**NON-DISCRIMINATION TESTING -** SECTION 105(h) (SELF-INSURED PLANS)

**Overview:**

Section 105(h) of the Internal Revenue Code permits employers to sponsor self-insured health plans that are not insurance policies. Employers must annually run two non-discrimination tests (NDT) to ensure the tax-favored benefits flowing through each self-insured health plan do not overly favor highly compensated individuals (HCIs).

**Applies To:**

All group benefit plan sponsors, regardless of size, that offer a self-insured health plan, including level-insured plans, self-insured dental/vision plans, health FSAs, and HRAs, as well as ICHRAs that reimburse more than just individual health insurance premiums.

**Go Deeper:**

There are two non-discrimination tests under §105(h) to run on each self-insured health plan:

1. The Eligibility Test
2. The Benefits Test

*Note that self-insured health plans which employees pay pre-tax from their paychecks are also subject to completely separate tests under §125 cafeteria plan rules. Cafeteria plan tests are not discussed here.*

Employers are allowed to vary benefits or contributions by reasonable classifications as long as they don’t overly favor HCIs. For example, many employers exclude part-time employees, which is permissible if testing is passed.

The plan cannot overly favor HCIs, defined as follows:

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| --- |
| **Highly Compensated Individuals** |
| One of the five highest paid officers |
| More-than-10% shareholders in the current year |
| Among the highest-paid 25% of all employees |

Pass-through entity owners are not able to participate in HRAs or pre-tax FSAs, so they are only part of this testing with respect to self-insured health plans that are not HRAs or FSAs.

*1. The Eligibility Test*

The first test needs to show that enough non-HCIs are eligible to participate. If the self-insured health plan excludes part-time and/or seasonal employees, they can be excluded from testing. The regulations generally define these excludable groups as follows:

* *Part-time:* Less than 35 hours per week if other employees performing similar work have substantially more hours, or less than 25 hours per week without comparing to other employees.
	+ We do not have guidance on whether the Affordable Care Act’s definition of part-time as less than 30 hours per week may be used instead. Without direct guidance, excluding ineligible employees under 25 hours per week from testing would mean those with 25 to less than 30 hours are included in the eligibility test.
* *Seasonal:* Customary annual employment is less than nine months if other employees performing similar work have substantially more months of work, or less than seven months without comparing to other employees.

The plan only needs to satisfy one of the three eligibility tests:

1. The 70% test, where 70% or more of all nonexcludable employees are *enrolled*; or
2. The 70%/80% test, where 70% or more of all nonexcludable employees are *eligible* and 80% or more of those eligible are *enrolled*; or
3. A two-part Nondiscriminatory Classification Test requiring
	1. A bona fide business classification for any exclusion; and
	2. A sufficient ratio of benefiting non-HCIs to benefiting HCIs (a numeric test).

*2. The Benefits Test*

The regulations require “all benefits provided for participants who are HCIs are provided for all other participants,” including benefits for dependents. Where optional (elective) benefits are made available, the test will be satisfied if:

 (1) all participants are eligible for the optional benefit; and

 (2) there is either no required contribution for the optional benefit or the contribution is identical for

 all participants.

Only employees *participating* in the self-insured health plan are included in the Benefits Test.

Regulations provide two components to the Benefits test:

1. No discrimination on the face of the plan; and
2. No discrimination in operation.

There are several steps to prove the self-insured health plan does not discriminate on its face:

1. The required employee contributions must be identical for each benefit level.
2. The maximum benefit level cannot vary based on age, years of service, or compensation.
3. All benefits subject to reimbursement under the plan must be provided on the same terms to both HCIs and non-HCIs.
4. Different waiting periods for different groups of employees are prohibited.

Finally, the plan cannot discriminate in operation. Choosing to cover certain self-insured health benefits only for HCIs or only during a time period that one or more HCIs needs them are examples of discriminating in operation.

**Safe Harbors**

There is a safe harbor to provide annual physicals with x-rays and blood tests to just executives or HCIs without running §105(h) NDT on these physicals, but the safe harbor does not extend to their dependents and there are limits to what can be covered.

Another safe harbor allows offering self-insured retiree health benefits without running §105(h) NDT on them. However, if an HCI retires and benefits from the self-insured health plan, then the HCI retiree may have to be added back to the §105(h) testing unless all retirees are eligible for the same self-insured retiree benefits under the same terms.

Finally, there is a safe harbor related to HMOs so that an employer providing the same contribution to the HMO plan as they provide to the self-insured plan and designating them as a single health plan may include the HMO participants as being enrolled in the self-insured plan for eligibility testing purposes.

**Consequences of Non-Compliance:**

To the extent a self-insured health plan overly favors HCIs, the favorable tax treatment is partially removed for those individuals with respect to that plan.

* A failure of the Eligibility Test results in HCIs being taxed on “excess reimbursements.”
	+ The plan must tax all HCI benefits by a ratio of total benefits paid during that plan year for all HCIs divided by total benefits paid during that plan year for all participants.
	+ For example, if HCIs in the aggregate received 40% of plan benefits, then 40% of each HCI’s actual reimbursements from the self-insured plan would be taxable.
* A failure of the Benefits Test results in taxing the “excess reimbursements” the HCI obtains above what a non-HCI may obtain. However, when coverage is paid for in part with employee after-tax contributions, a three-year lookback rule is applied to pro-rate this down.
	+ If a benefit is only available to HCIs, then it is 100% taxable to any HCI receiving that benefit. However, if the HCI was paying 10% of the cost of the coverage with after-tax dollars for each of the last three years, then only 90% of it is taxable rather than 100%.
	+ If a benefit is available to HCIs more favorably than to non-HCIs, then the extra HCIs receive above what non-HCIs can receive is taxable to the HCI. Again, employee after-tax contributions can further pro-rate that down.
* Failing NDT does not disqualify the entire self-insured plan or have any impact on non-HCIs.

**Practical Implications for Employers:**

NDT is supposed to be run at the end of each plan year to include all employees hired and terminated throughout the plan year, but employers often run a preliminary test so they can make proactive adjustments that hopefully prevent tax headaches later.

If the employer is in a controlled group or other close arrangement with other related employers, NDT rules expect them to test as if they are one large employer. Employee leasing entities may also be implicated. These complicated situations make it worth outsourcing the testing to an NDT expert.

Employers sponsoring a flexible spending arrangement (FSA) and/or health reimbursement arrangement (HRA) typically hire a third-party administrator (TPA) to administer those plans on their behalf. These TPAs can be an ideal partner to hire for NDT (including preliminary tests if you want to proactively ensure your plan looks like it will pass).

Issues can sometimes arise when:

* Sponsoring different self-insured health plans for different groups, such as salaried vs. hourly or in different geographic states,
* Charging some employees more than others,
* Basing employer contributions or benefits on age, years of service, or compensation,
* Members of a related group of corporations or businesses have different self-insured health plan benefits, premium contributions, waiting periods, etc.

Testing results are kept on file and do not have to be reported, but they must be provided to the IRS upon request and might be requested as part of a merger/acquisition due diligence review.