PHS Act §2716: Application of Code §105(h) to Insured Group Health Plans

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Treasury and the IRS has discretion in interpreting PHS Act §2716. First, Code §105(h) is subject to a range of possible interpretations. Although certain aspects of Code §105(h) were interpreted in Treas. Reg. §1.105-11 (T.D. 7754, 46 FR 3505, Jan. 15, 1981), these regulations may need to be withdrawn and re-proposed in light of PHS Act §2716. Second, PHS Act §2716(b)(1) provides for insured group health plans to be subject to rules similar to "paragraphs (3), (4), and (8) of section 105(h)." Because the rules need not be identical, Treasury and the IRS have discretion to create different nondiscrimination rules for insured plans as long as such rules are "similar."

A. General background.

1. What are PHS Act §2716 and Code §105(h) intended to do? Are these provisions intended to limit the tax subsidy for employer-sponsored health coverage or influence group health plan design?

    a. Pre-ACA Code §105(h) – Arguably, the intent was to limit the tax subsidy for employer-sponsored health coverage.

        (1) Tax provision only; not a three agency provision.

        (2) Applicable only to self-funded plans in which employer and employees receive a tax benefit.

        (3) Compliance failure results in income inclusion to highly-compensated individual; correction highly-compensated individual pays for coverage on an after-tax basis.

    b. Post-ACA PHS Act §2716 and Code §105(h) – Arguably intent was to influence health care plan offering and design.

        (1) PHS Act §2716 is a three agency health care provision included as one of the ACA market reform provisions that address health care plan design and coverage offerings.

        (2) The penalty is a severe excise tax under Code §4980D (up to $36,500 per affected employee per year), plus potential additional excise tax under Code §4980H.

2. Considerations.

    a. Application of Code §105(h) utilization test.

        (1) Employers can influence, but do not control enrollment.

(2) Employees may decline coverage for valid reasons beyond an employer's control due to enrollment in, e.g., Medicaid, Medicare, spouse's plan, or parent's plan.

b. Coordination with Code §4980H.

(1) How should Code §105(h) rules be interpreted in a post-ACA environment with the Code §4980H employer mandate and the availability for Exchange coverage with the benefit of a premium tax credit for eligible employees?

(2) Should any of the Code §4980H rules be incorporated into the PHS Act §2716 / Code §105(h) rules?

c. Health care policy concerns.

(1) How should PHS Act §2716 be interpreted if a purpose of the provision is to prevent employers from failing to offer coverage to high risk, non-highly-compensated employees who may seek coverage on the Exchange causing the cost of Exchange coverage to increase?

(2) How should PHS Act §2716 be interpreted as the provisions apply to small businesses that are not subject to Code §4980H and may not expect to be subject to rigid nondiscrimination rules?

B. Design-based versus utilization-based eligibility testing and employees who waive coverage.

Notice 2011-1, Item 2. The suggestion made in previous comments that the Departments have the authority to provide for an alternative method of compliance with §2716 that would involve only an availability of coverage test.

Notice 2011-1, Item 11. The treatment of employees who voluntarily waive employer coverage in favor of other coverage.

1. Background:

a. Support for the position that only an employee who actually enrolls in the plan "benefits" from the plan: A plan passes the 70%/80% test if at least 70% of non-excludable employees are eligible for the plan and at least 80% of eligible non-excludable employees actually enroll in the plan. In applying the 70%/80% test, only employees who are actually enrolled in a plan are treated as benefiting.

b. Support for the position that eligible employees may be treated as benefiting from the plan:

(1) As an alternative to the 70%/80% test, a plan is nondiscriminatory if it "benefits... 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." Code §105(h)(3)(A)(ii).

(2) Retirement plan testing. The word "benefit" does not mean the same thing for all retirement plan nondiscrimination tests. For purposes of the nondiscriminatory classification test applicable to retirement plans under Code §410(b)(2)(A)(i):

(a) An employee who is eligible to make contributions to Section 401(k) and (m) plans is treated as "benefiting" from the plan regardless of whether he or she actually chooses to make contributions. See Code §410(b)(6)(E) and Treas. Reg. §1.410(b)-3(a)(2)(i).

(b) In contrast, an employee is treated as "benefiting" from a noncontributory retirement plan "if and only if for that plan year, in the case of a defined contribution plan, the employer [sic – should be employee] receives an allocation taken into account under section 1.401(a)(4)-2(c)(2)(ii), or in the case of a defined benefit plan, the employee has an increase in a benefit accrued or treated as an accrued benefit under section 411(d)(6)." Treas. Reg. §1.410(b)-3(a)(1).

(3) Code §125(g)(3). "Benefiting" is interpreted in an example in the 2007 proposed cafeteria plan regulations as eligibility for enrollment (not actual enrollment). Prop. Treas. Reg. §1.125-7(b)(3)(iv), Example 1:

Same qualified benefit for same salary reduction amount. Employer A has one employer-provided accident and health insurance plan. The cost to participants electing the accident and health plan is $10,000 per year for single coverage. All employees have the same opportunity to salary reduce $10,000 for [the] accident and health plan. The cafeteria plan satisfies the eligibility test.

(4) Senate Democratic Policy Committee PPACA Summary. The Senate Democratic Policy Committee has a summary of PPACA on its website (http://www.dpc.senate.gov/dpcissue-sen_health_care_bill.cfm#) titled "Section-by-Section Analysis of the Patient Protection and Affordable Care Act, with Changes Made by Title X and the Health Care and Education Reconciliation Act included within Titles I-IX, where Appropriate (9/17/10)" (the "Senate Summary").

(a) The introduction to the Senate Summary states that "*Some parts of Title X (the Managers' Amendment) and the Health Care and Education Reconciliation Act (Reconciliation Act) made changes to provisions in Titles I – IX of the Patient Protection and Affordable Care Act. This section-by-section analysis includes a description of those provisions within the description of the section that was amended.*"

(b) The Senate Summary includes the following paragraph on PHS Act §2716:

Sec. 2716. <u>Prohibition of discrimination in favor of highly compensated individuals</u>. Employers that provide health coverage will be prohibited from limiting eligibility for coverage to highly compensated individuals.

c. A small employer buying group health insurance through the SHOP exchange is subject to a design-based eligibility standard and is not subject to a utilization-based standard (with the exception of a small employer enrolling outside of the annual open enrollment period).

(1) A small employer is qualified to purchase coverage through a SHOP exchange if it "[e]lects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP." 45 CFR §155.710(b)(2).

(2) CMS prohibits insurers from imposing minimum participation standards on small group policies issued during the SHOP annual open enrollment period (between November 15 and December 15). 45 CFR §147.104(b). In addition, CMS suspended the minimum participation requirements for renewals occurring between November 15 and December 15 in the federally-facilitated exchanges. FAQ ID 574 (Dec. 11, 2013) at https://www.regtap.info/faq_viewe.php?i=574&u=15307&a=9.

(3) An insurer may impose a minimum employer contribution for premiums, consistent with state law. 45 CFR §146.150(e).

2. <u>Suggestion</u>: Code §105(h)(3) is ambiguous and could be interpreted as testing either a design-based test (based on eligibility for coverage) or a utilization-based test (based on actual enrollment in coverage). Treasury and the IRS could interpret Code §105(h)(3) as a design-based test.

a. Query whether the risk of a test failure under PHS Act §2716 is likely to result in richer employer subsidies or an employer withdrawing from plan sponsorship.

b. A design-based eligibility test is consistent with consumer choice. A utilization-based test may have been more meaningful before PPACA when access to private coverage other than through an employer was limited. PPACA expands consumer choices for group health plan coverage.

c. It is possible to structure a utilization-based test to take into account employees who choose other employment-based coverage. However, such a test would be complex and intrusive. It would require employers to collect additional information from their employees, maintain records of employees' responses, and update such records when employees report changes to their other coverage.

3. Counterpoint: If the Treasury and IRS opt for utilization-based eligibility testing, would an employee need to receive a specified level (or value) of coverage in order to be treated as "benefiting"? Query whether an employer could circumvent a utilization-based eligibility test by providing a nominal benefit to all eligible employees. If all eligible employees receive a benefit (for example, a self-insured EAP), all eligible employees would be participants. Then, as long as all participants could elect the same benefit packages on the same basis (i.e., for the same employee contribution), the plan would pass both the eligibility test and the benefits test. The fact that a utilization test could be circumvented in this way could be seen as support for design-based eligibility testing.

C. Impact of 2014 market reforms.

Notice 2011-1, Item 3. The application of §2716 to insured group health plans beginning in 2014 when the health insurance exchanges become operational and the employer responsibility provisions (§4980H of the Code), the premium tax credit (§36B of the Code), and the individual responsibility provisions (§5000A of the Code) and related Affordable Care Act provisions are effective.

Notice 2011-1, Item 6. The suggestion in previous comments that the guidance should provide for "safe harbor" plan designs. Specifically, comments are requested on potential safe and unsafe harbor designs that are consistent with the substantive requirements of §105(h).

1. Background:

   a. The reference to a nondiscriminatory classification in Code §105(h)(3(A)(ii) pre-dates the Tax Reform Act of 1986 [PL 99-514] (TRA). Therefore, it could be interpreted as applying either pre-TRA or post-TRA testing methodology.

   b. Code §105(h)(3)(B) allows the exclusion of part-time employees from the testing group. Under Treas. Reg. §1.105-11(c)(2)(iii)(C), an employee may be treated as part-time if he or she works:

      (1) Less than 35 hours per week, if other employees in similar work have substantially more hours; or

      (2) Less than 25 hours per week.

2. Suggestions:

   a. As a proxy for the Pre-TRA fair cross section test, Treasury and the IRS could provide a safe harbor for medical coverage offered to substantially all (i.e., 95%) of an applicable large employer (ALE) member's full-time employees. If the same medical coverage option is offered to substantially all of the ALE member's full-time employees for the identical employee contributions (or for employee contributions that increase with income), treat the medical coverage as nondiscriminatory.

      If Treasury and IRS wanted a more stringent safe harbor for the Pre-TRA fair cross section test, they could require that coverage be affordable

(within the meaning of Code §4980H) with respect to a specified percentage of eligible NHCIs.

b. Allow employers to use the same definition of part-time employees for purposes of the exclusion from the testing group as will be used for purposes of determining penalties under Code §4980H. Although the definition of part-time employees for purposes of Code §4980H is narrower than the definition of part-time employees for purposes of Code §105(h), permissive use of the same definition would simplify data collection.

D. Nondiscriminatory benefits.

Notice 2011-1, Item 1. The basis on which the determination of what constitutes nondiscriminatory benefits under §105(h)(4) should be made and what is included in the term "benefits." For example, is the rate of employer contributions toward the cost of coverage (or the required percentage or amount of employee contributions) or the duration of an eligibility waiting period treated as a "benefit" that must be provided on a nondiscriminatory basis?

1. Background:

(1) Code §105(h)(4) does not define the "benefits" that must be provided on a nondiscriminatory basis.

(2) Treas. Reg. §1.105-11(k)(2) provides:

For purposes of this section, a benefit subject to reimbursement is a benefit described in the plan under which a claim for reimbursement or for a payment directly to the health service provider may be filed by a plan participant. It does not refer to actual claims or benefit reimbursements paid under a plan.

(3) Treas. Reg. §1.105-11(c)(3)(i) treats an employee who enrolled in one self-insured benefit package as receiving the benefits under other available self-insured benefit packages provided that "the required employee contributions are the same amount."

A plan that provides optional benefits to participants will be treated as providing a single benefit with respect to the benefits covered by the option provided that (A) all eligible participants may elect any of the benefits covered by the option and (B) there are either no required employee contributions or the required employee contributions are the same amount.

(4) Treas. Reg. §1.105-11(c)(4)(iii) treats an employee who enrolled in an HMO as receiving the benefits under a self-insured benefit package provided that the employer's contribution for the HMO is the same or more than the amount the employer would have paid for coverage under the self-insured benefit package.

For purposes of section 105(h)(2)(A) and paragraph (c)(2) of this section, a self-insured plan will be deemed to benefit an employee who has

enrolled in a health maintenance organization (HMO) that is offered on an optional basis by the employer in lieu of coverage under the self-insured plan if, with respect to that employee, the employer's contributions to the HMO plan equal or exceed those that would be made to the self-insured plan, and if the HMO plan is designated in accordance with subdivision (i) with the self-insured plan as a single plan.

(5) Code §125(b)(1)(B) prohibits discrimination in favor of highly-compensated participants as to contributions and benefits. The fact that contributions and benefits are separately named implies that contributions are not a type of benefit.

(6) Code §105(h)(3)(B)(i) allows an employer to exclude employees with less than three years of service from the testing group.

2. Suggestions:

a. Contributions as a benefit:

(1) If Treasury and the IRS opt for utilization-based eligibility testing, contributions should not be treated as a benefit.

(2) If Treasury and the IRS opt for design-based eligibility testing, contributions could be addressed in the context of testing discrimination as to eligibility. A design-based eligibility test could be applied to a plan (or benefit package) with uniform employee contributions. Employers could be given the option of uniformity as to either:

(a) the dollar amount of the employee contributions for each tier of coverage; or

(b) the rate of employee contributions for each tier of coverage.

b. Duration of the eligibility waiting period as a benefit: Do not treat the eligibility waiting period as a benefit for purposes of the nondiscriminatory benefits test. Employees who are not taken into account for purposes the application of penalties under Code §4980H should not be taken into account for purposes of PHS Act §2716 testing.

E. Taxable coverage and Code §4980D sanctions.

Notice 2011-1, Item 10. The suggestion in previous comments that coverage provided to a "highly compensated individual" (as defined in §105(h)(5)) on an after-tax basis should be disregarded in applying §2716.

Notice 2011-1, Item 13. The application of the sanctions for noncompliance with §2716.

1. Background: To date, it has been generally understood that employees (and in particular HCIs) who have been taxed on the value of their coverage do not need to be counted in performing the nondiscriminatory classification test.

Alternatively, an employee could pay 100% of the cost of coverage on an after-tax basis (with the substantively identical result).

2. Suggestions:

a. The penalty structure for failure of the nondiscrimination tests is radically different for self-insured group health plans and insured group health plans. If a self-insured group health plan is discriminatory, employees who are HCIs must include some or all benefits in income. If an insured group health plan is discriminatory, the plan is subject to an excise tax under Code §4980D. However, the difference in penalty structure does not dictate a different testing methodology. The testing methodology under PHS Act §2716 should treat an individual who has been taxed on the full premium for insured coverage as not benefiting under the plan. Such a rule would more closely follow the principles of Code §105(h) and would permit the employer to avoid potentially significant penalties under Code §4980D simply by taxing one or more HCIs on their health insurance premiums. (ERISA issues would need to be addressed.)

b. Treasury and the IRS should clarify the application of Code §4980D to a test failure. The penalty under Code §4980D is calculated "per affected individual." In this context, the "affected individual" could be:

(1) The HCIs who benefited from the discrimination; or

(2) The NHCIs who would have benefited had the plan not been discriminatory.

Comment: Identification of HCIs who benefited from the discrimination would be administratively simpler. To identify the NHCIs who would have benefited had the plan not been discriminatory would require the employer to model an alternative program based on the census of the year in question. Further, in most cases, treating HCIs who benefited from the discrimination as the affected individuals will result in a less catastrophic penalty.

F. Geographic variation and aggregation.

Notice 2011-1, Item 5. The suggestion in previous comments that the nondiscrimination standards should be applied separately to employers sponsoring insured group health plans in distinct geographic locations and on whether application of the standards on a geographic basis should be permissive or mandatory.

Notice 2011-1, Item 7. Whether employers should be permitted to aggregate different, but substantially similar, coverage options for purposes of §2716 and, if so, the basis upon which a "substantially similar" determination could be made.

1. Background: Treas. Reg. §1.105-11(c)(4)(i) provides in part:

An employer may designate two or more plans as constituting a single plan that is intended to satisfy the requirements of section 105(h)(2) and paragraph (c) of this section, in which case all plans so designated shall be considered as a single

plan in determining whether the requirements of such section are satisfied by each of the separate plan.

2. Suggestion: Treasury and the IRS could allow liberal restructuring (aggregation and disaggregation) of plans into uniform or comparable benefit packages for purposes of testing.

   a. Separate testing of coverage provided in distinct geographic areas is one way to address geographic variations in cost and state regulation.

   b. Another way to address geographic variation is to allow liberal aggregation of plans and benefit packages of comparable value. For example, an employer could be permitted to treat two or more plans (and/or two or more benefit packages within a single plan) as providing equivalent benefits (regardless of whether covered services and supplies are identical) if:

      (1) the plans (and/or benefit packages) are within the same metal level of actuarial value (bronze, silver, gold, or platinum); and

      (2) either:

         (a) the dollar amount of the employee contributions for each tier of coverage is the same for all of the aggregated plans (and/or benefit packages); or

         (b) the rate of employee contributions for each tier of coverage is the same for all of the aggregated plans (and/or benefit packages).

G. Definition of highly compensated individuals and safe harbor plan designs.

Notice 2011-1, Item 4. The suggestion in previous comments that the nondiscriminatory classification provision in §105(h)(3)(A)(iii) [ii] could be used as a basis to permit an insured health care plan to use a highly compensated employee definition in § 414(q) of the Code for purposes of determining the plan's nondiscriminatory classification.

1. Safe harbor based on Code §414(q) definition of HCE: The use of different definitions of prohibited group in testing for nondiscrimination in cafeteria plans, self-insured plans, and retirement plans confuses employers and adds to data and recordkeeping requirements. A uniform definition of the prohibited group is a laudable goal. However, the reference in PHS Act §2716(b)(2) to the definition of HCI in Code §105(h)(5) makes the use of the definition of HCE in Code §414(q) difficult.

2. Dollar floor on definition of HCI. To the extent Treasury and the IRS think they must construct tests based on the Code §105(h)(5) definition of HCI (top 25% by pay), Treasury and the IRS could provide a floor. For example, it would be reasonable to limit an employer's HCI group to the smaller of: (1) the top 25% of employees by pay; or (2) all employees with compensation in excess of 400% of the FPL for, e.g., a family of four.

a. “Compensation” could be based on the prior year’s pay or current year pay for new hires.

b. That would avoid the absurd situation where an employee who is labeled an HCI is potentially eligible for government subsidies to buy insurance on an exchange.

H. Post-acquisition transition periods.

Notice 2011-1, Item 12. Potential transition rules following a merger, acquisition, or other corporate transaction.

1. Background: Code §410(b)(6)(C)(ii) provides for a transition period after acquisitions and dispositions. The transition period extends to the last day of the first plan year that begins after the date of the transaction. During the transition period, a retirement plan is treated as meeting the applicable coverage standards provided that the standards were met before the transaction and the plan is not significantly changed during the transition period.

2. Suggestion: Group health plans need the same transition period after a transaction. It is common for a buyer to want replicate the seller’s group health coverage (or arrange to have the seller to continue its group health coverage) for acquired employees for a transitional period This is typically a positive for employees who are not then subjected to mid-year disruptions in coverage.

I. Expatriate plans.

Notice 2011-1, Item 8. The application of the nondiscrimination rules to “expatriate” and “inpatriate” coverage.

1. Background: Expatriate and inpatriate coverage will vary by country and its health care system and cannot be made uniform with coverage provided to employees working in their home countries.

2. Suggestion:

   a. Expatriate and inpatriate coverage should be excluded from the nondiscrimination rules and employees with expatriate and inpatriate coverage should be excluded from the testing group.

   b. Treasury and the IRS could use the same definition of expatriate and inpatriate coverage as applies for the purpose of relief from group market reforms.

   For purposes of the temporary transitional relief, an insured expatriate health plan is an insured group health plan with respect to which enrollment is limited to primary insureds for whom there is a good faith expectation that such individuals will reside outside of their home country or outside of the United States for at least six months of a 12-month period and any covered dependents, and also with respect to group health insurance coverage offered in conjunction with the expatriate group health plan. The 12-month period can fall within a single plan year

or across two consecutive plan years. DOL FAQs Part XVIII Q&A-6 (January 9, 2014).

J. Multiple employer plans.

Notice 2011-1, Item 9. The application of the nondiscrimination rules to multiple employer plans.

1. Background:

   a. PHS Act §2716 provides for rules "similar" to Code §105(h)(8) to apply. Code §105(h)(8) provides that all employees of entities in a controlled group are treated as employed by a single employer.

   b. Under Rev. Proc. 2002-21, retirement plan nondiscrimination testing is performed on an employer-by-employer basis.

2. Suggestion: Nondiscrimination testing for a multiple employer health plan should be conducted on an employer-by-employer basis.

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