



## Health Reimbursement Arrangement (HRA) Discrimination Tests

There are two HRA tests: one is an **Eligibility Test** and the second is a **Benefits Test**. If a plan fails either test the highly compensated employees will be taxed on any excess reimbursements. An HRA that is providing benefits to highly compensated employees cannot discriminate regarding reimbursement based on age, years of service, or compensation.

If an HRA provides the same benefits to all employees, has the same waiting periods, the same eligibility requirements and the same reimbursement amounts there should be no concern about discrimination testing problems. However, if the plan deviates in any way there may be discrimination concerns and proper council should be consulted.

Under the Benefits Test the benefits provided under the plan must not discriminate in favor of highly compensated employees. There are two requirements; the plan must be nondiscriminatory regarding the benefits offered and nondiscriminatory regarding the benefits under the operation of the plan.

Under the Eligibility Test the plan cannot discriminate in favor of highly compensated employees as to eligibility to participate. Here are three alternative tests the 70% test, the 70%/80% test and the Nondiscriminatory Classification Test. Only one needs to be passed for the plan to pass the Eligibility Test.

A self-insured medical plan that treats all employees the same generally needn't be concerned about the Code 105(h) discrimination rules. This is true even if utilization rates vary among participants, as they typically do. Treating employees differently in any way, however, whether in the plan document or in the operation of the plan raises red flags. The self-insured medical plan must satisfy the tests for each the plan year.

For the purposes of Code Section 105(h) rules defining highly compensated individuals to be used for the Eligibility and Benefits tests include the following:

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

### Definitions

Since there is no definition of officer; it is reasonable to use the definition found under Code Section 416 regulations. Under Code 416 whether an individual is an officer or not is determined on the basis of 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 continuous service* and it implies the continuity of service, not those employed first special or single transactions. Thus, an employee with the title of officer but not the authority of an officer is not an officer for these purposes.

Compensation for determining the five highest-paid officers is determined on the basis of the employee's compensation for the plan year. Thus, under regulations only current year compensation may be used to determine compensation levels for Code Section 105(h) purposes. There is no look-back year rule. In some situations it may be difficult to determine current year compensation.

The definition of a more-than-10% shareholder is defined by the ownership interest, measured by stock ownership which must be more than 10%. The ownership relates to an interest in the capital or profit interest in the employer. In identifying ownership, the constructive ownership rules of Code Section 318 apply. Under this provision, a spouse is deemed to own the ownership interest of the other spouse; an employee is deemed to own the ownership interest of his or her parents, children and grandchildren; a partner is deemed to own a proportionate amount of any ownership interest held by the partnership; and a corporation is deemed to own a proportionate share of any stock owned by a 50% or more shareholder of the corporation. See Code Section 318 ownership attribution rules for more details.

The definition of a highest-paid 25% of non-excludable employees includes: any individual in the highest-paid 25% of non-excludable employees. In determining the highest-paid 25% of all employees the number of employees included is rounded up to the next highest number. This can be important and significant for small employers. For example: if the employer has only five employees, the two highest paid employees are the highest-paid 25% of all employees. Under the regulations, the level of an employee's compensation is determined on the basis of the employee's compensation for the entire plan year.

Who may be excluded from the highest-paid 25% of all employees is defined under the plan rules. Code Section 105(h) excludes the following individuals from the highest-paid 25% of all employees provided they are not already participants:

- employees who have not completed three years of service at the start of the plan year;
- employees who have not attained age 25 at the start of the plan year;
- part-time or seasonal employees part-time employee works less than 35 hours per week and seasonal employees are generally defined as employed for less than nine months;
- collectively bargained employees; and
- non-resident aliens who receive no source of US income.

The individuals listed above are referred to as excluded employees. However, an employer will always have highly-compensated employees because the category is based on relative levels of compensation, the highest-paid 25%. The real issue becomes whether or not the self-insured medical plan discriminates in favor of highly-compensated employees.

The Eligibility Test asks, Does the plan discriminate in favor of highly-compensated individuals as to eligibility to participate? A self-insured medical reimbursement plan does not satisfy this Eligibility Test unless such plan benefits 70% or more of all employees or 80% or more of all employees who are eligible to benefit under the plan. If 70% or more of all employees are eligible to benefit under the plan or such employees as qualify under a classification set up by the employer are found by the IRS not be discriminatory in favor of highly-compensated individuals called a Nondiscrimination Classification Test; then the plan passes the Eligibility Test.

What exactly is being tested? Is it the employees who are eligible to participate who are tested or only those who actually benefit under the plan? A self-insured medical reimbursement plan must not discriminate in favor of highly-compensated and individuals as to eligibility to participate. It is obviously far easier for a plan to pass the eligibility test if to “benefit” just means to be “eligible”. A cautious employer will take the view that benefiting requires actual participation. A more generous interpretation is that to “benefit” means to be “eligible” to elect coverage. Some experts argue that Code Section 105 benefits be considered a defined benefit and eligibility should be tested in the same way as 401(k) plan eligibility testing. The 401(k) plan testing says that any employee who is eligible to make a salary deferral is deemed to benefit under the plan, whether or not salary deferrals are actually made.

If a self-insured medical plan is unable to pass either the 70% test or the 70%/80% Eligibility Test they 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 the following requirements are met:

- Reasonable Classification: classification for eligibility is based on all facts and circumstances and uses objective business criteria to identify categories of employees who benefit under the plan; or
- Nondiscrimination Classification: 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.

It is important that an HRA pass all required discrimination testing and also that it complete the mandatory Medicare Secondary Payer electronic reporting requirements. HIPAA Privacy rules must also be complied with. To learn more contact FlexMagic Consulting at 800-888-9084.

August 2011