May 4, 2011

Hon. Douglas Shulman
Commissioner
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, DC 20224

Re: Comments in Response to Notice 2010-63

Dear Commissioner Shulman:

Enclosed are comments on in response to notice 2010-63 concerning requirements prohibiting discrimination in favor of highly compensated individuals in insured group health plans. These comments represent the views of the American Bar Association Section of Taxation. They have not been approved by the Board of Governors or the House of Delegates of the American Bar Association, and should not be construed as representing the policy of the American Bar Association.

Sincerely,

Charles H. Egerton
Chair, Section of Taxation

Enclosure

cc: Michael Mundaca, Assistant Secretary (Tax Policy), Department of the Treasury
    William Wilkins, Chief Counsel, Internal Revenue Service
    Jeffrey Van Hove, Acting Tax Legislative Counsel, Department of the Treasury
These comments ("Comments") are submitted on behalf of the American Bar Association Section of Taxation and have not been approved by the House of Delegates or Board of Governors of the American Bar Association. Accordingly, these Comments should not be construed as representing the position of the American Bar Association.

Principal responsibility for preparing these Comments was exercised by Alden J. Bianchi, Co-Chair of the Subcommittee on Welfare Plan Design and Funding of the Employee Benefits Committee of the Section of Taxation. Substantive contributions were made by Matthew J. Eickman, Evelyn A. Haralampu, Linda R. Mendel, Christine P. Roberts, Juliana Reno, and Priscilla E. Ryan. These Comments were reviewed by Mark A. Bodron, a Committee Vice Chair, and John L. Utz, Committee Chair. The Comments were further reviewed by Roberta Casper Watson and James R. Raborn of the Section’s Committee on Government Submissions and by Thomas R. Hoecker, Council Director for the Employee Benefits Committee.

Although the members of the Section of Taxation who participated in preparing these Comments have clients who might be affected by the federal income tax principles addressed by these Comments, no such member or the firm or organization to which such member belongs has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these Comments.

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Date: May 4, 2011
EXECUTIVE SUMMARY

These Comments are submitted in response to the request for comments by the Department of the Treasury and Internal Revenue Service (collectively, the “Department”) in Notice 2010-63\(^1\) (the “Notice”). The Notice solicits the views of interested parties respecting the insurance non-discrimination provisions (the “insurance non-discrimination rule”) of section 10101(d) of the Patient Protection and Affordable Care Act of 2010\(^2\) (the “Affordable Care Act” or “Act”), which adds section 2716 of the Public Health Service Act\(^3\) (the “PHS Act”), which in turn references section 105(h) of the Internal Revenue Code of 1986.\(^4\)

In response to the invitation from the Department for comments regarding guidance to be issued with respect to the insurance non-discrimination rule, we recommend that the Department:

1. Apply the requirements of section 105(h) to fully insured plans, to the extent clear and well settled, with certain modifications noted in these Comments. Those requirements that we take as well settled include: (i) the basic structure, but not certain of the particulars, of the non-discrimination rules under section 105(h)(2), which tests discrimination on the basis of eligibility and benefits; (ii) the concept of, and related exclusions for, “excludable employees” under section 105(h)(3)(B); and (iii) the definition of highly compensated individual under section 105(h)(5). To the extent the requirements of section 105(h) are ambiguous or not well settled, we recommend that the Department interpret the requirements of section 2716 of the PHS Act to reduce, to the extent possible consistent with the intent of Congress, the burdens on plan sponsors and employers.

2. Adopt a rule under which the “eligibility test” of section 105(h)(3)(A) as applied under the insurance non-discrimination rule is “design-based” rather than “utilization-based.” If, however, the Department chooses to adopt a utilization-based approach (i.e., testing based on participant elections), we recommend that the Department exclude from the numerator and denominator of the testing fraction non-highly compensated individuals who elect or are eligible for coverage under the plan of a spouse, a governmental plan, a plan offered by a state-based insurance exchange (whether or not the coverage is subsidized), or the plan of another employer (e.g., a retiree medical plan).

3. Permit (but not require) a plan sponsor or employer to apply the exclusions under section 105(h)(3)(B) plan-by-plan, such that a more favorable eligibility provision in one plan would not prohibit a less favorable eligibility provision in another plan in the same controlled group.

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\(^1\) 2010-41 I.R.B. 420.
\(^4\) References to a “section” are to a section of the Internal Revenue Code of 1986, as amended (the “Code”), unless otherwise indicated.
4. Interpret section 2716 of the PHS Act such that plans, or benefit package options, are first tested for eligibility to determine the “testing” plan or benefit package option, and that the “benefits test” under section 105(h)(2)(B) be applied to the testing plan or benefit package option, as the case may be.

5. Define the term “plan” for testing purposes under the insurance non-discrimination rule by starting with the concept of “plan” under the Employee Retirement Income Security Act of 1974,\(^5\) as amended (“ERISA”), but by testing compliance with the insurance non-discrimination rule on the basis of benefit package options and contribution amounts. For this purpose, benefit package options and contribution amounts describe what services are covered, subject to what limits, and the amount of the premium paid by the employer for each coverage type (i.e., individual or family coverage).

6. Permit multiple benefit package options to be aggregated and tested at the “plan” level, such that eligibility for or benefiting under any option would be deemed to constitute eligibility for and benefiting under the plan, even though highly compensated individuals may choose the higher cost options or family coverage in greater numbers than non-highly compensated individuals.

7. Permit group health plans using the section 410(b) non-discriminatory classification test to apply either the non-discriminatory classification test that existed before the Tax Reform Act of 1986\(^6\) (“TRA ‘86”) or the test under current law, including the safe harbor standards of Regulation section 1.410(b)-4(c)(2). We further recommend that a plan or benefit package option be deemed to satisfy the non-discriminatory classification test under current law when coverage meets or exceeds the “unsafe harbor percentage” standard.

8. Establish a transitional rule for mergers and acquisitions under which plans and benefit package options may continue to be tested without regard to changes in the controlled group for a specified period following a merger or acquisition. We further recommend that such period extend at a minimum to the end of the second plan year following the merger or acquisition.

9. Permit plan sponsors and employers to separately test plans maintained by a single group of entities under common control (within the meaning of section 414(b), (c), and (m)) on the basis of the line of business that maintains the plan using the definition of “line of business” established by Regulation section 1.414(r)-1(b)(2)(ii), without any of the quantitative testing rules that otherwise govern the testing of qualified separate lines of business.

10. To the extent penalties may be assessed on health insurance issuers for violations of the insurance non-discrimination rule, permit health insurance issuers to rely on a written

representation of the plan sponsor or employer as to the sponsor’s or employer’s compliance with section 2716 of the PHS Act unless the insurer has actual knowledge of a violation.

11. Provide that plans with otherwise uniform benefits but with different waiting periods for different groups of employees be permitted to test compliance with the insurance non-discrimination rule as either (a) separate plans with different eligibility requirements or (b) a single plan with multiple levels of benefits.

12. In the case of plans and benefit package options that cover both self-employed individuals and common law employees, provide that self-employed individuals are excluded from the numerator and denominator of the testing fraction.

13. Establish a presumption in favor of formal, documentary compliance by insured plans in the absence of facially discriminatory plan terms.

14. Provide a limited exemption for insured, post-termination medical benefits provided under employment, severance, change-in-control, or other similar agreements, arrangements, or contracts entered into by employers with employees before March 23, 2010.

15. Clarify that employers may provide (otherwise discriminatory) post-termination medical coverage on a pre-tax basis to former employees under an individual market contract or policy or under a plan that covers less than two active employees.
BACKGROUND

The subject of these Comments is the insurance non-discrimination rule under section 2716 of the PHS Act, as added by section 10101(d) of the Affordable Care Act. The Affordable Care Act incorporates this rule into the Code and ERISA by reference. The insurance non-discrimination rule for the first time imposes on fully insured group health plans rules similar to those that apply to self-funded group health plans under section 105(h) (governing “self-insured medical reimbursement plans”).

In 1986, in section 1151 of TRA ‘86, Congress added section 89, which established a comprehensive set of non-discrimination rules that applied to a broad range of welfare and fringe benefit plans, including fully insured employer-sponsored group health plans. On March 7, 1989, the Department issued a notice of proposed rulemaking interpreting the then-new non-discrimination standards. This proposal, and indeed all of section 89, was the subject of intense criticism. In 1989, after delays in the effective dates and earnest attempts at simplification, section 89 was repealed, and the prior law rules were reinstated.

The Affordable Care Act requires group health plans (other than self-insured plans) to satisfy the basic non-discrimination requirements of section 105(h)(2) applying rules “similar to” the rules set out in section 105(h)(3) (relating to non-discriminatory eligibility classification), section 105(h)(4) (relating to non-discriminatory benefits), and section 105(h)(8) (relating to controlled groups). For purposes of applying the insurance non-discrimination rule, the term “highly compensated individual” has the meaning assigned by section 105(h)(5). In formulating these Comments, we have, when possible, favored broad, qualitative standards over strict, quantitative measurement. Although the latter furnish a comparatively higher level of certainty, they are necessarily accompanied by substantial administrative burdens. We take this approach based on prior experience with section 89, which was repealed shortly after the details of its implementation were set forth in proposed regulations.

We commend the extraordinary efforts by the Department, the Department of Labor, and the Department of Health and Human Services (collectively, the “Agencies”) to provide comprehensive regulations regarding the provisions of the Affordable Care Act. We hope that these Comments advance the Department’s and ultimately the Agencies’ ongoing process of developing guidance that applies the myriad new requirements applicable to group health plans in a clear, fair, and practical manner.

8 See H.R. 1864 (Apr. 13, 1989); S. 1129 (Jun. 6, 1989).
I. CONFORMITY WITH “WELL-SETTLED” ISSUES UNDER SECTION 105(h)

A. Summary

Section 2716 of the PHS Act provides that a group health plan (other than a self-insured plan) must:

(i) satisfy the requirements of section 105(h)(2);

(ii) satisfy rules similar to the rules of section 105 in paragraphs (h)(3) (non-discriminatory eligibility classification), (h)(4) (non-discriminatory benefits), and (h)(8) (certain controlled groups); and

(iii) be applied using the definition of “highly compensated individual” in section 105(h)(5).

This provision of the Affordable Care Act appears to presume that the law underlying each of these references is well settled. Although that presumption may be true in certain cases, we do not believe it to be universally accurate.

B. Recommendation

We recommend that the Department apply the requirements of section 105(h) to fully insured plans, to the extent clear and well settled, with certain modifications noted in these Comments. Those requirements that we take as well settled include: (i) the basic structure, but not certain of the particulars, of the non-discrimination rules under section 105(h)(2), which tests discrimination on the basis of eligibility and benefits; (ii) the concept of, and related exclusions for, “excludable employees” under section 105(h)(3)(B); and (iii) the definition of highly compensated individual under section 105(h)(5). To the extent the requirements of section 105(h) are ambiguous or not well settled, we recommend that the Department interpret the requirements of section 2716 of the PHS Act to reduce, to the extent possible consistent with the intent of Congress, the burdens on plan sponsors and employers.

C. Explanation

The Act applies the basic non-discrimination rules of section 105(h)(2), which tests discrimination on the basis of “eligibility” and “benefits,” and it establishes who is a “highly compensated individual” for testing purposes under rules established by section 105(h)(5). However, in our view only a limited portion of the testing requirements are clear and well settled. Thus, we would prefer that the Department limit its reliance on section 105(h) to those aspects of section 105(h) that are clear and well settled. Moreover, we note that the Act allows some flexibility in applying the non-discriminatory eligibility classification under
section 105(h)(3) and the non-discriminatory benefits under section 105(h)(4) and in identifying controlled groups under section 105(h)(8). We believe such flexibility is appropriate in the context of the insurance non-discrimination rule.

II. DESIGN-BASED VS. UTILIZATION-BASED ELIGIBILITY TESTING

A. Issue

Section 105(h)(2)(A) establishes the general rule that a plan must not discriminate “as to eligibility to participate.” However, section 105(h)(3)(A), which fleshes out the eligibility test, provides that a plan must “benefit” a certain percentage of persons. There is no guidance clarifying whether the eligibility test of section 105(h)(3)(A) is design based or enrollment or utilization based. The Act makes the eligibility test one of the cornerstones of the insurance non-discrimination rule. Thus, the manner in which this test is applied is critically important.

B. Recommendation

We recommend that the Department adopt a rule under which the “eligibility test” of section 105(h)(3)(A) as applied under the insurance non-discrimination rule is “design-based” rather than “utilization-based.” If, however, the Department chooses to adopt a utilization based approach (i.e., testing based on participant elections), we recommend that the Department exclude from the numerator and denominator of the testing fraction non-highly compensated individuals who elect or are eligible for coverage under the plan of a spouse, a plan offered by a state-based insurance exchange (whether or not the coverage is subsidized), a governmental plan, or the plan of another employer (e.g., a retiree medical plan).

C. Explanation

To impose a qualitative testing regime on employers would, in our view, complicate the maintenance and operation of group health plans. It would also burden employers with an additional layer of costs that many may deem unacceptable. This might lead to the wholesale abandonment of group health plans, particularly by smaller employers who are not subject to the Act’s “employer responsibility” requirements, which take effect in 2014. We believe that such a result would be counter to the intent of the insurance non-discrimination rule.

Moreover, we believe that there is little to be gained by such a rule. The benefit packages offered by employer-sponsored group health plans tend to be similar from employer to employer and from industry to industry, and the Act will further accelerate this trend by imposing on carriers rules governing essential health benefit packages. We believe a design-based test would ensure that highly compensated participants are not provided with greater contributions or more favorable benefit package options and contribution amounts.

Prior to the Act, a utilization-based test might have prevented employers from imposing higher employee contributions. Starting in 2014, however, an employer that offers health
coverage with high employee contributions will be subject to the unaffordable coverage penalty.\textsuperscript{10} We believe that an employer that offers coverage to all of its full-time employees should not be subject to penalties under section 2716 of the PHS Act simply because employees choose other available options. The Act was intended to preserve and expand employees’ group health care coverage.\textsuperscript{11} If an employer pays a penalty under section 4980H(b) for employees who elect to buy individual coverage in an “Exchange,” we do not believe the employer should be subject to a second penalty under section 2716 of the PHS Act as a result of the same employees’ election to buy coverage in an Exchange. Simply put, we believe a design-based test would fully protect non-highly compensated individuals without imposing unnecessary and costly administrative burdens on plan sponsors.

A design-based eligibility test would also be consistent with non-discrimination testing of contributory retirement plans.\textsuperscript{12} For purpose of the coverage test applicable to section 401(k) plans and plans that allow after-tax employee contributions, an employee is treated as benefiting under the plan if he or she is eligible for the plan.\textsuperscript{13} We therefore urge that, for purposes of contributory health plans, an employee should be treated as benefiting if he or she is eligible for the plan, irrespective of whether he or she actually enrolls.

\section*{III. APPLICATION OF SECTION 105(H)(3)(B)(I) AND (II) RELATING TO CERTAIN EXCLUDABLE EMPLOYEES}

\subsection*{A. Issue}

Section 105(h)(3)(B)(i) and (ii) permit plan sponsors to exclude for testing purposes employees who have less than three years of service or who are under age 25. Current law is silent on the matter of whether coverage by one plan of an employer of individuals with less than three years of service or under age 25 requires the testing of coverage of otherwise excludable individuals under all other plans of the same employer.

\subsection*{B. Recommendation}

We recommend that the Department permit (but not require) a plan sponsor or employer to apply the exclusions under section 105(h)(3)(B) plan-by-plan, such that a more favorable eligibility provision in one plan would not prohibit a less favorable eligibility provision in another plan in the same controlled group.

\begin{footnotes}
\item[11] See Act Title I, subtitle B (referring to and entitled, “Immediate Actions to Preserve and Expand Coverage”).
\item[13] I.R.C. § 410(b)(6)(E); Reg. § 1.410(b)-3(a)(2)(i).
\end{footnotes}
C. **Explanation**

Regulations implementing the insurance non-discrimination rule should, in our view, permit plan sponsors to establish who is an excludable employee, within the limits prescribed by section 105(h)(3)(B), plan-by-plan. We find nothing in section 105(h) that requires otherwise. We would expect that a contrary or more restrictive rule would create significant difficulties in sectors such as retail, franchise, restaurants, and staffing that operate multiple (or multi-tier) plans to accommodate transient portions of their workforce. Moreover, we believe a contrary rule would discourage employers from expanding group health plan coverage by limiting their flexibility to vary waiting periods in response to bona fide business needs.

IV. **APPLICATION OF THE ELIGIBILITY AND BENEFITS TESTS**

A. **Issue**

Although the current rules under section 105(h)(2) refer generally to testing based on “eligibility” and “benefits,” those rules do not clearly set out the manner in which testing ought to be carried out. For example, the non-discriminatory classification rules appear to apply to only one prong (i.e., eligibility) and not the other (i.e., benefits). This omission makes sense only if a plan is first identified and tested under the eligibility prong to establish the “testing” plan or benefit package option to which the benefits test is applied. Because the manner and order in which these rules are applied is central to applying the requirements of section 2716 of the PHS Act, we recommend that the Department clarify the manner in which testing ought to be carried out.

B. **Recommendation**

We recommend that the Department interpret section 2716 of the PHS Act such that plans, or benefit package options, are first tested for eligibility to determine the “testing” plan or benefit package option, and that the “benefits test” under section 105(h)(2)(B) be applied to the testing plan or benefit package option, as the case may be.

C. **Explanation**

The lack of details of how the section 105(h)(2) eligibility and benefits tests should be applied presents uncertainty in the implementation of section 2716 of the PHS Act. We believe, however, that this issue may be addressed in a reasonable and understandable manner by drawing on long-established notions and rules in the qualified plan context (i.e., the general non-discrimination and coverage tests under sections 401(a)(4) and 410(b)). Accordingly, we urge that this approach be followed in this instance.
V. DEFINITION OF “PLAN”

A. Issue

Although the Act defines the term “group health plan,” it is silent as to what constitutes the “plan” for purposes of applying the insurance non-discrimination rule.

B. Recommendation

We recommend that the Department define the term “plan” for testing purposes under the insurance non-discrimination rule by starting with the concept of “plan” under ERISA, but by providing employers and plan sponsors with the ability to test compliance with the insurance non-discrimination rule at the plan level or on the basis of benefit package options and contribution amounts. For this purpose, benefit package options and contribution amounts describe what services are covered, subject to what limits, and the amount of the premium paid by the employer for coverage type (i.e., individual or family coverage).

C. Explanation

This recommendation drives the testing process to the level of benefit package options and contribution amounts, which we submit is the correct level for purposes of the rule. The concept is simple to understand and apply, and we believe it would reward good faith efforts at compliance. It is also consistent with the grandfather rules\textsuperscript{14} and subsequent “soft” guidance,\textsuperscript{15} which tests eligibility for grandfather treatment benefit package-by-benefit package. It is also consistent with the approach used to test qualified retirement plans for non-discrimination. A qualified retirement plan with different contribution rates for different groups of employees may test each group separately for non-discrimination in benefits provided that each group separately passes the applicable coverage test.\textsuperscript{16}

VI. TESTING BASED ON MULTIPLE BENEFIT OPTIONS

A. Issue

Plan designs that permit choices among different benefit package options are common. For example, a plan sponsor may offer, under a single ERISA plan number, low-, medium- and high-options (e.g., preferred provider organization, point-of-service, and indemnity options). We believe that the regulations implementing the insurance non-discrimination rules should encourage and accommodate, or at a minimum not impede, such plan designs.

\textsuperscript{14} Reg. § 54.9815-1251T(a)(1)(i); 29 C.F.R. § 2590.715-1251(a)(1)(i); 45 C.F.R. § 147.140(a)(1)(i).
\textsuperscript{15} Department of Labor, Employee Benefits Security Administration, FAQs About the Affordable Care Act Implementation Part II, available at \url{http://www.dol.gov/ebsa/faqs/faq-aca2.html}, Q&A 2.
\textsuperscript{16} Reg. § 1.401(a)(4)-9(c)(1).
B. **Recommendation**

We recommend that the Department permit multiple benefit package options to be aggregated and tested at the “plan” level, such that eligibility for or benefiting under any option would be deemed to constitute eligibility for and benefiting under the plan, even though highly compensated individuals may choose the higher cost options or family coverage in greater numbers than non-highly compensated individuals.

C. **Explanation**

In our view, there is nothing inherently abusive or discriminatory in this approach, although younger employees and those with low rates of pay will in all likelihood disproportionately select the less expensive options in greater numbers. We intend that the approach suggested in this recommendation preserve the flexibility that plans with multiple benefit options provide to employers and their workforces.

VII. **APPLICATION OF THE NON-DISCRIMINATORY CLASSIFICATION TEST**

A. **Issue**

Under section 105(h)(3), a plan may pass the eligibility test by demonstrating that the plan benefits (i) 70% or more of all employees, (ii) 80% or more of all the employees who are eligible to benefit under the plan if 70% or more of all employees are eligible to benefit under the plan, or (iii) “a classification set up by the employer and found by the Secretary not to be discriminatory in favor of highly compensated individuals.” This last provision is called the “non-discriminatory classification test.”

The regulations under section 105(h) explain that the determination under the non-discriminatory classification test should be made “based upon the facts and circumstances of each case, applying the same standards as are applied under section 410(b)(1)(B).” The standards under section 410(b)(1)(B), which have since been relocated to section 410(b)(2)(A)(i), are specified in additional Treasury regulations. Section 105(h) was enacted before TRA ’86, which significantly modified the non-discriminatory classification test. Regulations implementing TRA ’86 added a safe harbor standard to what was previously only a facts and circumstances standard.

B. **Recommendation**

We recommend that the Department permit group health plans using the section 410(b) non-discriminatory classification test to apply either the non-discriminatory classification test

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17 Reg. § 1.105-11(c)(ii).
19 Reg. § 1.410(b)-4(c).
that existed before TRA ‘86 or the test under current law, including the safe harbor standards of Regulation section 1.410(b)-4(c)(2). We further recommend that a plan or benefit package option be deemed to satisfy the non-discriminatory classification test under current law when coverage meets or exceeds the “unsafe harbor percentage” standard.

C. **Explanation**

Both versions of the non-discriminatory classification test have the same goal. We believe that from a policy and compliance perspective, both standards should be available to plan sponsors to satisfy the eligibility test on the basis of a non-discriminatory classification. While the prior law standard may appear to be more liberal, it is the standard that Congress chose to apply when it enacted section 105(h). The 1986 amendments to the qualified plan non-discrimination testing rules substitute quantitative, numerical testing rules for the qualitative testing standards of prior law. But there is nothing to indicate that Congress intended to make a similar change to the nondiscrimination testing regime that applies to self-funded medical reimbursement arrangements. Therefore, we urge that compliance with the prior law non-discriminatory classification rules be permitted.

**VIII. MERGER AND ACQUISITION TRANSITIONAL RULE**

A. **Issue**

Complying with an ever-expanding list of benefits-related laws, regulations, and other requirements poses special and unique problems in the context of mergers or acquisitions of business entities.

B. **Recommendation**

We recommend that the Department establish a transitional rule for mergers and acquisitions under which plans and benefit package options may continue to be tested without regard to changes in the controlled group for a specified period following a merger or acquisition. We further recommend that such period extend at a minimum to the end of the second plan year following the merger or acquisition.

C. **Explanation**

In the context of the non-discrimination rules that apply to tax qualified plans, section 410(b)(6)(C)(ii) provides transition relief for up to two years, provided that the plan(s) satisfy the non-discrimination requirements immediately prior to the transaction and are not substantially changed during the transition period. A similar rule would ease administrative burdens associated with mergers and acquisitions involving one or more entities that maintain insured health plans by providing employers and plan sponsors with some time to evaluate their options.
IX. TESTING OF PLANS MAINTAINED BY MEMBERS OF GROUPS UNDER COMMON CONTROL

A. Issue

Rather than require a strict application of the controlled group rules, section 2716 of the PHS Act requires the application of rules “similar to” the requirements of section 105(h)(8) (applying the section 105(h) non-discrimination rules on the basis of the controlled group provisions of section 414(b), (c), and (m)). We believe this evidences an understanding and acknowledgment by Congress that a strict application of the controlled group rules in the context of the insurance non-discrimination rule does not reflect sound policy. Rather, we believe these rules need to be adapted to accommodate instances and issues (e.g., differences in costs based on location and demographics) that do not arise in the qualified plan context. Thus, in our view, these rules should be applied liberally to accommodate different plan designs when a single controlled group operates businesses in diverse industries, sectors, or locations.

B. Recommendation

We recommend that the Department permit plan sponsors and employers to separately test plans maintained by a single group of entities under common control (within the meaning of section 414(b), (c), and (m)) on the basis of the line of business that maintains the plan using the definition of “line of business” established by Regulation section 1.414(r)-1(b)(2)(ii), without any of the quantitative testing rules that otherwise govern the testing of qualified separate lines of business.

C. Explanation

Regulation section 1.414(r)-1(b)(2)(ii) defines a “line of business” as “a portion of an employer that is identified by the property or services it provides to customers of the employer.” We emphasize that this recommendation refers to and seeks to isolate lines of business for insurance non-discrimination testing purposes. For the reasons discussed above, we are not advocating the adoption of any of the substantial quantitative infrastructure that accompanies the testing of qualified separate lines of business for qualified plan purposes, nor do we think it is necessary to do so. Rather, we suggest that the focus be on identifying and permitting the separate testing of outward facing (e.g., customer focused) business units. Thus, for example, we believe a large, multi-state holding company with multiple, unrelated business units should be allowed to separately test the insured group medical plans business unit-by-business unit, subject to an anti-abuse rule to prevent an overly generous plan for management employees at a headquarters unit. On the other hand, under the suggested rule, insured group health plans maintained by a multi-state employer with only one “business” would be aggregated for testing purposes.
X. PROTECTION FOR HEALTH INSURANCE ISSUERS

A. Issue

The health insurance non-discrimination rule, by its terms, regulates insured “group health plans.” There is no separate reference to health insurance issuers. But the rule is part of a series of amendments to the PHS Act that cross-reference the Code and ERISA. Although it does not appear to us that health insurance issuers are subject to the insurance non-discrimination rule, we are not entirely certain that this is the case. Health insurance issuers have little control over many important design features of insured group health plans (e.g., they rarely exercise control over who is offered coverage or on what terms other than requiring, for underwriting purposes, some minimal level of aggregate participation and employer contribution).

B. Recommendation

To the extent penalties may be assessed on health insurance issuers for violations of the insurance non-discrimination rule, we recommend that the Department permit health insurance issuers to rely on a written representation of the plan sponsor or employer as to the sponsor’s or employer’s compliance with section 2716 of the PHS Act unless the insurer has actual knowledge of a violation.

C. Explanation

We do not believe health insurance issuers should be expected to enforce compliance with the insurance non-discrimination rules by their policyholders. To require that they do so would likely increase costs. Rather, we believe health insurance issuers acting in good faith, without knowledge of actual violations, should be able to rely on a plan sponsor’s or employer’s written representation that it complies with the rule.

XI. VARIABLE WAITING PERIODS

A. Issue

It is not uncommon for a plan with identical benefits for all participants to have different waiting periods for different classes of employees. Intuitively, we believe a plan with shorter waiting periods for highly compensated individuals should run afoul of the insurance non-discrimination rule. What is neither clear nor intuitive, however, is whether such a plan discriminates on the basis of eligibility or benefits. Nor are we sure that it matters.

B. Recommendation

We recommend that the Department provide that plans with otherwise uniform benefits but with different waiting periods for different groups of employees be permitted to test compliance with the insurance non-discrimination rule as either (a) separate plans with different eligibility requirements or (b) a single plan with multiple benefit levels.
C. **Explanation**

When viewed as a single plan with two or more different waiting periods, a plan might discriminate on the basis of benefits (*i.e.*, benefits are available to one group but not another for a period of time). If, however, each waiting period is deemed to be a separate plan, then the plan might fail to satisfy the applicable non-discrimination standard on the basis of eligibility. By way of example, a plan with otherwise-identical benefits might have a 60-day waiting period for rank-and-file employees but no waiting period for management employees. If this arrangement is tested as a single plan, the lack of coverage for 60 days for the rank-and-file will likely run afoul of benefits testing, since the management group has access to benefits (albeit for only 60 days) that are not available to rank-and-file employees. Alternatively, this arrangement might be tested as two plans, in which case the plan for management employees is viewed as discriminating on the basis of eligibility. We can discern no good policy or other reason to prefer one approach over the other.

**XII. EXCLUSION FOR SELF-EMPLOYED INDIVIDUALS**

A. **Issue**

For purposes of sections 105 and 106, the term “employee” means and includes (i) a common law employee, (ii) a full-time life insurance agent who is a current statutory employee, (iii) a retired employee, (iv) a widow or widower of an individual who died while an employee, (v) a widow or widower of a retired employee, and (vi) a leased employee under section 414(n). Self-employed individuals, partners, and two percent shareholders of S corporations are *not* employees for this purpose.

B. **Recommendation**

We recommend that the Department, in the case of plans and benefit package options that cover both self-employed individuals and common law employees, provide that self-employed individuals are excluded from the numerator and denominator of the testing fraction.

C. **Explanation**

Self-employed individuals are not eligible for the favorable tax treatment accorded by section 105(b). Rather, according to Regulation section 1.105-5, these individuals must include in gross income as “wages” the benefits paid from an employer-provided group health plan. Self-employed individuals are, however, entitled to a 100% medical expense deduction under section 162(l). Because these self-employed individuals are not eligible for the benefit of section 105, we believe they should similarly be excluded when applying the insurance non-discrimination rule.
XIII. PRESUMPTION OF DOCUMENTARY COMPLIANCE

A. Issue

The provisions of the insurance non-discrimination rule are operational in nature, but to the extent these provisions are applied to ERISA-covered plans, plan documentation is required. This raises the issue of whether a plan might be discriminatory on its face, thereby running afoul of the insurance non-discrimination rule without the need for testing of any kind.

B. Recommendation

We recommend that the Department establish a presumption in favor of formal, documentary compliance by insured plans in the absence of facially discriminatory plan terms.

C. Explanation

Although “plan documents” are not mentioned in section 105(b), the terms of a plan subject to ERISA must be set out in a written plan document. Moreover, it is common for plans that are not subject to ERISA (i.e., church and governmental plans) to have written plan documents. Conferring on plans the presumption that they do not discriminate (in all but the most egregious circumstances) would recognize and facilitate many common plan designs. By way of example, a plan that establishes classifications based on factors such as seniority, full-time vs. part-time employment, or job description would be presumed non-discriminatory in the absence of evidence that the plan discriminates in operation. But a plan that, by its terms, covers only executives, or one that provides that contributions are based on the amount or rate of compensation, would not be afforded the benefit of the presumption.

XIV. LIMITED EXEMPTION FOR INSURED, POST-TERMINATION MEDICAL BENEFITS

A. Issue

Post-employment medical benefits are a common feature of employment, severance, change in control, and other similar agreements. Prior to the Act, it was common for such agreements to continue to provide coverage for the former employee under the employer’s group health plan or to subsidize his or her COBRA coverage. When post-termination benefits were provided under a fully insured medical plan, these and similar arrangements raised no problems or concerns. But after the Act, such agreements and similar arrangements may run afoul of the insurance non-discrimination rule even though when entered into they complied with the applicable requirements.

B. Recommendation

We recommend that the Department provide a limited exemption for insured, post-termination medical benefits provided under employment, severance, change-in-control, or other
similar agreements, arrangements, or contracts entered into by employers with employees before March 23, 2010.

C. Explanation

The Act fundamentally alters the nature and structure of post-termination medical benefits provided under fully insured plans in ways that the parties to employment and other similar agreements could not have anticipated. Absent some sort of transitional rule, these agreements will need to be revisited, and the vast majority will likely need to be modified, which will require renegotiation to avoid substantial penalties on the employer. We submit that agreements covering terminated employees that include post-termination medical benefits ought to be honored without renegotiation.

XV. POST-TERMINATION MEDICAL BENEFITS PLAN DESIGNS

A. Issue

Because the penalties for violation of the section 105 non-discrimination rules differ from those that apply to violations of the insurance non-discrimination rule, not all of the approaches available to self-funded plans that provide post-termination medical benefits are available to similarly situated fully insured plans. For example, it will not be possible to “gross up” (or tax) the premium cost of the coverage, but we believe it should be possible to provide coverage in the individual market or under a plan that covers less than two active employees.

B. Recommendation

We recommend that the Department clarify that employers may provide (otherwise discriminatory) post-termination medical coverage on a pre-tax basis to former employees under an individual market contract or policy or under a plan that covers less than two active employees.

C. Explanation

In the preamble to the grandfather rule the Agencies determined that plans covering less than two active employees are not subject to the Act’s insurance market reforms. Accordingly, we believe the insurance non-discrimination rule should not apply when coverage is under a plan with fewer than two active employees. In addition, because the insurance non-discrimination rule applies to group health plans, and not individual market policies or contacts, we believe the purchase of individual market coverage should be permitted irrespective of whether the employer

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arranges and pays for the coverage directly or whether the employer reimburses the cost of coverage.\textsuperscript{21}

\footnote{\textit{See} Rev. Rul. 61-146, 1961-2 C.B. 25 (providing pre-tax treatment of amounts advanced for the purchase of retiree medical coverage in the individual market subject to proper substantiation).}