

Summary of IRC § 105(h) Non-Discrimination Rules

105(h) and Self-Funded Plans

Internal Revenue Code Section 105 contains the tax exclusion that allows benefits received for medical care to be nontaxable to participants and beneficiaries.¹ For self-funded medical plans, the non-discrimination rules included in subsection 105(h) are a critical component of this tax benefit. These non-discrimination rules have applied to self-funded group health plans for years with no active enforcement. Self-funded group health plans include major medical plans, dental and vision plans, Health Reimbursement Arrangements (HRAs) and Health Flexible Spending Arrangements (H-FSAs). Increased attention on section 105(h) non-discrimination rules came with the passage of the Affordable Care Act (ACA). Under the ACA, all insured non-grandfathered group health plans will be subject to 105(h) "like" non-discrimination rules. Although the IRS delayed the applicability of the 105(h) like structure to insured non-grandfathered plans pending the release of clearer regulations, we anticipate increased scrutiny on self-funded plans when the regulations on insured non-grandfathered plans are eventually released.

Two Required Tests

There are two non-discrimination tests that apply to self-funded health plans under section 105(h): an Eligibility test and a Benefits test. If a self-funded health plan fails to pass either test, some or all of the favorable tax treatment of reimbursements to Highly Compensated Individuals (HCIs) is lost (see additional discussion below). Note that the ACA provides a different penalty structure for discriminatory non-grandfathered insured group plans. Under the ACA, those plans, if discriminatory, will eventually be subject to an excise tax of \$100 per day per affected individual.

The Benefits Test

A plan cannot discriminate in favor of HCIs with respect to plan benefits. Benefits is generally interpreted to include all aspects of coverage such as differences in coverage, cost-sharing, and waiting periods. This test also requires that all benefits provided to HCIs and their dependents be provided to all other participants on the same terms. The Benefits test should be applied with respect to discrimination on the face of the plan and as to whether the plan is discriminatory in operation (e.g., was a benefit offered or expanded to coincide with a need of a HCI).

The term Highly Compensated Individual or "HCI" includes: (1) the top five highest-paid officers, (2) more than 10% shareholders, and (3) all employees who are among the highest paid 25% of non-excludable individuals. The highest paid 25% of employees will usually include all of the highest-paid officers and more than 10% shareholders. These individuals do not generally need to be counted separately and should not be counted twice. Note that this is a different definition than Highly Compensated Employee, which is used in testing certain other benefits like Dependent Care Accounts, or that is used in more general Cafeteria Plan testing. One challenge in non-discrimination testing is that HCI status should generally be determined as of the current plan year as opposed to being based on the prior plan year. Due to this administrative difficulty, many plans test based on prior year data, but this strategy should be discussed with counsel.

There is also debate surrounding what "benefiting" under a self-funded health plan actually means. The more generally held belief is that to benefit under a self-funded health plan requires actual coverage under the plan, as opposed to being merely eligible for benefits under the plan. However, a different interpretation is customarily used when applying section 105(h) to health flexible spending accounts (H-FSAs), which are also self-funded medical plans subject to section 105(h). For testing H-FSAs, benefiting is commonly interpreted as eligibility alone.

¹ Section 106 contains the tax exclusion for employer contributions towards the cost of medical coverage

The Eligibility/Participation Test

This Eligibility test requires a plan to measure actual enrollment and satisfy one of the three enrollment thresholds.

1. A 70% test — the plan benefits more than 70% of all non-excludable employees;
2. A 70% / 80% test — 70% of all non-excludable employees are eligible to participate and the plan benefits more than 80% of all non-excludable employees who are eligible;
3. A nondiscriminatory classification test — the plan satisfies the reasonable nondiscriminatory classification test under code section 410(b).

There is also a fair cross section test based on pre-1986 code 410(b) regulations. However, it is seldom used, and generally used only as a last resort.

A definition critical to the Eligibility test is who is an “excludable” employee. An employer may exclude the following employees for testing or measuring participation in its self-funded plan: (1) employees who have not completed three years of service, (2) employees who have not attained age 25, (3) part-time employees (customarily work less than 35 hours per week if other employees performing similar work have substantially more hours); (4) seasonal employees (customarily work less than nine months per year if other employees performing similar work have substantially more months of work), (5) collectively bargained employees as long as they are covered under a union plan and not the employer plan, and (6) nonresident aliens with no U.S. source income. Note that definitions of seasonal and part-time employee for 105(h) testing do not match the definitions of the terms as used under the ACA. Also, to simplify testing, under IRS guidance employers *can* exclude any “excludable” employees when measuring participation under the plan even if they *actually* participate in the plan.

The nondiscriminatory classification test requires the lowest percent of enrollment of non-HCIs, and is often relied on by plans to pass testing. It requires that the plan benefit employees who qualify under a reasonable classification established by the employer based on objective business criteria. For example, salaried versus hourly, full-time versus part-time, type of job, or geographic location. The classification also requires a sufficient number of non-HCIs to be enrolled in the plan but it is generally a lower percentage than the other tests require. It requires that the ratio percentage of benefiting total non-HCIs relative to benefiting total HCIs must be greater than certain percentages set out in the regulations that vary depending on the applicable non-HCI concentration percentage. The non-HCI concentration percentage is the ratio of non-excludable non-HCIs to all non-excludable employees. Because HCIs include the top paid 25% of all employees, it is generally held that the non-highly compensated employee concentration percentage is 75%. This puts the safe harbor percentage for enrollment of non-HCI at approximately 39% and the unsafe harbor percentage at approximately 29%. In sum, this calculation requires dividing a fraction (the number of benefiting non-HCIs divided by the total number of non-HCIs) by another fraction (the number of benefiting HCIs divided by the total number of HCIs) and comparing the results to percentages set forth in a chart in section 410(b).

Consequences of Failure

Generally, benefits received by an employee under a self-funded health plan are not taxable to the employee. An exception from this tax exclusion rule, however, applies to “excess reimbursements” received by HCIs under a self-funded plan which fails to satisfy certain nondiscrimination tests.

If a self-funded health plan fails the Eligibility Test, the amount taxable to HCIs is equal to the amount of benefits paid to an HCI multiplied by the ratio of the amount paid to all HCIs over the amount paid to all participants. In other words, each HCI is taxed on a percentage of the benefits the HCI receives under the discriminatory plan. For example, if HCIs receive 40% of plan benefits, then 40% of each HCI's benefits would be taxable. If a self-funded health plan fails the Benefits Test, any benefits paid to HCIs under the plan that are not available to all other participants are taxable to the HCIs. For example, if an HCI has access to dental benefits that are not available to all other participants, the plan would fail to meet the

Benefits Test and all dental benefit payments made to the HCI would be taxable. Note that this means the actual benefit dollars paid or reimbursed and not merely the premium or premium equivalent attributable to the cost of the coverage.

Restructuring Techniques for Testing

A plan restructuring technique that is permissible under the rules is to restructure the group health plan — solely for purposes of passing testing — into separate plans that each satisfies the Benefits test and the Eligibility test on their own. Once you create a separate plan, the Benefits test will be satisfied because it is based only on those who are eligible under that “plan.” However, satisfying the participation measures under the Eligibility test is more difficult because it includes all non-excludable employees. Generally, this approach requires a high number of enrolled non-HCIs. Utilizing this testing technique can also be mathematically and legally complicated. For example, measuring levels of participation in a “plan” where no highly compensated individuals are enrolled appears to yield results that may not be interpreted as passing. Plans that want to implement some of these more complex plan designs should work with outside counsel on any potential risks associated with these designs.

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