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On behalf of the Employers Council on Flexible Compensation ("ECFC"), we are submitting comments on the proposed cafeteria plan regulations published in the August 6, 2007 Federal Register (the "Proposed Regulations"). We appreciate the receptiveness of the Treasury Department/Internal Revenue Service to input from the employer/plan sponsor, benefits administrator and service provider community.

ECFC is a non-profit membership association committed to the study and promotion of 401(k) plans, cafeteria plans, and other elective compensation plans. The members of ECFC are plan sponsors, corporations, governments, unions, universities, hospitals, and clinics as well as leading actuarial, insurance, administrative and accounting firms that design and administer flexible benefit plans. Founded in 1981, ECFC has great expertise in designing and administering compensation and benefit programs that offer flexibility for employers and employees.

In response to the request for further comment in the Proposed Regulations we would like to express several questions and concerns relating to cafeteria plans. We raise these issues below in the order in which they appear in the Proposed Regulations.

I. Prop. Treas. Reg. § 1.125-1

1. Supplemental Military Pay Treated as Permitted Taxable Benefit

Issue: According to Rev. Rul. 69-136, the IRS does not consider differential pay (the difference between military pay and the civilian pay prior to leave) provided by an employer to employee on military leave as "wages" subject to withholding because the IRS treats such employees as terminated from employment (despite the fact that the Department of Labor and the USERRA regulations treat such individuals as on furlough or leave of absence). The IRS has not previously issued formal guidance indicating whether differential pay would qualify as cash or a cash equivalent (or under new terminology—a "permitted taxable benefit") under a cafeteria plan. Even if such employees are properly treated as former employees, the regulations are clear that former employees may participate in a cafeteria plan. Moreover, differential pay is still included in income and otherwise subject to constructive receipt—the principal reason a cafeteria plan is implemented. Thus, we see no reason to treat differential pay differently than other compensation treated as wages.

Suggested Revision: Please clarify that differential pay (much like severance) is a "permitted taxable benefit" as defined in Prop. Treas. Reg. §1.125-1(a)(2).

2. Taxable Disability Pay Treated as Permitted Taxable Benefit

Issue: Many employers provide short or long term disability benefits to employees. In some cases, these benefits are funded through the employer's general assets (*e.g.*, as salary continuation) and are treated as normal W-2 "wage" compensation. In other cases, such benefits are paid from a separate trust fund (which may or may not be a VEBA trust). These benefits may be included in the employee's W-2 from the employer (*e.g.*, when the employer controls payments from the trust) or, more frequently, on a W-2 issued by the benefits trust. The IRS has not previously issued formal guidance indicating whether disability pay from a trust associated with an employer-sponsored plan would qualify as cash or a cash equivalent (or under new terminology—a "permitted taxable benefit") under a cafeteria plan. Even if such employees are properly treated as former employees, the regulations are clear that former employees may participate in a cafeteria plan.

Suggested Revision: Please clarify that disability pay from a trust associated with an employer-sponsored plan (much like severance) is a "permitted taxable benefit" as defined in Prop. Treas. 1.125-1(a)(2).

3. COBRA Premiums as Qualified Benefits:

Issue: Prop. Treas. Reg. § 1.125-1(a)(3) indicates that COBRA premiums are qualified benefits. More specifically, 1.125-1(a)(3) indicates the following with respect to COBRA premiums that constitute "Qualified Benefits" for purposes of cafeteria plan rules:

> 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 an employer sponsoring the cafeteria plan under an accident and health plan sponsored by a different employer.

Also, Prop. Treas. Reg. § 1.125-1(l) indicates that COBRA premiums 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.

The two sections of the proposed regulations identified above -- read in conjunction with one another -- indicate that any COBRA premium that is excluded from income under Code § 106 is a non-taxable qualified benefit. The question that arises is whether this includes only COBRA coverage elected by the employee or COBRA coverage elected by the employee or spouse and dependent children as well. The proposed regulations do not specifically reference COBRA coverage of a spouse or dependent child. There is little question that COBRA coverage elected by an employee or former employee qualifies for the exclusion under Code § 106. Admittedly, Code § 106 is less clear regarding coverage maintained by a spouse/dependent but guidance issued by the IRS regarding employer provided coverage for a surviving spouse suggests that 106 applies both to coverage maintained by the employee and/or the spouse/tax dependents (see Rev. Rul. 82-196). In addition, Treas. Reg. § 1.125-4(c)(3)(iv) specifically contemplates election changes under the plan to accommodate increases in pre-tax salary reductions for COBRA coverage elected by a spouse or dependent child who is a tax dependent. We acknowledge that the Prop. Treas. Reg. § 1.125-1(g)(4) prohibits spouses and dependents from "participating" in the plan; however, such an approach does not appear to run afoul of this prohibition because only the employee will be provided the opportunity to make the election under the cafeteria plan.

Suggested Revision: We recommend adding language to the regulations to clarify that the following COBRA contributions constitute non-taxable qualified benefits under an employer's cafeteria plan:

- Continuation coverage as provided in Code § 4980B (or any similar state or federal law) for the employee, spouse, and/or dependent child(ren) *elected by the employee* under a health plan sponsored or contributed to by the employee's employer (including a multiemployer employer plan)
- Continuation coverage as provided in Code § 4980B (or any similar state or federal law) for the employee, spouse, and/or dependent child(ren) *elected by an employee* under a health plan sponsored or contributed to by the employee's former employer (including a multiemployer employer plan
- Continuation coverage as provided in Code § 4980B (or any similar state or federal law) of an employee's spouse under the plan sponsored or contributed to by the spouse's current or former employer (including a multiemployer employer plan)
- Continuation coverage as provided in Code § 4980B (or any similar state or federal law)of the employee's dependent child under a health plan sponsored or contributed to by the employer or a former employer of the employee, spouse or child (including a multiemployer employer plan)

In addition, please provide clarification regarding the ability to revoke the prior election to pay for COBRA premiums through the employer's cafeteria plan once the employee, spouse or dependent becomes eligible for the employer's health plan. For example, assume that Bob terminates employment with Employer A and then becomes employed by Employer B. B sponsors a health plan but there is a 90 day waiting period. Consequently Bob elects COBRA under A's health plan. B allows Bob to pay for his COBRA premiums under A's Health Plan through B's cafeteria plan. Presumably, the right to revoke the election under B's cafeteria plan to pay premiums for COBRA coverage under A's plan and elect health plan coverage under B's plan arises under Treas. Reg. § 1.125-4(f)(4)—change in coverage under another plan.

Finally, please clarify that the reference to COBRA coverage reflects that it encompasses similar coverage continuation such as USERRA coverage, state and federal law continuation coverage and COBRA coverage continuation under a multiemployer plan.

4. Premium Only Plan

Issue: The proposed regulations create a safe harbor exemption for "premium only plans" from the contributions and benefits test set forth in Prop. Treas. Reg. § 1.125-7(c) to the extent such plan passes the eligibility test set forth in Prop. Treas. Reg. § 1.125-7(b) (see Prop. Treas. Reg. § 1.125-7(f)). Prop. Treas. Reg. § 1.125-1(a)(5) defines "premium only plan" as a cafeteria plan that only offers a choice between cash and payment of the employer provided accident and health *insurance* premiums. At least one interpretation of (a)(5)—in particular the restrictions on choice to accident and health "insurance"—is that the premium only plan exemption applies only to fully insured health plans.

This potential interpretation does not appear to be based on substantive legal reasons. Legally, we see no reasonable basis for distinguishing between fully insured and self insured coverage in this instance. In fact, Code § 105(h), which prohibits non-discriminatory benefits in favor of highly compensated individuals, would prohibit the same type of discrimination that the 125 contributions and benefits test is designed to prevent so the legal justification for exempting premium only plans from the 125 contributions test still exists—in fact it may be more justified with respect to self insured accident and health coverage since there are no such nondiscrimination tests for fully insured accident and health coverage. Instead, this potential interpretation will arise from differences in terminology between the regulations and the Code. Code § 106 uses the term "accident and health plan."

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-1(a)(5) to add a clarification similar to that in Code § 105(e) that "accident and health insurance" includes coverage under a Code § 106 accident and health plan for employees (including HSA contributions) other than coverage under a flexible spending arrangement as defined in Code § 106(c)(2).

In addition, we recommend replacing the term "cash" with "permitted taxable benefits" to ensure consistency with the rules.

5. Dual Status Individuals

Issue: Example #1 under Prop. Treas. Reg. § 1.125-1(g)(2)(iii) indicates that an individual who is self employed at the beginning of the year but later becomes an employee of the corporation is deemed to be self employed for the entire year. This raises a significant question. What is the proper treatment of an individual who is an employee at the beginning of the year and then becomes a self employed individual during the same year? Is this individual treated as an employee for the entire year or is the individual treated like a self employed individual as of the date of the status change?

There are two desired but alternative outcomes in this situation: First, an individual who begins the year as an employee but changes to self employed during the year should be treated as an employee for the entire year—just as an individual who is self employed at the beginning of the year is treated as self employed for the entire year. Alternatively, the rule reflected in Example #1 should be revised such that a self employed individual who becomes an employee during the year is treated as an employee on and after the effective date of the status change.

Suggested Revision: We believe that the second interpretation noted in the preceding paragraph (ineligible prospectively) is the correct interpretation. Also, presumably, the change from self employed

to common law employee, or vice versa, is an "employment status change" described in Treas. Reg. § 1.125-4(c)(2)(iii). Please clarify whether these interpretations are correct.

Issue: Clarification is needed with respect to the prohibition of partners from participating in a cafeteria plan. Partners are not considered employees and therefore may not participate in a cafeteria plan. IRC §1372 generally provides that for fringe benefit purposes, more than 2% shareholders of an S Corporation are treated as partners in a partnership.

There are situations where an individual may be employed in two capacities – both as a partner and as an employee in another entity that is part of an affiliated service group or controlled group with the partnership (or deemed partnership in the case of an S Corporation). While it is clear that the individual cannot participate in a cafeteria plan in his or her capacity as a partner, it is not clear whether such individual may participate in the plan with respect to compensation received from the entity that is not a partnership or S Corporation.

Suggested Revision: We recommend that the regulations clarify that such individual may participate in the cafeteria plan with respect to compensation received as an employee even though the individual may also be a partner (or deemed partner under IRC § 1372) in another entity that is part of an affiliated service group or a controlled group that includes the entity sponsoring the cafeteria plan.

Issue: It is not clear as to the extent to which members of a Limited Liability Corporation (LLC) are treated as self-employed individuals. Based on the current guidance, if an LLC files as a partnership or S Corporation for tax purposes, then it appears that the members of the LLC should treated as partners or S Corporation members for cafeteria plan purposes. However, following that logic, if the LLC is taxed as a corporation, then the members of the LLC should be treated as employees for cafeteria plan purposes.

Suggested Revision: Please clarify how LLC members are treated for cafeteria plan purposes in these cases.

6. Individual accident and health insurance premiums

Issue #1: Prop. Treas. Reg. § 1.125-1(m) clarifies that employees' "substantiated" individual accident and health insurance premiums that are otherwise excluded under Code § 106 constitute "qualified benefits" for purposes of the cafeteria plan rules. Read literally, this provision is limited to policies maintained solely by the employee. Since the qualification as a qualified benefit appears to be conditioned on satisfaction of Code § 106, it would appear then that individual insurance policies maintained by spouses/dependents (to the extent they satisfy the "dependent" definition in Code § 105(b)) would also constitute a qualified benefit for purposes of Code § 125. [See discussion above regarding the application of Code § 106 to coverage of an employee and coverage of the employee's spouse/dependent].

Suggested Revision: We recommend adding language to indicate that premiums for individual policies maintained by the employee and/or the employee's spouse/dependent child constitute qualified benefits (to the extent that they are otherwise excluded under Code § 106).

We also request clarification regarding the definition of "substantiated"—especially with respect to direct reimbursement to the employee. Presumably, "substantiated" for purposes of direct reimbursement to the employee would follow the concepts set forth in Rev. Rul. 61-146, which indicated that employer provided reimbursement of an individual accident and health insurance policy is exempt from tax under Code § 106 provided that, among other things, the employee shows prior proof of payment. Examples of permissible methods of showing prior payment are also requested.

Issue #2: Last but not least, this provision of the proposed regulations has created much confusion with regard to two different issues related to the payment of premiums for individual policies with pre-tax salary reductions.

(a) First, many confuse the ability to pay for individual accident and health insurance premiums with pre-tax dollars under a cafeteria plan with the prohibition against reimbursement of premiums through a Health FSA under Prop. Treas. Reg. § 1.125-5(k)(4).

Suggested Revision: We recommend that the final regulations distinguish the two concepts. For example, in the case of permissible reimbursement of such premiums through the cafeteria plan, the employer would be required to approve in advance that the particular policy qualifies as an "accident and health insurance plan" under Code § 106 and the employee would be restricted under the plan to electing salary reductions amounts equal to the exact premium amount for that specific, pre-approved policy. Thus, the actual policy is offered through the plan and a salary reduction is made equal to the exact premiums under that policy. Whereas, ad hoc premium reimbursement from FSA funds set aside to reimburse general 213(d) medical expenses would be prohibited by Prop. Treas. Reg. § 1.125-5(k)(4). We suggest that the regulations incorporate a new defined term "Premium Reimbursement Account" to address this situation. NOTE: additional clarifications to the election change rules in Treas. Reg. § 1.125-4 are necessary to identify situations in which election changes may be made with respect to such policies. Currently, the election change rules seem to apply only to changes that impact coverage under an employer sponsored plan.

(b) Second, many confuse the ability to pay for individual insurance premiums with pre-tax salary reductions through a cafeteria plan under the cafeteria plan regulations as an absolute statement of approval of such practice under all federal laws—*e.g.*, HIPAA portability and nondiscrimination. Presumably, the proposed regulations simply indicate that Code § 125 is not violated to the extent that the requirements set forth in Prop. Treas. Reg. § 1.125-1(m) are satisfied and the regulations should not be construed to mean that inclusion of such benefits through the cafeteria plan and/or payment of the premiums for such policies with "employer" contributions (*e.g.*, pre-tax salary reductions) does not create issues under other applicable federal laws such as HIPAA.

Suggested Revision: We request language to clarify that satisfying the cafeteria plan regulations with respect to such policies should not be construed to mean that HIPAA and other federal laws are also satisfied.

7. Mandatory two-year election for vision or dental insurance

Issue: Prop. Treas. Reg. § 1.125-1(p)(4) indicates that the prohibition against providing benefits that deferred the receipt of compensation is not violated where a cafeteria plan offers vision and dental *insurance* that requires a mandatory two year coverage period to the extent certain conditions are satisfied. As noted above in #2 with regard to premium only plans, use of the term "insurance" implies that the rule applies only to fully insured coverage. We see no reasonable basis for distinguishing between fully insured dental and vision and self insured dental and vision in this instance.

Suggested Revision: We recommend that the regulations be revised to add a clarification similar to that in Code § 105(e) that "accident and health insurance" includes coverage under an accident and health plan for employees.

In addition, one of the two conditions that must be satisfied with respect to this rule is that no salary reductions or flex credits from the first year can be used to pay premiums in the second year of the two year coverage period. Presumably, the general exception to the deferred compensation prohibition set forth in Prop. Treas. Reg. § 1.125-1(p)(5)—salary reductions from last month of plan year may be used to pay for coverage in first month of subsequent plan year—applies equally in the case of dental and vision insurance with a mandatory two year coverage period. Consequently, we recommend that the regulations clarify that no amounts from the first year may be used to pay for coverage in the second year *except as otherwise permitted by the regulations.*

8. Using salary reductions from last month of plan year for coverage in first month of next plan year.

Prop. Treas. Reg. § 1.125-1(p)(5) indicates that a plan does not violate the deferred compensation rule solely because it uses salary reductions from the last month of the plan year to pay premiums for accident and health coverage provided in the first month of the subsequent plan year. Two issues arise with respect to this rule.

Issue #1: First, the use of the term "insurance" here (as in the other provisions identified above) implies that this exception does not apply to self insured accident and health coverage. We see no legal basis for distinguishing between self insured and fully insured in this instance and thus any confusion that may arise will result from general distinctions between "accident and health plan" and "accident and health insurance" coverage.

Suggested Revision: We recommend that the regulations be revised to add a clarification similar to that in Code § 105(e) that "accident and health insurance" includes coverage under an accident and health plan for employees.

Issue #2: Second, the regulations indicate that a grace period may apply to all qualified benefits (other than 401(k) and PTO) offered through the cafeteria plan (see Prop. Treas. Reg. § 1.125-1(e)(1)). The grace period function permits salary reductions from one plan year to be used for benefits provided during the "grace period," which is a period no longer than two months and fifteen days after the end of the plan year. Presumably, a plan that adopts a grace period for accident and health plan benefits would be permitted to use salary reductions from one plan year and apply them towards premiums for coverage not only in the first month of the next plan year as otherwise permitted in (p)(5) but also the second month and the first 15 days of the third month.

Suggested Revision: We recommend that the regulations be revised to indicate that the exception in (p)(5) applies to the extent that the plan has not adopted a grace period with respect to accident and health plan benefits.

9. Long-term care services

Issue: Prop. Treas. Reg. § 1.125-1(q)(1)(vi) indicates that long term care services are not "qualified" benefits under a cafeteria plan. Code § 125(f) indicates that any policy marketed, advertised or offered as "long term care" insurance is not a qualified benefit. Thus, it would appear from the statute, and also the proposed regulations, that any policy that is touted as long term care is not a qualified benefit. There is confusion regarding the scope of the long term policies addressed by (q)(1)(vi) and this confusion appears to arise from the prohibition in Code § 106(c) against reimbursement of "qualified" long term care services (as defined in Code § 7702B) from a health flexible spending arrangement. Qualified long term care expenses are those that are prescribed for someone who has been certified by a physician to be

"chronically ill." On the other hand, non-qualified long term care expenses are those that are provided for someone who has not been certified by a physician as "chronically ill." Based on the language in the statute, it would appear that long term care insurance in general, whether it provides qualified services or not, would be a "non-qualified benefit."

Suggested Revision: Please clarify whether prohibition applies to all "long term care" services or just "qualified" long term care services (as defined in Code § 7702B).

10. Allow for a de minimis rule for operational defects

Issue: Treas. Reg. § 1.125-1(c)(6) and (7) together provide that a plan is not a cafeteria plan if the plan is not in writing or fails to operate in accordance with its terms or otherwise fails to operate in compliance with Code § 125 or the regulations, and in such case, an employee's election between taxable and nontaxable benefits results in gross income to the employee.

Suggested Revision: We recommend revising Treas. Reg. § 1.125(c)(6) and (7) to provide that written plan defects or operational defects of a de minimis nature will not disqualify a plan or result in adverse tax consequences to employees if the plan sponsor takes appropriate action to correct the defect or prevent the defect(s) from recurring.

11. Transition Relief for New Inclusion Rule for Group Term Life Insurance.

Issue: IRS Notice 89-110 has set forth the inclusion rule for excess group term life insurance coverage paid for with salary reductions and/or flex credits under a cafeteria plan for *nearly twenty years*, and many ECFC members have worked meticulously to comply with that rule. Under the rule of Notice 89-110, 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 or employer flex credits used to pay for the excess group term life insurance coverage under the employer's cafeteria plan.

Prop. Treas. Reg. §1.125-1(k)(2) provides a new inclusion rule for excess group term life insurance offered under a cafeteria plan, effective August 6, 2007. Under the new rule, the amount includible in an employee's gross income is the Table I cost, subject to certain reductions for after-tax contributions. The entire amount of employee salary reductions and employer flex credits used to pay for excess group term life insurance coverage is excludible from the employee's income.

While ECFC members applaud the simplicity of the new rule, we also require time to transition to the new system. Both ECFC members who are imputing income for excess group term life insurance coverage on a payroll-by-payroll basis and those who impute income at the end of the year need transition relief. The calculation of imputed income is often automated as part of a larger payroll system. To require a change of this sort without advance warning and time to reprogram the necessary systems places too great a burden on employers. The IRS and Treasury recognized this issue in 1999 when Table I was last updated by providing an extended effective date on the new Table I rates.

Suggested Revision: ECFC members request that IRS and Treasury delay the effective date for the new rule until the first plan year following January 1, 2009, and to allow continued reliance on Notice 89-110 until that date. Additionally, because some ECFC members will be able to modify systems to take advantage of the new rule before that time, we request the ability to rely on the new rule effective August 6, 2007. We would need guidance providing this transitional relief on a faster track than the final regulations – as soon as possible prior to the end of 2007 so that employers can prepare and file accurate Forms W-2 for their employees.

II. Prop. Treas. Reg. § 1.125-2

1. Making and Revoking Elections

Issue #1: When are benefits currently available?
The proposed regulation provides that a plan must provide in writing that employees are permitted to make elections among the benefits offered for the plan year. All elections must be irrevocable (to the extent provided in the regulations) and must be made before the earlier of: A) the date when taxable benefits are currently available, or B) the first day of the plan year or other coverage period. As in prior proposed regulations, elections generally only may be made on a prospective basis.

When is a benefit currently available?

- Cash or another taxable benefit is currently available if it has been paid to the employee (*e.g.*, salary) or if the employee currently is able to receive the cash or taxable benefit at the employee's discretion.
- 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.
- A benefit is not currently available if the employee cannot receive it until a future date.

The proposed regulation also provides that "[t]he 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 [sic] section 451." The meaning of this statement is not entirely clear. This language is similar to election language in the Section 401(k) regulations. Does this suggest that, similar to Section 401(k) elections, an election can be made any time on or before the first pay date relating to the election? It's possible that such an election could occur during a coverage period (as opposed to prior to the first day of the pay period). This interpretation would be in conflict with the general election language cited above, which says that elections must be made before the coverage period begins (the period during which the benefits are provided.) Or perhaps this statement signifies that the traditional concept of constructive receipt provided in Section 451 is not entirely applicable to cafeteria plans. For purposes of a cafeteria plan, the IRS uses a slightly altered view of constructive receipt that differs from other benefit arrangements like 401(k) plans and qualified transportation plans. For example, under a qualified transportation plan, the IRS permits employees to revoke or change elections at any time before that salary paying for the benefit is earned. Under the cafeteria plan regulations, an election, even if it relates to salary not yet earned, may be changed only in limited circumstances (*i.e.*, change of election regulations) once the coverage period has begun.

Suggested Revision: Please clarify the intended meaning of the statement regarding Section 451.

Issue #2: **Incorporating the change of election regulations**.
Section 1.125-2(a)(4) relating to exceptions to the irrevocable election rule provides that the change in status rules in the final Section 1.125-4 regulations may be incorporated into a cafeteria plan. However, Section 1.125-4 relates to election changes for more than just change in status events. The Section 1.125-4 regulation also covers cost and coverage changes, and other rules that would permit a participant to change their elections. It is not clear whether this is an oversight or intentional.

Suggested Revision: Please clarify that the exception in Section 1.125-2(a)(4) relating to exceptions to the irrevocable election rule applies to the change of election rules as a whole.

Also, we understand that the IRS is not currently examining the Section 1.125-4 regulations at this time. An annual eligibility requirement is not readily apparent in the section 125 statute. Perhaps for the future, please reconsider those election change rules and provide for elections to be consistent with elections made for qualified transportation plans and HSAs where elections may begin, be changed or revoked prior to the pay period for which the benefits received relate (*e.g.*, on a prospective basis).

Issue #3: **Pre-tax and after-tax elections.**

Although considerable reference is given to after-tax contributions to a cafeteria plan (see Section 1.125-1(h)), there is no discussion of how taxable elections may be changed during the plan year. The types of elections that are irrevocable under the cafeteria plan rules are not clear. Is it pre-tax contributions? Does it also include an after-tax contribution? Does it include a particular insurer? Is it a matter of plan design? We would submit that the cafeteria plan election that the IRS has a tax interest in regulating is the pre-tax contribution -- that amount that the employee could have received as cash. Hand in hand with this is the election for a particular benefit option such as a health FSA or DCAP, but not a particular insurance carrier or coverage, such as an HMO or a PPO. The concept of what is considered to be "elected" through a cafeteria plan is indicated in the HSA comparability regulations. Those regulations provide that an HSA is offered through a cafeteria plan when "employees have the right to elect to receive cash or other taxable benefits in lieu of all or a portion of an HSA contribution (*i.e.*, all or a portion of the HSA contributions are available as pretax salary reduction amounts), regardless of whether an employee actually elects to contribute any amount to the HSA by salary reduction." Thus, it would seem that, subject to plan design, the pre-tax amounts would be considered the "election" regulated under the IRS rules, while after-tax elections would be outside the scope of these rules. After-tax elections for benefits should not be subject to the same restrictions as pre-tax elections and should be permitted to be changed at any time.

Suggested Revision: Please clarify exactly what election is considered irrevocable under the cafeteria plan rules.

Issue #4: Corrective measures
We believe that corrective measures to a cafeteria plan election, either for an administrative error or a discriminatory plan found during a plan year, for example, should be permissible under Section 1.125-2. In many cases, the IRS has given an informal nod to correcting errors or scaling back elections for a discriminatory plan, but not all employers are privy to this informal guidance, and thus, not all employers are on equal footing. For example, many feel their hands have been tied when it comes to correcting a mistake of election that is clearly erroneous. Employers would like to have some definitive guidance permitting corrective measures.

Suggested Revision: In the case of an administrative error, or where clearly an error has been made, the plan should be permitted to correct the error as if it had not been made. This should not be seen as an election change under the Section 1.125-4 regulations, but as implementing the election as it was originally intended, had the mistake or error not been made. Thus, the change of election rules and/or concept of a prospective change should not be implicated. For example, where an employee election confirmation statement shows a $500 election to a health FSA, but the administrator implements a $5,000 election, the error should be corrected as if had never been made.

The IRS may wish to set some limitations or parameters around such corrections. For example, changes for erroneous elections will only be permitted if discovered within the first 3 months of the plan year. The IRS may also wish to set parameters about the types of mistakes that are permissible to be corrected, such as an election from which the employee, spouse or dependents may not benefit (*e.g.*, a dependent

care election where the employee has no eligible dependents), where clearly the plan administrator has made a mistake implementing the election (*e.g.*, implementing a $120 election where the election confirmation statement shows a $1, 200 election), or where the employer feels there is clear evidence of an error. The Section 1.125-1 rules requiring consistent application of the cafeteria plan as written and in operation provides a disincentive for employers to allow disingenuous "corrections" and abuse a corrective measure provision. This type of corrective measure should also be applied to an employee who is entered into a default election at the beginning of their coverage period. The employee should have this same period of time in which to change from the default election.

Additionally, we recommend permitting reducing elections for highly compensated or key employees when a plan is found to be discriminatory (mid-year). Reducing the elections for highly compensated or key employees to comply with discrimination rules could preserve a portion of their tax-advantaged elections to the cafeteria plan. Employers who run nondiscrimination tests during the plan year, attempting to keep their cafeteria plan in compliance with the law, should be rewarded by being allowed to adjust elections for highly compensated or key employees, and permitting those employees to have a portion of their elected amount excluded from income.

2. Automatic Elections

Issue: Automatic or default elections are permitted in a cafeteria plan. The examples in section 1.125-2 provide for a default election included both a default election for employees who fail to timely elect into the cafeteria plan and also for subsequent year elections. Specifically, example (iv) describes default elections and the implications for new and current employees. The example provides that, "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."

First, it appears from the example that a current employee gets the benefit of an open enrollment period to change his election, while a new employee must make his election immediately, "when the employee is hired." It would seem reasonable to allow a newly hired employee to have at least a 30 day window to change this default election. Additionally, for a current employee, the election is made prior to the start of each "calendar year." Not all cafeteria plans are provided on a calendar year basis. Although it is an example, perhaps more appropriate wording would be "before the beginning of the cafeteria plan year."

Suggested Revision: It would be helpful if the IRS would clarify this example.

3. Optional Election Period for New Employees

The proposed regulations provide one exception to the general prospective election rule. A cafeteria plan can allow new employees 30 days after their date of hire in which to elect into the cafeteria plan, and be covered back to their date of hire. For instance, if an employer sponsors a cafeteria and makes new employees eligible for benefits on their first day at work, the new employee can take up to 30 days to elect into the plan and receive coverage back to the date of hire. However, salary reduction for the coverage must be deducted from compensation not yet available on the date of the election.

Issue #1 : Application to flexible spending accounts?
It would appear that this optional election period for new employees would apply to all benefits options offered under the cafeteria plan, including health and dependent care FSAs.

Suggested Revision: Confirmation of this application would be helpful.

Issue #2: 30-day rule does not work well for employee hired mid-month or at the end of a month when coverage starts at the beginning of the following month or where there is a waiting period.
The proposed regulation provides in Section 1.125-2(d) that a plan may permit new employees 30 days after their hire date to make elections and the election will be effective as of the date of hire. The regulation provides that salary reductions used to pay for this retroactive coverage must be from prospective compensation (*e.g.*, salary not yet earned). The regulation also provides in Section 1.125-2(a)(2) that an appropriate election 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 coverage period." This principal plays out nicely when coverage begins either (1) when the election is made or (2) at the end of a 30-day election period. For example, if an employee is hired on September 24th and coverage begins at the end of the 30-day election period, the employee can elect coverage on or before October 24th and receive coverage relating back 30 days to the date of hire, September 24th. But for many plans, coverage begins on the first of the month following the date of hire, even though the employee might be given 30 days to make an election. When coverage begins at the first of the month, the 30-day rule and the "earlier of" rule, when read together, effectively negate the value of this provision for someone who is hired near the end of the month. For example, if an employee is hired on September 24th and coverage under the health plan begins on the first of the month, October 1st, to receive coverage back to the date of hire, the employee will have 5 days to make his cafeteria plan elections. Because coverage commences at the beginning of each month (this is the first day of the coverage period), this employee's election must be made before October 1st, which is the "earlier of" date described above.

Suggested Revision: Please clarify how the 30-day rule and the "earlier of" rule operate together in instances of coverage beginning on the first of the month. Also, application of this rule to new employees who might be acquired through a merger or acquisition would also be valuable. Although these employees might not be considered "newly hired," they are "newly eligible" because they were acquired through a stock sale, for example, they would be receiving new benefits and making benefit elections in the same way as a newly hired employee. In that regard, it would also seem appropriate to extend this rule to employees who become newly eligible for a benefit either (1) during the plan year (*e.g.*, through a change in status event, a significant cost or coverage change or the introduction of a new benefit), or (2) at the start of a new plan year (e.g., a 30-day period to elect benefits with the election relating to the first day of the plan year or coverage period, whichever is earlier). Thus, application of this rule to those individuals acquired through a merger or acquisition or those newly eligible for the employer's benefit plan would be helpful.

III. Prop. Treas. Reg. § 1.125-5

1. Terminated Employees.

Issue: Prior informal guidance from the Service indicated that an employer could collect salary reduction contributions from a terminated employee's last paycheck. Prop. Treas. Reg. § 1.125-5(d)(3) seems to restrict this ability with respect to FSAs (health, dependent care and adoption assistance). It provides that an FSA must pay a terminated employee any amount the former participant previously paid for coverage to the extent that the previously paid amounts relate to the period after the employee ceases to be a participant. Read too literally, this could mean that an employer could not collect FSA contributions from a terminated employee's last paycheck, if those contributions related to a future period.

Suggested Revision. This presents an administrative issue for employers in that an employer could deduct premiums for health coverage from a last paycheck, but apparently not for FSA coverage. We think that as long as the coverage continues (*i.e.*, the individual is still a participant, albeit a terminated employee) that contributions for future coverage periods should be allowed (as long as consistent with FSA plan document provisions). Therefore, we recommend that this rule be clarified, and be replaced with a rule allowing employers to deduct FSA contributions from a terminated employee's last paycheck, even if the coverage amount relates to a future period (*e.g.,* through the end of the month).

2. Advance Orthodontia Expenses.

Issue: Prop. Treas. Reg. § 1.125-5(k)(3)(i) provides that a health FSA may reimburse participants for orthodontia services before the services are provided but only to the extent that the employee has actually made the payments "in order to receive the services." This language appears to suggest that advance reimbursement is only allowed if the advance payments are required. Thus, if the dental provider does not require advance payment for services, but merely permits advance payment, the FSA may not reimburse that amount in advance of the services being provided.

Suggested Revision. The above rule presents an issue for claims administrators because they would have to request additional proof that any advance payment is required, or at the very least have the participant certify that the advance payment is required. Further, to some extent, whether an advance payment is "required" or is "permitted" is a point of negotiation between the FSA participant and the dental provider. Therefore, to ease the additional burden on administrators that this rule would require and to simplify the reimbursement rule for FSA participants, we request that advance reimbursements of orthodontia expenses be allowed regardless of whether the advance payment is required or is permitted by the dental provider.

3. Advance Prenatal and Other Expenses.

Issue: The "orthodontia rule" in Prop. Treas. Reg. § 1.125-5(k)(3)(i) does not allow advance reimbursement of other expenses before the services are provided. Depending on the rules of the particular health care provider, certain other expenses are typically required to be paid in advance of the services being provided. Expenses that fall into this category include pre-natal expenses, child delivery expenses (hospital and the physician charges), surgical expenses and other dental treatments (such as root canal treatments).

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

Further, any health care provider can request to be paid in advance of performing any health services, and if the payment and the services span two plan years, this could create problems for FSA participants who have planned to use their FSA funds in a certain plan year.

Suggested Revision. We recommend expanding the orthodontia rule to include any Code § 213(d) expense that is paid in advance of an extended course of treatment/services being provided (e.g., pre-natal, surgical expenses, and dental treatments such as root canals).

4. Long Term Care.

Issue: Code § 106(c) provides that a health FSA may not reimburse qualified long term care services (as defined in Code § 7702). However, the Code does not prohibit the reimbursement of so-called "unqualified" long term care services. Prop. Treas. Reg. § 1.125-5(k)(4) provides that a health FSA may not reimburse expenses for "long term care services," without discussing whether that prohibition includes qualified or unqualified long term care services, or both.

Suggested Revision. We recommend revising the proposed regulations to adhere to the Code rule. Thus, reimbursement for qualified long term care services should be prohibited, but reimbursement of unqualified long term care services should be allowed.

5. Bona Fide Mistakes.

Issue: The new proposed regulations do not contain any exceptions for correcting FSA election mistakes. Election mistakes for cafeteria plan elections are common, especially for health and dependent care FSA elections. Regardless of the amount of information that employers provide for open enrollment, some employees will still elect dependent care FSA coverage when they really wanted to elect health FSA coverage. Further, some employees fail to understand the qualified individual rules for dependent care FSAs, and end up electing dependent care when they do not have a qualified individual. Many times these election mistakes are not discovered until after the beginning of the period of coverage when the employee files a claim.

Suggested Revision. While it is difficult to craft a well-worded exception that is both useful and not subject to abuse at the same time, we request that the Treasury and the Service allow the correction of FSA election errors due to a bona-fide mistake. A bona-fide mistake could be defined by using a safe harbor approach, such as certain mistakes are deemed to be bona fide mistakes (*e.g.,* electing dependent care FSA coverage when the person has no children) while others are based on the facts and circumstances. Further, the correction rule should take into account the fact that these errors are usually not discovered until after the period of coverage commences.

6. Mid-Year Plan Terminations.

Issue: Due to corporate mergers and acquisitions, many plan sponsors terminate FSA plans mid-year. Confusion exists regarding how to calculate FSA participants' coverage amounts after the termination date. For example, if a participant elects a $5,000 annual coverage amount and the plan is terminated mid-year on June 30th, the participant would have a coverage amount of $5,000 up to June 30th. After June 30th, it is unclear whether the participant would still have a $5,000 coverage amount for claims incurred on or before June 30th, or whether the coverage amount should be pro-rated to $2,500 to account for the short plan year.

Suggested Revision. Additional guidance is needed with respect to FSA terminations mid-year with respect to the operation of the uniform coverage rule. We request that this guidance provide that a FSA participants' annual coverage amount can be pro-rated based on the short plan year created by a mid-year plan termination.

7. Code § 105(h).

Issue: The proposed regulations (Prop. Treas. Reg. § 1.125-5(l)) provide that the nondiscrimination rules that apply to self-funded health plans under Code § 105(h) apply to health FSAs. The regulation further provides that a health FSA is treated as an "optional benefit" under Code § 105(h) and that, if taxable benefits are offered by the FSA, employer contributions are treated as employee contributions for purposes of the "optional benefit rule" under Treas. Reg. § 1.105-11(c)(3)(i).

Suggested Revision. The Code § 105(h) Treasury regulations pre-date health FSAs. The significance of the treatment as an "optional benefit" and the reference to the "optional benefit rule" is therefore unclear and should be described in greater detail in these regulations. We believe that this cross reference would mean that any FSA eligible employees would be treated as an FSA participant for purposes of the 105(h) eligibility test (although this is not entirely clear). We recommend providing an example concerning how these rules are intended to apply to health FSAs.

8. FSA/HSA Transfer.

Issue: The proposed regulations (Prop. Treas. Reg. § 1.125-5(n)) are apparently intended to include all of the rules described in Notice 2007-22. However, there is no mention of either of the following rules:

- Distribution must result in a zero balance in transferring account.
- Account balances must be "frozen" on the last day of the plan year and distributed within 2-1/2 months.

Suggested Revision. We request that the IRS simplify the rules described in Notice 2007-22 regarding tax-free transfers from health FSAs by eliminating the above requirements. It is administratively burdensome to require an employer to adopt a grace period for a health FSA simply to facilitate a tax-free transfer to an HSA, and we do not believe it should be necessary for the distribution to result in a zero balance. However, if these requirements cannot be eliminated, we request that the regulations clearly specify the circumstances in which these rules apply.

9. Post-deductible FSAs.

Issue: The proposed regulations (Prop. Treas. Reg. § 1.125-5(m)(4)) state that a post-deductible health FSA is one that reimburses expenses only after the deductible under the high deductible health plan is satisfied. Under Code § 223, a high deductible health plan is any plan with a deductible that equals or exceeds the statutory deductible in the Code. Accordingly, a post-deductible health FSA should satisfy all applicable requirements if it does not reimburse expenses below the statutory minimum in Code § 223, whether or not the deductible under the high deductible health plan is satisfied (this is the position the IRS took in Rev. Rul. 2004-45). Further, the proposed regulation states that an expense that is incurred before the deductible is satisfied may not be reimbursed from the post-deductible health FSA, even if such reimbursement is not made until after the minimum deductible is satisfied. There does not appear to be any statutory basis for this requirement.

Suggested Revision. Please clarify that a post-deductible health FSA satisfies all applicable requirements if it does not reimburse expenses below the statutory minimum in Code § 223, whether or not the deductible under the high deductible health plan is satisfied. Further, the IRS should consider allowing any qualified expense, whenever it is incurred, to be reimbursed from a post-deductible health FSA once the statutory deductible for the year has been satisfied.

IV. Prop. Treas. Reg. § 1.125-6

1. Timing of when expense is incurred.

Issue: 1.125-6(a) provides that an expense must be incurred after the later of the effective date and the date the employee is enrolled, and during the coverage period. The new proposed regulations in 1.125-2 allow for retroactive enrollment in certain cases.

Suggested Revision. Please clarify that retroactive enrollment in FSAs is permitted (pursuant to 1.125-2), and that FSA expenses incurred prior to the actual date of enrollment, but within the permissible retroactive enrollment period are reimbursable.

2. Issues related to Dependent Care expense timing.

Issue 1: It is a fairly common practice for certain seasonal employers (e.g., public school groups) to allow salary reductions for dependent care benefits (DCAP) to be pro-rated during the school year (regardless of whether employees are on a 9 month or 12 month pay cycle). Thus, for example, assuming monthly paychecks, and an election of $5,000 for dependent care, 1/9th of the $5,000 amount would be withheld from each paycheck. The language in 1.125-6(a)(4)(iii) was, presumably, intended to curtail elections that correlate to a specific incurred expense.

Suggested Revision. Please provide confirmation that the mere correlation of DCAP salary reductions to a work cycle (e.g., seasonal or annual) is permissible.

Issue 2: Example 1 in 1.125-6(a)(4) addresses the reimbursement of non-refundable child care fees. In the example, consistent with the recent dependent care tax credit regulations, the expense is not eligible for reimbursement until the dependent care commences. An example should be included confirming that a non-refundable placement fee paid in one calendar year (e.g., October, 2007) can be reimbursed with salary reduction amounts in a subsequent year (*e.g.*, 2008) where the care commences in a subsequent calendar year (*e.g.*, March of 2008).

Issue 3: Many dependent care providers require that dependent care expenses be paid in advance (*e.g.*, at the beginning of the month) of the time that care is to be provided. For a dependent care FSA participant, the provider may require advance payment at the same time that amounts are withheld for future DCAP reimbursements. This "double-pay" situation causes a financial hardship for those least able to pay for dependent care even though the routine predictable nature of dependent care expenses leaves little room for abuse. The IRS should consider a modification to the "expense incurred" rule to allow dependent care expenses of up to a certain specified period (*e.g.*, one month or 1/12th of the annual DCAP maximum) to be deemed to have been incurred when paid (even though services might subsequently be rendered).

3. Participant Certification requirement.

Issue: Prior proposed regulations required that participants certify that medical claims have not been reimbursed and would not be reimbursed from another source. This seems to have been included in the discussion of EOB reimbursement (1.125-6(b)(3)(ii)) but is not otherwise addressed. Presumably the participant certification requirement (as stated above) still applies. With regard to EOB substantiation, most participants enroll in such arrangements before the beginning of the year, and certify *at that time* that they either have no other coverage or will not submit the claim for reimbursement under any other plan (as contrasted with a participant certification provided after the claim is incurred).

Suggested Revision. Please provide confirmation that the advance certification *in the EOB rollover context* is permissible.

4. Timing of Expense substantiation.

Issue: 1.125-6(b)(4) provides that expenses cannot be reimbursed prior to substantiation.

Suggested Revision: Please clarify that the process set forth in 1.125-6(e)(3) for certain auto-adjudicated claims at medical providers does not run afoul of this requirement (*i.e.*, the process adequately substantiates claims).

5. Debit Card Guidance Generally.

Issue: The process for auto-adjudicating claims through the use of electronic payment card technology has evolved over the last ten or so years, and the rate of new developments is accelerating. No one can predict whether (and how) more sophisticated electronic payment card technologies will evolve in the future. The language set forth in 1.125-6(c)(3) seems to allow the IRS flexibility to address such future card processing evolution.

Suggested Revision: Please provide a formal approval process (*e.g.*, via letter ruling) for newly created substantiation techniques. Development in this area should not be stunted by a codification of existing accepted processing techniques.

Issue: Debit card receipts for qualified purchases may include hundreds of nominal purchases. At times IRS officials have informally indicated that debit card receipts should be retained for a period of time (*e.g.*, one year) after the close of the plan year in which the transaction occurs. The final regulations should clarify that participants need only retain receipts for 12 months following the close of the plan year in which a transaction occurs.

6. Claims processing based upon merchant or terminal identification number (Merchant ID or Terminal ID).

Issue: Many cases exist where health care providers that provide goods or services that are almost exclusively Section 213(d) eligible health care expenses do not have a medical provider merchant category code (as described in 1.125-6(d)(5)(i). In some cases the card payment card "swipe box" might have been acquired from a non-medical provider. More frequently, the health care provider is part of a larger entity (*e.g.*, a university hospital system) that is coded differently for MCC purposes. Card processors and FSA administrators are able to identify such providers by merchant identification number (Merchant ID) and/or terminal identification number (Terminal ID) and have achieved a high degree of certainty that the charges from such health care providers consist exclusively of eligible health care expenses. On previous occasions, IRS and Treasury officials have indicated that they would consider expanding the treatment provided under Rev. Rul. 2003-43 to encompass such situations. Indeed, such technology can actually be more precise at identifying a health care transaction than MCC. In this regard, it is important to note that such an approach has been found to be adequate substantiation for transit card substantiation purposes (see Rev. Rul. 2006-57).

Suggested Revision. The proposed regulations should be modified to allow for Merchant and/or Terminal ID arrangements to be treated under the rules set forth in 1.125-6(e) provided that 90% or more of expenses are eligible medical expenses.

7. Use of debit cards for COBRA continuees.

Issue: Prior guidance (Rev Rul 2003-43) seemed to restrict debit card use to active employees. 1.125-6(d)(4) seems to allow for card use as long as plan participation (including presumably COBRA) continuees.

Suggested Revision. The final regulations should confirm that continued card use for COBRA continuees is allowable. However, this should be an elective plan feature only, and not required (either by Section 125 or the COBRA rules).

8. Inclusion of statement on back of card.

Issue: 1.125-6(d)(2) requires that cards include a statement *on the card* that the employee certification requirements set forth in 1.125-6(d)(1) are re-affirmed each time the card is used. Standard practice in the electronic payment card industry is to address terms and conditions of card use in the plan document, SPD, and/or cardholder terms and conditions. These are all legally binding agreements.

Suggested Revision. The final regulations should remove the requirement that such statements actually be included on the card (where there is very little print space) provided that the requirement is in the enrollment materials, plan document or SPD, and/or the cardholder terms and conditions.

9. Use of debit cards issued to spouse or tax dependents for eligible expenses. It is a fairly common practice for health FSA debit cards to be issued to a health FSA plan participant for use by a spouse (and less frequently other eligible tax dependents) to be used in connection with purchasing eligible medical expenses. Prior to issuance, the participant agrees (through the cardholder terms and conditions and enrollment materials) that he/she (and other individuals to whom a card is issued) will only use the card for eligible expenses.

Suggested Revision. Consistent with informal comments from agency officials, the final regulations should confirm that this practice is permissible.

10. Multipurse card issues.

Issue: Many plans use "multi-purse" card arrangements whereby the same card can be used (under a variety of circumstances) to access FSA funds and/or funds from other accounts (*e.g.*, an HSA, or unrestricted credit account). In such cases, all of the rules in 1.125-6 are satisfied with respect to withdrawals from the FSA "purse." On the other hand, the FSA rules do not apply to non-FSA purses, so the 1.125-6 restrictions should not apply. Overly broad language in 1.125-6(d)(1 and 3) seems to suggest that the "card" (as opposed to the FSA purse under the card) must be limited to eligible expenses and to the FSA election amount.

Suggested Revision. The final regulations should clarify that this restriction applies only to FSA amounts accessed through a health FSA debit card – thereby enabling a single card to be used for non-FSA governed transactions.

11. Issues arising under Rev. Rul. 2003-43 and 1.125-6(e) and Suggested Revisions.

a) Previously, IRS officials have informally commented that the applicable "pay and chase" procedures described in 1.125-6(d)(7) could be applied in any order as long as treating the payment as general indebtedness of the employer was employed as a recovery method of last resort. By way of example, TPAs have almost universally discovered that "offsetting" otherwise eligible expenses provides for an immediate Plan recovery of unsubstantiated expenses and works more effectively than turning the card "off." The final regulations should clarify that the "pay and chase" mechanisms can be employed in any order as long as treating the un-recovered amount as "general business indebtedness" is applied last.

b) The final regulations should clarify that wage withholding and a Form W-2 are not required for uncollected amounts that are treated as "general business indebtedness" under the pay and chase process. If any reporting of such amounts is required at all, we believe that a Form 1099 should be issued (only for amounts in excess of $600).

c) The final regulations should clarify that an offset (as described in 1.125-6(d)(7)(iv) can occur in a subsequent plan year (*i.e.*, when the pay and chase process spans two plan years). Requiring such an offset to occur within 2 ½ months after the end of the plan year (as extended by any grace period) should ensure that no deferred compensation issue arises. Thus, for example, if an unsubstantiated expense occurs in 2007, an offset of eligible expenses incurred up until March 15, 2008 should be allowed (or, if longer, 2 ½ months after the end of any applicable grace period).

12. Comments related to Inventory Information Approval System (IIAS) and 1.125-6(f)

(a) 1.125-6(d)(3) requires that an IIAS system satisfy the requirements (including recordkeeping) set forth in 1.105-2, 1.125-1. 1.125-6, and Section 6001. In this regard, we believe it is sufficient for a health FSA plan to merely retain (or have access upon an audit request) the list of eligible medical products (described in 1.125-6(f)(2)(i)) used with regard to debit card purchases. Requiring that actual transaction information be retained is overly burdensome (especially in light of HIPAA's extensive privacy and security requirements) when access to the list should provide an adequate method for claims substantiation. In this regard, it is a common practice in the health care industry to provide health care services based on a prescribed list of covered services, and further claims-level detail is not required for expense reimbursement under a health FSA. For example, most third party administrators allow for reimbursement of prescription drug and HMO claims based solely on submission of "co-payment" information without further investigating specific medical services that have been provided. This process has been recognized as valid by IRS with regard to the "EOB rollover" concept and should equally apply in connection with health FSA claims generally.

(b) The proposed regulations retain the requirement that participants retain receipts for debit card transactions in 1.125-6(d)(1). Given that other system based substantiation methods are employed (*e.g.*, IIAS based on an approved list or co-pay match), we believe that the participant should be relieved of the obligation to keep (and retain) paper receipts. If the receipt requirement is retained, we believe that the duration for participant receipt retention should be restricted to be no more than 1 year after the close of the plan year in which the expense is incurred.

14. Debit card arrangements employed for dependent care expenses.

Issue: Consistent with Notice 2006-69, 1.125-6(g) describes how debit cards can be used to substantiate eligible dependent care expenses. Unfortunately, the described process requires that dependent care expenses be incurred *and substantiated* before future reimbursements, based on the previously incurred (or a lesser) amount and dependent care provider, are allowed for expenses incurred at the same dependent care provider. Very few dependent care FSA administrators employ this process due to its complexity.

Suggested Revision: In lieu of (or in addition to) this process, we believe that the final regulations should allow arrangements whereby payment can be made whenever the card system can determine that the payee is a dependent care provider (*i.e.*, without the requirement that the expense first be substantiated by non-electronic means). We believe that adequate safeguards exist to ensure that amounts are used exclusively for dependent care expenses as long as the debit card system can verify (by MCC, Merchant ID, or Terminal ID) that the payee is a dependent care provider. Concerns over whether the expense has been incurred (*i.e.*, care has actually been rendered) can be addressed by including language in the plan/SPD and/or cardholder agreement.

V. Prop. Treas. Reg. § 1.125-7

1. Penalties

Issue #1: The all-or-nothing nature of the penalties. The 2007 proposed regulations have two objective utilization tests: the 25% key employee concentration test, and the new aggregate-benefits-measured-as-a-percentage-of-aggregate-compensation test. If a plan fails the 25% key employee concentration test, then key employees get taxed on the full value of their salary reductions, plus the value of other taxable benefits with the greatest value that they could have elected to receive. If a plan fails the new aggregate-benefits-measured-as-a-percentage-of-aggregate-compensation test, then highly compensated participants (HCPs) get taxed on the full value of their salary reductions, plus the value of other taxable benefits with the greatest value that they could have elected to receive.

Suggested Revision: We recommend revising the regulations to provide that key employees and HCPs get taxed only on excess benefits—the benefits that exceed the nondiscrimination threshold. This could be accomplished by permitting an employer, within 12 months after the close of the plan year being tested, to recharacterize key employees' or HCPs' salary reductions as after-tax contributions, with such recharacterized salary reductions being included in the key employees' or HCPs' gross income (reported on Form W-2). Such a recharacterization approach is available to 401(k) plans as a mechanism to avoid failing the ADP test. See Treas. Reg. §§ 1.401(k)-2(b)(1)(i)(C) and (b)(3) (2004). For example, if after the close of the plan year it is discovered that key employees received 28% of the nontaxable benefits, the 25% key employee concentration test would be failed by 3%. Assume that the 3% represents $10,000 of nontaxable benefits received by key employees. To avoid failing the test, the employer would be permitted to recharacterize $10,000 of the key employees' salary reductions as after-tax contributions. The salary reductions of the key employee with the highest dollar value of salary reductions would be reduced by the amount required to cause that key employee's salary reductions to equal the dollar amount of the salary reductions for the key employee with the next highest dollar amount of salary reductions, and so on until a total of $10,000 in salary reductions has been recharacterized.

Suggested Revision: Revise Prop. Treas. Reg. § 1.125-7(m)(2) to provide examples of the amount to include in a HCP's or key employee's income when a plan is discriminatory. For instance, one example

could provide that if a cafeteria plan offers health insurance benefits and health FSA benefits, and the employer's only contribution is 75% of the health insurance premium for those employees who elect health insurance (there is no cash-out option for those who do not elect health insurance), and if an HCP or key employee elects health insurance funded $250 by salary reduction and $750 by employer contribution plus $2,000 of health FSA benefits funded entirely by salary reduction, then the amount includable in the HCP's or key employee's income would be $2,250.

2. Definition of highly compensated individual and highly compensated participant.

Issue #1: Current-year rule for new hires and definition of "officer."

Suggested Revision: In the Prop. Treas. Reg. § 1.125-7(a)(9) definition of "highly compensated," please consider eliminating the current-year rule for new hires. Under the 2007 proposed regulations, a highly compensated individual or participant includes an employee 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 Code § 414(q)(1)(B) ($100,000 for both 2007 and 2006). Also, we recommend revising the Prop. Treas. Reg. § 1.125-7(a)(7) definition of officer to include the Code § 416(i)(1)(A) limit on the number of officers that an employer is deemed to have. Since Prop. Treas. Reg. § 1.125-7 already borrows from the qualified retirement plan rules for determining who is highly compensated, incorporating the Code § 416(i)(1)(A) limit seems reasonable.

Issue #2: The IRS has come a long way in conforming the highly compensated definition with the rules applicable to 401(k) plans and DCAPs, but more conformity is needed to avoid duplicative effort and to reduce the potential for confusion.

Suggested Revision: We recommend revising the regulations to delete the current-year rule for new hires (the above parenthetical). Also, the similar parenthetical under the optional 20% top-paid group rule should be deleted. Under long-standing rules that apply when determining who is highly compensated for 401(k) plans and DCAPs, an individual who is a new hire is not considered to be highly compensated for his or her first year of employment even if the new hire's compensation received that year from the new employer exceeds the compensation threshold. We recommend modifying the definition of highly compensated for purposes of the cafeteria plan rules to conform as much as possible to the definition that is used for purposes of 401(k) plans and DCAPs. Failure to conform these definitions will result in a duplication of efforts and increased potential for error by employers, plan administrators, and recordkeepers.

Issue #3: The current-year rule and compensation thresholds.

Suggested Revision: If the current-year rule in the 2007 proposed regulations is retained, provide guidance with examples that illustrate whether the compensation threshold for the preceding year or the current year should be used when determining whether a new hire is highly compensated. Also, if the current-year rule is retained, provide guidance with examples that illustrate whether the compensation threshold for the preceding year or the current year should be used when determining whether a new hire is in the 20% top-paid group; and further, provide guidance with examples illustrating how new hires are to be counted for purposes of determining the number of employees an employer has and how many are in the top 20% (note that for 401(k) plans and DCAPs, the number of employees is based on data from the preceding plan year). Also, regarding the 20% top-paid group election, provide guidance stating that in determining the 20% top-paid group, the employer may use the optional exclusions to the extent provided in Code § 414(q)(5) and Treas. Reg. § 1.414(q)-1T, Q/A-9, except that the rule in Treas. Reg. § 1.414(q)-1T, Q/A-9(b)(2)(i) (regarding the election to apply to all plans) should not apply in the cafeteria plan

context because the 2007 proposed regulations merely borrow from Code § 414(q); Code § 125 does not dictate that the Code § 414(q) definition be used.

Issue #3: Prop. Treas. Reg. § 1.125-7(a)(4) defines a "highly compensated participant" (HCP) to be a "highly compensated individual (HCI) who is eligible to participate in the cafeteria plan."

Suggested Revision: Please revise the definition of nonhighly compensated participant at Prop. Treas. Reg. § 1.125-7(a)(6) to conform with the HCP definition, which states that a participant is an individual who is eligible to participate. We recommend revising Prop. Treas. Reg. § 1.125-7(a)(6) to read as follows: "The term nonhighly compensated participant means a nonhighly compensated individual who is eligible to participate in the cafeteria plan." Also, we recommend adding an explanation and an example that demonstrates that an HCI or non-HCI who is eligible to elect benefits and fund them with salary reductions, but who chooses not to elect any benefits and instead receives his or her full unreduced salary, is considered to be a participant "benefiting" under the plan. Note that for purposes of the ratio percentage test, Example 1 of Prop. Treas. Reg. § 1.125-7(b)(3)(iv) correctly assumes that an individual is considered to be "benefiting" in a cafeteria plan if he or she is eligible to participate. Also note that such a definition of benefiting (*i.e.*, if eligible, you are benefiting) applies for 401(k) plans (see Code § 410(b)(6)(E)) and should apply equally to cafeteria plans.

3. Compensation

Issue #1: The 2007 proposed regulations do not state whether compensation, using the Code § 415(c)(3) definition, is required to be annualized.

Suggested Revision: Please provide guidance stating that for all purposes under Code § 125 and Prop. Treas. Reg. § 1.125-7, compensation is an employee's actual compensation received. Also, please provide an example to illustrate that if a newly hired employee starts employment in December 2007 at an annual salary of $240,000 and gets paid $20,000 in December, the employee's 2007 compensation for purposes of the cafeteria plan nondiscrimination rules is $20,000; that is, the plan is not required to annualize the employee's compensation for discrimination testing purposes. Note that Treas. Reg. § 1.414(q)-1T, Q/A-13 expressly provides that compensation is not to be annualized—only actual compensation received is counted.

Issue #2: Employers and administrators may be confused about what compensation falls within the Code § 415(c)(3) definition of compensation.

Suggested Revision: We recommend reducing confusion by revising the regulations to provide that an acceptable definition of compensation would equal the W-2 Box 1 definition (Wages, tips, other compensation) plus the following amounts not included in Box 1: (1) salary reductions under Code § 125(a) (cafeteria plan) and under code § 132(f)(4) (qualified transportation fringe benefit plan); and (2) elective deferrals under Code § 402(c)(3) (401(k), SIMPLE, or 403(b)), under Code § 402(h)(1)(B) (SARSEP), under Code § 402(k) (SIMPLE IRA), and under Code § 457(b).

Issue #3: It is unclear whether cafeteria plans with non-calendar-year plan years can use the calendar-year compensation data election (see IRS Notice 97-45).

Suggested Revision: We recommend giving non-calendar-year plans the option to make a calendar-year compensation data election to determine who is highly compensated by virtue of exceeding the compensation amount specified in Code § 414(q)(1)(B), and to determine employees' compensation for use in the new aggregate-benefits-measured-as-a-percentage-of-aggregate-compensation test in Prop.

Treas. Reg. § 1.125-7(c)(2). Also, please provide guidance stating that an employer who makes such an election for its cafeteria plan is not required to make the same election for other plans that it maintains (*e.g.*, its 401(k) plan and DCAP); the regulations should be revised to provide that the consistency rule in Section VI(1) of IRS Notice 97-45 does not apply in the cafeteria plan context because the 2007 proposed regulations merely borrow from Code § 414(q); Code § 125 does not dictate that the Code § 414(q) definition be used.

4. Nondiscrimination as to eligibility

Issue #1: Employment requirement.

Suggested Revision: We recommend revising the subsection on nondiscrimination as to eligibility to add the statutory requirement in Code § 125(g)(3)(B)(ii) that "the employment requirement for each employee is the same." Also please give examples that demonstrate whether it is permissible to have one cafeteria plan with different waiting periods for different groups of employees (it does not appear that the statute permits different waiting periods). Also, please provide an example showing whether it is permissible to have an immediate-entry cafeteria plan (*i.e.*, all employees are eligible on the date of hire) under which salaried employees are offered health insurance and a health FSA as of the date of hire (they can elect it and start salary-reducing then), while hourly employees must complete three months of employment before they can elect health insurance (but like the salaried employees, the hourly employees can elect health FSA benefits as of the date of hire). Such an approach should be permissible if the plan were disaggregated for eligibility testing into separate salaried and hourly plans, and each such disaggregated plan could separately pass the eligibility test. (Note: Elsewhere in the regulations (at Prop. Treas. Reg. § 1.125-1(l)(2), Example (iii)), the concept of having an immediate-entry cafeteria plan with a three-month wait for health insurance is endorsed.)

Issue #2: Entry date. Code § 125(g)(3)(B)(ii) provides that "Any employee who has satisfied the employment requirement...and who is otherwise entitled to participate in the plan [must commence] participation no later than the first day of the first plan year beginning after the date the employment requirement was satisfied unless the employee was separated from service before the first day of that plan year." But the 2007 proposed requirements are worded differently, requiring any employee who has completed three years of employment (and who has satisfied any conditions for participation that are unrelated to length of employment) to be permitted to enter the 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)."

Suggested Revision: Please clarify the 2007 proposed regulations by adding an example showing that a plan with a one-year employment requirement will satisfy the entry date requirement if employees who meet the one-year requirement become eligible to participate no later than the first day of the first plan year beginning after the employee has satisfied the plan's one-year eligibility requirement.

Issue #3: Reasonable classification test. Examples 2, 3, and 4 of Prop. Treas. Reg. § 1.125-7(b)(3)(iv) add a "benefits" component to the eligibility test, under which unequal availability of benefits or employer flex credits for HCPs and non-HCPs, or unequal salary reductions to get the same benefits, may cause an eligibility test failure.

Suggested Revision: If such a benefits component is meant to be added to the reasonable classification test, then we recommend providing details of this very important rule in the body of the 2007 proposed regulations and not solely in examples. Also, please replace the current examples with more helpful examples showing a single cafeteria plan with a different set of benefits and contributions for (i)

employees in different geographic regions (since health benefits are often offered regionally); (ii) salaried employees vs. hourly employees; (iii) full-time employees vs. part-time employees; (iv) headquarters employees vs. factory employees; and (v) different employer contributions toward health insurance for employees who participate in a wellness program vs. those who do not. In the marketplace, cafeteria plans are not overtly designed to offer one set of benefits and contributions to HCPs and a different set of benefits and contributions to non-HCPs; rather, if a plan makes a distinction among participant groups, it is usually a distinction like salaried vs. hourly, etc.

In addition to creating new examples, we recommend revising the regulations to add a rule that permits a plan to have separate sets of benefits and contributions for different participant groups, as long as each group could pass the reasonable classification test (and satisfy the employment and entry requirements) on its own, and also pass the contributions and benefits test on its own. Note that an employer could achieve the same result by establishing a separate written plan for each participant group, if the separate plans could each pass the reasonable classification test (and satisfy the employment and entry requirements). It appears from Examples 2, 3, and 4 that the regulations would permit a plan to have separate benefit structures for different participant groups so long as the end result is not discriminatory (had it been intended that a cafeteria plan could never have separate benefit structures for different participant groups, the regulations could have said so, and there would have been no need for the examples). To repeat, the regulations need to be revised to state that a cafeteria plan can have separate benefit structures for different participant groups, as long as each group could pass the reasonable classification test (and satisfy the employment and entry requirements) on its own, and also pass the contributions and benefits test on its own.

Issue #4: When are employees considered to benefit in a cafeteria plan for purposes of calculating the ratio percentage for the safe harbor percentage component of the reasonable classification test? When calculating a cafeteria plan's ratio percentage, it seems that the regulations would have an employer calculate the percentage of non-HCIs and HCIs who are eligible to participate (*i.e.*, eligible to make an election) in the cafeteria plan. That is, for purposes of the ratio percentage test, it seems, per Example 1 of Prop. Treas. Reg. § 1.125-7(b)(3)(iv), that an individual is considered to be "benefiting" in a cafeteria plan if he or she is eligible to participate. Such a definition of benefiting (*i.e.*, if eligible, you are benefiting) applies for 401(k) plans (see Code § 410(b)(6)(E)) and should apply equally to cafeteria plans.

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7(b)(1) to state that an individual is considered to be benefiting in a cafeteria plan if he or she is eligible to participate (*i.e.*, eligible to make an election) in the cafeteria plan.

Issue #5: Which employees are excludable employees for purposes of the safe harbor percentage test? According to Prop. Treas. Reg. § 1.125-7(b)(3)(ii), three groups of employees can be excluded when running the safe harbor percentage test: certain employees covered by a collectively bargained plan; certain nonresident aliens with no U.S. source income, and employees participating in the cafeteria plan who are on COBRA.

As the regulations are currently written, it appears that the age-21 and 1,000-hour exclusions under Treas. Reg. § 1.410(b)-4 are not available when testing whether a cafeteria plan satisfies the safe harbor percentage test.

Suggested Revision: Given the close relationship between the cafeteria plan rules and the reasonable classification test for qualified plans, we recommend revising the regulations to permit employers to utilize the Treas. Reg. § 1.410(b)-4 exclusions for testing purposes. If not, we recommend the regulations clearly say that such exclusions do not apply for cafeteria plan testing purposes. Also, please provide an

example to demonstrate that part-time employees as a class can be excluded from participating in a cafeteria plan, but that they must be counted when testing whether the plan is discriminatory as to eligibility.

Issue #6: Unsafe harbor percentage component of the facts-and-circumstances test (see Prop. Treas. Reg. § 1.125-7(b)(3)(ii)). If a cafeteria plan fails the safe harbor percentage test, a "facts and circumstances" test is available, as a last resort, to show that the plan meets the non-discriminatory classification standard. To take advantage of the "facts-and-circumstances" test, the plan's ratio percentage must be greater than or equal to the plan's unsafe harbor percentage set forth in a table in the retirement plan regulations at Treas. Reg. § 1.410(b)-4(c). Then, the classification must be found to be nondiscriminatory by the IRS, based on all the relevant facts and circumstances of the sort described in Treas. Reg. § 1.410(b)-4(c)(3).

Suggested Revision: We recommend that the regulations state that a cafeteria plan can use the relevant facts and circumstances of the sort listed in Treas. Reg. § 1.410(b)-4(c)(3) to demonstrate that the classification is reasonable. Also, we recommend stating the extent to which the employer can determine by itself whether the classification is reasonable without IRS involvement (this point is raised because Treas. Reg. § 1.410(b)-4(c)(3) suggests that the IRS must be the party that determines whether a classification is reasonable; if this is so, then the standard is useless unless the IRS provides a formal process to rule on whether a classification is reasonable).

5. Permissive disaggregation

Issue #1: If a cafeteria plan benefits employees who have not completed three years of employment, an employer may attempt to show that the plan is not discriminatory as to eligibility (or contributions and benefits) by employing the permissive disaggregation technique in Prop. Treas. Reg. § 1.125-7(g): "the cafeteria plan is permitted to test for nondiscrimination ... as if the plan were two separate plans— (i) One plan benefiting the employees who completed [up to] three years of employment; and (ii) Another plan benefiting the employees who have completed three years of employment."

Suggested Revision: We recommend revising the regulation to state an individual is benefiting in a plan if the individual is eligible to participate (*i.e.*, eligible to make an election) in the cafeteria plan. Note that for purposes of the ratio percentage test, Example 1 of Prop. Treas. Reg. § 1.125-7(b)(3)(iv) correctly assumes that an individual is considered to be "benefiting" in a cafeteria plan if he or she is eligible to participate. Also note that such a definition of benefiting (*i.e.*, if eligible, you are benefiting) applies for 401(k) plans (see Code § 410(b)(6)(E)) and should apply equally to cafeteria plans.

Issue #2: Permissive disaggregation should also be allowed for a cafeteria plan that has different benefit or contribution structures for separate groups of employees. In addition, the Code § 414(r) separate-line-of-business (SLOB) rules should apply to all aspects of cafeteria plans.

Suggested Revision: We recommend revising the regulations to add a rule that permits a plan to have separate sets of benefits and contributions for different participant groups, as long as each group could pass the reasonable classification test (and satisfy the employment and entry requirements) on its own, and also pass the contributions and benefits test on its own.

Suggested Revision: The regulations should be revised to enable an employer to apply the Code § 414(r) separate-line-of-business (SLOB) rules to all aspects of its cafeteria plans. Since Prop. Treas. Reg. § 1.125-7 uses portions of the qualified retirement plan rules already (*e.g.*, portions of Code § 410(b)), it seems reasonable to permit an employer to use the SLOB rules when testing its cafeteria plans for

discrimination. Note that per Code § 414(r), the SLOB rules apply for purposes of Code § 410(b), as well as for purposes of the DCAP 55% test under Code § 129(d)(8);

6. Contributions and benefits test

Issue #1: Prop. Treas. Reg. § 1.125-7(c)(2) provides that: "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 ... with respect to both benefit availability and benefit utilization."

Suggested Revision: We recommend dividing Prop. Treas. Reg. § 1.125-7(c)(2) into three paragraphs, as follows: a new Prop. Treas. Reg. § 1.125-7(c)(2)(i) should house the general rule quoted above; a new Prop. Treas. Reg. § 1.125-7(c)(2)(ii) should provide details on the availability requirement; and a new Prop. Treas. Reg. § 1.125-7(c)(2)(iii) should provide details on the utilization requirement (the new aggregate-benefits-measured-as-a-percentage-of-aggregate-compensation test).

Issue #2: Availability requirement.

Suggested Revision: We recommend housing all aspects of the availability requirement in one place (the suggested new Prop. Treas. Reg. § 1.125-7(c)(2)(ii)) and expanding the requirement to explain that both salary reductions and other employer contributions must be available to non-HCPs to the same extent that they are available to similarly situated HCPs. Also, we recommend incorporating by reference the definition of similarly situated.

Suggested language for the suggested new Prop. Treas. Reg. § 1.125-7(c)(2)(ii): A cafeteria plan's qualified benefits and total benefits, and salary reductions and other employer contributions allocable to them, should be available to non-HCPs to the same extent that they are available to similarly situated HCPs. Also, non-HCPs must be given the same opportunity to elect qualified benefits and total benefits as is given to similarly situated HCPs, and to elect how salary reductions and other employer contributions are to be allocated toward the purchase of such benefits. The definition of "similarly situated" in Prop. Treas. Reg. § 1.125-7(e)(2) applies for purposes of this paragraph; and if employer contributions vary due to reasonable differences in plan benefits, then the employer contributions will be deemed to meet the availability standard even if participants can take cash in lieu of using the contributions to purchase benefits.

Issue #3: Utilization requirement.

Suggested Revision: We believe that the suggested new Prop. Treas. Reg. § 1.125-7(c)(2)(iii) should state the utilization requirement. The 2007 proposed regulation unnecessarily requires that both the actual election of qualified benefits must not be disproportionate by HCPs (while other participants elect permitted taxable benefits), and the actual election with respect to employer contributions for qualified benefits through the plan must not be disproportionate by HCPs (while other participants elect to receive employer contributions as permitted taxable benefits). The second prong is duplicative and confusing, and should be deleted (note that the example at current Prop. Treas. Reg. § 1.125-7(c)(3) relies only on the first prong in concluding that the plan passes the contributions and benefits test). If the regulations were revised to provide that the value of the elected statutory nontaxable benefits is the cost to acquire them (salary reductions plus other employer contributions), then the first prong alone adequately addresses the concern that HCPs should not disproportionately get nontaxable benefits through the cafeteria plan while non-HCPs get taxable benefits (note that the suggested revised language measures the cost of statutory

nontaxable benefits, rather than qualified benefits). Finally, assuming that the new aggregate-benefits-measured-as-a-percentage-of-aggregate-compensation test in Prop. Treas. Reg. § 1.125-7(c)(2) is to be retained, it should be revised to reflect the 1978 legislative history, permitting the percentage for HCPs to be higher than for non-HCPs so long as it is not "significantly greater." S. Rep. No. 95-1263, at 75 (1978) and H.R. Rep. No. 95-1445, at 64 (1978). Guidance should be provided as to the "significantly greater" standard.

Suggested language for the suggested new Prop. Treas. Reg. § 1.125-7(c)(2)(iii): The actual election of statutory nontaxable benefits through the plan must not be disproportionate by HCPs (while other participants elect permitted taxable benefits). Such statutory nontaxable benefits are disproportionately elected by HCPs if the aggregate statutory nontaxable benefits elected by HCPs, measured as a percentage of the aggregate compensation of HCPs, exceed, by more than 20%, the aggregate statutory nontaxable benefits elected by non-HCPs measured as a percentage of the aggregate compensation of non-HCPs. For purposes of this calculation, an employer may use employees' compensation during the prior year, and for non-calendar-year cafeteria plans, an employer may elect to use the calendar-year compensation data election. [Notes: See paragraph 3 of this article for information about the calendar-year compensation data election. Also, note that it is important that the regulation be revised to measure the cost of statutory nontaxable benefits, rather than qualified benefits—this will simplify testing as the employer must already gather the cost of statutory nontaxable benefits to run the key employee concentration test.]

Note: The above comments about the utilization requirement assume that the final regulations will retain some sort of aggregate-benefits-measured-as-a-percentage-of-aggregate-compensation test. But as such a test will be very costly and burdensome to run, a simpler test should be considered. Perhaps instead the regulations could employ a simpler HCP concentration percentage test, modeled after the key employee concentration test, only substituting 60% for 25% and substituting HCP for key employee. Note that the top-heavy rules applicable to retirement plans use a 60% threshold to measure whether a retirement plan is top-heavy.

7. Flex credits based on percentage of compensation

Issue #1: Flex credits based on percentage of compensation According to Prop. Treas. Reg. § 1.125-1(r)(3), "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." [emphasis added]

Suggested Revision: Please clarify whether the "specified percentages of compensation" language means that it is permissible to have an employer contribution formula that bases the amount of the employer contribution on a uniform percentage of each employee's pay (*e.g.*, each employee receives flex credits equal to 5% of annual compensation). Note that The President's 1978 Tax Program, Detailed Descriptions and Supporting Analyses of the Proposals, prepared by the Treasury Department, page 173 (Jan. 30, 1978), states that: "[A] cafeteria plan which allocated to participants an amount equal to a specified percentage of pay to be used for health and other benefits will be considered discriminatory."

8. Employers that employ only HCIs; and plans that benefit only non-HCPs

Issue #1: An employer employs only HCIs, and no non-HCIs, should be permitted to maintain a cafeteria plan, and the plan should be deemed to be nondiscriminatory—it does not discriminate against non-HCIs.

Suggested Revision: We recommend revising the regulations to provide that if an employer employs only HCIs, then its cafeteria plan will not be considered discriminatory as to eligibility or as to contributions and benefits (if no non-HCIs are employed, the plan does not discriminate against them). Compare the qualified retirement plan rules, where the minimum coverage requirements are deemed to be satisfied if an employer employs only highly compensated employees (Code § 410(b)(6)(F); Treas. Reg. § 1.410(b)-2(b)(5)). Also, if an employer employs only HCIs, state that it is permissible to have a unique benefit and contributions structure for one group of HCPs (*e.g.*, officers) and different (possibly less generous) benefits and contributions structures for other groups of HCPs.

Issue #2: If a cafeteria plan is designed so that only non-HCPs are eligible to participate, the plan should be deemed to be nondiscriminatory even if benefits and contributions vary amongst groups of non-HCPs.

Suggested Revision: We recommend revising the regulations to provide that if only non-HCPs are eligible to participate in an employer's cafeteria plan, then the cafeteria plan will not be considered discriminatory as to eligibility or as to contributions and benefits (if no HCPs are eligible, the plan does not discriminate in their favor). Also, for such a plan, we recommend stating that it is permissible to have a unique benefit and contributions structure for one group of non-HCPs (*e.g.*, office workers) and different (perhaps less generous) benefits and contributions structures for other groups of non-HCPs.

9. Contributions for part-time employees

Issue #1: Many cafeteria plans permit part-time employees to participate, but offer proportionately reduced flex credits or employer contributions for them (*e.g.*, flex credits for a half-time employee might be 50% of the flex credits for a full-time employee).

Suggested Revision: We recommend revising the regulations to provide that a cafeteria plan can offer proportionately reduced flex credits or employer contributions for part-time employees, and that doing so does not violate the benefits component of the eligibility test or the availability portion of the contributions and benefits test. Note that the repealed Code § 89 nondiscrimination rules would have permitted such proportionate reductions.

10. Code § 125(g)(2) safe harbor

Issue #1: Prop. Treas. Reg. § 1.125-7(e) incorporates the statutory language from Code § 125(g)(2), but with no elaboration as to how salary reductions are to be factored in. When Code § 125(g)(2) was enacted in 1978, salary reductions did not exist. Congress's apparent intent in enacting Code § 125(g)(2) was to give an employer's cafeteria plan an automatic pass (safe harbor) for the contributions and benefits test if the employer contributed the lion's share toward the cost of major medical benefits for all participants (see the 100% and 75% standards in Code § 125(g)(2)).

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7(e) to provide that for purposes of the safe harbor, only true employer contributions should be counted (*i.e.*, salary reductions should be disregarded).

Issue #2: Prop. Treas. Reg. § 1.125-7(e)(3) provides that "Health benefits for purposes of [the safe harbor] rule are limited to major medical coverage and exclude dental coverage and health FSAs."

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7(e)(3) to clarify that "major medical coverage" includes both insured and self-insured major medical coverage.

11. Key employee concentration test

Issue #1: What statutory nontaxable benefits should be taken into account when running the key employee concentration test?

Suggested Revisions: First, we recommend giving an example to illustrate that all statutory nontaxable benefits must be included when running the test (*e.g.*, health insurance, dental insurance, health FSA benefits, DCAP benefits, HSA contributions, etc.). Second, we recommend revising Prop. Treas. Reg. § 1.125-7(d) to explain, with examples, whether to include the following employer contributions and salary reductions when running the key employee concentration test: (i) employer pays 100% of the premium for employee-only health insurance but employees must elect salary reductions to pay the entire additional cost for family coverage and for health FSA and DCAP benefits (assume there is no cash-out option available for employees who waive health insurance); (ii) same as (i), except there is a cash-out option; (iii) employer pays 50% of the premium for employee-only or family health insurance, and employees must elect salary reductions to pay the entire additional cost for health insurance coverage and for health FSA and DCAP benefits (assume there is no cash-out option available for employees who waive health insurance); and (iv) same as (iii), except there is a cash-out option. In (ii), (iii), and (iv), all of the employer contributions that are applied toward health insurance plus all salary reductions should be counted—they represent the cost of the statutory nontaxable benefits elected under the cafeteria plan. And in (i), the employer contribution toward employee-only coverage should be counted for those employees who elect family coverage, because such coverage would not be available to such employees unless they first had employee-only coverage. (Note that if the regulations are revised as above with regard to (i), then the last sentence of Prop. Treas. Reg. § 1.125-1(b)(4)(iii), Example 4(v) should be conformed to indicate that Code § 125 *does* apply to the employee-only coverage when employees have the option to add family coverage.) Finally, one further revision is suggested: Add language to state that benefits do not need to be counted in the key employee concentration test if they become taxable because a component benefit plan nondiscrimination test is failed (*e.g.*, DCAP 55% average benefit test) or other requirement is not met.

Issue #2: Running the 25% key employee concentration test when all cafeteria plan participants are key employees.

Suggested Revision: We recommend stating in the regulations that the key employee concentration test is automatically passed if all cafeteria plan participants are key employees.

Issue #3: Permissive disaggregation and the key employee concentration test. To take advantage of the permissive-disaggregation rule in Prop. Treas. Reg. § 1.125-7(g), the two disaggregated plans must separately pass both the reasonable classification test and the contributions and benefits test, but what about the 25% key employee concentration test?

Suggested Revision: We recommend revising the regulation to state whether the two disaggregated plans must separately pass the key employee concentration test, or whether the key employee concentration test must be passed for the plan as a whole (disregarding the disaggregation). Presumably, the key employee concentration test would need to be passed for the plan as a whole.

Issue #4: Running the key employee concentration test when there are multiple cafeteria plans.

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7(e) to state whether, when an employer has two or more cafeteria plans and does not wish to aggregate them under the Prop. Treas. Reg. § 1.125-7(h) optional aggregation rule, the key employee concentration test is to be run separately

for each plan (as is required for the eligibility test and the contributions and benefits test), or whether it is to be run for all cafeteria plan benefits combined. It would appear that the key employee concentration test is to be run separately for each plan, as is the case for the eligibility test and the contributions and benefits test. And for the Prop. Treas. Reg. § 1.125-7(h) optional aggregation rule, we recommend stating whether the key employee concentration test must be passed for the aggregated plan and/or whether each plan before aggregation must pass the key employee concentration test.

12. Safe harbor for premium-only plans

Issue #1: According to Prop. Treas. Reg. § 1.125-7(f), "A premium-only-plan ... is deemed to satisfy the nondiscrimination rules in [Code §] 125(c) and this section for a plan year if, for that plan year, the plan satisfies the safe harbor percentage test for eligibility ...."

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7(f) to state that a premium-only plan is deemed also to satisfy Code § 125(b), including the key employee concentration test. While the example in Prop. Treas. Reg. § 1.125-7(f) reaches such a conclusion, the rule needs to be stated in the body of the regulation.

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7(f) to provide that an employer may maintain a separate premium-only plan and a separate salary reduction cafeteria plan with health FSA and DCAP benefits, and the premium-only plan can take advantage of the safe harbor though the other cafeteria plan cannot. Provide an example to illustrate the concept. It is anticipated that some employers will opt to maintain two cafeteria plans to assist them in passing the nondiscrimination tests.

Issue #2: The regulation is silent as to whether the employment requirement and the entry date requirement in Code § 125(g)(3)(B) must be satisfied in order for a premium-only plan to be able to use the safe harbor (presumably they must be, as they are part of the eligibility test in Code § 125(g)(3)).

Suggested Revision: We recommend stating whether the employment requirement and the entry date requirement in Code § 125(g)(3)(B) must also be satisfied in order for a premium-only plan to be able to use the safe harbor.

Issue #3: According to Prop. Treas. Reg. § 1.125-1(a)(5), "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)."

Suggested Revision: Please clarify that "employer-provided accident and health insurance" includes insured medical, dental, vision, LTD, ADD, and other insured accident and health plans whether through individual policies or group policies, as well as Medicare Part B and D coverage, and coverage under any health program offered by a state or other governmental entity. Also, we recommend revising the regulation to add that "employer-provided accident and health insurance" also includes self-insured plans, other than plans that constitute flexible spending arrangements as defined in Code § 106(c)(2). Finally, please revise the regulation to add that a premium-only plan will retain its status as a premium-only plan even if it permits participants to make health savings account contributions.

13. Time to perform nondiscrimination testing; and which employees to include

Issue #1: According to Prop. Treas. Reg. § 1.125-7(j), "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." For purposes of the eligibility test, a simpler standard is needed—one that would provide beginning-of-the-year certainty, taking into account only those employed on the last day of plan year preceding the year for which the plan is being tested.

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7(j) to provide that the eligibility test for a plan year is to be run using employee census data as of the last day of plan year preceding the year for which the plan is being tested, taking into account only those employees employed on the last day of plan year preceding the year for which the plan is being tested, so long as the employer's workforce on such last day is reasonably representative of the employer's workforce for the year as a whole. If such last day is not reasonably representative, then the employer should be permitted to use any one snapshot day in the current year to test eligibility so long as the chosen day in the current year is reasonably representative of the employer's workforce for the year as a whole.

Issue #2: The Example in Prop. Treas. Reg. § 1.125-7(j) is missing information.

Suggested Revision: Please state which nondiscrimination test the example is intended to apply to (presumably the new aggregate-benefits-measured-as-a-percentage-of-aggregate-compensation test in Prop. Treas. Reg. § 1.125-7(c)(2)), and please explain why the preceding year's compensation is used. Also, if it is intended that the preceding year's compensation is to be used, please state what compensation should be used for new hires who have no prior-year compensation. Also, if the regulations are revised to permit the eligibility test to take into account only those employees employed on the last day of the preceding plan year (see above suggested revision), then it would be helpful to have an example that illustrates the approach.

Issue #3: If an employer performs preliminary nondiscrimination testing for a plan year before the end of the plan year and determines that it appears likely that its cafeteria plan will fail the contributions and benefits test or the 25% key employee concentration test, then the employer should be permitted to modify the elections of HCPs or key employees during the plan year, on a uniform and consistent basis, in order to help the cafeteria plan pass the contributions and benefits test or the 25% key employee concentration test for the plan year.

Suggested Revision: Please add language permitting an employer to modify the elections of HCPs or key employees during the plan year, on a uniform and consistent basis, in order to help the cafeteria plan pass the contributions and benefits test or the 25% key employee concentration test. Also please specify that such election modifications do not violate Treas. Reg. § 1.125-4 or other cafeteria plan requirements.

14. Governmental Plans

Issue #1: Governmental plans are not subject to the Code's nondiscrimination requirements that apply to qualified plans. See, *e.g.*, Code §§ 410(c)(1)(A) and 401(a)(5)(G). Similarly, governmental plans should not be subject to any of the cafeteria plan nondiscrimination rules. (Note that governmental plans are not now subject to the 25% key employee concentration test because, per Code § 416(i)(1)(A), governmental entities do not have key employees.)

Suggested Revision: We recommend revising the regulations to provide that governmental plans as defined in Code § 414(d) are not subject to any of the nondiscrimination rules applicable to cafeteria plans. If the regulations are not revised to add such an exemption, then please revise Prop. Treas. Reg. § 1.125-7(a)(7) to provide guidance on the extent to which governmental entities may have officers.

15. Collectively Bargained Plans

Issue #1: Code § 125(g)(1) provides: "Collectively bargained plan not considered discriminatory. For purposes of this section, a plan shall not be treated as discriminatory if the plan is maintained under an agreement which the Secretary finds to be a collective bargaining agreement between employee representatives and one or more employers." Prop. Treas. Reg. § 1.125-7(a)(11) provides that 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." Prop. Treas. Reg. § 1.125-7(a)(11) provides helpful clarity to the definition of collectively bargained plan, first by providing that a portion of a plan can be considered to be a collectively bargained plan, and second by clarifying that there is no requirement for the IRS to pre-approve (or find) that the plan is maintained under a collective bargaining agreement. However, the regulations fail to include the important safe harbor in Code § 125(g)(1)—"Collectively bargained plan not considered discriminatory."

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7 to provide that a collectively bargained plan is not considered discriminatory. With an example, please show that a collectively bargained plan is not subject to the eligibility test, the contributions and benefits test, or the key employee concentration test.

Issue #2: Prop. Treas. Reg. § 1.125-7(a)(10) provides that: "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." And Prop. Treas. Reg. § 1.125-7(b)(3)(ii)(A) provides that employees (except key employees) covered by a collectively bargained plan can be excluded for purposes of the safe harbor percentage test.

Suggested Revision: We recommend revising Prop. Treas. Reg. § 1.125-7(b)(3)(ii)(A) by deleting the carve-out for key employees. Also, please revise Prop. Treas. Reg. § 1.125-7(a)(10) by deleting the sentence that says that a key employee covered by a collective bargaining agreement is a key employee. There does not appear to be statutory support for these provisions. If the key employee language is retained, please give several examples that show what the language is intended to accomplish. Also, please explain how such language is to be applied in the context of the safe harbor in Code § 125(g)(1)—"Collectively bargained plan not considered discriminatory." As stated above, the Prop. Treas. Reg. § 1.125-7 should state that a collectively bargained plan is not subject to the eligibility test, the contributions and benefits test, or the key employee concentration test.

16. Effective Date of Non-Discrimination Provisions

Unlike other portions of the proposed regulations, the Prop. Treas. Reg. § 1.125-7 nondiscrimination regulations are almost entirely new. The nondiscrimination regulations will have a tremendous impact on employers and administrators, imposing heavy data collection and testing burdens on them. Employers and administrators will need to devote millions of hours to nondiscrimination testing, but they should not be required to do so until the regulations are substantially revised and clarified. The regulations are a very good first effort at filling a void that has existed for years. About 60% of the text in Code § 125 focuses on nondiscrimination testing, yet until now we haven't seen meaningful regulations on the subject.

Suggested Revision: Given the huge importance of nondiscrimination testing, not only to employers and administrators, but also to Congress, it is urged that the Prop. Treas. Reg. § 1.125-7 nondiscrimination regulations be substantially revised to address the concerns in paragraphs 1 – 15 above and the concerns

that others may raise, and then be republished as proposed regulations prior to finalizing them. By republishing them as proposed regulations, the public will be provided another chance to comment. This second comment period will be invaluable—it should help the regulators produce a final regulation of the highest quality and community acceptance. Further, it is urged that the effective date be postponed, so that the revised regulations are effective no earlier than the first plan year that begins on or after January 1, 2010.

VI. Additional Areas For Which the Service Requested Comments

1. *The Final Regulations Should Expressly Permit Multiple Employers (Not in the Same Controlled Group) to Sponsor a Single Cafeteria Plan.*

Issue: Code § 125(d)(1)(A) currently requires that all cafeteria plan participants be "employees."

Suggested Revision: ECFC requests that IRS and Treasury include clarifying language in the final regulations that specifically permits employees to participate in cafeteria plans sponsored by more than one unrelated employer (a "multiple employer cafeteria plan") – similar to the rules provided for qualified plans under Rev. Proc. 2002-21.

Explanation: It is not always easy in today's changing workforce – with contract employees, temporary employees, independent contractors, permanently outsourced departments, and so on – to determine who an employee actually works for. In fact, a person's "employer" may change over the course of time even though the individual is sitting at the same desk, doing the same work. Today's employers need the ability to work with other employers, associations and professional employer organizations ("PEOs") to offer cafeteria plan benefits to their workforce – even if the workforce is not made up entirely of common law employees of a single employer.

Code § 413(c) permits multiple employer qualified retirement plans. IRS and Treasury have specifically set forth the application of Code § 413(c) to multiple employer qualified retirement plans for PEOs in Rev. Proc. 2002-21. Under the Rev. Proc., a PEO is permitted to sponsor a multiple employer plan which is then adopted by the organizations to whom the PEO provides a workforce.

There is a need for multiple employer cafeteria plans for the same reasons there is a need for multiple employer qualified retirement plans. Aside from PEOs, there are numerous situations where one cafeteria plan may be wanted for efficiency or in order to ensure that a plan does not violate the requirement that it only include employees. For example, two businesses may have common ownership and desire the same benefits, but they may not be part of a controlled group or an affiliated service group. Likewise, there may be a need for PEO or association-based plans. While there is no equivalent to Code Section § 413(c) for cafeteria plans, ECFC believes that the Treasury nevertheless has the authority to permit such plans. Code § 413(c) is not an enabling provision – rather it just sets forth special rules that apply to qualified retirement plans.

Moreover, Section 125 itself does not restrict cafeteria plans to single employers. A narrow reading of the law is not consistent with the statute or the purpose of the law. Consequently, we suggest that the definition of "cafeteria plan" also include plans maintained by multiple employers.

We recognize that a multiple employer cafeteria plan will not be appropriate in all cases – for example, a multiple employer health FSA would likely be prohibited by state laws barring self-funded health MEWAs. Nevertheless, today's employers need greater flexibility in offering cafeteria plan benefits to

their workforces, and ECFC's members need guidance that will permit the multiple employer cafeteria plan.

2. *The Final Regulations Should Expressly Permit Employers to Take Pre-Tax Salary Reductions from Employee Tips.*

Issue: There are many industries in the U.S. in which employees are paid fairly low wages, but receive additional income in the form of gratuities or "tips." Employers in these industries need the ability to take pre-tax salary reductions from these tips because, oftentimes, tipped employees do not receive enough money in the form of wages alone to pay for cafeteria plan benefits.

Suggested Revision: ECFC requests guidance confirming that pre-tax salary reductions are permitted from tips – it is inequitable to deny tipped employees the same tax benefits offered under cafeteria plans to hourly and salaried workers who receive only wages. Additionally, the final regulations should provide guidance confirming that pre-tax salary reductions are permitted from tipped income, regardless of whether it is provided on a regular basis or on an irregular basis, as described in the examples below.

Explanation: The following two examples show how pre-tax salary reductions might be taken from tipped employees.

First, consider a full-time waitress with most of her income paid in weekly disbursements of tips from her employer (taken from pooled cash tips and credit card tips accumulated over the week). If provided for under the terms of the cafeteria plan and assuming the waitress has made a timely election, the employer should be able to take a pre-tax salary reduction from this disbursement in order to pay for the waitress' cafeteria plan benefits, such as medical insurance, since the waitress has not actually received the tips.

Second, consider a day care center that receives holiday tips from parents – collectively, a significant sum of money -- and distributes those tips to all employees of the center. Some of the employees might wish to make a year-end, pre-tax contribution to a health savings account ("HSA") (assuming they are eligible). If provided for under the cafeteria plan and assuming the employee has made a timely election, the employer should be able to take a pre-tax salary reduction from the holiday tips and contribute it to the employee's HSA.

3. *The Final Regulations Should Provide that the Uniform Coverage Amount under a Health FSA May be Computed Under a Blended Approach Following a Mid-Year Change in Election.*

Issue: The current final regulations regarding changes in status provide that "a cafeteria plan may permit an employee to revoke an election during a period of coverage … and make a new election for the remaining portion of the period." Treas. Reg. § 1.125-4(c)(1). It is not clear how to apply this language to the uniform coverage requirement for health FSAs.

Suggested Revision: ECFC requests guidance clarifying that this language allows employers to adopt, by plan design, either a "separate period of coverage" approach or any reasonable "blended" approach to applying the uniform coverage rule.

Explanation: The separate period of coverage approach would require a plan to treat the period prior to the change of election and the period subsequent to the change of election as separate coverage periods. As a result, there could be potential forfeitures following the end of the coverage period prior to the change in election. However, it is unlikely that an employee would request a change in election if they realized it would result in a forfeiture of their health FSA dollars. A more likely result would be that an

employee would take advantage of his or her full election during the first coverage period (prior to the change of election), and then get a fresh start with a second election amount during the second coverage period (following the change of election). This creates an obvious potential for employee windfalls at the expense of the employer. Nevertheless, we understand that some employers and TPAs prefer this approach.

But, because of the potential windfalls available to employees under the separate coverage period approach, employers also should be able to adopt by plan design a reasonable blended approach. Under a blended approach, employers would be able to limit their exposure following changes in election by blending the amounts available before and after the change in election – with no forfeiture event occurring at the time of the election change.

Following are examples of reasonable blended approaches. Please note that these are only examples. There are other blended approaches used by other employers, and any guidance issued by IRS and Treasury should be worded broadly enough to contemplate any reasonable blended approach.

Health FSAs – Proposed methodology for participants raising their election – Participants who make an election under a Health FSA who subsequently have a change in status (for example, adding a new spouse) and increase the amount of their election because of the change, should be able to obtain reimbursements up to the amount elected at annual enrollment through the date of their change in status. In no event can reimbursements be made for expenses incurred before the change in status that exceed the original goal amount, less any reimbursements. After the change in status the participant is entitled to receive reimbursements up to the new goal amount. This process ensures that a participant's reimbursements prior to the change in status relate to their original election and that the increased goal amount is only available after the change in status to ensure the participant's increased goal amount would be consistent with the change in status.

Example - Participant A is employed by Big Company and participates in their Health FSA.

- during annual enrollment Participant A elects a Health FSA goal amount of $1,200
- in July, Participant gets married, which is a change in status that allows him to change his election
- Participant A changes his election to $3,200

Under these facts, through July, Participant A would be able to obtain reimbursements up to $1,200. After his change in election he should be able to be reimbursed up to $3,200, minus his reimbursements to date. For example, Participant A has $1,400 of eligible expenses through June; he should only be able to receive reimbursements up to $1,200. In that case $200 of his expense cannot be reimbursed. Also, in this case, after his change in election Participant A would have $3,200 minus the $1,200 of reimbursements to date, or $2,000 left in his Health FSA eligible for reimbursement for expenses incurred after the change in status. Participant A's contribution amount would change from $100 a month to $433 per month in July ($3,200 (new goal amount) minus $600 (contributions to date6 months X $100 per month) = $2,600 /6 months remaining in the year = $433 per month).

Health FSAs – Proposed methodology for participants lowering their election – Participants who make an election under a Health FSA who subsequently have a change in status (for example, a participant gets a divorce, and is not able to submit expenses on a spouse's behalf any longer) and decrease the amount of their election because of the change, should be able to obtain reimbursements

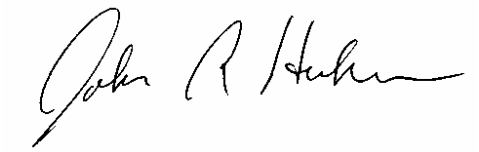
up to amount elected at annual enrollment through the date of their change in status. All claims must be incurred prior to the date of the change in status. In no event can reimbursements be made for expenses incurred before the change in status that exceed the original goal amount. After the change in status the participant is entitled to receive reimbursements only up to the new goal amount, less any prior reimbursements. This process ensures that a participant's reimbursements prior to the change in status relate to their original election and that the decreased goal amount available after the change in status would be consistent with the change in status. In addition, participant should not be able to reduce their election below claims to date. Allowing such changes permits employees to make changes that are not consistent with their change in status, since they have already used the contributions.

Example - Participant D is employed by Big Company and participates in their Health FSA.

- during annual enrollment Participant D elects a Health FSA goal amount of $1,200
- At the end of June, Participant D gets divorced, which is a change in status that allows him to decrease his election
- Participant D attempts to change his election to $900, and has claims incurred to date of $800

Under these facts, until Participant D has the change in status, he should be able to obtain reimbursements up to $1,200. After his change in election he should be able to be reimbursed up to $900, minus his reimbursements to date. Under the facts of this example, Participant A has $800 of eligible expenses through June, he should only be able to receive reimbursements up to $100, including claims incurred but not submitted before the change in status. Participant A's contribution amount would change from $100 a month to $50 per month in July to reflect the reduced goal.

Respectfully submitted



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