Flexible compensation programs have flourished since their inception and have become a popular method of delivering benefits. Even though there have been various arrangements for employers to deliver flexible compensation to employees, this article addresses the true flexible compensation arrangements in which employers provide employees with an amount of money and a choice of benefits to be purchased with that money.

Some of the considerations addressed in this article include employer objectives for adopting flexible compensation plans, the types of benefits commonly found within such plans (e.g., cash, medical care, dental care, vision care, reimbursement accounts, death benefits, disability benefits, vacation days, and 401(k) and 401(m) contributions), the strategies for allocating employer contributions to employees (e.g., benefit-based, flat-dollar, pay-related, and a combination of flat-dollar and pay-related), mid-year changes in elections (e.g., changes in family status, cost or coverage changes, cessation of required contributions, and separation from service), nondiscrimination rules, and a brief look into the future of flexible compensation plans.

In the early 1970s, a few employers made innovative changes in their benefit programs. Little did they know they were starting a trend that would significantly redesign the manner in which benefits are delivered in the United States. The changes those employers made allowed employees more freedom in selecting benefits—a design now commonly referred to as flexible compensation or cafeteria plans.

Since those early years, demographic changes, financial changes, and regulatory changes have made flexible arrangements attractive to employers of all sizes and in all industries.

DEMOGRAPHIC CHANGES

Changes in employee demographics have been well documented. Among the most important is the increased number of women in the work force. In 1965, 38.9 percent of the women between the ages of twenty-five and twenty-nine were employed outside the home. As of 1985, that number had increased to

Richard A. Rose, head of the Denver office of William M. Mercer, has concentrated for the past six years on flexible benefits. Cindy S. Birley, an attorney and a certified public accountant, is an associate in the Denver office of Mercer.
71.4 percent, with predictions that it will reach over 80 percent by the end of the century. These and other changes in the workforce mean that employee needs and preferences vary widely and that the mix of employee needs and preferences is likely to change over time.

FINANCIAL CHANGES

The 1970s and ‘80s were financially challenging for many benefit managers. During much of that time, the U.S. economy was in a significant downturn, which led to pressure to cut spending.

At the same time, a large element of the benefit budget, namely health care costs, was out of control. According to Health Care Financing Administration statistics, over the last twenty-five years the average cost of medical care per person in the United States has increased from $205 per year to more that $2,500. These same statistics project that by the year 2000, the cost could exceed $5,500. In fact, over the past twenty years, health care costs as a percentage of pre-tax corporate profits have increased from 11.4 percent to 48.6 percent. These cost increases have caused organizations of all types to consider new alternatives.

REGULATORY CHANGES

During this time, the legal environment became more favorable to flexible compensation plans. When the first plans were adopted, no statutory authority existed to support these favorable tax arrangements. The Internal Revenue Service generally refused to issue private letter rulings regarding the constructive-receipt issues, which made the IRS’s position on such flexible compensation arrangements unclear.

The enactment of the Employee Retirement Income Security Act of 1974 (ERISA) both helped and hindered the development of cafeteria plans. ERISA Section 2006 prevented the commissioner from adopting previously proposed regulations on salary reduction plans. Although those proposed regulations did not specifically address cafeteria plans, it was difficult to distinguish a cafeteria plan from the arrangements described in the proposed regulations. ERISA Section 2006 further provided that until new regulations were adopted, the law would be administered according to the legal principles in place before January 1, 1972, but only for those plans in existence on June 27, 1974. Because few cafeteria plans existed on June 27, 1974, the effect of ERISA Section 2006 was to prevent the formation of new cafeteria plans.

With the enactment of the Revenue Act of 1978, Section 125 of the Internal Revenue Code was created, which provided relief from ERISA Section 2006. Code Section 125 provides an exception to the constructive receipt doctrine for cafeteria plans.
Slight changes were made to these rules over the next few years. Then, in 1984, proposed regulations under Code Section 125 were issued and amended in light of the changes made by the Tax Reform Act of 1984. Early in 1986, short temporary regulations were issued, clarifying which benefits may be offered in a cafeteria plan.

In 1986, Congress considered a number of proposals that would have repealed Code Section 125 and inhibited the design of many flexible compensation plans. Those proposals were never adopted, and Code Section 125 survived relatively unchanged. Last year, more proposed regulations were issued that further clarified the IRS’s interpretation of certain areas, but some questions remain.

SPECTRUM OF FLEXIBLE COMPENSATION

A spectrum of programs all have been classified as flexible compensation arrangements:

- Arrangements offering choices among voluntary programs paid for exclusively by the employee
- Arrangements where the employee pays for health benefits on a pre-tax basis
- Stand-alone reimbursement accounts
- True flexible compensation arrangements, in which employees are provided an amount of money and an array of benefit choices from which to choose

It is these true flexible compensation arrangements that this article will cover. It will consider organizational objectives for adopting flexible compensation plans, the benefit options commonly found within such plans, the strategies for allocating employer contributions to employees, midyear changes in elections, nondiscrimination rules, and a look into the future.

ORGANIZATIONAL OBJECTIVES

Any discussion about benefit programs, including flex, should always start at the beginning, which would include a discussion of organizational objectives. What do employers want to accomplish when they consider flexible compensation?

A number of different objectives are frequently cited, but they can largely be classified into two main categories: increasing the employer’s return on investment in benefits, and better management and control of the cost of those benefits. The relative priority between these two main objectives has changed over the years.
Increased Return on Investment

In the early days of flex, the most commonly cited goal was to increase the organization’s return on its investment in benefits—enhancing employee satisfaction with current levels of corporate expenditures for compensation and benefits. Flex accomplishes this goal in several ways: by demonstrating that the employer is responding to the needs of a diverse work force, by making employees more aware of corporate expenditures for benefits, and by fostering new relationships with employees.

Making the compensation and benefits package more tax-efficient has also been mentioned frequently as a way to increase return on investment, but this proposition may be short-lived given the current federal budget deficit.

Responding to work force diversity

Understanding an organization’s current demographic makeup is important in deciding which flexible compensation alternatives to offer, given the wide variation in need and preference represented by demographic differences. However, there should be a broader recognition of the changing needs of employees throughout their careers. Flexible compensation arrangements give organizations the opportunity to establish a structure that will enable employees to meet their changing needs throughout their careers.

Increasing employee awareness

For years, employers have used different forms of communication, such as annual employee benefits statements, to describe to employees the total compensation they receive. Unfortunately, these efforts have had only limited educational success. Frequently, employees know very little about the costs of their benefits.

The knowledge gap can be overcome in a flex arrangement in which the employee has a specified amount of money to spend (commonly referred to as credits) on benefit decisions. The decisions that employees are forced to make in a flex plan require them to have a better understanding of the alternatives available.

It’s always enlightening to listen to employee comments in flex introduction meetings. A general hum rises as people start to look at the prices and the credits available to them. They are often shocked at the costs. The experience of the authors has been that flex plan participants understand and appreciate their benefits better than nonparticipants.

Improving employee-employer relationship

Research shows that employee satisfaction with benefits increases dramatically when an employee group is offered a flex plan. In 1985, Louis
Harris and Associates conducted a survey on corporate initiatives and employee attitudes toward flexible benefits for The Equitable. One of the findings was that 65 percent of the employees said they like flex a lot. The experience of the authors has been that this finding is true even when benefits are cut.

The satisfaction of flex participants increases, in part, because employees view management in a new light. People want more control over many aspects of their lives. The workplace is no exception. Even though the work environment is changing, there are still few opportunities to exercise control.

Giving employees control over their benefits shows that management trusts employees to make decisions. This trust creates a tremendous amount of goodwill and could well be the single most important reason for flex’s popularity among employees. Further, transferring the decision-making responsibility to employees creates a partnership with employees in the benefit program because they personally selected their benefits.

In sum, then, employees view flex favorably because they can tailor their benefits to suit their individual needs, are able to exercise control over their benefit credits, and enjoy being shown respect by being allowed to decide which benefits are most important to them.

**Better Cost Management and Control**

The other primary, and today the predominant, reason that employers adopt flexible compensation programs is cost. Cost objectives vary with the magnitude of the employer’s problems. Two objectives are frequently mentioned: to better manage and control future benefit cost increases, and to prevent additional costs from being incurred, by either the plan sponsor or the employee.

**Future cost control**

Controlling the rate of increase in benefits costs—particularly in the health care area—became a vital concern in the ‘70s and ‘80s and will become a national priority in the ‘90s. If the rate of increase in health care costs is not significantly curtailed in the first half of this decade, a groundswell of support for a national health program could well emerge in the second half of the ‘90s.

Employers offering a defined set of benefits have been saddled with automatic cost increases. Unless they cut benefits, costs automatically go up each year. Many employers are adopting flex arrangements to break that lockstep action.

In essence, these employers are reforming the fundamental nature of their promise. They are increasingly defining the organization’s commitment as a specific contribution (through flex credits) rather than a specific set of benefits. By using this *defined contribution* approach to benefits instead of a *defined...*
approach, the employer has a better control over the amount and timing of cost increases.

Employers are also beginning to change their view of benefits. Because benefits now represent such a substantial portion of the payroll, employers are beginning to treat benefits as part of total compensation, rather than as some form of entitlement. For example, in some instances future cost increases are limited to the increase in overall compensation.

Of course, these kinds of actions must be moderated in view of competitive positioning, but flexible compensation helps an employer maintain control over benefit expenditures. Even in situations where, initially, employees are still able to select the same benefits at no additional cost, flex keeps the control in the employer’s hands.

Cost avoidance

As mentioned earlier, a flex plan is a tool to improve the communication of benefits to employees. Through these improved communications, employees have greater understanding of the cost of benefits. Employees understand that their health care decisions will affect the overall compensation budget and that the costs are borne by their employer. This understanding works well with other cost-control initiatives, such as managed care or wellness campaigns, that an employer might undertake.

Introducing a flex plan does not guarantee that benefit costs will be reduced or will not increase as rapidly. On the contrary, if proper attention is not paid to pricing decisions, unit costs may soar because employees not only will select the benefits they are most likely to use, but they might also receive cash for benefits they never used before. A flex plan, however, can help an employer develop a partnership with employees so that the interests of both are better aligned.

BENEFIT OPTIONS

In a cafeteria plan, an employer may give its employees a choice of two or more benefits consisting of cash and qualified benefits. Qualified benefits must be excludable from an employee’s gross income under an express provision of the Code and, with limited exceptions, must not defer receipt of compensation to a future year.

Qualified benefits include medical care, dental care, vision care, disability, group term life insurance, dependent care, and Code Section 401(k) or 401(m) contributions. Certain nontaxable benefits are excluded from the term “qualified benefits”: scholarships and fellowships (Code Section 117), van-pooling (Code Section 124), educational assistance programs (Code Section 127), and certain
fringe benefits (Code Section 132). The term “cash” includes not only money, but also certain currently taxable benefits treated as cash.

Cash

Cash can be offered as a benefit option. Further, benefits that are purchased with after-tax employee contributions or that are currently taxable are treated as cash. These cash equivalents are subject to reporting and withholding. Thus, for example, an employer could offer employees the following options under a cafeteria plan: vacation days and group automobile insurance. Without this rule, employers would have to provide employees with a separate list of taxable benefit options outside the cafeteria plan. The cash-equivalent benefits may not, however, defer receipt of compensation. Thus, if an employer wants to offer employees whole life insurance, long-term-care insurance with a savings feature, or other benefits that defer compensation, such benefits must be offered outside of the cafeteria plan.

Finally, most plans allow for unused employer credits to be taken as additional taxable income. This option is very popular with employees.

Health Care

Health care benefits include medical, dental, and vision benefits. (Health care reimbursement accounts are discussed below under “reimbursement accounts.”)

Medical

Medical benefits are the most commonly offered benefit choice within a flexible compensation program. Arguably, medical benefits are also the most important; from the employee’s perspective they may be the most valuable, and from the employer’s perspective they are the most costly.

The first step in developing alternative medical choices is to define the extremes—the most and least generous options. After that, it can be decided what, if any, intermediate choices should be made available. A key element in designing a flexible compensation program is to offer meaningful choices to employees but not overwhelm them with too many choices.

Most generous option. In designing the most generous option, the best starting point is the current medical plan. From a communication perspective, it is important to include the current plan as an option in a new flex arrangement. This inclusion may prove to be problematic, however, if the current level of benefits is deemed to be too costly. The unacceptable level of cost may be due to overly generous benefit reimbursement, which promotes excessive consumption of health care services. This result occurs when the employee is insulated from any of the economic aspects of the consumption decision.
While a few super-rich plans remain in force, they clearly are the exception rather than the rule. Consequently, if the current plan provides for a comprehensive level of coverage, it is routinely offered as the high option. If, however, the current plan is considered too costly, the plan sponsor would be wise to eliminate that plan at the introduction of the flex plan. The introduction of a flex plan creates a significant amount of goodwill, and it is better to send balanced messages rather than to wait a year, then eliminate the plan and undermine management credibility.

If the current plan is the result of benefit cutbacks imposed some years earlier, it would be inappropriate to reinstate a more generous option. The negative employee-relations impact from reducing benefits would have already been weathered and backtracking would undermine cost-management efforts. Often, plan sponsors are seduced by the opportunity to reinstate generous benefits because they are able to charge the full cost to plan participants. However, the employees likely to elect such an option would be the high users of medical services, and actual claim expenditures are likely to be greater than expected. This adverse selection will lead to either rapidly increasing prices in later years or undesirable employer cost subsidies if the employer is not willing to pass on the full cost to the employee.

Least generous option. The level for the low option will depend on whether the employer permits employees to waive medical coverage or requires them to maintain some level of coverage, frequently referred to as core coverage.

Many employers are concerned about employees making inappropriate elections, going without needed coverage and then incurring significant expenses. One concern is legal liability due to a failure to properly inform employees of the consequences of their decisions. At a minimum, the employer may suffer from poor employee and community relations if a catastrophic event occurs. Other employers take the attitude that employees should be accountable for their actions. Depending upon the employer’s attitudes, objectives, and culture, this issue of core coverage must be resolved early in the design process.

If core coverage is required, the low option usually is a modest plan that primarily protects the employee from true catastrophic hardship. This core plan commonly has a very large annual deductible, at least $1,000, and high maximum out-of-pocket expense limits. The appropriate design is sometimes determined by an estimation of how large an out-of-pocket expense a lower paid employee could be exposed to without incurring financial ruin. That will, of course, vary by the nature of the employer’s work force.

If the decision is made to permit employees to waive coverage entirely, some people who have other coverage available will take this option. Because everyone who chooses to participate in medical benefits requires coverage of some type, the low option is generally somewhat better than when core coverage is required.
Intermediate options. Where there is a widespread between the high and low option, employers sometimes offer interim options. Typically, most employers limit the number of medical options to three or four.

In designing the middle option, the employer should be certain that there is a discernible difference between benefits provided by the options. However, if one of the employer’s objectives is to have employees elect a lower level of coverage than they have currently, it is important to keep the spread between the high and middle options sufficiently narrow to make the step palatable to employees.

Role for managed care. As employers continue to battle runaway health care costs, different alternatives have emerged for the delivery of health care benefits, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Undoubtedly, other alternatives will be developed. The key question for plan sponsors is how to use these arrangements within a flex plan.

HMOs have been around for years. Unfortunately, however, they are often ignored during the overall flex design process until it is time to communicate the plan.

Generally, the employer’s first concern is setting prices for the HMOs relative to the indemnity options. Because HMO benefits are typically very comprehensive, a trend is emerging to make the HMO the high option benefit and to price it accordingly. In organizations with significant operations in different parts of the country, local management may be allowed to select the HMOs best suited to their employees while at the same time fitting within an overall organizational structure. Alternatively, the employer may contract with a nationwide HMO organization.

PPOs can also have a significant role in a flex plan. The most common approach is to make the preferred arrangements part of each medical option. This approach extends the preferred arrangement to the largest part of the employee population possible. One outcome of having this managed care element in each of the options is fewer options. The employee would have an annual choice not only of a level of protection, but also of a delivery system. Plan designs must be straightforward to avoid confusing participants.

Coverage categories. Different categories of coverage are usually available depending on family status. In the early days of medical plans (and still today in a collectively bargained environment), two tiers or categories were available: coverage for the employee alone or for the employee and family, regardless of the number of dependents.

With changes in the workforce and the escalation of health care costs, the two-tiered approach has been refined into a three-tiered approach. The three-
tiered approach made coverage available to the employee, the employee and one
dependent, or the employee and two or more dependents.

    While this approach was an improvement and still is frequently used, it
ignored some actuarial realities. Specifically, the cost of an employee and spouse
is usually greater than the cost of an employee and children. The reason is that
although children tend to see the physician more often than adults, their illnesses
tend to be less severe.

    Consequently, a four-tiered approach has emerged, making coverage
available for the employee, the employee and children, the employee and spouse,
and the employee and the entire family. This approach makes coverage less
expensive for the single parent.

**Dental**

    According to the Louis Harris survey previously mentioned, the
introduction of a dental plan is the new benefit most appreciated by employees.\textsuperscript{19}
At the same time, a dental plan is far less costly to the employer than the medical
plan so there is less need for a wide range of options. Indeed, rarely does a flex
plan offer more than two dental options. However, it is important to recognize
that because dental expenses are both easy to predict and budget, dental plans are
subject to a considerable amount of adverse selection.

    One way to control adverse selection is through a single coverage election
for both medical and dental coverage. This means that an employee who chooses
single coverage under a medical option could only choose single coverage under
the dental plan. This approach is more restrictive, but does help stabilize costs.

**Vision**

    Typically, vision benefits provide reimbursement for examinations,
frames, lenses, and contacts. However, vision-related expenses are easy to predict
and budget, even more than dental expenses, and therefore are also subject to
adverse selection.

    With the advent of reimbursement accounts, an individual is able to
achieve the favorable tax treatment that would otherwise be offered through a
group vision plan. Actually, the new uniform-coverage rules (discussed below
under “Reimbursement Accounts”) make the payment of expenses even more
manageable (and thus adverse selection even greater). Thus, separate vision care
plans are not frequently found in flex plans. Where they do exist, they are
packaged with another benefit, such as the dental plan, to keep the effect of
adverse selection at a minimum.

    A substitute for the traditional indemnity arrangement for vision expenses
is the vision discount plan. This plan essentially furnishes services and supplies at
reduced charge levels from a provider who has contracted with the organization. These arrangements do not put the employer at risk for the cost of the services at all, yet they provide the participants with lower costs.

**Reimbursement Accounts**

The reimbursement-account provisions of a flex plan generally provide for a health care reimbursement account and a dependent care reimbursement account. These accounts are frequently referred to as flexible spending accounts (FSAs). [For recent developments in FSAs, see Bosco’s column in this issue of the *Benefits Law Journal*.]

**Health FSA**

Under a health FSA, an employee may elect a salary-reduction amount (or the employer may provide such amount) to be credited to an account to pay for medical expenses. Amounts credited to the health FSA are excludable from income, provided such amounts are used to reimburse medical expenses and certain other requirements are met.

The range for the maximum amount that may be contributed to the health FSA is generally between $1,000 and $3,000. Usually, about 20 percent of eligible employees participate in a health FSA.

**Uniform coverage rule.** Under the new proposed regulations, a health FSA will not qualify for tax-favored treatment under Code Sections 105 and 106 if the reimbursement arrangement eliminates all, or substantially all, of the risk of loss to the employer maintaining the plan or to the other insurer. To implement this new concept of employer risk of loss, the uniform coverage rule was established. This rule provides that the maximum annual contribution amount elected by the employee must be available for reimbursement at all times during the plan year, reduced for claims paid during that same period. For example, if the employee elects to contribute $150 a month to a health FSA, the annual maximum amount of $1,800 must be available for reimbursement of qualified medical expenses (less any amounts previously reimbursed) from the first day of coverage, even though the employee has not yet contributed the full amount to the health FSA. In addition, claims on health FSAs must be paid at least monthly or when the total claim amount equals a reasonable minimum (perhaps $50). The uniform coverage rule creates substantial risk to employers if claim payments exceed contributions when mid-year elections or terminations occur. Terminating employees could make only a few contributions, have large claims reimbursed early in a coverage period, then terminate employment and leave the employer with a substantial deficit. The new proposed regulations prohibit the employer from adjusting so-called premiums based on actual claim reimbursements, so coverage cannot be phased in as the employee pays more premiums, and terminating employees cannot be required to pay additional
contribution amounts. Employers could, however, require terminating employees who do not elect COBRA FSA coverage to forfeit unused health FSA account balances not attributable to a prepaid premium. This forfeiture may help reduce the employer’s economic risk of loss under the uniform coverage rule.

COBRA. The new proposed regulations confirm that the health FSA is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). An interesting design question is whether COBRA requires that each qualified beneficiary be able to receive coverage under a separate FSA. COBRA does require that each qualified beneficiary in a family unit be entitled to make separate COBRA elections. As a result, it may be concluded that COBRA also requires the availability of separate FSA elections.

The general policy of COBRA, however, is that qualified beneficiaries be treated no less favorably than active employees with respect to an employer’s health plans. Flex reimbursement accounts are almost always operated as a single FSA for the entire family. Furthermore, the premium for the FSA is determined on a per-FSA basis (without regard to the number of family members). Therefore, it would be reasonable to provide a single FSA to each qualified beneficiary family unit, rather than an FSA for each qualified beneficiary within the family.

Dependent care FSA

Under a dependent care FSA, an employee may elect a salary reduction amount (or the employer may provide such amount) to be credited to an account to pay for dependent care expenses. Amounts credited to the dependent care FSA are excludable from income provided they are used to reimburse the employee for expenses that qualify as dependent care assistance. Typically, participation by eligible employees in a dependent care FSA is 2 percent to 5 percent.

Unlike the health FSA, which must use the uniform coverage rule discussed above, a dependent care FSA may still use the accrual method for reimbursement of expenses. Under the accrual method, as salary reduction contributions are made each pay period, the employee builds up an account balance that is available for reimbursements. If the balance is not large enough to reimburse a submitted expense, a partial payment can be made or the bill can be held until enough money is available.

Pre-tax reimbursement vs. tax credit. Work-related child care and other dependent care benefits are frequently provided through a flex plan. Employees must choose between pre-tax reimbursement and the tax credit because the maximum amount of expenses eligible for reimbursement is reduced dollar-for-dollar by expenses reimbursed through a pre-tax dependent care reimbursement feature, and vice versa. Employees need to understand the tax consequences of using the dependent care reimbursement portion of a flex plan versus the tax
credit. To allow employees to make intelligent decisions regarding this choice, employers should provide general descriptions of the two tax approaches and the circumstances that might make one approach more advantageous to an employee than the other.

**Tax credit.** The amount of credit allowed under Code Section 21 on an individual’s federal personal income tax return is based on a maximum of $2,400 for one qualifying dependent and $4,800 for two or more qualifying dependents. The individual is allowed a tax credit based on a published percentage of these amounts. This published percentage varies from 20 percent to 30 percent, depending on the individual’s (or the individual’s and spouse’s) adjusted gross income. The percentage declines one percentage point for each $2,000 of adjusted gross income as the adjusted gross income rises above $10,000.

**Pre-tax reimbursement.** Code Section 129, which covers dependent care assistance programs, provides that the maximum excludable amount is $5,000 a year, or $2,500 a year if the individual is married and files a separate return.

**Documentation and payment of claims**

In response to IRS concerns that plan administrators failed to obtain adequate documentation regarding the reimbursement of employees from FSAs, the new proposed regulations establish stringent guidelines. In order to be reimbursed, the employee must provide a written statement from an independent third party itemizing expenses by date and amount. Also, the employee must state in writing that the claim has not been or will not be reimbursed by any other coverage. The employee’s representation regarding the reimbursement by another provider is intended to prohibit double payment for an expense.

Expenses reimbursed from an FSA must be incurred within the employee’s period of coverage. Expenses are deemed to have been incurred when actual medical treatment or dependent care was rendered and not when the employee is formally billed or charged, nor when the employee pays for the treatment. Expenses are not covered if the FSA was not in existence at the time of the treatment or if the employee was not participating in the FSA at the time of the treatment.

**Experience gains**

An FSA realizes an experience gain for the plan year if the collection of premiums, including earnings on premiums, exceeds the claims reimbursements and reasonable administrative costs. An experience gain may be used to benefit participants in several ways. First, a gain may be used to reduce the premiums for the next year, thereby reducing the cost for the same coverage. For example, $1,000 of FSA coverage may cost only $950.
Second, the gain may be distributed to the participants.\textsuperscript{42} Distribution must be on a “reasonable and uniform basis,” but not based on individual claims experience.\textsuperscript{43} The gain may be divided equally among participants without regard to their contributions. For example, if the plan has a $1,000 gain and five participants, each participant is entitled to $200. Although one participant’s contribution equals 30 percent of the total annual contributions and another participant’s contribution is 10 percent, both participants receive $200.

Under another approach, the plan administrator may distribute the gain according to each participant’s contribution as a percentage of the total annual contributions of all participants. Claim reimbursements are not deducted from the participant’s contribution. For instance, in the previous example, the first participant would receive $300 and the second participant would receive $100.

**Death Benefits**

Death benefits are also commonly offered within a flex plan.\textsuperscript{44} Death benefits may cover the death of the employee and/or dependents due to an accident or due to any cause. The range of choices must be provided through a term policy because whole life insurance and universal life insurance provided through a flex plan would violate the deferral-of-income prohibition.\textsuperscript{45}

**Employee life**

From the perspective of the survivors, objectives may include burial expenses, transitional income for survivors, and estate accumulation. The relative importance of these objectives varies depending upon personal situations, including the amount of life insurance available from other sources.

To the extent possible, employers should offer choices to cover these different needs. The key determinant is usually the employee’s pay, because the death benefit is intended to replace that income. The options are sometimes expressed in flat dollar amounts, but this approach can get complicated if too many options are available.

At the high end of the pay range, employers may be limited by state insurance requirements or insurance-company underwriting restrictions. A typical upper end is four times an employee’s pay.

At the lower end of the pay range, the question of core coverage again enters into the decision. Most employers provide some basic amount of coverage, such as $5,000 to $10,000, at no cost to the employee. The cost of providing this basic coverage is relatively low. In addition, most employers would rather not have to tell the employee’s survivors that the employee died without any life insurance coverage.
While this coverage is not so expensive as medical, there are still certain precautions that may be required by the insurance carriers to guard against adverse selection. Typically, at the first open enrollment there are no restrictions on an individual’s ability to select among the available options. The only possible exception would be certain highly compensated employees whose insurance needs might be quite sizeable. In that instance, the individual may need to satisfy insurability requirements.

At subsequent elections, restrictions and insurability requirements frequently apply regarding increases in coverage. Many times, an individual may not increase coverage by more than one level at any one election. Carriers also frequently require evidence of insurability before permitting the increased coverage. These restrictions are designed to protect the carrier and the plan from adverse selection.

**Dependent life**

Dependent life coverage tends to be much lower than employees’ coverage, largely because of state insurance restrictions. Optional life insurance benefits are sometimes available for either the employee’s spouse or children, or both. Coverage is typically a flat rate of $1,000, $2,000, or $5,000 for a spouse and $1,000 or $2,000 for children. Plan sponsors should make sure that state insurance limits are satisfied.

**Accidental death and dismemberment**

An extremely popular benefit is accidental death and dismemberment (AD&D). This benefit is appealing largely because of its low cost. The reason for the low cost is that claims are rare. Due to the low cost of this type of insurance, employees maybe lured into a false sense of security by purchasing a significant amount of this type of insurance coverage, yet not having any real protection should death not result from an accident.

Typically, with coverage levels mirroring basic life amounts, this benefit is totally optional, with no core coverage provided. Employers concerned about their employees’ confusion may make AD&D coverage available in flat-dollar amounts, rather than contingent upon compensation.

Finally, some plans provide supplemental AD&D coverage for the employee’s dependents. The coverage amount is usually a percentage of the employee’s AD&D coverage—such as spouse, 50 percent, and children, 25 percent.

**Disability**

Disability benefits can be offered in a flex plan. Disabilities fall into three groups: occasional—those expected to last at least a day, but not longer
than a week; short term—those which last more than a week, but are not expected to be permanent; and long term—those expected to be total and permanent and keep the employee from being gainfully employed for a year or more.

A well-designed disability program will replace a portion of the employee’s income during each of those periods. To date, most of the choice within a flex plan has been in the long-term disability area. However, more plans are beginning to offer short-term benefits.

**Occasional benefits**

Occasional disability benefits are generally covered under an employer’s sick leave policy. Thus, such occasional disability benefits are generally not found in a flex plan.

**Short-term benefits**

Many employers provide a comprehensive short-term disability program. However, some industries, such as financial services and health care, have programs where employees accumulate days of sick time with each year of service. In these situations, newer employees need protection in the event of disability until the long-term disability program or Social Security commences.

Short-term disability options above any basic coverage tend to be fully paid by the employee. Because it is voluntary, the plan is subject to adverse selection. Consequently, plans typically offer modest benefits in order to promote the employee’s return to work. They may also have a protracted elimination period (for example, benefits commence after thirty days of disability) to make it harder for employees to predict in advance that they will incur these expenses. Finally, to keep the risk to the employer to a minimum, these plans are frequently fully insured. Insurance carriers may require a minimum number of participants, or they may cancel coverage or increase rates significantly in subsequent years. These concerns have contributed to the limited growth in these optional plans.

**Long-term disability**

Long-term disability (LTD) coverage is typically for disabilities that last at least six months and are expected to continue for at least one year and to be total and permanent. Social Security also provides coverage for these types of disabilities.

At the high end of the range of options in a flex plan, the benefits should not be so generous as to promote malingering. The most generous option replaces 70 percent to 75 percent of pre-disability pay, which includes offsets for benefits received from other sources such as rehabilitative employment and family Social Security.48
At the lower end of the range, some benefits should be payable in addition to Social Security benefits. Almost all LTD benefits include a Social Security offset. For a lower-paid individual, the Social Security benefit can exceed 40 percent of pay. Thus, if the low option for LTD is 40 percent, some employees may pay for a benefit they could never receive. To avoid this situation, the low option frequently includes a minimum benefit of $50 or $100 a month to assure that a benefit is payable to all participants. Of course, as the percent of pay replaced by the low option increases, the need for this minimum is reduced.

Applying the principle that each choice be meaningful and distinct, not many choices are needed in this area. Typically, only two or three options are available, depending on whether any core coverage is required.

**Vacation Days**

Flex plans may offer an employee the option to “buy” or “sell” elective vacation days. Elective vacation days are those the employee may buy or sell for cash, but not for deferred compensation. Nonelective vacation days are days provided by the employer that the employee cannot redeem for cash, but may be carried over and accrued for future use as vacation days. A participant is deemed to use nonelective vacation days first. The ability to sell vacation days will become more critical as employees look for benefits to trade for increasingly expensive health benefits.

A participant may cash out unused elective vacation days but not carry them over to another year. The cash-out must be accomplished before the earlier of the last day of the plan year or the last day of the participant’s taxable year. The cash-out feature provides relief for employers who were previously caught between compliance with state law (which prohibits forfeitures of vacation days) and federal law (which prohibits the carryover of elective vacation days).

**401(k) and 401(m)**

A cafeteria plan may include a 401(k) plan. Proposed regulations issued in March 1989 also permit the inclusion of after-tax employee contributions and employer-matching contributions, a Code Section 401(m) arrangement, with or without a 401(k) feature in a cafeteria plan. Changes in election for elective 401(k) contributions and after-tax employee 401(m) contributions are permitted during the cafeteria plan year in accordance with Code Sections 401(k) and 401(m) and are not restricted by the election rules applicable to cafeteria plans.

**Unused credits**

Some employers have flexible benefit plans under which employees are given a set amount of employer credits to purchase health and other nontaxable benefits. Regular salary reduction is not permitted in such plans and no taxable benefits are available for purchase within the plan. Any unused employer credits
are automatically rolled into a defined contribution plan on behalf of such employees. This rollover does not qualify as a 401(k) contribution, because employees do not have the option to take the contribution in cash.56

Some employers believe that the flexible benefits plan is not subject to the Code Section 125 requirements because no taxable benefits are available under the plan.57 However, the IRS could view the contributions as taxable benefits because the employees ultimately will be taxed on them when they receive distributions from the defined contribution plan. If the IRS view were to prevail, then (1) the flexible benefits plan would have to satisfy the Code Section 125 requirements, (2) the rollover amounts would have to qualify as 401(k) elective deferrals, and (3) cash would probably have to be added as an option.58

Assuming that the previously described flexible benefits plan is not subject to the Code Section 125 requirements, these rollover amounts would also not be subject to the 1990 $7,979 limit on elective deferrals.59 They would, of course, be treated as annual additions subject to Code Section 415.60 The plan would have to satisfy the nondiscrimination rules under Code Section 401(a)(4) for nonelective deferrals; it would not be able to use the 401(k) average-deferral-percentage test to help the rollover amounts pass.

If the flexible benefits plan described above also offered some taxable benefit options within the plan, the plan would need to satisfy the Code Section 125 requirements.61 Because of the deferred compensation restriction under Code Section 125, the issue then becomes whether rollover contributions would qualify as 401(k) elective contributions under a qualified cash or deferred arrangement. Normally, in order to meet Code Section 401(k) requirements, the plan must offer a cash option.62 But perhaps the 401(k) cash-availability rule recognizes cash equivalencies, at least those also recognized under the cash equivalencies rule in the Code Section 125 regulations.63

If the cash equivalencies rule is also recognized for Code Section 401(k) purposes, then these automatic rollovers of unused employer credits may be treated as elective 401(k) contributions and the $7,979 elective deferral limit for 1990 would apply.64

In the absence of official IRS guidance, employers should be aware that the approach taken by using the automatic rollover of unused employer credits is aggressive and may jeopardize the tax status of a cafeteria plan.

**STRATEGIES FOR ALLOCATING EMPLOYER CONTRIBUTIONS**

How the employer provides participants with money to purchase their choices is frequently referred to as the *credit allocation strategy*. Several strategies have been used, including benefit based, flat dollar, percent of pay, and
combination of flat dollar and percent of pay. The choice of strategy is largely based on the employer’s objectives and the type of benefit programs involved.

**Benefit Based**

In the early years of flex plans, employers adopted benefit-based arrangements almost exclusively, to enhance employee relations. One of the key messages employers wanted to communicate to employees was that employees would be able to purchase the same benefits that they had immediately prior to the introduction of flex. Thus, employees were reassured that whatever elections they made, their economic position would not be worse than before the flex plan. From this objective evolved the benefit-based strategy, which provides employees with credits equal to the value of benefits provided immediately before the adoption of the flex plan. Thus, the employer would determine the value of each participant’s pre-flex package of benefits, considering only those benefits that would be included in the flex plan.

**Flat Dollar**

Another alternative is to express credits exclusively in flat dollar terms. This strategy works well when the employee is selecting from health-related benefits, the cost of which is generally computed on a per capita basis. If the flat dollar credits are derived from a benefit plan that is income based (such as life insurance), this strategy is more advantageous to the lower-compensated employees than to the higher-compensated employees.

**Pay Related**

Another approach is to express credits exclusively as a percentage of pay. The pay-related strategy is particularly effective when a significant portion of the benefits provided before the adoption of the flex plan were pay related. However, the pay-related strategy does favor highly compensated employees in the purchase of health benefits and can create adverse employee relations with lower-paid employees.

**Combination of Flat Dollar and Pay Related**

Under a combined flat dollar and pay-related strategy, employees are provided with a two-part credit—a flat dollar pan for health benefits and a pay-related part for income-related benefits.

**Comparison of Credit Allocation Strategies**

Here is how the different credit allocation strategies would work in a hypothetical employer situation.

*Example:* Employer A provides medical, dental and life insurance benefits.
Let’s look at the effect of the four credit allocation strategies on two employees. Employee No. 1 is single and earns $24,000 per year. Employee No. 2 is married, earns $48,000 per year and takes full family coverage. Each receives life insurance coverage of one times pay.

**Benefit based**

Under this strategy, the two employees would receive the following monthly credits:

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Monthly Cost</th>
<th>Employee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual:</td>
<td>$100</td>
<td>$0</td>
</tr>
<tr>
<td>Family:</td>
<td>$250</td>
<td>$30</td>
</tr>
<tr>
<td>Dental:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual:</td>
<td>$8</td>
<td>$0</td>
</tr>
<tr>
<td>Family:</td>
<td>$20</td>
<td>$3</td>
</tr>
<tr>
<td>Life insurance:</td>
<td>$0.20 per $1,000 of coverage</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>$112.80</td>
<td>$246.60</td>
</tr>
</tbody>
</table>

Because dependent coverage is subsidized, Employee No. 2 receives $129 more in credits for medical and dental coverage. Additionally, higher-paid employees would receive more credits because the life benefit is based on pay. Nevertheless, both employees are able to buy back the coverage that they had prior to the adoption of the flex plan without additional cost. In order to avoid materially increasing their costs, employers provided the additional credits for family coverage only if the employee selected family coverage.

**Flat dollar**

Under the benefit-based strategy, the total amount of credits available to both employees was $359.40 ($112.80 + $246.60). Reducing the $359.40 by the $129 subsidy for the cost of family coverage equals a credit amount of $230.40. Dividing this $230.40 between the two employees means that each employee would receive a credit equal to $115.20.

Thus, the lower-paid employee receives $2.40 more. The higher-paid employee receives $2.40 less than the $246.60 he received under the benefit based approach when the $129 family subsidy is added back in. As more income-
related benefits are included in the flex plan beyond just life insurance in this example, the lower-paid employee is able to buy relatively greater benefits than the higher-paid employee.

As health care costs continue to rise, some employers are concerned about the lower-paid employees’ ability to afford health care coverage. To provide more credits to lower-paid employees, employers are starting to further reduce the highly compensated employees’ credits (typically on a percent-of-pay basis). While this approach has some merit, it is important to understand the demographics of each work force. For example, if lower paid employees are primarily second wage earners, they might have a smaller need for benefits.

**Pay related**

Assume that available monthly credits are again $230.40, excluding the $129 family subsidy which the higher-paid employee receives. If these credits are reallocated exclusively based on pay, the result is approximately 3.8% of the annual payroll. Thus, Employee No. 1 would receive a monthly credit of $76.80 and Employee No. 2 would receive a monthly credit of $153.60. This result is usually not satisfactory unless the employer wants to dramatically move to support a philosophy of total compensation.

**Combination of flat dollar and pay related**

Under this strategy, a credit allocation formula might be $100 plus 0.2% of pay. In the first year of the flex plan, this typically results in credits that are substantially the same as the benefit-based approach. However, future employer contributions would not be completely tied to the cost of specific benefits. Rather, the future credit amount would be tied to other criteria, such as an increase in overall pay or a portion of future cost increases. This approach would start to break the notion that the employer would continue to pay the entire cost of the current level of benefits regardless of amount.

**Summary of Credit Allocation Strategies**

Each of these strategies has advantages and disadvantages, and no approach is the best for all situations. Before choosing a credit allocation strategy, the plan sponsor should consider the benefit history, financial situation, competitive labor environment, employee relations goals, and any other objectives.

**MIDYEAR CHANGES**

Participants are generally not allowed to change elections after the coverage period commences. However, midyear changes are permitted for changes in family status, cost or coverage changes, cessation of required contributions by the employee, and separation from service by the employee.
A plan is not required to permit midyear changes for any of these events. If, however, an employer wishes to permit changes for some or all of these events, the written plan must specifically permit such changes. There are special concerns with respect to health FSAs.

**Changes in Family Status**

Events that constitute changes in family status include the following:

- Marriage or divorce
- Death of spouse or dependent
- Birth or adoption of a child of the employee
- Termination or commencement of employment for the employee’s spouse
- Change in employment status for the employee or spouse (part-time to full-time employment or vice versa)
- Taking an unpaid leave of absence by the employee or spouse
- Significant change in health coverage of the employee or spouse attributable to the spouse’s employment

This list is not all-inclusive. For example, an employer may want to allow an election change for an employee moving outside an HMO area or being transferred to another city. The plan must specify the circumstances in which changes of election will be allowed. The change in election must be “on account of” and “consistent with” the change in family status.

**COST OR COVERAGE CHANGES**

A cafeteria plan may automatically adjust employee contributions to the plan in the event of health plan cost changes if required by a third party. If the cost significantly increases, the plan may also permit participants either to increase their premiums or to revoke their elections and receive coverage under another health plan with similar coverage. If coverage under a health plan provided by a third party is significantly curtailed or ceases, the plan may permit participants to revoke their elections and receive coverage under another health plan with similar coverage.

**Cessation of Required Contributions**

A plan may provide that if an employee does not make the required premium payments, the benefit coverage ceases. If the plan includes such a provision, the plan must also provide that the employee may not make a new election for the remainder of the plan year.
Separation from Service

A flex plan may specify that employees who separate from service

- are not eligible to continue coverage once they terminate; or
- are eligible to continue coverage if they continue to pay premiums, or
to revoke coverage upon termination (employees who revoke coverage
and return cannot make a new election for the remainder of the plan
year).75

In either case, employees must be extended COBRA rights for any health
coverage included in the flex plan.

NONDISCRIMINATION RULES

Like other benefit plans, flexible benefit plans are subject to
nondiscrimination rules though Code Section 125 and other Code sections.

Code Section 125 Nondiscrimination Rules

Code Section 125 imposes two nondiscrimination rules on cafeteria plans:
one rule for highly compensated employees and the other for key employees.

Highly compensated employees

Eligibility. A cafeteria plan may not discriminate in favor of highly
compensated individuals76 as to eligibility to participate.77 Code Section 125(g)
provides two safe harbors for this rule.

One safe harbor provides that a plan shall not be considered
discriminatory if it is maintained pursuant to a collective bargaining agreement.78

The second safe harbor has three conditions:

- nondiscriminatory classification—the same as qualified plan rule;79
- eligibility period—not exceeding three years; and
- entry date—no later than the first day of the first plan year after the
eligibility period is satisfied.80

Contributions and benefits. A cafeteria plan also cannot discriminate in
favor of highly compensated participants as to contributions and benefits.81 Code
Section 125(c) describes this test: “A cafeteria plan does not discriminate where
qualified benefits and total benefits (or employer contributions allocable to
statutory nontaxable benefits and employer contributions for total benefits) do not
discriminate in favor of highly compensated participants.” Further, Code
Section 125(g)(1) contains a special nondiscrimination rule for a cafeteria plan
that provides health benefits.
If a plan does discriminate in favor of the highly compensated, the plan is not disqualified, but the otherwise nontaxable benefits for highly compensated employees will become taxable to them.

**Key employees**

The nontaxable benefits provided to key employees, as defined in Code Section 416(1)(1), may not exceed 25 percent of the total of such benefits provided to all employees. Noncompliance with the key-employee test results in taxable benefits to the key employees.

**Other Nondiscrimination Rules**

A thorough discussion of the nondiscrimination rules found in other Code Sections is beyond the scope of this article.

**A LOOK INTO THE FUTURE**

The notion of choice has become well-accepted and popular in the American workplace. The ability to exercise control over the allocation of one’s total compensation appeals to employees. Flexible compensation will continue to expand to new plan sponsors and into new benefit areas among existing plan sponsors.

Some new areas into which flex will expand include new groups of participants, such as retirees, and new benefit areas, such as long-term care.

**Retiree Flex**

Several factors combine to make benefits choice more acceptable for retirees. Like active employees, retirees have experienced rapid increases in health care costs. The FASB’s pending accounting rules for post employment benefits are also causing employers to consider options for providing these types of programs. Beyond cost issues, there is a recognition that the notion of one-size-fits-all is no longer valid in the retiree population. Additionally, as flex becomes more common, former flex participants want to continue having the choices they enjoyed before retirement.

There are plan designs that can provide more choice to retirees while limiting the employer’s liability. Most provide credits based on the retiree’s years of service. The retiree is then able to select from a menu of benefits usually restricted to health care and life insurance, but not cash. Some plans create retiree spending accounts, in which the amount deposited may be rolled over from one year to the next without any forfeitures because the only deposits are employer contributions.

As these plans are designed, it is important to recognize Medicare’s significant role in providing health benefits; this role may limit the need to offer
medical choices to those over sixty-five. Further, some plans may restrict the retiree's ability to make choices as he or she ages.

**New Benefit Options**

The 1990s will see the continued expansion of benefit choices offered to flex plan participants. Already some plans offer such coverages as long-term care, group auto insurance, homeowners coverage, and umbrella liability.

In the future, new benefits will emerge in areas such as education and housing assistance. While these benefits are not qualified benefits, employers will, nevertheless, consolidate them into the flexible compensation plan.

**NOTES**

2. *Id.* at 7.
4. *Id.*
7. *Id.*
8. The Internal Revenue Code of 1986 was previously the Internal Revenue Code of 1954.
11. IRC § 135(d)(1)(B).
13. IRC § 125(f).
14. Prop. Reg. § 1.125-2(Q/A-4(b)).
15. IRC § 125(d)(1)(B).
16. Prop. Reg. § 1.125-2(Q/A-4(b)).
17. *Id.*
18. *Id.*
20 Prop. Reg. § 1.125-2(Q/A-7(b)(4) and (c)); IRC § 105(b).
22 Prop. Reg. § 1.125-2(Q/A-7(a)).
23 Prop. Reg. § 1.125-2(Q/A-7(b)(2)).
24 Id.
25 Id.
26 Prop. Reg. § 1.125-2(Q/A-7(b)(3)).
28 Prop. Reg. § 1.125-2(Q/A-7(b)(8) and (c)); IRC § 129(e)(1).
29 IRC § 129(e)(1).
30 Prop. Reg. § 1.125-2(Q/A-7(b)(8)).
31 IRC § 21(c); IRC § 129(e).97.
32 IRC § 21(c).
33 IRC § 21(a).
34 IRC § 129(a)(2)(A).
35 Prop. Reg. § 1.125-2(Q/A-7(b)(5)); Prop. Reg. § 1.125-2(Q/A-7(b)(8)).
36 Id.
37 Prop. Reg. § 1.25-2(Q/A-7(b)(6)); Prop. Reg. § 1.125-2(Q/A-7(b)(8)).
38 Id.
39 Id.
40 Prop. Reg. § 1.125-2(Q/A-7(b)(7)); Prop. Reg. § 1.125-2(Q/A-7(b)(8)).
41 Id.
42 Id.
43 Id.
44 IRC § 79(a) establishes an exclusion from gross income of the cost of up to $50,000 of
employer-provided group term insurance on the life of the employee. IRC § 79(a) provides
that the cost of any employer-provided group term insurance over these limits is includable in
the gross income of employees. However, group term insurance in excess of these amounts
may still be included in a flex plan as a qualified benefit. Prop. Reg. § 1.125-2(Q/A-
4(a)(2)(ii)). A separate exclusion from gross income of the cost of up to $2,000 of employer-
provided group term insurance on the life of a spouse or the dependents of an employee is
provided under IRS Notice 89-110, IRB 89-49. (Dec. 4, 1989). AD&D insurance can also be
included in a flex plan. Prop. Reg. § 1.125-2(Q/A-4(a)(2)(i)).
46 “Employee Benefits in Medium and Large Firms, 1988,” U.S. Department of Labor, Bureau
47 Prop. Reg. § 1.125-2(Q/A-4(a)(2)).
48 “Employee Benefits in Medium and Large Firms, 1988” supra, at 17.
49 Prop. Reg. § 1.125-2(Q/A-5(c)(1)).
50 Prop. Reg. § 1.125-2(Q/A-5(c)(2)).
51 Prop. Reg. § 1.125-2(Q/A-5(c)(3)).
52 Id.
54 Prop. Reg. § 1.125-2(Q/A-4(c)).
55 Prop. Reg. § 1.125-2(Q/A-6(f)).
56 IRC § 401(k)(2)(A).
57 IRC § 125(d)(l).
58 IRC § 401(k)(2)(A).
59 IRC § 402(g)(l).
60 IRC § 415(c).
62 IRC § 401(k)(2)(A).
63 Prop. Reg. § 1.125-2(Q/A-4(b)).
64 IRC § 402(g)(l).
65 Prop. Reg. § 1.125-2(Q/A-6(a)).
67 Id.
68 Prop. Reg. § 1.125-2(Q/A-6(c)).
69 Id.
70 Prop. Reg. § 1.125 2(Q/A-6(b)(1)).
71 Id.
72 Prop. Reg. § 1.125-2(Q/A-6(b)(2)).
73 Prop. Reg. § 1.125-2(Q/A-6(e)).
74 Id.
75 Prop. Reg. § 1.125-2(Q/A-6(d)).
76 IRC § 125(e) definition of highly compensated individuals differs from the definition found in IRC § 414(q).
77 IRC § 125(b)(1)(A).
78 IRC § 125(g)(l).
79 Prop. Reg. § 1.401(b)-4.
80 IRC § 125(g)(3).
81 IRC § 125(b)(1)(B).
82 IRC § 125(c).
83 IRC § 125(b)(2).
84 Id.
85 These retiree spending accounts are not established as Code Sections 125 spending accounts and therefore are not subject to Code Section 125. Typically, the benefits provided by these accounts are subject to the limitations of Code Section 105(h).