AMERICAN BAR ASSOCIATION
SECTION OF TAXATION
EMPLOYEE BENEFITS COMMITTEE

2011 MIDYEAR CLE MEETING
BOCA RATON, FLORIDA
January 20-22, 2011

Executive Compensation Subcommittee Meeting

Assessing the Impact of the Health Care Reform Insurance Non-discrimination Rules on Executive Employment Agreements

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I. Introduction

The individual and group insurance market reforms enacted as a part of Patient Protection and Affordable Care Act (the “PPACA”),1 as amended the Health Care and Education Reconciliation Act (the “Reconciliation Act”)2 (collectively, the “Affordable Care Act” or the “Act”) amend Public Health Service Act (“PHSA”) §§ § 2701 through 2728. PHSA §§ 2701 through 2719A are substantially new, though they incorporate some provisions of prior law; PHSA §§ 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes. These reforms impose new requirements on state-licensed health insurance issuers or carriers and health maintenance organizations. They also apply generally to group health plans (both insured and self-funded) under amendments to ERISA and the Internal Revenue Code.3

PHSA § 27164 for the first time imposes non-discrimination rules of insured group health plans, but with some important differences relating to enforcement. This extension of the non-discrimination rules will have important consequences for executive employment agreements that provide for a period of post-employment medical coverage. This paper’s purpose is to explore these consequences and to speculate as to how to comply with the new rules.

II. Prior Law and the Limitations Imposed by Code Section 105(h)

(a) Code §§ 104, 105 and 106

Three sections of the Code, Code §§ 104, 105 and 106, generally govern the Federal tax treatment of employer-provided health benefits. Under Code § 104, amounts received by, or benefits paid on behalf of, an employee or his or her dependents for personal injuries or sickness that is paid with after-tax dollars are not included in the employee’s income. For this purpose, the value of coverage provided to the employee’s spouse and dependents is treated as income to the employee.5 The operation of Code § 104 is most commonly encountered in employer-provided disability plans under which either the contributions or the benefits are taxed, and it is possible to provide employees with an annual election as to which approach they prefer.6

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4 PHSA § 1563(c)(6)
5 Id. § 1001, replaced by § 10101(d).
6 Treas. Reg. §§ 1.61-21(b)(1), (4).
Under Code § 105(a), amounts received by an employee through accident on health insurance for personal injuries or sickness are taxable to the extent such amounts are attributable to contributions by the employer, which were not includible in the gross income of the employee, or are paid by the employer. Code § 105(b) contains an important exception to the general rule of Code § 105(a) for amounts expended for medical care as defined in Code § 213(d) (i.e., medical expense reimbursements) for the employee and his or her dependents, and for permanent injury (i.e., disability) payments. Similarly, Code § 105(c)(1) allows for payment for the permanent loss or loss of use of a member or function of the body, or the permanent disfigurement of the employee, his or her spouse, or a dependent, so long as the payments are computed with reference to the nature of the injury and without regard to the period the employee is absent from work. It matters not for Code § 105 purposes whether the benefits are paid under a fully-insured plan or a plan that is self-funded, but as explained below self-funded plans must not discriminate as to plan “eligibility” or “benefits.” Whether a plan is fully insured or self-funded is determined based on the locus of the risk.\(^7\) Self-funded plans are subject to the nondiscrimination rules of Code § 105(h), which are discussed below.

Code § 106 provides that employer-paid coverage—i.e., the premium cost—under an accident or health plan is not taxable to the employee. Thus, under a typical insured medical plan, Code § 106 ensures that premiums paid by the employer on an employee's behalf are not included in the employee’s income, and Code § 105(b) exempts from the employee’s income any medical benefits paid on his or her behalf under the plan. These exclusions from income extend to employment taxes and income tax withholding otherwise required by Code §§3121(a)(2) and 3306(b)(2) and Treas. Reg. § 31.3401(a)-1(b)(8).

For purposes of Code §§ 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 Code § 414(n).\(^8\) Self-employed individuals, partners and 2% shareholders of S corporations are not employees for this purpose.\(^9\) These individuals generally are treated the same as employees under Code § 104(a)(3). Therefore, a self-employed individual who pays premiums with after-tax dollars for medical or disability insurance will be able to exclude benefit payments from income. Prior to the Act, self-employed workers could deduct medical expenses that exceed 7.5% of adjusted gross income, and under §162(l)(1) they can deduct up to 100% of the costs of providing accident and health insurance coverage. The Act increases the 7.5%-of-adjusted-gross-income floor to 10% effective January 1, 2010.\(^10\)

(b) **Insured vs. Self-funded plans**

Prior to the Act, no benefits-related, non-discrimination rules applied to an insured accident and health plan. Thus, an insured group health plan could cover management and other

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\(^7\) See Treas. Reg. § 1.105-11(b)(1)(ii) (defining an “insured” plan as a plan underwritten by a policy of insurance or a prepaid health care plan that involves the shifting of risk to an unrelated third party).

\(^8\) See Treas. Reg. §31.3401(c)-1 (defining an “employee” as a person performing services in an employer-employee relationship).

\(^9\) Code § 105(g).

\(^10\) PPACA § 9013(a), amending Code § 213(f).
highly paid employees under terms that were more favorable than those applicable to rank-and-file employees with impunity. It is this rule that led to the proliferation of “executive-only” premium medical plans—i.e., plans that provided enhanced medical benefits over and above those provided to rank and file employees on a purportedly fully-insured basis. This also made it relatively easy to provide post-termination medical benefits to executives on a discriminatory basis, although this task was made marginally more difficult with the addition of Code § 409A in American Jobs Creation Act of 2004.\footnote{America Jobs Creation Act of 2004, Pub. L. 108-357, 118 Stat. 1418 (2004), § 885.}

In contrast to their insured counterparts, self-funded plans are subject to the non-discrimination provisions of Code § 105(h) that govern self-insured medical reimbursement plans. The reasons for this disparate treatment are historical. Congress was originally of the view that insurance underwriting considerations generally preclude or effectively limit abuses in insured plans. As a result of advances in insurance underwriting and increasing competition in the health insurance markets, however, Congress had a change of heart. Section 1151 of Tax Reform Act of 1986 added Code § 89, which established a comprehensive set of nondiscrimination rules that applied to a broad range of welfare and fringe benefit plans including employer-provided group-term life insurance plans and accident and health plans (dependent care plans were subject to special rules). In 1989, the Treasury issued a proposed regulation interpreting the new nondiscrimination standards. Code §89 was the subject of intense criticism. Despite some delays in the effective dates, and in spite of an earnest attempt at simplification, intense lobbying pressure particularly by small business interests ultimately doomed the measure. Code § 89 was repealed in 1992 (retroactive to 1989) by Title II of the Debt Limit Extension Act, and the prior rules were reinstated.

Under Code § 105(h), the exclusion from income provided under Code § 105(b) is totally or partially denied to “highly compensated individuals” who are covered under a self-insured medical reimbursement plan that discriminates as to either eligibility (under Code § 105(h)(3)) or benefits (under Code § 105(h)(4)). When a self-insured medical reimbursement plan fails the nondiscrimination requirements of Code §105(h)(3) or Code § 105(h)(4), benefits paid to highly compensated individuals become taxable in whole or in part. A benefit paid to a highly compensated individual that is not available to all other participants is not excludible under Code § 105(b). Where a benefit is paid to a highly compensated individual in an amount that is greater than that available to any other participant, the excess is taxed to the highly compensated individual. Code § 105(h)(5) defines the term “highly compensated individual” to mean an individual who is (i) one of the five highest paid officers, (ii) a shareholder who owns (with the application of §318) more than 10% in value of the stock of the employer, or (iii) among the highest paid 25% of all employees. This determination is made on a control group basis.

The eligibility requirements of § 105(h)(3) are similar to the non-discrimination rules that applied to tax-qualified pension, profit sharing and stock bonus plans under Code § 410(b) prior to the Tax Reform Act of 1986. Under those rules, a plan must benefit either (i) 70% or more of all employees, or 80% or more of all employees who are eligible to benefit under the plan if 70% or more of all employees are eligible to benefit under the plan or (ii) a classification of employees set up by the employer and found by the Secretary of the Treasury not to be discriminatory in favor of highly compensated individuals. Under Code § 105(h)(4), a plan must
generally provide benefits on a nondiscriminatory basis. Benefits provided to highly compensated individuals (and their dependents) must also be provided to all other participants. Discrimination is determined by looking at the benefits available under the plan rather than the amounts paid.

For purposes of applying these tests, §105(h) allows employers to exclude the following: (i) employees who have not completed three years of service; (ii) employees who have not attained age twenty-five; (iii) part-time or seasonal employees; (iv) employees not included in the plan who are included in a unit of employees covered by an agreement between employee representatives and one or more employers which the Secretary of the Treasury finds to be a collective bargaining agreement, if accident and health benefits were the subject of good faith bargaining between such employee representatives and such employer or employers; and (v) employees who are nonresident aliens and receive no U.S. earned income.

(c) Post-termination medical coverage (prior to the Act)

Prior to the Act, employers generally followed one of three approaches to post-employment health care benefits:

(i) Provide the executive with an individual health insurance contract or policy from a state-licensed health insurance carrier.

There are two options under this prong. Under the first, the employer simply increases the amount of taxable, post-employment compensation to the executive thereby providing the executive with the funds to purchase coverage in the individual market. (Thus, the executive could forgo the coverage and simply pocket the extra money.) Here the benefits are non-taxable under Code § 104. Under the second option, the employee is required to purchase the coverage and provide substantiation, thereby making the benefit a pre-tax benefit. The employer in this latter instance has established a “plan,” the benefits under which are taxed according to Code § 105(b).

Prior to the Act, either prong worked fine: the first because there was no plan (it involved only the purchase of a single policy in the individual market); the second because there was nothing to prevent an employer from adopting a discriminatory medical reimbursement plan that is fully-insured.

(ii) Subsidize COBRA (or COBRA-like coverage) for the executive.

The seminal guidance on the tax treatment of subsidized COBRA coverage is set out PLR 9612008, which holds that medical benefits provided to a former employee under a severance plan are excludable from the employee’s income.

(iii) Continue the executive’s coverage under the employer’s group health plan for active employees.

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If the employer’s plan is fully-insured, then this approach is fine, since at least prior to the Act the Code’s non-discrimination requirements did not extend to such plans. Where the underlying coverage is under a self-funded group health plan, however, the result is a discriminatory benefit that is subject to Code § 105(h). The commonly accepted “fix” in this instance is to impute as additional income the fair market value of the coverage (e.g., at the COBRA working rate), thereby subjecting the benefit to the rules under Code § 104. Thus, the premiums are taxable but benefits are not. While formal guidance is lacking, it seems generally accepted that the providing COBRA coverage to highly compensated employee under a self-funded medical reimbursement plan pursuant to a severance arrangement, where such coverage is not routinely extended to the rank-and-file (who most likely do not get severance benefits in any case) is discriminatory in the absence of the “Code § 104 fix.” Alternatively, the employer can simply increase the executive’s taxable severance, and require the executive to pay premiums with after-tax dollars. While these approaches appear to be equivalent, at least one commentator has argued that the latter is preferable, since Code § 106 might not permit the former.²⁴

III. The PHSA § 2716 Nondiscrimination Rule

The Act, for the first time, extends the nondiscrimination rules that have applied to self-funded group medical plans to fully insured arrangements.¹⁵ Newly added PHSA § 2716 provides as follows:

‘‘(a) IN GENERAL.—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

‘‘(b) RULES AND DEFINITIONS.—For purposes of this section—

‘‘(1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

‘‘(2) HIGHLY COMPENSATED INDIVIDUAL.—The term ‘highly compensated individual’ has the meaning given such term by section 105(h)(5) of such Code.”

The term “group health plan” is defined in PPACA § 1301 is defined with reference to PHSA 2791(a), which generally includes all group health plans, whether fully insured or self-funded. PHSA § 2716(a) then carves out “self-insured plan[s].” Whether dividing line between fully insured and self-funded is the same as that prescribed by Code § 105(h) and Treas. Reg. § 1.1105-11(b)(1)(ii) is not yet clear. Wherever the line is drawn, however, the non-discrimination rules under the PHSA, and not those under the Code, will govern fully insured plans. As a consequence, violation of this non-discrimination standard does not result in income inclusion; rather, it triggers a penalty under the Act.

¹⁵ Id. §§ 1001, 1004(a), and 10101, adding PHSA § 2716.
Newly added PHSA § 2716(a) requires group health plans (other than self-insured plans, which are already subject to Code § 105(h)) to satisfy the requirements of Code § 105(h)(2) (relating to prohibition on discrimination in favor of highly compensated individuals). For this purpose, “rules similar to the rules contained in” Code §§ 105(h)(3) (relating to non-discriminatory eligibility), (4) (relating to non-discriminatory benefits) and (8) (apply the rules to controlled groups). Code § 105(h)(5) (relating to which employees are “highly compensated”) is not included, which means that the regulators have some latitude in identifying the “prohibited group.” Code § 105(h)(6) (defining what constitutes “self-insured medical reimbursement plan”) is also not included since it is not relevant.

What is not clear is whether the dividing line between fully insured and self-funded for purposes of the Act is the same as that prescribed by Code § 105(h) and Treas. Reg. § 1.105-11(b)(1)(ii). Wherever the line is drawn, however, the non-discrimination rules under the PHSA, and not those under the Code, will govern fully insured plans. As a consequence, violation of this non-discrimination standard does result in income inclusion; rather, it triggers a penalty under the Act’s insurance market enforcement provisions.

(a) Enforcement

The insurance market provisions of the Act, which include PHSA § 2716(a), are enforced under the PHSA § 2736. Under PHSA § 2736, non-federal governmental plans and health insurance issuers in the group or individual markets are subject to a penalty of up to $100 per day for each individual with respect to which a failure to comply has occurred. The amount of the penalty may be reduced where there is evidence of a previous record of compliance and taking into consideration the gravity of the violation. Conversely, where there are substantial or several aggravating circumstances, the amount of the penalty will be set close to or at the maximum permitted amount. No civil money penalty is assessed (i) for any period for which it is established to the satisfaction of the Centers for Medicare & Medicaid Services that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that the failure existed; or (ii) if a failure was due to reasonable cause and not to willful neglect, and the failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that the failure existed. (In all likelihood, HHS will issue a comprehensive enforcement rule implementing amended PHSA § 2736 as it applied to the plans and issuers under the Act.)

(b) Impact on executive post-employment benefits

This rule has some important consequences for executive post-employment medical benefits. Any current approach that relies on the use of fully-insured medical benefits to sidestep the Code non-discrimination rules is now called into question. Thus, subsidizing COBRA coverage, or continuing coverage, under a fully-insured plan for active employees, may not

16 42 USCS 300gg-22.
17 42 USCS 300gg-22(b)(2)(C)(i).
18 42 USCS 300gg-22(b)(2)(C)(ii).
19 45 CFR § 150.321.
20 42 USCS 300gg-22(b)(2)(C)(iii)
longer be viable options. More broadly, it would seem that PHSA § 2716 will prohibit employers from providing special health insurance coverage to their executives whether on a pre-tax or (perhaps even an) after tax basis, with perhaps the following exceptions:

- PHSA § 2716 does not apply to grandfathered plans. Thus, arrangements in effect on March 23, 2010 will not be disturbed, provided that they are not modified in a way that would result in the loss of grandfather status.\(^{21}\) Where coverage is provided under a plan that also covers active employees, grandfather status would need to be preserved as to that plan as well, which may not be possible in all cases.

- In the preamble to the grandfather rule, the IRS, DOL and HHS determined that stand-alone, retiree health plans are not subject to the Act’s insurance market reforms. Thus, to the extent that an executive post-termination benefit is (or can be designed to be) a stand-alone retiree benefit, it may pass muster.

- While not an ideal solution, it should be possible to provide additional after-tax income to an executive to enable (but not require) him or her to purchase individual market coverage.

- It has been suggested that continuing coverage under the employer’s plan on an after-tax basis will constitute compliance with PHSA § 2716. But it is possible and perhaps even likely that the regulators will adopt the definition of a “plan” for COBRA purposes under Treas. Reg. § 54.4980B-2, Q&A 2-1(a), under which looks to an individual’s employment-related connection to the employer or employee organization to determined whether there is a plan. Thus, even where an individual pays with after-tax dollars, he or she is getting access to coverage that is presumably better than that available in the individual market. Whether this is discriminatory for PHSA purposes remains to be seen. This is a matter that may be addressed in future rulemaking or other guidance.

(c) Three-agency guidance

The Act confers on the Secretary of HHS jurisdiction over the non-discrimination rules that apply to fully insured plans. But the Act’s individual and group market reforms, apply to group health plans and to state-licensed carriers that issue health insurance in the individual and group markets “as if” these provisions were included in ERISA and Chapter 100 of the Code.\(^{22}\) The PHSA sections incorporated by this reference are §§ 2701 through 2728. IRS, DOL and HHS, the agencies charged jointly with enforcing these requirements have routinely issued parallel regulations under a memorandum of understanding (the “MOU”) agreeing to coordinate their enforcement efforts to ensure that the requirements of these parallel provisions are enforced in the same manner by all three agencies.\(^{23}\) The MOU was issued under HIPAA Title I, Subtitle A (including limitations on pre-existing conditions, prohibition of discrimination based on health status) and Section 104 of Title IV (governing underwriting standards in the group health

\(^{22}\) ERISA § 715; Code § 9815(a)(2), as added by PPACA §§ 1562(e) and (f), re-designated as PPACA §§ 1563(e) and (f) by PPACA § 10107(b).
insurance market). The MOU’s basic structures has been carried forward and it will likely be followed in the case of guidance under the PHSA § 2716 non-discrimination rules.

In addition to providing substantive rules implementing PHSA § 2716, it would also be helpful to have transitional rules governing the treatment of existing agreements. One might hope, for example, that agreements entered into before March 23, 2010 would be eligible, but it will this require that the underlying group health plan, if any, retain its grandfather status? These and other questions await word from the Agencies.

IV. Conclusion.

Extending non-discrimination rules to fully-insured group health plans would be simple enough if there were some assurance that the design approaches to post-employment medical benefits would track the treatment of self-funded plans under Code § 105(h). But there is no guarantee of that. That the rules might change will not diminish in the least the desire of executives to gain access to coverage, so some accommodation will need to be made. At the moment, all that can safely be said is that any such accommodation will likely be more expensive, either because the underlying benefit will cost more to purchase (i.e., individual vs. group coverage) or because the benefit will no longer enjoy favorable tax treatment, or both.