

NEW NONDISCRIMINATION REQUIREMENTS FOR FULLY INSURED GROUP HEALTH PLANS UNDER PPACA

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The Patient Protection and Affordable Care Act ("PPACA") extends the nondiscrimination requirements of section 105(h) of the Internal Revenue Code of 1986 (the "Code"), to most insured group health plans. These rules, which previously applied only to self-funded group health plans, prohibit employers from discriminating in favor of highly compensated individuals relative to rank-and-file employees with respect to eligibility to participate in, and benefits provided under, a group health plan.

The new nondiscrimination requirements are effective for plan years beginning on or after September 23, 2010. However, section 1251 of PPACA excepts "grandfathered health plans" from the new nondiscrimination rule for as long as the plan maintains grandfathered status.

Insured health plans subject to the new nondiscrimination rules will face new and complex challenges in applying and satisfying those rules. This memorandum provides an overview of the new nondiscrimination rules and the existing 105(h) rules upon which they are based, highlighting a number of open issues.

BACKGROUND ON 105(h) AND CURRENT STATUS

PPACA does not literally extend section 105(h) of the Code to fully insured group health plans. It adds section 2716 to the Public Health Services Act ("PHSA"), which provides that insured plans must satisfy the substantive requirements of section 105(h). Section 2716 is incorporated by reference into the Employee Retirement Income Security Act of 1974 ("ERISA") and the Internal Revenue Code. This distinction is significant for a number of reasons as discussed more fully below. For the most part, however, it would appear that the rules applicable under PHSA section will track the 105(h) rules previously applied to self-funded plans.

Even though section 105(h) was added to the Internal Revenue Code in 1978 there is very little interpretive authority. The Treasury/IRS issued final regulations in 1981 as well as a handful of private letter rulings in the early 1980s. However, section 105(h) was temporarily repealed in 1986 in connection with the enactment of the more expansive nondiscrimination rules of section 89, which would have applied to fully insured group health plans. After a public outcry over its complexity and burdens, section 89 was repealed and section 105(h) was reinstated retroactively in 1989.

Since then, the Treasury/IRS has generally avoided the issue of nondiscrimination rules in the context of group health plans. The IRS has not issued any precedential guidance interpreting section 105(h) since the repeal of section 89 and has listed section 105(h) as a "no rule" area, which means that the IRS will not issue private letter rulings in the area. Moreover, the IRS has attempted to enforce section 105(h) on only rare occasions.

FUTURE GUIDANCE

The extension of section 105(h) to fully insured plans as part of PPACA could ultimately cause the government to reconsider whether further guidance is required. While it is anticipated that the Treasury Department might well take the lead in crafting any such new guidance, the inclusion of the provision in the PHSA (with certain cross-references to ERISA) makes it likely that any guidance that is published will likely come jointly from the three agencies responsible for much of the other PPACA guidance that has been released to date (Treasury, Labor and HHS).

Over the short-term, we understand that the agencies with interpretive authority over PPACA have been working on guidance, although it is not yet certain whether that guidance will be published prior to the September 23rd effective date. Informal indications are that if any guidance is published in the near-term, it is likely that the agencies will simply indicate that the existing 105(h) rules are the basis for the application of the new PPACA nondiscrimination rules with a request for comment on whether further guidance is needed.

SCOPE

Because the new nondiscrimination rules were added as part of the PHSA, rather than directly to section 105(h) of the Code, certain plans will be automatically excepted from its scope, even though those plans might have been subject to the 105(h) rules if the plans were self-insured.

Grandfathered Plans are Excepted

– Perhaps the broadest exception to the new nondiscrimination applies to plans that constitute “grandfathered plans” within the meaning of PPACA section 1251 and related tri-agency regulations. To be a grandfathered plan, a plan generally must (i) have provided coverage to at least one covered individual on March 23, 2010, and (ii) not undertake any actions (or fail to take any actions, such as with respect to certain notice and recordkeeping requirements that apply to grandfathered plans) that would cause the plan to lose grandfathered status, as set forth in the tri-agency regulations. Significantly, the regulations issued by Labor, Treasury and HHS are very restrictive and provide little flexibility for plan sponsors in terms of making changes or modifications to their plans.¹ Nonetheless, to the extent a fully insured plan qualifies as a grandfathered plan for purposes of PPACA section 1251, it is excepted from the new nondiscrimination rules.

¹ This is perhaps best evidenced by the statement in the preamble to the regulations that a “mid-range” estimate is that 66 percent of small employer plans and 45 percent of large employer plans will relinquish their grandfather status by the end of 2013.

HIPAA-Excepted Benefits are Not Covered

– Unlike section 105(h), which applies broadly to all self-insured plans that reimburse medical expenses, the PPACA version of section 105(h) does not apply to HIPAA excepted benefits,

including limited scope dental or vision benefits offered separately. Similarly, long-term care benefits that qualify as excepted benefits are not subject to the new nondiscrimination requirements.

Treatment of Former Employees

– Although not perfectly clear, it appears that the nondiscrimination rules may not be applicable to group health plans that provide benefits only to former employees. In this regard, notwithstanding the absence of an exemption in the PHSA, the relevant agencies have taken the position that the group market reforms in the PHSA, including section 2716, do not apply to a group health plan that covers fewer than two participants who are employees.² Note, however, given that section 105(h) clearly applies to former employees, it seems somewhat anomalous that section 2716 would be inapplicable to group health plans covering former employees.

² Preamble to Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under PPACA.

Governmental Plans

– For the same reason that PHSA section 2716 appears to be inapplicable to plans governing former employees, it appears that PPACA's nondiscrimination rules (unlike section 105(h)) will not be interpreted as applying to governmental plans. Whether this is in fact the case, however, is not entirely clear.

THE SECTION 105(h) NONDISCRIMINATION TESTS

When applicable, section 105(h) involves two separate and complex tests – somewhat mislabeled as (1) an eligibility test and (2) a benefits test. Both tests depend on whether the plan disproportionately favors “highly compensated individuals” relative to other employees.

Highly Compensated Individuals Defined

– For purposes of the 105(h) tests, highly compensated individuals are defined to include the following.

- The 5 highest paid officers;
- A 10% or more shareholder; and
- An individual who is among the highest paid 25% of all employees (other than excludable employees discussed below).

Note that this definition is much broader than the class that is taken into account under other nondiscrimination testing regimes, including the cafeteria plan rules and the tax-qualified plan rules. Any employee in the top quarter of the employee population will be considered a highly compensated individual. There is no minimum dollar threshold, such as the current \$110,000 for

highly compensated employee status under the cafeteria and retirement plan rules.

Excludable Employees

– Certain employees may be disregarded in performing the eligibility test (as discussed below), including employees who have not completed 3 years of service, part-time employees whose customary weekly employment is less than 35 hours, seasonal employees, employees subject to a collective bargaining agreement, employees who have not attained age 25, and nonresident aliens. These employees are not taken into account in the denominator in determining whether the employer's plan has satisfied the eligibility test.³

³ There is a substantial unanswered issue with respect to excludable employees. At times, the IRS has informally suggested that an otherwise excludable employee may not be excluded if the employer benefits some otherwise excludable employees. Thus, for example, if the employer provides group health plan coverage to some part-time employees but not all part-time employees, it is possible that all part-time employees must be taken into account in testing.

The Eligibility Test —

A plan satisfies the eligibility test if it satisfies any one of the following three tests:

- The plan benefits at least 70% or more of all employees,
- 70% of all employees are eligible to benefit under the plan, and at least 80% or more of those eligible in fact benefit; or
- The plan benefits a nondiscriminatory class of employees (the "nondiscriminatory classification test").

Although there is at least some ambiguity, the eligibility tests appear to apply based on who is actually *benefitting* under the plan, not on mere eligibility to participate. As a result, if a group health plan provides that employees must pay a portion of premiums, it appears that only employees who elect to pay their share of the premiums and, therefore, benefit under the program are taken into account in the numerator. Thus, to the extent that an employer designs a group health plan that results in a substantial portion of its population opting out, the plan may have an eligibility program. This may become an even greater issue if, for example, a substantial number of employees opt out to obtain coverage through a health insurance exchange or decide to obtain coverage from a spouse's employer.

Also, the eligibility test depends on numeric testing of the employer's workforce. The data gathering aspect of the tests alone could represent a substantial new burden for some employers. Moreover, the eligibility test applies on a controlled group basis. That is, all employers who share a common parent (generally based on 80% ownership) are treated as a single employer. There is no provision for separate testing of different entities, divisions, or lines of business.

Finally, by far the most flexible test is the nondiscriminatory classification test. It is, however, also by far the most complicated to apply. The section 105(h) regulations incorporate the nondiscriminatory classification test under section 410(b) for tax-preferred retirement plans.⁴ The 410(b) test requires that the eligibility class satisfy (i) a subjective standard that the classification is reasonable and established under objective business criteria and (ii) an objective standard that it is a nondiscriminatory classification under a numeric test that is based on covering a specified percentage of non-highly compensated individuals. The required percentage of non-highly compensated individuals that must be covered varies based on the percentage of highly compensated individuals who are covered and the extent to which the employer has a higher or lower concentration of highly compensated individuals overall. A table in the section 410(b) regulations specifies the relevant ratios for different concentrations of non-highly compensated employees in an employer's workforce. Based on the coverage of highly compensated employees relative to non-highly compensated employees in the workforce, the employer will either fit within a numeric safe harbor nondiscriminatory classification or, if the percentage is in a gray area, then the employer may be able to demonstrate that the classification is a nondiscriminatory classification based on the facts and circumstances.

⁴ Note that the section 105(h) regulations were published before the current 410(b) regulations were finalized. Thus, at the time the 105(h) regulations were published a different set of 410(b) regulations was in effect. It is fairly clear that a plan may rely on the current nondiscriminatory classification test under the 410(b) regulations. There is also an argument that the old law test – referred to as the fair classification test – is applicable.

An example in the section 410(b) regulations only begins to illustrate the complexity of the test: Example: Employer A has 200 nonexcludable employees, of whom 120 are non-highly compensated employees and 80 are highly compensated employees. Employer A maintains a plan that benefits 60 non-highly compensated employees and 72 highly compensated employees. The employer's non-highly compensated employee concentration percentage is 60 percent (120/200). Employer A's safe harbor percentage is 50 percent and its unsafe harbor percentage is 40 percent.⁵ The plan's ratio percentage is 55.56 percent $[60/120]/[72/80]=50\%/90\% = 0.5556$). Thus, in this case the plan's ratio percentage is greater than the safe harbor percentage and the plan is deemed to be a nondiscriminatory classification.⁶

⁵ This number is derived from the table in the IRS regulations.

⁶ If the facts had been different and the plan's ratio percentage was between 40% and 50%, then the plan could still satisfy the nondiscriminatory classification test under all the facts and circumstances. If the plan's ratio percentage were below 40%, then it would not satisfy the nondiscriminatory classification test.

The Benefits Test —

In contrast to the eligibility test, the benefits test is on its face quite simple, albeit strict. It states simply that all benefits provided for participants who are highly compensated individuals must be provided for all other participants. This test applies based on benefits subject to reimbursement, not to actual payments of claims. The benefits test, for example, precludes a lower deductible or co-pay for highly compensated individuals. It is not, however, affected by whether the actual utilization rate is higher for highly compensated individuals.

Treasury regulations do, however, provide a special rule for a plan that provides optional benefits that potentially softens the strict general benefits test. Under the special rule, an optional benefit will not run afoul of the rule requiring that all non-highly compensated individuals get the same benefits as highly compensated individuals if all eligible participants may elect the benefit and the required employee contributions are the same amount. Thus, for example, a plan may offer an indemnity option and an HMO option under the same plan without running afoul of the nondiscrimination rules, provided that both options are universally available and the employee's share of the premium is the same for all employees.

In contrast to retirement plans which generally permit benefits to vary relative to the compensation earned by a participant, Treasury regulations interpreting section 105(h) expressly provide that a plan discriminates if the benefits subject to reimbursement under the plan vary in proportion to compensation.

Interaction Between The Eligibility Test and the Benefits Test

– The line between the eligibility test and the benefits test may blur in certain circumstances. In a private letter ruling issued in the early 1980s, the IRS took the position that a plan which made certain highly compensated individuals immediately eligible for participation but imposed a 90-day waiting period for other employees ran afoul of the benefits test. That is, even though a waiting period is arguably an eligibility feature, the IRS tested it under the inflexible benefits test. As a result, the plan could not satisfy section 105(h) even if it passed the numeric coverage requirements during the waiting period.

This notion that eligibility features may be tested under the stringent benefits test of section 105(h) raises the specter that different employees may not be required to pay different shares of the premium obligation. It suggests, for example, that an employer may not fully subsidize premiums for highly compensated individuals while requiring that rank-and-file employees pay a portion of the premiums.

Operational Compliance

– The benefits tests must be satisfied in both form and in operation. It is not enough for a plan document to merely include provisions that satisfy section 105(h). The arrangement must be operated in a manner that is nondiscriminatory. A closely related issue has to do with the timing of amendments or plan changes. Treasury regulations provide that a plan change may cause the arrangement to run afoul of section 105(h) if the timing of the change, for example, a plan termination (or the elimination of a benefit under the plan) has the effect of discriminating in favor of highly compensated individuals.

Aggregation and Disaggregation

– An employer is largely free to define the “plan” subject to nondiscrimination testing. That is, the employer may aggregate and disaggregate arrangements into component plans. An employer may, for example, treat two different populations covered by a single written plan document as two separate plans for nondiscrimination testing purposes. This is sometimes done because differences in benefits would otherwise cause an arrangement to fail to satisfy section 105(h) but the plan is able to satisfy the eligibility requirements if each benefit structure is tested separately. Similarly, two or more plans may be aggregated for testing purposes, although this is done less frequently simply because differences in benefit structures may make aggregation impracticable. To the extent that an employer chooses to aggregate two plans together for testing purposes, it must do so for both the eligibility and benefits test.

Former Employees

– As mentioned above, it appears that PPACA's nondiscrimination rules do not apply to a retiree-only plan. However, to the extent that a fully insured group health plan covers both current and former employees, the rules will apply. There is, however, very little guidance on how section 105(h) applies to former employees. The regulations absolve a plan from performing numeric coverage testing with respect to a “retired employee” but provide that all benefits provided to a retired highly compensated individual must be provided to all retired employees. There is, however, no definition of retired employee. This could, for example, raise a question about whether an employer may pay COBRA premiums for former highly compensated individuals but not other individuals.⁷

⁷ More generally, it is not clear how COBRA elections will be taken into account, although presumably a plan will not fail the nondiscrimination rules solely because former highly compensated individuals elect COBRA coverage at a higher rate.

SOME IMPLICATIONS FOR INSURED PLANS

In general, fully insured benefits provided solely to highly compensated individuals will now run afoul of the new nondiscrimination requirements to the extent they apply (e.g., the plan is not grandfathered). As a result, fully insured executive medical plans will generally be prohibited. There is, however, an exception from the requirements of section 105(h) for “reimbursements paid under a plan for medical diagnostic procedures” for an employee, but not a dependent. This carve-out generally allows for executive physicals and related transportation expenses.

Treatment of After-Tax Premiums

– One approach to section 105(h) problems affecting self-insured plans is to provide that premiums paid on behalf of highly compensated individuals are paid with after-tax dollars. This generally has the effect of making the arrangement one that is taxed under section 104(a)(3) of Code, which has no nondiscrimination requirements. It appears, however, that this approach will not be effective under the PPACA for insured plans. That is, it appears that employee after-tax payments to a fully insured group health plan, and related benefits, will be subject to

nondiscrimination testing. In this regard, there is nothing analogous to section 104(a)(3) under the section 105(h) rules as incorporated in the PHSA, ERISA, and the Code by the PPACA.

Interaction with Cafeteria Plan Nondiscrimination Rules

– There is substantial overlap between the nondiscrimination requirements under Code section 125 for cafeteria plans and section 105(h). In this regard, for example, both sections impose an eligibility test that may be satisfied using the nondiscriminatory classification test. There are, however, substantial differences. For example, the two sections define highly compensated individuals differently, and the cafeteria rules include a key employee concentration test, which is often problematic.

Penalties for Failure to Satisfy Nondiscrimination Rules –

The consequences associated with a failure to satisfy section 2716 of the PHSA are not the same as those associated with a failure to satisfy section 105(h). Under 105(h) generally, highly compensated individuals in a discriminatory self-insured plan are taxed on medical expense reimbursements actually paid. However, a failure to satisfy PHSA section 2716 will, depending on the size of the plan sponsor, involve a different set of penalties under the Code, ERISA, and the PHSA.

As mentioned above, PPACA merely utilizes the nondiscrimination standards of section 105(h) of the Code without incorporating its penalties for failure. Instead, the employer sponsoring a fully insured group health plan that fails to satisfy section 105(h) is subject to an excise tax under section 4980D of the Code. Significantly, there is an exception from the excise tax for a group health plan maintained by a small employer, which is generally defined as an employer employing an average of at least 2 but not more than 50 employees on business days during the preceding calendar year. However, it is our understanding from speaking with Treasury representatives that the Department is likely to read the exception to only apply where the prohibited discrimination results from the underlying insurance policy itself versus employer plan design or related employer activity (such as discriminatory plan eligibility rules or employer premium subsidies).

The excise tax under Code section 4980D is \$100 per day during the noncompliance period with respect to “each individual to whom the failure relates”, not to exceed the lesser of 10% of the group health plan costs or \$500,000. There is, however, no penalty if the failure is not discovered exercising reasonable diligence, or if the failure is due to reasonable cause and corrected within 30 days of discovery.

In terms of identifying the individuals “to whom the failure relates”, it seems quite likely that the sponsor and/or issuer may need to look to different classes of persons depending on the nature of the failure. Take for example a failure related to excluding individuals from coverage generally. In this instance it would seem to be that appropriate individual to look to is *not* with respect to an enrollee, but rather to those participants who are being excluded from coverage. On the other hand, take for example a failure with respect benefits provided under the plan. In this instance, the correct approach would appear to be to look to the participants in the plan who subject to reduced benefits.

In addition, PPACA nondiscrimination requirements are included in ERISA and also the PHSA. With respect to the former, it appears likely that a participant (or the Department of Labor) is permitted to bring a lawsuit utilizing ERISA's remedial provisions to compel compliance with the

nondiscrimination standards. These remedies would be available with respect to both large and small group health plans.

With respect to the latter, there is some lack of clarity regarding whether issuers may be subject to penalty under the PHSA with respect to a discriminatory fully insured plan. In general the PHSA applies only to issuers and non-federal governmental plans. The basis for the lack of clarity is that new PHSA section 2716 states only that a fully insured "group health plan" shall not discriminate; there is no express reference to issuer (as included in various other PPACA insurance reforms). The absence of any reference to "issuer" leaves unclear whether issuers may be subject to penalty under the PHSA. Given that issuers are unlikely to know whether a plan is in fact discriminatory, this would seem to counsel against subjecting issuers to liability.

To the extent the nondiscrimination rules contained in PHSA section 2716 apply to issuers, the penalty regime is fairly similar to that provided under the Code (as set forth above), with several notable differences. As under the Code, the maximum amount of the penalty is \$100 per day with respect to each individual to whom the failure relates. However, unlike with regard to the excise tax under the Code, *no* maximum penalty applies for the tax year at issue; thus the penalty could exceed the \$500,000 threshold that applies for purposes of the Code. In determining the amount of the penalty, the statute provides that the HHS Secretary will consider the previous record of compliance of the entity and the gravity of the violation. The statute also provides that the penalty shall not apply (i) where the failure was not discovered despite the exercise of reasonable diligence, and (ii) where the failure was due to reasonable cause (and not willful neglect) and is corrected during the 30-day period beginning on the first day that any of the entities against which the penalty is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

IMPLICATIONS FOR SELF-INSURED PLANS

Although PPACA's nondiscrimination requirements are applicable only to certain fully insured group health plans, it is possible that the new requirements could ultimately have a material impact on self-insured plans. As mentioned above, Treasury/IRS has for many years avoided issues related to the interpretation of section 105(h). At some point, we anticipate that the responsible agencies could publish more substantive guidance interpreting the PHSA provisions and that guidance could (and most likely would) also have implications for the application of the currently vague rules of section 105(h).

NEXT STEPS

Employers and providers of insured group health plans other than grandfathered plans should be reviewing their demographics and plan design with an eye to the requirements of section 105(h). There will be a number of features where it is unclear how the new nondiscrimination requirements will apply. While the responsible agencies may issue interim guidance in the near future, it does not appear likely that such near-term guidance will address many of the uncertainties in application of the section 105(h) rules.

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Summary Code Section 105(h) Nondiscrimination Tests

