

July 2015

# Medical Expense Reimbursement Plans - Planning Opportunities Under the Final Section 105(h) Regulations

David L. Wolfe

Please take a moment to share how this work helps you [through this survey](#). Your feedback will be important as we plan further development of our repository.

Follow this and additional works at: <https://ideaexchange.uakron.edu/akronlawreview>

 Part of the [Health Law and Policy Commons](#)

---

## Recommended Citation

Wolfe, David L. (1982) "Medical Expense Reimbursement Plans - Planning Opportunities Under the Final Section 105(h) Regulations," *Akron Law Review*: Vol. 15 : Iss. 1 , Article 3.

Available at: <https://ideaexchange.uakron.edu/akronlawreview/vol15/iss1/3>

This Article is brought to you for free and open access by Akron Law Journals at IdeaExchange@UAkron, the institutional repository of The University of Akron in Akron, Ohio, USA. It has been accepted for inclusion in Akron Law Review by an authorized administrator of IdeaExchange@UAkron. For more information, please contact [mjon@uakron.edu](mailto:mjon@uakron.edu), [uapress@uakron.edu](mailto:uapress@uakron.edu).

Wolfe: Medical Expense Reimbursement  
**MEDICAL EXPENSE REIMBURSEMENT PLANS -  
PLANNING OPPORTUNITIES UNDER THE  
FINAL SECTION 105(h) REGULATIONS\***

DAVID L. WOLFE\*\*

**M**EDICAL EXPENSE reimbursement plans have become a popular fringe benefit in recent years, especially for closely held corporations concerned with the reasonableness of their total compensation packages established for shareholder-employees. Under these plans, employers undertake to pay specified medical care expenses incurred by an eligible employee or his spouse or dependents, either through direct payments to the service provider or by reimbursing the employee for his out-of-pocket expenses.

Often these plans are established on a self-insured basis, and frequently supplement the benefits available under the corporation's group insurance program. They are popular primarily because payments under the plan receive favorable tax treatment at both the corporate and recipient levels, even though the plan covers only a select group of key employees. As described in more detail below, these tax advantages include a deduction for the employer's payments under such a plan and a corresponding exclusion of the amounts so received from the gross income of the employee-recipient.

The Revenue Act of 1978<sup>1</sup>, however, has substantially altered the traditional ground rules for self-insured medical expense reimbursement plans by imposing new statutory standards of nondiscrimination, both as to the eligibility of participation and the amount of benefits provided. Unless the new standards are satisfied, payments made under these plans after December 31, 1979 are generally includable in the gross income of any highly compensated employee-recipient.

---

\*Copyright by David L. Wolfe 1981. All rights reserved.

\*\*Associate with Gardner, Carton & Douglas, Chicago, Illinois; B.S., University of Illinois, 1973; J.D., *cum laude*, University of Michigan, 1976; C.P.A., Illinois; member, Employee Benefits Committee of Chicago Bar Association.

<sup>1</sup> Revenue Act of 1978, Pub. L. No. 95-600, 92 Stat. 2763 (codified in scattered sections of I.R.C.) [hereinafter cited as the Revenue Act]. As a major piece of tax legislation, the Revenue Act includes numerous substantive provisions which are beyond the scope of this article. In fact, the discussion which follows focuses on one particular section of the Revenue Act: § 366 (codified at I.R.C. § 105(h)). § 366 adds a new subsection (h) to § 105 of the Internal Revenue Code of 1954, relating to the taxability of payments made to certain highly compensated individuals under self-insured medical expense reimbursement plans. Although the legislative history of the Revenue Act is unusually long and complex, portions thereof may affect future interpretations of new § 105(h). The most significant parts of that legislative history are in: S. REP. No. 1263, 95th Cong., 2d Sess. 1, *reprinted in* [1978] U.S. CODE CONG. & AD. NEWS 6761, 6949-50 [hereinafter cited as Senate Report]; H.R. REP. No. 1800, 95th Cong., 2d Sess. 1, *reprinted in* [1978] U.S. CODE CONG. & AD. NEWS 7198, 7251-2 [hereinafter cited as Conference Committee Report].

Because these new standards impact significantly upon preexisting medical expense reimbursement plans, this article will present a general overview of the traditional tax treatment of payments under such plans, describe the new nondiscrimination standards and their effective date, as well as outline several planning opportunities which remain available in this area.

### I. TRADITIONAL TAX TREATMENT TO EMPLOYEE AND EMPLOYER

The focal point for determining the tax treatment to employees of amounts received under accident and health plans is section 105 of the Internal Revenue Code of 1954, as amended.<sup>2</sup> The general inclusionary rule in section 105(a) provides that amounts received by an employee through accident or health insurance for personal injuries or sickness are to be included in the employee's gross income to the extent provided by the employer. Various exceptions are then carved out, principally in subsections (b), (c) and (d) of section 105.<sup>3</sup>

In particular, subsection (b) excludes from an employee's gross income any amounts received through accident or health insurance provided by the employer to reimburse the employee, directly or indirectly, for medical care expenses (as defined in section 213(e))<sup>4</sup> incurred by the employee or his spouse or dependents (as defined in section 152),<sup>5</sup> provided that the employee does not also deduct the expenses under section 213. Section 105(e) further provides that amounts received under an accident or health "plan for employees" will be treated as received through accident or health insurance for purposes of section 105. Accordingly, the section 105(b) exclusion has traditionally applied to amounts received under such a plan, even though the recipient does not actually pay the medical expenses in that year, and without statutory limitation as to amount.<sup>6</sup>

In the absence of specific statutory provisions such as those above pertaining to the employer's deduction for such payments, the deduction is governed by section 162(a). This section deals with "ordinary and necessary" business expenses in general. The regulations which the Internal

<sup>2</sup> Unless otherwise indicated, all section and regulation references in the text and footnotes relate to sections of the Internal Revenue Code of 1954, as amended to date, and the current regulations thereunder.

<sup>3</sup> I.R.C. § 105(c) provides an exclusion for amounts which constitute payment for permanent loss or loss of use of a bodily member or function, or permanent disfigurement, and which are computed with reference to the nature of the injury without regard to the period the employee is absent from work. § 105(d) excludes disability payments received under a statutory wage continuation plan.

<sup>4</sup> I.R.C. § 213(e)(1) defines the term "medical care" generally to include payments: (i) for the diagnosis, cure, mitigation, treatment or prevention of disease; (ii) for the purpose of affecting any bodily structure or function; (iii) for transportation primarily for and essential to (i) or (ii) above; and (iv) for certain insurance covering the above types of medical care. See also Treas. Reg. § 1.213-1(e).

<sup>5</sup> The definition of "dependent" used for purposes of the deduction for personal exemptions is found in I.R.C. § 151.

<sup>6</sup> Treas. Reg. § 1.105-2.

Revenue Service (Service) has issued under section 162(a) address the deductibility of these payments, but only in the following general terms:

Amounts paid or accrued within the taxable year for . . . a sickness, accident, hospitalization, medical expense, . . . welfare, or similar benefit plan, are deductible under section 162(a) if they are ordinary and necessary expenses of the trade or business. . . .<sup>7</sup>

Although the regulations provide no specific guidelines on the deductibility question, the Tax Court has held that payments under medical expense reimbursement plans are ordinary and necessary business expenses as long as the arrangement constitutes a "plan for employees" within the meaning of section 105(e).<sup>8</sup>

## II. EMERGING CONCEPT OF "PLAN FOR EMPLOYEES" PRIOR TO THE REVENUE ACT OF 1978

In analyzing the impact of the new nondiscrimination standards, it is important to understand the extent to which limited coverage under medical expense reimbursement plans has historically affected their status as a "plan for employees" under section 105(e). The definition of "accident or health plan" in the regulations under section 105 is an appropriate starting point:

In general, an accident or health plan is an arrangement for the payment of amounts to employees in the event of personal injuries or sickness. A plan may cover one or more employees, and there may be different plans for different employees or classes of employees. An accident or health plan may be either insured or noninsured, and it is not necessary that the plan be in writing or that the employee's rights to benefits under the plan be enforceable. However, if the employee's rights are not enforceable, an amount will be deemed to be received under a plan only if, on the date the employee became sick or injured, the employee was covered by a plan (or a program, policy, or custom having the effect of a plan) providing for the payment of amounts to the employee in the event of personal injuries or sickness, and notice or knowledge of such plan was reasonably available to the employee. . . .<sup>9</sup>

The broad and liberal wording of this provision has been frequently attributed at least in part to the legislative history of section 105.<sup>10</sup> Although

<sup>7</sup> Treas. Reg. § 1.162-10(a).

<sup>8</sup> See *Epstein v. Comm'r*, 31 T.C.M. 217, 221 (CCH 1972); *Smith v. Comm'r*, 29 T.C.M. 1065, 1068 (CCH 1970); *Bogone, Inc. v. Comm'r*, 27 T.C.M. 730, 734 (CCH 1968).

<sup>9</sup> Treas. Reg. § 1.105-5(a).

<sup>10</sup> *Lang v. Comm'r*, 41 T.C. 352, 356 n. 5 (1963); *Estate of Kaufman v. Comm'r*, 35 T.C. 663, 666 (1961), *aff'd*, 300 F.2d 128 (6th Cir. 1962). Relevant portions of that legislative history are as follows: H.R. 8300, 83d Cong., 2d Sess. § 105 (1954); H.R. REP. No. 1337, 83d Cong., 2d Sess. 15 and A32-A34 (1954); H.R. REP. No. 2543, 83d Cong., 2d Sess. 6-7 (1954); S. REP. No. 1622, 83d Cong., 2d Sess. 15-16 (1954); see also Rizzo, *Developing Concepts Affecting Medical Payment Plans and Salary Reimbursement Agreements*, MAJOR TAX PLANNING FOR 1974, 333, 340 (1974) (Twenty-Sixth Tax Inst., U. of So. Cal.).

the original House version contained strict coverage rules and benefit tests similar to those imposed by the Revenue Act of 1978,<sup>11</sup> the Senate Finance Committee deleted the qualification rules from the Senate version prior to adoption.<sup>12</sup>

The Senate Finance Committee stated that it agreed with the objectives of the House bill, but because the final version of the bill eliminated certain automatic qualification provisions relating to pension plans, the requirement of a "qualified" health or accident plan was also eliminated in order to avoid the necessity of obtaining private rulings on health and accident plans, similar to those now obtained for pension plans.<sup>13</sup>

In the absence of more explicit guidelines in this area, the Service has consistently sought judicial support for the imposition of a nondiscriminatory coverage requirement based upon the "plan for employees" language in section 105(e). The Service's arguments in this area are generally two-fold: that the arrangement is so informal that no "plan" exists, and that the payments constitute distributions as dividends to stockholders rather than medical expense reimbursements "for employees".<sup>14</sup> However, the courts have rejected the Service's arguments on several occasions, even where the only participants were corporate officers, and those officers were also stockholders of the corporation.<sup>15</sup>

Although a detailed recapitulation of the cases in this area is beyond the scope of this article, it is important to note that prior to the Revenue Act of 1978, one could design an arrangement with a minimum of advance planning which would be treated for tax purposes as a "plan for employees" within the meaning of section 105(e), even though it benefited a group of employees consisting primarily of shareholders. The existence of a "plan" could be established, for example, by (i) developing specific guidelines in advance concerning the identity of covered employees (either by name or employment classifications), the amount of coverage and the manner in which benefits might be obtained, (ii) reducing those terms to writing, (iii) distributing a copy of the underlying document or a summary of its provisions to each participating employee, and (iv) obtaining formal approval by the sponsoring corporation's board of directors.<sup>16</sup> Participation in the plan

<sup>11</sup> H.R. 8300, 83d Cong., 2d Sess. § 105(c)(1) (1954).

<sup>12</sup> S. REP. No. 1622, 83d Cong., 2d Sess. 15-16 (1954).

<sup>13</sup> *Id.* See also Internal Revenue Service Forms in the 5300 Series.

<sup>14</sup> See cases cited at note 8, *supra*.

<sup>15</sup> *Id.* See also *American Foundry v. Comm'r*, 59 T.C. 231 (1972), *rev'd in part*, 536 F.2d 289 (9th Cir. 1976).

<sup>16</sup> 59 T.C. at 239, 242-43. See also *Estate of Leidy v. Comm'r*, 34 T.C.M. 1476 (CCH 1975), *aff'd per curiam*, 77-1 U.S.T.C. ¶ 9144 (4th Cir. 1976); *Larkin v. Comm'r*, 48 T.C. 629 (1967), *aff'd*, 394 F.2d 494 (1st Cir. 1968); *Lang v. Comm'r*, 41 T.C. 352 (1963). See Rizzo, *supra* note 10, at 540. See also Ellis & Canan, *Tax-Free Medical Reimbursement Plan Can Heavily Favor Shareholder-Employee*, 14 TAX. ACCTS. 184 (1975); Kimmel,

could then be limited to shareholder-employees as long as the corporation established a rational basis other than ownership of stock to differentiate covered from noncovered employees.<sup>17</sup> The traditional basis for differentiation was that no employees excluded from coverage performed services similar to those performed by covered employees,<sup>18</sup> or that the excluded employees were participating in a group insurance arrangement.<sup>19</sup>

It should also be noted that although self-employed individuals are not considered employees for purposes of section 105,<sup>20</sup> if the spouse of a self-employed individual is an employee of the trade or business in question, the spouse may qualify for the section 105(b) exclusion even though a portion of the medical expenses being reimbursed was incurred by the self-employed individual.<sup>21</sup>

### III. THE NEW NONDISCRIMINATION STANDARDS

As was stated above, the Revenue Act has significantly altered the tax treatment of payments made to highly compensated individuals under most self-insured medical expense reimbursement plans after December 31, 1979. Section 366(a) of the Revenue Act has added section 105(h) to the Internal Revenue Code, which imposes new nondiscrimination standards for such plans with respect to both the eligibility to participate and the amount of benefits provided. If a plan is found to discriminate in favor of highly compensated individuals the section 105(b) exclusion will not be available. The gross income of these individuals will thus be increased by all or a portion of the payments received.

It should be noted at the outset that the Technical Corrections Act of 1979,<sup>22</sup> enacted April 1, 1980, revised section 105(h) in several respects. The Service published proposed regulations under section 105(h) on February 28, 1980,<sup>23</sup> and a public hearing was held on June 24, 1980. The regulations were subsequently revised and issued in final form on January 15, 1981.<sup>24</sup>

---

*Medical Reimbursement Plans for Closely Held Corporations*, 51 TAXES 243 (1973); Nicoletta, *Medical Reimbursement Plan is Popular Fringe Benefit for All Purposes*, 16 TAX. ACCTS. 51 (1976); Comment, *The Legal Benchmarks of a Plan for Employees: A Navigational Framework Under Section 105*, 8 LOY. L.A. L. REV. 363 (1975).

<sup>17</sup> 59 T.C. at 242. See also *Levine v. Comm'r*, 50 T.C. 422 (1968).

<sup>18</sup> 29 T.C.M. at 1065. See also *Charlie Sturgill Motor Co. v. Comm'r*, 32 T.C.M. 1336 (CCH 1973).

<sup>19</sup> 59 T.C. at 238-39, 242-43.

<sup>20</sup> I.R.C. § 105(g).

<sup>21</sup> Rev. Rul. 71-588, 1971-2 C.B. 91.

<sup>22</sup> Technical Corrections Act of 1979, Pub. L. No. 96-222 § 103(a)(13), 94 Stat. 194 (to be codified at I.R.C. §§ 105, 3401).

<sup>23</sup> Prop. Reg. § 1.105-7, reprinted in 45 Fed. Reg. 13123 (1980).

<sup>24</sup> Treas. Reg. §§ 1.105-11, T.D. 7754, 1981-13 I.R.B. 11, 17; Treas. Reg. § 31.3401(a)

It is also important to emphasize that the new section 105(h) standards apply only to *self-insured* plans.<sup>25</sup> A self-insured plan is defined as one in which reimbursements are "not provided under a policy of accident and health insurance."<sup>26</sup> According to the Senate Report, this includes any plan (or portion of a plan) under which benefits are not provided by a licensed insurance company.<sup>27</sup> The Report explains that the bill was not extended to insured plans because underwriting considerations generally preclude or effectively limit abuses in that setting.<sup>28</sup>

Accordingly, the threshold question which must be addressed under section 105(h) is whether a particular plan constitutes an insured or self-insured arrangement. This determination is important since many insurance companies have seized upon the above language in the Senate Report as an opportunity to promote a variety of creative insurance policies, for individuals or narrowly defined groups of key employees. Such policies are generally represented to employers as not being governed by the new non-discrimination rules. While the specific terms of these policies vary widely, the net effect under many of them is to base the amount of the employer's premium on the sum of the aggregate claims paid by the insurance company during the period in question, plus a specified percentage of such claims in the form of a direct or indirect service charge.

The final regulations expand the language of section 105(h)(6) and the Senate Report by defining a self-insured medical expense reimbursement plan as: (i) a separate written plan for employees; (ii) providing for payment of employee medical expenses referred to in section 105(b); (iii) other than under an individual or group policy of accident or health insurance issued by a licensed insurance company or an arrangement in the nature of a prepaid health care plan which is regulated under federal or state law in manner similar to the regulation of insurance companies.<sup>29</sup> It should be noted that clause (i) above accentuates the importance of formalizing the terms of the plan through a written plan document.

The regulations base the determination of whether a particular plan constitutes an insured or prepaid health care plan on whether there is a shifting of risk from the employer to an unrelated third party.<sup>30</sup> The regulations further specify that plans underwritten by the following types of insurance policies will be considered self-insured: (i) policies issued by a captive insurer (unless the premiums paid by companies unrelated to

<sup>25</sup> I.R.C. § 105(h)(1).

<sup>26</sup> I.R.C. § 105(h)(6).

<sup>27</sup> S. REP. No. 1263, 95th Cong., 2d Sess. at 186, reprinted in [1978] U.S. CODE CONG. & AD. NEWS at 6949.

<sup>28</sup> *Id.*

<sup>29</sup> Treas. Reg. § 1.105-11(b)(1)(i), T.D. 7754, 1981-13 I.R.B. 11, at 12.

<sup>30</sup> Treas. Reg. § 1.105-11(b)(1)(ii), T.D. 7754, 1981-13 I.R.B. 11, at 12.

the captive insurance company for the plan year in question equal or exceed 50% of the total premiums received and the policy is similar to policies sold to such unrelated companies);<sup>31</sup> (ii) cost-plus policies;<sup>32</sup> and (iii) policies which in effect merely provide administrative or bookkeeping services.<sup>33</sup> The regulations also provide, however, that a plan will not be considered self-insured merely because one factor the insurer uses in determining the premium is the employer's prior claims experience.<sup>34</sup>

According to the regulations, a plan of health maintenance organization established under the Health Maintenance Organization Act of 1973<sup>35</sup> will qualify as a prepaid health care plan.<sup>36</sup> On the other hand, the new rules will apply to a self-insured plan maintained by a voluntary employees' beneficiary association described in section 501(c)(9).<sup>37</sup>

Furthermore, if an employer's medical plan is only partly underwritten by insurance, the regulations will apply the new nondiscrimination rules to the self-insured portion.<sup>38</sup> For example, if a plan reimburses employees for benefits not covered under the employer's group insurance plan, or for deductible amounts under the insured plan, these payments are governed by the new rules. The regulations provide, however, that a plan which merely reimburses employees for premiums paid under an insured plan is not subject to section 105(h).<sup>39</sup>

In light of the above rules, an employer considering the adoption of one of the many "insured" plans on the market should ascertain whether the risk of loss is in fact being shifted from the employer under that particular arrangement. As an initial step, the employer should inquire of the insurance company whether the insurer has obtained or will obtain a ruling from the Service that the plan qualifies as an insured plan. If such a ruling has been issued, the employer should request a copy and retain it for future reference. In the absence of such a ruling, the insurance company may agree to provide the employer with an opinion of counsel stating that the plan in question is not subject to the new rules, and explaining the underlying basis for this conclusion. In any event, the employer should independently calculate the relationship between claims and premiums under the plan to determine the extent to which the insurance company is effectively bearing the risk of loss under the arrangement.

<sup>31</sup> Treas. Reg. § 1.105-11(b)(1)(iii), T.D. 7754, 1981-13 I.R.B. 11, at 12.

<sup>32</sup> Treas. Reg. § 1.105-11(b)(1)(ii), T.D. 7754, 1981-13 I.R.B. 11, at 12.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified in scattered sections of 12, 42 U.S.C.).

<sup>36</sup> Treas. Reg. § 1.105-11(b)(1)(i), T.D. 7754, 1981-13 I.R.B. 11, at 12.

<sup>37</sup> Treas. Reg. § 1.105-11(b)(1)(i), T.D. 7754, 1981-13 I.R.B. 11, at 12.

<sup>38</sup> Treas. Reg. § 1.105-11(b)(2), T.D. 7754, 1981-13 I.R.B. 11, at 12-13.



If a determination is made that a plan constitutes a self-insured arrangement under the above tests, the new section 105(h) rules will govern the taxability of payments made to "highly compensated individuals" thereunder. This group is defined to include (i) the employer's five highest paid officers, (ii) shareholders owning more than 10% in value of the employer's stock, and (iii) the highest paid 25% of all employees, including the five highest paid officers.<sup>40</sup> In computing stock ownership for purposes of the 10% threshold figure, the attribution rules of Section 318 are to be applied.<sup>41</sup>

The regulations provide that the status of an employee as an officer or shareholder is to be determined with respect to a particular benefit on the basis of the employee's officer status or stock ownership at the point in time when the benefit is provided.<sup>42</sup> In calculating the highest paid 25% of all employees, the number of employees to be included is to be rounded to the next highest number.<sup>43</sup> For example, if there are five employees, the top two are deemed to be highly compensated under the 25% rule. An employee's compensation for this purpose is generally to be determined on a plan-year basis.<sup>44</sup> However, fiscal-year plans may determine compensation on the basis of the calendar year ending within the plan year.<sup>45</sup>

The new eligibility standards are similar to the statutory tests in section 410(b) established for qualified retirement plans. Under these standards a self-insured medical expense reimbursement plan will automatically be considered to have nondiscriminatory eligibility classifications if it satisfies either of the two percentage tests on an annual basis. The plan must either benefit at least 70% of all employees, or at least 70% of all employees must be eligible to participate and 80% of the eligible employees must be benefited.<sup>46</sup> If neither percentage test is satisfied, it is also possible to qualify on an ad hoc basis by establishing to the satisfaction of the Service that the plan covers a representative cross section of employees.<sup>47</sup> Relying on the latter method may entail some risk, however, because it requires the Service's approval of the classification, through either an advance ruling or the audit process.<sup>48</sup>

---

<sup>40</sup> I.R.C. § 105(h)(5) and Treas. Reg. § 1.105-11(d). This group is somewhat comparable to the "prohibited group" under qualified retirement plans, as defined in I.R.C. §§ 401(a)(4), 410(b)(1)(B).

<sup>41</sup> I.R.C. § 105(h)(5)(B).

<sup>42</sup> Treas. Reg. § 1.105-11(d), T.D. 7754, 1981-13 I.R.B. 11, at 14-15.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> I.R.C. § 105(h)(3)(A)(i).

<sup>47</sup> I.R.C. § 105(h)(3)(A)(ii).

<sup>48</sup> *Id.*

Section 105(h)(3)(B) and the regulations thereunder specify that the following categories of employees may be excluded from the eligibility computation: employees who have not yet completed at least three years of service with the employer prior to the beginning of the plan year, employees who have not yet attained age 25 prior to the beginning of the plan year, part-time or seasonal employees, union employees if accident and health benefits were the subject of good-faith bargaining, and certain non-resident aliens.<sup>49</sup> In addition, if one or more of these groups is excluded from participation, the excluded individuals must also be disregarded under the compensation test used for determining which employees are highly compensated individuals.<sup>50</sup>

In determining an employee's years of service for this purpose, the regulations permit the use of any method which is "reasonable and consistent."<sup>51</sup> Although an employer is thus not required to measure service under the 1,000 hour-of-service rule generally used to compute full-time employment status for purposes of qualified retirement plans (as described in section 410(a)(3)), the use of this method will automatically be deemed reasonable.<sup>52</sup> In addition, the regulations expressly provide that all of an employee's years of service with the employer prior to a separation from service may be disregarded for purposes of the three-year rule.<sup>53</sup>

Part-time or seasonal employees may be excluded from participation under section 105(h)(3)(B)(iii), according to the regulations, if their customary employment is for less than 35 hours per week or nine months per year, respectively, and if other employees in similar work with the same employer (or, if no employees of the employer are in similar work, in similar work in the same industry and location) have substantially more than 35 hours or nine months of service included in their customary weekly or annual employment.<sup>54</sup> Unfortunately, however, the regulations do not define the terms "similar work" and "substantially" for this purpose. Under an alternative safe harbor, any employee whose customary employment is for less than 25 hours per week or seven months per year may be excluded from participation.<sup>55</sup>

Since the above eligibility tests and exclusions are applied on an annual basis, an employer would be well advised to maintain accurate and complete records of the age, compensation, length of service, and customary weekly

---

<sup>49</sup> Treas. Reg. § 1.105-11(c)(2)(iii), T.D. 7754, 1981-13 I.R.B. 11, at 13.

<sup>50</sup> I.R.C. § 105(h)(5)(C).

<sup>51</sup> Treas. Reg. § 1.105-11(c)(2)(iii)(A), T.D. 7754, 1981-13 I.R.B. 11, at 13.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> Treas. Reg. § 1.105-11(c)(2)(iii)(C), T.D. 7754, 1981-13 I.R.B. 11, at 13.

or annual work schedule of each employee to ensure that a sufficient number of non-excludable employees participate during each plan year.

The discrimination standard with respect to benefits requires that "all benefits" provided for highly compensated individuals also be provided for all other participants.<sup>56</sup> According to the regulations, this test is to be applied to benefits subject to reimbursement under the plan, rather than the actual benefit payments or claims thereunder.<sup>57</sup> This requires that both the type and amount of plan benefits be the same for all participants. For example, all benefits available for the dependents of employees who are highly compensated individuals must also be available on the same basis for the dependents of all other participants. In addition, any maximum reimbursement limits must be uniform for all participants and dependents, and thus may not be modified by reason of a participant's age or years of service. The regulations further indicate that a plan would be discriminatory under this test if benefits are payable in proportion to employee compensation.<sup>58</sup> In this respect, the benefit test is even more restrictive than the benefit standards imposed on qualified retirement plans, since benefits under the latter are not considered discriminatory if they are calculated in proportion to a participant's compensation.<sup>59</sup>

A plan that provides optional benefits for participants will be treated as providing a single benefit with respect to the benefits covered by the option only if all eligible participants may elect any of the benefits covered by the option and there are either no required employee contributions or the required employee contributions are in the same amount.<sup>60</sup> The regulations also state that if an employer provides benefits to a retired employee who was formerly a highly compensated individual, and such benefits would otherwise be excludable from gross income under the regular section 105(b) rules, they will not be considered discriminatory under the benefit test as long as the type, and dollar limitations, of benefits provided for retired employees who were highly compensated individuals are the same for all other retired participants.<sup>61</sup>

A plan which on its face provides the same benefits for all participants may nevertheless discriminate in operation if, for example, the plan (or a particular benefit provided by the plan) is terminated and the duration of the plan (or benefit) has the effect of discriminating in favor of highly compensated individuals.<sup>62</sup> This could occur, for example, where the duration

---

<sup>56</sup> I.R.C. § 105(h)(4).

<sup>57</sup> Treas. Reg. § 1.105-11(c)(3)(i), T.D. 7754, 1981-13 I.R.B. 11, at 13-14.

<sup>58</sup> *Id.*

<sup>59</sup> I.R.C. § 401(a)(5).

<sup>60</sup> Treas. Reg. § 1.105-11(c)(3)(i), T.D. 7754, 1981-13 I.R.B. 11, at 13-14.

<sup>61</sup> Treas. Reg. § 1.105-11(c)(3)(iii), T.D. 7754, 1981-13 I.R.B. 11, at 14.

<sup>62</sup> Treas. Reg. 1.105-11(c)(3)(ii), T.C. 7754, 1981-13 I.R.B. 11, at 14.

of a particular benefit coincides with the period during which a highly compensated individual utilizes the benefit. The regulations expressly state that this determination is to be applied on the basis of the facts and circumstances of each case.<sup>63</sup> However, the mere fact that highly compensated individuals utilize a broad range of benefits to a greater extent than other participants will not cause the plan to be considered discriminatory in operation.<sup>64</sup>

The regulations also provide that an employer's plan will not violate the section 105(h) benefit standard merely because benefits are offset by benefits paid under a self-insured or insured plan of the employer or another employer, or by the benefits paid under Medicare or other federal or state law or similar foreign law, to the extent that the type of benefit subject to reimbursement is the same under both plans.<sup>65</sup> Accordingly, if an employer offers a self-insured plan to key employees and group insurance to others, the former will not be discriminatory to the extent that rank-and-file employees receive the same type of benefits.

In applying both the eligibility and benefit standards, all employees of a controlled group of corporations or trades or businesses under common control as provided in subsection (b) or (c) of section 414, as well as all employees of an "affiliated service group" under section 414(m), are to be treated as employees of a single employer.<sup>66</sup> An obvious purpose of this provision is to foreclose the possibility of establishing separate corporations for highly compensated and rank-and-file employees as a means of circumventing section 105(h).

An employer may also designate two or more plans as constituting a single plan for purposes of satisfying the new nondiscrimination tests.<sup>67</sup> For example, the plan of a health maintenance organization may be designated with an employer's self-insured plan as a single plan. In that case, for eligibility purposes, the self-insured plan will be deemed to benefit an employee who has enrolled in the health maintenance organization on an optional basis if the employer's contributions to the health maintenance organization plan on that employee's behalf equal or exceed the contributions that it would otherwise make to the self-insured plan.<sup>68</sup> In addition, a determination that a combination of plans designated as a single plan does not satisfy the eligibility or benefit test does not preclude a determination that one or more of the plans, considered separately, satisfies the two

---

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> Treas. Reg. 1.105-11(c)(1), T.D. 7754, 1981-13 I.R.B. 11, at 13.

<sup>66</sup> I.R.C. § 105(h)(8).

<sup>67</sup> Treas. Reg. § 1.105-11(c)(4)(i), T.D. 7754, 1981-13 I.R.B. 11, at 14.

<sup>68</sup> Treas. Reg. § 1.105-11(c)(4)(iii), T.D. 7754, 1981-13 I.R.B. 11, at 14.

tests.<sup>69</sup> Alternatively, a single plan document may be used for two or more separate plans, "provided that the employer designates the plans that are to be considered separately and the applicable provisions of each separate plan."<sup>70</sup>

After December 31, 1979, under a self-insured plan covering only highly compensated individuals, all payments made to those individuals will be includable in their gross income.<sup>71</sup> Furthermore, if the plan provides a particular type of benefit for highly compensated individuals which is not available to all other participants, the amount paid to such individuals with respect to that benefit will be includable in their gross income.<sup>72</sup> This would include, for example, benefits paid for maternity, dependency or dental coverage for highly compensated individuals if such coverage is not provided to participants generally. Also, if all participants receive the same types of benefits but highly compensated individuals have a higher maximum reimbursement limit, any amount reimbursed above the maximum limit for the lowest paid rank-and-file participant will be taxable to the highly compensated individual. This rule would apply, for example, if all participants receive the same benefits but reimbursement is provided in proportion to employee compensation.<sup>73</sup>

On the other hand, if the plan is discriminatory as to eligibility but covers some rank-and-file employees, and provides benefits on the same basis to all participants, payments to highly compensated individuals will only be partially includable in their gross income. In that instance, the includable portion will be the total amount paid to a given highly compensated individual multiplied by a fraction, the numerator of which is the total amount paid under the plan to all highly compensated individuals for that plan year, and the denominator of which is the total amount paid to plan participants for that year.<sup>74</sup> Accordingly, if the plan covers most employees and the same benefits are available to all participants, the amount includable in the gross income of the highly compensated individuals may be minimized. Also, to avoid double taxation, any excess reimbursement resulting from benefit discrimination is excluded in computing the amount of excess reimbursement resulting from eligibility discrimination.<sup>75</sup> The income resulting from any such excess reimbursement is considered to be received in the taxable year of the highly compensated individual in which (or with which) the plan year ends.<sup>76</sup>

<sup>69</sup> Treas. Reg. § 1.105-11(c)(4)(i), T.D. 7754, 1981-13 I.R.B. 11, at 14.

<sup>70</sup> *Id.*

<sup>71</sup> I.R.C. § 105(h)(7)(B).

<sup>72</sup> I.R.C. § 105(h)(7)(A).

<sup>73</sup> Treas. Reg. 1.105-11(e)(4), example (6), T.D. 7754, 1981-13 I.R.B. 11, at 15.

<sup>74</sup> I.R.C. § 105(h)(7)(B).

<sup>75</sup> I.R.C. § 105(h)(7).

<sup>76</sup> I.R.C. § 105(h)(10), Treas. Reg. § 1.105-11(h), T.D. 7754, 1981-13 I.R.B. 11, at 16.

According to the regulations, if a self-insured medical expense reimbursement plan is included in a "cafeteria plan",<sup>77</sup> the section 105(h) rules will determine the status of the medical payments as a taxable or non-taxable fringe benefit and the new cafeteria-plan rules in section 125 of the Code will determine whether an employee is taxed as though he elected all available taxable benefits, including taxable benefits under a discriminatory medical expense reimbursement plan.<sup>78</sup>

The regulations also state that a self-insured plan may provide for both employer and employee contributions.<sup>79</sup> The tax treatment of reimbursements attributable to employee contributions under such a plan is governed by section 104(a)(3). The tax treatment of reimbursements attributable to employer contributions is determined under section 105, and the amount of reimbursement which is attributable to employer contributions is governed by Treasury Regulations section 1.105-1(e).<sup>80</sup>

#### IV. EFFECTIVE DATE OF THE NEW STANDARDS

Section 366(b) of the Revenue Act (as amended by section 103(a)(13)(D) of the Technical Corrections Act of 1979) states that new section 105(h) applies to amounts reimbursed after December 31, 1979.<sup>81</sup> With respect to plans maintained on the basis of a plan year ending other than on December 31, the regulations specify that the plan's eligibility and benefit provisions, as well as reimbursements made prior to January 1, 1980, will not be taken into account for the 1979-80 plan year.<sup>82</sup> Similarly, the new rules do not apply to expenses incurred in 1979 which are reimbursed in 1980.<sup>83</sup>

#### V. OPTIONS CURRENTLY AVAILABLE

As an initial matter, no payments should be made from self-insured medical expense reimbursement plans after December 31, 1979, without first considering the taxability of such payments under new section 105(h). If the plan does not comply with the new nondiscrimination standards, any excess reimbursements paid to highly compensated individuals after that date will be includable in their gross income.

It is important to note, however, that certain planning opportunities

---

<sup>77</sup> "Cafeteria plans" offer an employee a choice between tax-free benefits, such as medical, dental, or life insurance, and taxable compensation. Under § 125, added by § 134 of the Revenue Act, benefits provided under "qualified" cafeteria plans will be included in the employee's gross income only to the extent he elects taxable benefits.

<sup>78</sup> Treas. Reg. § 1.105-11(k)(1), T.D. 7754, 1981-13 I.R.B. 11, at 16-17.

<sup>79</sup> Treas. Reg. § 1.105-11(b)(1)(i), T.D. 7754, 1981-13 I.R.B. 11, at 12.

<sup>80</sup> Treas. Reg. § 1.105-11(i), T.D. 7754, 1981-13 I.R.B. 11, at 16.

<sup>81</sup> Revenue Act of 1978. Pub. L. No. 95-600, § 366(b), 92 Stat. 2763 (codified in I.R.C. § 105(h)).

<sup>82</sup> Treas. Reg. § 1.105-11(j), T.D. 7754, 1981-13 I.R.B. 11, at 16.

remain available even if a plan is not in total compliance with the new standards. For example, benefits paid to rank-and-file employees will not be taxable. Accordingly, if a plan covers such employees in addition to highly compensated individuals, an employer may well wish to continue its coverage at least for the lower-paid, non-shareholder participants, since a self-insured arrangement may prove less costly than an insured plan. Alternatively, if the highly compensated individuals participating in such a plan are either uninsurable or of a sufficient age that insurance coverage for them is prohibitively costly, they may well wish to continue a preexisting self-insured arrangement even though they will recognize additional income under the new rules. It should also be emphasized that such additional income can be minimized by amending the plan to cover a greater number of rank-and-file employees.

Since the Revenue Act has not expressly altered the traditional basis for deducting payments under these plans, an employer may also continue to deduct payments made to highly compensated individuals as an ordinary and necessary business expense under a "plan for employees" within the meaning of section 105(e). As long as this deduction is preserved, a non-qualified medical expense reimbursement plan will remain a useful tool in attacking any accumulated earnings problems<sup>84</sup> the employer may have.

Furthermore, when viewed as additional compensation to the highly compensated individual, any excess reimbursements will be taxable at the maximum fifty percent marginal rate for personal service income.<sup>85</sup> Section 103(a)(13)(A) of the Technical Corrections Act also added a new section 3401(a)(20) to the Internal Revenue Code, which excludes this income from the withholding tax rules of section 3402. The Conference Committee Report states that such payments are also not subject to social security tax.<sup>86</sup>

If, on the basis of the above analysis, an employer decides that the best course of action is one which permits the continued exclusion of all payments made to highly compensated individuals, the employer should consider the feasibility of providing such benefits on an insured basis after December 31, 1979, thus utilizing the express statutory exclusion for insured plans. If this option is not feasible, the continued exclusion of income under section 105(h) will generally be available only if the plan complies with the new eligibility and benefit standards. It should be reemphasized that if the employer intends to meet the first percentage test for eligibility purposes, 70% of the non-excludable employees must be benefited. Al-

---

<sup>84</sup>I.R.C. §§ 531-537.

<sup>85</sup>I.R.C. § 1348.

<sup>86</sup>H.R. REP. NO. 1800, 95th Cong., 2d Sess. at 254, reprinted in [1978] U.S. CODE CONG. & AD. NEWS, at 7252.

ternatively, the employer may limit eligibility to 70% of the non-excludable employees, as long as 56% of the non-excludable employees are benefited (80% of the 70%).

Although the Conference Committee Report states that advance rulings from the Service concerning compliance with the section 105(h) standards will not be required, the conferees expect that the Service will provide such rulings "in the typical case".<sup>87</sup> The Conference Committee also indicated that it does not expect that the Service will apply an unfavorable determination retroactively where the employer has made "reasonable efforts" to comply with the new standards.<sup>88</sup>

It should also be noted that under section 514(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (ERISA),<sup>89</sup> such a plan is not to be deemed an insurance company or other insurer or to be engaged in the business of insurance for purposes of any state law purporting to regulate insurance companies. Accordingly, if an employer elects to continue its sponsorship of a self-insured medical expense reimbursement plan after December 31, 1979, that sponsorship will not cause the employer to run afoul of state laws regulating the transaction of insurance business.<sup>90</sup>

Continued sponsorship of a plan which complies with the new section 105(h) standards may, however, subject the employer to additional reporting and disclosure obligations under part 1 of Title I of ERISA. For "employee welfare benefit plans" (as defined in section 3(1) of ERISA), which include self-insured medical expense reimbursement plans, these obligations generally include filing periodic financial reports for the plan with the United States Department of Labor, distributing summaries of such reports to each participant, and furnishing a summary plan description to plan participants and the Labor Department.<sup>91</sup> Under section 104(a)(3) of ERISA, the Labor Department is authorized to issue regulations exempting employee welfare benefit plans from all or a portion of these reporting obligations. One of the regulations which the Labor Department has issued under section 104(a)(3) expressly exempts unfunded employee welfare benefit plans which provide benefits for a select group of management or highly compensated employees from virtually all of the regular reporting obligations under Title I.<sup>92</sup> Although an unfunded medical expense reimbursement plan covering only corporate officers would usually fall within

---

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 514, 88 Stat. 829 (codified at 29 U.S.C. § 1144). [hereinafter ERISA].

<sup>90</sup> See ILL. REV. STAT. ch. 73, § 733 (1973).

<sup>91</sup> Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, §§ 101-11, (codified in scattered sections of 18, 29 U.S.C.).

<sup>92</sup> 29 C.F.R. § 2520.104-24 (1975).



this exemption, a plan which complies with the new eligibility standard in section 105(h) generally would not. Although the Labor Department has also exempted unfunded employee welfare benefit plans which cover fewer than one hundred participants at the beginning of the plan year from filing summary plan descriptions and annual reports with the Labor Department and distributing a summary annual report to plan participants, this provision does not exempt the plan administrator from furnishing a summary plan description to each participant.<sup>93</sup>

The regulations also draw the distinction, first proposed in the Conference Committee Report, between benefits provided by a self-insured medical expense reimbursement plan and payments for diagnostic procedures which can be considered independently of such a plan.<sup>94</sup> In reliance on this exception, an employer may decide to establish a separate plan providing diagnostic-procedure reimbursements for a select group of employees after December 31, 1979. The taxation of these arrangements will be governed by the section 105(b) rules in effect prior to the enactment of section 105(h).

The regulations would limit this exception to such diagnostic procedures as routine medical and dental examinations, blood tests and X-rays incurred other than in connection with a specific illness, condition or symptom. Activities undertaken for exercise, fitness, nutrition, recreation or the general improvement of health also fall outside of this exception, according to the regulations, unless the expenses are for medical care as defined in section 213(e). However, the regulations fail to extend the exception to diagnostic procedures undertaken for an employee's dependents. In order for the exception to apply, the diagnostic procedures must be performed at a facility which provides only services of a medical or ancillary nature. The regulations further indicate that "ordinary and necessary" travel expenses arising in connection with qualifying diagnostic procedures may also be reimbursed in this manner.

## VI. CONCLUSION

As the foregoing discussion indicates, new section 105(h) has significantly altered the taxability of payments to highly compensated individuals under most self-insured medical expense reimbursement plans after December 31, 1979. Nevertheless, several significant planning opportunities remain available in this area.

---

<sup>93</sup> 29 C.F.R. § 2520.104-20 (1978).

<sup>94</sup> Treas. Reg. § 1.105-11(g), T.D. 7754, 1981-13 I.R.B. 11, at 16.