DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

EXEMPT AND
MENT ENTITIES
IVISION

Date: June 6, 2002

Contact Person:
[redacted]
Identification Number:
[redacted]
Contact Number:
[redacted]

[redacted]

Employer Identification Number: [redacted]

Dear Applicant:

We have considered your application for recognition of exemption from federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(9). Based on the information submitted, we have concluded that you do not qualify for exemption under that section. The basis for our conclusion is set forth below.

A. Facts

You were established on [redacted] to provide benefits under a self-insured medical reimbursement plan (within the meaning of section 105(h)(6) of the Code and section 1.105-11(b)) of the Income Tax Regulations. You were funded through a combination of employer contributions and employee premiums.

For two of your sub-plans, eligibility for coverage depends on the employee's status as either a "salaried" (management and bi-weekly, non-exempt employee) or an "hourly" employee. For both salaried and hourly employees, participation in the VEBA requires the payment of regular premiums by the employee (either on a weekly or bi-weekly basis).

Description of Benefits

Your self-insured medical reimbursement plan comprises three sub-plans. These are as follows:

Hospital Plus: This sub-plan provides coverage for the costs of hospital admissions (including limited reimbursement for mental and nervous disorders, alcoholism and drug addition) and certain outpatient procedures. Each participant has a choice as to the scope of the coverage (i.e., participant only, participant plus one dependent, or family coverage). Benefits are subject to deductibles, coinsurance charges and lifetime maximum amounts.

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There are two versions of the Hospital Plus Plan: one for salaried employees and one for hourly employees. Coverage and benefits are identical for the two groups of employees, as are the required premiums. However, the version for hourly employees imposes a 24-month "eligibility waiting period" (measured from the date of hire) before coverage under the plan will begin. The version for salaried employees imposes no such waiting period.

Coverage is provided to retirees and their spouses and dependents. The coverage provided varies according to when the retirement took place. For retirements that took (or take) place after July 1, 1993, the following conditions apply. If the retiree is under age 65, coverage can be continued under the plan pursuant to the so-called COBRA requirements. If the retiree is over age 65, the employer will provide a Medicare supplement policy at "minimal cost", but only if the retiree had earned a minimum number of years of service with the sponsor. This minimum amount of service varies according to whether the retiree had been a salaried employee or an hourly employee. For salaried employees, the minimum number of years is 15; for hourly employees, the minimum number of years is 20.

Extended Plan: This sub-plan provides coverage for hospital admissions (including limited reimbursement for mental and nervous disorders, alcoholism and drug addition) and certain outpatient procedures. It also provides major medical benefits, as well as limited reimbursement for routine physical exams, vision examinations, and dental care. Catastrophic or long-term conditions are subject to managed care. Each participant has a choice as to the scope of the coverage (i.e., participant only, participant plus one dependent, or family coverage). Benefits are subject to deductibles, coinsurance charges and lifetime maximum amounts (and these are generally more favorable than those under the Hospital Plus Plan).

There are two versions of the Extended Plan: one for salaried employees and one for hourly employees. Coverage is identical for the two groups of employees. However, unlike the Hospital Plus Plan, benefits and required premiums are not identical for the two groups. Salaried employees, but not hourly employees, receive limited reimbursement for orthodontic appliances (i.e., "braces"). In addition, although all covered employees receive reimbursement for the cost of outpatient hemodialysis, hourly employees (but not salaried) employees appear to be subject to a $25 co-payment.

As was the case for the Hospital Plus Plan, the version of the Extended Plan for hourly employees imposes a 24-month "eligibility waiting period" (measured from the date of hire) before coverage under the plan will be begin. The version for salaried employees imposes no such waiting period.

Coverage is provided to retirees and their spouses and dependents. The conditions for coverage provided are substantially the same as for the Hospital Plus Plan. In particular, minimum amount of service necessary for receiving coverage is 15 years for salaried employees, but 20 years for hourly employees.

Day One Medical Plan: This sub-plan provides for the payment or reimbursement of hospital, medical and surgical charges. Coverage is extended to all full-time employees and is available to them as of the date of hire. Benefits under the plan are subject to deductibles and coinsurance charges, as well as an annual maximum of $5,000 (an amount which is far smaller

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than the annual maximums provided under the other two sub-plans). Except for benefits provided pursuant to the continuation-of-coverage provisions of COBRA, covered employees must be actively employed by the taxpayer. No benefits under this sub-plan are provided to retirees.

Coverage under more than one plan

It is unclear whether there are participants who are covered by more than one of the three sub-plans. We note that the Extended Plan can be viewed as a more generous version of the Hospital Plus Plan and, consequently, we believe it unlikely that an employee would choose to be covered under both plans. However, despite its meager annual maximum, the Day One Medical Plan imposes a much smaller per-occurrence deductible than either of the other two plans and it is conceivable that some employees might wish to purchase this coverage in addition to one of the other plans. In this regard, we note that the three sub-plans each make provision for "coordination of benefits" with other plans sponsored by the employer (and the Hospital Plus Plan makes explicit provision for coordination with the Day One Medical Plan). Thus, it appears that the drafters of the sub-plans recognized at least a possibility that participants might be covered under more than one plan. Nonetheless, we will make the assumption that there are no participants covered under more than one plan.

B. Nondiscriminatory Benefits Test: Subplans Must Be Tested Separately

Relevant Law

Section 501(c)(9) of the Internal Revenue code describes voluntary employees' beneficiary associations providing for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, if no part of the net earnings of such association inures (other than through such payments) to the benefit of any private shareholder or individual.

Section 505(a)(1) of the Code provides, in relevant part, that an organization described in section 501(c)(9) will not be exempt under section 501(a) unless it meets the requirements of section 505(b).

Section 505(b)(3) of the Code provides that in the case of any benefit for which some other Code section provides nondiscrimination rules, section 505(b) will be satisfied only if the nondiscrimination rules so provided are satisfied with respect to such benefit.

Section 105(h) of the Code sets forth nondiscrimination rules for self-insured medical reimbursement plans.

Section 105(h)(2)(A) provides that a self-insured medical reimbursement plan satisfies the requirements of section 105(h) only if the plan does not discriminate in favor of highly compensated individuals as to eligibility to participate.

Section 105(h)(2)(B) provides that a self-insured medical reimbursement plan satisfies

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the requirements of section 105(h) only if the benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals.

Section 1.105-11(c) of the regulations provides that a self-insured medical reimbursement plan does not satisfy the requirements of section 105(h) of the Code unless (i) it satisfies requirements as to eligibility to participate and (ii) it provides nondiscriminatory benefits. The requirements as to eligibility can be satisfied either by passing a percentage test or a classification test. The classification test is satisfied if the plan benefits such employees as qualify under a classification of employees set up by the employer which is found to be nondiscriminatory in favor of highly-compensated individuals. In general, this determination is made by applying the standards of section 410(b)(1)(B) of the Code, without regard to the special rules in section 401(a)(5) concerning eligibility to participate.

Section 1.105-11(c)(3)(i) of the regulations provides that benefits subject to reimbursement under a plan must not discriminate in favor of highly compensated individuals. Plan benefits will not satisfy the requirements of this subparagraph unless all the benefits provided for participants who are highly compensated individuals are provided for all other participants. In addition, all the benefits available for the dependents of employees who are highly compensated individuals must also be available on the same basis for the dependents of all other employees who are participants.

Section 1.105-11(c)(3)(iii) of the regulations discusses the question of whether discriminatory benefits are being provided to employees. This regulation states that any such benefits provided to a retired employee who was a highly-compensated individual will be deemed discriminatory unless the type and dollar limitations of such benefits are the same as those provided to all other retired participants.

Analysis

The differing benefits provided under each of the sub-plans prevents them from being considered as a single plan for purposes of testing non-discrimination (because such a single plan would run afoul of the regulatory requirement that all benefits provided to highly-compensated individuals be provided to non-highly-compensated individuals under section 1.105-11(c)(3)(i)). In addition to differences in benefits such as deductibles, lifetime maximums, and employee premiums, we note that your Extended Plan provides certain dental benefits only to salaried employees and, possibly, requires co-payments for outpatient hemodialysis only from hourly employees. Also, under both the Hospital Plus Plan and the Extended Plan, retirees with between 15 and 20 years of service with the sponsor are eligible for retiree coverage only if they had been salaried employees. Similarly situated hourly employees are not so eligible.

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C. Nondiscriminatory Eligibility Classification

Relevant Law

Section 105(h)(3)(A) of the Code provides that a self-insured medical reimbursement plan does not satisfy the eligibility requirements of section 105(h)(2)(A) unless such plan (i) benefits 70 percent of or more of all employees, (the 70% benefit test) or 80 percent or more of all the employees who are eligible to benefit under the plan if 70 percent or more of all employees are eligible to benefit under the plan (the 70/80% test); or (ii) such employees as qualify under a classification set up by the employer and found by the Secretary not to be discriminatory in favor of highly compensated individuals

Section 1.105-11(c)(2)(ii) of the regulations provides that whether a plan satisfies the requirements of section 105(h)(3)(A)(ii) will be determined based upon the facts and circumstances of each case applying the same standards as are applied under section 410(b)(1)(B) (relating to qualified pension, profit-sharing and stock bonus plans), without regard to the special rules in section 401(a)(5), concerning eligibility to participate.

Section 105(h)(3)(B) of the Code provides that for purposes of determining whether a plan meets the eligibility requirements there may be excluded from employees who have not completed 3 years of service; employees who have not attained age 25; part-time or seasonal employees; employees not included in the plan who are included in a unit of employees covered by a collective bargaining agreement if accident and health benefits were the subject of good faith bargaining; and employees who are nonresident aliens and who receive no earned income from the employer which constitutes income from sources within the United States.

Analysis

We have noted above that your three subplans must be tested separately. Despite our requests, you did not provide any census information beyond that which was already provided on the original Form 1024 and the subsequent "VEBA Census" forms (i.e., the forms used by the revenue agent who had done the initial analysis for this case). The census forms address only "non-excludable" employees and are broken down only according to the three sub-plans described above. There is no further breakdown between salaried and hourly employees. Thus, for example, you provided the number of "non-excludable" employees participating in the Hospital Plus Plan, but did not state how many of them are participating in the salaried-only version. Therefore, we are unable to form any definitive opinion as to whether any of the various sub-plans are discriminatory within the meaning of section 410(b) (as modified for purposes of section 105(h) of the Code). Nonetheless, because we think it likely that most (if not all) of the highly-compensated employees are salaried employees, we believe it likely that the salaried-only versions of the Hospital Plus Plan and the Extended Plan are discriminatory.

Finally, we would like to add some comments on the treatment of excludable employees. As provided by section 1.105-11(c)(1) of the regulations, a self-insured medical reimbursement plan will not satisfy the requirements of section 105(h) of the Code unless it satisfies the

requirements as to eligibility to participate and nondiscriminatory benefits. For purposes of the eligibility test, the regulation permits the sponsor to exclude employees who have not yet completed three years of service. The question is whether you can use the exclusion.

A literal reading of the statute and regulation suggests that you may be able to use the exclusion. However, we believe that the statute and regulation should not be given such a literal reading. Consider the case of a plan sponsored by a newly established company. In such a case, all employees of the company would necessarily be "excludable" for the first three years of the plan's existence by virtue of the fact that they can not possibly have attained more than three years of service with the employer. The literal reading of the statute and regulation suggests that, so long as your classification of eligible employees is not unreasonable on its face, your plan would be immune from all other aspects of the nondiscrimination tests for those first three years. In effect, the literal reading grants a broad exemption from discrimination testing to all companies during their first three years of existence. We believe that if Congress had really intended such a broad exemption it would have stated it explicitly in section 105(h) of the Code.

An alternative reading of the regulation would mimic the standards used under section 410(b) of the Code in the pension context. There, a plan can avail itself of an age or service exclusion for purposes of testing nondiscrimination only if the plan actually does exclude from participation all employees who do not meet the age or service conditions. Applying that concept to you, all hourly employees would be included in the tests (even those who have not yet satisfied the two-year waiting period), because you do not exclude from participation all employees who have not yet satisfied the two-year waiting period.

In the situation where some, but not all, employees were required to satisfy an initial waiting period before participating in the plan (i.e., the very situation that concerns us in your case), the Service has taken a third approach. The Service found that employees who were in the midst of their waiting periods nonetheless were participants in the plan, but with a maximum reimbursement limit of zero dollars during the waiting period. As a consequence, the plans were not discriminatory by virtue of the selectively applied waiting period. However, to the extent that any highly-compensated participant received reimbursement for expenses incurred during what would otherwise have been the waiting period, such reimbursement was taxable income to the participant pursuant to the excess reimbursement provisions of section 105(h)(7)(A) of the Code and section 1.105-11(e) of the regulations.

As we stated earlier, we believe it likely that the salaried-only versions of the Hospital Plus Plan and the Extended Plan are discriminatory within the meaning of section 410(b) (as modified for purposes of section 105(h) of the Code). This belief would become a virtual certainty if the regulation were to be given the "alternative" interpretation discussed above (i.e., the interpretation that would include all hourly employees in the tests, even those who have not yet satisfied the two-year waiting period).