HEALTH & WELFARE PLAN LUNCH GROUP

November 2, 2006

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DOL Provides Important Follow-Up Guidance on HSAs and ERISA Issues

The EBSA issued important guidance on HSAs and ERISA issues in the form of Field Assistance Bulletin 2006-02. FAB 2006-02 follows up on DOL's earlier guidance concerning when ERISA applies to HSAs (FAB 2004-1) and addresses a number of "recurring questions about the guidance and evolving practices regarding the offering of HSAs. HSA custodians, HDHP insurers, employers, financial institutions and service providers should take heed of this very important guidance to avoid running afoul of many frequently overlooked compliance issues. The complete text of the bulletin can be found at http://www.dol.gov/ebsa/pdf/fab2006-2.pdf.

The following is a brief overview of the issues addressed in the FAB 2006-02 question and answer (Q&A) guidance:

- **Q-1: Can an HSA be established without consent and still be voluntary?** An HSA is still "completely voluntary" (an essential element of the FAB 2004-1 safe harbor ERISA exception) even if the employer unilaterally establishes an HSA for employees and subsequently deposits employer funds in the HSA. The intent of the "voluntary" requirement in FAB 2004-1 is to ensure that employee contributions to an HSA, including salary reductions, are voluntary. NOTE: IRS Notice 2004-50 specifically allows an employer to provide negative cafeteria plan elections for HSA contributions so long as the requirements of Rev. Ruling 2002-27 are satisfied. Reading this guidance, FAB 2004-1 and the applicable IRS guidance together, it would appear that ERISA might not apply solely because an employer establishes an arrangement under which accounts are established by an employer and pre-tax salary reduction contributions are subsequently made by negative election (i.e., with notice and an opportunity to opt out). Also, it is important to ensure that state and federal banking requirements applicable to account establishment are satisfied.

- **Q-2: Employers do not trigger ERISA applicability solely by choosing one or more HSA provider to which it will make contributions.** The DOL clarifies that employer neutrality in communicating that the HSA is an employee welfare benefit plan is a required element of the FAB 2004-1 ERISA exception; however, "endorsement" of the arrangement itself (as typically used in the ERISA group insurance arrangement exception) is not an element. Thus making contributions to a single HSA custodian, which would normally be construed as "endorsement" does not by itself trigger ERISA. CAUTION: There is a thin line between endorsement (as used in the group insurance exception context) and employer neutrality in communicating the arrangement is not an employee welfare benefit sponsored by the employer. Employers will still need to take care in how they communicate the HSA to employees; ensuring that employees understand that the HSA is not an employer sponsored plan despite the fact that the employer has chosen this particular custodian to which it will make contributions.

- **Q-3 An employer is not "making or influencing investment decisions" in violation of FAB 2004-1 solely by choosing an HSA vendor who offers the same investments offered by the employer under its 401(k) plan as long as employees are afforded a reasonable choice of investments and are not limited in moving funds to another HSA.** Note, however, that a single investment option is not considered to be a "reasonable choice of investments". Does this mean that a single "certificate of deposit" or "interest bearing account" option is problematic by itself ? We hope not. One interpretation is that the guidance is referring to situations where the investments under the HSA mirror the 401(k) . Additional guidance is needed from the DOL on this issue. Also, while although not specifically addressed in the FAB, prior informal conversations with DOL officials indicate that ERISA may be triggered where the employer influences the scope of investments that the HSA custodian/trustee actually offers to its employees (e.g. where the employer requires investments be offered that the custodian/trustee does not typically offer). Finally, while not directly applicable, it remains to be seen how much of the recent Pension Protection Act guidance on investments may apply here.

- **Q-4 An employer's FICA and FUTA tax savings through a cafeteria plan are not "payment or compensation" that would trigger ERISA under 2004-1.**

- **Q-5 Employers can pay the employees' HSA fees without triggering ERISA.** Caution: Guidance is still needed from IRS as to whether direct withdrawal of fees from the HSA will be considered a non-taxable distribution.

- **Q-6 HSA Vendors may offer their employees the same HSA product that they offer "in the regular course of business" to the public without triggering ERISA.** Although good news, additional detail is still needed. For example, prior IRA related guidance from the DOL indicates that ERISA applies where IRA custodian's charge their own employees a fee. Although not directly applicable to HSAs, it raises the question as to whether employers may charge their own employees a fee if they charge non-employee HSA accountholders a fee? Informal guidance from DOL officials indicates that a market fee may be charged to employees who establish HSAs with the employer/HSA custodian without triggering ERISA. Also, since employers generally can pay HSA fees, we believe that discounted fee for employees should be permissible as well.

- **Q-7 An employer is considered to have received "payment or compensation", and thus triggers ERISA (and potential prohibited transaction issues), if it receives any discounts on other products offered by HSA vendors selected by the employer.** For example, it would appear that an arrangement where the HSA product is combined with other products offered by the HSA Vendor (e.g., other administrative services or HDHP coverage) and the vendor charges a lower fee for such products as a result of the HSA relationship than where the product is offered on a stand-alone basis would result in issues for the employer. Such receipt of compensation may also be in violation of the prohibited transaction rules.

- **Q-8 EBSA clarifies that an employer's failure to promptly forward employee HSA contributions to the HSA custodian is a prohibited transaction under IRS 4975 (without regard to whether ERISA applies).** Caution. Although not specifically stated, failure of an HSA administrator to forward such contributions to the HSA custodian would appear to also be a prohibited transaction.

- **Q-9 The class exemptions previously issued for IRAs (e.g., where the IRA custodian/trustee provided nominal incentives or reduced or no cost banking services/products to IRA owners) do NOT apply to HSAs.** Thus, any incentive provided to HSA account holders (other than those deposited in the HSA under AO 2004-09) are generally impermissible -- absent an HSA specific individual or class exemption.

- **Q-10 EBSA reaffirms the DOL's guidance in DOL Adv. Op. 2004-09A that it is not a prohibited transaction to offer a cash incentive for establishing an HSA so long as the incentive is paid directly to the HSA.** Presumably, payment to the individual's personal account would be a prohibited transaction.

- **Q-11 Addresses whether a line of credit issued by the HSA Vendor and the HSA accountholder is a prohibited transaction.** EBSA merely restated general law in this area. While certain activities are clearly prohibited (e.g., borrowing or pledging the HSA assets, or "receiv[ing] a benefit in his or her own individual capacity as a result of opening or maintaining an HSA" the mere issuance of credit by an HSA vendor in an arms length transaction and the account holder's directing HSA funds to the credit line vendor for HSA expenses paid with a credit card are not automatically prohibited. {Note: credit could not be issued on the condition that the account holder assign his rights to HSA funds to the credit line vendor, but voluntary, revocable payments directed by the account holder to the credit line vendor do not appear to be automatically impermissible.} The answer depends on the particular facts and circumstances. EBSA refers to DOL Adv. Op. 89-12A as general guidance. {In 89-12A, the DOL held that offering free checking services to IRA accountholders who invest a portion of the IRA assets with bank owned mutual funds was a prohibited transaction). Although not directly applicable to HSAs, the concept set forth in the 89-12A and the subsequent IRA rulings is that it is a prohibited transaction to provide an accountholder with consideration for his personal account as a result of establishing or maintaining an HSA or for using HSA funds.

If you have any questions, please feel free to contact John Hickman (jhickman@alston.com 404-881-7885) or Ashley Gillihan (agillihan@alston.com 404-881-7390).

U.S. Department of Labor **Employee Benefits Security Administration**
Washington, D.C. 20210

FIELD ASSISTANCE BULLETIN NO. 2006-02

DATE: OCTOBER 27, 2006

MEMORANDUM FOR: VIRGINIA C. SMITH, DIRECTOR OF ENFORCEMENT
REGIONAL DIRECTORS

FROM: ROBERT J. DOYLE
DIRECTOR OF REGULATIONS AND INTERPRETATIONS

SUBJECT: HEALTH SAVINGS ACCOUNTS – ERISA QS & AS

BACKGROUND:

In general, a Health Savings Account (HSA) is an account established pursuant to section 223 of the Internal Revenue Code (Code) to pay or reimburse the qualified medical expenses of eligible individuals. Although the requirements for tax qualified HSAs are found in the Code, questions regarding the application of the Employee Retirement Income Security Act of 1974 (ERISA) to HSAs arise because employers may establish and contribute to an employee's HSA. On April 7, 2004, the Department of Labor's Employee Benefits Security Administration issued Field Assistance Bulletin (FAB) 2004-01 addressing the status of HSAs under ERISA. That guidance explained that HSAs generally will not constitute "employee welfare benefit plans" covered by Title I of ERISA where employer involvement with the HSA is limited.

In FAB 2004-01, the Department specifically indicated that employer contributions to HSAs would not give rise to an ERISA-covered plan where the establishment of the HSA is completely voluntary on the part of the employees and the employer does not: limit the ability of eligible individuals to move their funds to another HSA or impose conditions on utilization of HSA funds beyond those permitted under the Code; make or influence the investment decisions with respect to funds contributed to an HSA; represent that the HSA is an employee welfare benefit plan established or maintained by the employer; or receive any payment or compensation in connection with an HSA.

Since the issuance of FAB 2004-01, the Department has received a number of recurring questions about the guidance and the evolving practices regarding the offering of HSAs.

The following provides further guidance on many of the frequently asked questions raised with the Department.

QUESTIONS AND ANSWERS:

Q-1. In the absence of an employee's affirmative consent, may an employer open an HSA for an employee and deposit employer funds into the HSA without violating the condition in the FAB that requires that the establishment of an HSA by an employee be "completely voluntary"?

A-1. Yes. The intended purpose of the "completely voluntary" condition in FAB 2004-01 is to ensure that any contributions an employee makes to an HSA, including salary reduction amounts, will be voluntary. HSA accountholders have sole control and are exclusively responsible for expending HSA funds and generally may move the funds to another HSA or otherwise withdraw the funds. The fact that an employer unilaterally opens an HSA for an employee and deposits employer funds into the HSA does not divest the HSA accountholder of this control and responsibility and, therefore, would not give rise to an ERISA-covered plan so long as the conditions described in FAB 2004-01 are met.

Q-2. If an employer maintains a high deductible health plan (HDHP) for its employees, can the employer limit the HSA providers that it allows to market their HSA products in the workplace or select a single HSA provider to which it will forward contributions without making the HSA part of the employer's ERISA-covered group health plan?

A-2. Yes. As stated in FAB 2004-01, an employer may offer an HSA to its employees without establishing an ERISA-covered plan in one of two ways. The employer may rely on the group-type insurance safe harbor in 29 C.F.R. § 2510.3-1(j), in which case the employer cannot make contributions to the HSA, or it may rely on the separate conditions outlined in FAB 2004-01, in which case the employer may or may not elect to make employer contributions to the HSA.

If the employer relies on the group-type insurance safe harbor in 29 C.F.R. § 2510.3-1(j), it cannot "endorse" the HSA provider. In the Department's view, an employer would not be considered to "endorse" an HSA within the meaning of the regulation merely by limiting the HSA providers that it allows to market their HSA products in the workplace or selecting a single HSA provider to which it will forward contributions. Employers may also provide employees general information on the advisability of using an HSA in conjunction with the HDHP without "endorsing" the program. *See generally* Interpretive Bulletin 99-1, 29 C.F.R. § 2509.99-1.

The separate conditions in FAB 2004-01, though including completely voluntary employee participation and employer neutrality in not representing that the HSA is an employee welfare benefit plan established or maintained by the employer, do not include the group-type insurance safe harbor's prohibition on employer "endorsement." As explained in FAB 2004-01, an employer could limit the HSA providers that it allows to market their HSA products in the workplace or select a single HSA provider to which it will forward contributions and still satisfy the conditions outlined in the FAB without converting the HSA into an ERISA-covered plan.

Q-3. Would an employer be viewed as "making or influencing" the HSA investment decisions of employees, within the meaning of the FAB, merely because the employer selects an HSA provider that offers some or all of the investment options made available to the employees in their 401(k) plan?

A-3. No. The mere fact that an employer selects an HSA provider to which it will forward contributions that offers a limited selection of investment options or investment options that replicate the investment options available to employees under their 401(k) plan would not, in the view of the Department, constitute the making or influencing of an employee's investment decisions giving rise to an ERISA-covered plan, so long as employees are afforded a reasonable choice of investment options and employees are not limited in moving their funds to another HSA. The selection of a single HSA provider that offers a single investment option would not, in the view the Department, afford employees a reasonable choice of investment options.

Q-4. If contributions to an HSA are made through a cafeteria plan, would the savings that benefit the employer from non-payment of FICA and FUTA taxes on those contributions be considered "payment or compensation received in connection with an HSA" that would subject the HSA to Title I coverage?

A-4. No. The Department does not view an employer's non-payment of FICA and FUTA taxes on amounts contributed to an HSA as "payment or compensation" for purposes of the guidance issued in FAB 2004-01.

Q-5. Can an employer pay the fees associated with the HSA that the employee would normally be expected or required to pay without causing the HSA to become an ERISA-covered plan?

A-5. Yes. As stated in the FAB, the mere fact that an employer contributes to an HSA does not result in the HSA being an ERISA-covered plan. Therefore, the Department does not believe that an employer paying fees associated with an HSA that the employee would otherwise be required to pay would make that HSA an ERISA-covered plan.

Q-6. May an HSA vendor offer an HSA product it offers to the public to its own employees without the HSAs being considered employee benefit plans covered by ERISA?

A-6. Yes. Offering HSA products that the employer offers to the public in the regular course of business would not mean the HSA provider established or is maintaining the HSA as an employer to provide benefits to its employees.

Q-7. If the employer limits the number of HSA vendors to which it will forward contributions, may the employer receive a discount on another product from one of the selected HSA vendors?

A-7. No. In the Department's view, receiving a discount on another product from an HSA vendor selected by the employer would constitute the employer receiving a "payment" or "compensation" in connection with an HSA. In the Department's view, the arrangement would also give rise to fiduciary and prohibited transaction issues.

Q-8. Are HSAs subject to the prohibited transaction provisions of section 4975 of the Internal Revenue Code?

A-8. Yes. Although the Department believes that HSAs meeting the conditions of FAB 2004-01 generally will not be ERISA-covered plans, the Medicare Modernization Act specifically provided that HSAs will be subject to the prohibited transaction provisions in section 4975 of the Code. In that regard, the Department's plan asset regulation at 29 C.F.R. § 2510.3-102 states, in relevant part, that "[f]or purposes of [certain specified provisions of ERISA] and section 4975 of the Internal Revenue Code only . . . the assets of the plan include amounts . . . that a participant or beneficiary pays to an employer, or amounts that a participant has withheld from his wages by an employer, for contribution to the plan as of the earliest date on which such contributions can reasonably be segregated from the employer's general assets." (Emphasis added). As a result, employers who fail to transmit promptly participants' HSA contributions may violate the prohibited transaction provisions of section 4975 of the Code. *See* Code § 4975(c)(1)(D) (prohibited transactions include the "transfer to, or use by or for the benefit of, a disqualified person of the income or assets of a plan").

Q-9. Do the class prohibited transaction exemptions for owners of individual retirement accounts (IRAs) apply to accountholders of HSAs?

A-9. No. The class exemptions issued by the Department for products and services offered owners of IRAs, PTE 97-11, PTE 93-33, PTE 93-1, do not apply to HSA accountholders.

Q-10. Is it a prohibited transaction for an HSA provider to offer a cash incentive for establishing an HSA with that provider?

A-10. No, if the provider deposits the incentive into the HSA. The Department stated in Advisory Opinion 2004-09A that, in certain situations, an HSA provider would not violate the prohibited transaction provisions under Code section 4975(c) or ERISA section 406 where the HSA provider offers an incentive to individuals for establishing an HSA with that provider by depositing cash directly into the individual's HSA. A cash contribution to an HSA generally would not be considered a "sale or exchange of property" or "a transfer of plan assets" for purposes of the prohibited transaction provisions of the Code. Because the cash contribution goes to the HSA and not the HSA account holder, the HSA's receipt of the cash contribution also would not be considered an act of self dealing on the part of the HSA account holder nor a receipt by the HSA account holder in his or her individual capacity of any consideration from a party dealing with the HSA.

Q-11. May an HSA vendor provide a line of credit for HSA expenses to an HSA accountholder choosing its HSA?

A-11. The Internal Revenue Service has issued guidance permitting eligible individuals to use debit, credit, or stored-value cards to receive distributions from an HSA for qualified medical expenses. *See* IRS Notice 2004-2, Q&A 37. Subsequent guidance by the Service explains that, under section 223(e)(2) of the Code, account beneficiaries, HSA trustees, and HSA custodians may not enter into certain "prohibited transactions" with an HSA. *See* IRS Notice 2004-50, Q&A 67, 68. For example, an account beneficiary may not borrow or pledge the assets of the HSA or receive a benefit in his or her own individual capacity as a result of opening or maintaining an HSA because such a transaction would constitute a prohibited transfer to or use of the HSA assets by or for the benefit of the account beneficiary. *See* Advisory Opinion 89-12A. Whether a credit card arrangement between a vendor and owner of an HSA results in a prohibited transaction would depend on specific facts and circumstances. A prohibited transaction would not result merely from an HSA accountholder directing the payment of HSA funds to the credit line vendor to reimburse the vendor for HSA expenses paid with a credit card.

On Death, Marriage, and Taxes: Potential Tax Impact of Domestic Partner Coverage on Consumer-Driven Health Arrangements (HRAs and HSAs)

In Revenue Ruling 2006-36 (published September 6, 2006), the IRS provided focused guidance on whether health reimbursement arrangements (HRAs) can benefit individuals other than employees, their spouses and their tax dependents. This Revenue Ruling should prompt health benefit plan sponsors to carefully review their current tax treatment for coverage of domestic partners (and others who do not qualify as the employee's "spouse" or "dependent" under relevant provisions of the Internal Revenue Code (the "Code")). This article addresses the tax impact of providing coverage to non-tax dependents through consumer-driven health care arrangements (i.e., HRAs and HSAs).

Background on "Spouses" and "Dependents"

Generally, employees are not taxed on the value of employer-provided health coverage (i.e., the employer-paid premiums) and the benefits under such plans (i.e., the actual medical reimbursements), whether provided to themselves, their spouses or their tax dependents. For purposes of receiving this favorable tax treatment, a spouse cannot be a person of the same sex as the employee.[1] Also, a dependent must meet the newly revised "dependent" definition as set forth in section 105(b) of the Code (commonly referred to as a "Tax Dependent").[2] While there are differing state law definitions of "spouse" and "dependent" for various purposes, state laws do not affect the federal tax law requirement that a spouse be of the opposite sex and that a dependent be a Tax Dependent.

Health plans can (and often do) provide coverage to a broader class of individuals than spouse and/or Tax Dependent, but to ensure that actual medical reimbursements are tax free, the employee will generally be treated as having received compensation equal to the value of any employer subsidy for the health coverage of the individual who is neither a spouse nor Tax Dependent. Where such coverage is not taxed, the amount of medical expense benefits actually provided to such individuals will be taxable to the employee. To the extent that either of these amounts is taxable to the employee, the employer would need to comply with federal (and applicable state and local) income tax withholding and employment tax requirements.

Revenue Ruling 2006-36 and Its Impact on HRAs

Revenue Ruling 2006-36 addressed an employer-sponsored health reimbursement arrangement (or HRA) that provided coverage to non-spouses and non-Tax Dependents in limited circumstances. The Plan described in the ruling:

1. Was funded solely by the employer (and not through a salary-reduction election under a Code section 125 cafeteria plan);

2. Reimbursed the employee for medical care expenses incurred by the employee and the employee's spouse and Tax Dependents and, upon the employee's death, the substantiated medical care expenses of the surviving spouse and Tax Dependents;

3. Provided reimbursements up to a maximum dollar amount for a coverage period with any unused portion of the maximum dollar amount at the end of a coverage period carried forward to increase the maximum reimbursement amount in subsequent coverage periods; and

4. Allowed the participating employee to designate any individual as a beneficiary so that if the employee died and no surviving spouse or Tax Dependent remained, any unused reimbursement amount was available to reimburse medical expenses incurred by that designated beneficiary. The Plan did not include the value of the coverage for the designated beneficiary in the gross income of the employee, but treated the reimbursement to the designated beneficiary as taxable to the designated beneficiary.

The Revenue Ruling concluded that, because a beneficiary other than the employee's spouse or Tax Dependent may receive medical reimbursements, all amounts paid "under the reimbursement plan described in this ruling" must be included in the employee's income, even those amounts paid to reimburse the medical expenses of the employee or the employee's spouse or tax Dependents. This harsh consequence (taxation of all Plan benefits) is the same as the consequence that the IRS imposed, in Notice 2002-45, on HRAs that provide benefits other than reimbursement of medical care expenses.

The Revenue Ruling provided transition relief by delaying its effective date until plan years beginning after December 31, 2008 for certain pre-existing plans.

HRAs

The most obvious reaction to the consequence declared in Revenue Ruling 2006-36 would be to strictly limit HRA participation to employees, their spouses and Tax Dependents. Such a limitation would eliminate coverage for non-Tax Dependent domestic partners, however, and may be undesirable for business reasons. But does the ruling really forbid any HRA coverage for non-Tax Dependent domestic partners? A careful reading suggests that it does not.

The IRS carefully revised the original version of the ruling to reflect that its adverse consequences were limited to amounts paid "under the reimbursement plan described in this ruling." The implication is that the ruling should not apply to amounts paid under a plan that does *not* have the characteristics described in the Plan addressed in the Ruling. Thus, where the value of any coverage for non-tax dependents is funded on an after-tax

basis (or the value of any subsidy is imputed in the employee's income) any benefits should continue to be tax free under Section 104(a)(3) of the Code.[3] Such a feature would be in clear contrast to the Plan described in the ruling, which did not include the value of the coverage for the designated beneficiary in the gross income of the employee. This "imputed income" or "after-tax dollar" approach to non-Tax Dependent coverage is consistent with established law under a line of private letter rulings by the IRS.[4]

HDHPs and HSAs

Employer-sponsored HDHPs are no different from most other employer-provided health plans in terms of the basic tax treatment of coverage and benefits provided to participants and beneficiaries. That is, employees are not taxed on the value of employer-provided health coverage and benefits provided to themselves, their spouse and Tax Dependents. As to coverage and benefits extended to domestic partners and other non-spouse and non-Tax Dependents (for convenience, referred to collectively as "domestic partners"), relevant tax considerations include the following:

- If the domestic partner is a Tax Dependent (i.e., "dependent" as defined in Code section 105(b)), then there generally exists no difference in the tax treatment of their coverage and benefits as compared to the coverage and benefits for other eligible dependents under the same plan.
- If the domestic partner is not a Tax Dependent:
  - The value of coverage provided to the domestic partner is not excludable from the employee's gross income. That value, therefore, would need to be determined and treated as taxable compensation to the employee;[5]
  - However, to the extent the value of coverage is included in the employee's gross income, the reimbursement benefits received from such coverage may receive tax-free treatment.[6]

With regard to HSAs, if the employer-sponsored HDHP covers employees and their domestic partners, the HDHP coverage is "family coverage" (i.e., in order to be family coverage for HSA purposes the coverage need merely cover one additional person). Furthermore:

- The employee, if otherwise eligible[7], can contribute to an HSA up to the contribution limit applicable to individuals with HDHP *family* coverage; and
- While HSA contributions of married individuals are subject to a joint limit[8], this joint limit likely does not apply to employees and their domestic partners. Therefore, the domestic partner, if he/she is not a Tax Dependent and is otherwise eligible[9], can also establish and contribute to his/her own HSA up to the contribution limit applicable to individuals with HDHP *family* coverage.

[1] Prior to enactment of the "Defense of Marriage Act", P.L. 104-199 (September 21, 1996), the IRS' position was that the marital status of individuals as determined under state law is recognized for federal tax law purposes. Section 3 of the Defense of Marriage Act changed this position by providing that "[i]n determining the meaning of any Act of Congress, or of any ruling, regulation or interpretation of the various administrative bureaus or agencies of the United States, the word "marriage" means only a legal union between one man and one woman as husband and wife, and the word "spouse" refers only to a person of the opposite sex who is a husband or a wife."

[2] The definition of "dependent" under Code section 105(b) is slightly broader than the definition in Code section 152. In specific, "dependent" is defined in Code section 105(b) in reference to the Code section 152 definition, but without regard to certain exceptions in Code section 152(b)(1) and (b)(2), and also without regard to the gross income limitations in Code section 152(d)(1)(B).

[3] The amount would be considered "wages" and be subject to income tax withholding, FICA and FUTA requirements. There may be some instances in which the plan may be able to "gross up" the individual so that the adverse consequence to the employee is effectively eliminated.

[4] See, e.g., PLRs 200339001 (September 26, 2003); 200108010 (February 23, 2001); 9850011 (December 11, 1998); 9717018 (April 25, 1997). While private letter rulings are binding only on the applicants to whom the rulings are directed, they general provide, in the absence of other guidance to the contrary, a good indication of the position taken by the IRS with respect to the subject matter addressed.

[5] The amount would be considered "wages" and be subject to income tax withholding, FICA and FUTA requirements. There may be some instances in which the plan may be able to "gross up" the individual so that the adverse consequence to the employee is effectively eliminated.

[6] See endnote 4 above.

[7] I.e., the individual has no coverage under any other non-HDHP health plan other than permitted insurance or permitted coverage as described in Code section 223(c).

[8] I.e., their contributions, in the aggregate, must not exceed the HDHP deductible for family coverage or, if less, the amount specified in Code section 223(b)(2).

[9] See endnote 7 above.

VEBA Compliance and Welfare Plan Nondiscrimination Testing

Health and Welfare Lunch Group

November & December 2006

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VEBAS

- Voluntary Employees' Beneficiary Association
- Tax exempt organization
  - But see UBIT below
- Qualified under IRC §501(c)(9)
  - Tax filing required
- Nondiscrimination Requirements Apply
- Limitations on Deductions
  - Qualified Direct Cost plus
  - Qualified Asset Account (QAA)

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VEBA/Plan Correlation

- **No direct correlation between number of VEBAs and plans:**
  - **Plan can be funded by multiple VEBAs**
  - **VEBA can fund multiple plans**

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Permissible Benefits

- Can accumulate tax free funds for:
  - Life, Sickness, Accident
  - Supplemental unemployment benefits
  - Severance pay
  - Education or training programs

Eligible Member/Participants

- Must be eligible for coverage under plan
- At least 90% must be employees related by employment-related common bond
  - Current employees
  - Former employees (LOA or retirees)
  - Surviving spouse and dependents
- Other 10% may be
  - Sole proprietor, independent contractors, non-employee directors, etc.

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Who May Receive Benefits

- Members or eligible dependents
  - spouse
  - minors and students of member or spouse
  - tax dependents
- Rulings allow for deminimis amount to others
  - 2-3% threshold
  - domestic partner benefits

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Impact of VEBA on Benefits

- VEBA-funded benefits generally treated as employer-paid:
  - Accident/health benefits:
    - Section 106 exclusion for coverage
    - Section 105(b) exclusion for benefits
  - Life benefits
    - Section 79 exclusion for some of coverage
    - Section 101 exclusion for insured proceeds

Permissible Benefits

- Can accumulate tax free funds for:
  - Life
    - Life may be provided directly or through insurance
    - Whole life owned by VEBA may be feasible
  - Sickness or accident coverage (other than w/comp)
    - Insurance or direct expense reimbursement
    - Could include Medicare premiums
  - Supplemental unemployment benefits
  - Severance pay
  - Education or training programs

Prohibited Inurement

- VEBA earnings cannot inure to plan sponsor or to individuals *other than* as a permissible benefit
  - No reversions
  - No disproportionate benefits in favor of HCE
  - Upon termination, assets must be paid out as permissible benefits or distributed to members pro-rata

Nondiscrimination Requirements

- Coverage and benefits must be nondiscriminatory
  - For plans with own nondiscrimination rules (e.g., 105(h), 79, etc.), the VEBA rules do not apply
- Discriminatory if any benefit (except group term life) is based on pay over $220,000 (indexed)
- Failure of discrimination requirement results in loss of VEBA tax exclusion
- Rules n/a collectively bargained plans

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Nondiscrimination Requirements

- **Under VEBA test, HCE is defined as in 414(q):**
  - **More than 5% owner (with attribution)**
  - **Employee paid more than $100,000 in prior year**

419 Deduction Limitations

- Deductible employer contributions generally limited to qualified cost
  - Actual cost of benefits provided (Qualified Direct Cost); plus
  - Permissible Additions to Qualified Asset Account (QAA) under 419A
    - Amounts for permissible pre-funding
    - Amount for reasonable "run-out" claims
- Deductible amount reduced by after-tax income and employee contributions
- Carryover allowed for unused deductions

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419A Deductions For Reserves

- Additional deduction allowed for additions to Qualified Asset Account (QAA) consisting of:
  - IBNR expense (i.e., "runout" claims)
  - Reserves for:
    - post-retirement medical (funded over working lives and determined on basis of current medical costs)
    - post-retirement life (not to exceed $50,000 in coverage)
    - severance benefits (75% of average of any 2 of last 7 years)
    - disability benefits
- Separate account required for key employees

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Unrelated Business Income Tax

- For retiree medical, UBIT paid by trust at regular trust rates on the lesser of:
  - the VEBA income (not including member contributions); or
  - the total amount set aside at the end of the year (including member contributions) minus the qualified asset account limit (QAA).
  - For this purpose, the QAA is calculated without regard to permissible retiree medical reserves (i.e., all taxable retiree medical earnings are subject to UBIT)

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Unrelated Business Income Tax

- **Exemptions from UBIT**
  - **Collectively bargained plans**
  - **Tax-exempt investments**
  - **Employee-pay-all plans**

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VEBA Excise Tax

- One-hundred percent excise tax if employer provides disqualified benefits:
  - Retiree medical or life benefits paid to key employee unless from separate account
  - Retiree medical or life benefits from discriminatory plan
  - Reversions to employer

Overview of Nondiscrimination Testing

- Generally-The IRC prohibits certain welfare benefit plans from discriminating in favor of
  - Highly compensated employees (HCEs) and/or
  - Key Employees
- Welfare Benefit Plans that require nondiscrimination testing
  - Group Term Life Insurance Plans—Code Section 79
  - Self-Insured Medical Reimbursement Plans (Health FSAs, HRAs, Major Medical Plans)—Code Section 105
  - Cafeteria Plans-Code Section 125
  - Educational Assistance Plans—Code Section 127
  - Dependent Care Assistance Plans—Code Section 129
- VEBAs are also prohibited from discriminating in favor of HCEs-Code Section 505

Group Term Life Insurance

- Applies to "Group Term Life Insurance Plans"
- Cannot discriminate in favor of Key Employees with regard to
  - Eligibility
  - Benefits
- What is a Key Employee?
  - Defined by Code Section 416(i)
  - Any employee who at any time during the Plan Year is
    - An officer with compensation in excess of $140k
    - A more than 5% owner
    - A more than 1% owner with compensation in excess of $150k

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Group Term Life Insurance

- Eligibility Test Passes if
  - 70% of all employees are covered Or
  - 85% or more of all participants are not Key Employees Or
  - the Plan benefits a classification of employees found by IRS not to be discriminatory Or
  - *The Cafeteria Plans nondiscrimination tests are satisfied (if the plan is offered under a cafeteria plan)*
- "Employee" means
  - Employees and former employees
  - all employees (and former employees) of employers in the controlled group
- Employees and former employees are tested separately
- Permissible Exclusions
  - Employees with less than 3 years of service
  - Part-time/seasonal employees
  - Certain union employees
  - Non-resident aliens with no U.S. source income

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Group Term Life Insurance

- Benefits Test passes if
  - All benefits made available to key employee participants are made available to non-key employees
  - The amount of insurance MAY bear a uniform relationship to compensation
    - E.g. All employees will receive life insurance equal to 1x compensation. A key employee who makes $200k per year will receive more life insurance than the non-key employee who makes $50k per year.
    - This is not discrimination as to benefits.
  - No Exclusions
  - Benefits for employees and former employees tested separately

Group Term Life Insurance

- **What are the consequences of failing the Section 79 Nondiscrimination tests:**
  - **Key employee must include "cost" of insurance in income**
  - **Formula to determine "cost" provided in regulations**

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Self-insured Medical Reimbursement Plans

- Health FSAs, HRAs, Major Medical/Dental/Vision Plans not provided pursuant to an insurance contract
  - What is an "insured" plan?
    - Third party is paid an amount to be financially responsible for all claims payable under an insurance policy
    - Minimum Premium Payment Arrangements/Cost Plus?
- Plans may not discriminate in favor of HCEs as to eligibility and benefits
- What is an HCE for purposes of Code Section 105 testing?
  - One of the 5 highest paid officers
  - A shareholder who owns more than 10% of the company
  - Among the highest paid 25% of all employees
- Compensation is presumably determined as of the Plan Year being tested
  - For other HCE determinations, it is a look back year

Self-insured Medical Reimbursement Plans

- **Eligibility Test Passes if**
  - 70% of all employees "benefit" under the plan Or
  - 80% benefit if 70% or more are eligible Or
  - The nondiscriminatory classification test is passed (410(b) test) or the fair cross section test
    - Most employers will use one of these tests
- **Permitted Exclusions:**
  - Employees with less than 3 years of service
  - Employees under age 25
  - Part-time/seasonal employees
    - Although not clear, conservative view is that the above must be actually excluded from participating in the plan as well to be excluded for testing
  - Certain union employees

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Self-Insured Medical Reimbursement Plans

- What does "Benefit Mean"?
  - All "eligible" employees w/o regard to participation (this is the rule for virtually same "classification" test under Code Section 125 and 129) or
  - Just Those Who Have Elected Coverage
    - The first 2 eligibility sub tests use participation as benchmark
- In an analogous situation (voluntary salary deferrals for 401(k) plans), "benefiting" has been interpreted to mean all employees who are *eligible* to participate under the plan. Treas. Reg. § 1.410(b)-3(a)(2).

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Self-Insured Medical Reimbursement Plans

- **Recurring Issues**
  - Salaried-only plans
  - Plans that exclude part-time employees
  - Plans that cover employees in one division but not another
  - Multiple plans

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Self-Insured Medical Reimbursement Plans

- **The Benefits Test is passed if**
  - **All benefits provided for participants who are highly compensated individuals are provided for other individuals. Code § 105(h)(4) AND**
  - **Benefits are not modified by reason of**
    - **Age**
    - **Service**
    - **Compensation**
  - **No Exclusions**

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Self-Insured Medical Reimbursement Plan

- Recurring Issues for Benefits Test
  - Only HCEs elect health FSA coverage
  - Dental benefits available to a limited group of employees (insured vs. self-funded).
  - Different health plans for different groups
  - Health FSA benefits available to a limited group of employees
  - Health FSA with no annual limit
  - Different entry dates for different benefits
  - Lower health FSA limit for certain employees
  - Different flex credits
    - For different geographic areas
    - For full-time vs. part-time employees
    - Based on years of service
    - Based on compensation
- Is Disaggregation Permitted?

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Self-Insured Medical Reimbursement Plans

- What are the consequences of failing tests?
  - HCEs must include "excess" reimbursement in income
  - Eligibility test
    - Excess reimbursement equals benefits received by HCE during the year multiplied by the ratio of benefits provided to all HCEs to benefits provided to all employees
  - Benefits Test
    - Excess reimbursement equals benefits received by HCE that are not received by non-HCEs

Cafeteria Plans

- Do cafeteria plans tests after you do underlying benefit plan tests
- Plans may not discriminate in favor of HCEs as to Eligibility and Benefits
- Plans may not discriminate in favor of Key Employees
- What is an HCE for purposes of the cafeteria plans tests
  - An officer, or
  - A more-than-5% owner, or
  - A highly compensated individual based on a facts and circumstances analysis:
    - Many plans borrow the dollar threshold from the definition of HCE under Section 414(q) used for 401(k) plan testing
    - The borrowed definition includes any person who during the preceding year was an employee who received compensation in excess of $100,000 (as indexed) or, if elected, top 20% rule.
  - A spouse or dependent of any of the above
- What is a Key Employee?
  - Code Section 416(i) definition-same as GTL

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Cafeteria Plans

- The Eligibility Test is passed if
  - The nondiscriminatory classification test is passed
    - Is the classification reasonable (e.g., all salaried employees)?
    - A minimum percentage of non-HCEs must "benefit"
      - Although not clear, presumably this is the same 410(b) test applied under 105
      - All eligibles or just participants?
        - In this context, benefit appears to mean "eligible"
  - Same service requirement (waiting period) must apply to all participants
    - Maximum three years
  - Employees must enter the plan by the first day of the plan year after completing the waiting period (if any)

Cafeteria Plans

- **Permitted Exclusions for Eligibility Test:**
  - **Neither Code § 125 Nor the § 125 Regulations Contain Rules on Permitted Exclusions**
  - **Possibly Can Borrow Exclusions From the Code § 410(b) Pension Rules**
    - **Employees younger than 21, if the plan excludes them**
    - **Employees with less than one year of service (defined as 1,000 hours of service or its equivalent during a 12-month period), if the plan excludes them**
    - **Certain non-resident aliens without U.S. source earned income**
    - **Certain union employees**

Cafeteria Plans

- **Recurring Issues**
  - Salaried-only plans
  - Plans that exclude part-time employees
  - Plans that cover employees in one division but not another
  - Multiple plans
  - Plans with different entry dates for different groups of employees

Cafeteria Plans

- **The contributions and benefits test is passed if:**
  - **qualified benefits and total benefits (or employer contributions allocable to qualified benefits and employer contributions for total benefits) do not discriminate in favor of highly compensated participants.**
    - **Availability Test**
    - **Utilization Test**
    - **Nondiscrimination in Actual Operation**

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Cafeteria Plans

- Recurring Issues for Benefits Plan Test
  - In a salary reduction plan, only HCEs can afford to elect health coverage
  - Different health plans for different groups
  - Health FSA benefits available to a limited group of employees
  - Dental insurance available to a limited group of employees
  - Different entry dates for different benefits
  - Lower health FSA limit for certain employees
  - Different flex credits
    - For different geographic areas
    - For full-time vs. part-time employees
    - Based on years of service
    - Based on compensation
- Is Disaggregation Permitted?

Cafeteria Plans

- **The Key Employee Concentration Test is passed if:**
  - No more than 25% of the total non-taxable benefits provided under the Plan may be provided to Key Employee
  - What is a "non-taxable" benefit?
    - Salary reductions
    - Employer contributions associated with coverage for which employee must also contribute with pre-tax salary reductions
      - E.G. employer pays 100% of self-only coverage but employees must pay the difference between family and self-only if they want family coverage
      - Are employer contributions counted for the employee with self-only? Likely not
      - What about the employee with family? Yes
    - Issue: Determining nontaxable benefits after a component plan has failed its nondiscrimination tests

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Cafeteria Plans

- What are the consequences of failing the tests?
  - Pre-tax contributions are included in gross income
  - Issue: Affect of failure of component benefit plan tests

Dependent Care Assistance Plans

- Dependent care assistance plans may not discriminate in favor of HCEs as to Eligibility and Benefits
- Average benefits provided to non-HCEs must equal or exceed 55% of the average benefit provided to HCEs
- No more than 25% of the benefits provided under the plan can be provided to more than 5% shareholders
- What is an HCE for purposes of these tests?
  - More-than-5% owner in current or prior year
  - > $100,000 (indexed) compensation in prior year (Optional: members of top 20% paid group if elected for ALL PLANS, including pension plans)

Dependent Care Assistance Plans

- **Eligibility Test is passed if:**
  - The nondiscriminatory classification test is passed
  - This is the same 410(b) type test conducted for self insured medical and cafeteria plans
  - Same issues that arise under Cafeteria Plans Eligibility Test arise here
- **Permitted Exclusions**
  - Employees < age 21 (if plan excludes them)
  - Employees < 1 year of service (if plan excludes them)
  - Certain union employees

Dependent Care Assistance Plans

- Salaried-only plans
- Plans that exclude part-time employees
- Plans that cover employees in one division but not another
- Multiple plans

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Dependent Care Assistance Plans

- The Benefits Test is passed if:
  - No regulations and no guidance
  - Presumably this is an "availability" test
  - IRS guidance is needed
- Recurring Issues
  - Lower DCAP limit for certain employees
  - Different flex credits
    - For different geographic areas
    - For full-time vs. part-time employees
    - Based on years of service
    - Based on compensation
  - Does the 55% Test supersede the general Benefits Test?

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Dependent Care Assistance Plans

- The 55% average benefits test
  - Ensures that HCEs do not participate disproportionately (not more than 45% of the total average benefits)
  - Focuses on average (not aggregate) benefits
  - TESTS ALL DEPENDENT CARE ASSISTANCE PLANS OF THE EMPLOYER AS A SINGLE PLAN
- It is a Utilization Test
  - "Benefits provided" means the amount of dependent care reimbursement that the employee actually receives under the DCAP (not just salary reductions)
  - Forfeitures under the DCAP aren't benefits
  - If testing at the beginning of the year, plan sponsors can presumably assume that the annual election will equal benefits provided
- Who Must Be Included in the Test?
  - Approach #1: Count all employees (other than Excludables), even if they aren't eligible to participate in the DCAP?
  - Approach #2: Count only the employees who are eligible to participate in the DCAP?
    - Can DCAP provide that only eligible if have no children?
  - Approach #3: Count only those who actually participate? This is no-n0
- Approach #1 appears more technically correct based statutory language and congress' actions

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Dependent Care Assistance Plans

- Who Can Be Excluded ("Excludables")?
  - Employees who have not completed one year of service by the end of the year
  - Employees who have not reached age 21 by the end of the year
  - Certain union employees
  - For benefits provided through pre-tax salary reduction, any employee whose compensation is less than $25,000
- EGTRAA Increases the Chance of Failure
  - The increase in the tax credit ($6,000 in 2003) means that NHCEs will probably elect fewer DCAP benefits
  - The $25,000 salary reduction exclusion needs to be increased
- Many companies fail this test

Dependent Care Assistance Plans

- More than 5% shareholder test
  - Run the same as Key Employee Concentration Test
  - Measure benefits provided
    - May assume that annual election will equal benefits provided
- What are the consequences of failing the tests?
  - Benefits received by HCEs under the Plan included in income

Educational Assistance Plans

- Cannot discriminate in favor of HCEs as to Eligibility
- No more than 5% of educational benefits provided by the employer during the year may be provided to
  - More than 5% shareholders
  - More than 5% owners
  - Spouses and/or dependents of the foregoing
- What is HCE for purposes of this test?
  - Same as Dependent Care Assistance Plan (414(q))
- Eligibility Test is passed if:
  - The nondiscriminatory classification test is passed
  - Presumably, this is the same 410(b) type test conducted for cafeteria plans/dependent care assistance plans
  - Use only those actually eligible

Educational Assistance Plans

- What is not discrimination?
  - Utilization is greater among HCEs
  - Requiring completion of the course, a particular grade as a condition precedent to receiving benefits or a condition subsequent (such as remaining employed for a period of time after completion)
- Permitted exclusions:
  - Certain union employees
  - Other 410(b) exclusions?
- What are the consequences of failing the tests?
  - Educational benefits provided to HCEs or other prohibited group (shareholders, owners) are taxable

Common Terms and Principles

- **Compensation**
  - All W-2
  - All salary reductions made under a 401(k), cafeteria plans and transit plan (includes cashable flex credits)
- **Officer**
  - Someone with authority of officer
  - Title alone not sufficient
- **When should you test**
  - Prior to or shortly after the beginning of the plan year
  - Presumably, adjustments may be made to elections if done during the year
  - No adjustments after the end of the year