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EMPLOYEE MEDICAL REIMBURSEMENT PLANS IN THE AGE OF ERISA¹

ROBERT D. ROSEWATER*

INTRODUCTION

THE EMPLOYEE MEDICAL reimbursement plan presents a new dimension in the spectrum of available corporate fringe benefits. Its attractiveness lies in the relative ease by which the plan may be adopted and administered as well as the favorable federal income tax consequences to both the corporation and its participating employees. These plans undoubtedly will proliferate as other traditional fringe benefits become less attractive due to changes in tax laws,² as medical expenses continue to increase, and as the advantages of employee medical reimbursement plans become more widely known. The scope of this article is to discuss the purposes of these plans, to determine who should adopt them, to guide draftsmen in their preparation, and to aid administrators and fiduciaries in their management.

I. PURPOSES AND GENERAL FEATURES

The principal purpose of an employee medical reimbursement plan is to require a corporation to reimburse certain of its employees for specified medical or medical-related expenses incurred by those employees or their spouses and dependents. Thus, an employee medical reimbursement plan is an integral part of a corporation's fringe benefit package for those employees who are permitted by the terms of the plan to participate.

Under ERISA, employee medical reimbursement plans have been accorded two highly desirable federal income tax features. The first is that monies paid by an employer pursuant to such a plan are deductible by the employer for Federal income tax purposes as an ordinary and necessary business expense.³ The second is that the reimbursement of expenses by an employer to a qualified employee of expenses incurred by the employee is not recognized as income on the employee's federal income tax return, except to the extent that he was allowed a deduction under Section 213 of the Internal Revenue Code (relating to medical and similar expenses) for any

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¹ Employee Retirement Income Security Act of 1974, 88 Stat. 829 (codified in scattered sections of 5, 18, 26, 29 U.S.C.) [hereinafter cited as ERISA].

² For example, reporting, disclosure, accelerated vesting, and other requirements of ERISA have led to the termination of many qualified pension and profit sharing plans. Also, these requirements undoubtedly have caused many employers to be reluctant to adopt new qualified plans.

³ INT. REV. CODE OF 1954, §162; Treas. Reg. §1.162-10(a). See E. B. Smith, 39 P-H TAX CT. MEM. ¶70,243 (1970); Bogene, Inc., 37 P-H TAX CT. MEM. ¶68,147 (1968).

prior taxable year.⁴ Thus employee medical reimbursement plans provide one of the rare exceptions to the customary rule that for every deduction to one person or entity there is reportable income to another.⁵ This is the tax feature which has made employee medical reimbursement plans highly attractive.

II. AVAILABILITY AND DESIRABILITY

The tax benefits of employee medical reimbursement plans are not available to everyone; nor is adoption of the plan always desirable for those who meet the requisite criteria.

As a practical matter, employee medical reimbursement plans are available only to corporate employers. Since self-employed individuals are excluded from realizing the tax benefits of such plans,⁶ partners and proprietors have little incentive to adopt such plans for their employees. However, if a proprietorship adopts such a plan, its employees will be entitled to the benefit of nonrecognition of payments received under the plan.⁷ The same logic should apply to a partnership.

Moreover, employee medical reimbursement plans are an employee fringe benefit. As with pension or profit sharing plans, they are not especially desirable where, for economic reasons, basic compensation paid to employees is insufficient or barely sufficient. The corporation which cannot or will not pay competitive salaries or wages should not expect to become competitive offering a medical reimbursement plan. First, such an attempt probably will be ineffective as a means of competing for employees, and second, may fail as a method for obtaining an income tax deduction. In addition, since plans of this type are not customarily funded through separate trusts, but instead are funded with general corporate funds, the plan will be meaningless if the employer has difficulty paying its debts and if its assets become encumbered by creditor's claims.

The corporation which has or contemplates a qualified pension or profit sharing plan may consider implementing a medical reimbursement plan for its retired employees, their spouses and dependents. Inclusion of such a plan as part of its qualified pension or profit sharing plan will confer upon the corporation and its covered employees tax advantages beyond those of a separate medical reimbursement plan. The corporation will be

⁴ INT. REV. CODE of 1954, §105(b).

⁵ See, e.g., INT. REV. CODE of 1954, §404(a)(5), regarding the tax treatment accorded non-qualified deferred compensation plans.

⁶ INT. REV. CODE of 1954, §105(g).

⁷ *Rev. Rul. 71-588, 1971-2 CB 91.* However, self-employed individuals are themselves excluded from the benefit of nonrecognition of payments. INT. REV. CODE of 1954, §105(g).

able to deduct contributions to such a plan when made⁸ and to allow a fund for such a plan to accumulate tax-free.⁹ The participant will be able to defer personal income taxation on sums expended from the fund for his benefit or for the benefit of his dependent, and if proper precautions are implemented, distributions received as a death benefit will escape federal estate taxation.¹⁰ In short, the corporation and its participating employees will have all the benefits of a qualified plan. Of course, for these benefits to inure, the plan must comply with the requirements relating to qualified plans. For example, participation and vesting provisions¹¹ must be followed, and in particular, the plan will not be permitted to discriminate, in terms of contributions or benefits, in favor of employees who are officers, shareholders, or highly compensated.¹²

Where the only full-time employees of a corporation are also its shareholders, there is some risk that the tax benefits of a medical reimbursement plan may be challenged by the Internal Revenue Service on the basis that the plan is principally designed to benefit shareholders. However, the likelihood of a successful Internal Revenue Service challenge will be lessened where the shareholder-employees are unrelated by either blood or marriage.¹⁴ Moreover, a new trend in the law appears to be developing whereby the corporation will still be privy to all tax benefits of the plan, even though the shareholders are the only qualified full-time employees, if it can be shown that the benefits are allocated with respect to the individual's status as a corporate employee rather than as a shareholder.¹⁵

An Internal Revenue Service challenge to an employee medical reimbursement plan would proceed on the theory that sums paid under the plan actually are disguised dividends benefiting the corporate shareholders. A successful IRS challenge would result in the disallowance of the corporation's deduction, and the employee would be required to treat the payments

⁸ INT. REV. CODE OF 1954, §§401(h), 404.

⁹ INT. REV. CODE OF 1954, §501(a).

¹⁰ INT. REV. CODE OF 1954, §2039(c)(1).

¹¹ See generally Briner, *Federal Income Tax Developments: 1974*, 8 AKRON L. REV. 276-85 (1975).

¹² INT. REV. CODE OF 1954, §401(a)(4).

¹³ Edward D. Smithback, 38 P-H TAX CT. MEM. ¶69,136 (1969).

¹⁴ Bogene, Inc., 37 P-H TAX CT. MEM. ¶68,147 (1968).

¹⁵ See, e.g., *American Foundry v. Commissioner*, CCH STAND. FED. TAX REP., U.S. TAX CAS. (76-1, at 84,041) ¶9401 (9th Cir. April 23, 1976), *aff'd and rev'd* 59 T.C. 231 (1972), in which the court stated that the validity of medical reimbursement plans limited to corporate officers who are also shareholders is determined by "whether the expected benefits of the plan are to be paid with respect to the individual's capacity as an employee of the corporation and whether there is any rational basis other than ownership to differentiate that individual from other employees." *Id.* at 84,044. The court found the plan to be a plan for employees.

made on his behalf as ordinary income.¹⁶ In some situations, the Internal Revenue Service has won a partial victory, with only the corporation salvaging the benefits of advantageous tax treatment. In those cases, the sums paid by reason of the plan are treated as compensation to the employee for services rendered. Although the payments are taxable as ordinary income to the employee, Section 162 of the Internal Revenue Code operates to allow a corresponding deduction to the corporation.¹⁷ The adverse tax consequences to the employee are mitigated somewhat, however, by the possibility that a substantial portion of the reimbursement may be offset as a medical expense deduction.¹⁸

III. ADOPTION OF THE PLAN

Once a corporation has determined that it desires to adopt a separate employee medical reimbursement plan, care must be exercised in preparing the plan and communicating it to employees. Failure to avoid the various pitfalls surrounding the plan's adoption will result in the loss of favorable tax treatment.

A. TIMING

The timing of a plan's adoption can be critical. Wherever possible, a plan should be adopted while the key shareholder-employees and their dependents are in good health and do not contemplate immediate large medical expenses. Otherwise the plan may fail to achieve its tax advantage since the plan may be challenged as being implemented solely for the benefit of the shareholder as a shareholder, even though the plan may also incidentally benefit nonshareholder-employees.¹⁹

B. WRITTEN PLAN

Under pre-ERISA law, it was good practice for a medical reimbursement plan to be written to avoid the possibility of a successful challenge by the Internal Revenue Service. What was good practice under pre-ERISA law

¹⁶ Sebastian Bongiovanni, P-H TAX CT. MEM. 1976-131; Alan B. Larkin, 48 T.C. 629, 635 (1967), *aff'd sub nom.* Larkin v. Commissioner, 394 F.2d 494 (1st Cir. 1968).

¹⁷ See, e.g., Charlie Sturgill Motor Co., 42 P-H TAX CT. MEM. ¶73,281 (1973).

¹⁸ See Boehm, *Settlement of Personal Injury Claims Affected by Recent IRS Rulings*, 49 OHIO BAR 155, 159 n.2 (1976). However, the extent to which a medical expense deduction is available is determined by the amount that such expenses exceed a percentage (3%) of an employee's annual income. Thus, high salaried personnel more likely than not will fail to derive significant benefit from the deduction's availability unless considerable medical expenses are incurred within a particular tax year.

¹⁹ Compare *Estate of Leidy*, 44 P-H TAX CT. MEM. ¶75,340 (1975), with Nathan Epstein, 41 P-H TAX CT. MEM. ¶72,053 (1972).

is now a legal requirement under ERISA. The plan *must* be in writing.²⁰ However, it does not follow from the written-plan requirement that a particular form must be utilized. It need not be in the form of a trust,²¹ and, in fact, most plans are not in trust form. At present it appears to be sufficient for the plan to consist solely of a resolution in the employer's corporate minutes.²² However, it is more sensible and safer for the plan to be embodied in a separate document executed by the employer pursuant to authority contained in the employer's minutes.

C. COMMUNICATION TO COVERED EMPLOYEES

Once adopted, the plan should be promptly communicated to the covered employees. Whether the nonshareholder-employees covered by a medical reimbursement plan had been made aware of the plan is a factor considered by the Tax Court in assessing the validity and intent of a plan.²³ While no statutes, regulations, or cases have prescribed a particular mode of communication, a logical approach would be either to distribute a copy of the plan to each covered employee or to announce the plan by a method reasonably calculated to reach each employee, such as posting the announcement in a conspicuous location such as on the company bulletin board. If posting is utilized, the employer should advise the employees in its announcement that a copy of the plan is available for inspection at a specified, readily accessible location during the employer's normal business hours. Wherever possible, distribution of a copy of the plan to each covered employee is undoubtedly the preferable method.²⁴

D. DRAFTING CONSIDERATIONS

While drafting an employee medical reimbursement plan is far easier than the preparation of a qualified pension or profit sharing plan, nevertheless it requires considerable attention to several areas delineated by the following:

1. *Definition of Covered Employees.* Most plans that fail to pass Internal Revenue Service scrutiny do so because of improper coverage. The

²⁰ ERISA §402(a)(1), INT. REV. CODE of 1954, §1102(a)(1). For examples of pre-ERISA cases which denied tax benefits for periods prior to the adoption of a formal written plan, see *American Foundry*, 59 T.C. 231 (1972); Arthur R. Seidel, 40 P-H TAX CT. MEM. ¶71,238 (1971).

²¹ ERISA §403(b)(4), INT. REV. CODE of 1954, §1103(b)(4); Proposed Reg. §2552.1, 39 Fed. Reg. 44456 (1974).

²² See *Bogone, Inc.*, 37 P-H TAX CT. MEM. ¶68,147 (1968).

²³ See *Samuel Levine*, 50 T.C. 422, 426 (1968); *John C. Lang*, 41 T.C. 352, 355 (1963).

²⁴ Cf. Rev. Rul. 71-90, 1971-1 CUM. BULL. 115 (relating to qualified plans).

plans that fail are those which overly benefit shareholder-employees and exclude or discriminate against nonshareholder-employees.

The regulations issued under Section 105 of the Internal Revenue Code require the plan to be for the benefit of "employees."²⁵ Neither the Code nor the Regulations contain any definition of the class of employees which may or must be covered or excluded in order to achieve desirable tax results. Indeed, the Senate Finance Committee eliminated a requirement previously proposed by the House of Representatives that medical reimbursement plans be nondiscriminatory in the same manner as qualified pension and profit sharing plans.²⁶ Nor does ERISA illuminate the subject, since unfunded medical reimbursement plans are specifically excluded from its coverage requirements.²⁷

Plans which limit their coverage to employees who are also stockholders²⁸ or, conversely, which extend coverage to stockholders who are not employees,²⁹ are likely targets of an Internal Revenue Service inquiry. This may be true even where the only full-time employees are stockholders and the corporation has no other choice as to coverage if it desires to adopt a plan.³⁰ Thus, wherever possible, it is advisable to include within the plan's coverage at least one employee who is not a shareholder.

Normally, a plan will survive an Internal Revenue Service challenge if its sponsor can demonstrate a rational basis for distinction between covered and excluded employees. Thus, unlike a qualified pension or profit sharing plan, an employee medical reimbursement plan will pass muster even though its coverage is limited to key management employees,³¹ officers,³² executive and managerial employees,³³ or key personnel and buyers and sellers of machinery.³⁴ However, where there is no rational basis for dis-

²⁵ Treas. Reg. §1.105-1(a).

²⁶ See *Bogene, Inc.*, 37 P-H TAX CT. MEM. ¶68,147 (1968).

²⁷ ERISA §201(1), INT. REV. CODE of 1954, §1051(1).

²⁸ *Edward D. Smithback*, 38 P-H TAX CT. MEM. ¶69,136 (1969); *Samuel Levine*, 50 T.C. 422, 427 (1968).

²⁹ *Sebastian Bongiovanni*, P-H TAX CT. MEM. ¶1976-131; *Charlie Sturgill Motor Co.*, 42 P-H TAX CT. MEM. ¶73,281 (1973).

³⁰ See *Edward D. Smithback*, 38 P-H TAX CT. MEM. ¶69,136 (1969).

³¹ *Bogene, Inc.*, 37 P-H TAX CT. MEM. ¶68,147 (1968).

³² *E. B. Smith*, 39 P-H TAX CT. MEM. ¶70,243 (1970).

³³ *Nathan Epstein*, 41 P-H TAX CT. MEM. ¶72,053 (1972).

³⁴ *Id.*

tinguishing between covered and excluded employees, the plan is likely to fail.³⁵

It appears that a plan may limit its coverage to full-time or year-round employees,³⁶ or to employees with a specified length of service or salary level, as long as these criteria are not related to shareholder status, either in the plan documents or in fact. If the plan excludes certain persons because of factors relating to their employment, the exclusion should be deemed proper. However, if the plan excludes or discriminates against certain persons because of factors relating to their shareholding status, the distinction should be deemed improper.

It is worthy of note that it is possible, and, in fact has become a common practice, to extend coverage under a medical reimbursement plan not only to covered employees but also to their spouses and their dependents, as that term is defined in the Internal Revenue Code.³⁷

2. Definition of Covered Expenses. The kinds of medical expenses which may be covered by a medical reimbursement plan are limited by the Internal Revenue Code and by the regulations issued thereunder.

Section 105(b) of the Internal Revenue Code provides that, subject to certain exceptions,

gross income does not include amounts [paid by reason of an employee medical reimbursement plan] if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for . . . medical care (as defined in Section 213(e)

Under Section 213(e) of the Internal Revenue Code, "medical care" is defined to include three categories of expenses. The first of these is "amounts paid . . . for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structures or function of the body."³⁸ Regulations issued under Section 213(e) specify that such expenses include obstetrical expenses, expenses of therapy, x-ray treatments, hospital services, nursing services (including nurses' board where paid by the taxpayer), medical, laboratory, surgical, dental and other diagnostic and healing services, x-rays, artificial teeth or limbs, and ambulance hire.³⁹

³⁵ Estate of Leidy, 44 P-H TAX CT. MEM. ¶75,340 (1975); American Foundry, 59 T.C. 231, 242 (1972), *rev'd*, CCH STAND. FED. TAX REP., U.S. TAX CAS. (76-1, at 84,041) ¶9401 (9th Cir. April 23, 1976).

³⁶ E. B. Smith, 39 P-H TAX CT. MEM. ¶70,243 (1970).

³⁷ INT. REV. CODE of 1954, §105(b).

³⁸ INT. REV. CODE of 1954, §213(e)(1)(A).

³⁹ Treas. Reg. §1.213-1(c)(1)(i) and (ii).

Also included are medicine and drugs; which must be "legally procured and generally accepted as falling within the category of medicine and drugs," although they need not require a prescription.⁴⁰ Medically related capital expenditures may be included if their primary purpose falls within the definition of medical care and are not related to permanent improvement or betterment of property. Examples are expenditures for eyeglasses, a seeing eye dog, artificial teeth and limbs, a wheel chair, crutches, and inclinators, and an air conditioner which is detachable from the property and purchased only for the use of an ill person.⁴¹ Expenditures made for the operation or maintenance of a capital asset are likewise includable as covered expenses if their primary purpose is the medical care of the taxpayer, his spouse, or his dependent.⁴² A medical reimbursement plan should expressly exclude from coverage items that are expressly excluded from the definition of "medical care" in the Regulations. These would include amounts expended for illegal operations or treatments,⁴³ expenditures, such as for vacations, which are "merely beneficial to the general health of an individual,"⁴⁴ and toiletries, cosmetics or similar preparations as toothpaste, shaving lotion, shaving cream, deodorants or hand lotions.⁴⁵

The second category of expenses which may be covered by a medical reimbursement plan is expenses paid "for transportation primarily for and essential to medical care."⁴⁶ Covered transportation expenses may not include costs of meals or lodging while receiving medical treatment away from home, and may not include expenses of travel undertaken merely for the general improvement of health.⁴⁷

The third category of expenses which may be covered by a medical reimbursement plan is expenses paid for "insurance . . . covering medical care."⁴⁸ This category expressly includes premiums for supplementary or "Part B" Medicare benefits.⁴⁹ However, excluded are premiums for insurance providing indemnity for loss of income or loss of life, limb, or sight.⁵⁰

⁴⁰ Treas. Reg. §1.213-1(e)(2).

⁴¹ Treas. Reg. §1.213-1(e)(1)(iii).

⁴² *Id.*

⁴³ Treas. Reg. §1.213-1(e)(1)(ii).

⁴⁴ *Id.*

⁴⁵ Treas. Reg. §1.213-1(e)(2).

⁴⁶ INT. REV. CODE of 1954, §213(e)(1)(B).

⁴⁷ Treas. Reg. §1.213-1(e)(1)(iv).

⁴⁸ INT. REV. CODE of 1954, §213(e)(1)(C).

⁴⁹ *See* Rev. Rul. 67-315, 1967-2 CUM. BULL. 85.

⁵⁰ Treas. Reg. §1.213-1(e)(4)(i)(a).

A contemplated plan need not cover all three of these categories, nor need it include all possible benefits within any one category. However, it would not be wise for the coverage of a plan to be tailored in such a manner that its use could be contemplated by only one or more stockholder-employees or their families.

To avoid unnecessary duplication, it is advisable to provide that the plan will not cover expenses reimbursable from other sources such as insurance and indemnity policies and workmen's compensation. Moreover, since the tax benefits discussed above extend only to expenses incurred after the plan is effective, the plan should expressly exclude coverage for expenses incurred prior to the date of its operation.

3. *Amount of Benefits to be Paid.* As a matter of both sensible corporate economic policy and good tax planning, limits should be placed on the benefits which may be paid under an employee medical reimbursement plan. Where the benefits payable under such a plan are disproportionate to the employer corporation's income and resources, the plan will be suspect.⁵¹ Conversely, an economically justifiable ceiling on benefits payable may carry considerable evidentiary weight in favor of allowing the plan's tax advantages.⁵² The ceiling on allowable benefits may be expressed in terms of dollars, as a percentage of the covered employee's compensation, or in any other suitable manner. But in no situation should it be proportionate to the shareholdings of the covered employees in the employer corporation,⁵³ nor should the formula operate disproportionately in favor of shareholders.⁵⁴

4. *Procedural Clauses.* Under ERISA, an employee medical reimbursement plan must provide a claims procedure and a procedure for review of all denied claims.⁵⁵ The review procedure must specifically include a provision for written notice to the claimant containing (1) the specific reason or reasons for the denial, (2) specific reference to the provisions of the plan

⁵¹ See Samuel Levine, 50 T.C. 422 (1968), holding that one of the factors resulting in the disallowance of favorable tax treatment was the lack of a reasonable ceiling on benefits payable under the plan to a majority shareholder.

⁵² Bogene, Inc., 37 P-H TAX CT. MEM. ¶68,147 (1968).

⁵³ Several medical reimbursement plans survived Internal Revenue Service attacks at least in part because benefits were not anticipated to be, and, in fact, were not in proportion to shareholdings. See, e.g., Nathan Epstein, 41 P-H TAX CT. MEM. ¶72,053 (1972); Arthur Seidel, 40 P-H TAX CT. MEM. ¶71,238 (1971); Bogene, Inc., 37 P-H TAX CT. MEM. ¶68,147 (1968).

⁵⁴ See Estate of Leidy, 44 P-H TAX CT. MEM. ¶75,340 (1975) (two shareholders received 70% of the benefits although the number of covered employees ranged from 21 to 40); Alan B. Larkin 48 T.C. 629, 635 (1967), *aff'd sub nom.* Larkin v. Commissioner, 394 F.2d 494 (1st Cir. 1968) (nonshareholder-employees were "only incidentally and sporadically" benefited).

on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim including an explanation of why such material or information is necessary, and (4) an explanation of the plan's claim review procedure. The review process must be completed within a reasonable time and must be written in a manner calculated to be understood by the claimant.⁵⁶

In addition to the procedures required by ERISA, it may be advisable as sound administrative practice to accurately describe in the plan the proof required before reimbursement is to be paid and to specify the time limits within which the proof must be presented. For example, the proof required may include the presentation of a statement or bill by the physician, hospital, insurer, or other provider of medical care together with a receipt, cancelled check or other similar and customary proof of payment by the employee. A reasonable time limit might be ninety days after actual payment of the expense by the covered employee. Probably, it is better to base the time limit on payment of the expense rather than on its accrual at the time of receiving medical care, in order to avoid penalizing an employee for delaying payment of a medical bill in the event that it is disputed or that he temporarily is unable to make payment.

5. Provisions Regarding Fiduciaries. Under ERISA, a medical reimbursement plan is a kind of a "welfare plan."⁵⁷ All welfare plans must either designate a named fiduciary or specify how a named fiduciary is to be selected.⁵⁸ The named fiduciary is the person, legal or natural, with authority to manage the operation and administration of the plan.⁵⁹ Also, under ERISA, any "fiduciary" may be exposed to substantial liability. The term fiduciary carries a very broad as well as a somewhat ambiguous definition;⁶⁰ the potential liability which a fiduciary may incur may cause prospective fiduciaries to be unwilling to accept administrative positions unless

⁵⁶ Proposed Reg. §§2560.7(b), 2560.8(b), 39 Fed. Reg. 42243 (1974).

⁵⁷ ERISA §3(1), INT. REV. CODE of 1954, §1002(1).

⁵⁸ ERISA §402(a), INT. REV. CODE of 1954, §1102(a).

⁵⁹ *Id.*

⁶⁰ ERISA §3(21)(A), INT. REV. CODE of 1954, §1102(a) provides:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 405(c)(1)(B).

they are appropriately protected. Therefore, for the fiduciaries' protection, the draftsman of a plan should consider requiring the employer to indemnify and defend the fiduciaries against claims arising from any act or failure to act other than an act involving gross negligence or wilful misconduct.⁶¹ Where more than one fiduciary is named, the plan should preclude imputation of liability for a breach of responsibility by a co-fiduciary to the extent that such relief from liability is legally permitted.⁶²

6. *Amendment and Termination.* Under ERISA every "employee benefit plan," and therefore every employee medical reimbursement plan,⁶³ must "provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan."⁶⁴ Therefore, the plan must contain an appropriate amendment clause. Sound administrative policy also suggests that analogous provisions be included with respect to termination of the plan. As a matter of good employee relations as well as law, any decision to terminate a plan should be communicated promptly to the covered employees.⁶⁵

IV. ADMINISTRATION OF THE PLAN

A. GENERAL

The enactment of ERISA generated an entirely new vocabulary with respect to the administration of employee medical reimbursement plans. In addition to the named fiduciary and the other fiduciaries previously noted,⁶⁶ the administrator and the plan sponsor must be considered. The administrator is charged with various reporting and other responsibilities. The administrator is the employer unless the plan otherwise provides.⁶⁷ In the case of a plan established or maintained by a single employer, the typical case with respect to employee medical reimbursement plans, the plan sponsor is the employer.⁶⁸

⁶¹ Although clauses purporting to relieve fiduciaries of their statutory obligations are void as being against public policy, clauses providing for indemnification of a fiduciary by an employer are valid and enforceable. See ERISA §410(a), INT. REV. CODE of 1954, §1110(a); ERISA INTERPRETATIVE BULL. 75-4.

⁶² For the extent to which relief is permitted, see ERISA §405(a), INT. REV. CODE of 1954, §1105(a).

⁶³ ERISA §3(3), INT. REV. CODE of 1954, §1002(3).

⁶⁴ ERISA §402(b)(3), INT. REV. CODE of 1954, §1102(b)(3).

⁶⁵ Pursuant to ERISA §101(c)(2), INT. REV. CODE of 1954, §1021(c)(2), the Secretary of Labor may require terminal reports to be filed with regard to any employee welfare benefit plan which is winding up its affairs. ERISA contemplates that the Secretary of Labor will promulgate regulations setting forth applicable procedures. The Pension Benefit Guaranty Corporation has promulgated regulations, but they do not apply to welfare benefit plans. ERISA §4021(a), INT. REV. CODE of 1954, §1321(a).

⁶⁶ See notes 58-60 and accompanying text *supra*.

⁶⁷ ERISA §3(16)(A), INT. REV. CODE of 1954, §1002(16)(A).

B. BONDING

ERISA requires the bonding of "every fiduciary" and "every person who handles funds or other property" of employee benefit plans.⁶⁹ Medical reimbursement plans are a species of "employee benefit plans."⁷⁰ However, to the extent that an employee medical reimbursement plan contemplates the payment of benefits from the employer's general assets rather than from a separate fund, the plan's administrator, officers and employees are exempt from the ERISA bonding requirements.⁷¹ The statute seems to contain an ambiguity in that there may be a *fiduciary* of an unfunded plan who is neither an *administrator* nor an *officer* nor an *employee* of the plan. Such a fiduciary would technically not be exempted from the ERISA bonding requirements. However, since the amount of the required bond is based on the amount of funds handled,⁷² and since a medical reimbursement plan need not and normally does not involve the handling of a separate fund,⁷³ the practical application of the bonding requirement to such a fiduciary would be difficult. Nevertheless, in view of this uncertainty, it is advisable, in order to avoid the expense of obtaining and maintaining a bond, to specify that only the designated administrator (or the employer if no administrator is expressly designated) or designated officers and employees of the plan act as fiduciaries or handle any funds or property which might belong, however briefly, to the plan.

C. REPORTING AND DISCLOSURE.

Most of the reporting and disclosure requirements of ERISA are inapplicable to employee medical reimbursement plans. While ERISA requires a plan administrator to provide each participant with a "summary plan description,"⁷⁴ and to publish an annual report complete with financial statements,⁷⁵ it also permits the Secretary of Labor to exempt by regulation any welfare benefit plan, of which an employee medical reimbursement plan is an example, from these requirements.⁷⁶ In fact, the Secretary of Labor has

⁶⁸ ERISA §3(16)(B), INT. REV. CODE of 1954, §1002(16)(B).

⁶⁹ ERISA §412(a), INT. REV. CODE of 1954, §1112(a).

⁷⁰ ERISA §3(1), INT. REV. CODE of 1954, §1002(1).

⁷¹ ERISA §412(a), INT. REV. CODE of 1954, §1112(a). However, there is some uncertainty as to when a plan contemplates payment of benefits out of the employer's general assets. The use of a separate bank account or even separately maintained books and records may prohibit the exemption for unfunded plans. 29 C.F.R. §464.3(d) (1963).

⁷² ERISA §412(a), INT. REV. CODE of 1954, §1112(a).

⁷³ See notes 7 and 71 *supra*.

⁷⁴ ERISA §101(a)(1), INT. REV. CODE of 1954, §1021(a)(1).

⁷⁵ ERISA §103(a)(1), INT. REV. CODE of 1954, §1023(a)(1).

⁷⁶ ERISA §104(a)(3), INT. REV. CODE of 1954, §1024(a)(3). See also ERISA §3(1), INT. REV. CODE of 1954, §1003(1).

exempted such plans from summary plan description, annual reporting and similar requirements if fewer than one hundred persons are participants at all times during the applicable plan year.⁷⁷ Certain annual reporting requirements, such as the filing of financial statements and schedules and the engaging of an independent public accountant concerning them, are not required for unfunded employee welfare benefit plans, including medical reimbursement plans.⁷⁸

Moreover, the requirement that certain plan administrators must furnish to participants upon written request certain benefit information or suffer a penalty of \$100.00 per day does not apply to medical reimbursement plans because they are not employee *pension* benefit plans.⁷⁹

Finally, the administrators of employee medical reimbursement plans need not concern themselves with Pension Benefit Guaranty Corporation requirements. These requirements also apply only to employee *pension* benefit plans.

CONCLUSION

Any corporation which enjoys a healthy financial condition and pays its employees adequate and competitive basic benefits should consider adopting a medical reimbursement plan as a fringe benefit. It is relatively easy and inexpensive to draft and to administer, and the combination of deductibility to the corporation and nonrecognition of income to the participant makes it a very attractive tax planning device.

The law discussed above as applied to employee medical reimbursement plans is generally favorable and workable, but some refinements may be in order.

First, the benefit of nonrecognition of income should not be denied to self-employed individuals. Section 105(g) of the Internal Revenue Code should be repealed to treat partners and proprietors on a parity with corporate principals.⁸¹ There is no logical reason why a senior principal in an incorporated law office should be reimbursed for medical care expenses without

⁷⁷ 29 C.F.R. §2520.104-20(a) (1975).

⁷⁸ Proposed Reg. §2520.104-44(a), 40 Fed. Reg. 53718 (1975).

⁷⁹ Compare ERISA §3(2), INT. REV. CODE of 1954, §1003(2), with ERISA §105(a), INT. REV. CODE of 1954, §1025(a).

⁸⁰ ERISA §4021(a), INT. REV. CODE of 1954, §1321(a).

⁸¹ Congress recognized the desirability of moving toward such parity in the tax treatment of corporate (qualified pension and profit sharing) plans and self-employed individual plans. H.R. REP. NO. 779, 93rd Cong. 1st Sess. 3 (1974), 3 CUM. BULL. 415, 494 (1974). Such parity seems equally desirable with respect to employee medical reimbursement plans.

having to recognize the reimbursement as taxable income while a partner in a law partnership or a sole practitioner who receives identical reimbursement for identical expenses should be required to include this reimbursement as taxable income. This inconsistency should be eliminated.

Second, the tax advantages accorded medical reimbursement plans should be legislated to apply to corporate plans where all of the employees are also shareholders of the corporation. It seems unfair to deny these tax advantages or to allow them only after expensive litigation under circumstances where a corporation has extended the privilege of stock ownership to all of its employees. If abuse is feared, a limit on the amount of reimbursement for which the tax advantages are available to both the corporation and individuals can be imposed by legislation. This limit may be expressed either by a dollar amount or by a percentage of compensation.

Third, it is apparent that the theory behind ERISA is inapplicable to employee medical reimbursement plans. The abuses which led to the enactment of ERISA, such as underfunding, fund mismanagement, and loss of anticipated retirement benefits due to lack of vesting provisions, are not relevant to medical reimbursement plans, since they are not separately funded and are not required to cover a full cross-section of employees.⁸² Through legislative exceptions and administrative exemptions, ERISA is substantially inapplicable to these plans. However, there remain a few ambiguities, and correspondingly ERISA should be amended to provide that unfunded employee medical reimbursement plans are clearly and expressly exempted from its coverage.

In short, the implementation of these suggested refinements would serve to promote the availability of medical reimbursement plans as well as to increase their utility as an effective tax planning device.

⁸² See text accompanying notes 25 through 27 *supra*. See also ERISA §201(1), INT. REV. CODE of 1954, §1050(1). <http://idea.ohio-state.edu/akronlawreview/vol10/iss1/10>