LUSE GORMAN November 1, 2010

LEGAL UPDATES AND NEWS

Executive Health Benefits May Trigger Big Penalties

Under the Patient Protection and Affordable Care Act, enacted March 23, 2010 ("Health Reform Laws") providing health care benefits to the top 25% of wage earners in your workforce (including former employees) that are more favorable than those provided to the rest of your employees is likely to subject your Company to an excise tax of up to $500,000 per year. Providing more favorable coverage or benefits to even one current or former executive can trigger a significant penalty since the penalty is based on the persons against whom the plan discriminates and not on the person(s) who receive the more favorable benefit. The penalty can arise even where the more favorable coverage is the result of a negotiated promise under a binding employment or severance agreement or arrangement.

Self-insured health plans have been subject to discrimination rules for years under Section 105(h) of the Internal Revenue Code ("Code"). However, insured health plans have never been subject to discrimination rules – until now. Now the Health Reform Laws apply rules similar to the rules of Code Section 105(h) to insured health plans, unless the plan is a "grandfathered plan" or satisfies other limited exceptions discussed below. An insured group health plan that was in existence on March 23, 2010 (e.g., the date of enactment of the Health Reform Laws) is "grandfathered" and not subject to the non-discrimination rules, provided that an employer does not take some action that would cause the plan to lose grandfathered status. Plans that are not grandfathered become subject to the discrimination rules in the first plan year beginning after September 23, 2010. Failure of a non-grandfathered insured health plan to comply with the new Health Reform Laws after they become effective with respect to such plan will subject the plan to excise taxes of $100 per day for each individual who is discriminated against (or $36,500 per employee), up to the lesser of 10% of the aggregate amount paid or incurred by the employer during the preceding taxable year for the group health plan or $500,000, whichever is less.[1]

Common Examples of Potential Discrimination

- Salaried employees receive immediate health care insurance while part-time employees have a three-month waiting period for coverage;
- Company offer letter promises fully-paid health insurance to new executive vice-president while other employees are generally subject to a 50% co-pay;
- Employment agreement provides that the covered executive will receive fully-paid health insurance for any number of years following a termination without cause;

[1] The preamble to the Interim Final Rule provides a "mid-range" estimate that 66% of small employer plans and 45% of large employer plans will relinquish their grandfathered status by the end of 2013. The high-end estimate is that 80% of small employers and 64% of large employers will lose grandfathered status by that time.

- Employment agreement with long-term Chief Executive Officer promises health coverage for life; and

- Executives in the principal business office receive fully-paid health individual coverage with 50% co-pay for family coverage, while other employees generally have a 50% co-pay for self or family coverage.

Whether any of these examples will, in fact, be discriminatory will depend on: (i) complex numerical testing discussed in the Interim Final Rules published in the Federal Register on June 17, 2010, and (ii) the possibility of further exceptions that could be implemented in additional guidance that has yet to be issued.

Exception for Grandfathered Health Plans

However, as noted above, grandfathered plans will not be subject to these rules unless the employer takes some action that would cause the plan to fail to lose its status as a grandfathered plan. A plan will not fail to be a grandfathered plan because one or more persons enrolled on March 23, 2010 ceases to be covered, provided that the group health plan has covered someone (not necessarily the same person) at all times since March 23, 2010. The term "grandfathered health plan" includes individual insurance coverage that otherwise satisfies this criteria.

Neither the Health Reform Laws nor the Interim Final Rules define the term "plan" for purposes of these rules. However, the Interim Final Rules indicate that the rules apply separately to "each benefit package made available under a group health plan." Accordingly, it appears that a plan could lose its grandfathered status with respect to one benefit package but not with respect to other benefit packages.

To maintain grandfathered plan status, a group health plan must maintain records documenting the terms of the plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify such terms. In addition, the employer must not take certain action specified in the Interim Final Rules. If an action is not specified in the Interim Final Rules as one that would cause a loss of grandfathered status, then grandfathered status would not be lost as the result of such action. Disregarding the special rules for collectively bargained plans, the following actions are listed as those that would trigger a loss of grandfathered status with respect to a health plan:

- **Changing insurance contracts or carriers** (however, frequently asked questions (FAQs) issued September 20, 2010, by the Department of Labor, the Treasury Department and Health and Human Services suggest that there may be some circumstances in which a Company can change carriers without losing grandfathered status);
- **Elimination of all or substantially all benefits to diagnose or treat a particular condition**;
- **Any increase in percentage cost-sharing**;
- **Increases in fixed–amount cost sharing**;

    - inflationary adjustments of up to 15% above medical inflation are allowed, with medical inflation determined as the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U));
    - special rules exist for co-payments that permit increases that do not exceed the greater of (1) $5, increased by medical inflation since March 23, 2010; or (2) 15% above medical inflation since March 23, 2010;
- **A decrease in the rate of employer contributions** for any tier of similarly situated individuals by more than 5% below the contribution rate on March 23, 2010; or
- **Certain changes to the annual limits under the plan**:
    - Imposing an overall or lifetime limit where none previously existed, or
    - If the plan has an overall limit but no annual limit, imposing an annual limit that is less than the lifetime limit in place on March 23, 2010.

The Interim Final Rules contain complex numerical tests that an employer may need to perform to determine if grandfathered status has been lost due to changes in cost sharing arrangements. What is clear is that as soon as the new Health Reform Laws apply to an employer's health plans (which may be as soon as January 1, 2011 for calendar year plans), and such plan(s) are discriminatory, the employer may be penalized $100 per day per employee who does not receive the discriminatory coverage/benefits.

Other Health Benefits Not Subject to Discrimination Testing

In addition to the exception for grandfathered health plans, the Health Reform Laws exempt from the discrimination tests the following types of health plans, to the extent that such plans would also be exempt under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) :

- **Retiree Only Health Plans**, e.g., plans that on the first day of the plan year have fewer than two participants who are current employees;
- **Accidental Death and Dismemberment Plans**;
- **Disability Insurance Coverage**;
- **Limited Scope Dental Benefits** (e.g., benefits substantially all of which are for the treatment of the mouth (including any organ or structure within the mouth);
- **Vision benefits**;
- **Long-term Care Benefits**;
- **Health Flexible Spending Arrangements**;
- **Noncoordinated Excepted Benefits** if such benefits satisfy additional conditions (such as being provided under a separate policy or contract with no coordination of benefits under a group health plan maintained by the same employer); and
- **Supplemental Excepted Benefits** provided under a separate policy, certificate or contract of insurance (e.g., Medigap insurance).

Such plans are typically excepted under HIPAA if: (i) they are offered under a separate policy, certificate or contract of insurance, or (ii) they are not an integral part of the plan (i.e., a participant must have a right not to receive such coverage and, if they do elect coverage, must pay an additional premium).

What to Do Now

Review Plans and Arrangements for Discrimination. For any health plans or arrangements that your Company sponsors, other than any of those identified immediately above that have been excepted from these provisions, the Company should appoint an individual or team that should prepare a schedule documenting not only the plan year (to determine when the plan would first become subject to the rules), but also whether the plan provides any better benefit or cost-sharing arrangement to management employees, owner employees, former management or owner employees, former management or owner employees of a company or institution that the Company has acquired or employees or former employees with whom the Company has entered into an employment or severance agreement. In order to make these determinations, individual employment agreements, severance agreements, offer letters and other ancillary documents may also need to be reviewed, including "old and cold" agreements from prior acquisitions that promised lifetime health coverage or similar extended period coverage if such coverage is provided under the Company's insured health plan.

Determine if Grandfathering is Desired. If better benefits or coverage is provided to highly compensated individuals and continuation of the arrangement is desired, you should carefully document the arrangement (e.g., cost-sharing provisions, deductibles, benefit limits, coverage, etc.) as it existed on March 23, 2010 (the date of enactment of one of the Health Reform Laws) in order to be able to test on a going forward basis if grandfathered status has been maintained. If grandfathered status is not desirable or feasible (which will often be the case), then arrangements should be made to replace the discriminatory coverage with a cash payment that the executive can use to purchase their own health insurance coverage. Of course, employer-provided health benefits are non-taxable and replacing those benefits with cash is likely to result in taxable income to the individual. Accordingly a tax gross up may be need to provide an equivalent economic benefit.

Be Prepared to Modify or Amend Existing Agreements. Existing employment agreements and severance agreements that promise post-termination health coverage that is not generally available to rank and file employees should be modified to change the promise to another form of benefit that will not trigger the penalty (e.g., such as a cash payment in lieu of employer-sponsored health benefits). Since the Company, and not the executive, is penalized for providing a discriminatory benefit, the Company may have to enhance the cash payment in order to obtain the executive's consent. Even assuming an inflation adjustment (or tax gross up) is necessary in order to obtain the employee's or former employee's consent to such modification, such adjustment or gross-up is preferable to incurring the penalty that could be incurred from operating a discriminatory plan. One caution, however, in that any promise of future cash payments is likely to be subject to Section 409A of the Internal Revenue Code (as nonqualified deferred compensation) and therefore must be carefully structured.

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This newsletter does not discuss all of the nuances of the new discrimination rules. Many of these rules may be further clarified in yet-to-be written guidance. However, if you offer any health plan provisions, arrangements or contracts about which you are concerned, please contact any of the persons listed below to determine if any amendments or modifications are necessary.

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