1989

Chaos in Wonderland: A Review of the Regulations Issued Under IRC Section 89

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Repository Citation
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The author acknowledges that the law establishing these non-discrimination rules is in a state of change. As of the date of this outline, both houses of Congress had voted to repeal these rules. The Senate backed off from repeal late in the evening of October 14, 1989. By the time you receive this, a whole new set of rules might apply.

I. Nondiscrimination Requirements [Section 1.89(a)-1].

Q-1 What are the Section 89 nondiscrimination rules?

A-1 A. Nondiscrimination rules (testing).

1. In general. Gross income of highly compensated employee (HCE) includes discriminatory excess benefit (basis of Section 89).

2. Timing of inclusion and deduction.

   a. Excess benefit treated as received on last day of testing year. Included in employee's W-2 for calendar year with or within which the testing year ends.

   b. Excess benefit treated as paid by the employer on the last day of the testing year. Deductible in taxable year of employer with or within which the testing year ends.

   c. Other timing issues.

B. Discriminatory employee benefit plan.

1. In general.

   a. Plan is discriminatory unless satisfies C. and D. below.

   b. May satisfy E. in lieu of D.
2. Disability coverage.
   a. Disability plans are generally not subject to the nondiscrimination requirements.
   b. However, nondiscrimination requirements apply to disability coverage that is excludable under Section 105.

3. No employer provided benefit.
   a. Such plans are not subject to the nondiscrimination requirements and cannot be taken into account in determining whether other plans meet the nondiscrimination requirements.

4. Employers with only highly compensated employees.
   a. Plans of such employers not subject to the nondiscrimination requirements.

C. Nondiscriminatory provisions requirement.
   1. In general.
      a. Prohibits provision which by its terms, operation, or otherwise discriminates in favor of HCE’s.
   2. Waiting periods under core health plans.
      a. Where two or more core plans have different waiting periods, each plan must satisfy the 50% eligibility test.
   3. Examples.
      
      **SURPRISE:** Testing dates cannot be on a day that does not fairly represent the employee pool and business operation during most of the fiscal year (i.e. a school district cannot test on July 1).

D. Eligibility and benefit requirements.
   1. In general.
   2. 90%/50% eligibility test.
      a. In general.
      b. Example.
3. 50% eligibility test.
   a. Generally, can satisfy this test by passing the 50% eligibility test or the nondiscriminatory ratio test.
   b. Example.
4. 75% benefits test.
   a. In general.
   b. Example.
E. 80% coverage test. (The Alternative Test)
   1. Plans of the same type may pass the test separately or together (if they can be aggregated).
   2. Comparability and aggregation rules are at Q&A-4.
   3. The employer must elect in writing to use the 80% test.
F. Definitions
   1. Statutory employee benefit plan.
      a. In general.
         i. Accident or health plan under Section 105 or 106 including accidental death and dismemberment plans, business travel accident insurance, medical diagnostic procedures plan and physical examination plans. Does not include disability plans.
         ii. Group-term life insurance under Section 79.
         iii. Certain other plans may qualify.
      b. Church plans.
         i. Not "statutory employee benefit plan".
      c. Plans maintained by governments.
         i. Generally treated as "statutory employee benefit plan".
      d. Workers' compensation.
         i. Generally not included.
2. Plans of the same type.
   a. In general two or more plans are treated as plans of the same type if they are one of the following:
      i. Accident or health plans.
      ii. Group-term life insurance.
      iii. Qualified group legal services.
      iv. Educational assistance plans.
      v. Dependent care assistance plans.
   b. 75% test election.
      i. For purposes of the 75% test, can elect to aggregate plans other than health plans for testing purposes.
      ii. If the health plan passes the 75% test on its own, can then aggregate with other plans to help them pass the 75% test.

3. Employer-provided benefit is the value of the coverage under the plan that is attributable to employer contributions. Different rules apply for insured vs. non-insured type plans.

4. Highly compensated employee is as defined in Section 414(q) based on the Section 89 testing year.

5. Nonhighly compensated employee.

6. Employee.
   a. In general.
      i. Common-law employees.
      ii. Self-employed under Section 401(c)(1).
      iii. Other.
   b. Leased employees.
      i. Generally, leased employees are treated as employees.
         (1) May disregard a leased employee from testing if the leased employee receives health coverage from the leasing organization which is at least 50% as valuable as the highest employer-provided care benefit available to an HCE.
ii. Authority to issue additional requirements.

c. Excluded employees.

7. Core health benefits generally refer to coverage providing comprehensive major medical and hospitalization benefits and similar types of health benefits.

G. Written election.

1. By January 31 of the year following the year the benefit is includible in income.

2. Must facilitate reconstruction of employer's testing method.

Q-2 What transitional and special rules are available to health plans under Section 89?

A-2 A. Transitional rule for 75% benefits test.

1. In general applies to testing years ending in 1989 and 1990.

2. Employer election.

   a. Must make written election for application of transition rules to a testing year.

3. Includible coverage for applicable group of employees.

   a. Satisfied only if employer-provided benefit under all health plans are treated as excess benefit for "applicable group of employees".

      i. Amounts includible in gross income are considered after-tax employee contributions for purposes of the 90%/50% test and the 50% test.

      QUERY: Does this mean there's no ordering rule to the tests? However, see Q&A-9.

   b. Applicable group of employees.

      i. 1989 testing year:

         (1) More than 5% owners as determined by Section 416(i) at any time between January 1, 1988 and the end of the testing year, and
(2) Applicable group of highly compensated employees receiving the most compensation, limited to 20% of the HCE's (not greater than 1,000, not less than 10 unless the total number is less than 10).

ii. 1990 testing year:

(1) More than 5% owners as determined by Section 416(i) at any time between January 1, 1989 and the end of the testing year, and

(2) Applicable group of highly compensated employees receiving the most compensation limited to 40% (not greater than 2,000, not less than 50 unless the total number is less than 50).

iii. Compensation for this purpose is defined by Section 414(q)(7).

B. Transitional rule for the 90%/50% eligibility test.

1. Can substitute 80%/60% eligibility test if using transitional 75% benefits test for 1989 testing year.

2. Employer must elect.

3. Cannot use this rule to determine excess benefits (i.e. if fail the 80%/60% test must use the 90%/50% test to calculate the excess benefit).

C. Special rule for certain large employers.

1. In general, if an employer meets the requirements of this rule, then the health plans are deemed to satisfy the eligibility and benefits requirements.

   a. Special rules apply for determining excludable and non-excludable employees.

2. Employer election must be in writing for the testing year.

   a. If one health plan tested under this rule, then all health plans must be tested.

3. Minimum number of employees.

   a. At least 5,000 employees on at least 1 day of each quarter of the testing year.
4. Minimum % of nonhighly compensated employees (NHCE).
   a. At least 90% of active employees must be NHCE's.

5. Maximum % of highly compensated employees.
   a. Less than .75% of active employees have compensation greater than $108,960.

6. Health plan eligibility.
   a. At least 80% of the employees eligible to participate in each health plan are NHCE's. The 95% comparability rule applies.
   b. 80%/80% eligibility test (as opposed to a 90%/50% test).

7. 66%/66% core health coverage eligibility test.

8. Cannot use this alternative to determine any excess benefits.

9. Must also meet the nondiscriminatory provisions test.

Q-3 Under what circumstances may employees be disregarded for purposes of Section 89 when the employees receive health coverage from other employers, or when employees do not have a family, or have a family whose members receive health coverage from another employer?

A-3 A. In general.

B. Eligibility tests.

1. An employee may be treated as eligible to receive family coverage without regard to existence of spouse and dependents and without regard to whether there is a required employee contribution or election.

C. 75% benefits test and 80% coverage test.

1. Employer can elect for a testing year to test employee coverage separately from family coverage for the 75% or the 80% tests.

2. Presumption of family status for the 75% or the 80% tests.

3. Other core health coverage for purposes of the 75% test and 80% test.

   a. An employer that does not select separate testing of employee and family coverage may disregard an employee who has a family, if the employee and family members have core coverage elsewhere.
b. An employer that elects separate testing of family health coverage may disregard an employee who does not have a family or the family receives core coverage elsewhere.
   
i. Similarly, when testing employee only coverage, can disregard an employee who has core coverage elsewhere.

4. Sworn statements.
   a. An employer cannot elect the rules of 3. above unless adequate sworn statements are obtained and maintained.
   b. Adequate sworn statement.
      i. Must contain sufficient information indicating:
         (1) whether the employee has a spouse and number of dependents, and
         (2) current receipt by employee, spouse and dependents of core health coverage under a plan of another employer.
      ii. Sworn statements need not be notarized, but must be signed under penalty of perjury after 1989 testing year.
      iii. Example.
   c. Exception - If an employee is eligible to receive employee or family coverage at no cost to the employee and the employee does not elect to receive coverage, then the employer can treat that employee as having completed an adequate sworn statement and that the employee has core health coverage from another employer.
   d. Sworn statements must be collected once every 3 years.

5. Certain HCE’s cannot be disregarded for testing purposes.

6. NHCE’s cannot be disregarded unless if other coverage ceases the employee can elect coverage under the employer’s plan. This "open season" rule must be offered for at least 30 days.
   a. Cannot disregard NHCE as having no family unless "open season" rule is available if the employee has a change in family status.

7. For purposes of the 80% test, cannot disregard an employee unless the 80% test would be satisfied based on eligibility to participate instead of actual coverage received.
What is a health plan under the Section 89 nondiscrimination rules and to what extent are health plans comparable or aggregated for purposes of such rules?

A. Definition of health plan:

1. Generally, a uniform entitlement provided to employees for payments due to personal injury or sickness, including specified medical claims, expenses, products or services.

2. Any difference in entitlement or cost creates separate health plans.

3. Each coverage option is treated as a separate health plan.

B. Comparable health plans may be treated as a single plan for the 50% eligibility test (comparable plans - smallest benefit is at least 95% of largest benefit).

C. 1. Comparable health plans may be treated as a single plan for the 80% coverage test (comparable plans - smallest benefit is at least 90% of the largest benefit).

2. Employer can elect comparable plans if the smallest benefit is at least 80% of largest benefit, if 90% of NHCEs are covered under plan(s).

3. Generally, plans failing the 50% eligibility test do not qualify to be a comparable plan for the 80% test unless:
   a. The employer-provided benefit is at least 95% of the benefit of the failed plan, and
   b. The failed plan and the group of comparable plans must be comparable under C.1. or C.2.

4. Deemed comparability rule.
   a. Health plans are deemed to be comparable if:
      i. The employer-provided benefit is greater than the benefit provided by the comparable plans; and
      ii. NHCE % is at least 80% of HCE % before and after inclusion in the group.
   b. HCE and NHCE % defined.
   c. Examples.
5. Employee cost comparability.
   a. Generally, health plans can be treated as comparable if they are available to all covered employees on the same terms and the difference between the largest and smallest employee cost is $100 or less.
   b. Coordination rule - a health plan not meeting C.5.i. may be treated as comparable if meeting C.1. through C.4.
   c. Health plans treated as comparable under a special employee cost rule.
   d. The term "employee cost" defined.

D. Mandatory aggregation of plans for the 50% eligibility test.
   1. For 50% eligibility test, if an employee may receive coverage under 2 or more health plans, the plans must be aggregated into an additional health plan.
      a. NHCE - eligible for both aggregated and separate plans.
      b. HCE - eligible only for aggregated plan.
   2. For plan years beginning after December 31, 1989, any non-core health benefits are not considered available to an employee if they are attributable to NHCE's salary reductions that exceed the greater of $2,000 or the employee's actual salary reduction contribution.
   3. Examples.

E. Mandatory aggregation of plans for 80% coverage test.
   1. For 80% coverage test, if an employee may receive coverage under 2 or more health plans, the plans must be aggregated into an additional health plan.
      a. NHCE - treated as covered under both aggregated separate plan.
      b. HCE - treated as covered under the aggregated plan.
   2. Exception if 90% of NHCEs are eligible for coverage under all plans on the same terms as other employees and each plan meets 80% coverage test.
   3. Examples.
F. For the 50% eligibility test and 80% coverage, an employer may restructure 2 or more health plans on the basis of the value of coverage.

G. Authority for IRS to issue additional guidance.

Q-5 What is the methodology for applying the nondiscrimination rules under Section 89?

A-5 A. Generally, discrimination determination is based on employee facts existing on the testing day, treated as if such facts were applicable to the whole plan year.

B. Adjustments to facts on the testing day:

1. Benefits for the testing year must be adjusted to reflect a change in plan terms for employees covered on the testing day.

2. a. Benefits for the testing year must be adjusted to reflect election changes made by HCEs.

   b. Limitations on adjustments for election changes during the first quarter of the election year.

3. Changes in plan terms v. elections.

   a. Changes in elections include only changes controlled exclusively by employee.

   b. Change of benefits during an open season is considered a change in plan terms, not an election change.

   c. Increase in employee or employer contributions is a change in plan terms.

4. a. Generally, adjustments are taken into account as of the effective date of the change in the benefit.

   b. Adjustment period rule.

      i. An employer may treat benefit changes as effective on the first day of the adjustment period if:

      ii. At least 24 adjustment periods (i.e., 2-week pay periods) are used for the testing year; and

      iii. For NHCEs, the lowest benefit during the adjustment period is taken into account during the current adjustment period or the adjustment period following benefit change. The highest benefit of HCEs is taken into account during the same periods.
   a. For testing years beginning before July 1, 1989, the employer may use the following rules:
   b. Facts in existence on the testing day are treated as in existence for the entire partial year. Partial year begins earliest of July 1, 1989, testing day, or first day of the month beginning 3 months before the end of the testing year. Partial year ends on the last day of the testing year.
   c. Adjustments are made for elections and plan design changes during the partial year.
   d. The benefit for the partial testing year must be annualized.
   e. The transition rule does not apply to:
      i. Health plans providing benefits for the partial test year less than benefits provided for the portion of the testing year preceding the partial test year.
      ii. New plans or new coverage on or after January 1, 1989.
      iii. Discriminatory plans - (less than 25% of eligible employees are NHCEs or plan fails the 50% eligibility test).
   f. Examples.

C. Testing day, unless elected in writing, last day of testing year.
   1. Plans treated as the same type or plans tested together for nondiscrimination must have the same testing day.

D. Sampling - written election and valid sample required.

Q-6 What is the period for testing whether the nondiscrimination rules of Section 89 are satisfied?

A-6 A. Testing year.
   1. a. The testing year begins on the first day of a calendar month and ends on the last day of a calendar month.
   b. Unless otherwise elected, the testing year is the calendar year.
   2. An employer may elect a different 12-month testing year.
   3. The election must be made in writing prior to the testing year.
B. First testing year in 1989.

1. For plans of the same type, the employer may elect to apply the test on the basis of any 12-month period beginning on or after January 1, 1989, but no later than the first day a plan becomes subject to the Section 89 tests.

2. a. For plans of the same type, the employer may elect to apply the test to its first testing year in 1989 that is shorter than 12 months.

b. Second testing year must be 12 months.

c. No benefits can be excluded or considered in more than one testing year.

3. Election.

   a. First day.

      i. An employer must elect (in writing) the first day of the first testing year beginning in 1989 before the earlier of the 1st day of the second testing year or January 1, 1990.

      ii. If election is not made, the first day is January 1, 1989.

   b. Last day.

      i. If an employer uses a first short testing year, the employer must elect (in writing) the last day prior to the last day.

C. 1. Testing where not all plans are subject to Section 89 for entire testing year.

2. All benefits from plans of the same type available during the first testing year are taken into account when testing - even if Section 89 would not yet apply to some plans.

3. Excess benefit calculation.

   a. If one plan fails the nondiscrimination tests and another plan of the same type is not yet subject to the nondiscrimination rules, then:

   b. The excess benefit is calculated as if all benefits were subject to Section 89.

   c. Excess benefit subject to Section 89.
i. Determination with respect to the 90%/50 eligibility and 75% benefits tests.

ii. Determination with respect to 50% eligibility and 80% coverage test.

D. Changes in testing year.

1. An employer may elect year for plans of the same type prior to the beginning of the new testing year.

2. This election may be made without prior approval from the Commissioner if:
   a. 1st day of new testing year is on or before January 1, 1991;
   b. Change meets (D)(1); or
   c. No discriminatory effect.

3. Example.

Q-7 For purposes of applying Section 89(a) to an employer's health plan, what rules apply for determining the employer-provided benefit and calculating the excess benefits?

A-7 A. Generally, the employer-provided benefit is the value of health coverage attributable to employer contributions.

B. Actuarially reasonable valuation method permitted before the effective date of Section 89(g)(3)(B).
   1. De minimus exclusions (not disproportionately available to HCEs) are permitted.
   2. If cost method not used (COBRA value under Section 4980B), valuation method presumed unreasonable if relative values are different than cost.
   3. De minimus effect defined.
   4. Exception to disproportionately available to HCEs for de minimus exclusion.

C. Reasonable cost method.
   1. General rule - deemed a reasonable valuation method if actuarially reasonable. COBRA value is a reasonable cost method.
2. Permitted adjustments.
   a. General - an employer may elect (in writing) to make
      adjustments to eliminate cost differences unrelated to the
      general value of the coverage.
   b. Geographic adjustment.
   c. Demographic adjustment (other than family status).
   d. Utilization adjustment.

D. Effect of cost containment features/method of health benefit
   delivery (indemnity plans, HMOs and preferred provider plans).

E. Consistency rule - same valuation method for same plans tested
   together.

F. Valuing health coverage under a flexible spending arrangement.

G. 1. Determining the value of health coverage attributable to
    employer contributions.
    a. Deductible expenses under Section 162(m) considered
       employer contributions.
    2. Disregard employer-provided benefit if less than (or equal to)
       2% of the total cost.
    3. Salary reduction contributions. (See Q-8 below)

H. Calculating excess benefits - based on cost using COBRA principles
   without adjustments.

Q-8 How are salary reduction contributions treated for purposes of the
Section 89 nondiscrimination tests?

A-8 A. Treatment of salary reduction contributions.
   1. In general, treated as employer contributions.
   2. Defined - all employer contributions excludable from an
      employee’s gross income under Section 125.

B. 90%/50% eligibility test.
   1. Salary reduction contributions treated as employee
      contributions.
   2. Election to treat as employer contributions.
      a. Written.
b. Requirements to qualify for election.

i. General.

ii. All benefits available to all employees on same terms.

iii. NHCE's eligibility to participate cannot exceed HCE's eligibility to participate.

iv. If the same type of benefits are available outside cafeteria plan, they must be available to all employees.

C. Mandatory treatment of salary reduction contributions.

1. General - applies only to 90%/50% test and the 80%/66% and 80%/80% alternative eligibility tests).

2. a. The amount by which HCE core health coverage attributable to salary reduction exceeds 100% of the portion attributable is considered an employer contribution (part of employer-provided benefit).

b. Examples.

3. The amount by which NHCE salary reductions for core benefits exceed 100% of employer's contribution is considered an employee contributions (not part of employer-provided benefit).


D. Part-time employees - See Section 89(g)(3)(D)(i).

Q-9 How is an excess benefit under the Section 89 nondiscrimination rules to be determined with respect to health plans?

A-9 A. Discrimination tests differ from calculation of excess benefit. Excess benefit is COBRA premium and then the nondiscrimination tests are reapplied.

B. 1. Excess benefits are determined under the nondiscrimination test that the plan failed.

2. If multiple nondiscrimination tests are failed, first apply the 50% eligibility test. Next, the 90%/50% test and then the 75% benefits test.
C. 1. All employer-provided benefits to HCEs are considered in determining excess benefits (not just benefits to HCEs employed on the testing date), but, include only those benefits actually received during the year.

2. Special transitional rule.

D. A HCE’s excess benefit for a plan which flunks the 50% eligibility test is the difference between the benefit actually received and the benefit which would meet the 50% test when comparable plans are considered.

E. A HCE’s excess benefit for a plan which flunks the 90%/50% test is the difference between the benefit actually received that exceeds 200% of the largest benefit available to 90% of the NHCEs.

F. 1. To calculate the excess benefit for plans that fail the 75% test, if plans of different types are tested together, they are treated as plans of the same type.

2. Reapply the test considering only the benefits the HCE’s actually received.

3. Amount of excess benefit is determined by reducing the highest employer-provided to the next highest employer-provided benefit and reapplying the test. Then the employer-provided benefit is reduced to the next highest HCE benefit until the test is passed or the employee no longer has any employer-provided benefit.

G. 1. The excess benefit under 80% coverage test is that amount which exceeds the maximum permissible benefit a plan may have when included with comparable plans.

2. Examples.

Q-10 What are the effective dates of the Section 89 nondiscrimination and qualified rules?


2. a. If the plan is pursuant to a collective bargaining agreement ratified before March 1, 1986, Section 89 applies the earlier of January 1, 1991 or when the agreement expires without extensions.

b. Definition of collectively bargained plan.
c. If non-collectively bargained employees are covered by a collectively bargained plan, the delayed effective date won’t apply to the non-union employees.

d. Unless an employer elects to include employees in a grandfathered collectively bargained plan in the Section 89 testing, they are considered excludable employees.

e. Examples.

B. 1. Plan year definition - if no plan year is designated in the written document for plans other than group term life or health plans, the plan year is the calendar year (5550 designations of plan years are disregarded).

2. a. If no plan year is stated in the written plan, the plan year is the policy year for health and insurance plans. If no policy year exists, the employer may elect the limit/deductible year, the calendar year or the employer’s fiscal year. Default is calendar year.

b. Self insured plans - if no designation in written plan, the employer may elect the limit/deductible year, calendar year or employer’s fiscal year. Default is calendar year.

c. Limit/deductible year defined.

3. Anti-abuse rules:

a. First plan year beginning in 1989 cannot exceed 12 months from first plan year beginning in 1988. 1988 plan years cannot exceed 12 months.

b. i. Exceptions.

ii. Three month rule - if the health plan’s 1989 plan year is not more than three months later than the health plan’s 1988 plan year for bona fide business reasons unrelated to Section 89.

iii. New carrier selected for bona fide business reasons.

iv. If the same start date for the previous plan year is selected if that plan covered 25% of the employees (for mergers and acquisitions).

c. Retroactive plan year designations are disregarded.

d. Regulation authority.
4. New plans must offer substantially different coverage and benefits than 1988 plans.

5. If a person ceases to be a member of a commonly controlled group, the Section 89(j)(8) transition rule may not apply in 1988.

II. Qualification Requirements [Section 1.89(k)-1]

A. Basic Requirements [Section 1.89(k)-1(Q&A-1)]

1. Definitions Provided - No surprises [Q&A-1(b)] but may vary from discrimination tests.
   a. Benefit
   b. Employee Provided Benefit [Contrast to definition under discrimination tests at Section 1.89(a)-1(Q&A-1)(f)(3).]

B. Plans Subject [Section 1.89(k)-1(Q&A-2)]

1. General: Group life, accident or health, dependent care, tuition reduction, cafeteria plan, no-additional-cost services, qualified employee discount, employer-operating facilities.
   a. Includes plans normally exempt from ERISA - governmental units.
   b. "Maintained" by an employer [Q&A-2(a)(2)] - Includes plans where employee pays 100% of cost with after-tax dollars, if value is greater than cost. Valuation issue again.

2. Special rules for health and accident plans [Q&A-2(b)].
   a. SURPRISE: Benefits not excludable under Sections 101 or 105(b) or (c) are not subject to Section 89(k).

QUERY: What about plans covering only partners or shareholder employees? They are not excludable under Section 105 due to part (g). However, they are deductible under Section 162(m). Is this plan not subject to Section 89(k)? Are we talking benefits, i.e. premium, or benefits, i.e. covered expenses?

This is apparently aimed at after-tax employee contributions, not the above, but without regard to the valuation/benefit differential noted above.
Small Employer Planning Point: Raise pay to pay benefit with after-tax dollars. Granted lose benefit of exclusion but need not incur costs of compliance with Section 89(k).

b. Death and Dismemberment [Q&A-2(b)(2)].

c. Disability and Other Sick Pay [Q&A-2(b)(3)].

Rely on B.1.b. above to exclude from Section 89(k).

d. Worker's Compensation - SURPRISE - Certain governmental worker's compensation plans may be subject to Section 89(k).

e. 401(h) accounts - These are separate parts of a retirement plan that provide health benefits. SURPRISE, in spite of the rules already applied by ERISA, these are subject to Section 89(k).

3. Other Benefits [Q&A-2(c)] - No surprises.

4. Plans to which IRC Section 505 applies - No surprises.

5. Multiemployer Plans - No surprises.

6. Church Plans - Watch definition not IRC Section 414(e) but Section 3(2)(w). This is much broader than qualified plan exemption.

7. Excess Benefits [Q&A-2(g)] - If full benefit becomes taxable under Section 89(a) plan is still subject to Section 89(k). Exemption under B.1.b. above would not apply.

8. Changes in Business Structure [Q&A-2(h)] - SURPRISE: NO exception or transition period for qualification rules due to business disposition or acquisitions.

C. Written Plan Requirement [Section 1.89(k)-1(Q&A-3)]

1. General rule is that all material terms are in one document by direct inclusion or incorporation by reference. Several plans can be incorporated in one document.

a. Incorporation by reference [Q&A-3(b)(2)]

e.g. Insurance contract,
Contracts with other providers of benefits,
Contracts with third party administrators,
Trust or other funding arrangements,
Employer resolutions,
Bargaining agreements,
Administrative pronouncements.
b. Contents [Q&A-3(c)]

i. Recitation of Qualification rules - must actually state legally enforceable and exclusive benefit of employees requirements.

ii. Definitions of Material Terms [Q&A-3(c)(4)]
Any term relating to a right. This regulation is surprisingly specific. The employer's right to terminate must be disclosed.

iii. Related Code Definitions, i.e. terms required under Section 105, 125, 129 etc.

c. Timing [Q&A-3(d)]

i. Generally must be in writing before benefit is available.

ii. Exceptions:

(1) Clarifications of initial document - generally have 120 days from effective or adoption date.

(2) Extension of time where other suitable notice is given - generally 120 days. Notice must state that the terms are legally enforceable.

(3) Retroactive modifications of material terms acceptable if ALL of the following are met:

(a) Modification increases benefits.

(b) Affected employees are notified within 60 days.

(c) Formal amendment within 120 days.

(d) Modification must apply for at least 12 months.

(e) Modification is non-discriminatory on its own.

(4) Modifications to non-material terms must be incorporated within 120 days of adoption or effective date.

QUERY: Since the written plan document includes administration notices and board resolutions aren't these automatically included in plan document? See example 2.
(5) Certain on-site medical and eating facilities are exempt from the written plan requirement if terms of this section are covered. [Q&A-3(d)(3)] SURPRISE is that no physician care is ever provided on site, i.e. nurses okay but no doctors.

(6) Transition rule: Plan need not be in writing during 1989 plan year.

D. Legally Enforceable [Section 1.89(k)-1(Q&A-4)]

1. General Rule - Terms are definitely determinable and employee can compel compliance.

2. Employer Discretion.
   a. Impermissible if employer can through discretion, include or exclude any participant. Includes enforcing conditions not in written plan or waiving published standards.

      The establishment of objective conditions that are within the control of the employer may violate this standard.

      QUERY: What does this mean? Many conditions (hours, job classification, payroll status - hourly or salaried) are subject to employer's control. Is this a per se violation or a subjective standard? We will hold it to be a subjective standard until more information is granted.

   b. Who is "Employer" for this rule? It includes plan sponsor and trustee, third party administrators, etc. Requires very specific definitions in the plan. Appears that the more flexible "arbitrary and capricious" standard of qualified plans will not be applicable here.

   c. Permissible Discretion
      i. Qualified medical opinion, 2nd opinion, etc.
      ii. Clearly defined criteria contained in plan.

   d. Examples.


E. Reasonable Notice [Section 1.89(k)-1(Q&A-5)]

1. General Rule - Notice goes to all eligible regardless of whether claiming benefits. Not to dependents eligible solely due to employee status. Dependents eligible due to COBRA
without regard to employee's status would have to receive notice. Includes persons who have not satisfied the waiting period.

2. Content: Must describe terms that are "reasonably likely" to be significant, whatever that means.

Alternatively can provide a copy of the plan and all related documents incorporated by reference. This alternative does not apply for health or accident plans.

SURPRISE: For this alternative the plan document must satisfy ERISA's definition of an SPD [DOL Reg. 2520.102-2].

3. Special rules apply to dependent care plans [Q&A-5(d)].

4. Notice must state that a copy of the plan is available for inspection.

5. Method for distribution is the same as the ERISA Summary Annual Report, DOL Reg. 2520.104b-1(b)(1). If using alternative method in 2. above, distribution must be hand delivery or first class mail to last known address.

6. Timing [Q&A-5(g)].

   a. General rule is prior to effective date.
   b. Modification to plan - Notice within 60 days following effective date.
   c. New Employees - First 60 days of employment, not clear where employee must contribute or make an election. (See examples 4 & 5.)
   d. Transition Rule: No notice required before July 1, 1989.
   e. Examples.

F. Exclusive Benefit Requirement [Section 1.89(k)-1(Q&A-6)]

1. Common-law employees are only allowable participants. This includes:

   a. Limited VEBA exception,
   b. Beneficiaries,
   c. Self-employed persons under IRC Section 401(c)(1),
   d. Certain persons who provide non-employee services and pay for coverage with after-tax dollars,
e. Former employees,
f. Leased employees.

2. Examples.

3. Transition Rule: Applicable first day of 1990 plan year.

G. Indefinite Period [Section 1.89(k)-1(Q&A-7)].

1. General rule - Plan provision must apply for at least 12 months.

   QUERY: Does this mean we can only change premium amounts annually?

2. Can retain right to amend or terminate.

3. Twelve month rule may be waived if there is a good business reason and is nondiscriminatory.

4. Transition Rule - This section does not contain a specific transition date but Q&A-7(b)(3) implies the 12-month rule will only get reviewed after 1989.

5. This rule does not apply to no-additional-cost services and qualified employee discounts. [Q&A-7(d)].

H. Sanctions [Section 1.89(k)-1(Q&A-8)]

1. General Rule - NO exclusion.

2. No income pick-up if employee has paid the full cost.

3. Q&A-8(a)(4) contains a very convoluted concept. Basically, it says that the value of coverage may be excludable if the non-discrimination tests are met, but the benefits received may still be taxable due to a failure to satisfy Section 89(k).

4. Exception - Minor failures that are corrected within 90 days will not trigger these penalties. To be minor there must have been:

   a. Good faith effort,
   
   b. No discrimination,
c. No retroactive reduction in coverage.

To correct, the provisions of Section 89(k) must be met and an adversely affected participant must be made financially whole.

5. Amount taxable [Q&A-8(c)]

a. When received, or when first available, if employee could elect to defer. The calculation is based on the plan year of the failed plan (not on the testing year for discrimination testing).

b. All benefits under the plan unless the failure relates to a specific benefit that can be segregated from the plan in total. See examples.

c. SURPRISE: Limit on taxable amount [Q&A-8(c)(4)].

Taxable amount shall not exceed the sum of:

i. 10 percent of employee’s compensation up to and including $54,480 (the 1989 IRC Section 414(g)(1)(C) limit as adjusted), plus

ii. 25 percent of compensation over $54,480 but not more than $108,960 (two times the Section 414(q)(1)(C) base), plus

iii. 75 percent of compensation over $108,960 but not more than $163,440 (three times this base), plus

iv. 100 percent of compensation over $163,440 as adjusted.

Employee compensation is based on the plan year.

Example: If an employee’s regular compensation was $20,000 and their nonexcludable benefit was $50,000, their taxable benefit would only be $2,000 (10 percent of $20,000). If the employee’s salary was $200,000 and their nonexcludable benefit was $230,000, their taxable benefit would be:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Amount</th>
<th>Taxable Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>$54,480</td>
<td>$5,448</td>
</tr>
<tr>
<td>25%</td>
<td>$54,480</td>
<td>$13,620</td>
</tr>
<tr>
<td>75%</td>
<td>$54,480</td>
<td>$40,860</td>
</tr>
<tr>
<td>100%</td>
<td>$36,560</td>
<td>$36,560</td>
</tr>
</tbody>
</table>

Total $96,488
d. Only benefits attributable to employer contributions can become taxable. Can allocate between employer and after-tax employee contributions based on specific methods.

e. SURPRISE - No double tax [Q&A-8(e)(2)]

If an employee is taxable on an excess benefit due to failure to meet the discrimination test and the same benefit is taxable as a nonexcludable benefits due to a Section 89(k) failure, the increase in taxable income will be the greater of the two income additions, not the sum of the two. The implementation of this rule depends upon which discrimination tests (e.g. 80%, 50/90%, 75%, etc.) result in the benefit being an excess benefit. See Q&A-8(e)(2)(ii).

f. The Commissioner retains authority to further limit the amount of taxable benefits.

III. Additional Rules for Cafeteria Plans [Section 1.125-1 & 2]

A. Sec. 1.125-1 Question 30 additional rules for Cafeteria plans.

Sec. 1.125-2 supersedes proposed regulations 1.125-1 if inconsistency exists between the regulations.

B. Effective Dates [Section 1.125-2(Q&A-1)].


2. Flexible Spending Arrangements - plan years beginning after 12/31/89.

C. Constructive Receipt Doctrine Exception [Section 1.125-2(Q&A-2)].

D. Cafeteria Plan Defined [Section 1.125-2(Q&A-3)].

1. Choice of benefits limited to cash and qualified benefits.

2. Qualification requirements of Section 89(k) must be satisfied.

3. Plan document must describe maximum amount of elective contribution.

   a. Maximum dollar amount,

   b. Maximum percentage of compensation, or

   c. Method of determining dollar or percentage limitation.
E. Definition of Qualified Benefits and Cash [Section 1.125-2(Q&A-4)].

1. Qualified benefits [Q&A-4(a)(1)].
   a. A benefit that does not defer receipt of compensation, and
   b. Is excluded from income by the Internal Revenue Code.

2. Specific Qualified Benefits [Q&A-4(a)(2)].
   a. Accident or health plans.
      i. Qualified under Section 106.
      ii. Long-term disability and accidental death and
dismemberment coverage may be qualified benefits.
      i. Coverage in excess of $50,000 still qualified benefit.
      ii. Must meet Section 79 rules.
   c. Certain discriminatory benefits.
      i. Accident and health coverage, group term life
coverage and dependent care assistance are still
qualified benefits even if nondiscrimination
standards of Section 89 failed.
      ii. Dependent care assistance is still a qualified
benefit if it fails nondiscrimination standards of
IRC Section 129(d).
   d. Certain dependent care assistance benefits.
      i. Change in law eliminating overnight camp expenses and
age limitation for qualifying dependents do not fail
to be qualified benefits with exceptions.
      ii. Treated the same as cash.

3. Currently taxable benefits treated as cash [Q&A-4(b)].
   a. Benefit same as cash if not deferring receipt of
compensation, and
   b. Benefit purchased with after-tax employee contributions.
   c. Taxable benefits not described in Q&A-4(a) and not treated
as cash are not permissible benefits of a cafeteria plan.
4. Qualified cash or deferred arrangements (CODA’s) [Q&A-4(c)].
   a. CODA’s permitted.
   b. After-tax employee contributions subject to Section 401(m) permitted.

5. Benefits not constituting qualified benefits or cash [Q&A-4(d)].
   a. Qualified scholarships (Section 117) not permitted.
   b. Fringe benefits under Section 132 not permitted.

F. Benefits Deferring Receipt of Compensation [Section 1.125-2(Q&A-5)].

1. General Rule [Q&A-5(a)].
   a. Benefits that defer the receipt of compensation are not permissible.
   b. Whole life insurance not permissible.
   c. Carry-over of unused credits or benefits not permissible.
   d. Reimbursing premium payments for other health coverage extending beyond the end of the plan year not permissible.
   e. Using contributions from one plan year to purchase benefits in another plan year not permissible.

2. Exceptions [Q&A-5(b)].
   a. CODA’s.
   b. After-tax contributions subject to Section 401(m).
   c. Reasonable premium rebates or policy dividends paid out before end of following plan year.

3. Paid vacation days [Q&A-5(c)].
   a. Generally allowed.
   b. Nonelective days deemed first used.
   c. Unused elective days may be cashed out but not carried forward.
G. Revoking existing elections in a cafeteria plan [Section 1.125-2 (Q&A-6)]

1. General rule [Q&A-6(a)].
   a. Not allowed.
   b. Must make election among benefits offered in plan.
   c. Election deemed not made if permitted to revoke election during period of coverage.

2. Significant cost or coverage changes [Q&A-6(b)].
   a. Cost changes.
      i. Automatic changes permitted to elective contributions by plan if health coverage increases or decreases.
      ii. Participants may change or revoke election if significant increase in premiums.
   b. Coverage changes - Participants may revoke election if third-party provider curtails or ceases coverage, or, alternatively, if receive basic coverage under another plan.

3. Changes in family status [Q&A-6(c)].
   Participant may revoke or change election if change in family status:
   a. Marriage or divorce,
   b. Death of spouse or dependent,
   c. Birth or adoption of child,
   d. Termination of employment of employee's spouse,
   e. Switching from part-time to full-time employment or vice versa by employee or employee's spouse,
   f. Taking an unpaid leave of absence, or
   g. Significant change of health coverage of employee or spouse attributable to spouse's employment.

4. Separation from service [Q&A-6(d)].
   Election can be revoked on separation from service.
5. Cessation of required contribution [Q&A-6(e)].
   a. Contributions by employee ceases - benefits cease.
   b. No new election for remainder of plan year allowed.

6. Elective contributions under IRC Sec. 401(k) (CODA’s) [Q&A-6(f)].
   a. May change or revoke election to CODA’s.
   b. May change or revoke election for after-tax contributions subject to Section 401(m).

H. Flexible Spending Arrangements (FSA’s) [Section 1.125-2(Q&A-7)].

1. General rule [Q&A-7(a)].
   a. Health FSA’s must conform to Sections 105 and 106.
   b. Must exhibit risk shifting and risk distribution characteristics of insurance.
   c. May reimburse expenses during period of coverage only.
   d. Expected coverage must be for plan year, not, specific period (i.e., not one month’s coverage only).
   e. Employer must bear some risk of loss.

2. Special requirements [Q&A-7(b)].

   Health FSA’s must satisfy certain of the requirements of Q&A-7(b) to qualify for exclusion from income under Sections 105 and 106.

3. General Rule [Q&A-7(b)(1)].
   a. Uniform coverage throughout period.
      i. Maximum reimbursement must be available at all times during the period of coverage.
      ii. Reimbursement paid at least monthly or after attaining certain dollar amount.
   b. Twelve month period of coverage.
      i. Must be for twelve months.
      ii. Short plan year allowed in first year or in year of change.
iii. FSA elections cannot be changed unless change in family status and only for period in which change in status applies.

c. Prohibited reimbursement [Q&A-7(b)(4)].
   i. Reimbursement available only for medical expenses as defined under Section 213.
   ii. Reimbursement for other health coverage not allowed (i.e., coverage provided by employer of spouse or dependent).

d. Claims substantiation [Q&A-7(b)(5)].
   i. Written statement from independent third-party to substantiate claims is required.
   ii. Advance payments for projected expense not allowed.

e. Claims incurred [Q&A-7(b)(6)].
   i. Expenses must be incurred during period of coverage.
   ii. Expense prior to enrollment or FSA existence not allowed.

f. FSA experience gains (excess of premiums paid over FSA claims) [Q&A-7(b)(7)].
   i. May be applied to reduce following year’s contributions.
   ii. May be allocated and paid to participants on a reasonable basis.

g. Dependent care assistance [Q&A-7(b)(8)].

Similar rules apply to dependent care assistance programs except for uniform coverage throughout coverage period.

4. Flexible spending arrangement definition [Q&A-7(c)].

   a. FSA is a benefit program providing employees with specified coverage where expenses may be reimbursed.

   b. Maximum reimbursement not substantially in excess of total premiums paid.

Not substantially in excess if reimbursement not greater than 500% of premium.
c. FSA rules effective for plan years beginning after December 31, 1989.

5. Effective date of Q&A-7 - for plan years beginning after December 31, 1989.

6. The Commissioner retains authority to modify or issue additional requirements as may be necessary to insure compliance.