



AMERICAN BENEFITS GROUP

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NONDISCRIMINATION TESTING GUIDE



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When to Perform Testing

Under the 2007 proposed regulations, Code Section 125 nondiscrimination tests are to be performed as of the last day of the plan year, taking into account all non-excludable employees who were employed on any day during the plan year.

It is recommended that employers do one test mid plan year in order to determine whether additional steps must be taken before the end of the plan year so that the plan passes the nondiscrimination tests and preserves the tax treatment for the key and highly compensated. A second and final test would then be conducted as of the last day of the plan year.

Employee salary reductions cannot be re-characterized as after-tax contributions after the end of the plan year. If it is determined after the close of the plan year that a test is failed, then the applicable key or highly compensated will be taxed in accordance with the test rules. The cafeteria plan will continue to be a valid Code §125 plan even if it is discriminatory. A qualified benefit does not cease to be a qualified benefit solely because it is taxable as a result of the violation of a nondiscrimination rule.

Controlled and Affiliated Service Groups

For plan-testing purposes, the Code treats two or more employers as a single employer if there is enough common ownership or a combination of joint ownership and common activity. These rules are described in Code §§414(b), (c), and (m), which are directly incorporated into the cafeteria plan rules. The determination of whether or not there is a controlled group of companies is the responsibility of the employer sponsoring the plan, along with their legal counsel, and is not a determination that can be made by American Benefits Group.

If providing testing data for a controlled group, include employees from all companies within the controlled group in one testing template.

Cafeteria Plan

Cafeteria Plan Eligibility Test

What: This is a three part test to ensure that enough non-highly compensated individuals (non-HCEs) are eligible to benefit from the cafeteria plan. A plan will not be treated as discriminatory if:

(A) No employee is required to complete more than three years of service with the employer maintaining the plan as a condition of participation in the plan and this employment requirement is the same for each employee.

(B) An employee who has satisfied the employment requirement of (A) above and who is otherwise entitled to participate in the plan commences participation no later than the first day of the plan year beginning after the date the employment requirement was satisfied -unless the employee was separated from service before the first day of that plan year.

(C) The plan benefits a group of employees who: (1) qualify under a classification established by the employer; and (2) the group of employees included in the classification satisfies the safe harbor percentage test or the unsafe harbor percentage component of the facts and circumstances test. This two-part test is referred to as the Nondiscriminatory Classification Test.

Reasonable Classification Defined: Reasonable classifications generally include specified job categories, nature of compensation (i.e., salaried or hourly), geographic location, and similar bona fide business criteria. Examples that would satisfy this requirement include salaried, hourly, full-time, part-time, type of job (e.g., electricians are covered, but the purchasing department is not), geographic location (e.g., St. Louis employees may participate, but Chicago employees may not), division, subsidiary, business unit, and profit center distinctions.

Who to include: All employees (including leased employees) of the plan sponsor and any other business that is a member of a related group of corporations or businesses who were employed on any day during the plan year.

For the Nondiscriminatory Classification Test ((C) above), part-time employees must be included, even if they are not eligible to participate in the plan. Because the 2007 proposed regulations do not allow employees who have not met the plan's age and service requirements to be excluded from testing (unless the plan has three-year waiting period), employers with part-time employees may have to extend participation to at least some part-time employees in order to pass the Eligibility Test.

Who to exclude: (1) employees (other than Keys/HCPs) covered by a collectively bargained plan (if cafeteria plan benefits were the subject of bargaining); (2) nonresident aliens with no U.S. source income from the employer; and (3) employees participating in the cafeteria plan under a COBRA continuation provision.

Employees who have not met the waiting period under the cafeteria plan may be excluded only if the plan restricts participation to employees who have completed three years of employment. A special "permissive disaggregation" rule allows plans with a waiting period of less than three years to conduct the Eligibility and Contributions and Benefits (described later) tests as if there were two separate plans: one benefiting employees with less than three years of employment and the other benefiting employees with three or more years of employment. If this option is elected, both tests must be passed on a disaggregated basis.

Prohibited Group: Highly compensated individuals and participants (HCP) (see Definitions Section). The term highly compensated individual simply means an individual who satisfies the same criteria as a highly compensated participant. There is no difference between "individuals" and "participants" in this context. The term "individuals" is used for the Eligibility Test because the test is to determine who is eligible. This may include more persons than just those who are highly compensated. Officers, more-than-5% shareholders, and certain spouses and dependents may be considered an HCP without meeting a threshold level of compensation.

The definitions of "highly compensated individual" and "highly compensated participant" used for purposes of Code §125 testing are not the same as the definition of "highly compensated individual" used for testing a health FSA under Code §105(h) or the definition of "highly compensated employee" used for testing a DCAP or 401(k) plan.

Consequences if test fails: The HCPs will lose the favorable tax treatment for their benefits. Unless corrections are made during the plan year, the HCPs will have imputed income equal to the taxable benefit amount that they could have elected to receive for the plan year, even if they elected all qualified benefits. Non-HCPs are not affected.

Cafeteria Plan Contributions and Benefits (C&B) Test

What: The Contributions and Benefits Test is a three part test designed to make sure that contributions and benefits are available on a nondiscriminatory basis and that highly compensated participants (HCPs) do not select more nontaxable benefits than non-HCPs do. Testing includes nontaxable benefits that are qualified benefits under a cafeteria plan, such as medical, dental and vision coverage, health FSAs, and dependent care FSAs (DCAPS).

Who to include: Employees who are actually eligible to: 1) select the benefits under the plan; and 2) if applicable, to make salary reductions to pay for those benefits. This would include treating employees who gained or lost eligibility during a plan year as participants for that year, and to consider benefits available to and compensation received by these employees during their period of participation for testing purposes.

Who to exclude: Collectively bargained plans may be excluded. If a plan covers both union and nonunion employees and the benefits for the union employees were subject to bargaining, then this exception would apply only to the portion of the plan covering the union employees.

Prohibited Group: Highly compensated participants (HCP) (see Definitions Section). This may include more persons than just those who are highly compensated. Officers, more-than-5% shareholders, and certain spouses and dependents may be considered an HCP without meeting a threshold level of compensation.

The definitions of “highly compensated participant” used for purposes of Code §125 testing are not the same as the definition of “highly compensated individual” used for testing a health FSA under Code §105(h) or the definition of “highly compensated employee” used for testing a DCAP or 401(k) plan.

C&B -Safe Harbor for Health Plans Test

What: The Safe Harbor tests are applied only to major medical health insurance benefits included in a Cafeteria Plan. For purposes of this test, major medical health insurance excludes dental coverage and health FSAs. Failing the Safe Harbor tests does not mean that a plan is discriminatory. It means the other facts and circumstances of the plan should be reviewed to determine any possible discrimination.

A plan will not be discriminatory with respect to insurance if:

1. Contributions for health insurance under the plan on behalf of each participant include an amount which:
 - A.) Equals 100% of the cost of the health benefit coverage under the plan of the majority of similarly situated highly compensated participants, **or**
 - B.) Equals or exceeds 75% of the cost of the health benefit coverage of the participant (similarly situated) having the highest cost health benefit coverage under the plan, and
2. Contributions or benefits under the plan in excess of those described above bear a uniform relationship to compensation.

Similarly situated refers to geographic region or coverage election (i.e. single, SPD, family).

C&B -The Availability Standard

What: The regulations provide two ways to satisfy the Availability Standard: (a) demonstrate that employer contributions are available on a nondiscriminatory basis; or (b) demonstrate that benefits are available on a nondiscriminatory basis.

In essence, the same qualified benefits must be available for similarly situated participants at the same cost. Also, the available employer contributions for similarly situated participants must be the same, and all participants must have the same options to use them.

(a) demonstrate that **employer contributions** are available on a nondiscriminatory basis

- Non-HCPs must be given the same opportunity as similarly situated HCPs to use employer contributions to pay for nontaxable benefits. Also, all similarly situated participants must be given the same opportunity to apply employer contributions toward taxable benefits. For example, if there is a cash-out option, it must be available to all.
- Not only must the availability of employer contributions be nondiscriminatory, but no non-HCP can be charged more than any similarly situated HCP for the exact same benefit, whether measured by the gross charge or the charge net of the employer's contribution.
- “Employer contributions” for purposes of testing nondiscriminatory availability presumably means only real employer contributions (from the employer's own money) and does not include employer contributions made pursuant to salary reductions.
- It is unclear whether a plan with prorated contributions for part-time employees will satisfy the availability requirement (e.g., a \$2,000 contribution for full-time employees and a \$1,000 contribution for half-time employees). EBIA's view is that if the Availability Standard is otherwise satisfied making prorated contributions for part-time employees should be permitted.

or

(b) demonstrate that benefits are available on a nondiscriminatory basis

- Not only must the availability of benefits be nondiscriminatory, but no non-HCP can be charged more than any similarly situated HCP for the exact same benefit, whether measured by the gross charge or the charge net of the employer's contribution.
- The "total benefits" portion of this standard effectively embodies an equal contributions element. If, for example, an employer contributes \$100 more for HCPs than it does for similarly situated non-HCPs, then the HCPs will have greater total benefits available to them, and the standard will not be satisfied.

Satisfying the Availability Standard on a benefits basis (b), as opposed to an employer contributions basis

(a) is most desirable for an employer that has a single cafeteria plan and contributes different amounts for different health insurance coverages at different geographic locations.

C&B -The Utilization Standard

What: The actual election of qualified benefits through a cafeteria plan must not be disproportionate by highly compensated participants.

Two ratios must be calculated and compared: (1) the aggregate qualified benefits elected (or employer contributions utilized, as applicable) by the HCPs divided by the aggregate compensation of the HCP group; and (2) the aggregate qualified benefits elected (or employer contributions utilized, as applicable) by the non-HCPs divided by the aggregate compensation of the non-HCP group. The HCP ratio must be less than or equal to the non-HCP ratio.

Consequences if C&B tests fail: The HCPs will lose the favorable tax treatment for their benefits. Unless corrections are made during the plan year, the HCPs will have imputed income equal to the taxable benefit amount that they could have elected to receive for the plan year, even if they elected all qualified benefits. Non-HCPs are not affected.

C&B -Frequently Asked Questions

- Q.1 Can an employer make different contributions for employees who take employee-only versus family coverage and still meet the Availability Standard or the Code §125(g)(2) safe harbor?
- A.1 A difference of this type should not cause a plan to fail the Availability Standard or Code §125(g)(2) safe harbor—contributions are the same for similarly situated participants.
- Q.2 Can an employer make different contributions for employees at different geographic locations based on market differences and still pass the C&B Test?
- A.2 Yes, so long as contributions are the same for similarly situated participants.
- Q.3 Can an employer vary contributions or benefits based on an employee's division or location for reasons other than market differences in the cost of benefits?
- A.3 Plans that vary benefits or contributions for reasons other than geographic market differences in benefit costs may have difficulty passing the C&B Test. In particular, such plans may not meet the Availability Standard. However, it may be possible to pass the C&B Test by maintaining separate plans for the groups that receive different benefits.
- Q.4 Can an employer vary contributions or benefits for part-time employees who are otherwise eligible for its cafeteria plan?
- A.4 A cafeteria plan under which employer contributions vary based on hours worked is unlikely to qualify for the Code §125(g)(2) safe harbor. The law is unclear. EBIA believes that proportionately reduced contributions for part-time employees should not violate the Availability Standard, so long as all part-timers have access to all the same benefits that are available to full-time employees.

- Q.5 Some states have enacted laws requiring certain employers to maintain cafeteria plans that permit employees to pay premiums for health insurance coverage that is not sponsored by the employer on a pre-tax basis. Could complying with such a law cause a cafeteria plan to fail the C&B Test—for example, if employees in other states can only use the plan to pay for employer-sponsored coverage?
- A.5 Quite possibly. One way to avoid a possible test failure is to maintain a separate cafeteria plan for employees in that state. This would entail additional administrative effort (e.g., a separate plan document, separate discrimination testing, etc.) but should help to keep any potential discrimination issue associated with the variety of coverages within the separately maintained plan.

Cafeteria Plan 25% Key Employee Concentration Test

What: Test is to ensure that Key Employees (Keys) do not receive more than 25% of the aggregate benefits offered through the cafeteria plan. Determines the total value of nontaxable benefits provided under the cafeteria plan (whether funded by true employer contributions or employer contributions made through salary reduction elections) and tests whether Keys receive more than 25%.

Who to include: Only plan participants who have elected some nontaxable benefits are considered for this test. Participants who have gained or lost eligibility during a plan year are counted as participants for those nontaxable benefits that were provided to them during their dates of participation. Also, since the definition of “Key Employee” excludes officers or employees of governmental entities, the Key Employee Concentration Test does not apply to cafeteria plans maintained by these entities.

Who to exclude: Employees who are not participants in the cafeteria plan. There is a collectively bargained plan exception where a plan will not be treated as discriminatory if the plan is maintained under a collective bargaining agreement between employee representatives and one or more employers.

Prohibited Group: Key Employees (Keys) (see Definitions Section).

Consequences if test fails: The Key employees will lose the favorable tax treatment for their benefits. Unless corrections are made during the plan year, the Key employees will have imputed income equal to the taxable benefit amount that they could have elected to receive for the plan year, even if they elected all qualified benefits. Non-Key employees are not affected.

Health FSA

Health FSA Eligibility Test

What: A health FSA cannot discriminate in favor of highly-compensated individuals (HCIs) as to eligibility to participate. A health FSA that satisfies any one of the three tests will pass the Health FSA Eligibility Test.

We suggest applying the third test, Post-TRA Nondiscriminatory Classification Test, first. Given the low participation rates for health FSAs, the 70% and 70%/80% Tests will seldom be satisfied.

- 1) **The 70% Test Alternative #1 of 3 Eligibility Test:** To pass, the health FSA must benefit 70 percent or more of all employees.
- 2) **The 70%/80% Test Alternative #2 of 3 Eligibility Test:**
To pass, the health FSA must benefit 80 percent or more of all the employees who are eligible to benefit under the plan if 70 percent or more of all employees are eligible to benefit under the plan.
- 3) **The Nondiscriminatory Classification Test Alternative #3 of 3 Eligibility Test:** Self-insured medical plans that are unable to pass either the 70% Test or the 70%/80% Test should next try to pass the Post-TRA Nondiscriminatory Classification Test.

A plan will satisfy this test for a plan year only if for the plan year both of the following requirements are met:

- **Reasonable Classification.** The plan “benefits” employees who qualify under a reasonable classification established by the employer. A reasonable classification is established if, based on all the facts and circumstances, the classification is reasonable and uses objective business criteria that identify the category of employees who benefit under the plan. Reasonable classifications generally include specified job categories, nature of compensation (i.e., salaried or hourly), geographic location, and similar bona fide business criteria.
- **Nondiscriminatory Classification.** The classification of employees is nondiscriminatory. This means that the group of employees included in the classification benefiting under the plan must satisfy either an objective Safe Harbor Percentage Test or a subjective Facts and Circumstances Test for the plan year.

Who to include: The conservative approach is to define “benefit” as actual participants who elect to participate in the health FSA. Count anyone who elected to salary-reduce or received free coverage from the employer during the plan year. Terminated employees are counted for purposes of the Health FSA Eligibility Test for cafeteria plans.

Who to exclude: Employees who are not participating in the Health FSA.

Prohibited Group: For purposes of the Code §105(h) rules, the prohibited group includes highly compensated individuals (HCIs) (see Definitions Section). This definition differs from HCEs, HCPs and Key employees.

Consequences if test fails: If a health FSA is discriminatory as to eligibility to participate, the HCIs will lose their income tax exclusions on any benefits paid to them under the discriminatory plan. For discriminatory coverage, the amount includible in an HCI's gross income is determined by multiplying the benefit payments by a fraction—the numerator is the total benefits paid to HCIs during the plan year and the denominator is the total benefits paid to all participants for the plan year.

If a health FSA is discriminatory, the non-HCIs will not lose their tax benefits (i.e., the income exclusion), nor will the health FSA cease to be a valid Code §105 plan just because it is discriminatory. The health FSA will not cease to be a qualified benefit under the cafeteria plan rules.

Health FSA Benefits Test

What: Under the Benefits Test, benefits provided under a health FSA must not discriminate in favor of participants who are highly compensated individuals (HCIs). This requires that all benefits provided for participants who are HCIs must be provided for all other participants and that all benefits available for HCIs' dependents must also be available for dependents of all non-HCI participants.

The health FSA must satisfy the following conditions as a matter of plan design and in operation:

- the required employee contributions must be identical for each benefit level;
- the maximum benefit level that can be elected cannot vary based on percent of compensation, age, or years of service;
- the same type of benefits (e.g., medical expenses) provided to HCIs must be provided to all other participants; and
- disparate waiting periods cannot be imposed.

Who to include: Count anyone who elected to salary-reduce or received free coverage from the employer during the plan year. Terminated employees are counted for purposes of the Health FSA benefits test for cafeteria plans.

Who to exclude: Employees not participating in the Health FSA.

Prohibited Group: The term “participants who are highly compensated individuals” (HCIs) is used for the Benefits Test. The definition used is the definition within Code §105(h)(5). See Definitions Section.

Consequences if test fails: If a health FSA is discriminatory as to eligibility to participate, the HCIs will lose their income tax exclusions on any benefits paid to them under the discriminatory plan. For discriminatory coverage, the amount includible in an HCI's gross income is determined by multiplying the benefit payments by a fraction—the numerator is the total benefits paid to HCIs during the plan year and the denominator is the total benefits paid to all participants for the plan year.

If a health FSA is discriminatory, the non-HCIs will not lose their tax benefits (i.e., the income exclusion), nor will the health FSA cease to be a valid Code §105 plan just because it is discriminatory. The health FSA will not cease to be a qualified benefit under the cafeteria plan rules.

Dependent Care (DCAP)

DCAP Eligibility

What: The Eligibility Test ensures that a reasonable percentage of non-HCEs are eligible to participate in the DCAP. If not enough non-HCEs can get in, the DCAP will fail the Eligibility Test. Many employers automatically pass the Eligibility Test by plan design. If all employees are eligible to participate in the DCAP, the plan will automatically pass the Eligibility Test.

Who to include: All employees (including leased employees) of the plan sponsor and any other business that is a member of a related group of corporations or businesses. An employee who was eligible at any time during the year but terminated employment prior to year-end should be counted when performing DCAP Eligibility Testing.

Who to exclude: Employees who have not attained age 21 or completed a year of service and are excluded from the plan, as well as certain collectively bargained employees who are excluded from participation.

Prohibited Group: HCEs (within the meaning of Code §414(q)) and their dependents (see Definitions Section).

Consequences if test fails: If a DCAP discriminates in favor of HCEs, then the benefits provided to the HCEs will be included in their gross income. The DCAP nondiscrimination rules only require the HCE to include in gross income those amounts (or reimbursements) that were actually received as dependent care assistance. Discriminatory amounts under a DCAP are reported as wages in Box 1 of the Form W

2. If a nondiscrimination testing failure is not discovered until after Form W-2s have been issued, it will be necessary to issue amended Form W-2s to report the taxable amounts.

DCAP Contributions and Benefits

What: Requires that benefits and contributions available to eligible employees under the DCAP do not favor HCEs. The test looks at the contribution and benefit level (not the utilization rate) for the different types of assistance available under the DCAP plan. It ensures that HCEs or their dependents aren't eligible to receive better benefits and aren't authorized to make lower contributions for equal benefits than non-HCEs.

Who to include: All employees, including terminated employees.

Who to exclude: Employees who have not attained age 21 or completed a year of service and are excluded from the plan, as well as certain collectively bargained employees who are excluded from participation.

Prohibited Group: HCEs (within the meaning of Code §414(q)) and their dependents (see Definitions Section).

Consequences if test fails: If a DCAP discriminates in favor of HCEs, then the benefits provided to the HCEs will be included in their gross income. The DCAP nondiscrimination rules only require the HCE to include in gross income those amounts (or reimbursements) that were actually received as dependent care assistance. Discriminatory amounts under a DCAP are reported as wages in Box 1 of the Form W2. If a nondiscrimination testing failure is not discovered until after Form W-2s have been issued, it will be necessary to issue amended Form W-2s to report the taxable amounts.

DCAP More-Than-5% Owners Concentration Test

What: DCAP benefits provided to more-than-5% owners cannot exceed 25% of the benefits provided for all employees under the plan. Because this test looks at amounts paid or incurred during the year, all benefits provided during the year should be taken into account, even if received by employees whose employment terminated during the year. The More-Than-5% Owners Concentration Test is a utilization test.

Who to include: All employees (including leased employees) of the plan sponsor and any other business that is a member of a related group of corporations or businesses.

Who to exclude: Employees who have not attained age 21 or completed a year of service and are excluded from the plan, as well as certain collectively bargained employees who are excluded from participation.

Prohibited Group: The prohibited group consists of shareholders or owners owning more than 5% of the employer and their spouses and dependents. An individual is considered to be a more-than-5% shareholder or owner if he or she owns more than 5% of the stock or the capital or profits interest in the employer on any day of the year. Because the definition includes more-than-5% owners on any day of the year, this would include more-than-5% owners who terminated employment during the year.

Consequences if test fails: Failure to satisfy the More-Than-5% Owners Concentration Test affects all HCEs, not just the more-than-5% owners. If the DCAP fails this test, all HCEs (not just more-than-5% owners) will have the DCAP amounts included in gross income. The DCAP nondiscrimination rules only require the HCE to include in gross income those amounts (or reimbursements) that were actually received as dependent care assistance. Discriminatory amounts under a DCAP are reported as wages in Box 1 of the Form W-2. If a nondiscrimination testing failure is not discovered until after Form W-2s have been issued, it will be necessary to issue amended Form W-2s to report the taxable amounts.

DCAP 55% Average Benefits Test

What: The 55% Average Benefits Test is meant to ensure that HCEs do not participate disproportionately. The 55% Average Benefits Test focuses on the average (per capita) benefit received by HCEs as compared to that received by non-HCEs. A plan meets the requirements if the average benefits provided to employees who are non-HCEs under all DCAP plans of the employer is at least 55 percent of the average benefits provided to HCEs under all DCAP plans of the employer.

Who to include: All employees are included, even employees who are not eligible to participate and even if the plan is able to exclude them from participation without failing the DCAP Eligibility Test. Terminated employees should also be included in the testing group (unless they are covered by another exclusion). The 55% Average Benefits Test must be applied to all DCAPs sponsored by an employer.

Who to exclude: In the case of DCAP benefits provided through a salary reduction agreement, the plan may disregard employees whose compensation is less than \$25,000. There is also an exclusion for certain employees who are under age 21, who have not completed a year of service, and for certain collectively bargained employees, if the plan excludes these employees from participation. However, if they participate in a separate, collectively bargained dependent care plan, they would be included because the 55% Average Benefits Test considers all of an employer's DCAPs.

Prohibited Group: HCEs are the prohibited group for purposes of the 55% Average Benefits Test based on §414(q) definition (see Definitions Section).

Consequences if test fails: If the non-HCE average is not at least 55% of the HCE average, the HCEs are taxed on all DCAP benefits received. The DCAP nondiscrimination rules only require the HCE to include in gross income those amounts (or reimbursements) that were actually received as dependent care assistance. Discriminatory amounts under a DCAP are reported as wages in Box 1 of the Form W2. If a nondiscrimination testing failure is not discovered until after Form W-2s have been issued, it will be necessary to issue amended Form W-2s to report the taxable amounts.

Health Reimbursement Arrangement (HRA)

HRA Eligibility Test

What: An HRA cannot discriminate in favor of highly-compensated individuals (HCIs) as to eligibility to participate. An HRA that satisfies any one of the three tests will pass the HRA Eligibility Test.

- 4) **The 70% Test Alternative #1 of 3 Eligibility Test:** To pass, the HRA must benefit 70 percent or more of all employees.
- 5) **The 70%/80% Test Alternative #2 of 3 Eligibility Test:** To pass, the HRA must benefit 80 percent or more of all the employees who are eligible to benefit under the plan if 70 percent or more of all employees are eligible to benefit under the plan.
- 6) **The Nondiscriminatory Classification Test Alternative #3 of 3 Eligibility Test:** Self-insured medical plans that are unable to pass either the 70% Test or the 70%/80% Test should next try to pass the Post-TRA Nondiscriminatory Classification Test.

A plan will satisfy this test for a plan year only if for the plan year both of the following requirements are met:

- Reasonable Classification. The plan “benefits” employees who qualify under a reasonable classification established by the employer. A reasonable classification is established if, based on all the facts and circumstances, the classification is reasonable and uses objective business criteria that identify the category of employees who benefit under the plan. Reasonable classifications generally include specified job categories, nature of compensation (i.e., salaried or hourly), geographic location, and similar bona fide business criteria.
- Nondiscriminatory Classification. The classification of employees is nondiscriminatory. This means that the group of employees included in the classification benefiting under the plan must satisfy either an objective Safe Harbor Percentage Test or a subjective Facts and Circumstances Test for the plan year.

Who to include: The conservative approach is to define “benefit” as actual participants who elect to participate in the HRA. Count anyone who received coverage from the employer during the plan year.

Who to exclude: Unless already participating in the HRA, employees that are excluded from testing include employees who have not completed three years of service prior to the beginning of the plan year, employees who have not attained age 25 before the plan year, part-time and seasonal employees, and nonresident aliens who do not receive U.S.-source earned income. Employees covered by a collective bargaining agreement can be excluded from the Eligibility Test, but only if medical benefits were the subject of collective bargaining and if the employees were not eligible for the plan.

Prohibited Group: For purposes of the Code §105(h) rules, the prohibited group includes highly compensated individuals (HCIs) (see Definitions Section).

Consequences if test fails: If an HRA is discriminatory as to eligibility to participate (i.e., it provides discriminatory coverage), HCIs will lose some of the income tax exclusion on their HRA benefits. Generally, the amount includible in an HCI's gross income as a result of discriminatory self-insured medical coverage for a plan year (the “excess reimbursement”) is determined by multiplying the benefit payments for the HCI during the plan year by a fraction—the numerator of which is the total benefits paid to all HCIs for the plan year, and the denominator of which is the total benefits paid to all participants for the plan year.

HRA Benefits Test

What: Under the Benefits Test, benefits provided under a HRA must not discriminate in favor of participants who are highly compensated individuals (HCIs). This requires that all benefits provided for participants who are HCIs must be provided for all other participants and that all benefits available for HCIs' dependents must also be available for dependents of all non-HCI participants.

The Benefits Test consists of two subtests: one tests for discrimination on the face of the plan, and the other tests for discrimination in operation. Both must be passed in order for the HRA to pass the Benefits Test.

Discriminatory Benefits on the Face of the HRA

The HRA must satisfy the following conditions as a matter of plan design and in operation in order to not be discriminatory:

- the maximum benefit level that can be elected cannot vary based on percent of compensation, age, or years of service;
- the same type of benefits (e.g., medical expenses) provided to HCIs must be provided to all other participants; and
- disparate waiting periods cannot be imposed.

Discriminatory Benefits in Operation

In addition to observing the requirements above, whether or not a plan discriminates in operation is a “facts and circumstances” determination. Discrimination in operation “may occur where the duration of a particular benefit coincides with the period during which [an HCI] utilizes the benefit.” Thus, if an HRA is amended or terminated so that the duration of the benefit favors HCIs, the plan would be discriminatory.

Discrimination in Operation could occur if an HRA approves certain claims for medical expenses for HCIs while denying them for non-HCIs when there is no justifiable reason for treating them differently. This could occur, for example, by applying lower claims substantiation standards for HCIs (e.g., requiring a medical practitioner's note from non-HCIs for dual-purpose expenses, while not requiring the same for similar claims from HCIs).

Who to include: Count anyone who received HRA coverage from the employer during the plan year, including terminated employees who participated during the plan year tested.

Who to exclude: Unless already participating in the HRA, employees that are excluded from testing include employees who have not completed three years of service prior to the beginning of the plan year, employees who have not attained age 25 before the plan year, part-time and seasonal employees, those who are covered by a collective bargaining agreement, and nonresident aliens who do not receive U.S. source earned income. Employees covered by a collective bargaining agreement can be excluded but only if medical benefits were the subject of collective bargaining and if the employees were not eligible for the plan.

Prohibited Group: The term “participants who are highly compensated individuals” (HCIs) is used for the Benefits Test. The definition used is the definition within Code §105(h)(5). See Definitions Section.

Consequences if test fails: If an HRA is discriminatory as to benefits, the amount included in gross income is the amount reimbursed to an HCI for the discriminatory benefits, referred to as the “excess reimbursement.” If a benefit is available only to one or more HCIs and not to all other participants, the total amount reimbursed to the HCIs for that benefit is includible in gross income (it is all excess reimbursement). If HCIs can have coverage without regard to a waiting period that applies to non-HCEs, all of the benefits paid during the waiting period would be taxable to the HCIs.

If a benefit is available to non-HCIs but in a lesser amount, then the amount available to HCIs will be offset by the amount available to non-HCIs. The non-HCIs will not lose their tax benefits (i.e., the income exclusion), nor will the plan cease to be a valid Code §105 plan just because it is discriminatory.

When HRA accruals are greater for HCIs, the excess would likely be the amount of the reimbursements attributable to the HRA accruals that the HCIs received in excess of the HRA accrual received by the non-HCI with the lowest HRA accrual under the plan. Applied this way, excess HRA accruals carried over into future years would not be taxed until they are actually used to make reimbursements. This makes the determination extremely complicated because unused HRA amounts carry over—sometimes for many years—and whether an excess reimbursement will occur cannot be determined at the time of the accrual. Employers would need to track the carryover of HCIs' excess accruals so that the appropriate tax treatment could be applied when those accruals are used to pay reimbursements. There is no IRS guidance on this issue.

Self-Insured Medical Plan 105(h)

Self-Insured Medical Plan 105(h) Eligibility Test

What: A Self-Insured Medical Plan cannot discriminate in favor of highly-compensated individuals (HCIs) as to eligibility to participate. A Self-Insured Medical Plan that satisfies any one of the three tests will pass the Self-Insured Medical Plan Eligibility Test.

- 7) **The 70% Test Alternative #1 of 3 Eligibility Test:** To pass, the Self-Insured Medical Plan must benefit 70 percent or more of all employees.
- 8) **The 70%/80% Test Alternative #2 of 3 Eligibility Test:** To pass, the Self-Insured Medical Plan must benefit 80 percent or more of all the employees who are eligible to benefit under the plan if 70 percent or more of all employees are eligible to benefit under the plan.
- 9) **The Nondiscriminatory Classification Test Alternative #3 of 3 Eligibility Test:** Self-insured medical plans that are unable to pass either the 70% Test or the 70%/80% Test should next try to pass the Post-TRA Nondiscriminatory Classification Test.

A plan will satisfy this test for a plan year only if for the plan year both of the following requirements are met:

- Reasonable Classification. The plan “benefits” employees who qualify under a reasonable classification established by the employer. A reasonable classification is established if, based on all the facts and circumstances, the classification is reasonable and uses objective business criteria that identify the category of employees who benefit under the plan. Reasonable classifications generally include specified job categories, nature of compensation (i.e., salaried or hourly), geographic location, and similar bona fide business criteria.
- Nondiscriminatory Classification. The classification of employees is nondiscriminatory. This means that the group of employees included in the classification benefiting under the plan must satisfy either an objective Safe Harbor Percentage Test or a subjective Facts and Circumstances Test for the plan year.

Who to include: The conservative approach is to define “benefit” as actual participants who elect to participate in the Self-Insured Medical Plan. Count anyone who received coverage from the employer during the plan year.

Who to exclude: Unless already participating in the Self-Insured Medical Plan, employees that are excluded from testing include employees who have not completed three years of service prior to the beginning of the plan year, employees who have not attained age 25 before the plan year, part-time and seasonal employees, and nonresident aliens who do not receive U.S.-source earned income. Employees covered by a collective bargaining agreement can be excluded from the Eligibility Test, but only if medical benefits were the subject of collective bargaining and if the employees were not eligible for the plan.

Prohibited Group: For purposes of the Code §105(h) rules, the prohibited group includes highly compensated individuals (HCIs) (see Definitions Section).

Consequences if test fails: If an Self-Insured Medical Plan is discriminatory as to eligibility to participate (i.e., it provides discriminatory coverage), HCIs will lose some of the income tax exclusion on their Self-Insured Medical Plan benefits. Generally, the amount includible in an HCI's gross income as a result of discriminatory self-insured medical coverage for a plan year (the “excess reimbursement”) is determined by multiplying the benefit payments for the HCI during the plan year by a fraction—the numerator of which is the total benefits paid to all HCIs for the plan year, and the denominator of which is the total benefits paid to all participants for the plan year.

$$\text{HCI Benefit Payments x } \frac{\text{Total Benefits Paid to all HCIs for the Plan Year}}{\text{Total Benefits Paid to all Participants for the Plan Year}}$$

Self-Insured Medical Plan 105(h) Benefits Test

What: Under the Benefits Test, benefits provided under a Self-Insured Medical Plan must not discriminate in favor of participants who are highly compensated individuals (HCIs). This requires that all benefits provided for participants who are HCIs must be provided for all other participants and that all benefits available for HCIs' dependents must also be available for dependents of all non-HCI participants.

The Benefits Test consists of two subtests: one tests for discrimination on the face of the plan, and the other tests for discrimination in operation. Both must be passed in order for the Self-Insured Medical Plan to pass the Benefits Test.

Discriminatory Benefits on the Face of the Self-Insured Medical Plan

The Self-Insured Medical Plan must satisfy the following conditions as a matter of plan design and in operation in order to not be discriminatory:

- the maximum benefit level that can be elected cannot vary based on percent of compensation, age, or years of service;
- the same type of benefits (e.g., medical expenses) provided to HCIs must be provided to all other participants; and
- disparate waiting periods cannot be imposed.

Discriminatory Benefits in Operation

In addition to observing the requirements above, whether or not a plan discriminates in operation is a "facts and circumstances" determination. Discrimination in operation "may occur where the duration of a particular benefit coincides with the period during which [an HCI] utilizes the benefit." Thus, if an Self-Insured Medical Plan is amended or terminated so that the duration of the benefit favors HCIs, the plan would be discriminatory.

Discrimination in Operation could occur if an Self-Insured Medical Plan approves certain claims for medical expenses for HCIs while denying them for non-HCIs when there is no justifiable reason for treating them differently. This could occur, for example, by applying lower claims substantiation standards for HCIs (e.g., requiring a medical practitioner's note from non-HCIs for dual-purpose expenses, while not requiring the same for similar claims from HCIs).

Who to include: Count anyone who received Self-Insured Medical Plan coverage from the employer during the plan year, including terminated employees who participated during the plan year tested.

Who to exclude: Unless already participating in the Self-Insured Medical Plan, employees that are excluded from testing include employees who have not completed three years of service prior to the beginning of the plan year, employees who have not attained age 25 before the plan year, part-time and seasonal employees, those who are covered by a collective bargaining agreement, and nonresident aliens who do not receive U.S.-source earned income. Employees covered by a collective bargaining agreement can be excluded but only if medical benefits were the subject of collective bargaining and if the employees were not eligible for the plan.

Prohibited Group: The term "participants who are highly compensated individuals" (HCIs) is used for the Benefits Test. The definition used is the definition within Code §105(h)(5). See Definitions Section.

Consequences if test fails: If an Self-Insured Medical Plan is discriminatory as to benefits, the amount included in gross income is the amount reimbursed to an HCI for the discriminatory benefits, referred to as the "excess reimbursement." If a benefit is available only to one or more HCIs and not to all other participants, the total amount reimbursed to the HCIs for that benefit is includible in gross income (it is all excess reimbursement). If HCIs can have coverage without regard to a waiting period that applies to non-HCEs, all of the benefits paid during the waiting period would be taxable to the HCIs.

If a benefit is available to non-HCIs but in a lesser amount, then the amount available to HCIs will be offset by the amount available to non-HCIs. The non-HCIs will not lose their tax benefits (i.e., the income exclusion), nor will the plan cease to be a valid Code §105 plan just because it is discriminatory.

When Self-Insured Medical Plan accruals are greater for HCIs, the excess would likely be the amount of the reimbursements attributable to the Self-Insured Medical Plan accruals that the HCIs received in excess of the Self-Insured Medical Plan accrual received by the non-HCI with the lowest Self-Insured Medical Plan accrual under the plan. Applied this way, excess Self-Insured Medical Plan accruals carried over into future years would not be taxed until they are actually used to make reimbursements. This makes the determination extremely complicated because unused Self-Insured Medical Plan amounts carry over—sometimes for many years—and whether an excess reimbursement will occur cannot be determined at the time of the accrual. Employers would need to track the carryover of HCIs' excess accruals so that the appropriate tax treatment could be applied when those accruals are used to pay reimbursements. There is no IRS guidance on this issue.

Definitions Section

Key Employee (Key)

Code §125(b)(2) provides that a Key Employee is an individual defined in Code §416(i)(1) (Code §416 contains the top-heavy rules pertaining to qualified retirement plans.) Under the 2007 proposed regulations, Key Employee status is determined based on the preceding plan year. Thus, a plan will look to prior year data to determine Key Employee status during the current plan year (i.e., the plan year for which nondiscrimination testing is conducted).

Under Code §416, a Key is any employee (or former employee, including a deceased employee) who, during the plan year, was:

- an officer of the employer with annual compensation in excess of a specified dollar threshold \$175,000 (2018), \$175,000 (2019);
- a more-than-5% owner of the employer; or
- a more-than-1% owner of the employer with annual compensation in excess of \$150,000 (not indexed).

Looking ahead to 2019 plan year definitions, the Key Employee salary criteria increases to \$180,000

The 2007 proposed regulations provide that a Key Employee covered by a collective bargaining agreement is a Key.

Code §416 regulations provide that compensation may be measured based on the employee's Form W-2 for the calendar year that ends with or within the plan year. For purposes of determining who is a Key, the employer looks at the employee's actual compensation for the relevant period. Therefore, an employee hired late in the year might not exceed the applicable threshold for the first year of employment, even though on an annualized basis the new hire's salary exceeds the threshold.

If an employer has no non-Keys (i.e., everyone is a Key, such as in a small professional company), then the literal requirements of the Key Employee Concentration Test would be violated. The 2007 proposed regulations provide no exceptions or special rules for plans, and the IRS has informally indicated that the literal statutory rule must be followed even when the employer has no non-Keys.

Highly Compensated Employee (HCE)

Under Code §414(q), an employee is an HCE if—

- the employee was a more-than-5% owner of the employer at any time during the current or preceding plan year, applying the attribution rules of Code §318 (in general, these rules count any ownership of the employee's spouse, parents, children, and grandchildren when determining the employee's ownership percentage); or
- for the preceding plan year, the employee had compensation in excess of a specified dollar threshold (for example, the \$120,000 threshold for 2018 generally is used to determine HCEs for 2019 plan year testing), and, if elected by the employer, the employee was also in the "top-paid group" (generally constituting the top 20%).

An individual who owns exactly 5% of the employer will not qualify as a more-than-5% owner.

Looking ahead to 2019 plan year definitions, the salary for HCEs rises to \$125,000.

If an individual has an option to acquire stock, then the stock subject to that option is considered to be owned by that person. Also, if an individual has an option to acquire stock, then the stock subject to the stock option is considered to be owned by that person for stock attribution purposes. Generally, stock owned by a qualified plan, such as stock held in an ESOP, is not considered to be owned by the individual even if it is allocated to the participant's account.

If the employer is a partnership or other form of business entity, ownership is determined on the basis of the individual's capital or profits interest in the employer.

In identifying ownership for this purpose, the constructive ownership rules of Code §318 apply. For example:

- a spouse is deemed to own the interest held by the other spouse;
- an individual is deemed to own the interest held by his or her parents, children, and grandchildren;
- a partner is deemed to own a proportionate amount of any interest held by the partnership; and
- a shareholder who owns 50% or more of a corporation is deemed to own a proportionate share of any stock owned by the corporation.

Under Code §414(q), the plan year for which the HCE determination is being made is called the determination year (which is the same as the year being tested—the testing year). The prior 12-month period, during which the compensation threshold is examined, is called the look-back year. To be considered an HCE in the determination year, an individual generally must have compensation exceeding the applicable dollar threshold during the look-back year. The following chart illustrates how to apply the dollar threshold for a calendar-year plan. The 2007 proposed regulations modified this rule for cafeteria plan purposes by providing that individuals in their first year of employment can be highly compensated individuals or participants based on their compensation during the current plan year.

The term “participant's compensation” shall include: (i) any elective deferral (as defined in section 402(g)(3)), and (ii) any amount which is contributed or deferred by the employer at the election of the employee and which is not includible in the gross income of the employee by reason of section 125, 132(f)(4), or 457.

Calendar Year Plan		
Determination Year (same as testing year)	Look Back Year	Apply Threshold for Look Back Year
2017	2016	\$120,000
2018	2017	\$120,000
2019	2018	\$120,000
2020	2019	\$125,000

Non-calendar-year plans may use the prior plan year as the look-back year or may elect to use the calendar year beginning in the prior plan year as the look-back year (the calendar-year data election). When the look-back year is not a calendar year, the applicable dollar threshold is the dollar threshold for the calendar year in which the look-back year begins. The following chart illustrates how to apply the dollar threshold for a non-calendar plan year that begins on April 1.

Plan Year Begins April 1				
Determination Year (same as testing year) Begins April 1	Alternative #1: Prior Year as Look Back Year Begins April 1	Apply Threshold for Calendar Year in Which Look Back Year Begins	Alternative #2: Calendar Year Beginning in Prior Years as Look Back Year	Apply Threshold for Calendar Year Beginning in Prior Year
2017	2016	\$110,000	2017	\$120,000
2018	2017	\$115,000	2018	\$120,000
2019	2018	\$115,000	2019	\$120,000
2020	2019	\$120,000	2020	\$125,000

* Typically, the IRS announces the COLA adjustments in the last quarter of each calendar year.

Highly Compensated Individuals (HCI)

For purposes of the Code §105(h) rules, the prohibited group (called HCIs) generally consists of highly compensated individuals. The term “highly compensated individual” is used for the Eligibility Test. The term “participants who are highly compensated individuals” is used for the Benefits Test. Code §105(h)(5) defines “highly compensated individual” as an individual who is:

- one of the five highest-paid officers;
- a shareholder who owns more than 10% of the value of stock of the employer's stock; or
- among the highest-paid 25% of all employees (other than excludable employees who aren't participants).

The five highest-paid officers and the more-than-10% shareholders often will be included in the group of highest-paid 25% of all employees, but this should never be assumed.

Because only the five highest-paid officers are HCIs, it is also necessary to determine the employee officer's level of compensation. Under the regulations, the “level of an employee's compensation is determined on the basis of the employee's compensation for the plan year.” For these purposes, “fiscal year plans may determine employee compensation on the basis of the calendar year ending within the plan year.” Thus, under regulations, only current-year compensation may be used to determine compensation levels for Code §105(h) purposes—there is no look-back rule (as there is in the Code §414(q) highly compensated rules).

An employer will always have HCIs, because the Code §105(h) definition includes one category that is based on relative levels of compensation (the highest-paid 25%).

Code §105(h) excludes the following individuals from the highest-paid 25% of all employees, provided that they are not already participants:

- employees who have not completed three years of service;
- employees who have not attained age 25;
- part-time or seasonal employees;
- collectively bargained employees; and
- nonresident aliens who receive no U.S. source earned income.

The term “participant's compensation” shall include: (i) any elective deferral (as defined in section 402(g)(3)), and (ii) any amount which is contributed or deferred by the employer at the election of the employee and which is not includible in the gross income of the employee by reason of section 125, 132(f)(4), or 457.

Highly Compensated Participant (HCP)

The term highly compensated participant means a highly compensated individual who is eligible to participate in the cafeteria plan.

Officer

The term includes anyone who was an officer during the preceding plan year or the current plan year in the case of an individual's first year of employment. Whether an individual is an officer is determined based on all the facts and circumstances, including the source of the person's authority, the term for which he or she is elected or appointed, and the nature and extent of the officer's duties.

Generally, an “officer” means an administrative executive who is in regular and continued service, and it implies a continuity of service, exclusive of those employed for a special or single transaction. An employee with the title of officer, but not the authority of an officer, is not considered to be an officer. Similarly, an employee who does not have the title of an officer, but who has the authority of an officer, is an officer. Sole proprietorships, partnerships, and associations, among other unincorporated entities, may have officers.

In most respects, this definition parallels the definition of officer in the Code §416 regulations, which applies when determining who is a Key for purposes of the Key Employee Concentration Test. However,

Source: Thomson Reuters Checkpoint (EBIA) it appears that the limitation on the number of officers under Code §416 does not apply when determining who is an officer for Code §125 purposes.

It also appears that there is no exception for governmental entities that sponsor cafeteria plans, so they too will have officers for purposes of determining who is a highly compensated participant.

More-Than-5% Shareholder

Someone owning more than 5% of the voting power or value of all classes of stock of the employer. An individual who owns exactly 5% of the shares would not qualify under this definition. The 2007 proposed regulations also clarify that an individual's stock ownership is determined without attribution. Consequently, the Code §318 attribution rules will not apply in defining a more-than-5% shareholder.

Spouse or Dependent

A spouse or a dependent (as defined in Code §125(e)(1)(D)) of an individual who is an officer, a more-than-5% shareholder, or highly compensated falls within the group of highly compensated individuals subject to the cafeteria plan tests. The definition of dependent is the same as the one that applies when determining who is a tax dependent for health coverage purposes.

Highly Compensated

The definition of “highly compensated” in Code §125 is circular: It defines highly compensated participants as those who are “highly compensated,” plus officers, more-than-5% shareholders, and certain spouses and dependents. The 2007 proposed regulations define the term “highly compensated” as an individual who, for the preceding plan year—or the current plan year in the case of the first year of employment—had compensation in excess of the Code §414(q)(1)(B) compensation threshold and, if elected by the employer, was also in the “top-paid group” of employees (as determined under Code §414(q)(3)) for the preceding or current plan year, as applicable. It is unclear whether the compensation threshold for the preceding year or the current year should be used when determining whether a new hire is highly compensated under Code §125. Pending further guidance, it seems logical to use the compensation threshold for the current year for new hires. Note, however, that this definition only determines who is “highly compensated” by compensation level—to determine the entire highly compensated group for purposes of Code §125 testing, the other individuals specified in Code §125 (officers, more-than-5% shareholders, spouses, and dependents) must also be taken into account.