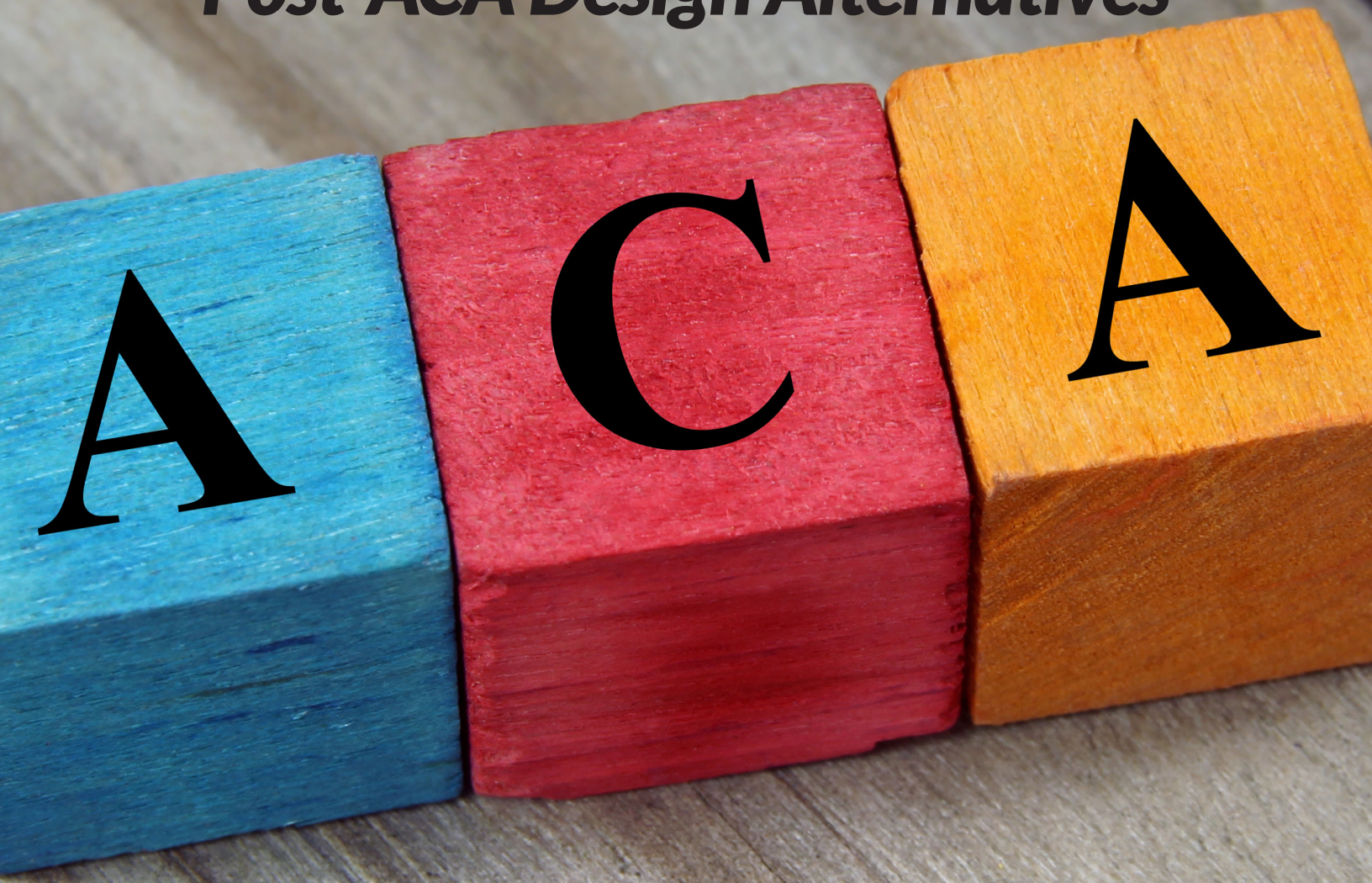
Nondiscrimination Testing for Health Plans: *Code Section 105(h) and Post-ACA Design Alternatives*



Prepared by:
Tonie L. Bitseff
Buchalter

LORMAN®

Published online at www.lorman.com - November 2019

INTRODUCING

Lorman's New Approach to Continuing Education

ALL-ACCESS PASS

The All-Access Pass grants you UNLIMITED access to Lorman's ever-growing library of training resources:

- ☑ **Unlimited Live Webinars** - 110+ live webinars added every month
- ☑ **Unlimited OnDemand and MP3 Downloads** - Over 3,500 courses available
- ☑ **Videos** - More than 1,800 available
- ☑ **Slide Decks** - More than 2,800 available
- ☑ **White Papers** - More than 1,800 available
- ☑ **Reports**
- ☑ **Articles**
- ☑ **... and much more!**

Join the thousands of other pass-holders that have already trusted us for their professional development by choosing the All-Access Pass.

Get Your All-Access Pass Today!

SAVE 20%

Learn more: **www.lorman.com/pass/?s=special20**

Use Discount Code Q7014393 and Priority Code 18536 to receive the 20% AAP discount.

*Discount cannot be combined with any other discounts.

Nondiscrimination Testing for Health Plans: Code Section 105(h) and Post-ACA Design Alternatives

The Affordable Care Act (ACA) explicitly prohibits eligibility exclusions and discrimination based on compensation, health status, protected classifications, and excess waiting periods. These rules build on prior Internal Revenue Code (IRC) rules that protected rank and file employees from discrimination and protected certain vulnerable groups, like the sick and disabled. Post ACA, employers and health coverage providers are increasingly sensitive to perceived and actual discrimination. There is a renewed effort to design programs to avoid discrimination and to test actual operations to ensure that those designs translate into actual protections.

IRC Nondiscrimination Rules

Originally Congress expected ACA rules that prevented insured health plans from discriminating against rank-and-file employees to become effective by 2014. It included a statutory provision that authorized the IRS to develop nondiscrimination rules similar to those that apply to self-funded plans under Code Section 105(h)(2). In reality, that Code section is very limited in application and contains rules that are seldom understood or applied. Most health benefits are subject to nondiscrimination rules, but those rules are found in Section 125 of the Code and apply to any plan that allows employees to contribute to the cost of coverage on a pre-tax basis. The Section 125 rules are similar to nondiscrimination testing for

401(k) plans, which means they are rules that many employers and advisors are familiar with. The Code Section 105(h)(2) rules are not, but they are the rules that Congress required the IRS to use as a model. Not surprisingly, the IRS has been unable to develop workable rules and the requirement is delayed until after final regulations are issued.

Current Self-funded Health Plan Nondiscrimination Rule

To understand how Nondiscrimination rules will impact eligibility, it is necessary to understand the procedures for IRC Section 105(h)(2) testing and main testing strategies using restructuring. This testing currently applies to self-funded health plans. Failure to pass the testing results in taxation for the "prohibited group." The Affordable Care Act applies testing based on IRC Section 105(h)(2) to insured health plans, but failure to pass the testing results in an excise tax imposed on the plan sponsor or administrator. IRC Section 105(h)(2) and the applicable regulations are relatively old rules. There was an attempt to modernize them with IRC Section 89, but when that failed, the old Section 105(h) rules were revitalized. This makes the rules difficult to apply to modern health coverage that was not contemplated by the rules or regulations. As a result, many self-funded plans do not test and enforcement has been sparse and sporadic, focusing primarily on retiree health benefits and MEWAs.

The Prohibited Group ("HCIs") and Excludable Employees

The "prohibited group" also known as "highly compensated individuals" ("HCIs") is different for purposes of Section 105(h) testing than other testing. Instead of looking at prior year compensation under an IRC Section 414 definition, the test looks at current year compensation. As a result, it is not possible to run the actual test until after the end of the year, but it is not possible to correct after the end of

the year, which makes it difficult to advise employers as to when to test. Running the test twice is advised.

Instead of imposing a dollar threshold, the top-paid quarter of the workforce is treated as highly compensated. Code §105(h)(5) defines "highly compensated individual" as an individual who is one of the five highest-paid officers; a shareholder who owns more than 10% of the value of stock of the employer's stock; or among the highest-paid 25% of all employees (other than excludable employees who are not participants). Employees that are excluded from testing include employees who have not completed three years of service prior to the beginning of the plan year, employees who have not attained age 25 before the plan year, part-time and seasonal employees (using definitions that are not consistent with current ACA employer mandate definitions), those who are covered by a collective bargaining agreement, and nonresident aliens who do not receive U.S.-source earned income, but only if those individuals are excluded from eligibility. Under the Affordable Care Act, many of these exclusions will not apply.

The Benefits Test and the Eligibility Test

The Code §105(h) rules require self-funded plans to satisfy two tests:

The Benefits Test: A plan fails the benefits test by design if the maximum benefit level that can be elected may vary based on compensation, age, or years of service; the same type of benefits (e.g., medical expenses) that are provided to HCIs are not provided to all other participants; or disparate waiting periods are imposed Employer contributions "must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reason of a participant's age or years of service" and "the type or the amount of benefits

subject to reimbursement…[may not be determined] in proportion to employee compensation." In short, a plan design that provides a higher level of coverage for any individual in the prohibited group would be discriminatory on its face. A plan that is facially nondiscriminatory also cannot be operated so that it is discriminatory based on the facts and circumstances. This could occur, for example, by applying lower claims substantiation standards for HCIs (e.g., requiring a medical practitioner's note from non-HCIs for dual-purpose expenses, while not requiring the same for similar claims from HCIs). The reality is that if is very difficult for modern health care coverage to pass the benefits test, particularly if coverage is extended to diverse geographic areas.

The Eligibility Test: Under the Eligibility Test, a self-funded plan cannot discriminate in favor of HCIs as to eligibility to participate. This test consists of three alternative tests—the 70% Test (the Plan benefits 70% of nonexcludable participants); the 70%/80% Test (70% of all nonexcludable participants are eligible and 80% of those who are eligible benefit); and the Nondiscriminatory Classification Test (the plan "benefits…such employees as qualify under a classification set up by the employer and found by the [IRS] not to be discriminatory in favor of highly compensated individuals.) There are two ways to show that the classification is nondiscriminatory. The nondiscriminatory classification test found in Code §410(b)(2)(A)(i) and Treas. Reg. §1.410(b)-4 (the Post-TRA Nondiscriminatory Classification Test); or the fair cross-section test that was used under Code §410(b) before the TRA (the Pre-TRA Fair Cross-Section Test). The availability of the nondiscriminatory classification test makes it fairly easy for plan terms that have a nondiscriminatory business purpose to pass the test. This is true for two reasons: first, the test can be passed with a fairly low ratio percentage and, second, there is a good argument that "benefiting" for

purposes of the nondiscriminatory classification test, unlike the 70% or the 70%/80% test, is based eligibility not the actual coverage under the plan. This is because the classification itself is being tested under the plain wording, not enrollment.

Restructuring

In order to address the testing obstacles created by IRC Section 105(h)(2)'s strict benefits test, it is often necessary to "restructure" self-funded plans so that a single plan will be treated for testing purposes as separate plans. This restructuring treats each separate benefit level, option, subsidy, or waiting period as a separate plan. That separate plan then needs to separately pass eligibility testing, but because the nondiscriminatory classification test is lenient, that test usually can be passed by each restructured component plan. Authority for this type of restructuring is provided by Treasury Regulation §1.105-11(c)(4), which states that "a single plan document may be utilized for two or more separate plans provided that the employer designates the plans that are to be considered separately and the applicable provisions of each separate plan." The employer then "may" designate one or more of the plans as a single plan for discrimination testing purposes. Neither the Code nor the regulations provide any guidance on exactly how (or when) this restructuring must be accomplished. Ideally, the restructuring would be made in advance of the beginning of the plan year and as a part of the plan document, but that is not explicitly required. Finally, before restructuring, a few issues need to be considered.

First, the classification must be based on a business distinction that is not facially discriminatory. For example, distinctions between different working groups, hourly/salary, or different locations would be bona-fide, but simply treating

executives or those making more money better would not be. Second, a preliminary assessment should be done to make sure that each restructured plan will pass nondiscriminatory classification testing. If it does not, all HCI benefits will be taxable for that component plan. That may produce less desirable tax consequences than failing the benefits test where the HCI would only be taxed on the excess benefit (the amount of benefit that the HCIs' receive that others do not). Any restructuring should be carefully considered and not mechanically done

Insured Health Plan Nondiscrimination Rules

We do not have regulations outlining the Nondiscrimination Rules that will apply to insured plans and it is difficult to understand how the existing Section 105(h) rules will apply. Employers should watch for regulations, but should not expect this rule to go into effect until 2017 or later. There are a few items that employer's should consider as they wait to see if these rules actually go into effect. First, they should maintain grandfathered status if possible for their insured executive plans. Second, if they anticipate losing grandfathered status for their executive plans, they should explore self-funding because the consequences of failing nondiscrimination testing in a self-funded plan is a tax on the executive, but if an insured non-grandfathered plan fails, testing, an ACA excise tax is imposed on the plan and sponsor. Third, they should review executive employment contracts in advance of final regulations to avoid any conflict between the contract terms and the nondiscrimination rules.

Health Status

The Affordable Care Act prohibits discrimination in eligibility for coverage based on a health factor by incorporating the prohibition by reference into ERISA Sections 702 and 715 and Code Sections 9802 and 9815. Before the Affordable Care Act, Health Insurance Portability and Accountability Act (HIPAA), prohibited discrimination based on one or more health factors, but regulations implementing this provision permit more favorable rules for eligibility or reduced premiums or contributions based on an adverse health factor (sometimes referred to as benign discrimination). In sub-regulatory guidance, the agencies have clearly stated that an employer cannot offer cash in lieu of health coverage to employees with a high-claims-risk regardless of whether (1) the cash payment is treated by the employer as pre-tax or post-tax to the employee,(2) the employer is involved in the selection or purchase of any individual market product, or (3) the employee obtains any individual health insurance.

According to the Q&As, such offers fail to qualify as benign discrimination for two reasons. First, if an employer offers a choice of additional cash or enrollment in the employer's plan to a high-claims-risk employee, the opt-out offer does not reduce the amount charged to the employee with the adverse health factor. Instead, the employer's offer of cash to a high-claims-risk employee who opts out of the employer's plan increases the cost to that employee because they must forgo the cash and pay their portion of the premium to participate.

Second, benign discrimination generally permits providing enhancements to eligibility for coverage based on an adverse health factor, but not cash as an alternative to the plan. In particular, the regulations permit providing plan eligibility criteria that offer extended coverage within the plan and subsidization of

the cost of coverage within the plan based on an adverse health factor, for example disabled children may be covered beyond age 26 even though other children are not and the plan may provide coverage free of charge to disabled participants. Providing cash as an alternative to health coverage for individuals with adverse health factors is not the same according the the Q&As because it is an eligibility rule that discourages participation in the group health plan.

Protected Classifications

Section 1557 of the Affordable Care Act provides that individuals cannot be subject to discrimination based on their race, color, national origin, sex, age, or disability. Section 1557 has been in effect since its enactment in 2010 and the HHS Office for Civil Rights (OCR) has been enforcing the provision since it was enacted. Section 1557 applies to any health program or activity, any part of which receives funding from HHS, such as hospitals that accept Medicare patients or doctors who treat Medicaid patients. It applies to any health program that HHS itself administers. And it applies to the Marketplaces and to all plans offered by issuers that participate in those Marketplaces.

HHS Rules

Department of Health and Human Services (HHS) issued final rules implementing Section 1557 to advance health equity and reduce disparities in health care and to harmonize protections provided by existing, well-established federal civil rights laws. Section 1557 is the first federal civil rights law to prohibit discrimination on the basis of sex in health care. It extends nondiscrimination protections to individuals enrolled in coverage through the Health Insurance Marketplaces and

certain other health coverage plans. And it provides that HHS's health programs are covered by the rule.

The rule addresses some of the populations that have historically been subject to discrimination. For example, the rule includes prohibitions on gender identity discrimination as a form of sex discrimination, enhances language assistance for people with limited English proficiency, and requires effective communication for individuals with disabilities. The rule requires that women have equal access to the health care they receive and the insurance they obtain. Moreover, the rule makes clear that sex discrimination includes discrimination based on gender identity. For example, individuals cannot be denied health care or health coverage based on their sex, including their gender identity.

Religious Exemptions

Nothing in the rule would affect the application of existing protections for religious beliefs and practices, such as provider conscience laws and the regulations issued under the ACA related to preventive health services. When the rule was proposed, the agency requests comment on whether Section 1557 should include an exemption for religious organizations and what the scope of any such exemption should be. The final rule did not contain a religious exemption, which led to legal actions brought by a religious organization resulting in a nationwide injunction enjoining Section 1557's prohibition against discrimination on the basis of gender identity and pregnancy termination. Categorical exclusions may still be deemed discrimination by the EEOC under the ADA and Executive Order 11246 still applies similar rules to federal contractors.

Communication with Individuals with Limited English Proficiency and with Individuals with Disabilities.

The rule adopts the longstanding principle that covered entities must take reasonable steps to provide meaningful access to individuals with limited English proficiency. Covered entities would be required to:

- Post a notice of consumer rights providing information about communication assistance; and
- Post taglines in the top 15 languages spoken by individuals with LEP nationally, indicating the availability of such assistance.

To reduce burden and costs, OCR provides a sample notice and translated taglines for use by covered entities and translates the notice into 15 languages and provide the translated notices to covered entities, should they wish to post one or more of those notices for their consumers.

The rule also requires covered entities to provide effective communication for individuals with disabilities by providing access to auxiliary aids and services, including alternative formats and sign language interpreters, unless the entity can show an undue burden or a fundamental alteration. The notice that covered entities must post provides information about these services.

Waiting Periods

The Affordable Care Act provides that a group health plan or health insurance issuer offering group health insurance coverage will not apply any waiting period that exceeds 90 days. The administrative departments issued proposed regulations that could be relied on in 2014 and that were finalized effective for 2015. Under the regulations, substantive eligibility conditions will not violate this rule unless

they are based solely on the lapse of time or are designed to avoid compliance with the 90-day waiting period limitation. There are a number of examples.

- Examples in the regulations specifically refers to “job title” as a substantive eligibility condition.
- Working a specified number of hours in each month is considered a substantive eligibility provision. The regulations specifically state that when it cannot be determined that a newly-hired employee is reasonably expected to work the specified number of hours in each month, the plan may take a reasonable period of time (generally 12 months) to determine whether the employee will meet the requirements.
- If a group health plan or health insurance issuer conditions eligibility on an employee’s having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.
- A bonafide orientation period of not more than three months is also allowed as a substantive eligibility requirement.

Additional requirements not linked directly to hours worked over specified periods of time are acceptable alternatives and will not be confined by the 1200 hour and 12-month period limitations contained in the proposed and final regulations.

Compliance with the 90-day rule is not determinative of compliance with any other provision of State or Federal law including the Employer Mandate of Section

4980H, which requires applicable large employers to offer coverage to full-time employees and their dependents or make an assessable payment.

Union Plans

Plans established or maintained pursuant to collective bargaining are treated differently from other plans under several eligibility rules.

First, collectively bargained employees are exempt from the Nondiscrimination rules under Code Sections 125 and 105(h)(2). Second, an employer who contributes to a collectively bargained health plan that provides affordable minimum value will not be penalized under Section 4980 in any month that the employer makes a contribution pursuant to the bargaining agreement even if the plan does not actually cover the employee in the same month. This allows the use of hours banks and similar structures common in collectively bargained arrangements.

In the collectively bargained context, some argue that a cumulative hours-of-service requirement can be used instead of a monthly measurement period or look-back period. The argument to inject the cumulative hours-of-service rule into 4980 is found through an interpretation of a cross reference to the waiting period rules. The argument couples the cross reference with some deletion in the footnotes to the final regulations. Some contend that this signals IRS approval of the cumulative hours-of-service rule's use in section 4980H. This position ignores the plain language of the regulation. It also ignores the fact that the cumulative hours-of-service rule is a substantive eligibility requirement (akin to an orientation period) and not a substitute for the 12-month measurement period. The new

orientation rules are clearer on this distinction in the preamble, but do not explicitly address cumulative service.

Some also argue that a more flexible application of the rules under the eligibility sections of the Affordable Care Act apply to multi-employer plans. In fact, proposed regulations contained a statement that the rules were designed to offer flexibility to both single and multi-employer plans and contained a favorable multi-employer plan example. Additionally, the proposed regulations solicited comments on application to multi-employer plans implying that a multi-employer plan should perhaps be given even more flexibility. The final regulations retain the example, but provide no further relief or clarifications for multi-employer plans. Based on this difference, a more conservative compliance approach for multi-employer plans would focus on utilizing the special rules contained in the regulations, but avoiding the inclination to expand that flexibility beyond the specifically recognized exceptions.