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SECTION 89

INTERNAL REVENUE CODE

TAX ON EMPLOYEE FRINGE BENEFITS

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First Quarter

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SECTION 89, INTERNAL REVENUE CODE

TAX ON EMPLOYEE FRINGE BENEFITS

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Section 89 Internal Revenue Code

Tax on Employee Fringe Benefits

By: Matt W. Zeigler

**Employers, Employees, and
Qualification Rules §89(k).**

**I. OVERVIEW, PRELIMINARY
COMPLIANCE AND
EFFECTIVE DATES.**

A. Overview.

Section 89 of Internal Revenue Code ("§89") was passed as a part of the Tax Reform Act of 1986¹ ("TRA 1986"). §89 imposes a tax on the fringe benefits that are provided to employees and paid for by their employers who deduct these benefits as business expenses under various sections of the Internal Revenue Code (the "Code"). Unless certain coverage or eligibility requirements and/or certain written documentation standards are met, some or perhaps all employees will have to pay tax on the value of the employer-provided fringe benefits.

The effect of §89 is primarily to raise revenue to help meet the deficit of the federal government and secondarily (the stated primary purpose) to broaden the coverage of various health care and other employee fringe benefit programs to more employees without regard to compensation. The General Explanation of the Tax Reform Act of 1986, the so-called "Blue Book" ("BB"), anticipates that the revenue effect of this provision is to raise additional taxes of \$72 million in 1988, \$128 million in 1989, \$140 million in 1990 and \$154 million in 1991, for almost a half a billion dollars in total.

The Technical and Miscellaneous Revenue Act of 1988² ("TAMRA") passed by Congress and signed by President Reagan on No-

vember 10, 1988, provided some temporary relief to some of the more stringent provisions of §89. TAMRA included comprehensive explanatory provisions in a Conference Report, called the Statement of Managers ("S.M."). (Reference to the S.M. in this article will be to the Government Printing Office edition, dated October 21, 1988.)

Proposed Regulations. The Proposed Regulations to §89 (the "Regulations") were published on March 7, 1989 and were 219 pages in length. (54 CFR 9460.) The proposed Regulations contain specific language which permits an employer to rely on them. Generally, the Regulations delayed four of the five qualification/disclosure issues until 1990 and the fifth one only to July 1, 1989 (the "reasonable notification" rule). The nondiscrimination rules were not delayed, so employers and employees face the issue of additional income tax or penalties in 1989. But employers are now permitted an election to use a short testing year in 1989 so long as the second testing year is a full 12 months in duration. §1.89(a)-1, Q&A-6(b)(2).

Although comprehensive, the Regulations did not address the following issues: multiemployer plan rules adopted in TAMRA; the separate line of business rules of section 414(r); the availability of employer disaggregation under section 89; the group-term life insurance rules; and the application of section 89 to former employees and the exclusion of employees under §89(h). These areas are to be addressed in future guidance. This monograph is written incorporating the relief and changes provided by TAMRA and the Regulations.

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The Tax. Section 89 taxes the employer-provided fringe benefits under a discriminatory employee benefit plan. The gross income of a highly compensated employee who is a participant in a discriminatory employee benefit plan during any testing year shall include an amount equal to such employee's excess benefit under the plan. §89(a).

The Excess Benefit. Under §89(b), the excess benefit of an highly compensated employee is the amount over the highest permitted benefit. The highest permitted benefit is determined by reducing the nontaxable benefits of the highly compensated employees, beginning with the highly compensated employees with the highest nontaxable benefit, until the plan is not discriminatory. To compute the excess benefit, there shall be taken into account all plans of the same type. Nontaxable benefit means any benefit provided under a statutory employee benefit plan as defined in §89(i) which includes the cost of group-term life insurance under §79.

What §89 Is Not. §89 covers many kinds of employer-provided fringe benefit plans, but it does not require (1) an equalization of employee fringe benefits; (2) any minimal level benefit or coverage; (3) mandated minimum of number or classifications of nonhighly compensated employees who must be covered by health or accident insurance; or (4) prohibit highly compensated employees from receiving more valuable benefits than other employees. Instead, the general idea behind §89 is that if the level of employer-provided fringe benefits supplied to highly compensated employees as compared to those supplied to nonhighly compensated employees are significantly unequal, the highly

compensated employee must pay tax on the amount of the differential, the "excess benefit."

Transitional Relief for 1989 and 1990. The Regulations provided a transitional rule that will substantially simplify §89 compliance for many employers. This rule permits an employer to pass the 75% Benefits Test if it elects to treat all of the health coverage provided to a portion (20% in 1989; 40% in 1990, subject to some maximum and minimum numbers) of its highly compensated employees as a taxable benefit. §1.89(a)-1; Q&A-2(a). If this transition rule is used, then a 80%/66% Eligibility Test may be substituted for the 90%/50% Eligibility Test. §1.89(a)-1, Q&A-2(b).

B. Preliminary Compliance.

If an employer does nothing in response to §89(k), every employee, whether highly or not highly compensated, will have to pay income tax on the value of the employer-provided fringe benefits. To avoid this consequence, an employer must, starting, in part on July 1, 1989 and then fully beginning at the earliest, in January 1990, describe in writing and give notice to eligible employees of the provisions of the employer-provided fringe benefit plans.

A summary review of the employee population and the coverage and eligibility conditions of each employee benefit plan should be conducted first. This review should determine the number and kinds of plans, the identification of highly compensated employees, the cost of the benefits, the criteria for eligibility and the amounts of any employee contributions for coverage. This overview should be performed early and before gathering large volumes of employee information.

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**Section 89
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If it appears that at least 80% of the nonhighly compensated but eligible employees may not be covered, then an employer could explore whether minor, cost effective adjustments to the eligibility criteria for that particular plan might increase the percentage of nonhighly compensated employees included under the plan. TAMRA allows employers, at their option, to test one or more times in 1989 to determine whether or not the tests are met.

Finally, plan provisions should be reviewed for any "discriminatory provision" which will, by its terms or by its operation under all facts and circumstances, discriminate in favor of highly compensated employees. Such a provision could cause any otherwise qualified plan benefit to become taxable to highly compensated employees. An employer could modify the plan design so that the discriminatory effect is eliminated or, alternatively, broaden the otherwise discriminatory provision to include nonhighly compensated employees.

The rules do provide a type of compliance transition period. Until January 1, 1990, or until the beginning of the second testing year beginning after December 31, 1988, the Regulations set out a compliance standard whereby an employer will be treated as having satisfied §89 if the employer makes a reasonable and good faith "effort" to comply with §89 and its legislative history. The "effort" must include the gathering and analysis of employee information. Whether the employer's effort is in good faith will be based upon the facts and circumstances and upon whether the employer always resolves unclear issues in its favor.

C. Effective Date.

Section 89 generally is effective for all plans for the plan years that

begin on and after January 1, 1989. If your health care or other fringe benefit plan year begins on January 1, 1989, then that is the effective date. If your health care or other fringe benefit plan year begins, for example, on May 1, 1989, then that is the effective date. The Regulations did not change these dates either for the qualification rules of §89(k) or for the nondiscrimination testing. §1.89(a)-1, Q&A-10(a). However, special transition rules have delayed the immediate effect for the qualification rules. (See below.) Special transition rules also have provided some simpler methodology for the nondiscrimination rules, but only for plan years that begin in 1989.

For plans covering employees who are subject to a collective bargaining agreement ("CBA"), the effective date is January 1, 1989, unless the CBA was ratified on or before March 1, 1986. If the CBA was ratified on or before March 1, 1986, the effective date of §89 is the plan year beginning after the earlier of the date on which the CBA terminates (disregarding extensions after February 28, 1986) or January 1, 1991. If the CBA was ratified after March 1, 1986, the effective date of §89 is the first day of the plan year beginning after December 31, 1988. The Regulations add a modification to this provision: if both union and nonunion employees are covered under the same plan, and §89 is not yet effective for the employees covered by the CBA, the non-union employees must be tested for the nondiscrimination rules in 1989 and the union employees tested under the delayed effective date rules. §1.89(a)-1, Q&A-10(a)(2)(iii).

Congress, in the Conference Committee Agreement, discussed the issue of the effective date of §89 with respect to employers who

changed the plan year of their employee benefit plans to "delay substantially" the effective date of the nondiscrimination rules. The Conference Committee Notes state "The conferees expect that Treasury rules will disregard such changes for effective date purposes".

Moreover, the Regulations provide a special rule (and exceptions) also designed to prevent effective date delays. The rule is that §89 becomes effective, for health and group-term life insurance plans, on the anniversary date "... of the plan's first plan year beginning in 1988." §1.89(a)-1, Q&A-10(b)(3). There are three exceptions to this rule: (1) if the health plan's year commences not more than 3 months later in 1989 than it did in 1988 and the selection of the new plan year was for bona fide business reasons unrelated to §89; (2) if there in a new and unrelated health care insurance carrier and the change of the carrier was for bona fide business reasons unrelated to §89; and (3) if there is a selection of a uniform plan year so long as the first day of the plan year is the same as that which began in 1988 for plans of the same type that provide at least 25% of the total employer-provided benefits provided by all plans of the same type during 1988 and the selection of the new plan year was for bonafide business reasons unrelated to §89. Other permissible events will permit differing effective dates for §89, for example, the institution of substantially new plans; and changes resulting from mergers or acquisitions. *Id.*

II. EMPLOYERS COVERED.

A. Controlled Group Rules.

Employees working for members of a controlled group under §414(t) are treated as single employer for

purposes of §89. Specifically included are: members of a controlled group of corporations (§414(b)); members of partnerships or sole proprietorships under common control (§414(c)); members of an affiliated service group (§414(m)); leased employees (§414(n)); and separate organizations or other arrangements described in regulations under §414(o).

B. Other Employers. The definition of employer also includes: an individual owning all of an unincorporated business, who is treated as his own employer; and a partnership, which is treated as the employer of each partner, and the partners are treated as employees. §89(j)(6).

C. Separate Line of Business Rules.

1. These rules allow for qualification and testing based upon separate lines of business, without the need to apply the controlled group rules bridging one line of business to another. As a precondition to the application of these separate line of business rules, the plan must meet the classification test of §410(b)(1)(B). This qualified plan minimum coverage rule requires that the plan must cover a fair cross-section of employees, i.e., a representative number of employees in each pay bracket. If that classification test is passed, then the separate line of business must meet the following conditions of §414(r):

(a) there must be a bona-fide business reason for the separate line of business, or there must be operating units in separate geographic areas at least 35

miles apart operating for a bonafide business reason; (b) the separate line of business must have 50 or more eligible employees; (c) the employer must notify the IRS of the election to treat this line of business as separate; and (d) the separate line of business must meet regulatory guidelines (that are yet to be published) or the employer must receive a ruling from the Secretary permitting the separate treatment.

2. There is a **safe harbor rule** (§414(r)(3)) for meeting the regulatory guidelines described above in subparagraph (C)(1)(d). This safe harbor rule cannot be satisfied if there is a concentration of, or an absence of, highly compensated employees in that separate line of business. The safe harbor rule is: the percentage of the highly compensated employees in that line of business may not be (a) less than 50% and (b) more than 200% of the percentage of highly compensated employees of the employer considered as a whole. The employer is treated as meeting the "not less than 50%" requirement if 10% or more of all highly compensated employees of the employer perform services for this line of business.

3. TAMRA provided some clarification of the safe harbor rules. The safe harbor is met if, (a) the above requirements were met for the preceding year, and (b) no more than a "de minimis number" of employees were shifted to or from the line of business after the close of the preceding year, and the employees shifted

after the close of that preceding year contained a substantially proportional number of highly compensated employees. §414(r)(3)(B).

4. The rules for excluded employees under §§89(h)(2) and (3), discussed below, shall be separately applied for different lines of business. §89(h)(4).

D. Exception for Churches.

Employee benefit plans which are maintained for church employees by a church or a church-controlled organization as defined by Code §3121(w)(3)(A) and (B) are not covered by §89. §89(i)(4).

E. No Exception for Charities.

Even though a plan is maintained by an organization that is exempt from tax under §501(a), the charitable organization must comply with §89. The Regulations state this explicitly with respect to the §89(k) plan qualification requirements. §1.89(k)-1, Q&A-2(a)(1).

F. No Exception for Federal, State or Local Government.

There is no exception for governmental units under §89. The underlying concept is that if the governmental unit does not want the income from a discriminatory health or other fringe benefit programs included in the wages of its employees, then the federal, state or local governmental unit employer must comply with the qualification and nondiscrimination rules of §89. §1.89(k)-1; Q&A-2(a)(1). The Regulations have added a large employer rule for employers with over 5,000 employees to ease the burden of complying with §89. (See G., below.)

G. Large Employer Special Rule. The Regulations provide for a comprehensive set of rules for large employers with over 5,000

active employees on at least 1 day of each quarter of a testing year. §1.89(a)-1, Q&A-2(c)(3).

H. Small Employer Transitional Rule for Part-time Employees. Generally, any employer who has one or more employees must comply. However, TAMRA provides a phase-in rule for small employers who have less than 10 employees on a normal working day during a testing year. For purposes of the 80% Coverage Test only, such small employers may, for testing years beginning in 1989, exclude those part-time employees normally working 35 or less hours per week; for testing years beginning in 1990, exclude those employees normally working 25 or less hours per week; and for testing years beginning in 1991, exclude those employees normally working 17-1/2 or less hours per week. TAMRA §6070; S.M., p.165.

I. Employers with Only Highly Compensated Employees. If an employer has only highly compensated employees, then the requirements of §89(d), the eligibility test, and §89(e), the benefits test, do not apply. §89(j)(12). However, the qualification/disclosure rules of §89(k) do apply.

III. EMPLOYEES EXCLUDED.

A. In General. An employer may exclude the following employees, both nonhighly compensated and highly compensated (some exceptions) for all testing purposes:

1. for "core" plans, health, accident and the like, employees who have not completed 6 months of service; for "non-core" plans, life insurance, dental plans and the like, 1 year of service;

2. employees normally working less than 17 1/2 hours per week;
3. temporary employees normally working 6 months or less during any year;
4. employees under age 21;
5. union employees (but see the discussion below); and
6. non-resident aliens with no U.S. source income.

These exclusions apply unless the employer provides for a shorter period of service or lesser age requirements under the plan, and, in such event, the shorter period or lesser age is applicable for testing. §89(h)(1). Furthermore, if the employer covers any excluded employee under a plan, then all similarly excluded employees must be taken into account for purposes of testing all plans of the same type. §89(h)(2).

These exclusions are available only if the employer imposes the same exclusions on all plans of the same type (§89(h)(3)(A)), except if there is a difference in waiting periods for core and noncore benefits provided by health plans. §89(h)(3)(B).

If the employer has a group of employees who are under the age requirement or who fail to meet the minimum service requirement but who are nevertheless covered under a plan of the employer, then such plan may meet the requirements of §89 separately with respect to the excluded employees. If the plan covering excluded employees passes the §89 testing requirements alone, then such employees may be excluded in determining whether other plans of the employer pass the requirements of §89. §89(h)(5).

For purposes of the initial service rules (six months or one year), benefits provided under a

core accident or health plan may be considered provided under a separate plan from noncore benefits. BB, p. 799-800.

B. Part-time, Temporary Employees and "Normally Work". TAMRA provided a new meaning to the concept of "normally work". §89(h)(1)(B) and (C) and S.M., p. 55. Basically, this is an elapsed time rule, not an actual counting of hours. An employee is considered to "normally work" the average number of hours worked in the testing year prior to the testing date. However, it is not a pure average, rather it is the average of the "scheduled" hours of service. (Hours of service has the same meaning as the qualified plan definition.) To calculate this average of scheduled hours, weeks not worked or scheduled for work are disregarded. Further, this average of hours scheduled is to be made in good faith and is to take into account periods in which it is expected that hours worked will be higher due to seasonal business cycles.

Employees with less than 60 days of service are considered to "normally work" (1) the average number of hours worked during the prior testing year, or (2) if the employee did not work at least 60 days during the prior testing year, the average number of hours such employee is scheduled to work as of the testing date, during the longer of (i) the next 60 days, or (ii) the period between the testing date and the end of the testing year. S.M., pp. 55-56.

The entry date or the enrollment date can be delayed up to a maximum of 31 days following completion of the initial service requirement. S.M., p. 57.

C. Students Hired under a Work-Study Program. Students

hired under a work-study program and to whom core health plan coverage is made available by their employer may be excluded as not eligible under §89(h)(1)(G). These students must be performing services as described in Code §3121(b)(10), which are, generally, services performed by an enrolled student who is employed by that same school or university.

D. Former Employees. §89(j)(3) requires plans to test former employees separately for nondiscrimination purposes. Although the Secretary is directed to address this subject by regulation, (and the Regulations published to date have not addressed this matter) the Blue Book indicates that the employer can may restrict the class of former employees to be tested to those who have reached a certain retirement age, those who retired after a certain amount of years, or those who are on disability retirement. In addition, "employers may make reasonable assumptions regarding mortality, so that they do not have to determine those former employees not covered by a plan who are still alive." BB, p. 809.

TAMRA (§3021(c)(2), S.M., pp.52-53) provided that employees who separated from service before January 1, 1989 and who were not reemployed after that date are not to be considered in determining whether the plans are non-discriminatory under §89. If a former employee is reemployed after January 1, 1989, then the "grandfathered" status of that former employee is lost.

Benefit increases after December 31, 1988 to former employees who separated from service before January 1, 1989 are disregarded if they are provided in the "same manner" to employees who separated both before and after December 31, 1988 and are nondiscrimi-

natory with respect to those employees who separated after December 31, 1988. A Federally mandated increase in benefits with respect to a former employee separated from service prior to December 31, 1988 is not considered a benefit increase.

Benefit reductions after December 31, 1988 to former employees who separated from service before January 1, 1989 are to be tested under a special rule (See S.M., pp. 52-53) which is designed to prevent discrimination in favor of highly compensated former employees through a nonuniform reduction in benefits. These benefit reductions are to be tested subject to the same exceptions applicable to benefit increases.

E. Union Employees. Although §89(h)(1)(E) provides for an exclusion of union employees, employers who cover under any employee benefit plan subject to §89 any of their employees covered by a collective bargaining agreement, whether a single employer unit or a multiemployer bargaining unit, must include those union employees with the group of non-union employees for purposes of testing employer-provided benefits under §89 after the applicable effective date. This is true unless neither the plan nor any other plan of the same type is available to any employee in that unit. BB, p. 798. This rule seems incongruous with the qualified plan rule which is written in the same manner.

The Regulations, confirming this interpretation, have clearly taken the position that union employees, unless certain narrowly defined events have occurred, must be tested with the group of non-union employees. Union membership alone does not of itself give rise to a valid employee exclusion.

Reg. §1.89, Explanation Of Rules, at paragraph 1.

There is a narrowly defined rule which allows union employees to be excluded from the group of non-union employees for nondiscrimination testing purposes. An employer may disregard union members from the testing group including non-union employees if the collective bargaining unit were offered a benefit in bargaining, and refused to accept that particular fringe benefit, e.g. dental coverage. Then the employer could exclude those union employees for purposes of testing the dental plan only. §89(h)(1)(E).

Another special rule relates to the eligibility criteria with respect to multiemployer plans and how they are applied. The rule is that the initial service, part-time status, seasonal status, and age provisions, (§89(h)(1)(A)-(D)), are not taken into account in determining the extent to which the statutory exclusions are applied with respect to the other plans of the employer. For example, if the core union plan had a one month service requirement, and the non-union plan had a three month service requirement for core health benefits, the fact that the union plan had a shorter service requirement would not, of itself, reduce the employer's service exclusion for the non-union employees to one month with respect to its non-union core health plans. §89(h)(6). This special rule does not apply if the multiemployer plan is on behalf of any employee who performs professional services. ("Professional services include the following services: legal, medical, engineering, architecture, actuarial science, financial, consulting, accounting and such other services as the Secretary shall determine." S.M., p. 57 and §89(g)(3)(E)(iii).

Moreover, if there is any cross-

over between non-union participants in a union plan and union participants in a non-union plan, then the separate status accorded those plans under the above special rules will not be available. BB, p.798-800.

Written Election. An employer may elect in writing to include union employees for testing purposes even though, under the delayed effective date rules for collectively bargained plans, those union employees otherwise would be excludable. "Such an election must be made with respect to all collectively bargained employees, regardless of bargaining unit, and once made applies to all subsequent testing years. Such an election does not accelerate the otherwise applicable effective date with respect to the application of the qualification rules of section 89(k) to such collectively bargained plan or plans. However, if the employer makes an election under this paragraph (a)(2)(iv), then the nondiscrimination rules of section 89 are effective with respect to such plan or plans and thus a highly compensated employee within the group of otherwise excludable employees (i.e., nonexcludable by reason of such election), may have an excess benefit under section 89(b)". §1.89(a)-1, Q&A-10(a)(2)(iv).

F. Employees Covered under Core Plan with Another Employer; Sworn Statement Exclusion.

1. In General. Employees and/or their family members who are covered with core health benefits of another employer may, at the employer's election, be excluded from testing for core health plans. §89(g)(2). The effect of a failure to have an adequate

sworn statement to this effect is that the presumptions set forth in §89(g)(2)(C) will apply. (See F. 5 below.) Special rules apply, but the use of these statements may help increase the percentage of employees covered under the plan, and thus lower the cost for those that may have to pay taxes.

To exclude employees from testing under this exclusion, an employer must obtain from the employee who has other coverage, an adequate "sworn statement". An adequate sworn statement must identify whether that "...employee has a spouse or any dependents, and, if so, the number of dependents and the current receipt by the employee and any spouse or dependents of core health coverage under a plan of another employer or the employer of the spouse or dependent." §1.89(a)-1, Q&A-3(c)(4)(ii). A sworn statement is not required to be notarized or to be completed on a form approved in advance by the Commissioner. S.M., p. 46. The sworn statement also must identify the core coverage from the first employer, if any, the identity of the other employer and the core coverage from the other employer. §89(g)(2)(B).

a. Triennial/Annual collection. After the sworn statements are initially collected, then they need only be collected once every three years. If an employer does not obtain adequate sworn statements from substantially all of its employees, or from a representative sample of employees, dis-

cussed below, then the employer must obtain them annually. §1.89(a)-1, Q&A-3(c)(4)(iv).

b. Fact Collection Date. The collection of facts may relate to the facts in existence on any date within 6 months of the actual collection and need not relate to the facts in existence on the annual testing date. For nondiscrimination testing purposes, the collection fact date must precede the testing date, and the one closest in time to the testing date is the one that must be used. S.M., p. 47.

c. Option To Return; effective 1/1/91. Once a nonhighly compensated employee has signed a sworn statement indicating that either he or she or a member of the employee's family has core medical coverage elsewhere, and after that other employer-provided coverage has ceased for any reason, §89(g)(2)(E) provides that the employee must be allowed to elect coverage under the plan of the first employer even if an election is not otherwise available. This election period (to elect back in) must be no shorter than 30 days. The terms and conditions of the election back into the first employer's plan must be the same as if such employee was making the election during a subsequent open enrollment period; for example, reentry into the plan could be conditioned on a showing of insurability. In the

event that other types of coverages are made available to an employee during this open enrollment period, then those same coverages are to be made available to an employee whose coverage from the other employer has ceased and is now electing under the first employer's plan. The same rule applies in the event an employee is single and elects coverage under the plan of another employer and then has a family. The Regulations made this special rule effective for testing years beginning after December 31, 1990. This rule then, is not applicable for plan years beginning in 1989 or 1990. If this election is not available to the nonhighly compensated employee, that employee may not be disregarded for purposes of the election to exclude employees on the basis of a sworn statement. (§89(g)(2)(E)). (S.M., pp.46-48). §1.89(a)-1, Q&A-3(c)(6).

d. IRS Model Language; Other Reasonable Method. TAMRA directed the IRS to and the IRS has supplied model language, (not a model form) that must be included in a sworn statement. See the sample language contained in §1.89(a)-1, Q&A-3(c)(4)(ii). (A sample sworn statement form is appended to this monograph.) In lieu of including information about the employer-provided health coverage being received by an employee under the em-

ployer's health plans, an employer may use any other reasonable method to enable it to determine, for each testing year, the extent to which an employee who is receiving core health coverage under a plan of another employer also is receiving employer-provided health coverage from the employer. *Id.*

e. Effective Date: 1989. The Regulations do not allow employers to delay the collection of adequate sworn statements for years beginning in 1989. So, for testing years beginning in 1989, they will have to be collected in order to utilize the exclusion. However, the Regulations do state that the sworn statements used in 1989 cannot be relied on for testing years beginning after 1989 unless they are made under penalty of perjury and contain a description of the employee's current employer-provided core health coverage and the other requirements stated above. §1.89(a)-1, Q&A-3(c)(4)(ii).

2. 75% Benefits Test and 80% Coverage Test Only. TAMRA provided that employees excluded from the first employer's testing based upon sworn statements now could be excluded from the 80% Coverage Test, rather than the 75% Benefits Test only as provided originally by TRA 1986. §89(g)(2)(A).

3. Coverage at No Cost; Exclusion without Sworn Statement. In the event that an employer makes available

to an employee the employee-only core health coverage at no cost and the employee rejects that coverage, then that employer may exclude that individual as if he or she signed a sworn statement. Similarly, if an employee is eligible to receive family-only coverage under a core health plan of the employer with a "substantial" employer-provided benefit at no cost and the employee rejects that coverage, the employer may treat such employee as having completed an adequate sworn statement that the employee has no family or has a family all the members of which receive other core health coverage. §1.89(a)-1, Q&A-3(c)(4)(iii).

4. 80% Eligibility Test Prerequisite. Before an employer may exclude those employees who have provided sworn statements indicating that they have core coverage elsewhere, that employer must first pass the 80% Coverage Test on the basis of **eligibility** to participate, rather than coverage. §89(g)(2)(A). If the plan being tested does not pass the special 80% Eligibility Test, those employees excluded by the sworn statements would be eliminated only from the 75% Benefits Test. However, this exclusion from the 75% Benefits Test applies **only** to the testing of the health or accident plan of the employer; the exclusion does not apply to any other type of plans even if aggregated with plans of a different type for purposes of the 75% Benefits Test. BB p. 802. So, the effect of a failure to pass the special 80% Eligibility Test is to exclude an employee

from being tested under the 75% Benefits Test only for the core health plan, but that same employee could not be excluded from the testing of the group-term life insurance plan. §1.89(a)-1, Q&A-3(c)(7).

5. Dual Adverse Presumption of Family Status. In the absence of a sworn statement, there is a dual adverse presumption: on the one hand, nonhighly compensated employees shall be treated for testing purposes as not having other coverage and as having a spouse and dependents without other coverage. On the other hand, a highly compensated employee shall be treated as a single person with other coverage. A sworn statement can defeat this presumption of family or single coverage. §1.89(a)-1, Q&A-3(c)(4). The employer has the option of testing family coverage separately. Simply put, this presumption operates so that a nonhighly compensated employee has a family unless there is a sworn statement indicating that such person is single, and a highly compensated employee is single unless there is a sworn statement indicating that such person has a family.

§89(g)(2)(C).

This presumption may be defeated as follows: an employee who has signed a sworn statement representing to the employer that his spouse or dependents have coverage under the accident or health plan of another employer or that he is single, may be excluded from testing the Employer's dependent coverage plans. Such an employee is appropriately considered

under the employer's plans as a single person. Similarly, an employee who has signed a sworn statement representing to the employer that he has coverage for himself elsewhere may be excluded from testing the employee-only plan. Further, if a plan requires different levels of co-payments depending upon which plan the employee chooses for coverage, then that employee will be presumed to participate in the plan for which he or she is paying.

6. Special 133% Rule for Highly Compensated. In addition, there is a special 133% rule which prevents an employer from disregarding highly compensated employees who may have signed a sworn statement. If any highly compensated employee receives an employer-provided benefit under all health plans of the employer which is more than 133% of the average employer-provided benefit under all such plans provided for the nonhighly compensated employees, the employer may not disregard such employees, their spouses or dependents. Further, that employer may not elect to apply the 75% Benefits Test separately with respect to coverage of spouses or dependents by such plans. §89(g)(2)(D) and §1.89(a)-1, Q&A-3(c)(5).

7. Other Ineligible Employees. If an employee is in a class of employees who are not eligible for the accident or health plan of this employer and that ineligible employee signs a sworn statement representing that he or she has coverage elsewhere or is single, then that employee can

be disregarded for purposes of the 75% Benefits Test or the 80% Coverage Test even though, if this employee lost that coverage or acquired a family, he or she would not be eligible for such coverage. S.M., p. 48.

8. Election in Writing. For purpose of the 80% Coverage Test and the 75% Benefits Test, the Regulations provide that an employer may elect in writing to test employee-only coverage separately from family-only (spouse and dependent) coverage. §1.89(a)-1, Q&A-3(c)(1).

9. Sampling. To aid in determining whether a plan is discriminatory, TAMRA (§89(g)(2)(B); S.M., p. 36-37) provides that statistically valid random sampling can be used for purposes of identifying the kinds of coverages available to the nonhighly compensated employees for testing purposes. To be valid, such sampling must be confirmed by an independent third person, and there must be a 95% probability that the results obtained will have a margin of error not greater than 3%. §1.89(a)-1, Q&A-5(d).

IV. EMPLOYEES INCLUDED

A. Common Law Employee.

"The term 'employee' generally means an individual who performs service for the employer maintaining the plan and who is...a common law employee of the employer...." §1.89(a)-1, Q&A-1(f)(6)(i).

B. Leased Employees. Leased employees are treated in the same

manner as employees of the employer for whom they perform services. The ERISA exemption with respect to individuals covered by a safe-harbor plans (§414(n)(5)) does not apply to §89 testing. §1.89(a)-1, Q&A-1(f)(6)(ii)(A); BB, p. 793. The rule of §414(n)(1)(B) permitting a recipient to take into account certain benefits provided by the lessor is available with respect to the benefits under §89. §1.89(a)-1, Q&A-1(f)(6)(ii)(A). However, the Regulations added a special rule with respect to leased employees:

Nevertheless, a leased employee may be disregarded by an employer-recipient when testing its health plans if the employer-recipient treats the health coverage received by the leased employee from the leasing organization as health coverage received from another employer and, on such basis, applies the rules of Q&A-3 (relating to sworn statement exclusions) of this section with respect to such leased employee. Notwithstanding the immediately preceding sentence, no leased employee described in this paragraph (f)(6)(ii) may be disregarded as having coverage from another employer unless the value of employer-provided core health benefits actually received by the leased employee from the leasing organization under its plan is at least 50 percent as valuable as the highest employer-provided core health benefit available to any highly compensated employee of the employer-recipient. §1.89(a)-1, Q&A-1(f)(6)(ii)(A).

C. Self-employed Individuals.

"Employee" means any self-employed individual, as defined in §401(c) (1). §89(j) (6)(A) and §1.89(a)-1, Q&A-1(f)(6)(i).

D. Sole Proprietor. An individual who owns the entire interest in an unincorporated trade or business shall be treated as his own employer. §89(j)(6)(B).

E. Partners. Each partner shall be treated as an employee of the partnership and the partnership as the employer. §89(j)(6)(B).

F. Other Employees. The term employee also means any "...individual who is treated as an employee with respect to the employer for purposes of the provision (e.g., section 106) that provides for the exclusion of the benefit being tested under section 89". §1.89(a)-1, Q&A-1(f)(6)(i).

V. HIGHLY COMPENSATED EMPLOYEES

Highly Compensated Employees.

(1) A highly compensated employee is an employee who, during the current year or in the preceding year, was (a) a 5% or more owner; (b) earned wages in excess of \$75,000 (1988: \$78,353; 1989: \$81,720); (c) earned wages in excess of \$50,000 (1988: \$52,235; 1989: \$54,480) and was in the top 20% of all employees based on wages; or (d) an officer with wages greater than \$45,000. In addition to these shortened definitions, §414(q) of the Internal Revenue Code and regulations thereunder provide more elaborate details. Section 414(q)(6)(A) and (B) attributes income earned by certain family members of the highly compensated employees to that highly paid employee. §414(q)(5) requires that at least 1 officer be taken into account, and that a maximum of 50 officers, but not less than the greater of 3 or 10% of the employees, shall be treated as officers.

TAMRA (§414(q)(12)) provides a simplified method for determining who is a highly compensated em-

ployee: an employer may elect during any year to reduce the amount in (b) from \$75,000 to \$50,000 and to ignore the application of paragraph (c) above.

TAMRA (S.M., p. 54) clarified the fact that the nondiscrimination rules of §89 do not apply if an employer has no nonhighly compensated employees. §89(j)(12).

VI. PLANS COVERED.

A. Plans Covered. All statutory fringe benefit plans, as defined in §89(i), are covered by §89. The general rule is that any plan which pays a non-taxable employer-provided benefit, is subject to the new qualification and nondiscrimination rules and a resultant tax in the event of failure to pass those tests. Specifically, both the qualification and nondiscrimination parts of §89 cover the following group plans providing employees with benefits that are tax-free under the Code sections indicated: group health or accident insurance, (§§105 and 106) including self-insured medical reimbursement plans; accidental death and dismemberment plans (§105); and group life insurance (§79) (although some special rules apply). In addition, the qualification rules of §89(k), but not the nondiscrimination rules of §89(a), also apply to: a qualified tuition reduction program (§117(d)); a cafeteria plan (§125(c)) (some special rules apply); fringe benefit programs providing no-additional-cost services (§132(b)); qualified employee discounts (§132(c)); employer operated eating facilities (§132(e)(2)); and plans to which §505 applies (voluntary employee's beneficiary associations ("VEBAs")); exempt organizations under §501(c)(9); and supplementary unemployment benefit funds under exempt §501(c)(17), even if maintained

Unless that status changes, educational assistance plans and group legal services plans are not subject to §89.

under a collective bargaining agreement. Some individual workers, disability compensation plans may be covered (See B., below). §1.89(k)-1, Q&A-2(b)(4). There is no exception if any of these plans are maintained by a multiemployer bargaining group. Such a plan is maintained by all of the contributing employers in that group. §1.89(k)-1, Q&A-2(e).

Under §89(i)(2), an employer may, at its option, elect to treat the following additional plans as statutory benefit plans for purposes of the nondiscrimination rules, but an election with respect to any one plan shall apply with respect to all plans of the same type as the elected plans: a qualified group legal services plan (§120(b)); a dependent care assistance program (§129(d)); and an educational assistance plan (§127(b)). (Note that with respect to an educational assistance plan and a group legal services plan, at the time of this writing, the exclusion from income for the employee-beneficiary have not been extended by TAMRA and, thus, there are no pre-tax benefits which are employer-provided. Unless that status changes, educational assistance plans and group legal services plans are not subject to §89.)

Plans which fail the various eligibility and coverage testing under §89(a), even if the entire value of the employer-provided coverage thereunder is treated as an excess benefit under §89(b), still must comply with the disclosure rules of §89(k). §1.89(k)-1, Q&A-2(g).

An accident and health plan maintained pursuant to a qualified pension or annuity plan under §401(h) is subject to the §89(k) qualification standards. §1.89(k)-1, Q&A-2(b)(5).

B. Plans Not Covered. Section 89 does not apply to plans that pro-

vide taxable benefits to employees, such as short or long-term disability plans or other wage continuation programs where the benefits paid to the employee are taxable and are included in his or her gross income and reported on Form W2 or 1099. Workers compensation plans maintained pursuant to state or federal laws, the benefits of which are excludable under §104(a)(1) of the Code, are not subject to the qualification rules of §89(k). However, accident and health plans maintained pursuant to state or federal laws, the benefits of which are excludable under §105(b) or (c) of the Code do not qualify as a workers compensation plans and they are subject to the qualification rules of §89(k). §1.89(k)-1, Q&A-2(b)(4). These would include payments for the loss of a bodily member or function which are computed without reference to the period of absence from work.

The only specific exception to §89 is for church plans as discussed above.

C. Separate Rules for Determining Value of Plans Subject to §89(k) and §89(a). §89(k): **Value of the Benefits.** Those plans which are subject to §89(k) have employer-provided "...benefits received by an individual that is attributable to employer contributions, including salary reduction contributions under a cafeteria plan." §1.89(k)-1, Q&A-1(b)(2). "Benefits" means "...those payments, reimbursements, products and services provided under the plan to a participant on account of such participant's claim, need or event that is covered under the plan. §1.89(k)-1, Q&A-1(b)(1). The plans subject to §89(k) are discussed at length at §1.89(k)-1, Q&A-2.

§89(a): Value of the Coverage. For plans which are subject to §89(a), the nondiscrimination rules, the employer-provided benefit is defined (§1.89(a)-1, Q&A-1(f)(3)) as the "value of the coverage" or "the value of the entitlement to receive payment" as a result of injury or sickness and not the value of the services or benefits received under the health plan. For group-term life insurance plans, the "value of the coverage" is the cost of the insurance determined under §79(c) assuming the employee is age 40. §89(g)(3)(C). Any death benefit paid under a life insurance plan is not included for purposes of the nondiscrimination testing. §1.89(a)-1, Q&A-1(a)(1). In the case of other plans, the "value of the coverage" is the value of the employer-provided benefits provided rather than the value of the coverage (i.e., the same definition as for the qualification rules, above). §1.89(a)-1, Q&A-1(f)(3).

VII. STEPS FOR QUALIFICATION: DESCRIPTION AND DISCLOSURE.

A. Requirements. In order to avoid the tax on the value of benefits of all the nonhighly and highly compensated employees, all of the fringe benefit plans subject to §89(k) need to be adequately described and disclosed to all employees. If a plan is not formalized in writing, either by a single document or by a collection of documents (as discussed below), then all of the employees covered by that plan, both nonhighly compensated and highly compensated alike, will have to pay the tax on the value of the benefits. This result will occur whether or not any of the plans pass the nondiscrimination testing. The plans subject to §89(k) are discussed at length at §1.89(k)-1; Q&A-2.

B. Section 89(k) Requirements.

Section 89(k)(1) requires that the gross income of any employee shall include an amount equal to the employer-provided benefit unless such plan meets the following criteria:

- (1) the plan is in writing;
- (2) the employee's rights under the plan are legally enforceable;
- (3) employees are provided reasonable notification of benefits available under the plan;
- (4) the plan is maintained for the exclusive benefit of employees; and
- (5) the plan was established with the intention of being maintained for an indefinite period of time.

The Regulations have significantly elaborated on each of these requirements. The earliest date for compliance relates to the reasonable notice provision in (C) which date has been delayed to July 1, 1989. The remaining four plan provisions have been delayed to the first day of the second plan year beginning after December 31, 1988.

C. Plans Covered. Those plans that are described in paragraph VI. A., above, are covered under the qualification rules of §89(k). The qualification rules have been broadened under the Regulations to include "...plans without regard to whether they are statutory employee benefit plans (as defined in §89(i)) subject to the nondiscrimination rules of section 89 and without regard to whether they are subject to Title I of ERISA." §1.89(k)-1, Q&A-2(a)(1). In addition, plans maintained by employee organizations as defined in §3(4) of ERISA or maintained pursuant to one or more collective bar-

One possible alternative discussed for an employer to avoid §89 altogether was for the employees to form a separate group receiving a group status from an insurance carrier and to pay for the premium cost in all after-tax employee payments.

gaining agreements also must meet the requirements of §89(k). §1.89(k)-1, Q&A-2(a)(2). Regardless of the employer's election to include the legal services plan, the educational or dependent care assistance programs as statutory employee benefits programs, as discussed in paragraph VI., above, these plans must comply with §89(k), provided that, for the group legal services and educational assistance programs, §§120 and 127, respectively, are in effect. §1.89(k)-1, Q&A-2(c).

One possible alternative discussed for an employer to avoid §89 altogether was for the employees to form a separate group receiving a group status from an insurance carrier and to pay for the premium cost in all after-tax employee payments. Aside from the practical matter of whether a carrier would agree to this arrangement, the §89(k) question was did such a plan have to comply with the qualification rules. The Regulations provided the answer: "...a plan 'maintained by an employer' (and subject to §89(k)) is any plan of, or subsidized by, an employer who employs participants in the plan. A plan is maintained by an employer even if the cost of such plan is borne by the employees (including their spouses and dependents) through after-tax employee contributions, as long as the value of the coverage under the plan for any employee is greater than such employee's after-tax contributions." §1.89(k)-1, Q&A-2(a)(2). This position is to forestall grossing up a highly compensated employee's pay and deeming that total compliance with §89. However, with respect to health plans, if the after-tax employee contributions equal or exceed the COBRA premium, under §4980B(f)(4), then that plan is not required to comply with §89(k). §1.89(k)-1, Q&A-

2(b)(1). With respect to group-term life insurance plans, a plan is subject to §89(k), if it is a plan described in the regulations under §79. §1.89(k)-1, Q&A-2(a)(1).

D. The Writing Requirement: §89(k)(1)(A); Transitional Rule. Under TAMRA, a plan is adequately described and disclosed under the provisions of subsection §89(k)(1)(A) (the "writing" requirement) with respect to any testing year if the provisions of the plan are contained in a single document, or a collection of documents, which meet the following criteria: (a) the plan is in writing before the close of such year; (b) the employees had reasonable notice of the plan's essential features on or before the beginning of such year; and (c) the provisions of the written plan apply for the entire year.

Delayed Effective Date. The Regulations delayed the effective date of the written documentation requirement beyond the TAMRA extension. This requirement now does not have to be met for plan years beginning in 1989. The effective date is, instead, the later of (1) the first day of the second plan year commencing after December 31, 1988 or (2) "...the day following the end of the 12-month period beginning on the first day of the first plan year in 1989 that the plan is subject to section 89." §1.89(k)-1, Q&A-3(d)(4).

Single Document. A "single written document" means one document containing all material terms of the plan which are either contained in one written instrument, or incorporated by reference, or incorporated using a combination of both methods. A single written document can incorporate by reference several written documents, and/or several different plans can be incorporated into a

single written instrument. The kinds of documents that can be incorporated by reference are a very wide variety of instruments, including insurance policies and contracts, collective bargaining agreements, third party interpretations of material terms relating to the plan and annual returns. §1.89(k)-1, Q&A-3(b)(1) and (2).

The single document must contain a recitation of the qualification requirements of §89(k)(1)(B) and (D) and any information that is required under any other provision of the law. §1.89(k)-1, Q&A-3(c)(2). The fact that the various plans are treated as separate plans under the principal of disaggregation does not require more than one "single written document" as discussed above. §1.89(a)-1, Q&A-4(a).

"Material Terms of The Plan" has the same meaning as the required contents of a summary plan description under ERISA. §1.89(k)-1, Q&A-3(c)(4) provides a nonexclusive list of requirements of the single document:

...the eligibility rules governing plan participation; terms relating to the periods during which coverage or benefits are provided; descriptions of available benefits; the procedures governing participants' elections under the plan, including the period during which an election may be made, the extent to which elections are irrevocable, and the periods with respect to which elections are effective; the manner in which employer contributions may be made under the plan, such as by salary reduction agreements between a participant and the employer and by nonelective employer contributions, as

well as any maximum limitation on employer contributions on behalf of any participant; terms relating to the timing or amount of salary reduction or employee contributions to the plan; terms relating to deductibles, co-payments or similar requirements, including any dollar limit on any benefit; conditions precedent or subsequent with regard to a participant's qualification or continued qualification for any coverage or benefit, including any limitations or restrictions relating to benefits, such as a pre-existing condition limitation; provisions relating to the procedure under which claims are to be made and evaluated for reimbursement; provisions relating to health continuation coverage under section 4980B; and the procedures or circumstances under which the plan may be terminated, including a statement, if applicable, that the plan may be terminated at will by the employer.

At the ABA meeting of the Employee Benefits Section of the Section on Taxation held in Toronto in August 1988, an IRS representative addressed the disclosure requirements. The following suggestions made at that meeting have not been included in the Regulations. At that time, the IRS suggested that a description of the plan benefits should contain the following: a provision that ERISA and §89 prevail over inconsistent or conflicting insurance contract language; an identification of fiduciaries or trustees and an allocation of responsibility among them; an identification of the payment procedures; language that ERISA and §89 preempt state laws; and an "anti-alienation" provision.

TAMRA adds the concepts of "testing year" and "testing day"; §89(g)(6)(D)(i) specifically provides for the designation of a testing day in the plan. Nevertheless, the Regulations specifically provide that the testing day need not be specified in the §89(k) single written plan document, even though the testing day election must be made in writing. §1.89(a)-1, Q&A-5(c). This election, along with many other elections relating to nondiscrimination testing, "must be written in a manner that will allow a reconstruction of the employer's method of testing." §1.89(a)-1, Q&A-1(g). In the event the employer fails to designate a testing day, it is the last day of the testing year. §89(g)(6)(D)(ii). Thus, under the Regulations, the elections relating to testing, while they must be in writing, are not subject to §89(k).

Modifications, amendments or extensions to the material terms of the plans also must be in writing prior to the effective date of the change. §1.89(k)-1, Q&A-3(d)(1). However, if a change has a de minimus impact on the eligible individuals, is nonmaterial, or is simply a clarification, then the written plan amendment does not have to be made until 120 days following the effective date of the change. Retroactive modifications of material terms of plans which expand coverage, which will last 12 or more months, which are nondiscriminatory and notice of which is provided to those eligible, are permitted so long as these and certain other conditions are met. §1.89(k)-1, Q&A-3(d)(2)(iii).

E. Legal Enforceability: §89(k)(1)(B). "A plan is considered legally enforceable only if the conditions required for an employee to participate, receive coverage and obtain a benefit are

definitely determinable under the terms of the plan and an employee satisfying such conditions is able to compel such participation, coverage and benefit." §1.89(k)-1, Q&A-4(a).

Employer Discretion. The exercise of some types of discretion by the employer, plan administrator, fiduciary, actuary or third party administrator will cause the plan to fail this requirement. Some examples of this kind of discretion are as follows: employer discretion regarding the right of an employee to participate in the plan, and the waiver of one of the written conditions of the plan or the imposition of a condition that is not contained in the written documentation. Moreover, if the plan contains unclear objective conditions for participation which are within the control of the employer, then that is impermissible discretion. §1.89(k)-1, Q&A-4(b). However, if the written plan instrument contains objective conditions relative to the administration of the plan or clear objective conditions for participation, or if discretion is exercised based on medical opinions, that is permissible. §1.89(k)-1, Q&A-4(b)(2). The Regulations define what is and what is not the permissible exercise of discretion by an employer. §1.89(k)-1, Q&A-4(b)(2)(i)-(iv).

Delayed Effective Date. The Regulations have provided a delayed effective date for this provision, i.e., the first day of the second plan year beginning after December 31, 1988. §1.89(k)-1, Q&A-4(e).

F. Reasonable Notification: §89(k)(1)(C). The employer, or the plan administrator under a multiemployer plan, has the obligation to provide the notice required under §89(k)(1)(C). The employees who are eligible to receive the benefits under the plans, not

their spouses or dependents or others who derive their coverage from the employee, are the persons entitled to the notice. The notice is mandatory even though any election, waiting period or service prerequisite has not been completed. The notice requirement applies to all former employees and qualified beneficiaries entitled to continue health coverage as determined under COBRA. §1.89(k)-1, Q&A-5(a).

1. Contents of the Notice.

The notice must summarize fairly the material terms of the plan which are significant to the employee. The terms of the notice are to include at least the following:

...a general description of who is eligible to participate in the plan; a general description of the coverage or coverages offered (including the general types of benefits provided under the plan, basic limitations on such benefits, and required deductibles and co-payments); the timing and method of any election to participate; the cost to the employee relating to the plan, whether by way of salary reduction or employee contributions; the method by which a copy of the plan may be obtained; and the name and means of contacting a person from whom to request further information about the plan. §1.89(k)-1, Q&A-5(b).

Dependent Care Assistance programs have additional content requirements, relating to the §21 dependent care credit, under §1.89(k)-1, Q&A-5(d), beginning with plan years after 1989.

The notice must state that the single written plan document is available to all eligible employees for inspection, at no cost, and that copying, at the permitted cost, is available upon reasonable notice. §1.89(k)-1, Q&A-5(e).

2. Method of Notification. Although the employer has the primary obligation to provide the notice, the duty can be satisfied if an otherwise adequate notice is provided by an insurance company, health maintenance organization or other health care entity. Notice must be made in conformity with all material aspects of 29 CFR §2520.104b-1(b)(1). This notice must be provided to each eligible employee either by hand or by mail with first class postage prepaid to the last known address of that person. §1.89(k)-1; Q&A-5(f).

3. Alternative Form of Compliance. Alternatively, an employer may furnish each eligible employee with the single written document and any documents incorporated by reference (see the discussion, above, titled "Single Document") so long as these documents comply in all material respects with the rules for a summary plan description of 29 CFR §2520.102-2. §1.89(k)-1, Q&A-5(c). This alternative form of compliance is not permitted for an accident or health plan.

4. Timing of the Notice. These rules are similar to those of the written plan requirements discussed above and require this notice to be given prior to the first day on which coverage is provided, or a modification of the coverage is made, or benefits or a modification of the benefits are made available to an employee. The latest time permitted for the notice is no later than a "...reasonable time prior to

the availability of any election with respect to participation under such plan." §1.89(k)-1, Q&A-5(g)(1). If there are material modifications to the terms of the plan, then the notice shall be given, as required, not later than 60 days following the effective date of the modification. §1.89(k)-1, Q&A-5(g)(2).

In the event that the employee is a new hire who will be covered by the plan within the first 60 days of employment and participation in the plan is not determined by an employee election, then the employer has 60 days following that employee's commencement of employment to provide the notice. §1.89(k)-1, Q&A-5(g)(3).

5. Delayed Effective Date: July 1, 1989. The Regulations have provided a delayed effective date for this notice provision: for plans with an effective date for §89 purposes on or after January 1, 1989 and prior to July 1, 1989, the effective date of the requirements for reasonable notification of the essential features of the plan is July 1, 1989. For plans with the first day of the first plan year beginning after July 1, 1989, the effective date is the first day of the plan year. §1.89(k)-1, Q&A-5(g)(4).

G. Exclusive Benefit: §89(k)(1)(D). The employer must maintain the plan for the exclusive benefit of those employees who participate in the plan. This is a facts and circumstances test and a plan can fail this requirement based on the terms or operation of the plan. §1.89(k)-1, Q&A-6(a). This requirement is not violated if the plan is maintained under a multiple employer plan or a multiemployer plan maintained by two or more employers or includes employees of unions or of the plan itself. §1.89(k)-1, Q&A-6(c).

1. Deemed Employee-Participants. If all of the participants in the plan are the common law employees of the employer or employers maintaining the plan, then the exclusive benefit requirement will be met. "In the case of a voluntary employees' beneficiary association described in section 501(c)(9) (VEBA) that is part of a plan which must satisfy the requirements of section 89(k)(1)(D), those individuals who may participate in the plan include those who may be members of the VEBA under section 1.501(c)(9)-2(a)." §1.89(k)-1, Q&A-6(b)(1). In addition, COBRA recipients and other qualified beneficiaries are deemed to be employees for purposes of this rule. Moreover, other persons who are not employees but who are nevertheless able to exclude from income the benefits provided under §§79, 105, 106, 129 and 132, are deemed to be employees of the employer. §1.89(k)-1, Q&A-6(b)(2). Self-employed individuals are deemed to be employees under this rule. §1.89(k)-1, Q&A-6(b)(3)(ii).

Some examples of benefits which do not violate the exclusive benefit provisions are provided in the Regulations, and include the use of air transportation by an employee's parent; dependent coverage under a medical plan; an independent contractor with continuation coverage; a full-time life insurance salesman; a former employee; and a leased employee. §1.89(k)-1, Q&A-6(b)(4).

2. Non-employee Participants; Disregarded. Certain

persons who are covered under the plan, who are not common law employees of the employer, but who perform significant services for the employer and who pay for all of their benefits with after-tax contributions, may be disregarded for purposes of determining a violation of this provision. §1.89(k)-1, Q&A-6(b)(3).

3. Delayed Effective Date.

The Regulations have provided a delayed effective date for this provision. It is the first day of the second plan year beginning after December 31, 1988. §1.89(k)-1, Q&A-6(f).

H. Indefinite Period of Time:

§89(k)(1)(E). The employer must establish the plan with the intention that it be maintained for an indefinite period of time. As with the exclusive benefit rule, this is a facts and circumstances test. A plan generally will meet the requirement if it is established and maintained for at least a consecutive 12-month period even if the employer intends to terminate the plan after the 12-month period. §1.89(k)-1, Q&A-7(a) and (b)(2). The right to modify or terminate the plan, the failure to renew, or the termination of a plan does not violate this provision. Further, the change of an insurance carrier or health care provider does not cause the plan to fail this condition if the benefits are not substantially modified. However, a presumption can be created that a plan was not established with the requisite intention if, under certain (unspecified) circumstances, there are significant modifications in coverage or benefits or a termination of coverage or benefits. §1.89(k)-1, Q&A-7(b)(1).

Special Scrutiny Delayed until January 1, 1990. For plan years beginning on and after January 1, 1990, any material modifications and terminations made to a plan that has been in effect for less than 12 consecutive months will receive "special scrutiny." "Special scrutiny" is not defined. When there is demonstration of a substantial business reason, such as a merger and consolidation or advance notice that plan benefits will terminate within one year, then there will be a sufficient demonstration to satisfy the facts and circumstances test, provided the modification or termination does not discriminate in favor of highly compensated employees. §1.89(k)-1, Q&A-7(b)(3).

This rule does not apply to plans providing no-additional cost services or to any plans providing qualified employee discounts. §1.89(k)-1, Q&A-7(d).

I. Sanctions. "If a plan subject to section 89(k) fails to satisfy any of the requirements of that section, the employer-provided benefits under the plan generally are not eligible for any exclusion from gross income under ... the Code." §1.89(k)-1, Q&A-8(a)(1).

The Regulations have provided the necessary clarification to the §89 sanctions. In introducing some of the changes, Mr. James J. McGovern, of the Office Of Chief Counsel in his remarks of March 2, 1989, stated:

You may have heard the story about the janitor who just underwent major heart surgery. The good news is that he passed the medical ordeal with flying colors. The bad news is that his employer failed the section 89 qualification rules, and thus the janitor will have \$150,000 included in his income. That result is not

The §89 penalty provisions apply only to the employer-provided benefit, assuming the plans were non-discriminatory when the benefits were received.

reached under these regulations.

The §89 penalty provisions apply only to the employer-provided benefit, assuming the plans were nondiscriminatory when the benefits were received. The §89(k) sanctions do not apply to the insurance reimbursements, or life insurance benefits received. This result is accomplished through the definition of employer-provided benefit. (Note that employee-provided benefits are not subject to §89(k). §1.89(k)-1, Q&A-8(a)(2).) The definition of employer-provided benefit for §89(k) purposes is different than the definition of employer-provided benefit for §89(a) nondiscrimination rules (which is the value of the coverage for medical and group-term life insurance plans). §1.89(a)-1, Q&A-1(f)(3). Here, benefit means the value of the payments, reimbursements, services and products provided under the plan to a participant stemming from a covered claim, less any amount paid by the employee. §1.89(k)-1, Q&A-8(c)(1). (Note that this method of valuation is the same as the §89(a) rules for statutory benefit plans other than accident and health and group-term life insurance plans.) More specifically, "employer-provided benefit" means that portion of the benefits received by an individual that is attributable to employer contributions, including elective salary reduction contributions under a cafeteria plan which otherwise would be taxable. §1.89(k)-1, Q&A-1(b)(1) and (2). (See also the discussion of the difference in the definition of benefits under paragraph VI.C., above.)

Some examples provided in the Regulations are the reimbursement of a covered participant's deductible portion of a hospital bill, the fair market value of the participant's use of an on-site child

care facility under a dependent care program, and the payment of a "death benefit under a group-term life insurance plan to which §79 applies." *Id.* That last quotation seems to conflict with the statement of Mr. McGovern set forth above. However, the definition of employer-provided benefit suggests that the benefit subject to the tax for failure to qualify under §89(k) is that amount attributable to employer contributions rather than the \$10,000 death benefit. The author hopes that is the intended result, but the language does not clearly support that proposition.

1. Amount of Nonexcludable Excess Benefit. The amount of the excess benefit, or the now "nonexcludable" benefit for failure of a plan to qualify, is based upon the plan year as determined under §1.89(a)-1, Q&A-10(b), not the testing year. §1.89(k)-1, Q&A-8(c). The amount of the nonexcludable benefits received by the employee will include all of the benefits received under the plan, subject to new limitations.

The excess benefits as calculated under the non-discrimination rules of §89(b) are treated as employer-provided benefits for a plan which also violates §89(k). The employee is taxed on the greater of the §89(b) excess benefit or the §89(k) nonexcludable amount. §1.89(k)-1, Q&A-8(e)(2).

2. De Minimis Failure; Writing and Reasonable Notice; §89(k)(1)(A) and (D). If a plan fails to meet the writing and reasonable notice requirements, if the employer's failure was in good faith, if the employer made a

reasonable effort to comply, if the failure is corrected by the employer within 90 days after learning of the failure without reducing the coverage retroactively, and if the defect did not have the effect of discrimination in favor of the highly compensated employees, then the plan will be deemed to have complied with §89(k).

§1.89(k)-1 Q&A-8(b). The term "corrected" has a special meaning: "...that the employer performs all the necessary acts in order to comply with section 89(k) and places the affected employees in a financial position not worse than that in which they would have been if the employer had been in full compliance with section 89(k)." §1.89(k)-1, Q&A-8(b)(3).

Partial Failures. In the event that a portion of a plan fails to qualify under §89(k), the Regulations permit that aspect of the failed plan to be treated as a separate plan for purposes of the inclusion in income relating to that failed portion. The remainder of the plan can continue to be treated as qualified. §1.89(k)-1, Q&A-8(c)(2)(ii).

3. Limitation on Nonexcludable Amount. The amount that must be included in income for a plan that fails §89(k) is limited to the sum of: 10 percent of the first \$50,000 of the employee's compensation; 25 percent for compensation between \$50,000 and \$100,000; 75 percent for amounts between \$100,000 and \$150,000; and 100 percent of the compensation in excess of \$150,000. §1.89(k)-1, Q&A-8(c)(4).

The \$50,000, \$100,000 and \$150,000 amounts are expressed in percentages of the dollar amount specified in §414(q)(1)(C) and are indexed for inflation.

4. Special Rules for Coordination of Amounts. The Regulations provide for the method and order in which to calculate the amounts to be reported on the Form W-2 of the failed plan participants. §1.89(k)-1, Q&A-8(c)(4), (d), (e) and (f).

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FOOTNOTES

1 Public Law 99-514.

2 Public Law 100-647.

3 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272.

SWORN STATEMENT

EMPLOYEE'S ELECTION OF ALTERNATE MEDICAL COVERAGE FROM ANOTHER EMPLOYER

EMPLOYER-COMPANY NAME: _____

DATE FORM COMPLETED: _____

1. Employee's Name: _____

Address: _____

City: _____

D.O.B.: _____

Marital status: Single Married

2. List all Dependents of the Employee including Spouse, children and other dependents, if none, state none:

Name of Dependent	D.O.B.	Relationship	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. I have accident and health insurance coverage provided by my Employer named above for the following persons:

- (a) Employee Only: Yes No
- (b) Employee-Spouse: Yes No
- (c) E-ee+Spouse+Dep: Yes No
- (d) Spouse Only: Yes No
- (e) Dependent Only: Yes No

4. I have accident and health insurance coverage provided by ANOTHER EMPLOYER for the following persons:

Yes, I have other coverage: No, I don't:

If yes, indicate those persons covered by this insurance:

- | | | |
|----------------------|------------------------------|-----------------------------|
| (a) Employee Only: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Employee+Spouse: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) E-ee+Spouse+Dep: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Spouse Only: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Dependent Only: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

5. Name of other Employer under whose plan this employee is covered:

(a) Other Employer's Name: _____

Address: _____

City: _____

(b) Policy Number: _____

(c) Identify the other coverage of this Employee:

(i) Other Insurer's Name: _____

(ii) Type of other group insurance coverage provided:

Accident/Health: Yes No

(d) Identify the person through whom you receive the other insurance:

(i) Spouse of Employee: Yes No

(ii) Other dependent of the Employee:

(Specify) _____

Under penalties of perjury, I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct, and complete. I will notify my Employer at once if any of this information changes and will provide any information that has changed. I understand that evidence of insurability may be required in order to be covered under the plan of the employer.

Witness:

Employee's Signature

Dated: _____

**Matt W. Zeigler
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SECTION 89

INTERNAL REVENUE CODE

TAX ON EMPLOYEE FRINGE BENEFITS

PART II

By: Matt W. Zeigler, Esq.

Unpublished

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TAX ON EMPLOYEE FRINGE BENEFITS

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SECTION 89 INTERNAL REVENUE CODE

TAXATION OF EMPLOYEE FRINGE BENEFITS

By Matt W. Zeigler

SECTION 89 NEWS.

On Monday, May 1, 1989, in a speech before the U. S. Chamber of Commerce, Secretary Brady announced that he had ordered a delay from July 1 to October 1, 1989 in the beginning date for testing plans for compliance with Section 89 regulations. Further he said: "The cost of compliance with Section 89, as it presently stands, is excessive. The law needs to be changed, and we stand ready to encourage, support and work with Congress to revise and improve it".

The Treasury Department has issued a clarifying Notice 89-65, scheduled for publication June 12, 1989, which has officially delayed compliance for both the nondiscrimination testing and the written reasonable notification rules of Section 89 from July 1, 1989 until October 1, 1989. Treasury stated that this announcement may be relied on until final Regulations are published. Under the law up until July 1, 1989, and now through October 1, 1989, Employers can essentially ignore the facts in existence up to that time under special rules set out in the proposed Regulations for Section 89.

There has been no fewer than thirteen proposals made before Congress that would impact on section 89. The two most prominent ones, the House and Senate Simplification Bills, keep all of the qualification/disclosure rules of §89(k) in place and also keep the present law in effect as an optional form of compliance (assuming a bill is passed this year). It should be an interesting year.

PART II

This is Part II of a monograph on Section 89. Part I was published in the 1989 First Quarter issue of the Michigan Tax Lawyer and dealt with the qualification issues and the definitions under Section 89 ("§89"). Those definitions will be used here as described in Part I.

This Part will address plan aggregation, comparability rules, testing periods and dates as well as the nondiscrimination rules and the various tests. Since the rules which apply to the tests are contained in several pieces of legislative history as well as the Proposed Regulations (54 CFR 9460) (the "Regulations"), what is presented here is all of the principles relating to each test gathered and organized by test.

VIII. PLAN

A. Definition Of Plan. The effect of §89 on the definition of a plan is disaggregation. In the past, a plan was considered a single plan with multiple options, §89(j)(11) now makes each difference under a plan a different "plan".

Under the Act, each option or different benefit offered is, except in the two instances described in 'Single plan' below, treated as a separate plan. This means, for example, that if two types of insurance coverage vary in any way

(including the amount of the employee contribution), they will be considered separate plans. Thus, in the case of health plans under which there are different levels or types of coverage, each separate level or type of health coverage is considered a separate plan under the nondiscrimination rules. (Blue Book ("BB") p. 785)

Under these rules for example, each health maintenance organization is considered a separate plan because of the different providers of services. If an employee and his family is covered by a plan, he is treated as if he has two separate plans: one, individual coverage for himself, and two, family coverage with respect to his family. If an employer offers health insurance for an employee and 1 family member, and employee and 2 or more family members, there are 3 plans: (1) employee only coverage; (2) coverage of 1 family member; and (3) coverage of additional family members.

Cafeteria Plans or Flexible Spending Arrangements. Under cafeteria or flexible spending arrangements, "Each different amount by which an employee may elect to reduce his or her salary for a year is a separate health plan under the FSA (flexible spending arrangement)". §1.89(a), Q&A-7(f).

The Secretary of the Treasury is to address the problems created in the event there are overlapping coverages and an employee is considered only partially eligible or covered by both plans. The Blue Book (p. 787) discusses this problem: for employees who are eligible for or who receive coverage under more than one accident or health plan, then, "...for purposes of the 50-percent test and the 80-percent test, such plans are to be considered one plan with respect to such employee.

B. Two Exceptions. 1. Group Term Life Insurance. For purposes of testing group-term life insurance plans, each different option of treated as a separate plan. However there are two exceptions to this rule. (a) Any group-term life insurance plan will not be treated as two or more plans merely because the amount of life insurance under the plan on behalf of employees bears a uniform relationship to the compensation of such employees. §89(j)(4)(A). However, if there is life insurance based upon a multiple of compensation and there is compensation over \$200,000, then the employer-provided life insurance over that limit is considered a separate plan. §89(j)(4)(B). (b) Similarly, any group-term life insurance plan will not be treated as two or more plans merely because required employee contributions vary according to the age of the employee, but only up to a specified limit (e.g., the employee's cost may not exceed \$X per \$1,000 of coverage). Moreover, the use of age brackets of up to five years with increasing employee contributions corresponding to each age bracket will not require separate plan treatment. S.M., p. 62. However, there is a limitation under §89(j)(4)(C) which states that this exception to the disaggregation of group-term life insurance plans does not apply if the life insurance plan is aggregated with plans of other types for purposes of the 75 Percent Benefits Test.

2. Proportionate Reduction of Part-time Benefits. Health and accident plans will continue to be treated as a single plan if the employer-provided benefit is proportionately reduced for employees

who normally work less than thirty (30) hours per week and the plans are identical. This applies to the 75% Benefits Test and the 50% component of the 90%/50% Test. This proportionate reduction in benefits has two levels: the first level is for those part-time employees who work more than 22 1/2 hours per week but less than 30 hours per week, here the permissible reduction is 25%; and the second level is for those part-time employees who work more than 17 1/2 hours per week but less than 22 1/2 hours per week, there the permissible reduction is 50%. The 50% reduction is to be applied to all employees on a uniform and nondiscriminatory basis. BB p. 786.

Benefits provided under a core accident or health plan may be considered provided under a separate plan from noncore benefits for purposes of the initial service rules (six months or one year). BB, p. 799.

TAMRA¹ modified the definition of plan. (See TAMRA Statement of Managers ("S.M.")², §§cc, p.70.) A plan is not a separate plan merely because an option is valued separately, but the "...effect of these changes is only one of terminology rather than of substance". For purposes of the nondiscrimination rules, there is no modification of the concept of disaggregation of plans for the testing purposes.

Thus, each plan, unless it falls within the general comparability range of another plan (discussed below), has to be tested separately for purposes of the 80% Coverage Test, the 50% Test, the Alternative (50%) Eligibility Percentage Test, the 90% component of the 90%/50% Test; however, all of the plans of the same type, i.e. deductible under the same Internal Revenue Code (the "Code") section have to be aggregated for purposes of the 50% component of the 90%/50% Test and the 75% Benefits Test. (BB., p. 785) The Regulations have provided no relief from this principle of disaggregation. So, unless the various plans may be aggregated under the comparability rules, the plans are to be tested separately. §1.89(a)-1, Q&A-4(a).

Presumption of Coverage For Family Plan. There is a presumption, under §89(g)(2)(C), that all single nonhighly compensated employees of an employer who are or would be eligible to participate in an accident or health plan, under the §89 eligibility rules, have a spouse or dependents not covered by such a plan of another employer. This presumption applies for purposes of the 80% test only. In order to defeat this presumption of family coverage, it is necessary to obtain and maintain adequate sworn statements which will demonstrate an employee's single status or that he or she has core benefits under a plan of another employer. This is the rule for noncontributory plans or for plans with the same level of employee contributions regardless of whether or not an employee elects single or family coverage under the plan. S.M., p. 48. (There is appended to Part I a form of Sworn Statement for use in identifying single or married employees for proper determination under the proper plan.) (Under §89(g)(2)(C), there is an opposite presumption for highly compensated employees. See discussion in Part I, p. 37.)

In the event that an employer has a contributory plan, and there are different levels of employee contributions depending upon the employee's election of single or family coverage or another family-type option under the plan, then the employee will be deemed covered by the plan for which he makes designated level of contribution. Also, if an employee who has a spouse and/or dependents is required to make a contribution to a health plan in order to receive family coverage, and is not required to make a contribution in order to receive single coverage, and this employee does not make the contribution, then he will be presumed to be covered by the single plan. S.M., p. 49.

The Sworn Statement may be used to defeat the presumption of family coverage when, for example, an employee has elected single coverage under an accident or health plan and has a family. Such an employee is appropriately considered under this employer's plans as a single person. (See discussion in Part I, p. 34 et. seq.)

IX. AGGREGATION OF PLANS

A. Aggregation of accident or health plans. Accident or health plans that are "helper plans" may be aggregated with one or more other "non-helper plans" accident or health plans if they meet the comparability rules. This is true so long as those other accident or health plans ("helper plans") are not aggregated with other non-helper plans. The Blue Book defines "helper" and "nonhelper" plans" at page 787:

A "Helper" plan, of one or more accident or health plans is:

any plan in the group of aggregated plans that satisfies the 50-percent test without regard to aggregation.

A "Nonhelper" plan, of one or more accident or health plans, is:

any plan in the group of aggregated plans that separately do not satisfy the 50-percent test.

These aggregation rules are applicable for purposes of the all of the plans of the same type, i.e. deductible under the same Code section. BB, p. 799. Further, all plans have to be must be aggregated for purposes of the 50% component of the 90%/50% Test and the 75% Benefits Test; i.e. the plan disaggregation rules do not apply to these two tests. BB., p. 785.

B. Mandatory Aggregation of Plans:

Treasury rules may require that if participants are provided benefits by more than one (1) plan, those plans will be required to be aggregated with respect to that employee. 89(g)(1)(C).

The Treasury rules have been published and they do require aggregation.

1. Coverage Under Two or More Health Plans. If an employee is eligible for or receives coverage under two or more accident or health plans, then, for purposes of the 50% Eligibility Test and the 80% Coverage Test, such plans must be considered a single plan for that employee. BB, p. 787. These mandatory aggregation rules must be applied prior to the application of the comparability rules, below.

Such health plans must be aggregated into an additional, single health plan that provides all of the coverage that is provided under any of the separate plans. The additional plan is treated as having an employer-provided benefit equal to the sum of the employer-provided benefits of each of the included plans (with an appropriate adjustment to eliminate the multiple inclusion of overlapping coverage). A nonhighly compensated employee is treated as eligible for both the additional plan and the separate plans. A highly compensated employee is treated as eligible only for the additional plan and is no longer treated as eligible for the separate plans. §1.89(a)-1, Q&A-4(e)(1).

2. Exception: If 90% Eligible and 80% Covered. These mandatory aggregation rules does not apply "... with respect to two or more health plans if at least 90 percent of the nonhighly compensated employees eligible for coverage under each plan are eligible for coverage under all of such plans on the same terms and conditions as other employees, and each plan (prior to application of the comparability rules of paragraph (c) of this Q&A-4) satisfies the 80 percent coverage test". §1.89(a)-1, Q&A-4(e)(2).

3. Examples. Comprehensive examples of the application of these rules are given at §1.89(a)-1, Q&A-4(e)(3).

4. Permissive Plan Restructuring. For purposes of the 80% Coverage Test and the 50% Eligibility Test, the Regulations permit an employer to restructure two or more of its health plans on the basis of the value of the coverages provided. This permits a lowering of the value only, not the number of plans, to the lowest level of difference under the several plans. Any permissive plan restructuring may only be applied to a plan after the mandatory aggregation and plan comparability rules have been applied. For example, the following plans may be restructured as follows: Plan 1, \$7,000; Plan 2, \$5,000; Plan 3, \$4,000. Restructured they are: Plan 1, \$4,000; Plan 2, \$2,000; Plan 3, \$1,000. In essence, a common benefit level (\$3,000) has been eliminated leaving only the minimum differentials between the plans. §1.89(a)-1, Q&A-4(f). Since the differences are maintained, there would be no change in the amount of the excess benefit and the resultant tax to be paid.

C. Permissive Aggregation Of Plans. For purposes of the 75% Benefits Test, an employer may aggregate certain plans to aid the group to pass this test. However, some kinds of aggregation are not permissible. In short, the rule is that a health plan can help a non-health plan pass the 75% Benefits Test, but non-health plans cannot help a health plan pass this test. S.M., p. 44-45.

X. GENERAL COMPARABILITY RULES

Since each option as to coverage, cost, co-pay amounts or different benefit level or entitlement is treated as a separate plan for testing purposes, §89 has provided plan comparability rules that permit plans of differing values to be tested as a single plan. These plan comparability rules and the concepts of disaggregation and aggregation apply solely for the purposes of testing the plans for compliance with the nondiscrimination rules and the determination of the excess benefits which are then subject to taxation. These rules do not create new or additional plans that must separately pass the written plan qualification rules. §1.89(a)-1, Q&A-4(a).

The concept of comparability of the plans is set out in the Blue Book, at page 787, and refined in the Regulations:

A group of plans is comparable if the smallest employer-provided benefit available to any employee in any plan in the group is at least 95 percent of the largest employer-provided benefit available to any employee in any plan in the group." (See the mandatory aggregation rules that may be applicable before the application of this paragraph. §1.89(a)-1, Q&A-4(b).

Each separate, disaggregated plan must be valued separately and must satisfy the 50% Eligibility Test and the 80% Coverage Test. BB, p. 785. However, passing either of the longer or shorter routes through §89, discussed below, will be sufficient demonstrated compliance.

Temporary Valuation Rule: Value may be determined under the COBRA rules (§4980B(f)(4)) of the 1986 Code, as amended by TAMRA, or any other reasonable method selected by the employer. TAMRA §3021(c). See discussion of value of plans below, at XI.

A. 50% Test; 95% Comparability Standard. For purposes of this test, one or more accident or health "nonhelper" plans may be aggregated with one or more comparable "helper" plans that are not aggregated with other "nonhelper" plans for this purpose. The 95% comparability standard set out at §89(g)(1)(B), but quoted above, is used for purposes of this test.

If a plan fails the 50% Eligibility Test, then its ability to be aggregated with other comparable plans is restricted. Such a failing plan cannot be included with any other plan in a group of comparable plans under paragraphs 2 or 3, below, unless both of the following two requirements are met: (1) the failed plan has a comparable value within the 95 percent comparability range and, (2) the failed plan and the group of comparable plans, considered together, must be comparable using either the 90% or the 80% comparability standards discussed below. §1.89(a)-1, Q&A-4(c)(3).

B. 80% Coverage Test; 90% Comparability Rule. For purposes of this test, one or more accident or health "nonhelper" plans may be aggregated with one or more comparable "helper" plans that are not aggregated with other "nonhelper" plans for this purpose. A group of plans is comparable and may be aggregated with other plans of the same type using a 90 percent comparability standard. (See the mandatory

aggregation rules that may be applicable before the application of this paragraph.) §1.89(a)-1, Q&A-4(c). S.M., p. 40. See the Deemed Comparability discussion below.

C. Alternate 80% Test: 90% Coverage Test; 80% Comparability Rule.

At the employer's written election, a group of plans is comparable and may be aggregated with other plans of the same type using a 90 percent comparability standard. This rule is available only if the employer applies the requirements of §89(f) by substituting 90 percent for 80 percent. Thus, this alternative general comparability rule applies only if at least 90 percent of the nonhighly compensated employees are covered under the health plan or group of comparable plans being tested. §89(g) (1) (D) (ii). §1.89(a)-1, Q&A-4(c) (2).

D. Plans Outside the General Comparability Range; "Deemed Comparability".

1. A Plan with a greater value. If a plan, or group of plans, has an employer-provided value that is outside the general comparability range, then that plan, or group of plans, may be aggregated with plans of a lesser value if nonhighly compensated coverage percentage is at least 80 percent (or, if elected, 90%) of the highly compensated coverage percentage. (S.M., p. 40). The Regulations further refined this concept to permit aggregation of such plans as being "deemed comparable" if (a) the plan with the larger value replaces a former plan with a lesser value; (b) the former health plan's nonhighly compensated coverage percentage is at least 80 percent (or, if elected, 90%) of the highly compensated coverage percentage; and, (c) after the inclusion of the former plan in a group with the latter plan, the nonhighly compensated coverage percentage remains at least 80 percent (or, if elected, 90%) of the highly compensated coverage percentage for such group. §1.89(a)-1, Q&A-4(c) (4). These coverage percentages are determined "...dividing the number of nonhighly compensated employees covered by the plan (or the group) by the total number of nonhighly compensated employees of the employer". The highly compensated coverage percentage is determined in the same manner. §1.89(a)-1, Q&A-4(c) (4) (ii).

These general comparability standards are enlarged for purposes of this 80-percent coverage test to permit more valuable plans to be aggregated with a group of less valuable plans if a plan of greater value than permitted by the 95 percent comparability standard satisfies the alternative 50 percent eligibility percentage test under §89(d) (2) based on actual coverage (like the 80 percent coverage test) rather than on eligibility. BB, p. 787. Presumably, the 95 percent standard would be reduced to 90 percent under TAMRA. This Deemed Comparability provision could be used when there is a substitution of plans and there is a high percentage of persons participating in the plans.

2. A Plan with a lesser value. No plan can be "deemed comparable" if it has an employer-provided benefit smaller than the employer-provided benefit of the other plan if the other plan has previously been included in the group of comparable plans under the general comparability rules. §1.89(a)-1, Q&A-4(c) (4). However, if the plan of lesser value has not been included in a comparable group, then, if the same coverage percentages are met (as discussed in (i) immediately above), then the plan of lesser

value can be "deemed comparable" and included with the other plan to form a group of plans. §1.89(a)-1, Q&A-4(c)(4)(iii).

The concept of comparability will permit plans to be comparable with respect to the special rule for part-time employees outlined above. Plans may be considered comparable if the only fact which prohibits the comparability standard from being met is the fact that benefits are proportionately reduced for part-time employees working less than 30 hours per week. BB, p.788.

E. Comparability Safe Harbor; Employee Cost \$100 Or Less. §89(g)(1)(D)(i)(II) provides that

A group of plans shall be treated as comparable with respect to a group of employees if (I) such plans are available to all employees in the group on the same terms, and (II) the difference in annual cost to employees between the plans with the lowest and highest annual employee cost is not greater than \$100.

The \$100 is adjusted for testing years beginning after 1989 in accordance with the consumer price index. §89(g)(1)(E)(v); §1.89(a)-1, Q&A-4(c)(4). The term "employee cost" is specifically defined to include after-tax employee contributions and salary reduction amounts under a cafeteria plan, and they are applied cumulatively. §1.89(a)-1, Q&A-4(c)(5)(vi).

The Regulations have broadened the narrow applicability of this rule to include situations where an employee, at his or her option, is eligible to participate in one of several plans each with different plan values and/or differing employee deductibles. The rules under which plans not otherwise comparable may nevertheless be aggregated under this safe harbor are at §1.89(a)-1, Q&A-4(c)(5)(i)-(iii).

XI. EMPLOYER-PROVIDED VALUE: VALUE OF BENEFIT:

A. Accident or health plan. The "...employee's employer-provided benefit is the value of the coverage provided to or on behalf of such employee, to the extent attributable to contributions made by the employer." BB p.788. Whether it is insured or self-insured, the concept is that the value is the value of the insurance, not the amount of the claims or the services rendered. The Secretary of the Treasury is to promulgate tables which shall be the "exclusive method of valuing accident or health coverage". BB p.788.

B. Valuation Of Benefits; COBRA Cost. TAMRA gave the IRS additional time to publish valuation tables for health plans, not any other kind of plan. These temporary valuation rules applicable to health plans will apply for "...testing years beginning before the later of January 1, 1991, or the day 1 year after the Secretary of the Treasury or his delegate first issue such valuation rules as are necessary to apply the provisions of section 89 of the 1986 Code (or if later the effective date of such rules)..." §3021(c). Until such time, the value of health plans is determined under the COBRA rules of Act §4980B(f)(4) or any other reasonable method selected by the employer so long as the employer can demonstrate that it is "actuarially reasonable" and any differences are nondiscriminatory and "de minimus". Annual

physical examinations are not considered "de minimus" and must be taken into account in valuing coverage. §1.89(a), Q&A-7(b)(1).

COBRA cost is still reasonable even when certain permitted adjustments are made. These adjustments, when made, cannot effect the relative value of these plans, must be elected in writing and, if so elected, they must apply to all plans of the same type. Id., at (e). Some permitted cost adjustments are for differences in cost attributable to geographic factors, demographic factors and for differences in utilization. Id., at (b)(2). Reasonable methods also include certain cost containment features such as second opinion requirements. Id., at (d).

Valuation methods other than COBRA cost are presumed to not be reasonable where the values obtained do not reasonable reflect the relative costs as determined under COBRA. See an example at §1.89(a), Q&A-7(b)(2). Other methods that fail the reasonableness test are the cost of a plan with more than a "de minimus" difference in value unless it passes the 50% eligibility test, Id., at (b)(2), and adjustments depending on the method of health care delivery, such as an insurance carrier, a health maintenance organization, or a preferred provider organization. Id., at (d).

C. Employer-Provided Benefit. The value of the coverage for a health plan is the proportionate value of the health plan, whether table value or COBRA cost, and is determined by multiplying this value by a fraction. "The numerator of the fraction is the employer-paid cost of the health plan, and the denominator of the fraction is the sum of the employer-paid cost and the employee-paid cost of the health plan." §1.89(a), Q&A-7(g). If the result of this fraction is a cost (treating salary reduction contributions as employer contributions) of less than or equal to 2%, then the employer may treat this plan as providing no employer-provided benefit. Id.

D. Salary Reduction Contributions. For purposes of the 50% Eligibility Test, the 75% Benefits Test, and the 80% Coverage Test, salary reduction contributions are treated as employer contributions. §1.89(a), Q&A-8(a). Unless an employer elects otherwise in writing, for purposes of the 90%/50% Eligibility Test, salary reduction contributions are treated as employee contributions. An employer is permitted to make this written election provided: (1) all, not a few, salary reduction contributions are treated as employer contributions with respect to all plans of the same type; (2) the cafeteria plan benefits are available to all employees on the same terms and conditions; (3) the percentage of nonhighly compensated employees eligible for the plan the same percentage of highly compensated employees; and (4) no highly compensated employee can participate in the cafeteria plan and another plan of the same type in which the nonhighly compensated employee cannot participate. Id. at (b).

E. Salary Reduction Contributions; Mandatory Treatment; Transitional Rule-Delay Permitted For 1 Year. For purposes of only the 90%/50% Eligibility Test, including the alternative 80%/66% Eligibility Test and the 80%/80% (Large Employer) Eligibility Test, some or all salary reduction contributions available to highly compensated employees must be treated as employer contributions and some or all salary reduction contributions available to nonhighly compensated employees

must be treated as employee contributions. The rules of this paragraph are effective for testing years commencing after January 1, 1990. Id. at (c) (1) and (4).

For highly compensated employees, the excess of salary reduction contributions over the amount of the employer contributions is treated as employer contributions. This rule applies only if the employer has not made the written election to treat all salary reduction contributions as employer contributions for purposes of the 90%/50% Eligibility Test. Id. at (c) (2).

For nonhighly compensated employees, the excess of salary reduction contributions over the amount of the employer contributions is treated as employer contributions. This rule applies only if the employer has made the written election to treat all salary reduction contributions as employer contributions for purposes of the 90%/50% Eligibility Test. Id. at (c) (3).

For part-time employee, the amounts of the salary reduction contributions may be treated as a proportionately reduced employer-provided benefit except for purposes of the 50% component of the 90%/50% Eligibility Test. Id. at (d).

F. Other plans. For plans other than accident or health or group-term life insurance, "...employee's employer-provided benefit is defined as the value of the benefits provided to or on behalf of such employee, to the extent attributable to contributions made by the employer." BB p.788.

G. Cafeteria or Flexible Spending Arrangements. In addition to the employer-provided benefits and any salary reduction arrangements, the value of the benefits here are the total cost including "after-tax employee contributions". §1.89(a), Q&A-7(f).

H. Group Legal Services, Dependent Care Assistance, and Educational Assistance Plans. The value of these plans are the contributions made by the employer, not employee, or the other employer-provided benefits under the plan. §1.89(a), Q&A-1(f) (3).

I. Multiemployer Plans. The value of these multiemployer plans, except those covering professionals, are the contributions made by the employer, subject to some minor adjustments, even after the Treasury tables are issued. §89(g) (3) (E).

XII. TESTING PERIODS; TESTING DATE AND TESTING YEAR

The Regulations have substantially clarified the rules governing the proper testing periods and how to apply them to the first year and subsequent years that §89 is effective for each plan.

A. Testing Date. 1. In General. The term testing date means any single day within the testing year designated in writing in the plan for purposes of the §89 nondiscrimination tests, or, if there is no designation in writing, the testing day is the last day of the calendar year. The same testing date must be designated for all other plans of the employer of the same type except that plans of the same type may have different testing dates if plans are

being tested on the basis of a separate line of business. Even if plans of a different type are being treated as the same type, e.g. under the 75% Benefits Test, they must have the same testing date. After such a designation in 1989 or in 1990, then, for the testing years beginning in 1991 and thereafterwards, the testing date may only be changed with the consent of the Commissioner of the Internal Revenue Service or in accordance with rules promulgated by the Commissioner. The testing date does not need to be a date certain every year, but instead could be determined by a fixed method, such as the last friday in July each year. §89(g)(6)(D); §89(j)(13); §1.89(a)-1, Q&A-5(c).

2. Election. This election of the testing day is required to be made in writing but is not required to be designated in the single written instrument required under §89(k)(1)(A). The election of the testing day is subject to the nondiscriminatory provision test of §89(d)(1)(C); §1.89(a)-1, Q&A-1(c). The facts and circumstances of the testing date must "...reasonably reflect the employee pool of the employer and the business of the employer throughout the year", otherwise, the election of a particular testing date will fail that test. §1.89(a)-1, Q&A-5(c).

3. Adjustment To Facts On The Testing Day. Changes in the employer-provided benefit levels for all employees occurring during a testing year are required to be adjusted to mirror the levels occurring both before and after the change. Adjustments stemming from changes in plan terms and changes in employee elections are treated differently. Adjustments in benefits levels arising from changes in plan terms must be reflected as of the "adjustment period" occurring both before and after the change. Adjustments in benefits levels arising from changes in employee elections must be reflected as of the "adjustment period" occurring both before and after the change only for highly compensated employees, unless the election change is made during the first quarter of the testing year. (For certain types of highly compensated employees only (i.e. those who were highly compensated employees during the prior testing year, who were in the top 100 highly compensated employees or who are 5 percent owners as defined in §416(i)), even election changes made during the first quarter of the testing year are required to be adjusted and included in the calculations.) For nonhighly compensated employees, adjustments in benefits levels arising from changes in employee elections are not required to be reflected. §1.89(a)-1, Q&A-5(b)(2).

a. Distinction Between Changes In Plan Terms and Changes In Employee Elections. A change in the terms of a plan means a change in the employer-provided benefit level of a plan or another plan of the same type caused by an employer decision relative to the plan. For example, "...an increase or decrease in the after-tax employee contributions or employer contributions, including salary reduction contributions, is treated as a change in plan terms". §1.89(a)-1, Q&A-5(b)(3). Moreover, a change in plan terms is a change to any one or more of the plans available to an employee, for example during an open enrollment period. Even if an employee elects to change health plan coverage which results in a employer-driven change in the amount of the employer-

provided benefit, during an open season enrollment period, such employee's change is treated as a change in plan terms even if the employee is not covered, either before or after the open season, by a health plan that changed. Id.

b. Changes In Employee Elections. A change in the employer-provided benefit level of a plan or another plan of the same type caused by a different election by an employee qualifies (i.e. employee-driven change) as employee election change only if "...if such change is exclusively attributable to an election change by the employee that is not in connection with or otherwise related to any change in the terms of the plan..." §1.89(a)-1, Q&A-5(b)(3).

c. Adjustment Periods: 24 Or More Per Year. Changes in the amount of the employer-provided benefits during a testing year resulting from changes in plan terms or employee elections are taken into account as of the effective date of the change. Id., at Q&A-5(b)(4). These changes cannot be rounded to the nearest month end or beginning of a month; instead, they must be rounded to the nearest semi-monthly, two-week, or more frequent adjustment (pay) period so long as the employer makes benefit adjustments on that basis.

The benefit levels received by the employees in the adjustment period in which or at the beginning or end of which the change occurred are treated differently. For nonhighly compensated employees, the lowest benefit of such employee is to be treated as received during the entire current adjustment period or for the entire adjustment period immediately following the effective date of the change. For highly compensated employees, the highest benefit of such employee is to be treated as received during the entire current adjustment period or for the entire adjustment period immediately following the effective date of the change. Id., at Q&A-5(b)(4)(ii)(C).

d. Transition Rule For 1989; Modification By IRS Notice 89-65. (i) Partial Testing Year. This transition rule was modified on May 5, 1989 by IRS Notice 89-65 which announced that the final regulations when published would delay the effective date of the testing of statutory benefit plans for compliance with §89 from July 1, 1989 to October 1, 1989. The effect of this transition rule is to permit an employer to make changes in the early part of 1989, up to October 1, 1989, and not be penalized for making those changes. The changes in benefits, once made, are then annualized for the remainder of 1989 as if they were paid during the entire testing year. The discriminatory excess, if any, would then be tested based on and attributable to the assumed annualized new benefit level provided.

The transitional rule has another effect: to permit the Congress and the Bush Administration time to consider and implement simplification legislation for §89 before employers have to spend considerable time and money in order to demonstrate their compliance with §89. Whether or not this will be accomplished remains to be seen.

The first day of the partial testing year must begin on the "...earliest of October 1, 1989; the testing day for such testing year; or the first day of the calendar month beginning three months before the end of the testing year. The last day of the partial testing year is the last day of such testing year". §1.89(a)-1, Q&A-5(b)(5)(ii) (as amended). For a calendar year plan, the partial testing year would be October 1 through December 3, 1989.

Adjustments to levels of employer-provided benefits are to be made, as discussed above, proportionately prorated as if the partial testing year were the entire testing year.

The employer-provided benefits received by the employees during the partial testing year are then annualized as if paid for a full 12 month period. This is accomplished through the multiplication of the benefits provided for the partial testing year by a fraction. "The numerator of the applicable fraction for a testing year is the total number of calendar months in the testing year and the denominator of such fraction is the number of calendar months in the partial testing year. §1.89(a)-1, Q&A-5(b)(5)(iv). For example, using a calendar year testing year and a partial testing year of October 1, 1989 to December 31, 1989, the fraction would be 12/3. Then the employer-provided benefits during the partial year would be multiplied by 4 to annualize the benefits for the entire testing year. *Id.*, at (vi).

(ii) Eligible Plan. The Regulations contained various restrictions on whether or not a plan was eligible to use the Transition Rule. §1.89(a)-1, Q&A-5(b)(5)(v). All of these restrictions will be eliminated in the Final Regulations, according to Notice 89-65.

B. Testing Year. 1. 12-Month Period; Written Election. The term Testing Year means any 12-month period that begins with the first day of any calendar month and ends with the last day of any calendar month regardless of the beginning or ending of the plan years. An employer, in order to select a uniform testing year other than the calendar year, must make an election in writing prior to the commencement date of the testing year. Unless an employer makes this election in writing, the testing year shall be the calendar year. The testing year must be same for all other plans of the employer of the same type except that plans of the same type may have different testing years if plans are being tested on the basis of a separate line of business. If an employer will aggregate plans of different types for purposes of the 75% Benefits Test, then those plans aggregated must have the same testing year. §89(j)(13). §1.89(a)-1, Q&A-6(a).

2. First Testing Year In 1989. For testing years beginning in 1989, the testing year can be any 12-month period for all plans of the same type that commences not later than the effective date of §89 for the first plan of such a group of plans that becomes subject to §89. This rule applies even though plans of the same type have different plan years for 1989. §1.89(a)-1, Q&A-6(b).

For plans with effective dates later than the first day of the entire first testing year, the employer-provided benefits under those plans are not prorated for the time which §89 is applicable for such plans; rather, the benefits provided under those plans with later effective dates are included as though they were already subject to §89. §1.89(a)-1, Q&A-6(b), (c)(1) and example at (c)(2).

There are special rules for the determination of the proper proportion excess benefit when all of the employer-provided benefits are not yet subject to §89, but nevertheless are required to be calculated as if they were depending on which of the Nondiscrimination Tests the tested plan failed. Simply put, the rules figure a proportionate share of the benefits subject to §89 or figure a weighted average. For plans flunking the 90%/50% Eligibility Test and the 75% Benefits Test, the rules are at §1.89(a)-1, Q&A-6(c)(3)(iii)(A). For the 50% Eligibility Test and the 80% Coverage Test, the rules are at §1.89(a)-1, Q&A-6(c)(3)(iii)(B).

3. Short First Testing Year. An employer may elect to apply §89 on the basis of a short first year for all plans of the same type. If such an election is made, then the second testing year must be 12 months in duration. §1.89(a)-1, Q&A-6(b)(2).

4. Testing Year Election Decision. The written election determining the first day of the first testing year in 1989 must be made prior to the earlier of first day of the second testing year or January 1, 1990. If an employer fails to make this election, then the default rule date of January 1, 1989 applies. If an employer uses a short first testing year, as discussed immediately above, the employer must elect, in writing, the last day of such year prior to that last day. §1.89(a)-1, Q&A-6(b)(3)(ii).

5. Period For Making Changes in Testing Year, Extended. After an election for a testing year is made on or before January 1, 1990, changes in the testing year can still be made so long as the first day of new testing years begins on or before January 1, 1991. These changes can be made without the consent of the Commissioner of the Internal Revenue Service. However, for the years following that, the testing year may only be changed with the consent of the Commissioner or such changes must meet such requirements yet to be prescribed. In any case, any change in the testing year may not result in a benefit being excluded from a testing year and may not be included in more than one testing year. §1.89(a)-1, Q&A-6(d). Prior to the Regulations, changes to the testing year and date occurring in 1990, could not be made without the approval of the Secretary of the Treasury. S.M., p.34.

XIII. THE NONDISCRIMINATION RULES; EXCESS BENEFITS

A. In General. Value of the Benefits. §89(a) provides that all plans must pass certain nondiscrimination rules to permit the exclusion from gross income the amount of the employer-provided benefit of highly compensated employees. (If a plan fails to pass one of the tests addressed in this Part, non-highly compensated employees will incur no additional income subject to tax as a result of the failure. The

determination of excess benefit applies only to highly compensated employees.) Employer-provided benefit is defined in §1.89(a)-1, Q&A-1(f)(3) and is defined differently for the nondiscrimination rules than for the plan qualification rules. For nondiscrimination testing purposes, the employer-provided benefit under a health plan is defined as the "value of the coverage" and not the value of the services received under the health plan. For group-term life insurance plans, the "value of the coverage" is the cost of the insurance determined under §79(c) assuming the employee is age 40. §89(g)(3)(C). Any death benefit paid under a life insurance plan is not included for purposes of the nondiscrimination testing. §1.89(a)-1, Q&A-1(a)(1). In the case of other plans, i.e., dental, vision and other non-core plans, the "value of the coverage" is the value of the employer-provided benefits provided rather than the value of the coverage. (See paragraph VI. A., Part I, for the definition of the value of the benefits for purposes of the qualification rules under §89(k).)

B. Excess Benefit Calculation. If a plan passes the several nondiscrimination tests, then that plan will not have an excess benefit subject to income taxation. The method of determining the excess benefits of a discriminatory benefit plan is different than the method of determining whether a plan is discriminatory in the first place under the various tests. Thus, the Regulations state that there will be no additional taxes even if different results could be reached under the different valuation methodologies for purposes of the nondiscrimination rules and the excess benefits rules. So, it is possible to have a discriminatory benefit plan without any excess benefit subject to tax; and it is possible to have a plan that would be discriminatory using the valuations as determined under the excess benefit calculation rules, but no tax would be due because the plan is not discriminatory. §1.89(a)-1, Q&A-9(a).

C. Failure To Pass More A Test; Written Election To Use Different Excess Benefit Calculation. Generally, a plan is required to calculate the excess benefit under the rules that relate to that particular test that it failed. For example, if a plan passes the 50% Eligibility Test but fails the 75% Benefits Test, the excess benefit is calculated only under the 75% Benefits Test. However, a plan may elect in writing to use the determination of the excess benefit under the 80% Coverage Test notwithstanding the fact that the plan failed under a different test. Similarly, plan may elect in writing to use the determination of the excess benefit under the Nondiscriminatory Provision Test, or the longer testing route, the 50%-AET-90%/50%-75% route, notwithstanding the fact that the plan failed under the 80% Coverage Test. §1.89(a)-1, Q&A-9(b).

D. Failure To Pass More Than One Test; "Smoothing". In the event an employer's plan fails to pass more than one of the various tests, the tests are to be applied in the following order: the 50% Eligibility Test; the 90%/50% Eligibility Test; and the 75% Benefits Test. If a plan fails to pass the the 90%/50% Eligibility Test or the 75% Benefits Test, the excess benefit calculations are first determined under the first of the tests that plan failed and then credited against the excess benefit determined under the second or third tests the plan failed. For example, if the a plan failed the 75% Benefits Test, the amount of the excess benefit determined under the 75% Benefits Test would be reduced by the amounts first determined under the 50% Eligibility Test and then the 90%/50% Eligibility Test. §1.89(a)-1, Q&A-9(b)(2).

E. All Highly Compensated Employees Included. All highly compensated employees employed by the employer throughout the testing year who received employer-provided benefits under a plan that failed a nondiscrimination test, must be included in the calculation of the excess benefits based on the benefits received during the testing year regardless of whether or not they were employed on the testing date. However, the calculation of the excess benefits must be made based on the actual amount of the benefits they received regardless of any assumptions made during the determination of the discriminatory status of a plan. §1.89(a)-1, Q&A-9(c).

F. Partial Testing Years. An employer may elect the special transition rule which annualizes the employer-provided benefits for the partial testing year, as discussed in paragraph XI.A.3.d., above, as amended by IRS Notice 89-65. If an employer makes that election, then it must afford its highly compensated employees the opportunity to show that they have actually received benefits less than the amount assumed for purposes of the testing. Id., at (c) (2).

XIV. THE 80 PERCENT COVERAGE TEST

A. The Test. §89(f) states as follows:

(f) Special Rule Where Health Or Group-Term Plan Meets 80-Percent Coverage Test. If at least 80 percent of the employees who are not highly compensated employees are covered under a health plan or a group-term life insurance plan during the testing year, such plan shall be treated as meeting the requirement of subsections (d) (the several eligibility tests) and (e) (the 75% Benefits Test) for such year....

This tests only the non-highly compensated employees and operates as follows. First, determine the number of non-highly compensated employees employed on the testing date and subtract from that number those employees who can be excluded under the exclusion rules of §89(h), i.e. age, hours, months of service, etc. (The employee exclusion rules are discussed in Part I, paragraph III, at page 31.) The result is the number of employees who are not excluded. Next, determine the number of covered employees, i.e. those who are actually receiving employer-provided benefits under the plan being tested. Then, divide the number of covered employees by the number of employees who not excluded under the employee exclusion rules. (The fraction is: the number of non-highly compensated employees covered on the testing date divided by the number of non-highly compensated employees not excluded.) If the result is .80 or higher, then the test is met. If not, then an employer may want to adjust some of the various plan criteria to extend coverage to more employees, and to retest. Here the calculation only looks to actual benefits paid on behalf of an employee and not simply eligibility for coverage. This test is an alternative to the longer testing route discussed below. If an employer fails this test, then it must utilize the longer and more complicated testing route discussed following this paragraph. BB, p. 782-4.

B. Health and Group-Term Life Insurance Plans Only. The 80% Coverage Test applies only to two kinds of employee benefit plans: accident or health plans and group-term life insurance plans. BB, p. 784. §1.89(a)-1, Q&A-1(e).

C. Written Election. An employer who elects to use this test must make an election in writing. §1.89(a)-1, Q&A-1(e). The election must be in writing by January 31 of the year following the calendar year in which the excess benefits are treated as received. If an employer make the election to delay the inclusion of benefits in income for one year as provided under §89(a)(2)(B), then the time to make an election is similarly delayed. §1.89(a)-1, Q&A-1(g).

D. Special Rules Applicable.

1. a. Part-time Employees; Proportionate Reduction Of Benefits. The rules permitting the proportionate reduction of employer-provided benefits for part-time employees who normally work less than 30 hours per week is only available for use under this 80% Coverage Test. §89(j)(5).

b. Small Employer/Part-Time Employee Phase-In Rule. In applying the 80-percent test to a plan maintained by an employer with 9 or less employees on a normal working day in a testing year, the employer may disregard (i) employees who normally work 35 hours or less per week in applying the test to plan years beginning in 1989; (ii) employees who normally work 25 hours in applying the test to plan years beginning in 1990; and (iii) the present law rule of 17 1/2 hours or less per week applies to plan years beginning in or after 1991. The provision is effective as if included in the 1986 Act. S.M., p.165.

2. Aggregation/Disaggregation. Each plan is to be valued separately for purposes of this test, and each plan must separately satisfy this test. Some plans may be required to be aggregated and for others, aggregation is permissible. See the discussion of Aggregation Of Plans at paragraph IX, above.

3. Mandatory Aggregation. The mandatory aggregation rules discussed under paragraph IX., B. apply here to require aggregation of employees covered by two or more health plans prior to the application of the comparability rules. §1.89(a)-1, Q&A-4(e). However, this rule does not apply if each of the two or more plan each pass a 90% Eligibility Test. §1.89(a)-1, Q&A-4(e)(2).

4. Comparability. Comparable plans may be aggregated for purposes of satisfying this test. BB p. 787. See the discussion of the General Comparability Rules at paragraph X, above.

5. Sworn Statement. Sworn Statement exclusions are available only to health plans as discussed in Part I, paragraph III, F. page 34. (See also a form of Sworn Statement that is appended to Part I.) However, if employees are to be excluded on the basis of a sworn statement, the plan being tested must first pass an 80% Eligibility Test. §1.89(a)-1, Q&A-3(c)(7). See discussion at Part I, page 36. In order to make certain elections, discussed immediately below, an employer must obtain and maintain adequate Sworn Statements. §1.89(a)-1, Q&A-3(c)(4).

6. Written Election For Separate Testing of Employee-only And Family-only Coverage. For purposes of this test, an employer may

elect, in writing to test employee-only coverage separately from family-only coverage. If an employer elects to test family-only coverage separately from employee-only coverage, then all family-only coverage must be tested together. §1.89(a)-1, Q&A-3(c)(1)-(6). See also Part I, III., F., page 34. If an employer does elect to test these plans separately, then in testing the family-only plan, employees may be disregarded from testing the plan for purposes of this test: (a) if the employee is single (as demonstrated by a sworn statement); or (b) the employee has a family and all of the family members have core health coverage from another employer. If an employer makes this election, then in testing the employee-only plan, employees may be disregarded from testing the plan for purposes of this test only if the employee has core health coverage from another employer. §1.89(a)-1, Q&A-3(c)(3)(ii). If an employer does not elect to test such plans separately, only in certain circumstances can employees with families be disregarded from testing the family-only plan for purposes of this test: (a) if the employee and family members all have core health coverage from another employer; or (b) if the employer does not offer family-only coverage. §1.89(a)-1, Q&A-3(c)(3)(i). An employee will be disregarded only if the sworn statement indicates that the coverage elsewhere is of the same type as the plan being tested. In other words, if an employee has signed a sworn statement indicating that he or she has dependant only coverage under that plan of another employer, then that employee may be excluded from the testing of that dependant only plan; however that employee would not be excluded from a plan that tests full family coverage.

7. The Nondiscriminatory Provision Test. Even if the plan passes the 80% Coverage Test, it must still pass the nondiscriminatory provision test outlined below.

8. Cafeteria And Flexible Spending Arrangements ("FSA"). If an employer is testing the employee-only coverage and the family-only coverage separately under this 80% Coverage Test, it may elect to treat 40% of the value of the coverage attributable to the family-only plan and 60% of such value attributable to the employee-only plan. §1.89(a)-1, Q&A-7(f). Under this test, "...each different level of coverage under the health FSA is a separate health plan with a value equal to the cost of such level of coverage. Id.

9. Excess Benefit Calculation; 90% Comparability Standard. The amount of the excess benefit determined for a plan failing this test

...is equal to that portion of the employer-provided benefit received by such employee under the plan that is in excess of the maximum employer-provided benefit that such plan may have and be included in a group of comparable plans under ... (the 90% comparability standard or the alternate 80% comparability standard; see Q&A-4(c))...that satisfies the 80 percent coverage test. §1.89(a)-1, Q&A-9(g).

The calculation is made by taking the employer-provided benefit under a plan that passes this 80% test (taking into account the mandatory and permissive aggregation rules) and multiplying that

benefit by 1.1111111. That benefit is then 90% of the largest benefit available to any employee in the group of comparable plans (not using the alternate 80% test). For example, plan A has a value of \$3,000 and passes this test; and plan B with a \$4,000 employer-provided benefit does not. The largest employer-provided benefit an employee could receive and still permit the plan to pass the test is \$3,333 ($\$3,000 \times 1.1111111$). The excess benefit is then \$666 ($\$4,000 - \$3,333$). Id. If plan B does not pass the 50% Eligibility Test first (in order to be included in a group of comparable plans), the excess benefit is calculated using the 95% comparability standard of the 50% Eligibility Test, discussed below.

10. Excess Benefit Proportionate Calculation; Special Rule For Short Or First Testing Years. With respect to both this 80% Coverage Test and the 50% Eligibility Test, the following special rules for determination of the Excess Benefit for the first or short testing years apply. For plans that fails these test, the excess benefit for any highly compensated employee is calculated by multiplying the amount determined under paragraph 8., above, times a fraction which represents the proportionate share of the employer-provided benefit for the short or first year. These rules have been summarized above at XI., B., 2. and are set out at §1.89(a)-1, Q&A-6(c)(3)(iii)(B).

XV. NONDISCRIMINATORY PROVISION TEST

A. In General. This test is an eligibility test. It is based on all the facts and circumstances surrounding a plan under §89(d)(1)(C) which may cause a plan to fail when the plan was otherwise qualified under §89(a) and would pass all remaining tests. For example, if a medical plan covered all regular medical illnesses and any employee who had a "rare illness", and only one highly compensated employee had this "rare illness", or through some application of the plan discriminated in such an employee's favor, the plan would fail this test. Other examples of plans failing this test are a school district or a retail store which selects a testing date during a period of vacation. The plans fail because the number of employees on those dates is not fairly representative of regular employee complement during the rest of the year. §1.89(a)-1, Q&A-1(c). If a plan fails this test, the plan will not be disqualified, but rather the intended result is an attempt to quantify the amount of the discriminatory benefit and then to tax it.

For core health plans with different waiting periods, in order to pass this test, each plan must separately pass the 50% eligibility test, outlined below, individually or aggregated only with comparable plans with the same or shorter waiting periods. §1.89(a)-1, Q&A-1(c)(2).

B. Excess Benefit Calculation. The excess benefit for inclusion in the income of a highly compensated employee-participant in such a failing plan is equal to the employer-provided benefit during the shorter waiting period. For example, if there were two plans, one with a 1 month and a second with a 4 month waiting period, assuming that the 1 month plan does not pass the 50% eligibility test, then the excess benefit is the value of the 3 month shorter waiting period. §1.89(a)-1, Q&A-1(c)(3), Ex 4.

If the plan passes this 80% test, and it passes the nondiscriminatory provision test, then it is deemed to meet all of the requirements of both §89 (d) (all of the longer route eligibility tests) and §89(e), the 75% Benefits Test and there is no additional taxable income to the highly compensated employees. If the plan fails, then the plan must be tested by using the longer route of §89 starting with the 50% Test, below.

XVI. THE LONGER TESTING ROUTE

In the event that the plan being tested does not pass the shortcut test through §89, consisting of the 80 Percent Test and the Nondiscriminatory Provision Test, then that plan must proceed through the longer route of §89. The longer route consists of the 50% Eligibility Test, the Alternative Eligibility Percentage or Ratio Test, the 90%/50% Eligibility Test, the Nondiscriminatory Eligibility Test and the 75% Benefits Test.

Generally, the order to testing as stated in the BB, at page 790, is: (1) 50% Eligibility Test, (2) the 90%/50% Eligibility Test, and (3) the 75% Benefits Test.

XVII. 50% ELIGIBILITY TEST

A. The Test. The 50% Test is an eligibility test. To pass this test,

...at least 50 percent of the employees eligible to participate in such plan are not highly compensated employees.... §89(d) (1) (B).

The Blue Book states, at page 790, that the order in which the testing is to be performed to determine the discriminatory excess begins with the 50% Test. The Regulations discuss this test at §1.89(a)-1, Q&A-1(d) (3).

An example, will illustrate this test. Assume that an employer had a restaurant with unit of employees consisting of fifty-one employees, one highly compensated employee ("HCE") and fifty nonhighly compensated employees ("NHCEs"); and further, assume that all of employees were not excluded under the exclusion criteria of the plan, such as the minimum age, service, etc. Of those fifty NHCEs assume that they were divided into two groups of employees, ten cooks and forty waitresses. Moreover, assume that the employer defined the group of employees who were eligible to participate in and be covered by the plan as only the cooks and the owner, HCE. Waitresses were simply not able to participate in or be covered by the plan because of the plan definition: they are ineligible. This plan would not pass this 50% Eligibility Test because of the ineligibility of the waitresses. The percentage would be determined as follows: 10 employees eligible/50 not excluded is 20%. To pass this test, 25 NHCEs would have to be eligible to participate in the plan.

The same result would occur if an employer had a plan prerequisite of 35 hours normally worked per week to be eligible for participation in its health plan and used a substantial number of part-time employees who worked less than 35 hours per week but more than 17 1/2 hours per week

(the minimum number under which an employer could exclude employees from participation). If the employer had more than 50% of its nonhighly compensated employees in this area of ineligibility (between 17 1/2 and 35 hours) the plan would fail this eligibility test.

B. Mandatory Aggregation.

1. Coverage Under Two Or More Health Plans. The mandatory aggregation rules that must be applied under this rule are the same as discussed under the 80% Coverage Test at XIII., D., 3., above, (but not the exception). §1.89(a)-1, Q&A-4(d).

2. Limitation for Non-Core Salary Reduction Contributions. For plan years beginning on and after January 1, 1990, to the extent that nonhighly compensated employee salary reduction contributions exceed the greater of \$2,000 (as indexed for inflation under §89(g)(1)(E)(v)) or that employee's actual salary reduction contribution, the excess is not considered available to that employee. §1.89(a)-1, Q&A-4(d)(2). The effect of this is to limit the sumed or aggregated value of the various plans for those nonhighly compensated employees.

3. Permissive Plan Restructuring. For purposes of this 50% Eligibility Test and the 80% Coverage Test, this restructuring is permitted. The discussion of paragraph IX., B.,4., above, is fully applicable here. §1.89(a)-1, Q&A-4(f).

C. Excess Benefit Calculation; 95% Comparability Standard.

1. The amount of the excess benefit determined for a plan failing this test

...is equal to that portion of the employer-provided benefit actually received by such employee under the plan that is in excess of the maximum employer-provided benefit that such plan may have and be included in a group of comparable plans ... (using the 95% comparability standard)...that satisfies the 50 percent eligibility test. §1.89(a)-1, Q&A-9(d).

The calculation is made by taking the smallest employer-provided benefit under a plan that passes this 50% test (taking into account the mandatory and permissive aggregation rules) and multiplying that smallest benefit by 1.0526666. That smallest benefit is then 95% of the largest benefit available to any employee in the group of comparable plans. For example, assume that a plan with a \$3,000 employer-provided benefit passes this test and a plan with a \$4,000 employer-provided benefit does not. The largest employer-provided benefit an employee could receive and still permit the plan to pass the test is \$3,158 (\$3,000 x 1.0526666). The excess benefit is then \$842 (\$4,000 - \$3,158). Id.

2. Excess Benefit Proportionate Calculation; Special Rule For Short Or First Testing Years. With respect to both this 50% Eligibility Test and the 80% Coverage Test, special rules for determination of the Excess Benefit for the first or short testing years apply. See discussion under paragraph XIII., D., 10. under 80% Coverage Test, above.

XVIII. ALTERNATIVE ELIGIBILITY PERCENTAGE TEST

A. The Test. The Alternative Eligibility Percentage Test is an eligibility test. An employer's plan may pass this test if

...(A) the percentage determined by dividing the number of highly compensated employees eligible to participate in such plan by the total number of highly compensated employees, does not exceed

(B) the percentage similarly determined with respect to employees who are not highly compensated employees. §89(d)(2).

This Test is an alternative to the 50% Eligibility Test. If a plan does not pass the 50% Eligibility Test, but does pass this alternative, then that plan will be deemed to pass the 50% Eligibility Test. The remainder of the rules relative to the 50% Eligibility Test, discussed immediately above, apply to this Test.

XIX. 90%/50% TEST

A. The Test. The 90%/50% Test is an 90% eligibility test and a 50% benefits test. This Test is performed following the 50% Eligibility Test. To pass this two step test,

(i) 90% of all non-highly compensated employees are eligible to participate in the Plan, and

(ii) would (if they participated) have available a employer-provided benefit which is at least 50% of the value of the largest benefit available under all such plans to any highly compensated employee. §89(d)(1)(A).

Benefit that is the yardstick in (ii) is the highly compensated employee with highest level of benefits. To determine this employee, all plans of the same type are aggregated and the values are added together. For example, if an employee is eligible to participate in two or more plans of the same type, the employee is considered eligible for a benefit with a value equal to the sum of the values available under the plans for which the employee is eligible. If an employee is eligible to participate in only one of the two plans of different values, then he is considered eligible for the most valuable benefit. BB, p. 783. §1.89(a)-1, Q&A-1(d)(2).

In measuring the benefit for the 50% component of the 90%/50% Test, even though plans may not be comparable and may not be of the same type, they are still aggregated for all purposes of this test. The concept is a "pot" of plans, which would include health, group-term life insurance and other different types of employee benefits like vision or dental plans. The total of all those benefits is totalled.

Cafeteria And Flexible Spending Arrangements (FSA). For purposes of this 90%/50% Test, "... (if salary reduction contributions are treated as employer contributions under the rules of Q&A-8 of this section), the health plan under the FSA with the largest employer-provided benefit is the plan with the ... maximum reimbursement". §1.89(a), Q&A-7(f).

B. Mandatory, Permissive Aggregation Rules. The mandatory and permissive aggregation rules applicable to the 50% Eligibility Test, discussed above, apply here as well.

C. Proportionate Reduction of Part-time Benefits. Health and accident insurance plans will continue to be treated as a single plan if the plans are identical and if the employer-provided benefit is proportionately reduced for employees who normally work less than thirty (30) hours per week. This applies to the 75% Benefits Test and the 50% component of the 90%/50% Test. An employee normally working between 22.5 and 30 hours per week may be treated as receiving a benefit that is two-thirds the value of a full-time employee's benefit; and employee normally working between 17.5 and 22.5 hours per week may be treated as receiving a benefit that is one-half of the value of a full-time employee's benefit. BB, p. 786.

D. Special Transition Rule For 1989: 80%/66% Test. The Regulations provided another special Transition Rule or testing years ending in 1989 permitting an election by an employer who passes the 75% Benefits Test. If the employer makes an election, in writing, under this Transition Rule for application of the 90%/50% Eligibility Test, it may substitute "80 percent" for "90 percent" and substitute "66 percent" for "50 percent" (i.e., the test may be treated as an 80%/66% eligibility test). This rule is applicable for the eligibility testing only and not for purposes of determining excess benefits under section 89(b). §1.89(a)-1, Q&A-2(b).

E. 1. Excess Benefit Calculation; Excess Over Twice The Common Benefit. The amount of the excess benefit determined for a plan failing this test

...is equal to that portion of the employer-provided benefit actually received by such employee under such plans that is in excess of 200 percent of the largest amount of employer-provided benefit available to at least 90 percent of the employer's nonhighly compensated employees. §1.89(a)-1, Q&A-9(e).

The calculation is made by taking half of the highest employer-provided benefit under a plan of the same type being tested that is available to a highly compensated employee and then determining whether that figure is available to 90% of the nonhighly compensated employees (taking into account the mandatory and permissive aggregation rules). For example, assume that a plan with a \$3,000 employer-provided benefit passes this test. If any highly compensated employee receives a benefit in excess of \$6,000, then the excess over the \$6,000 is the amount of the excess benefit and subject to tax. If no amount of benefit is available to 90% of the nonhighly compensated employee, then all of the employer-provided benefit any highly compensated employee is taxed. Id.

2. Excess Benefit Proportionate Calculation; Special Rule For Short Or First Testing Years. With respect to both this 90%/50% Eligibility Test and the 75% Benefits Test, the following special rules for determination of the excess benefit for the first or short testing years apply.

For plans that fails these test, the excess benefit for each highly compensated employee is calculated by multiplying the amount determined under paragraph E.1., above, times a fraction which represents the proportionate share of the employer-provided benefit for the short or first year. This fraction is different than the fraction used in determining the proportionate benefits under the 50% Eligibility Test and the 80% Coverage Test. Here, the numerator of the fraction is

The numerator of the fraction is the total employer-provided benefit for the highly compensated employee under the plan or plans being tested that are subject to section 89, and the denominator is the total employer-provided benefit for the highly compensated employee under the plan or plans being tested for the first testing year, whether or not they are subject to section 89. §1.89(a)-1, Q&A-6(c)(3)(iii)(A).

The next step in the longer route through §89, is the Benefits Test.

XX. THE 75 PERCENT BENEFITS TEST

A. The Test. This is a benefits test. To pass this test, §89(e) states:

(1) In general. A plan meets the benefits requirements of this subsection for any testing year if the average employer-provided benefit received by the employees other than highly compensated employees under all plans of the employer of the same type is at least 75 percent of the average employer-provided benefit received by highly compensated employees under all plans of the employer of the same type.

(2) Average Employer-provided Benefit. ... 'average employer-provided benefit' means, with respect to the highly compensated employees, an amount equal to (A) the aggregate employer-provided benefits received by the highly compensated employees under all plans of the same type being tested divided by (B) the number of highly compensated employees (whether or not covered under such plans). The average employer-provided benefit with respect to employees other than highly compensated employees shall be determined in the same manner as the average employer-provided benefit for highly compensated employees.

"Plans of the same type" means two or more plans are treated as of the same type if those plans are described in only one of the following groups of plans: all plans described under Code §§105 and 106 relating to an accident or health plans; all kinds of group-term life insurance described under Code §79; qualified group legal services plans (§120); educational assistance programs (§127); or dependent care assistance programs (§129). §1.89(a)-1, Q&A-1(f)(2).

B. Written Election. An employer may elect, in writing, to apply the 75% Benefits Test to all plans specified in the election as plans of the same type other than health plans. If a health plan passes this

Test, it then can be combined with other groups of plans, as discussed immediately above. However, if the health plan does not pass, then it may not be so combined. (No non-health plan can help a health plan.) If an election is made to aggregate one of a type of a plan, then all of such plan types must be aggregated. §1.89(a)-1, Q&A-1(f)(2)(ii). If this cross-method of aggregation is used, then all plans combined must use the lowest age and service requirement from any of the plans aggregated as if they were a plan of the same type. BB p. 807.

C. Sworn Statement Exclusion Applies. For purposes of this test, an employer may disregard, for purposes of testing a health or accident plan, employees who have signed a sworn statement indicating that they have coverage under the core plan of another employer. See the discussion of sworn statements in Part I, III., F., page 34. See also XIII., D., 6 for treatment of the election for separate testing of employee-only and family-only coverages.

D. 133% Rule Applies. A highly compensated employee, even if he or she has signed a sworn statement to the contrary, may not be disregarded from the testing of a health or accident plan if the value of the employer-provided coverage under all accident and health plans of the employer has a value in excess of 133% of the average employer-provided benefit provided with respect to nonhighly compensated employees. BB, p. 804. §1.89(a)-1, Q&A-3(c)(5). If separate testing of employee-only or family-only coverage is elected, then this rule applies to each such plan being tested.

E. Modifications For Large Employer Election. For employer with at least 5,000 active employees on at least 1 day in each quarter of a testing year, it may elect, in writing, special treatment if it satisfies the following additional conditions: 90% of those employees are nonhighly compensated employees; if less than .75% of those employees have annual compensation of less than the §414(q)(1)(C) (\$52,235 for 1989) limit of compensation; the health plan eligibility rules are generally satisfied by an 80% Eligibility Test and the 90%/50% Eligibility Test is satisfied by a 80%/80% Eligibility Test; and the 75% Benefits Test is satisfied by a 66% Benefits Test. §1.89(a)-1, Q&A-2(c)(1)-(7).

F. Cafeteria And Flexible Spending Arrangements (FSA). If an employer is testing separately the employee-only coverage and the family-only coverage under this 75% Benefits Test, it may elect to treat 40% of the value of the coverage attributable to the family-only plan and 60% of such value attributable to the employee-only plan. §1.89(a)-1, Q&A-7(f). "...if an employee elects to receive health coverage under the FSA providing for the reimbursement of up to \$1,200 of health expenses for a year, the value of such coverage received for the year is \$1,200. This is the case without regard to whether the employee actually pays the total required premium for the coverage, as long as the employee receives the coverage". Id.

G. Excess Benefit Calculation; "Smoothing". In General. This rule applies to those plans which are of the same type when they are tested together for purposes of this test and when plans of different types are tested together. The excess benefit calculation was set out in the Blue Book, at page 790, but was expanded on in the Regulations. The amount of the excess benefits for a plan failing this test

...are determined by reducing the employer-provided benefit of the highly compensated employee or employees with the highest amount of employer-provided benefit for the testing year, under the 75 percent benefits test as reapplied in accordance with this paragraph (f), until either such employee's employer-provided benefit is equal to the next highest amount of employer-provided benefit for any highly compensated employee or if no next highest such employee exists, until the employee no longer has any employer-provided benefit. This method of reduction is then applied with respect to additional highly compensated employees (beginning with highly compensated employees with the highest remaining amounts of employer-provided benefits) until the 75 percent benefits test is satisfied in accordance with this paragraph (f). A highly compensated employee's excess benefit is equal to the total amount of such employee's employer-provided benefit that is reduced under this paragraph (f). §1.89(a)-1, Q&A-9(f).

The calculation is made by taking the average nonhighly compensated employee's employer-provided benefit under a plan (taking into account the mandatory and permissive aggregation rules) and multiplying that average benefit by 1.3333333. Next, multiply that highest permitted benefit by the number of highly compensated employees (or their proportionate share of the year) to reach the total of the highest permitted benefit that may be provided. The discriminatory excess, if any, is the amount over that figure. Assume that the average employer-provided benefit for the nonhighly compensated employees is \$3,000. The maximum amount of employer-provided benefit that a highly compensated employee could have and not fail this test is \$4,000 ($\$3,000 \times 1.3333333$). If the benefits of any highly compensated employee is in excess of \$4,000, then the stepped reduction must take place with respect to each highly compensated employee with benefits exceeding \$4,000. Retesting is to be done at each level of reduction of the average benefit of the highly compensated employees until the \$4,000 level is achieved or all of the benefits of the highly compensated employees is reduced to zero. The excess benefit is the sum, by employee, of the reductions of the benefits of these highly compensated employees.

There is a detailed illustration of this "smoothing" in the Statement of Managers beginning at page 35.

H. Excess Benefit Proportionate Calculation; Special Rule For Short Or First Testing Years. With respect to both this 75% Benefits Test and the 90%/50% Eligibility Test, the special rules for determination of the excess benefit for the first or short testing years apply are outlined in paragraph XVIII., E., 2. under the discussion of the 90%/50% Eligibility Test, above.

I. Special Transition Rule for 1989 and 1990. The Regulations provided an optional written election for an employer to pass all of the eligibility tests, the 50% the 90%/50%, and this 75% Benefits Test if, for a testing year ending in calendar year 1989: (1) the employer elects in writing to (2) treat 20% of its highly compensated employees owning 5% or more of the stock, based on the prior year, and 20% of its employees who receive most of the compensation, based on the prior year, but not more than 1,000 but not less than the lesser of 10 or the actual

number of such persons, as (3) receiving all of their benefits under all health plans of the employer as excess benefits; i.e. after-tax contributions. The same written election is available to an employer for testing years ending in calendar year 1990, except that the percentage of the employees is 40% and the number of employees is not more than 2,000 but not less than the lesser of 50 or the actual number of such persons. §1.89(a)-1, Q&A-2(a).

XXI. GROUP-TERM LIFE INSURANCE

A. Group Term Life Insurance. Plans Not Covered. Under §89 the plans not covered include: corporate owned life insurance, life insurance on the lives of dependants or held in qualified plans or split dollar plans. Of course, it does not apply to individual term or permanent policies paid for with after tax dollars.

B. Nondiscrimination Testing. When testing the employer-provided group-term insurance coverage, the values included are not the premiums actually paid. Instead, one uses the §79(c) Table 1 costs for such insurance that is employer-provided based on the assumption that the insured is age 40. (Note that the valuation rules regarding this coverage have not been delayed by TAMRA. The Temporary Valuation Rules only delay the rules that apply to health plans. See Transitional Provisions For Purposes Of Section 89(1) and (1)(A). TRA §3021(c).

The Regulations have not addressed how to test group-term life insurance, so the only guidance is the text of the law itself and the Blue Book. The Blue Book, at page 789, states:

Under the Act, certain special valuation rules apply for purposes of applying the nondiscrimination rules to group-term life insurance plans. Other special rules apply for purposes of valuing life insurance coverage determined to be discriminatory. In all cases, all employer-provided coverage (including coverage over \$50,000) is taken into account.

In applying the (75%) benefits test and the 50-percent component of the 90-percent/50-percent test to a group-term life insurance plan, the first step in valuing the employer-provided benefit under a plan is to determine the amount of group-term life insurance coverage that is employer-provided. The next step is to determine the value of the employer-provided coverage under section 79(c) as if the insured were age 40. Except in the case where group-term life insurance plans are aggregated with plans of a different type for purposes of the benefits test ((see discussion below) omitted), this value may then be adjusted depending on the compensation of the employee. The permissible adjustment is made by multiplying the amount by a fraction the numerator of which is a uniform amount for all plans and the denominator of which is the employee's compensation.

For purposes of the above rules, the definition of compensation (including the limitation on the amount that may be taken into account) applicable to qualified plans ((see Part B.1. and Part D., above) omitted) applies.

In determining the value of discriminatory coverage, the special valuation rules described above - regarding the

age 40 assumption and the compensation adjustment - do not apply. Instead, the value of the discriminatory coverage is the greater of the cost of the coverage under section 79(c) or the actual cost of the coverage. The same special rules also do not apply for purposes of determining the value of any inclusion amounts attributable to a failure to satisfy the qualification requirement described below or for purposes of determining the amount subject to the employer-level sanction described below (omitted).

In testing the group-term life insurance plans under the 80-percent test or the 50-percent test, if one of the exceptions, relating to the separate plan rules as discussed in VII., A., above, is used with respect to a plan, the same exception must be used with respect to all plans aggregated with such plan. S.M., p. 62.

In testing the group-term life insurance plans under the 90-percent/50-percent test and the 75-percent benefits test, the employer may use the general definition of a group-term life insurance plan §89(j)(4)(A) or one of the two exceptions, permitting variance for differences in compensation or varying contribution depending on the age of the employee, despite the fact that the employer did not use the same definition for purposes of applying the 50-percent test to any particular plan. S.M., p. 62.

C. Calculation of Discriminatory Excess for Life Insurance. This section only applies in the event that the group term life insurance plan is found to be discriminatory. Further, the effect of a finding that the life insurance plan is discriminatory is to include in income the excess, if any, of the actual cost of the discriminatory coverage over the cost of such coverage under §79(c). SM, p.65. Moreover, this applies only with respect to the employer-provided coverage under \$50,000 which is treated as taxable. The coverage over \$50,000 is treated as non-taxable and not included in the calculation of the amount of additional income. BB, p. 790-791. (Of course, if the plan fails to satisfy the plan qualification rules under §89(k), then it is the employer's obligation to report the entire value of the employer-provided benefit as income for that beneficiary; it is not income for that employee. SM, p.66.)

In summary then, the first step is to determine whether or not the plan is discriminatory under the tests for eligibility and benefits.

STEP ONE. Determination of Discrimination. The calculation of the values for the various tests to determine whether or not the group-term life insurance plan is discriminatory uses the age 40 assumption. §89(g)(3)(C)(i). To make this determination, it is necessary to (1) calculate the value of the employer-provided group-term insurance coverage per thousand dollars of insurance under §79(c) for all of the employees tested, assuming the employee/insureds are age 40; (2) subtract any employee co-pays; (3) test these amounts for both the highly compensated and the nonhighly compensated employees under the terms of the various tests; for example the 80% Coverage Test. (This summary assumes that the group-term life insurance plan tested is being aggregated with other plans for purposes of the 75% benefits test. The effect of this assumption is to simplify the calculation by eliminating the multiplication by the permissible adjustment fraction for compensation quoted above from the BB, p. 789.)

For example, assume that an employer is providing \$10,000 worth of protection for its nonhighly compensated employees, then the §79(c) Table 1 is \$20.40. (§79(c) Table 1 cost per \$1,000 of group term life insurance protection for a 40 year old for a one (1) month period is \$0.17.³ So, the Table 1 cost for an \$10,000.00 is \$20.40. ($\$0.17/1,000 \times 12 \text{ months} = \$2.04/1,000 \times 10 = \$20.40/\text{year.}$)

Further, assume that an employer is providing \$50,000 worth of protection for its highly compensated employees, the §79(c) Table 1 is \$20.40. (§79(c) Table 1 cost per \$1,000 of group term life insurance protection for a 40 year old for a one (1) month period is \$0.17. So, the Table 1 cost for an \$50,000.00 is \$102.00. ($\$0.17/1,000 \times 12 \text{ months} = \$2.04/1,000 \times 50 = \$102.00/\text{year.}$)

STEP TWO. Discriminatory Excess Amount. The second step is to determine the discriminatory excess, if any, of the actual cost, (expressed in dollars of coverage) of the life insurance of the highly compensated employee paid by the employer over the §79(c) costs. That is the amount included in the employee's W-2. Assume that the employer fails the 80-percent coverage test (the use of this test is limited to accident and health plans and group term life insurance plans only). The calculation to determine the discriminatory excess of the group-term life insurance plan does not use the age 40 assumption or the permissible adjustment fraction for compensation quoted above from the Blue Book. (This example of the calculation also does not use the permissible compensation adjustment fraction. The permissible compensation adjustment fraction is nowhere defined.) Instead, it uses all of the 5-year age brackets of §79(c) Table 1 costs.

An example of this calculation of this discriminatory excess is: if the annual value of this group-term life insurance for any employee at age 35 for a \$50,000.00 policy is \$150.00 per year, then the actual cost per thousand is \$3.00. The §79(c) Table 1 values for this insurance is \$1.32/1,000. If the plan is found to be discriminatory, then the highly compensated employees must report the excess of the actual cost over the Table 1 values. The calculation is $\$3.00/1,000 - \$1.32/1,000 = \$1.68/1,000$. The excess benefit then is $\$1.68 \times 50 = \84.00 .

Generally, I have found that, because of the economy afforded to employers offering term insurance to groups of employees, the actual cost of group-term life insurance for the younger highly compensated employees tends to cost less than the §79(c) Table 1 costs. So that the effect of a finding that such a plan fails the nondiscrimination tests is that there is no additional attribution of income to those employees. As the age of the highly compensated employee increase, then the greater the likelihood that the actual cost of the life insurance will exceed the Table 1 costs.

XXII. INFORMATIONAL REPORTING/RECORDKEEPING REQUIREMENTS

A. Informational Returns; §6039D. New informational reporting return obligations were created for specified fringe benefits plans meaning any plan under Code sections: 790, 105, 106, 120, 125, 127, or 129. The return shall show the number of highly and nonhighly compensated employees of the employer; the number of highly and nonhighly compensated employees eligible to participate in the plan; the

number of highly and nonhighly compensated employees participating in the plan; the total cost of the plan during the year; and the usual identification information about the employer.

B. Recordkeeping Requirements. §6039D(b) requires that any employer who maintains a specified fringe benefit plan during any year shall keep such records necessary to determine whether the requirement of the exclusion from income have been met.

XXIII. REPORTING OF INCOME AND OPTIONAL DELAY

A. In General. For calendar year plans beginning in 1989, the additional income from discriminatory plans will have to be reported on that employee's Form W-2 for 1989 when it is furnished in January of 1990. For a plan with a plan year of May 1, 1989 to April 30, 1990, any additional income does not have to be reported on an employee's Form W-2 for 1990 until it is furnished in January of 1991. However, an employer with a testing year ending in the fourth quarter of 1989, can elect to delay the reporting of the discriminatory excess for an additional year if it also delays the related tax deduction.

B. Payroll Taxes. The additional income from a discriminatory plan is subject to the FICA, FUTA and income tax withholding provisions.

XXIV. MISCELLANEOUS DEFINITIONS

Core Benefits. Core benefits means benefits provided under an accident or health plan. BB, p. 799.

Noncore Benefits. Noncore benefits means benefits provided under an accident or health plan which consist of dental, vision, psychological, orthodontia expenses, elective cosmetic surgery, and benefits under a salary reduction medical reimbursement plan or a low-level nonelective medical reimbursement plan. BB, p. 799 and 802.

XXV. CONCLUSION/GOOD FAITH COMPLIANCE.

A careful review of each of the several employee benefit plans and the employer's individual characteristics coupled with an adequate description of the plans and the disclosure to employees of the essential provisions of the plans, may, indeed, avoid some, if not all, of the taxation of these fringe benefits to highly compensated employees. At least, it may eliminate the taxation of the benefits at the non-highly compensated level. In addition, an initial review may well obviate the need for any comprehensive testing.

The IRS has announced that "...an employer's compliance with its reasonable interpretation, if made in good faith, constitutes compliance with Section 89". However, if an employer consistently resolves unclear issues in its favor, or does not make use of reasonable inferences from rules issued by the Secretary, then that will not be evidence of good faith. A fair attempt at dealing with the complexity of §89 would be evidence of good faith compliance.

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FOOTNOTES

1. Tax And Miscellaneous Revenue Act of 1988 enacted November 10, 1988.
2. TAMRA included comprehensive explanation provisions in a Conference Report called the Statement of Managers. Reference to the Statement of Managers in the article will be to the Government Printing Office edition, dated October 21, 1988.
3. Treasury Regulation §1.79-3 as amended by T.D. 7924 on December 6, 1983. These Regulations presently include the cost per \$1,000 of protection in 5-year age brackets for insureds through the age of 63. These Regulations are to be amended to include the cost per \$1,000 of protection in 5-year age brackets for insureds over the age of 63.

SECTION 89 Flowchart

