any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications used to treat an existing illness, injury or condition.

IV. Contributions

Q–28. Who may make contributions on behalf of an eligible individual?

A–28. Although Q&A 11 of Notice 2004–2 only refers to contributions by employers or family members, any person (an employer, a family member or any other person) may make contributions to an HSA on behalf of an eligible individual.

Q–29. May a state government make an HSA contribution on behalf of eligible individuals insured under the state's comprehensive health insurance programs for high-risk individuals (state high-risk pool)?

A–29. Yes. See also Q&A 13.

Q–30. How is the maximum annual HSA contribution limit in section 223(b)(2) determined for an eligible individual with family coverage under an HDHP that includes embedded individual deductibles and an umbrella deductible?

A–30. Generally, under section 223 (b)(2)(B), the maximum annual HSA contribution limit for an eligible individual with family coverage under an HDHP (without regard to catch-up contributions) is the lesser of: (1) the annual deductible under the HDHP, or (2) the statutory limit on family coverage contributions as indexed by section 223(g). An HDHP often has a stated maximum amount of expenses the family could incur before receiving benefits (*i.e.*, the umbrella deductible), but also provides payments for covered medical expenses if any individual member of the family incurs medical expenses in excess of the minimum annual deductible in section 223(c)(2)(A)(i)(II) (the embedded individual deductible). The maximum annual HSA contribution limit for an eligible individual who has family coverage

under an HDHP with embedded individual deductibles and an umbrella deductible as described above, is the least of the following amounts:

1. the maximum annual contribution limit for family coverage specified in section 223(b)(2)(B)(ii) ($5,150 for calendar year 2004);

2. the umbrella deductible; or

3. the embedded individual deductible multiplied by the number of family members covered by the plan.

See Notice 2004–2, Q&A 3, which requires that the embedded individual deductible satisfy the minimum annual deductible for an HDHP.

Example (1). In 2004, H and W, a married couple, have HDHP coverage for themselves and their two dependent children. The HDHP will pay benefits for any family member whose covered expenses exceed $2,000 (the embedded individual deductible), and will pay benefits for all family members after their covered expenses exceed $5,000 (the umbrella deductible). The maximum annual contribution limit under section 223(b)(2)(B)(ii) is $5,150. The embedded deductible multiplied by the number of family members covered is $8,000 (4 X $2,000). The maximum annual contribution which H and W can make to their HSAs is $5,000 (the least of $5,000, $5,150 or $8,000). The $5,000 limit is divided equally between H and W, unless they agree to a different division. See Q&A 32 and Notice 2004–2, Q&A 15.

Example (2). The same facts as Example 1, except the HDHP provides coverage only for H and W. The maximum annual contribution limit under section 223(b)(2)(B)(ii) is $5,150. The umbrella deductible is $5,000. The embedded individual deductible multiplied by the number of family members covered is $4,000 (2 X $2,000). The maximum annual contribution which H and W can make to their HSAs for 2004 is $4,000 (the least of $5,000, $5,150 or $4,000).

Q–31. How do the maximum annual HSA contribution limits apply to family HDHP coverage that may include an ineligible individual?

A–31. The maximum annual HSA contribution for a married couple with family HDHP coverage is the lesser of: (1) the lowest HDHP family deductible applicable to the family (minimum $2,000) or (2) the section 223(b)(2)(B) statutory maximum ($5,150 in 2004). Although the special rule for married individuals in section 223(b)(5) generally allows a married couple to divide the maximum HSA contribution between spouses, if only one spouse is an eligible individual, only that spouse may contribute to an HSA (notwithstanding the treatment under section 223(b)(5)(A) of both spouses as having only family coverage). For an HDHP with embedded individual deductibles see Q&A 30.

Example (1). In 2004, H and W are a married couple and neither qualifies for catch-up contributions under section 223(b)(3). H and W have family HDHP coverage with a $5,000 deductible. H is an eligible individual and has no other coverage. W also has self-only coverage with a $200 deductible. W, who has coverage under a low-deductible plan, is not an eligible individual. H may contribute $5,000 (the lesser of $5,000 or $5,150) to an HSA while W may not contribute to an HSA.

Example (2). The same facts as Example 1, except that, in addition to the family HDHP with a $5,000 deductible, W has self-only HDHP coverage with a $2,000 deductible rather than self-only coverage with a $200 deductible. Both H and W are eligible individuals. H and W are treated as having only family coverage under section 223(b)(5). The maximum combined HSA contribution by H and W is $5,000, to be divided between them by agreement.

Example (3). The same facts as Example 1, except that, in addition to the family HDHP with a $5,000 deductible, W has family HDHP coverage with a $3,000 deductible rather than self-only coverage with a $200 deductible. Both H and W are eligible individuals. H and W are treated as having family HDHP coverage with the lowest annual deductible under section 223(b)(5)(A). The maximum combined HSA contribution by H and W is $3,000, to be divided between them by agreement.

Example (4). The same facts as Example 1, except that, in addition to family coverage under the HDHP with a $5,000 deductible, W has family coverage with a $500 deductible rather than self-only coverage with a $200 deductible. H and W are treated as having family coverage with the lowest annual deductible under section 223(b)(5)(A). Neither H nor W is an eligible individual and neither may contribute to an HSA.

Example (5). The same facts as Example 1, except that, in addition to the family HDHP with a $5,000 deductible, W is enrolled in Medicare rather than having self-only coverage with a $200 deductible. W is not an eligible individual. H may contribute $5,000 to an HSA while W may not contribute to an HSA.

Example (6). Individual X is a single individual who does not qualify for catch-up contributions. X is an eligible individual and has a dependent. X and his dependent have family HDHP coverage with a $5,000 deductible. The dependent also has self-only coverage with a $200 deductible. X may contribute $5,000 to an HSA while the dependent may not contribute to an HSA.

Q–32. How may spouses agree to divide the annual HSA contribution limit between themselves?

A–32. Section 223(b)(5) provides special rules for married individuals and states that HSA contributions (without regard to the catch-up contribution) "shall be divided equally between them unless they agree on a different division." Thus, spouses can divide the annual HSA contribution in any way they want, including allocating nothing to one spouse. See also Notice 2004–2, Q&A 15.

Example. In 2004, X, an eligible individual, has self-only HDHP coverage with a $1,200 deductible from January 1 through March 31. In March, X and Y marry. Neither X nor Y qualifies for the catch-up contribution. From April 1 through December 31, 2004, X and Y have HDHP family coverage with a $2,400 deductible. Y is an eligible individual from April 1 through December 31, 2004. X and Y's contribution limit for the nine months of family coverage is $1,800 (nine months of the deductible for family coverage. 9/12 x $2,400). X and Y divide the $1,800 between them. X's contribution limit to his HSA for the three months of single coverage is $300 (three months of the deductible for self-only coverage. 3/12 x $1,200). The $300 limit is not divided between X and Y. See also Q&A 23.

Q–33. What is the contribution limit for an eligible individual covered by an HDHP and also by a post-deductible health reimbursement arrangement (HRA)?

A–33. Rev. Rul. 2004–45, Situation 4, describes a post-deductible HRA that does not pay or reimburse any medical expense incurred before the minimum annual deductible under section 223(c)(2)(A)(i) is satisfied. The ruling states that the deductible for the HRA need not be the same as the deductible for the HDHP, but in no event may the HDHP or other coverage provide benefits before the minimum annual deductible under section 223(c)(2)(A)(i) is satisfied. Where the HDHP and the other coverage do not have identical deductibles, contributions to the HSA are limited to the lower of the deductibles. In addition, although the deductibles of the HDHP and the other coverage may be satisfied independently by separate expenses, no benefits may be paid by the HDHP or the other coverage before the minimum annual deductible under section 223(c)(2)(A)(i) has been satisfied.

Example. In 2004, an individual has self-only coverage under an HDHP with a deductible of $2,500. The individual is also covered under a post-deductible HRA (as described in Rev. Rul. 2004–45) which pays or reimburses qualified medical expenses only after $2,000 of the HDHP's deductible has been satisfied (*i.e.*, if the individual incurs covered medical expenses of $2,250, the HRA will pay $250). Because the HRA's deductible of $2,000 is less than the HDHP's deductible of $2,500, the individual's HSA contribution limit is $2,000.

Q–34. An account beneficiary wants to withdraw an excess contribution from an HSA before the due date of his or her

federal income tax return (including extensions), to avoid the 6 percent excise tax under section 4973(a)(5). How is the net income attributable to the excess contribution computed?

A–34. Section 223(f)(3)(A)(ii) provides that any distribution of excess contribution to an HSA must be "accompanied by the amount of net income attributable to such excess contribution." Any net income is included in the individual's gross income. The rules for computing attributable net income for excess IRA contributions apply to HSAs. See Treas. Reg. § 1.408–11 and Notice 2004–2, Q&A 22.

Q–35. May an individual who has not made excess HSA contributions treat a distribution from an HSA other than for qualified medical expenses as the withdrawal of excess HSA contributions?

A–35. No. This withdrawal is deemed a withdrawal for non-qualified medical expenses and includable in the individual's gross income under section 223(f)(2). (The additional tax under section 223(f)(4) also applies, unless otherwise excepted).

V. Distributions

Q–36. If an account beneficiary's spouse or dependents are covered under a non-HDHP, are distributions from an HSA to pay their qualified medical expenses excluded from the account beneficiary's gross income?

A–36. Yes. Distributions from an HSA are excluded from income if made for any qualified medical expense of the account beneficiary, the account beneficiary's spouse and dependents (without regard to their status as eligible individuals). However, distributions made for expenses reimbursed by another health plan are not excludable from gross income, whether or not the other health plan is an HDHP. See Notice 2004–2, Q&A 26.

Q–37. An account beneficiary receives an HSA distribution as the result of a mistake of fact due to reasonable cause (*e.g.*, the account beneficiary reasonably, but mistakenly, believed that an expense was a qualified medical expense and was reimbursed for that expense from the HSA). The account beneficiary then repays the mistaken distribution to the HSA. Is the mistaken distribution included in gross income under section 223(f)(2) and subject to the 10 percent additional tax under section 223(f)(4) or subject to the excise tax on excess contributions under section 4973(a)(5)?

A–37. If there is clear and convincing evidence that amounts were distributed from an HSA because of a mistake of fact due to reasonable cause, the account beneficiary may repay the mistaken distribution no later than April 15 following the first year the account beneficiary knew or should have known the distribution was a mistake. Under these circumstances, the distribution is not included in gross income under section 223(f)(2), or subject to the 10 percent additional tax under section 223(f)(4), and the repayment is not subject to the excise tax on excess contributions under section 4973(a)(5). But see Q&A 76 on the trustee's or custodian's obligation to accept a return of mistaken distributions.

Q–38. If both spouses have HSAs and one spouse uses distributions from his or her HSA to pay or reimburse the section 213(d) qualified medical expenses of the other spouse, are the distributions excluded from the account beneficiary's gross income under section 223(f)?

A–38. Yes. However, both HSAs may not reimburse the same expense amounts.

Q–39. When must a distribution from an HSA be taken to pay or reimburse, on a tax-free basis, qualified medical expenses incurred in the current year?

A–39. An account beneficiary may defer to later taxable years distributions from HSAs to pay or reimburse qualified medical expenses incurred in the current year as long as the expenses were incurred after the HSA was established. Similarly, a distribution from an HSA in the current year can be used to pay or reimburse expenses incurred in any prior year as long as the expenses were incurred after the HSA was established. Thus, there is no time limit on when the distribution must occur. However, to be excludable from the account beneficiary's gross income, he or she must keep records sufficient to later show that the distributions were exclusively to pay or reimburse qualified medical expenses, that the qualified medical expenses have not been previously paid or reimbursed from another source and that the medical expenses have not been taken as an itemized deduction in any prior taxable year. See Notice 2004–2, Q&A 31 and also Notice 2004–25, for transition relief in calendar year 2004 for reimbursement of medical expenses incurred before opening an HSA.

Example. An eligible individual contributes $1,000 to an HSA in 2004. On December 1, 2004, the individual incurs a $1,500 qualified medical expense and has a balance in his HSA of $1,025. On January 3, 2005, the individual contributes another $1,000 to the HSA, bringing the balance in the HSA to $2,025. In June, 2005, the individual receives a distribution of $1,500 to reimburse him for the $1,500 medical expense incurred in 2004. The individual can show that the $1,500 HSA distribution in 2005 is a reimbursement for a qualified medical expense that has not been previously paid or otherwise reimbursed and has not been taken as an itemized deduction. The distribution is excludable from the account beneficiary's gross income.

Q–40. May an account beneficiary pay qualified long-term care insurance premiums with distributions from an HSA if contributions to the HSA are made by salary-reduction though a section 125 cafeteria plan?

A–40. Yes. Section 125(f) provides that the term "qualified benefit" under a section 125 cafeteria plan shall not include any product which is advertised, marketed, or offered as long-term care insurance. However, for HSA purposes, section 223(d)(2)(C)(ii) provides that the payment of any expense for coverage under a qualified long-term care insurance contract (as defined in section 7702B(b)) is a qualified medical expense. Where an HSA that is offered under a cafeteria plan pays or reimburses individuals for qualified long-term care insurance premiums, section 125(f) is not applicable because it is the HSA and not the long-term care insurance that is offered under the cafeteria plan.

Q–41. Do the section 213(d)(10) limits on the deduction for "eligible long-term care premiums" restrict the amount of distributions for qualified medical expenses that may be excluded from income under an HSA?

A–41. Yes. "Eligible long-term care premiums" are deductible medical expenses under section 213, but the deduction is limited to the annually adjusted amounts in section 213(d)(10) (based on age). See Rev. Proc. 2003–85 § 3.18, 2003–49 I.R.B. 1184 for the 2004 limits. Thus, although HSA distributions to pay or reimburse qualified long-term care insurance premiums are qualified medical expenses, the exclusion from gross income is limited to the adjusted amounts under section 213(d)(10). Any excess premium

reimbursements are includable in gross income and may also be subject to the 10 percent penalty under section 223(f)(4).

Example. In 2004, X, age 41, pays premiums of $1,290 for a qualified long term care insurance contract. The section 213(d)(10) limit in calendar year 2004 for deductions for persons age 40, but not more than 50, is $490. X's HSA can reimburse X up to $490 on a tax-free basis for the long-term care premiums. The remaining $800 ($1,290-$490), if reimbursed from the HSA, is not for qualified medical expenses and is includable in gross income.

Q–42. Are distributions from an HSA for long-term care services qualified medical expenses which are excluded from income?

A–42. Yes. Section 106(c) provides that employer-provided coverage for long-term care services provided through a flexible spending or similar arrangement are included in an employee's gross income. Section 213(d)(1)(C) provides that amounts paid for qualified long-term care services are medical care and section 223(f)(1) provides that amounts paid or distributed out of an HSA used to pay for qualified medical expenses are not includible in gross income. Qualified medical expenses are amounts paid for medical care (as defined in section 213(d)) for the account beneficiary, his or her spouse and dependents. Although section 106(c) applies to benefits provided by a flexible spending or similar arrangement, it does not apply to distributions from an HSA, which is a personal health care savings vehicle used to pay for qualified medical expenses through a trust or custodial account, whether or not the HSA is funded by salary-reduction contributions through a section 125 cafeteria plan.

Q–43. May a retiree who is age 65 or older receive tax-free distributions from an HSA to pay the retiree's contribution to an employer's self-insured retiree health coverage?

A–43. Yes. Pursuant to section 223 (d)(2)(B), the purchase of health insurance is generally not a qualified medical expense that can be paid or reimbursed by an HSA. See Notice 2004–2, Q&A 27. However, section 223(d)(2)(C)(iv) provides an exception for coverage for health insurance once an account beneficiary has attained age 65. The exception applies to both insured and self-insured plans.

Q–44. May an individual who is under age 65 and has end stage renal disease (ESRD) or is disabled receive tax-free distributions from an HSA to pay for health insurance premiums?

A–44. No. Section 223(d)(2)(B) provides that health insurance may not be paid by an HSA. However, section 223(d)(2)(C)(iv) provides that payment of health insurance premiums are qualified medical expenses, but only in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act (*i.e.*, age 65).

Q–45. If a retiree who is enrolled in Medicare receives a distribution from an HSA to reimburse the retiree's Medicare premiums, is the reimbursement a qualified medical expense under section 223(d)(2)?

A–45. Yes. Where premiums for Medicare are deducted from Social Security benefit payments, an HSA distribution to reimburse the Medicare beneficiary equal to the Medicare premium deduction is a qualified medical expense.

VI. Comparability

Q–46. Does an employer who offers to make available a contribution to the HSA of each employee who is an eligible individual in an amount equal to the employee's HSA contribution or a percentage of the employee's HSA contribution (*i.e.*, "matching contributions") satisfy the requirement under section 4980G that all comparable participating employees receive comparable contributions?

A–46. If all employees who are eligible individuals do not contribute the same amount to their HSAs and, consequently, do not receive comparable contributions to their HSAs, the section 4980G comparability rules are not satisfied, notwithstanding that the employer offers to make available the same contribution amount to each employee who is an eligible individual. But see Q&A 47 on comparable contributions made through a cafeteria plan.

Q–47. If an employer makes contributions through a cafeteria plan to the HSA of each employee who is an eligible individual in an amount equal to the amount of the employee's HSA contribution or a percentage of the amount of the employee's HSA contribution (*i.e.*, "matching contributions"), are the contributions subject to the section 4980G comparability rules?

A–47. No. The conference report for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that the comparability rules do not apply to contributions made through a cafeteria plan. Conf. Rep. No. 391, 108th Cong., 1st Sess. 840 (2003). Notice 2004–2, Q&A 32 similarly provides that the comparability rules do not apply to HSA contributions made through a cafeteria plan. Thus, where matching contributions are made by an employer through a cafeteria plan, the contributions are not subject to the comparability rules of section 4980G. However, contributions, including "matching contributions", to an HSA made under a cafeteria plan are subject to the section 125 nondiscrimination rules (eligibility rules, contributions and benefits tests and key employee concentration tests). See section 125(b), (c) and (g) and Prop. Treas. Reg. § 1.125–1, Q&A 19.

Q–48. If an employer conditions contributions by the employer to an employee's HSA on an employee's participation in health assessments, disease management programs or wellness programs and makes the same contributions available to all employees who participate in the programs, do the contributions satisfy the section 4980G comparability rules?

A–48. If all eligible employees do not elect to participate in all the programs and consequently, all employees who are eligible individuals do not receive comparable contributions to their HSAs, the employer contributions fail to satisfy the section 4980G comparability rules. But see Q&A 49 on comparable contributions made through a cafeteria plan.

Q–49. If under the employer's cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA, unless the employee elects cash, are the contributions subject to the section 4980G comparability rules?

A–49. No. The comparability rules under section 4980G do not apply to employer contributions to an HSA through a cafeteria plan.

Q–50. If an employer offers to make available additional HSA contributions to all employees who are eligible individuals and who have attained a specified age or who qualify for the additional contri-

butions under section 223(b)(3) (catch-up contributions), do the contributions satisfy the section 4980G comparability rules?

A–50. No. If all employees who are eligible individuals do not meet the age requirement or do not qualify for the additional contributions under section 223(b)(3), all employees who are eligible individuals do not receive comparable contributions to their HSAs and the employer contributions fail to satisfy the section 4980G comparability rules.

Q–51. How do the comparability rules in section 4980G apply to employer contributions to employees' HSAs if some employees work full-time during the entire calendar year, and other employees work full-time for less than the entire calendar year?

A–51. An employer contributing to HSAs of employees who work full-time for less than twelve months, satisfies the comparability rules if the contribution amount is comparable when determined on a month-to-month basis. For example, if the employer contributes $240 to the HSAs of each full-time employee who works the entire calendar year, the employer must contribute $60 to the HSA of a full-time employee who works three months of the year. See section 4980G(b) and section 4980E(d)(2)(B). See also Notice 2004–2, Q&A 32 on comparability rules for part-time employees (*i.e.*, employees who are customarily employed for fewer than 30 hours per week).

Q–52. What is the testing period for making comparable contributions to employees' HSAs?

A–52. To satisfy the comparability rule in section 4980G, an employer must make comparable contributions for the calendar year to HSAs of employees who are eligible individuals. See section 4980G and section 4980E(d).

Q–53. Under section 4980G, must an employer make comparable contributions to all employees who are eligible individuals or only to those employees who are eligible individuals and are also covered by an HDHP provided by the employer?

A–53. If during a calendar year, an employer contributes to the HSA of any employee covered under an HDHP provided by the employer, the employer is required to make comparable contributions to all eligible individuals with coverage under any HDHP provided by the employer. An employer that contributes to the HSAs of employees with coverage under the HDHP provided by the employer is not required to make comparable contributions to HSAs of employees who are not covered under the HDHP provided by the employer. However, an employer that contributes to the HSA of any eligible individual with coverage under any HDHP, even if that coverage is not an HDHP of the employer, must make comparable contributions to all eligible individuals whether or not covered under an HDHP of the employer. See also Notice 2004–2, Q&A 32.

Example (1). An employer offers an HDHP to its full-time employees. Most full-time employees are covered under the employer's HDHP and the employer makes comparable contributions only to these employees' HSAs. Employee D, a full-time employee and an eligible individual (as defined in section 223(c)(1)), is covered under his spouse's HDHP and not under his employer's HDHP. The employer is not required to make comparable contributions to D's HSA.

Example (2). An employer does not offer an HDHP. Several full-time employees, who are eligible individuals (as defined in section 223(c)(1)), have HSAs. The employer contributes to these employees' HSAs. The employer must make comparable contributions to the HSAs of all full-time employees who are eligible individuals.

Example (3). An employer offers an HDHP to its full-time employees. Most full-time employees are covered under the employer's HDHP and the employer makes comparable contributions to these employees' HSAs and also to HSAs of full-time employees not covered under the employer's HDHP. Employee E, a full-time employee and an eligible individual (as defined in section 223(c)(1)), is covered under his spouse's HDHP and not under his employer's HDHP. The employer must make comparable contributions to E's HSA.

Q–54. If an employee requests that his or her employer deduct after-tax amounts from the employee's compensation and forward these amounts as employee contributions to the employee's HSA, do the section 4980G comparability rules apply to these amounts?

A–54. No. Section 106(d) provides that amounts contributed by an employer to an eligible employee's HSA shall be treated as employer-provided coverage for medical expenses and excludable from the employee's gross income up to the limit in section 223(b). After-tax employee contributions to the HSA are not subject to section 4980G because they are not employer contributions under section 106(d). See Notice 2004–2, Q&A 12 on aggregation of HSA contributions.

VII. Rollovers

Q–55. How frequently may an account beneficiary make rollover contributions to an HSA under section 223(f)(5)?

A–55. An account beneficiary may make only one rollover contribution to an HSA during a 1-year period. In addition, to qualify as a rollover, any amount paid or distributed from an HSA to an account beneficiary must be paid over to an HSA within 60 days after the date of receipt of the payment or distribution. But see Q&A 78 regarding trustee's or custodian's obligation to accept rollovers. See also Notice 2004–2, Q&A 23 for additional rules on rollovers.

Q–56. Are transfers of HSA amounts from one HSA trustee directly to another HSA trustee (trustee-to-trustee transfers), subject to the rollover restrictions?

A–56. No. The rules under section 223(f)(5) limiting the number of rollover contributions to one a year do not apply to trustee-to-trustee transfers. Thus, there is no limit on the number of trustee-to-trustee transfers allowed during a year.

VIII. Cafeteria Plans and HSAs

Q–57. Which requirements that apply to health flexible spending arrangements (FSAs) under a section 125 cafeteria plan do not apply to HSAs?

A–57. The following requirements for health FSAs under a section 125 cafeteria plan (which are generally imposed so that health FSAs operate in a manner similar to "insurance-type" accident or health plans under section 105) are not applicable to HSAs: (1) the prohibition against a benefit that defers compensation by permitting employees to carry over unused elective contributions or plan benefits from one plan year to another plan year (See section 125(d)(2)(D)); (2) the requirement that the maximum amount of reimbursement must be available at all times during the coverage period; and (3) the mandatory twelve-month period of coverage.

Q–58. Do the section 125 change in status rules apply to elections of HSA contributions through a cafeteria plan?

A–58. A cafeteria plan may permit an employee to revoke an election during a period of coverage with respect to a qualified benefit and make a new election for the remaining portion of the period only as

provided in Treas. Reg. § 1.125–4. Because the eligibility requirements and contribution limits for HSAs are determined on a month-by-month basis, rather than on an annual basis, an employee who elects to make HSA contributions under a cafeteria plan may start or stop the election or increase or decrease the election at any time as long as the change is effective prospectively (*i.e.*, after the request for the change is received). If an employer places additional restrictions on the election of HSA contributions under a cafeteria plan, the same restrictions must apply to all employees.

Q–59. Can an employer permit employees to elect an HSA mid-year if offered as a new benefit under the employer's cafeteria plan?

A–59. Yes, if the election for the HSA is made on a prospective basis. However, the HSA election does not permit a change or revocation of any other coverage under the cafeteria plan unless the change is permitted by Treas. Reg. § 1.125–4. Thus, while an HSA may be offered to and elected by an employee mid-year, the employee may have other coverage under the cafeteria plan that cannot be changed, (*e.g.*, coverage under a health FSA), which may prevent the employee from being an eligible individual. See Rev. Rul. 2004–45.

Q–60. If an employee elects to make contributions to an HSA through the employer's cafeteria plan, may the employer contribute amounts to an employee's HSA to cover qualified medical expenses incurred by an employee that exceed the employee's current HSA balance?

A–60. Yes. Where an employee elects to make contributions to an HSA through a cafeteria plan, the employer may, but is not required to, contribute amounts to an employee's HSA up to the maximum amount elected by the employee. While any accelerated contribution made by the employer must be equally available to all participating employees throughout the plan year and must be provided to all participating employees on the same terms, the employee must repay the amount of the accelerated contribution by the end of the plan year. But see Q&A 82 on recoupment of HSA contributions by an employer.

Q–61. Can employers provide negative elections for HSAs if offered through a cafeteria plan?

A–61. Yes. See Rev. Rul. 2002–27, 2002–1 C.B. 925.

IX. Account Administration

Q–62. Are there model IRS forms for establishing HSAs?

A–62. Yes. See Form 5305-B "*Health Savings Trust Account*" and Form 5305-C "*Health Savings Custodial Account*."

Q–63. May a husband and wife have a joint HSA?

A–63. No. Each spouse who is an "eligible individual" as described in section 223(c)(1) and wants to make contributions to an HSA must open a separate HSA. Thus, only one person may be the account beneficiary of an HSA. But see Q&A 32 concerning allocating contributions between spouses. See also Q&A 38 concerning reimbursements from spousal HSAs.

Q–64. May an eligible individual have more than one HSA?

A–64. Yes. An eligible individual may establish more than one HSA, and may contribute to more than one HSA. The same rules governing HSAs apply (*e.g.*, maximum contribution limit), regardless of the number of HSAs established by an eligible individual. See also Notice 2004–2, Q&A 12.

Example. For 2004, eligible individual A's maximum contribution to an HSA is $2,400. For 2004, A's employer contributes $1,000 to an HSA on behalf of A. A opens a second HSA and contributes $1,400. If additional contributions are made for 2004 to either of the HSAs, then there are excess contributions to A's HSAs.

Q–65. What are permissible investments for HSAs?

A–65. HSA funds may be invested in investments approved for IRAs (*e.g.*, bank accounts, annuities, certificates of deposit, stocks, mutual funds, or bonds). HSAs may not invest in life insurance contracts, or in collectibles (*e.g.*, any work of art, antique, metal, gem, stamp, coin, alcoholic beverage, or other tangible personal property specified in IRS guidance under section 408(m)). HSAs may, however, invest in certain types of bullion or coins, as described in section 408(m)(3). The HSA trust or custodial agreement may restrict investments to certain types of permissible investments (*e.g.*, particular investment funds).

Q–66. May HSA funds be commingled in a common trust fund or common investment fund?

A–66. Section 223(d)(1)(D) states that the HSA trust assets may not be commingled except in a common trust fund or common investment fund. Thus, individual accounts maintained on behalf of individual HSA account beneficiaries may be held in a common trust fund or common investment fund. A "common trust fund" is defined in Treas. Reg. § 1.408–2(b)(5)(ii). A "common investment fund" is defined in section 584(a)(1).

Q–67. Are there any transactions which account beneficiaries are prohibited from entering into with an HSA?

A–67. Yes. Section 223(e)(2) provides that rules similar to the rules of section 408(e)(2) and (4) shall apply to HSAs. Therefore, account beneficiaries may not enter into "prohibited transactions" with an HSA (*e.g.*, the account beneficiary may not sell, exchange, or lease property, borrow or lend money, furnish goods, services or facilities, transfer to or use by or for the benefit of himself/herself any assets, pledge the HSA, etc.). Any amount treated as distributed as the result of a prohibited transaction will not be treated as used to pay for qualified medical expenses. The account beneficiary must, therefore, include the distribution in gross income and generally will be subject to the additional 10 percent tax on distributions not made for qualified medical expenses. See Notice 2004–2, Q&A 25.

Q–68. Are HSA trustees and custodians also subject to the rules against prohibited transactions?

A–68. Yes. The same rules that apply to account beneficiaries apply to trustees and custodians.

Q–69. If administration and account maintenance fees (*e.g.*, flat administrative fees) are withdrawn from the HSA, are the withdrawn amounts treated as taxable distributions to the account beneficiary?

A–69. No. Amounts withdrawn from an HSA for administration and account maintenance fees will not be treated as a taxable distribution and will not be included in the account beneficiary's gross income.

Q–70. If administration and account maintenance fees are withdrawn from the HSA, does the withdrawn amount increase

the maximum annual HSA contribution limit?

A–70. No. For example, if the maximum annual contribution limit is $2,000, and a $25 administration fee is withdrawn from the HSA, the annual contribution limit is still $2,000, not $2,025.

Q–71. If administration and account maintenance fees are paid by the account beneficiary or employer directly to the trustee or custodian, do these payments count toward the annual maximum contribution limit for the HSA?

A–71. No. Administration and account maintenance fees paid directly by the account beneficiary or employer will not be considered contributions to the HSA. For example, an individual contributes the maximum annual amount to his HSA of $2,000. The account beneficiary pays an annual administration fee of $25 directly to the trustee. The individual's maximum annual contribution limit is not affected by the payment of the administration fee.

X. Trustees and Custodians

Q–72. Is any insurance company a qualified HSA trustee or custodian?

A–72. Yes. Any insurance company or any bank (including a similar financial institution as defined in section 408(n)) can be an HSA trustee or custodian. In addition, any other person already approved by the IRS to be a trustee or custodian of IRAs or Archer MSAs is automatically approved to be an HSA trustee or custodian. Other persons may request approval to be a trustee or custodian in accordance with the procedures set forth in Treas. Reg. § 1.408–2(e) (relating to IRA nonbank trustees).

Q–73. Is there a limit on the annual HSA contribution which the trustee or custodian may accept?

A–73. Yes. Except in the case of rollover contributions described in section 223(f)(5) or trustee-to-trustee transfers, the trustee or custodian may not accept annual contributions to any HSA that exceed the sum of: (1) the dollar amount in effect under section 223(b)(2)(B)(ii) (*i.e.*, the maximum family coverage deductible) plus (2) the dollar amount in effect under section 223(b)(3)(B) (*i.e.*, the catch-up contribution amount). All contributions must be in cash, other than rollover contributions or trustee-to-trustee transfers. See section 223(d)(1)(A).

Q–74. Is the HSA trustee or custodian responsible for determining whether contributions to an HSA exceed the maximum annual contribution for a particular account beneficiary?

A–74. No. This is the responsibility of the account beneficiary, who is also responsible for notifying the trustee or custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution. The HSA trustee or custodian is, however, responsible for accepting cash contributions within the limits in Q&A 73 and for filing required information returns with the IRS (Form 5498-SA and Form 1099-SA).

Q–75. Is the trustee or custodian responsible for tracking the account beneficiary's age?

A–75. Yes. However, the trustee or custodian may rely on the account beneficiary's representation as to his or her date of birth.

Q–76. Must the trustee or custodian allow account beneficiaries to return mistaken distributions to the HSA?

A–76. No, this is optional. If the HSA trust or custodial agreement allows the return of mistaken distributions as described in Q&A 37, the trustee or custodian may rely on the account beneficiary's representation that the distribution was, in fact, a mistake.

Q–77. May an HSA trust or custodial agreement restrict the account beneficiary's ability to rollover amounts from that HSA?

A–77. No. Section 223(f)(5) permits the rollover of amounts in an HSA to another HSA, and transfers from one trustee to another trustee.

Q–78. Are HSA trustees or custodians required to accept rollover contributions or trustee-to-trustee transfers?

A–78. No. Rollover contributions or trustee-to-trustee transfers from other HSAs or from Archer MSAs are allowed, but trustees or custodians are not required to accept them. See Notice 2004–2, Q&A 23.

Q–79. May an HSA trust or custodial agreement restrict HSA distributions to pay or reimburse only the account beneficiary's qualified medical expenses?

A–79. No. The HSA trust or custodial agreement may not contain a provision that restricts HSA distributions to pay or reimburse only the account beneficiary's qualified medical expenses. Thus, the account beneficiary is entitled to distributions for any purpose and distributions may be used to pay or reimburse qualified medical expenses or for other nonmedical expenditures. Only the account beneficiary may determine how the HSA distributions will be used. But see Notice 2004–2, Q&A 25 on the taxation of HSA distributions not used exclusively for qualified medical expenses. See also Q&A 80 on restrictions on the frequency or minimum amount of HSA distributions.

Q–80. May a trustee or custodian restrict the frequency or minimum amount of distributions from an HSA?

A–80. Yes. Trustees or custodians may place reasonable restrictions on both the frequency and the minimum amount of distributions from an HSA. For example, the trustee may prohibit distributions for amounts of less than $50 or only allow a certain number of distributions per month. Generally, the terms regarding the frequency or minimum amount of distributions from an HSA are matters of contract between the trustee and the account beneficiary.

XI. Other Issues

Q–81. Are employers who contribute to an employee's HSA responsible for determining whether the employee is an eligible individual and the employee's maximum annual contribution limit?

A–81. Employers are only responsible for determining the following with respect to an employee's eligibility and maximum annual contribution limit on HSA contributions: (1) whether the employee is covered under an HDHP (and the deductible) or low deductible health plan or plans (including health FSAs and HRAs) sponsored by that employer; and (2) the employee's age (for catch-up contributions). The employer may rely on the employee's representation as to his or her date of birth.

Q–82. May the employer recoup from an employee's HSA any portion of the employer's contribution to the employee's HSA?

A–82. No. Under section 223(d)(1)(E), an account beneficiary's interest in an

HSA is nonforfeitable. For example, on January 2, 2005, the employer makes the maximum annual contribution to employees' HSAs, in the expectation that the employees would work for the entire calendar year 2005. On February 1, 2005, one employee terminates employment. The employer may not recoup from that employee's HSA any portion of the contribution previously made to the employee's HSA.

Q–83. Is an HSA distribution subject to the nondiscrimination rules of section 105(h)?

A–83. No. For amounts reimbursed to a highly compensated individual by a self-insured medical reimbursement plan to be fully excludable from the individual's gross income under section 105(b), the self-insured medical reimbursement plan must satisfy the requirements of section 105(h). Section 105(h) is not satisfied if the plan discriminates in favor of highly compensated individuals as to eligibility to participate or benefits. Because the exclusion from gross income for amounts distributed from an HSA is not determined by section 105(b), but by section 223(b), section 105(h) does not apply to HSAs.

Q–84. Is a deduction under section 223(a) for contributions to a self-employed individual's own HSA taken into account in determining net earnings from self-employment under section 1402(a)?

A–84. No. The deduction is an adjustment to gross income under section 62(a)(19), and is reportable on the self-employed individual's Form 1040 as an adjustment to gross income. It is not a deduction attributable to the self-employed individual's trade or business so it is not taken as a deduction on Schedule C, Form 1040, nor is it taken into account in determining net earnings from self-employment on Schedule SE, Form 1040.

Q–85. Does an employer's contribution to an employee's HSA affect the computation of the earned income credit (EIC) under section 32?

A–85. No. An employer's contributions to an employee's HSAs are not treated as earned income for EIC purposes.

Q–86. May an HDHP apply any required cost-of-living adjustments under section 223(g) to the minimum annual deductible amounts or maximum annual out-of-pocket expense limits on the renewal date of the HDHP if that date is after January 1st?

A–86. Yes. Generally, an HDHP is a health plan that satisfies certain requirements with respect to minimum annual deductibles and maximum annual out-of-pocket expense. These annual amounts are indexed for inflation using annual cost-of-living adjustments. Any required change to the deductibles and out-of-pocket expense limits may be applied as of the renewal date of the HDHP in cases where the renewal date is after the beginning of the calendar year, but in no event longer than a 12-month period ending on the renewal date. Thus, a fiscal year plan that satisfies the minimum annual deductible on the first day of the first month of its fiscal year may apply that deductible for the entire fiscal year, even if the minimum annual deductible increases on January 1 of the next calendar year.

Example. An individual obtains self-only coverage under an HDHP on June 1, 2004, the first day of the plan year, with an annual deductible of $1,000. Assume that the cost-of living adjustments require the minimum deductible amount to be increased for 2005. The plan's deductible is not increased to comply with the increased minimum deductible amount until the plan's renewal date of June 1, 2005. The plan satisfies the requirements for an HDHP with respect to deductibles through May 30, 2005.

Q–87. Are HSAs available to *bona fide* residents of the Commonwealth of Puerto Rico, American Samoa, the U.S. Virgin Islands, Guam, and the Commonwealth of the Northern Mariana Islands?

A–87. *Bona fide* residents of the U.S. Virgin Islands, Guam and the Commonwealth of the Northern Mariana Islands may establish HSAs. However, *bona fide* residents of Puerto Rico and American Samoa may establish HSAs only after statutory provisions similar to sections 223 and 106(d) are enacted.

Q–88. If a C corporation makes a contribution to the HSA of a shareholder who is not an employee of the C corporation, what are the tax consequences to the shareholder and to the C corporation?

A–88. If a C corporation makes a contribution to the HSA of a shareholder who is not an employee of the C corporation, the contribution will be treated as a distribution under section 301. The distribution is treated as a dividend to the extent the C corporation has earnings and profits. The portion of the distribution which is not a dividend is applied against and reduces the adjusted basis of the stock. To the extent the amount of the distribution exceeds the adjusted basis of the stock, the balance is treated as gain from a sale or exchange of property.

EFFECT ON OTHER DOCUMENTS

Notice 2004–2, 2004–2 I.R.B. 269, is changed as follows:

The second sentence of A–2 is changed to read: An "eligible individual" means ... (3) is not enrolled in Medicare ...."

The last sentence in the first paragraph of A–12 is changed to read: "In addition to the maximum contribution amount, catch-up contributions, as described in [Notice 2004–2] A–14, may be made by or on behalf of individuals age 55 and older, who are not enrolled in Medicare."

The first sentence of A–14 is changed to read: "For individuals (and their spouses covered under the HDHP) who have attained 55 and are also not enrolled in Medicare ...."

The first sentence of the Example in A–14 is changed to read: "An individual attains age 65 and becomes enrolled in Medicare ...."

TRANSITION RELIEF

For months before January 1, 2005, a health plan that would otherwise qualify as an HDHP but for the lack of an express maximum on payments above the deductible that complies with the out-of-pocket requirement, as set forth in Q&A 17 and 20 will be treated as an HDHP. Individuals covered under these health plans will continue to be eligible to contribute to HSAs before January 1, 2005.

For months before January 1, 2006, a health plan that would otherwise qualify as an HDHP but for an annual deductible that does not satisfy the rule in Q&A 24 (concerning deductibles for periods of more than 12 months) will be treated as an HDHP if the plan was in effect or submitted to approval to state insurance regulators as of the date of publication of this notice in the Internal Revenue Bulletin. Individuals covered under these health plans will continue to be eligible to contribute to HSAs before January 1, 2006.

APPENDIX N

FEDERAL REGISTER

26 CFR Part 1

Tax Treatment of Cafeteria Plans

[EE-16-79]

49 FR 19321

May 7, 1984

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to the tax treatment of cafeteria plans. Changes to the applicable tax law were made by the Revenue Act of 1978, by the Technical Corrections Act of 1979 and by the Miscellaneous Revenue Act of 1980. The proposed regulations would provide the public with the guidance needed to comply with those Acts and would affect employees who participate in cafeteria plans.

DATES: Written comments and requests for a public hearing must be delivered or mailed by July 6, 1984. The regulations are generally proposed to be effective for plan years beginning after December 31, 1978, except with respect to certain provisions set forth in Q&A-21 which would be effective as of September 4, 1984. In addition, transitional relief is provided with respect to employer contributions made before June 1, 1984, pursuant to certain "flexible spending arrangements" that satisfy specified conditions. Also, the provision relating to qualified cash or deferred arrangements would be effective for plan years beginning after December 31, 1980.

ADDRESS: Send comments and requests for a public hearing to: Commissioner of Internal Revenue, Attention: CC:LR:T (EE-16-79), Washington, D.C. 20224.
FOR FURTHER INFORMATION CONTACT: Harry Beker of the Employee Plans and Exempt Organizations Division, Office of the Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, D.C. 20224 (Attention: CC:EE) (202-566-6212) (not a toll-free call).

TEXT: SUPPLEMENTARY INFORMATION:

Background

This document contains proposed Income Tax Regulations (26 CFR Part 1) under *section 125 of the Internal Revenue Code of 1954*. These proposed regulations are to be issued pursuant to section 134 of the Revenue Act of 1978

(92 Stat. 2763), section 101 of the Technical Corrections Act of 1979 (92 Stat. 2227), section 226 of the Miscellaneous Revenue Act of 1980 (94 Stat. 3529) and under the authority contained in section 7805 of the Code (68A Stat. 917, *26 U.S.C. 7805).*

Format

These proposed regulations are presented in the form of questions and answers. The questions and answers do not address various issues regarding the application of the discrimination standards under section 125. Written comments are requested specifically with respect to the application of these discrimination standards. In particular, comments are requested regarding tests that a plan may use to determine whether it is nondiscriminatory, methods by which to value benefits, appropriate safe harbors from discrimination, and tests to assure that the pricing of benefits under a cafeteria plan is not discriminatory.

The guidance provided by these questions and answers may be relied upon to comply with provisions of section 125 and will be applied by the Internal Revenue Service in resolving issues arising under cafeteria plans and related Code sections. However, pending the issuance of final regulations, advance determinations and rulings regarding whether a cafeteria plan is or is not discriminatory will not be issued; determinations regarding discrimination will be made only on audit.

If final regulations are more restrictive than the guidance in this Notice, the regulations will not be applied retroactively. No inference, however, should be drawn regarding issues not expressly raised that may be suggested by a particular question or answer or by the inclusion or exclusion of certain questions.

Nonapplicability of Executive Order 12291

The Treasury Department has determined that this Regulation is not subject to review under Executive Order 12291 or the Treasury and Office of Management and Budget implementation of the Order dated April 28, 1982.

Regulatory Flexibility Act

Although this document is a notice of proposed rulemaking which solicits public comments, the Internal Revenue Service has concluded that the regulations proposed herein are interpretative and that the notice and public procedure requirements of *5 U.S.C. 553* do not apply. Accordingly, these proposed regulations do not constitute regulations subject to the Regulatory Flexibility Act *(5 U.S.C. chapter 6).*

Comments and Requests for a Public Hearing

Before adopting these proposed regulations, consideration will be given to any written comments that are submitted (preferably seven copies) to the Commissioner of Internal Revenue. All comments will be available for public inspection and copying. A public hearing will be held on a date announced in the notice of public hearing appearing elsewhere in this Federal Register.

Drafting Information

The principal author of these proposed regulations is Harry Beker of the Employee Plans and Exempt Organizations Division of the Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing the regulations, both on

matters of substance and style.

List of Subjects in 26 CFR Parts 1.61-1-1.281-4

Income taxes, Taxable income.

PART 1 -- [AMENDED]

Proposed Amendments to the Regulations

Accordingly, it is proposed to amend the Income Tax Regulations, 26 CFR Part 1, by adding the following new section:

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

Q-1: What does *section 125 of the Internal Revenue Code* provide?

A-1: Section 125 provides that a participant in a nondiscriminatory cafeteria plan will not be treated as having received the taxable benefits offered under the plan solely because the participant has the opportunity, before the benefits become currently available to the participant, to choose among the taxable and nontaxable benefits offered under the plan.

Q-2: What is a "cafeteria plan" under section 125?

A-2: A "cafeteria plan" is a separate written benefit plan maintained by an employer for the benefit of its employees, under which all participants are employees and each participant has the opportunity to select the particular benefits that he desires. A cafeteria plan may offer participants the opportunity to select among various taxable benefits and nontaxable benefits, but a plan must offer at least one taxable benefit and at least one nontaxable benefit. For example, if participants are given the opportunity to elect only among two or more nontxable benefits, the plan is not a cafeteria plan.

Q-3: What must the written cafeteria plan document contain?

A-3: The written document embodying a cafeteria plan must contain at least the following information: (i) A specific description of each of the benefits available under the plan, including the periods during which the benefits are provided (i.e., the periods of coverage), (ii) the plan's eligibility rules governing participation, (iii) the procedures governing participants' elections under the plan, including the period during which elections may be made, the extent to which elections are irrevocable, and the periods with respect to which elections are effective, (iv) the manner in which employer contributions may be made under the plan, such as by salary reduction agreement between the participant and the employer or by nonelective employer contributions to the plan, (v) the maximum amount of employer contributions available to any participant under the plan, and (vi) the plan year on which the cafeteria plan operates.

In describing the benefits available under the cafeteria plan, the plan document need not be self-contained. For example, the plan document may include by reference benefits established under other "separate written plans," such as coverage under a qualified group legal services plan (section 120) or under a dependent care assistance program (section 129), without describing in full the benefits established under these other plans. But, for example, if the plan offers different maximum levels of coverage under a dependent care assistance program, the descriptions must specify the available maximums. In addition, an arrangement under which a participant is provided with coverage under a dependent care assistance program for dependent care expenses incurred during the period of coverage up to a specified amount (e.g., $500) and the right to receive, either directly or indirectly in the form of cash or any other benefit, any

portion of the specified amount that is not reimbursed for such expenses will be considered a single benefit and must be fully described as such in the plan document. This also is the case with other benefits, such as coverage under an accident or health plan and coverage under a qualified group legal services plan. See Q&A-17 and Q&A-18 regarding the taxability of such benefit arrangements.

Q-4: What does the term "employees" mean under section 125?

A-4: The term "employees" includes present and former employees of the employer. All employees who are treated as employed by a single employer under subsections (b), (c), or (m) of section 414 are treated as employed by a single employer for purposes of section 125. The term "employees" does not, however, include self-employed individuals described in section 401(c) of the Code. Even though former employees generally are treated as employees, a cafeteria plan may not be established predominantly for the benefit of former employees of the employer.

In addition, even though the spouses and other beneficiaries of participants may not be participants in a cafeteria plan, a plan may provide benefits to spouses and beneficiaries of participants. For example, the spouse of a participant may not be permitted to participate actively in a cafeteria plan (i.e., the spouse may not be given the opportunity to select or purchase benefits offered by the plan), but the spouse of a participant may benefit from the participant's selection of family medical insurance coverage or of coverage under a dependent care assistance program. A participant's spouse will not be treated as actively participating in a cafeteria plan merely because the spouse has the right, upon the death of the participant, to select among various settlement options available with respect to a death benefit selected by the participant under the cafeteria plan or to elect among permissible distribution options with respect to the deceased participant's benefits under a cash or deferred arrangement that is part of the cafeteria plan.

Q-5: What benefits may be offered to participants under a cafeteria plan?

A-5: With the exception of benefits that defer the receipt of compensation (see Q&A-7), a cafeteria plan may offer participants the opportunity to select among certain taxable benefits and nontaxable benefits described in the plan document. The term "taxable benefit" means cash, property, or other benefits attributable to employer contributions that are currently taxable to the participant under the Internal Revenue Code upon receipt by the participant. The term "nontaxable benefit" means any benefit attributable to employer contributions to the extent that such benefit is not currently taxable to the participant under the Internal Revenue Code upon receipt of the benefit. Thus, a cafeteria plan may offer participants the following benefits, which will be nontaxable when provided in accordance with the applicable provisions of the Internal Revenue Code: group-term life insurance up to $50,000 (section 79), coverage under an accident or health plan (section 106), coverage under a qualified group legal services plan (section 120), and coverage under a dependent care assistance program (section 129). Also, amounts received by participants under one of these benefits may or may not be taxable depending upon whether such amounts qualify for an exclusion from gross income. See Q&A-17 and Q&A-18 regarding the inclusion of an accident or health plan, dependent care assistance program, or qualified group legal services plan in a cafeteria plan. Also, see Q&A-7 regarding the inclusion of deferred compensation benefits in a cafeteria plan.

In addition, a cafeteria plan may offer benefits that are nontaxable because they are attributable to after-tax employee contributions. For example, a cafeteria plan may offer participants the opportunity to purchase, with after-tax employee contributions, coverage under an accident or health plan providing for the payment of disability benefits. A participant's receipt of coverage under such an accident or health plan would not trigger taxable income because the coverage would be purchased with after-tax employee contributions. Similarly, any amounts paid to a participant under such an accident or health plan on account of disability incurred during the year of coverage may be nontaxable under section 104(a)(3).

Q-6: May employer contributions to a cafeteria plan be made pursuant to a salary reduction agreement between the participant and employer?

A-6: Yes. The term "employer contributions" means amounts that have not been actually or constructively received (after taking section 125 into account) by the participant and have been specified in the plan document as available to a participant for the purpose of selecting or "purchasing" benefits under the plan. A plan document may provide that the employer will make employer contributions, in whole or in part, pursuant to salary reduction agreements under which participants elect to reduce their compensation or to forgo increases in compensation and to have such amounts contributed, as employer contributions, by the employer on their behalf. A salary reduction agreement will have the effect of causing the amounts contributed thereunder to be treated as employer contributions under a cafeteria plan only to the extent the agreement relates to compensation that has not been actually or constructively received by the participant as of the date of the agreement (after taking section 125 into account) and, subsequently, does not become currently available to the participant. In addition, a plan document also may provide that the employer will make employer contributions on behalf of participants equal to specified amounts (or specified percentages of compensation) and that such nonelective contributions will be available to participants for the selection or purchase of benefits under the plan.

Q-7: May a cafeteria plan offer a benefit that defers the receipt of compensation?

A-7: No. A cafeteria plan does not include any plan that offers a benefit that defers the receipt of compensation, with the exception of the opportunity for participants to make elective contributions under a qualified cash or deferred arrangement defined in section 401(k). Thus, employer contributions made at a participant's election to a profit-sharing plan containing a qualified cash or deferred arrangement will be treated as nontaxable benefits under a cafeteria plan.

In addition, a cafeteria plan does not include a plan that operates in a manner that enables participants to defer the receipt of compensation. Generally, a plan that permits participants to carry over unused benefits or contributions from one plan year to a subsequent plan year operates to enable participants to defer the receipt of compensation. This is the case regardless of whether the plan permits participants to convert the unused contributions or benefits into another benefit in the subsequent plan year. For example, a plan that offers participants the opportunity to purchase vacation days (or to receive cash or other benefits under the plan in lieu of vacation days) will not be a cafeteria plan if participants who purchase the vacation days for a plan year are allowed to use any unused days in a subsequent plan year. This is the case even though the plan does not permit the participant to convert, in the subsequent plan year, the unused vacation days into any other benefit. In determining whether a plan permits participants to carry over unused vacation days, a participant will be deemed to have used his nonelective vacation days (i.e., the vacation days with respect to which the participant had no election under the plan) before his elective vacation days. For example, assume that an employer provides a participant with three weeks of vacation for a year and, under the plan, the participant is permitted to receive cash or other benefits in lieu of one of these three weeks. Assume that the participant elects not to exchange the one elective week of vacation for another benefit. If the participant uses two weeks of vacation during the year, he will be treated as having used the two nonelective weeks of vacation. Thus, if the participant is permitted to carry the one unused week over to the next year, the plan will be treated as operating to enable participants to defer the receipt of compensation. Thus, the plan will fail to be a cafeteria plan and the section 125 exception to the constructive receipt rules will not apply.

In addition, a plan that allows participants to use employer contributions for one plan year to purchase a benefit that will be provided in a subsequent plan year operates to enable participants to defer the receipt of compensation.

Q-8: What requirements apply to participants' elections under a cafeteria plan?

A-8: A plan is not a cafeteria plan unless the plan requires that participants make elections among the benefits offered under the plan. A plan may provide that elections may be made at any time. However, benefit elections under a cafeteria plan should be made in accordance with certain guidelines (see Q&A-15) in order for participants to qualify for the protections of the section 125 exception to the constructive receipt rules. An election will not be deemed to have been made if, after a participant has elected and begun to receive a benefit under the plan, the participant is permitted to revoke the election, even if the revocation relates only to that portion of the benefit that has not yet been provided to the

participant. For example, a plan that permits a participant to revoke his election of coverage under a dependent care assistance program or of coverage under an accident or health plan after the period of coverage has commenced will not be a cafeteria plan. However, a cafeteria plan may permit a participant to revoke a benefit election after the period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage if both the revocation and new election are on account of and consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of child, and termination of employment of spouse).

Q-9: What is the tax treatment of benefits offered under a nondiscriminatory cafeteria plan?

A-9: A participant in a nondiscriminatory cafeteria plan will not be treated as having received taxable benefits offered under the plan and thus will not be required to include the benefits in gross income solely because the plan offers the participants the opportunity, before the benefits become currently available to the participant, to elect to receive or not to receive the benefits. Section 125 thus provides an exception to the constructive receipt rules that apply with respect to empoloyee elections among nontaxable and taxable benefits (including cash). These constructive receipt rules generally provide that an individual will be required to include in gross income the taxable benefits that he could have elected to receive if the individual had the opportunity to elect to receive or not to receive the benefits event though both the opportunity to make this election occurs and the actual election is made before the benefits become currently available to the individual. Section 125 does not, however, alter the application of the constructive receipt rules to a situation in which benefits become currently available to an individual even though the individual elects not to receive and does not actually receive the benefits. Thus, if taxable benefits become currently available to a participant in a nondiscriminatory cafeteria plan, the participant will be taxable on the benefits, even though the participant has elected or subsequently elects not to receive the benefits and does not actually receive the benefits.

Q-10: What is the tax treatment of benefits offered under a discriminatory cafeteria plan?

A-10: The section 125 exception to the constructive receipt rules is not available to the highly compensated participants in a cafeteria plan that is discriminatory for a plan year. Thus, a highly compensated participant in a cafeteria plan that is discriminatory for a plan year will be taxable on the combination of the taxable benefits with the greatest aggregate value that he could have selected for the plan year. The section 125 exception to the constructive receipt rules remains available to participants who are not highly compensated without regard to whether the cafeteria plan is discriminatory.

Q-11: How are the amounts taxable to a highly compensated participant because a cafeteria plan is discriminatory for a plan year to be allocated among the benefits actually selected by the participant for the plan year?

A-11: A highly compensated participant in a discriminatory cafeteria plan is taxable on the maximum taxable benefits that he could have selected for the plan year. For example, assume that a cafeteria plan provides a highly compensated participant with the opportunity to select, for a plan year, benefits costing $1300 from among the following: up to $300 in cash, coverage under an accident or health plan providing medical expense reimbursement (cost of $600), coverage under an accident or health plan providing disability benefits (cost of $200), coverage under a qualified legal services plan (cost of $400), and coverage under a dependent care assistance program (cost of $400). For the plan year in question, the participant elects to receive $100 in cash, coverage under both of the accident or health plans ($600 and $200), and coverage under the dependent care assistance program ($400). If the cafeteria plan is discriminatory for the plan year, the participant will be taxable on the $100 cash benefit actually selected and on the $200 cash benefit that the participant could have selected. This $300 will be allocated, first, to the taxable benefits actually selected by the participant and, second, on a pro rata basis to the nontaxable benefits actually selected by the participant. Thus, $100 is allocated to the $100 cash benefit actually received and the $200 is allocated as employee contributions among the nontaxable benefits actually selected as follows: $100 to coverage under the accident or health plan for medical care, $33.33 to the coverage under the accident or health plan for disability benefits, and $66.67 to the coverage under the dependent care assistance program. This allocation would not affect the nontaxable status of any of these benefits -- the purchase of coverage under any of these plans with employee contributions would not trigger

taxable income -- but it may affect the taxability of amounts received under any of the plans. In addition, depending upon whether other conditions are satisfied, the participant may be able to deduct under section 213 some or all of the employee cost of the coverage under the accident or health plan for medical care. Thus, reimbursements received by the participant for medical care expenses incurred during the year of coverage may be nontaxable under either section 104(a)(3) or section 105(b), depending upon whether the reimbursements are attributable to after-tax employee or pre-tax employer contributions. Also, if the participant became disabled during the year of coverage, benefits provided under the accident or health plan would be nontaxable to the participant under section 104(a)(3) to the extent that the benefits were attributable to the portion of the coverage purchased with the after-tax employee contributions. Finally, any reimbursements received under the dependent care assistance program for the year of coverage will be nontaxable under section 129 if the requirements of that section are satisfied.

Q-12: When must a highly compensated participant in a discriminatory cafeteria plan include in gross income amounts attributable to the taxable benefits that the participants could have selected, but did not in fact select?

A-12: Amounts required to be included in gross income by a highly compensated participant because a cafeteria plan does not satisfy the applicable nondiscrimination standards for a plan year will be treated as received or accrued in the participant's taxable year within which ends the plan year with respect to which an election was or could have been made.

Q-13: Who are highly compensated participants under section 125?

A-13: The term "highly compensated participant" means a participant who is an officer, a shareholder owning more than 5 percent of the voting power or value of all classes of stock of the employer, or highly compensated. The classification of a participant as highly compensated for this purpose will be made on the basis of the facts and circumstances of each case. A spouse or a dependent (within the meaning of section 152) of any such "highly compensated participant" will be treated as highly compensated.

Q-14: When will a benefit be treated as currently available to a participant in a cafeteria plan?

A-14: A benefit is treated as currently available to a participant if the participant is free to receive the benefit currently at his discretion or the participant could receive the benefit currently if an election or notice of an intent to receive the benefit were given. A benefit will not be treated as not currently available merely because of a requirement that the participant must elect or give notice of intent to receive the benefit in advance of receipt of the benefit. However, a benefit is not currently available to a participant if there is a substantial limitation or restriction on the participant's receipt of the benefit. A benefit will not be treated as currently available if the participant may under no circumstances receive the benefit before a particular time in the future and there is a substantial risk that, if the participant does not fulfill specified conditions during the period preceding this time, the participant will not receive the benefit.

Q-15: What procedures with respect to benefit elections should a cafeteria plan adopt in order to assure that participants are not subject to tax, under the constructive receipt rules, on taxable benefits that the participants have elected not to receive?

A-15: Generally, in order for participants to avoid constructive receipt with respect to taxable benefits offered under a cafeteria plan, the taxable benefits must at no time become currently available to the participants. Thus, a cafeteria plan should require participants to elect the specific benefits that they will receive before the taxable benefits become currently available. A benefit will not be treated as currently available as of the time of the election if the election specifies the future period for which the benefit will be provided and the election is made before the beginning of this period.

In addition, after the beginning of the specified period for which the benefits are provided, the taxable benefits must not become currently available to the participants. After the commencement of this period, taxable benefits will be

treated as currently available if participants have the right to revoke their elections of nontaxable benefits and instead to receive the taxable benefits for such period, without regard to whether the participants actually revoke their elections. For example, assume that a cafeteria plan offers each participant the opportunity to elect, for a plan year, between coverage under a dependent care assistance program for up to $2000 of the dependent care expenses incurred by the participant during the plan year or a cash benefit of $2000 for the year. If the plan requires participants to elect between these benefits before the beginning of the plan year and, after the year has commenced, the participants are prohibited from revoking their elections, participants who elected coverage under the dependent care assistance program will not be taxable on the cash benefit of $2000. But if, after the beginning of the plan year, participants have the right to revoke their elections of coverage under the dependent care assistance program and thereby to receive the cash benefit, the participants will be treated as having received the $2000 in cash even though they do not revoke their elections. The same result would obtain even though the cash benefit is not payable until the end of the plan year. See Q&A-8, however, regarding the revocation of elections on account of changes in family status.

Q-16: Do the rules of section 125 affect whether any particular benefit offered under a cafeteria plan is a taxable or nontaxable benefit?

A-16: Generally, no. A benefit that is nontaxable under its Internal Revenue Code when offered separately is treated as a nontaxable benefit under a cafeteria plan only if the rules providing for the exclusion of the benefit from gross income continue to be satisfied when the benefit is offered under the cafeteria plan. For example, if $50,000 in group-term life insurance is offered under a cafeteria plan and the rules under section 79(a) governing the exclusion of the cost of this benefit from gross income are satisfied, the rules of section 79(d) still apply to determine the status of the benefit as taxable or nontaxable for key employees who participate in the plan. See Q&A-17 and Q&A-18, however, regarding the inclusion of coverage under an accident or health plan, dependent care assistance program, or qualified group legal services plan in a cafeteria plan.

Similarly, if a cafeteria plan offers benefits that are nontaxable under the Internal Revenue Code when offered outside of a cafeteria plan, but are prohibited from inclusion in a cafeteria plan, the benefits will be treated as taxable benefits under the cafeteria plan. Thus, coverage under a qualified transportation plan (section 124) and coverage under an educational assistance program (section 127) will be treated as taxable benefits if offered under a cafeteria plan. Also, any benefits (either reimbursement for expenses or in kind benefits) received by a participant under a qualified transportation plan or an educational assistance program will be taxable if the benefits are provided under a cafeteria plan.

Finally, if a benefit that is taxable under the Internal Revenue Code when offered separately is offered under a cafeteria plan, the benefit will continue to be a taxable benefit under the cafeteria plan. For example, if a cafeteria plan offers a participant the opportunity to direct the employer to make charitable contributions or contributions to an individual retirement account on behalf of the participant, such contributions must be included in the participant's gross income for income and employment tax purposes without regard to whether the plan satisfies section 125 and without regard to whether the contributions are deductible by the participant.

Q-17: How are the specific rules of section 105, providing an income exclusion for amounts received as reimbursement for medical care expenses under an accident or health plan, to be applied when coverage under an accident or health plan is offered as a benefit under a cafeteria plan?

A-17: Section 105(b) provides an exclusion from gross income for amounts that are paid to an employee under an employer-funded accident or health plan specifically to reimburse the employee for certain medical care expenses incurred by the employee during the period for which the benefit is provided to the employee, i.e., the period during which the employee is covered under the accident or health plan. Section 105(h) provides that the exclusion provided by section 105(b) is not available with respect to certain amounts received by a highly compensated individual (as defined in section 105(h)(5)) under a discriminatory self-insured medical reimbursement plan. Several rules are of particular importance when coverage under an accident or health plan is a benefit offered under a cafeteria plan.

First, in order for medical care reimbursements paid to a participant under a cafeteria plan to be treated as nontaxable under section 105(b), the reimbursements must be paid pursuant to an employer-funded "accident or health plan," as defined in section 105(e) and § 1.105-5. This means that, although the reimbursements need not be provided under a commercial insurance contract, the reimbursements must be provided under a benefit that exhibits the risk-shifting and risk-distribution characteristics of insurance. A benefit will not exhibit the required risk-shifting and risk-distribution characteristics, even though the benefit is provided under a commercial insurance contract, if the ordinary actuarial risk of the insurer is negated either under the terms of the benefit or by any related benefit or arrangement (including arrangements formally outside of the cafeteria plan).

Second, a cafeteria plan benefit under which a participant will receive reimbursements of medical expenses is a benefit within sections 106 and 105(b) only if, under the benefit, reimbursements are paid specifically to reimburse the participant for medical expenses incurred during the period of coverage. Amounts paid to a participant as reimbursement are not treated as paid specifically to reimburse the participant for medical expenses, if, under the benefit, the participant is entitled to the amounts, in the form of cash (e.g., routine payment of salary) or any other taxable or nontaxable benefit, irrespective of whether or not he incurs medical expenses during the period of coverage, even if the participant will not receive the amounts not used for expense reimbursement until the end of the period. A benefit under which participants will receive reimbursement for medical expenses up to a specified amount and, if they incur no expenses, will receive cash or any other benefit in lieu of the reimbursements is not a benefit that qualifies for the exclusions under sections 106 and 105(b). See § 1.105-2. This is the case without regard to whether the benefit was purchased with contributions made at the employer's discretion, at the participant's discretion (such as pursuant to a salary reduction agreement), or pursuant to a collective bargaining agreement. For example, if a cafeteria plan offers participants coverage under an employer-funded plan that provides for the reimbursement of medical expenses incurred during the plan year up to a specified amount (e.g., $1,000) and the participants are entitled to receive, in the form of any other taxable or nontaxable benefits (including deferrals under a cash or deferred arrangement), any portion of the specified amount that is not paid as reimbursement for medical expenses, the employer contributions used to purchase the coverage will not qualify for the section 106 exclusion and any reimbursements paid to participants for expenses incurred during the year of coverage will not be eligible for the section 105(b) exception. Arrangements formally outside of the cafeteria plan that provide for the adjustment of a participant's compensation or a participant's receipt of any other benefits on the basis of the expenses incurred or reimbursements received by the participant will be considered in determining whether the reimbursements are provided under a benefit eligible for the exclusions under sections 106 and 105(b).

Third, the medical expenses that are reimbursed under an accident or health plan must have been incurred during the period for which the participant is actually covered by the accident or health plan in order for the reimbursements to be excluded from gross income under section 105(b). For purposes of this rule, expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed, charged for, or pays for the medical care. Also, for purposes of this rule, medical expenses that are incurred before the later of the date the plan is in existence and the date the participant is enrolled in the plan will not be treated as having been incurred during the period for which the participant is covered by the plan. Thus, in order for reimbursements to be excluded from gross income under section 105(b), the accident or health plan must provide a participant the right to reimbursement for medical expenses incurred during a specified period of plan coverage. Reimbursements of expenses incurred prior to or after the specified period of coverage will not be excluded under section 105(b). However, the actual reimbursement of covered medical care expenses may be made after the applicable period of coverage.

Fourth, in order for reimbursements under an accident or health plan to qualify for the section 105(b) exclusion, the cafeteria plan may not operate in a manner that enables participants to purchase coverage under the accident or health plan only for periods during which the participants expect to incur medical care. For example, if a cafeteria plan permits participants to purchase coverage under an accident or health plan on a month-by-month or an expense-by-expense basis, reimbursements under the accident or health plan will not qualify for the section 105(b) exclusion. If, however,

the period of coverage under an accident or health plan offered in a cafeteria plan is twelve months (or, in the case of a cafeteria plan's initial plan year, at least equal to the plan year) and the plan does not permit a participant to select specific amounts of coverage, reimbursement, or salary reduction for less than twelve months, the cafeteria plan will be deemed not to operate to enable participants to purchase coverage only for periods during which medical care will be incurred. See Q&A-8 regarding the revocation of elections during a period of coverage on account of changes in family status.

Fifth, in order for reimbursements to a highly compensated individual under a self-insured accident or health plan to be treated as nontaxable under a cafeteria plan, the discrimination rules of section 105(h) must be satisfied. For purposes of these rules, coverage under a self-insured accident or health plan offered by a cafeteria plan will be treated as an optional benefit (even if only one level and type of coverage is offered) and, for purposes of the optional benefit rule in § 1.105-11(c)(3)(i), employer contributions will be treated as employee contributions to the extent that taxable benefits are offered by the plan. In addition, the accident or health plan offered by the cafeteria plan must provide for the nondiscriminatory reimbursement of expenses on a per capita basis, rather than as a proportion of compensation.

Q-18: How are the specific rules of section 129, providing an income exclusion for dependent care assistance provided under a dependent care assistance program, to be applied when coverage under a dependent care assistance program is offered as a benefit under a cafeteria plan?

A-18: Section 129(a) provides an employee with an exclusion from gross income both for employer-funded coverage under a dependent care assistance program and for amounts paid or incurred by the employer for dependent care assistance provided to the employee if the amounts are paid or incurred under a dependent care assistance program. A program under which participants receive reimbursements of dependent care expenses up to a specified amount and are entitled to receive, in the form of any other taxable or nontaxable benefits, any portion of the specified amount not used for reimbursement is to be treated as a single benefit that is not a dependent care assistance program within the scope of section 129. Thus, dependent care assistance provided under a cafeteria plan will be treated as provided under a dependent care assistance program only if, after the participant has elected coverage under the program and the period of coverage has commenced, the participant does not have the right to receive amounts under the program other than as reimbursements for dependent care expenses. This is the case without regard to whether coverage under the program was purchased with contributions made at the employer's discretion, at the participant's discretion, or pursuant to a collective bargaining agreement. For example, assume a cafeteria plan allows participants to elect to receive, for a particular plan year, either the right to reimbursements of dependent care expenses incurred during the year up to $2000 or a cash benefit of $2000. If the participant elects the right to receive reimbursements of dependent care expenses, the reimbursements will not be treated as made under a dependent care assistance program if, after the period of coverage has commenced, the participant has the right to revoke his election of this benefit and instead to receive the cash or if, under the terms of the program itself, the participant is entitled to receive, in the form of cash (e.g., routine payment of salary) or any other benefit, any amounts not reimbursed for dependent care provided during the period of coverage. Arrangements formally outside of the cafeteria plan that provide for the adjustment of a participant's compensation or a participant's receipt of any other benefits on the basis of the assistance or reimbursements received by the participant will be considered in determining whether a dependent care benefit is a dependent care assistance program under section 129.

Moreover, in order for dependent care assistance to be treated as provided under a dependent care assistance program eligible for the section 129 exclusion, the care must be provided to or on behalf of the participant during the period for which the participant is covered by the program. For example, if a participant elects coverage for a plan year under a dependent care assistance program that provides for the reimbursement of dependent care expenses, only reimbursements for dependent care expenses incurred during that plan year will be treated as having been provided under a dependent care assistance program within the scope of section 129. For purposes of this rule, dependent care expenses will be treated as having been incurred when the dependent care is provided, and not when the participant is formally billed, charged for, or pays for the dependent care. Also, for purposes of this rule, expenses that are incurred before the later of the date the program is in existence and the date the participant is enrolled in the program will not be

treated as having been incurred during the period for which the participant is covered by the program. Similarly, if the dependent care assistance program furnishes the dependent care in kind (e.g., under an employer-maintained child care facility), only dependent care provided during the plan year of coverage will be treated as having been provided under an dependent care assistance program within the scope of section 129.

In addition, in order for dependent care assistance under a cafeteria plan to be treated as provided under a dependent care assistance program eligible for the section 129 exclusion, the plan may not operate in a manner that enables participants to purchase coverage under the program only for periods during which the participants expect to receive dependent care assistance. If the period of coverage under a dependent care assistance program offered by a cafeteria plan is twelve months (or, in the case of a cafeteria plan's initial plan year, at least equal to the plan year) and the plan does not permit a participant to select specific amounts of coverage, reimbursement, or salary reduction for less than twelve months, the plan will be deemed not to operate to enable participants to purchase coverage only for periods during which dependent care assistance will be received. See Q&A-8 regarding the revocation of elections during the period of coverage on account of changes in family status.

Finally, if coverage under a dependent care assistance program is a benefit offered under a cafeteria plan, the rules of section 129 will determine the status of the benefit as a taxable or nontaxable benefit. As a result, coverage under a dependent care assistance program in a cafeteria plan will be nontaxable for a plan year only if, among other requirements, the principal shareholder and owner discrimination test contained in section 129(d)(4) is satisfied with respect to employer contributions actually used to provide participants with dependent care assistance during the plan year. In addition, amounts paid or incurred by the employer under a dependent care assistance program are excludable from gross income only to the extent that these amounts do not exceed the lesser of the participant's earned income or the participant's spouse's earned income.

Rules similar to the rules applicable to dependent care assistance program apply with respect to coverage under a qualified group legal services plan (section 120) offered as a benefit under a cafeteria plan.

Q-19: what are the rules governing whether a cafeteria plan is discriminatory?

A-19: The applicable discrimination rules under section 125 provide that, in order to be treated as nondiscriminatory for a plan year, a cafeteria plan must not discriminate in favor of highly compensated participants as to benefits and contributions for that plan year. Generally, this discrimination determination will be made on the basis of the facts and circumstances of each case. Section 125(c) provides that a cafeteria plan does not discriminate where either (i) total nontaxable benefits and total benefits or (ii) employer contributions allocable to total nontaxable benefits and employer contributions allocable to total benefits do not discriminate in favor of highly compensated participants. A cafeteria plan must satisfy section 125(c) with respect to both benefit availability and benefit selection. Thus, a plan must give each participant an equal opportunity to select nontaxable benefits, and the actual selection of nontaxable benefits under the plan must not be discriminatory, i.e., highly compensated participants do not disproportionately select nontaxable benefits while other participants select taxable benefits.

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

Q-20: May nontaxable benefits provided under a cafeteria plan be counted as "compensation" under section 401(a)(5) for purposes of determining whether a qualified pension, profit-sharing, or stock bonus plan discriminates under section 401(a)(4), or under section 415 for purposes of the limitations contained in that section?

A-20: A qualified pension, profit-sharing, or stock bonus plan will not be treated as discriminatory within the meaning of section 401(a)(4) merely because, for purposes of allocating contributions to the participant or calculating

the participant's benefit under the plan, the plan considers nontaxable benefits provided to a participant as compensation. For example, if a participant in a cafeteria plan elects coverage under an accident or health plan, the value of such coverage may be considered as compensation under a qualified plan for purposes of calculating the participant's allocation or benefit under the qualified plan. Nontaxable reimbursements under the accident or health plan, however, generally may not be treated as compensation under a qualified plan. Similarly, the value of coverage under a dependent care assistance program may be counted as compensation under a qualified plan for allocation and benefit purposes, but nontaxable reimbursements of dependent care expenses under the program generally may not be treated as compensation for these purposes. On the other hand, a qualified plan will not be treated as discriminatory under section 401(a)(4) merely because the plan does not consider nontaxable benefits, such as coverage under an accident or health plan or coverage under a dependent care assistance program, as compensation for allocation or benefit purposes under the plan.

For purposes of section 415, "compensation" does not include amounts that are excluded from gross income, such as premiums for group-term life insurance under section 79 or employer contributions to an accident or health plan excluded under section 106.

Q-21: What are the effective dates of the rules contained in these questions and answers?

A-21: These rules contained in questions and answers relating to section 125 generally shall apply to plan years of cafeteria plans beginning after December 31, 1978. However, a cafeteria plan that failed to satisfy one or more of the following rules for plan years beginning before May 7, 1984 will not be deemed thereby to have failed to satisfy section 125 for such plan years if, by September 4, 1984, the plan is amended to operate in accordance with these rules: (i) the rules requiring certain information to be included in the cafeteria plan document (Q&A-3), (ii) the rules governing the active participation of a participant's spouse in a cafeteria plan (Q&A-4). (iii) only in the case of a plan under which participants were permitted neither to carry over unused benefits for more than one plan year nor to convert, into any other benefits, any unused benefits that had been carried over to a subsequent plan year, the rules prohibiting the carryover of any unused contribution or benefit from one plan year to a subsequent plan year (Q&A-7), and (iv) the rules limiting the revocability of benefit elections (Q&A-8). A cafeteria plan may treat the portion of its current plan year remaining after September 4, 1984 as a new period of coverage for purposes of satisfying the rules governing benefit elections (Q&A-8). Also, a benefit offering participants the opportunity to make elective contributions under a qualified cash or deferred arrangement may be included in a cafeteria plan only in plan years beginning after December 31, 1980.

The rules contained in Q&A-17 governing the taxability of coverage and benefits under an accident or health plan relate specifically to sections 105 and 106 and thus generally are effective with respect to all taxable years beginning after December 31, 1953. The rules contained in Q&A-18 governing the taxability of coverage and benefits under a dependent care assistance program relate specifically to section 129 and thus generally are effective with respect to all taxable years beginning after December 31, 1981. The rules contained in Q&A-18 governing the taxability of coverage and benefits under a qualified group legal services plan relate specifically to section 120 and thus generally are effective with respect to all taxable years beginning after December 31, 1976. However, if coverage under an accident or health plan, dependent care assistance program, or qualified group legal services plan was offered as a benefit under a cafeteria plan and such benefit failed to satisfy, before May 7, 1984, the rule prohibiting a plan from operating to enable a participant to elect coverage under an accident or health plan, a dependent care assistance program, or a qualified group legal services plan only for periods during which the participant expects to receive medical care, dependent care, or legal services (Q&A-17 and Q&A-18), such benefit will not be deemed solely on account of such failure to have failed to satisfy the statutory rules providing for the income exclusion of such coverage or of any benefits provided thereunder, if, by September 4, 1984, the cafeteria plan is amended to operate in accordance with such election of coverage rule. A cafeteria plan may treat the portion of its current plan year remaining after September 4, 1984 as a new period of coverage and as an initial plan year for purposes of satisfying the rule prohibiting a plan from operating to enable participants to elect coverage under an accident or health plan, dependent care assistance program, or qualified

group legal services plan only for periods during which they expect to receive medial care, dependent care, or legal services (Q&A-17 and Q&A-18).

In addition, if the conditions set forth below are satisfied, employer contributions (including elective and nonelective contributions) made before June 1, 1984, under an arrangement described in the next sentence which is part of a cafeteria plan, will not be treated as having been made to an accident or health plan, dependent care assistance program, or qualified group legal services plan that fails to satisfy the rules contained in the second and third paragraphs of Q&A-17 and the first paragraph of Q&A-18, merely because, for a plan year, a participant was entitled to receive, in the form of cash or any other taxable or nontaxable benefit, amounts available for reimbursement under the arrangement without regard to whether covered expenses are incurred. An arrangement is described in this sentence only if, under the arrangement,

(i) An account was actually established on behalf of the participant by the employer, by an entry on the employer's books or in similar fashion, prior to the beginning of the plan year (or prior to the date on which an individual first becomes eligible to participate under the arrangement in the case of an individual who first becomes eligible to participate, on account of years of employment, during the plan year);

(ii) The amount (or specific rate) of contributions to the account under the arrangement was fixed prior to the beginning of the plan year;

(iii) Neither the participant nor the employer possessed the right to increase or decrease contributions to the account during the plan year (but a plan may provide that contributions could be terminated during the year on account of the participant's (a) separation from service or (b) cessation of participation under the arrangement for the remainder of the plan year);

(iv) Contributions were actually deposited in or credited to the account before being made available for reimbursement; and

(v) Distributions were not available for reasons other than reimbursement of covered expenses until the end of the plan year (but a plan may provide that a single distribution of the unreimbursed balance may be made on account of the participant's (a) separation from service or (b) cessation of participation under the arrangement for the remainder of the plan year).

A cafeteria plan may operate on a plan year other than the calendar year for purposes of this transitional rule, so long as terms of the plan permit contributions to a plan to be fixed only once during, and a distribution of the unreimbursed amount to be received, only once for any plan year, provided that contributions may be fixed for a short plan year of the plan's first period of operation. This transitional rule does not affect or alter the requirement of Q&A-17 and-18 that expenses that are reimbursed under an arrangement must have been incurred during the period for which the participant actually is covered by the arrangement.

Roscoe L. Egger, Jr.,

Commissioner of Internal Revenue.

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APPENDIX O

Tax Policy Memorandum No. 95-07

TO: All U.C. Tax Division Staff

FROM: Donald W. Russell, Jr., Director, U.C. Tax Division

SUBJECT: Taxability Of Cafeteria Plan Benefits

DATE: June 27, 1995

Purpose: The purpose of this Tax Policy Memorandum is to establish policy with regard to the taxability of benefits provided under Cafeteria Plans.

References: Ohio Revised Code, section 4141.01 (H) (1) (a); divisions (b) (2) to (b) (16) of section 3306 of the "Federal Unemployment Tax Act," 84 Stat. 713, 26 U.S.C. A. 3301 as amended; and the Internal Revenue Service Circular E, Employer's Tax Guide.

Background: The taxability of benefits provided under Cafeteria Plans is not specifically addressed in the Ohio Revised Code, or the Ohio Administrative Code.

Section 4141.01 (H) (1) (a) of the O.R.C. excludes from the term "Remuneration" any payment excluded under the provisions of section 3306, Divisions (b) (2) to (b) (16) of the "Federal Unemployment Tax Act, "84 Stat. 713, 26 U.S.C.A. 3301, as amended;

Section 3306, Division (b) (5) (G) of the Federal Unemployment Tax Act excludes the amount of any payment "under a Cafeteria Plan (within the meaning of section 125) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received."

Policy: Through consultation with the Internal Revenue Service, we have determined that with the exception of cash payment(s) received by an employee

in lieu of other benefits, payments made under a "Qualified" Cafeteria Plan (within the meaning of section 125) are generally excluded under the Federal Unemployment Tax Act. Therefore, pursuant to section 4141.01 (H) (1) (a) of the O.R.C., this type of payment is excluded under the Ohio Unemployment Compensation Law as well.

The Internal Revenue Service employs the following general guidelines in determination of a "Qualified" plan:

1. The plan must be in written format.

2. The plan must contain a description of benefits offered.

3. The plan must include rules of eligibility (class or classes of employees who may participate).

4. The plan must have a procedure which governs election to participate (open enrollment periods, etc.)

5. The plan must outline the manner in which contributions are made under the plan.

6. The plan must define maximum contributions which are permitted.

7. The plan must define the plan year (i.e.; fiscal or calendar).

The Internal Revenue Service does not have a formal procedure requiring employers to submit established plans for approval. Nor does the IRS, under normal circumstances, issue any type of letter of exemption relative to wage reduction under a Cafeteria Plan.

Should employers require additional information or definition regarding the IRS's treatment of Cafeteria Plans, they should be referred to the IRS at 1-800-829-1040.