Brown & Brown

EMPLOYEE BENEFITS

Employer Welfare Benefit Taxation Guide

From the Brown & Brown Regulatory and Legislative Strategy Group

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Introduction

This guide provides an overview of the most relevant tax considerations for employee health and welfare benefit plans. This guide does not address the tax considerations applicable to retirement plans, nor does it include all of a plan sponsor's/employer's tax considerations under all applicable federal, state, or local tax laws. It is important to remember that many of the issues addressed in this guide involve complex tax and legal considerations. As a result, employers and individuals must work with their tax advisors and legal counsel when making decisions regarding these issues.

Section 125 General Rules[1]

Section 125 of the Internal Revenue Code governs cafeteria plans and allows employees to make pre-tax salary reduction contributions for health and welfare benefits elected under a cafeteria plan.

Plan Document

To enable employees to make pre-tax salary reduction contributions for health and welfare benefits, an employer must establish a Section 125 plan (cafeteria plan). The terms of a cafeteria plan must be set forth in a written plan document. Technically, if an employer does not have a written cafeteria plan document, employees may not pay for health and welfare benefits on a pre-tax basis. Employees who contribute pre-tax dollars towards benefits that would otherwise be eligible for pre-tax payment could be responsible for the payment of applicable taxes to the IRS for those benefits if a written cafeteria plan document has not been adopted.

Election Changes[2]

Participants must make irrevocable elections prior to the first day of the plan year, and any permitted mid-year election changes made under a cafeteria plan must be effective on a prospective basis (except under limited circumstances). In other words, coverage should be effective after an employee requests a change to their election. There are limited exceptions to this "prospective election" rule.

Exceptions to the Prospective Election Rule

The first exception to the "prospective election" rule applies in the case of birth or adoption of a dependent (a HIPAA special enrollment event). In this scenario, coverage changes made to a medical plan are required to be retroactively effective (back to the date of the birth/adoption of the dependent). In addition, the employee can pay for that retroactive coverage on a pre-tax basis. However, even for the birth or adoption of a dependent, payment for retroactive coverage must come from income not currently available at the time of the election change.

The other exception to the "prospective election" rule that allows an employee to make a retroactive election is reserved for new employees. A new employee may have their coverage retroactively effective, back to the date of hire, if there is no eligibility waiting period and the employee's new election is made within their first 30 days of employment.

[1] The rules described in this document are found in the Section 125 regulations and IRS Notice 2014-55.

[2] This guide provides an overview of certain cafeteria plan election change issues. For additional information see the Summary of Status Change Events (and Corresponding Permitted Election Changes).

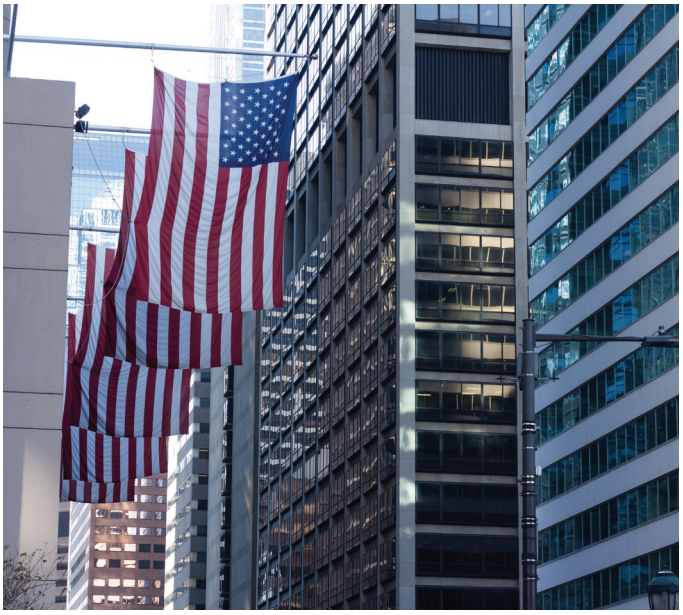
Which Events Permit a Change?

If the cafeteria plan document permits mid-year election changes by employees, employees may change/revoke their initial plan year elections in accordance with IRS regulations. In most cases, a cafeteria plan is not required to allow any pre-tax election changes.[3] This is true even if certain other laws (e.g., HIPAA portability rules) require the underlying health plan to allow mid-year enrollment changes (e.g., HIPAA special enrollment).

A cafeteria plan may be selective in which mid-year changes are allowed, so long as such changes are permitted within IRC Section 125 rules. However, it would be unusual for a plan not to allow any mid-year election changes. If a cafeteria plan does allow changes, both the cafeteria plan document and the ERISA plan document should list the situations in which mid-year election changes are allowed within the plan(s).

The Change Requested Must be Consistent with the Event Experienced

The cafeteria plan status change rules are one of several exceptions to the requirement that elections be irrevocable. Under the status change rules, any midyear election change must satisfy a general consistency rule (e.g., any election change must be "on account of and consistent with" the status change event). This consistency rule does not apply to the other exceptions to the irrevocable election rule.



Is the employee requesting an election change "on account of" the event they experienced?

No general IRS rule prescribes the period after a qualifying status change event occurs by which an employee must notify the plan administrator of their intent to make a mid-year election change. However, subject to the IRS general consistency rule, election change requests to an employer/plan administrator should not occur so long after the event that the election is not "on account" of the event. Requests to modify elections should not be approved if they are too far removed from the date the event occurred.

To ensure plan terms are applied consistently to all employees, most cafeteria plans designate a specific time limit within which employees must notify the plan administrator of the event that would allow a mid-year pre-tax election change. When cafeteria plan document terms require employees/former employees to notify the plan administrator of their intent to change their election mid-year within a specified period after a qualified status change event occurs, employers/plan administrators are generally required to enforce any such deadline contained in the cafeteria plan document.

Is the change the employee requests consistent with the event they experienced?

For the election change to be consistent with the event, the change in status event must affect eligibility for coverage under an employer's plan. In other words, it must affect eligibility under the cafeteria plan, component benefit plan, or both. According to the regulations, a change in status affects eligibility under an employer's plan if the change "results in an increase or decrease in the number of an employee's family members or dependents who may benefit from coverage under the plan." It is unclear whether "benefiting" from coverage under the plan is based on actual eligibility or applies in a more practical sense.

In limited circumstances, a change in eligibility for non-employer-sponsored coverage (e.g., Exchange enrollment, Medicare, or Medicaid) can also result in a permitted election change event.

[3] An exception applies for HSA contributions. If employees can make pre-tax HSA contributions through the cafeteria plan, they must be allowed to change their HSA elections on at least a monthly basis.

SPECIAL CONSISTENCY RULES

Group-Term Life and Disability – Under the special consistency rule for group-term life and disability coverage, an election change increasing/decreasing coverage due to any status change event is permitted even if it does not affect eligibility.[4]

Dependent Care and Adoption Assistance – In addition to changes permitted under the general consistency rule described above, election changes satisfy this special consistency rule if the election change corresponds with an event that affects expenses for dependent care or adoption assistance under Code §129 or 137.[5]

Loss of Spouse's/Dependent's Eligibility – This special consistency rule states that if the status change event is the employee's divorce, annulment or legal separation, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, an employee can cancel accident or health insurance coverage only for the spouse/dependent who ceases to satisfy the plan's eligibility requirement. In other words, coverage cannot be canceled for anyone else whose eligibility was not impacted by the event.[6]

Gaining Eligibility Under a Family Member's Employer's Plan – If, due to a change in marital status or change in employment status, an employee, spouse or dependent gains eligibility under a family member's employer's plan, the employee can cease or decrease coverage for that individual if the coverage under the other employer's plan becomes effective.[7]

Eligible Participants

Only current and former employees are eligible to participate in a cafeteria plan. Sole proprietors, partners and shareholders of a Subchapter-S corporation holding more than 2% ownership are not employees under the Internal Revenue Code and ineligible to participate in the employer's cafeteria plan.

In addition, due to ownership attribution rules the spouses and children of more than 2% shareholders of a Subchapter-S corporation are also ineligible to participate. Spouses and children of sole proprietors and partners generally can participate if they are employees.

In most cases LLCs are treated as partnerships and LLC members are not eligible to participate in a cafeteria plan. However, if an LLC elects to be taxed as a C Corporation any LLC members treated as employees for tax purposes could be permitted to participate in a cafeteria plan.

[4] Treas. Reg. §1.125-4(c)(3)(iii)
[5] Treas. Reg. §1.125-4(c)(3)(ii)
[6] Treas. Reg. §1.125-4(c)(3)(iii)
[7] Treas. Reg. §1.125-4(c)(3)(iii)

Dependent Coverage

Section 125 of the Internal Revenue Code excludes the value of benefits provided to employees through a qualified cafeteria plan. In addition, current and former employees can elect to pay for coverage for their legal spouse, their children (who are younger than age 27 by the end of the tax year), and their health care tax dependents[8].

Domestic Partners

The general rule allowing employees to exclude the fair market value of benefits from their income for benefits provided to employees, their legal spouse and dependent children does not apply to domestic partners nor the dependent children of an employee's domestic partner unless they qualify as the employee's tax dependent, which is relatively rare. The fair market value of coverage for a domestic partner and their children may be subject to federal, FICA, state, local and any other applicable payroll taxes.[9]

No official IRS guidance has been released that specifies the methodology that must be used to determine the fair market value (FMV) of a domestic partner's group health plan coverage that must be included in the employee's taxable income. However, informal IRS guidance indicates that an employer may use the individual COBRA premium rate (excluding the 2% COBRA administrative fee) as the fair market value of coverage for each individual who is not an employee's tax dependent that is covered under an employer-sponsored group health plan as a reasonable approach.[10]

However, other potential methods may exist due to the IRS's silence on this issue, including calculating the FMV of coverage provided to a non-qualified tax dependent based on the increase in cost over the next-lower applicable coverage tier. Employers that wish to use something other than the applicable COBRA premium should discuss alternative approaches with their tax and/or legal advisors.

Benefits that may be Offered under a Cafeteria Plan

Section 125 of the Internal Revenue Code defines which qualified benefits an employer may offer under a cafeteria plan. The most common benefits provided under an employer's cafeteria plan include health plan premiums[11], health flexible spending accounts (FSA), dependent care FSAs and health savings accounts. However, a wide variety of benefits may be offered under a Section 125 cafeteria plan, including 401(k) contributions and vacation purchasing programs. In addition, employers may choose to provide life insurance and disability insurance benefits on a pre-tax basis. However, these benefits are more commonly paid on a post-tax basis due to potentially adverse tax consequences to an employee caused when these benefits are paid for on a pre-tax basis (as later discussed in this document). Finally, if an employer offers an opt-out arrangement, where employees are given the option to elect the health plan or receive an additional taxable cash payment from the employer, this arrangement should be included in the employer's cafeteria plan.[12]

Nondiscrimination Testing under IRC Section 125

Cafeteria plans are subject to three nondiscrimination tests for eligibility, benefits and contributions and key employee concentration. The tests are designed to prevent the plan from favoring highly compensated and key employees to an impermissible degree. The tests apply with respect to any health and welfare benefits offered by the employer to which employees make pre-tax salary reduction contributions.

[8] Treas. Reg. §1.106-1
[9] The June 2015 Supreme Court ruling in Obergefell v. Hodges requires all states to license and recognize same-sex marriages. As a result, employers no longer need to impute federal or state income tax on benefits for same-sex spouses. However, the fair market value of coverage provided to domestic partners who are not legal spouses should be treated as taxable employee wages (unless the domestic partner is a tax dependent of the employee).
[10] Please be advised that informal IRS guidance, unlike guidance published in the Internal Revenue Bulletin, cannot be relied upon as support for the correctness of a tax reporting position.
[11] Treas. Reg. §1.105-5: "an arrangement for the payment of amounts to employees in the event of personal injuries or sickness."
[12] For additional information about "opt-out arrangements" see Cash-in-Lieu of Benefits Arrangements

Highly Compensated Employee (HCE)

The following are considered highly compensated employees for purposes of the eligibility, and benefits and contributions Section 125 nondiscrimination tests:

- An officer of the company (based on facts and circumstances, not their job title) determined based on the preceding plan year (or current plan year if the HCE was not employed in the prior year)
- An employee owning 5% or more of the voting power or value of all classes of stock of the employer during the current or preceding plan year
- An employee earning more than a threshold amount[13] and, if elected by the employer[14], in the top 20% highest paid employees (top-paid group), determined based on the preceding plan year (or current plan year if the HCE was not employed in the prior year)
- Spouses and dependents of any of the foregoing.

Eligibility

To maintain the tax exclusion for contributions made by highly compensated employees under a Section 125 plan, employers must ensure that they do not discriminate in favor of highly compensated participants as to eligibility to participate. Examples of plan designs that may cause a Section 125 plan to fail the eligibility test are:

- Failing to offer the same waiting period/ entry date to all participants
- Utilizing a classification that favors HCEs, and that would not be considered an objective business classification (e.g., salaried, hourly, full-time, parttime, type of job, geographic location, division, subsidiary, business unit or profit center, family vs. employee only coverage), to determine eligibility
- Failing to ensure a sufficient ratio of non-HCEs to HCEs are eligible to participate in the cafeteria plan

[13] https://www.irs.gov/retirement-plans/plan-participant-employee/definitions#:~:text=For%20the%20preceding%20year%2C%20received,top%2020%25%20of%20employees%20when

[14] *Conditions to utilizing the top paid group election are as follows:*

- *A top-paid group election, once made, applies for all subsequent determination years unless changed by the employer.*
- *A top-paid group election made by an employer must apply consistently to the determination years of all plans of the employer that begin with or within the same calendar year (both retirement and nonretirement).*
- *If an employer makes either a top-paid group or calendar year data election for a determination year, a plan that contains the definition of HCE must reflect the election.*
- *If the employer changes a top-paid group data election the plan must be amended to reflect the change.*
- *A plan is not required to add a definition of HCE merely to reflect a top-paid group election.*

Contributions and Benefits

To maintain the tax exclusion for contributions made by highly compensated employees under a Section 125 plan, employers must ensure that they do not discriminate in favor of highly compensated participants as to contributions and benefits. Examples of plan designs that may cause a Section 125 plan to fail the contributions and benefits test are:

- Offering additional benefits to HCEs
- Making more plan benefits or employer contributions available to HCEs than to non-HCEs
- HCEs taking benefits or utilizing employer contributions disproportionately when compared to non-HCEs

Key Employee[15]

The following are considered key employees for purposes of the Section 125 nondiscrimination tests:

- An officer earning more than a threshold amount[16] during the prior plan year (subject to a maximum number of officers)
- A 5% or more owner during the prior plan year
- A 1% or more owner with compensation of $150,000 (not indexed) during the prior plan year

Key Employee Concentration

The income exclusion typically available for cafeteria plan contributions is not available to key employees if the qualified benefits provided to key employees exceed 25% of qualified benefits provided for all employees under the plan.

Discriminatory Plans

To be considered nondiscriminatory, a plan must pass each applicable test on each day of the plan year as tested on the last day of the plan year. Therefore, to minimize the need for retroactive adjustments to highly compensated or key participant elections, more frequent testing may be advisable. If an employer does not correct a discrimination issue by adjusting highly compensated or key participant elections by the end of the plan year, corrections cannot be made to satisfy the nondiscrimination requirements. The exclusion from gross income will not apply for highly compensated or key participants to any benefit attributable to a plan year for which the plan discriminates in favor of highly compensated or key participants.

[15] As governmental employers do not have officers or owners the key employee concentration test will not apply to plans sponsored by governmental employers.
[16] https://www.irs.gov/pub/irs-drop/n-22-55.pdf
[17] Prop. Reg. 1.125-7(j)

IRS Sections 105 and 106

Employers rely on Internal Revenue Code §105 and §106 to provide tax favored benefits under medical, dental and vision plans, health FSAs (limited and general purpose), and health reimbursement arrangements (HRAs). Specifically, §105 determines whether benefits received under accident and health plans for employees, former employees, spouses and dependents can be excluded from employees' taxable income, whereas, §106 determines whether employer contributions for accident and health plans can be excluded from employees' taxable income.

Self-funded Health Plans and IRC Section 105(h)

Internal Revenue Code §105 requires a written plan for the benefits provided under a self-insured health plan to be excluded from an employee's taxable income. To comply with this requirement, employers often combine ERISA-required documentation, such as the formal plan document and summary plan description, with the required documentation under §105.

Nondiscrimination Testing under IRC Section 105(h)

Self-funded health plans (including healthcare FSAs and HRAs) are subject to two nondiscrimination tests: eligibility and benefits. Per the Affordable Care Act (ACA), this testing was to also apply to fully insured plans. However, the compliance date has been delayed until regulations or other guidance is issued. The IRS appears to have no plans to do so for the foreseeable future.

For purposes of these rules, self-insured health plans are not permitted to discriminate in favor of the following "Highly Compensated Individuals" (HCIs):

- **One of the five highest-paid officers (in the current plan year)**
  - "Officer" is not specifically defined in the regulations.
  - The individual's responsibilities and degree of authority over the plan's operation should be considered (as opposed to exclusively focusing on job title).
- **Among the top 25% compensated of all employees (in the current plan year)**
  - Certain individuals who are not participants[18] are excluded when making this determination.
  - "Compensation" is not specifically defined in the regulations. A reasonable definition applies and should be based on the employee's current year compensation.
- **More than 10% shareholder**
  - Percentage of ownership is determined at the time the benefit is provided during the plan year.
  - Attribution rules apply. Therefore, spouses and dependents of shareholders are deemed to own proportionate shares of ownership interest.

[18] IRC Section 105 provides for exclusion of certain employees from consideration if the employees are not already participants, "(i) employees who have not completed 3 years of service;(ii) employees who have not attained age 25;(iii) part-time or seasonal employees;(iv) employees not included in the plan who are included in a unit of employees covered by an agreement between employee representatives and one or more employers which the Secretary finds to be a collective bargaining agreement, if accident and health benefits were the subject of good faith bargaining between such employee representatives and such employer or employers; and(v) employees who are nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3))."

Eligibility

A self-insured medical reimbursement plan satisfies the requirements of the discrimination rules only if the plan does not discriminate in favor of highly compensated individuals as to eligibility to participate. Examples of plan designs that may cause a self-insured medical reimbursement plan to fail the eligibility test are:

- Failing to offer the same waiting period/ entry date to all participants
- Utilizing a classification that favors HCIs, and that would not be considered an objective business classification (e.g., salaried, hourly, full-time, parttime, type of job, geographic location, division, subsidiary, business unit or profit center, family vs. employee only coverage), to determine eligibility
- Failing to ensure a sufficient ratio of non-HCIs to HCIs are eligible to participate in the cafeteria plan

Benefits

A self-insured medical reimbursement plan satisfies the requirements of the discrimination rules only if the benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals. Examples of plan designs that may cause a self-insured medical reimbursement plan to fail the benefits test are:

- Offering additional benefits to HCEs
- Making more plan benefits available to HCIs than to non-HCIs
- Failing to require either no participant contributions or an identical contribution from all participants

Discriminatory Plans

In general, HCIs will be taxed on the “excess reimbursement” if a self-insured medical reimburse plan fails to comply with nondiscrimination requirements. However, the method to calculate the excess reimbursement will depend on whether the plan failed the eligibility or benefits test, or both. If a plan fails the eligibility test, HCIs should typically be taxed on the pro-rata share of discriminatory coverage. If a plan fails the benefits test, HCIs should typically be taxed on the specific benefit amount provided to that employee under the discriminatory plan. If an employer does not correct a discrimination issue by adjusting benefits provided to HCIs by the end of the plan year, corrections cannot be made to satisfy the nondiscrimination requirements.

Group Term Life[19]

Under IRC § 79, up to $50,000 of group-term life insurance (GTL) coverage[20] is generally excludable from an employee's income. This exclusion is available for nondiscriminatory employer-provided group-term life coverage. The entire value of the benefit is taxable for certain key employees when the plan design is discriminatory.

Imputing Income to Employees for Nondiscriminatory Plans

Many employers offer GTL insurance exceeding a $50,000 death benefit. In many cases, depending on whether it is considered to be provided by an employer, the value of the additional coverage (above a $50,000 death benefit) must be included in the employee's gross income. "Value," as used here, does not refer to the premium paid by the employer or employee but to the cost for the coverage, determined using Table 2-2 rates in IRS Publication 15-B: Employer's Tax Guide to Fringe Benefits and briefly in the Proposed Cafeteria Plan Regulations. The taxable value of the GTL coverage added to an employee's gross income is called "imputed income." Imputed income means that the "value" of the additional coverage (above a $50,000 death benefit) will be treated as wages paid to an employee subject to income tax but is not subject to mandatory income tax withholding. The imputed income is, however, subject to FICA withholding.

The Proposed Cafeteria Plan Regulations issued in August of 2007 confirmed that, in compliance with IRC Code § 79, employers must impute the value of non-discriminatory GTL coverage in excess of a $50,000 death benefit. GTL coverage for this purpose includes both basic employer-paid coverage and any voluntary/ supplemental GTL coverage purchased by the employee if premiums straddle Table 2-2 rates in IRS Publication 15-B.

The Proposed Regulations clarified that flex credits/dollars available under a cafeteria plan can be used to purchase GTL. However, if these flex credits/dollars are pre-tax and the death benefit under such policy coverage exceeds $50,000, the value of that excess coverage must be imputed as taxable income to the employee. Additional IRS guidance on how to apply the calculation of the imputed value is described in IRS Publication 15-B.

In general, the employer must impute income to an employee for the value of all the total policy amounts combined for all GTL insurance coverage received by an employee (employer-paid GTL insurance in addition to any employee-purchased life insurance coverage that qualifies as GTL insurance). The employer then deducts the statutory non-taxable amount of $50,000 from the total amount of the employee's GTL insurance coverage to determine the amount of excess coverage. The monthly value of that excess coverage is determined by multiplying the volume of excess GTL insurance coverage by the applicable IRS Publication Table 2-2 rate (based on age). The volume is the number of $1,000 increments (e.g., a policy of $10,000 equals ten units of volume). The rate is the cost per unit based on the individual's age. The IRS Table 2-2 rates are categorized in increments of five-year age bands. For determining the applicable IRS Table 2-2 rate, the employee's age at the end of the calendar year is used.

Once the monthly value has been determined, the value is multiplied by 12 (or the number of months this coverage was provided during the tax year, if less) to obtain the annual value of the coverage. The amount of imputed income is equal to the annual value of the excess coverage minus any amounts an employee pays for GTL insurance coverage on a post-tax basis during the year.

[19] This guide provides an overview of the taxation requirements applicable to group term life insurance. For additional information see the Group Term Life Insurance Guide.
[20] References to group term life insurance do not include permanent benefits (i.e., whole or universal life policies, which are not subject to this rule) or accidental death and dismemberment benefits.

Imputing Income for Discriminatory Plans

For group-term life insurance plans that discriminate in favor of key employees with respect to eligibility or benefits, key employees would not be eligible for the income tax exclusion on the first $50,000 of coverage.[21] For this purpose, key employees are defined as employees who, during the plan year, were:

1. Officers earning over $130,000 per year (indexed for inflation[22])
2. More than 5% owners of the company
3. More than 1% owners of the company earning over $150,000 per year (not indexed for inflation)

GTL plans are subject to an eligibility and benefits test to determine whether the plans are discriminatory.[24] When the GTL plan is discriminatory, the employer must add the value of the group-term life insurance coverage, based on the entire amount provided, to the key employee's W-2 earnings. This imputed income is not subject to income tax withholding, but it is subject to employee withholding and employer-matching FICA tax. The taxable value for key employees is the greater of the actual cost of coverage or the benefit amount (in $1,000 multiples) times the applicable Table 2-2 rate. The actual cost for this purpose is determined under an apportionment formula in the regulations. It will not necessarily be the same as the rates charged by the insurer for key employees' coverage.

Note: To determine whether the coverage provided for key employees is discriminatory, both employer-paid and employee-paid benefits are included. Nondiscrimination testing is recommended.

Voluntary Life

In some cases, supplemental coverage purchased by employees on an after-tax basis will not be carried directly or indirectly by the employer. If so, it will not be subject to the preceding taxation rules. For that to be the case, the employer must elect to treat the supplemental coverage as being provided under a separate policy from employer-paid coverage, assuming they are typically deemed provided under a single policy since the same insurance carrier or affiliate issues them. In addition, the rates for the supplemental coverage must not straddle the IRS Publication 15-B Table 2-2 rates. An employer may elect to treat the policies as separate if the premiums for each policy are properly allocated between the policies (e.g., the carrier separately and independently determines the premiums and accounts for the finances for each policy). In the paragraph above, references to GTL do not include voluntary life insurance benefits not carried by the employer.

[21] See Treas. Reg. § 1.79-4T Questions and answers relating to the nondiscrimination requirements for group-term life insurance.
[22] Inflation adjustments are determined annually and published in an IRS Notice entitled "Limitations Adjusted as Provided in Section 415(d), etc."
[23] Ownership attribution rules apply when determining an employee's ownership interest.
[24] Certain church plans are exempt. Furthermore, under the regulations, sponsors of governmental plans do not have any key employees making the requirements inapplicable to those plans as well.

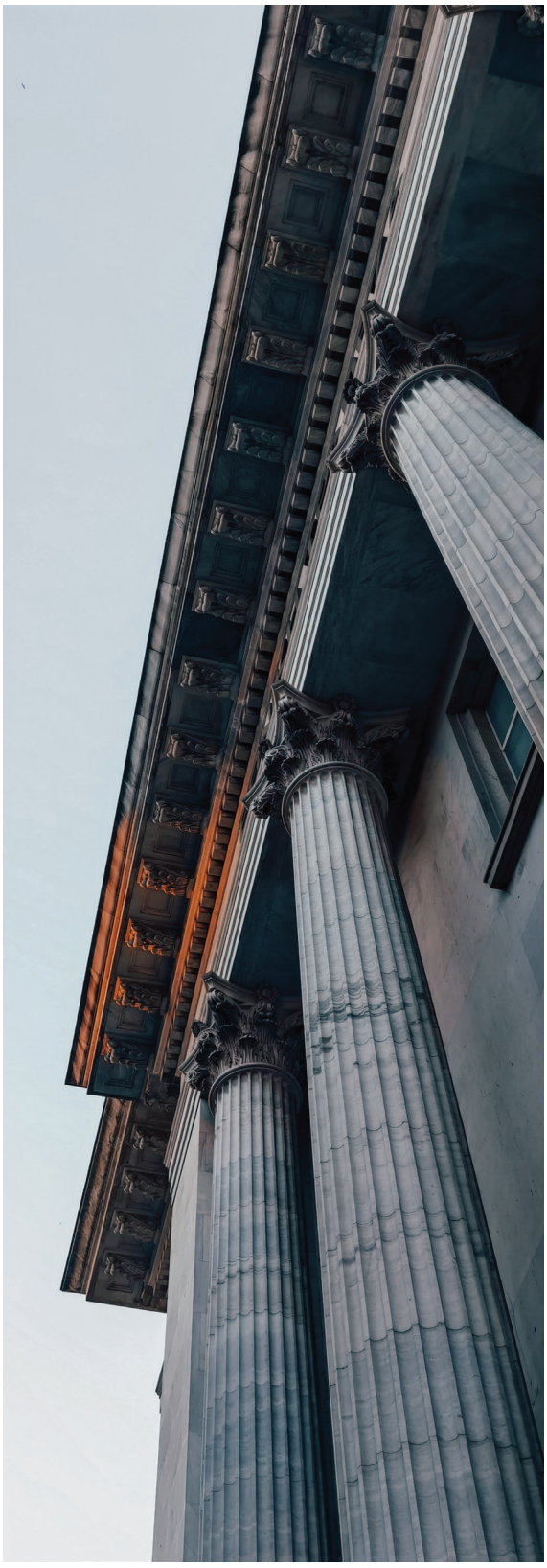
Employer-Provided Dependent Life

Under the IRS rules, a limited income exclusion is allowed for employer-provided dependent GTL insurance, covering the life of the employee's spouse or dependents. For employer-provided coverage, the employer pays all or a portion of the premium. If the employee pays the full premium for the dependent coverage on a post-tax basis,[25] there is no potential taxation of the benefit to the employee, other than the employee's requirement to pay such premiums on an after-tax basis.

The income exclusion only applies if the benefit qualifies as a "de minimis" benefit. See IRS Notice 89-110. Determination of the de minimis status of the benefit varies depending on whether the employer pays the entire premium:

- **Employer-Paid Only:** De minimis in this situation is defined by the IRS as life insurance coverage up to a face/policy amount of $2,000.
- **Employer and Employee-Paid:** According to Notice 89-110, "in determining whether employer-provided dependent group-term life insurance with a higher face amount [i.e., a face amount in excess of $2,000] is a de minimis fringe benefit, only the excess (if any) of the cost of such insurance over the amount paid for the insurance by the employee on an after-tax basis shall be taken into account." The meaning of this statement is unclear. It could mean that the coverage constitutes a de minimis benefit if the excess portion of the life insurance coverage (i.e., the portion the cost of which is not paid by the employee) does not exceed $2,000. Or, as stated in IRS Publication 15-B, it could mean that the coverage constitutes a de minimis benefit "if the excess (if any) of the cost of insurance over the amount the employee paid for it on an after-tax basis is so small that accounting for it is unreasonable or administratively impracticable." Employers should seek legal or tax advice from their own advisor regarding this situation.

If the "de minimis" exception does not apply, the full value of the employer-provided dependent term life insurance coverage is imputed as income in the employee's W-2 earnings. The value of the employer-provided dependent term life insurance coverage is determined based on the IRS Publication 15-B Table 2-2 rates. The imputed income in this situation must be reported as wages on the employee's Form W-2. It is also subject to income tax withholding,



[25] Premiums for dependent life insurance must be paid with after-tax dollars. Dependent life insurance is not a qualified benefit for purposes of IRC Section 125 (i.e., there is no way for employees to pay them on a pre-tax basis).

Disability[26]

Short-term and long-term disability plans are both considered qualified benefits eligible for pre-tax treatment of contributions under a Section 125 cafeteria plan. In addition, employer contributions are generally excludable from taxable income. However, as the taxability of the disability income will generally depend on how the premiums for the coverage were paid during the year of the disabling event, employers may choose to treat the value of the coverage as taxable income to the employee.[27]

- **Pre-Tax:** If premiums for the disability benefit are paid entirely with pre-tax dollars (by the employer and/or employee), the benefits received when the employee becomes disabled are taxable.
- **Post-Tax:** If premiums for the disability benefit are paid entirely with post-tax dollars (by the employer via imputed income to the employee and/or with premiums paid by an employee with post-tax dollars), then the benefits received when the employee becomes disabled are not taxable (i.e., are not included in the employee's taxable income).
  - ***Example 1*** **-** Employer-Paid Imputed or Gross-Up: When an employer pays 100% of the disability premiums and reports the amount on the employee's Form W-2 as taxable income, the premiums are considered paid on a post-tax basis. Any payments received by an employee/former employee during the time of their disability are not included in the employee's taxable income.
  - ***Example 2*** **-** Employee-Paid Post-Tax: When an employee's only option is paying premiums for disability coverage on an after-tax basis, or the employee makes an irrevocable annual election under the employer's cafeteria plan to pay premiums for disability coverage on an after-tax basis and subsequently becomes disabled, wage replacement/salary continuation payments made to a covered individual are generally non-taxable.
- ***Combination Pre-Tax and Post-Tax:*** If premiums are paid with a combination of pre-tax and post-tax dollars, then the taxable portion of the disability benefits are determined using a three-year look-back method. Under the look-back rule, the ratio is calculated by dividing the taxable portion of the premiums (employer-paid imputed/gross-up and employee-paid post-tax) by the total premiums paid by the employer and employee over three years.

Plan sponsors should communicate the tax consequences of paying for disability benefits on a pre-tax basis to employees. They should also make arrangements to ensure compliance with the withholding and reporting obligations that apply to any taxable benefit payments. Due to potentially significant taxation of disability benefit payments to an employee, employers may want to consider offering employees the option to pay their disability premiums on a post-tax basis.

[26] This guide provides an overview of the taxation requirements applicable to disability plans. For additional information see the Employer-Sponsored Disability Benefits - General Overview.
[27] Rev. Rul. 2004-55

Dependent Care Assistance[28]

Section 129 of the Internal Revenue Code (the "Code") allows an employer to provide tax-advantaged dependent care assistance benefits to its employees.[29] Employer-sponsored dependent care benefit programs provided to employees under the Code's requirements are typically referred to as Dependent Care Assistance Programs (DCAPs) or Dependent Care Flexible Spending Accounts (Dependent Care FSAs). Dependent Care FSAs are dependent care programs in a Section 125 plan allowing employees to make pre-tax salary reduction contributions to an account providing tax-free reimbursements of eligible dependent care expenses. DCAPs also include Dependent Care FSAs and programs provided outside of a Section 125 plan, such as a program where an employer provides on-site dependent care for employees or a program where an employer pays a dependent care provider directly for care provided to employees' dependents. Both programs are subject to the tax rules found in Section 129.

Note: In this document, we use the term DCAP to refer to any dependent care benefits program sponsored by an employer for its employees.

Section 129 Requirements

For an employer to provide tax-free benefits to its employees, a DCAP must comply with several legal requirements under Code Section 129. This includes the requirement to adopt and maintain a written plan document that describes the DCAP and otherwise complies with the requirements of the section.[30] In addition, a DCAP must be established for the exclusive benefit of its employees. Code Section 129 also provides that an employer must provide "reasonable notification" to employees of the availability and terms of its DCAP.[31] The terms of the DCAP, as described in the plan document, must permit the reimbursement of dependent care expenses for qualifying individuals and the expense must be considered an "employment-related expense" under the regulations.[32]

Under IRS regulations, reimbursement for dependent care expenses cannot be provided prior to the expense being incurred.[33] Dependent care expenses are incurred when the dependent care is provided. Furthermore, DCAP claims must be substantiated through "information from a third-party that is independent of the employee and the employee's spouse and dependents."[34] The information provided by the independent third-party must include a description of the service, its date and the amount of the expense. IRS regulations allow for the use of DCAP debit cards.[35] However, the substantiation requirements described above create a practical issue if the care provider charges an up-front amount that must be paid in advance of services. To provide some relief regarding this issue, the IRS has provided a "rolling funding" method for DCAP debit cards based on expenses previously incurred, which must be followed.[36]

[28] This guide provides an overview of the taxation requirements applicable to dependent care assistance plans. For additional information see the Dependent Care Assistance Plan (DCAP) Guide
[29] These benefits are typically provided solely to common law employees of the employer. However, Section 129 authorizes certain self-employed individuals (including sole proprietors, partners, more-than-2% shareholders of a Subchapter S corporation and others) to participate in a DCAP. Code §129(e)(3). Such self-employed individuals cannot participate in a Section 125 plan and cannot make pre-tax contributions to a DCAP. As a result, such individuals generally can participate only in a DCAP funded by the employer.
[30] Code §129(d)(1).
[31] Code §129(d)(6).
[32] Code §129(e)(1).
[33] Prop. Treas. Reg. §1.125-6(a)(4)
[34] Prop. Treas. Reg. §1.125-6(b).
[35] Prop. Treas. Reg. §1.125-6(g).
[36] IRS Notice 2006-69.

Nondiscrimination Requirements

Under Code Section 129, DCAP benefits provided to highly compensated employees will be tax-free only if the DCAP does not discriminate in favor of highly compensated employees.[37] To be considered nondiscriminatory, a plan must pass each applicable test on each day of the plan year as tested on the last day of the plan year.

For purposes of Code Section 129's nondiscrimination rules, "highly compensated employees" are employees who earned in excess of a certain indexed income threshold[38] in the preceding plan year or who are more than 5% owners in the current or preceding plan year.[39] DCAPs are subject to four separate tests under Code Section 129's nondiscrimination rules: 1) the eligibility test; 2) the contributions and benefits test; 3) the more than-5% owner concentration test; and 4) the 55% average benefit test.

Eligibility

To maintain tax qualified status of benefits provided to highly compensated employees under a DCAP, employers must ensure that they do not discriminate in favor of highly compensated participants as to eligibility to participate. Examples of plan designs that may cause a DCAP plan to fail the eligibility test are:

- Utilizing a classification that favors HCIs, and that would not be considered an objective business classification (e.g., salaried, hourly, full-time, parttime, type of job, geographic location, division, subsidiary, business unit or profit center, family vs. employee only coverage), to determine eligibility
- Failing to ensure a sufficient ratio of non-HCEs to HCEs are eligible to participate in the cafeteria plan

Contributions and Benefits

To maintain tax qualified status of benefits provided to highly compensated employees under a DCAP, employers must ensure that they do not discriminate in favor of highly compensated participants as to contributions and benefits. Examples of plan designs that may cause a DCAP plan to fail the eligibility test are:

- Placing a lower contribution cap on non-HCEs than on HCEs
- Offering a matching contributions to HCEs and not to non-HCEs

More than-5% Owner Concentration

To maintain tax qualified status of benefits provided to highly compensated employees under a DCAP, employers must ensure that no more than 25% of benefits may be provided to more than 5% shareholders or owners (or their spouses and dependents).

55% Average Benefit Test

To maintain tax qualified status of benefits provided to highly compensated employees under a DCAP, employers must ensure that the average benefits provided to non-HCEs are at least 55% of benefits received by HCEs.

Discriminatory Programs

If in a particular plan year, a DCAP discriminates in favor of highly compensated employees in any way, no DCAP benefits provided to the highly compensated employees for that plan year are excludable from taxable income under Section 129. All benefits provided to highly compensated employees will need to be included in their gross income and reported as wages in Box 1 of IRS Form W-2. If the DCAP takes the form of pre-tax salary reductions offered through a cafeteria plan pursuant to Section 125, additional nondiscrimination requirements will apply (see above discussion of Section 125 nondiscrimination rules).

Limit on Tax Exclusion

The amount of dependent care assistance an individual can exclude from income for federal tax purposes is limited by Section 129. The limit is not indexed for inflation and is based on a calendar year rather than a plan year. The limit is **the lesser of:**

- $5,000 (for single individuals or married couples who file their taxes jointly),
- $2,500 (for married individuals who file their taxes separately),
- The employees' earned income for the year; or
- If the employee is married, their spouse's earned income for the year.[40]

For married couples jointly filing taxes, it is important to emphasize the $5,000 limit is a shared limit, not a limit applying to each spouse individually. If each spouse participates in a DCAP at their respective employers, their combined limit is $5,000.

[37] Code §129(d)(1).
[38] The indexed income threshold is the same that applies for 401(k) plan nondiscrimination testing. See https://www.irs.gov/retirement-plans/plan-participant-employee/definitions#:~:text=For%20the%20prece
[39] Code §129(d)(2)-(3).
[40] Note, under the regulations, an employee's spouse who is a full-time student or incapable of self-care (and lives at the employee's home for more than half the year) is considered to be gainfully employed and to have an earned income of, not less than (a) $250 per month.

Wellness Program Incentives[41]

The tax implications of wellness program incentives will largely depend on the incentive or benefit offered. For example, cash or cash equivalent rewards (e.g., gift cards) would be included in the employee's income and subject to wage withholding and employment taxes. Rewards including employer's payment of a portion of a participant's premium costs or cost-sharing (e.g., copayments or deductibles) or employer contributions to HSAs, HRAs or health FSAs are generally excluded from an employee's income and not subject to wage withholding or employment taxes. Employers should consult with their legal counsel and tax advisors for specific guidance regarding the taxability of their wellness program incentives.

Offerings That May be Problematic

Recently, vendors have offered programs to employers under which employees make pre-tax contributions to participate in "fixed indemnity wellness programs" or "health management arrangements" and then receive non-taxable reimbursements from the program. There are potential issues with these kinds of vendor offerings, which the IRS has addressed in a 2017 Chief Counsel Advice memorandum.[42]

Previously released proposed regulations stated that if fixed indemnity coverage is purchased on a pre-tax basis through a Section 125 plan, any benefit payments received by the insured that exceed the insured's unreimbursed medical care expenses are taxable wages subject to withholding and reporting. For example, the IRS guidance states that "if a fixed indemnity health plan with premiums paid on a pre-tax basis through a 125 cafeteria plan paid $200 for a medical office visit and the covered individual's unreimbursed medical costs as the result of the visit were $30, $30 would be excluded from gross income under [Code §]105(b) and the excess amount of $170 would be included in gross income." The final regulations did not adopt this proposed rule.[43]

This analysis also applies to other fixed indemnity plans commonly offered as voluntary worksite benefits by employers. For example, hospital indemnity or cancer policies are typically paid by employees on a post-tax basis so that any payments received from the policies are not considered taxable income to the employee.[44]

Other vendors may offer a program reimbursing employee expenses through a health management claims payment program. Under these arrangements, employees may pay a small after-tax amount to participate in the program and are provided "a fixed cash payment benefit for participating in certain activities that are related to health (for example, calling a toll-free telephone number that provides general health-related information, attending a seminar that provides general health-related information, participating in a biometric screening, or attending a counseling session). The employees are not charged for participating in any of the activities. The fixed-dollar amount employees receive under the self-funded health plan, on a non-taxable basis for each covered activity (for example, $1,425 per activity) is much greater than the amount of the after-tax premium the employees pay to participate in the self-funded health plan (for example, $60 per month)."[45] Since these programs do not include any element of risk-shifting and cannot be considered insurance, the IRS concluded payments received from these programs are taxable income.

[41] For additional information about wellness programs, see the Wellness Programs – General Overview.
[42] https://www.irs.gov/pub/irs-wd/201703013.pdf
[43] Proposed regulations would require all payments received under fixed indemnity plans purchased with pre-tax contributions to be taxable wages. The final regulations did not adopt this provision, and it is not clear at this point whether the regulators will decide to adopt this requirement in future rulemaking. For additional information, see the Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage Rule.
[44] In addition, employers often choose not to permit these benefits to be paid on a pre-tax basis through their cafeteria plans in an attempt to preserve the voluntary plan exception to ERISA. In other words, these benefits may not be subject to ERISA if they are paid by employees on a post-tax basis so long as there is no element of employer sponsorship or endorsement.
[45] Office of Chief Counsel Internal Revenue Service Memorandum Number: 201719025

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