Acadia BENEFITS

UBA ACAAdvisor

Cafeteria Plans: Participant Contributions

Cafeteria plans, or plans governed by IRS Code Section 125, allow employees to pay for expenses such as health insurance with pre-tax dollars. Employees are given a choice between a taxable benefit (cash) and specified pre-tax qualified benefits, for example, health insurance. Employees are given the opportunity to select the benefits they want, just like an individual standing in the cafeteria line at lunch.

Only certain benefits can be offered through a cafeteria plan:

1) Coverage under an accident or health plan (which can include traditional health insurance, health maintenance organizations (HMOs), self-insured medical reimbursement plans, dental, vision, and more)
2) Dependent care assistance benefits or DCAPs
3) Group term life insurance
4) Paid time off, which allows employees the opportunity to buy or sell paid time off days
5) 401(k) contributions
6) Adoption assistance benefits
7) Health savings accounts or HSAs under IRS Code Section 223

Some employers want to offer other benefits through a cafeteria plan, but this is prohibited. Benefits that you cannot offer through a cafeteria plan include scholarships, group term life insurance for non-employees, transportation and other fringe benefits, long-term care, and health reimbursement arrangements (unless very specific rules are met by providing one in conjunction with a high deductible health plan). Benefits that defer compensation are also prohibited under cafeteria plan rules.

Under IRS Code Section 125, a valid cafeteria plan must be in writing. The cafeteria plan document must reflect Section 125 and its regulations. Further, the employer must adopt the cafeteria plan document before the first day of the plan year. If these elements are missing, then the plan doesn't qualify as a cafeteria plan and employee elections will result in gross income.

Cafeteria plans as a whole are not subject to ERISA, but all or some of the underlying benefits or components under the plan can be. The Patient Protection and Affordable Care Act (ACA) has also affected aspects of cafeteria plan administration.

Employees are allowed to choose the benefits they want by making elections. Only the employee can make elections, but they can make choices that cover other individuals such as spouses or dependents. Employees must be considered eligible by the plan to make elections. Elections, with an exception for new hires, must be prospective. Cafeteria plan selections are considered irrevocable and cannot be changed during the plan year, unless a permitted change in status occurs. There is an exception for mandatory two-year elections relating to dental or vision plans that meet certain requirements. Participants may only make election changes based on IRS provided changes in status, or certain triggering events as contained in the Health Insurance Portability and Accountability Act (HIPAA).

Cafeteria Plan Funding

Cafeteria plans are funded or paid for in a variety of ways. Employers can allow employees to reduce their salary on a pre-tax basis (salary reduction) to pay for the benefits, or may use after-tax dollars (payroll deduction) to pay for benefits. Salary reductions are the most common funding source for cafeteria plans. Employers may also offer credits or contributions toward a purchase of benefits offered under the cafeteria plan. These are non-elective employer contributions. Employers may also make contributions for employees who opt out of a core benefit.

The IRS Code treats salary reductions as employer contributions, whereas the Employee Retirement Income Security Act (ERISA) views salary reductions as participant contributions that become a plan asset (and subject to ERISA protections).

Participant Pay Falls Short

Plan participants who have a low rate of pay, take an unpaid leave of absence, are paid based on commissions, are tipped employees, or who have a wage garnishment, might not earn enough at times to pay for their elections. Sometimes the pay shortage will be combined with or is the result of an event that causes a loss of benefit eligibility. Sometimes though, a participant will remain eligible for the plan. Employers are left to determine how to handle the pay shortage.

The IRS has not provided guidance or regulation for handling pay shortages without a loss of benefit eligibility. As a result, employers often refer to the rules provided for handling employee contributions during an employee's unpaid Family Medical Leave Act (FMLA) leave. There are three options that employers have during unpaid FMLA leave:

- Pre-payment
- Pay-as-you-go on an after-tax basis
- Catch-up salary reduction upon return from leave

These methods give employers some latitude when determining how to recoup a missed payment. In the context of a pay shortage, pre-payment is unlikely to be a viable option. Pay-as-you-go might be an option for some employees (who have savings or other sources of income) but the catch-up salary reduction is most likely the easiest method for an employer to administer. Employers may allow employees to make catch-up salary reduction payments over a period of time of their choosing.

Best Practices

Employers should ensure that they have a written policy that is available to employees regarding pay shortages in relation to benefit elections. The written policy should be uniformly enforced for all employees. Employers may set a time limit for the employee to catch up on contributions before terminating coverage, as well as a maximum period of time over which employees may spread payments. Thirty or 60 days is likely to be a reasonable time limit to allow employees to make up missed payments. Employees should be allowed uniform periods of time to pay back missed contributions; for instance, management should not be given three months to pay back missed contributions when other staff members are only given one month (or vice versa).

Employers should also have a written policy regarding the order of benefit funding in case an employee has elected multiple benefits (such as health, life insurance, dental, or disability). It would be in many employers' best interest to require that health coverage be funded first for purposes of health care reform.

Employers should also review what, if any, of the change in status events the plan recognizes. Plans may allow participants to change elections based on the following changes in status:

- Change in marital status
- Change in the number of dependents
- Change in employment status

- A dependent satisfying or ceasing to satisfy dependent eligibility requirements
- Change in residence
- Commencement or termination of adoption proceedings

Plans may also allow participants to change elections based on the following changes that are not a change in status but nonetheless can trigger an election change:

- Significant cost changes
- Significant curtailment (or reduction) of coverage
- Addition or improvement of benefit package option
- Change in coverage of spouse or dependent under another employer plan
- Loss of certain other health coverage (such as government provided coverage, such as Medicaid)
- Changes in 401(k) contributions
- COBRA qualifying event
- Judgment, decrees, or orders
- Entitlement to Medicare or Medicaid
- Family Medical Leave Act (FMLA) leave
- Pre-tax health savings account (HSA) contributions
- Reduction of hours (new under the ACA)
- Exchange/Marketplace enrollment (new under the ACA)

Together, the change in status events and other recognized changes are considered “permitted election change events.”

If an employer’s plan only allows a change in participant elections under limited circumstances, the employer is at a higher risk for having periods of time that an employee is unable to pay his or her contribution. Plans that allow an employee to change or reduce elections (pursuant to the rules) under all allowable change in status events – particularly the Patient Protection and Affordable Care Act (ACA) provided “reduction in hours” event and Exchange or Marketplace Enrollment event – will give employees more opportunity to change their elections proactively and potentially drop their benefits before funding becomes an issue.

Please be aware that there are a few situations under which an employee has a right to make certain election changes:

- HIPAA special enrollment rights (contains requirements for HIPAA subject plans)
- Inadequate notice of Medicare Part D creditable coverage disclosure

Health Flexible Spending Accounts (FSAs)

Employers should remember that eligible expenses incurred by an employee during a pay shortage would have to be reimbursed under a health FSA, because that coverage remains in effect. It is important to note that, while FSAs are codified under Section 125, they require a more complex plan document than just a premium-only plan for pre-tax contributions for the employee’s portions of the cost of coverage.

Termination Issues: COBRA, ACA

If an employee fails to make up missed payments in accordance with the written policy and the employer terminates the employee's benefits, questions arise regarding COBRA as well as implications for ACA employer shared responsibility (play-or-pay) obligations for applicable large employers (ALEs).

If coverage is terminated due to lack of employee contribution, there is no COBRA qualifying event, and the employer is not obligated to offer COBRA coverage. Similarly, an employer would not be liable for penalties under the employer shared responsibility provisions for failure to offer coverage if coverage was cancelled due to lack of payment. Penalties regarding affordability could apply, depending on the totality of the situation and cost of coverage.

Rescission of Coverage

Although employers may terminate coverage due to non-payment by a plan participant, except in cases of fraud or intentional misrepresentation of material fact, group health plans and insurers are, in general, prohibited from rescinding coverage from individuals who are covered under the plan. A rescission is a cancellation or discontinuation that has a retroactive effect. There are some narrow circumstances under which the failure to pay a premium might allow a retroactive cancellation, but those should only be determined with the assistance of counsel, and in accordance with applicable state and federal laws.

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