HEALTH CARE REFORM: Nondiscrimination Compliance Strategies

November 8, 2010
Timeline: 2010

- Small business tax credit
- Early retiree reinsurance
- Recognition of taxation of retiree drug subsidy
- Nursing mothers
- State high risk pools
- Automatic enrollment (effective when guidance issued)
Timeline: Plan years beginning on or after September 23, 2010

- Restrictions on rescission
- Dependent coverage for adult children under the age of 26
- Changes to appeals process
- First dollar coverage required for certain evidence based preventative care (including well child care and certain immunizations)
Timeline: Plan years beginning on or after September 23, 2010

- Elimination of the pre-existing condition exclusion for children under age 19
- Elimination of lifetime limits related to essential health benefits
- Reasonable annual limits related to essential health benefits
Timeline: Plan years beginning on or after September 23, 2010

- Participants can select primary care provider
- No preauthorization or increased cost-sharing for emergency
- No preauthorization or referral requirement for OB/GYN services
- **Nondiscrimination requirements** apply to fully insured plans
Timeline: 2011

• Over the counter medications are no longer eligible for reimbursement under a health flexible spending account, health reimbursement arrangement or health savings account

• CLASS ACT: National voluntary employee funded long term care benefit

• Insurance rebates required to the extent that more than 20% of the premium revenue is spent on costs other than benefit claims
Timeline: 2011

- Simple Section 125 cafeteria plans are available for companies with less than 100 employees
- Tax on distributions from a health savings account is increased from 10% to 20%
- Adoption assistance limits increased and extended
Timeline: 2012

• 1099 reporting requirements expanded to require a 1099 to be issued to any corporation, other than a tax exempt, for any property or services over $600:

• Report health care quality and wellness initiatives to HHS
Timeline: Plan years ending on or after September 30, 2012

- Fee of $2 per average number of enrollees/lives ($1 for policy/plan years ending during fiscal year 2013):
  - If fully insured, issuer pays
  - If self-funded, plan sponsor pays
  - Indexed
  - This fee sunsets after 2019
Timeline: 2013

• Additional 0.9% Medicare tax on wages in excess of $250,000 for joint return filers, and $200,000 for others

• 3.8% tax on unearned income for joint filers with modified AGI in excess of $250,000, $200,000 for singles, $120,000 for married filing separately

• Effective January 1, 2013 the maximum amount that can be made available through a health flexible spending account is limited to $2,500, indexed
Timeline: 2013

• Employer notice must be provided beginning on March 1, 2013 to notify employees in writing:
  – Of the existence of the Exchange
  – Of potential eligibility for federal assistance if the employer’s health plan is “unaffordable”
  – That they may lose the employer’s contribution if they purchase health insurance through the Exchange without a voucher

• 60-day advanced notice of material modifications
Timeline: 2014

- Establishment of state health insurance exchanges for individuals and small businesses with 100 or less employees
- Individual mandate requiring all individuals to have health insurance
- Employer mandate regarding coverage
Timeline: 2014

- Elimination of pre-existing condition exclusions for all participants
- No annual dollar limits
- Waiting periods cannot exceed 90 days
- No cost sharing in excess of the limits on high deductible health plans
- Limit on wellness incentives is increased from 20% to 30%
- Cover routine costs of patients who are part of clinical trials
Timeline: 2018

• Cadillac plan tax becomes effective
  – 40% tax on “excess health coverage”
  – Tax imposed on issuers of fully-insured plans and on administrators with respect to self-funded plans
  – $10,200 for single and $27,500 for family
  – Retirees and high risk professions: $11,850 for single and $30,950 for families
  – Adjusted for inflation
Grandfathered Plans

• A grandfathered plan is generally any plan in which an individual was enrolled on March 23, 2010

• Grandfathered plans do not have to comply with the following requirements:
  – Nondiscrimination requirements for fully insured plans
  – Providing participants with the right to select a primary care provider/pediatrician
Grandfathered Plans

– Elimination of any pre-authorization or increased cost sharing for emergency services
– Elimination of preauthorization or referral for OB/GYN services
– Changes to the appeals process
– First dollar coverage for preventative care
Grandfathered Plans

– Reporting health care quality and wellness initiatives to HHS
– Incorporating cost-sharing limits on out of pocket and deductible expenses
– Coverage of routine costs of patients who are part of clinical trials
– Providing for minimum essential benefits
Grandfathered Plans

• To maintain a plan’s grandfathered status only limited changes can be made to the plan as it existed on March 23, 2010

• The following changes to a group health plan will affect a plan’s grandfathered status:
  – Entering into a new policy, certificate or contract of insurance with the insurance issuer or changing the insurance issuer (limited exception applies to collectively bargained plans)
Grandfathered Plans

– Eliminating all or substantially all benefits to diagnose or treat a condition, or any necessary element to diagnose or treat a condition

– Increasing any percentage cost-sharing requirement (coinsurance)

– Increasing a fixed-amount cost-sharing requirement, other than a copayment, by more than the sum of medical inflation plus 15 percentage points
Grandfathered Plans

– Increasing a fixed-amount copayment by more than the greater of: $5 increased by medical inflation or a total percentage that is more than the sum of medical inflation plus 15 percentage points

– Decreasing the employer's contribution rate toward the cost of any tier of coverage by more than 5 percentage points
Grandfathered Plans

– Decreasing or imposing a new annual limit on the dollar value of benefits
  • plans with an existing lifetime limit are permitted to adopt an overall annual limit at a dollar value that is not lower than the dollar value of the plan's lifetime limit

– Anti-abuse rules apply to certain mergers, acquisitions and plan transfers that are completed in order to attempt to maintain grandfathered status
Grandfathered Plans

- The following changes do not affect a plan’s grandfathered status:
  - Changing a self-insured plan's third-party administrator
  - Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010
  - Changes adopted prior to the Regulations that would otherwise cause the plan or coverage to lose grandfathered health plan status, if such changes are revoked or modified effective as of the first day of the first plan year on or after Sept. 23, 2010
Grandfathered Plans

– Voluntary changes to increase benefits, to conform to required legal changes (including health care reform mandates), and to voluntarily adopt health care reform requirements

– Increasing a fixed-amount copayment or other fixed amount cost sharing within provided limits
Grandfathered Plans

• Notice requirement: In order to maintain a grandfathered plan, plan materials must include a statement that the plan is grandfathered and include contact information for questions and complaints
  – Model language is included in the Regulations
Nondiscrimination Testing

- For plan years beginning on or after September 23, 2010, nondiscrimination requirements *similar* to those under Section 105(h) of the Internal Revenue Code will apply to fully insured plans
  - Future guidance -- IRS Notice 2010-63
  - There are two nondiscrimination tests the "eligibility test" and the "benefits test"
Nondiscrimination Testing

• Penalties for failing to comply with the nondiscrimination requirements
  – Employer excise tax $100/day for each person to whom the failure relates (those discriminated against)
    • not applicable to small employers of less than 50 (however, exception may not apply to employer actions)
    • maximum excise tax is lesser of 10% of health plan costs or $500,000
Nondiscrimination Testing

- Employees may be able to take action against the plan if discriminatory
- Issuers may be subject to a similar penalty (without maximum limit) but not clear.
Nondiscrimination Testing
Eligibility Test

• The eligibility test provides that a plan cannot discriminate in favor of highly compensated individuals ("HCIs") as to eligibility to participate
  – HCIs are
    • the five highest paid officers, or
    • shareholders who own more that 10% of the value of the employer stock, or
    • the highest paid 25% of all employees
Nondiscrimination Testing
Eligibility Test

– Excludable employees (exclusions may not be available if some of the employees in a category are covered):

  • employees who have less than 3 years of service
  • employees who have not attained age 25
  • part-time (under 35 hours -- if everyone else works substantially more) and seasonal employees (less than 9 months)
  • collectively bargained employees and
  • non-resident aliens with no U.S. source income
Nondiscrimination Testing
Eligibility Test

• Three alternative tests can be used to satisfy the eligibility test
  – The 70% test
  – The 70%/80% test and
  – The nondiscriminatory classification test
Nondiscrimination Testing
Eligibility Test

• The 70% test is satisfied if the plan *benefits* 70% or more of all employees.
  – under this alternative, the employer can pick and choose which employees participate.
  – certain employees may be excluded from consideration.
  – using a conservative approach "benefitting" means that the employee must be enrolled in the plan and not just eligible
  – a more aggressive approach is to consider all those eligible to elect coverage as benefitting.
Nondiscrimination Testing
Eligibility Test

- The 70%/80% test is satisfied if (1) 70% or more of all employees are eligible to benefit under the plan and (2) the plan benefits 80% or more of all of the employees who are eligible.
  - To run this test it is necessary to first determine whether at least 70% of employees are eligible under the plan.
  - Then it must be determined whether at least 80% of those eligible employees actually participate in the plan.
Nondiscrimination Testing: Eligibility Test

- The nondiscriminatory classification test is satisfied by demonstrating that the plan benefits a class of employees that does not discriminate in favor of HCIs.

- Although not completely clear, there are generally two accepted methods that may be used to satisfy the nondiscrimination classification alternative for the eligibility test:
  - The *post-TRA nondiscriminatory classification test* under Code Section 410(b)
  - The *pre-TRA fair cross section test*. 
Nondiscrimination Testing
Eligibility Test

• A plan will satisfy the post-TRA nondiscrimination classification test if the following two requirements are met:
  – The plan benefits employees who qualify under a reasonable classification established by the employer
    • the classification must be reasonable using objective business criteria to identify the category of employees who benefit under the plan (hourly/salaried, geography)
  – The classification of employees is nondiscriminatory.
    • the employees included in the classification benefiting under the plan satisfies either an objective safe harbor percentage test or a subjective facts and circumstances test for the plan year.
Nondiscrimination Testing
Eligibility Test

- Example of Post TRA: Employer A has 200 nonexcludable employees of whom 120 are non-HCIs and 80 are HCIs. Employer A maintains a plan that benefits 60 non-HCIs and 72 HCIs. The employer’s non-HCI concentration percentage is 60% (120/200). Employer A’s safe harbor percentage is 50 percent and its unsafe harbor is 40%. The plans ratio percentage is 55.56% (60/120)/(72/80) = 50%/90% = .5556). Because the plan’s ratio percentage is greater than the safe harbor percentage it is deemed nondiscriminatory.

  - NOTE: If the facts had been different and the plan’s ratio percentage was between 40% and 50% plan could pass based on facts and circumstances; Under 40% and it would fail.
Nondiscrimination Testing
Eligibility Test

• A plan will satisfy the pre-TRA fair cross-section test even when most plan participants are members of the prohibited group, if the following requirements are met:
  – compensation of the plan participants is substantially the same as that of the excluded employees;
  – the plan covers employees in all compensation ranges;
  – those in the middle and lower compensation range are covered in more than nominal numbers; and
  – the classification on its face does not discriminate in favor of employees who are officers, shareholders, or HCIs.
Nondiscrimination Testing

Benefits Test

• The benefits test ensures that benefits provided for participants who are HCIs (and their dependents), are also provided to non-HCIs (and their dependents)

• The benefits test requires that the plan not discriminate based on terms of the plan or in operation of the plan
Nondiscrimination Testing

Benefits Test

• To be nondiscriminatory on its terms:
  – required employee contributions must be identical for each benefit level
  – maximum benefit level must not vary based on age, years of service, or compensation
  – the same type of benefits must be available to HCIs and to non-HCIs
  – different waiting periods must not be imposed
Nondiscrimination Testing
Benefits Test

- Whether a plan discriminates in actual operation is a facts and circumstances determination
- Discrimination in operation may occur where the duration of a particular benefit coincides with the period during which only HCIs utilize the benefit
Nondiscrimination Testing Options

- Offer the benefits on the same basis to all employees
- Increase compensation for those who currently pay less for benefits
- Simple cafeteria plan (maybe)
Q & A
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