

PRIVILEGED AND CONFIDENTIAL

MEMORANDUM

NEW NONDISCRIMINATION REQUIREMENTS FOR INSURED GROUP HEALTH PLANS

The Patient Protection and Affordable Care Act (“PPACA”) extends the nondiscrimination requirements of section 105(h) of the Internal Revenue Code of 1986 (the “Code”), to most insured group health plans. These rules, which previously applied only to self-funded group health plans, prohibit employers from discriminating in favor of highly compensated individuals relative to rank-and-file employees with respect to eligibility to participate in, and benefits provided under, a group health plan.

The new nondiscrimination requirements are effective for plan years beginning on or after September 23, 2010. However, section 1251 of PPACA excepts “grandfathered health plans” from the new nondiscrimination rule for as long as the plan maintains grandfathered status.

Insured health plans subject to the new nondiscrimination rules will face new and complex challenges in applying and satisfying those rules. This memorandum provides an overview of the new nondiscrimination rules and the existing section 105(h) rules upon which they are based, highlighting a number of open issues.

BACKGROUND ON SECTION 105(h)

PPACA does not literally extend section 105(h) of the Code to fully insured group health plans. It adds section 2716 to the Public Health Services Act (“PHSA”), which provides that insured plans must satisfy the substantive requirements of section 105(h). Section 2716 is incorporated by reference into the Employee Retirement Income Security Act of 1974 (“ERISA”) and the Code. This distinction is significant for a number of reasons as discussed more fully below. For the most part, however, it would appear that the rules applicable under PHSA section 2716 will track the section 105(h) rules previously applied to self-funded plans.

Even though section 105(h) was added to the Internal Revenue Code in 1978 there is very little interpretive authority. The Treasury/IRS issued final regulations in 1981 as well as a handful of private letter rulings in the early 1980s. However, section 105(h) was temporarily repealed in 1986 in connection with the enactment of the more expansive nondiscrimination rules of section 89, which would have applied to fully insured group health plans. After a public outcry over its complexity and burdens, section 89 was repealed and section 105(h) was reinstated retroactively in 1989.

Since then, the Treasury/IRS has generally avoided the issue of nondiscrimination rules in the context of group health plans. The IRS has not issued any precedential guidance interpreting section 105(h) since the repeal of section 89 and has listed section 105(h) as a “no rule” area,

which means that the IRS will not issue private letter rulings in the area. Moreover, the IRS has attempted to enforce section 105(h) on only rare occasions.

RECENT IRS NOTICE 2010-63 AND FUTURE GUIDANCE

On September 20, 2010, the IRS issued Notice 2010-63. The Notice suggests that insured plans should use existing Treasury regulations under Code section 105(h) as the starting point for compliance with the new nondiscrimination rules.

The Notice also requests comments on whether the IRS should issue additional guidance with respect to insured plans, likely in acknowledgement of the difficulties of applying the existing regulations to insured plans. Interestingly, in limiting the request for comments to insured plans, it appears that the IRS is not seeking comment on the rules applicable to self-insured plans.

SCOPE

Because the new nondiscrimination rules were added as part of the PHSA, rather than directly to section 105(h) of the Code, certain plans will be automatically excepted from its scope, even though those plans might have been subject to the section 105(h) rules if the plans were self-insured.

Grandfathered Plans are Excepted – Perhaps the broadest exception to the new nondiscrimination applies to plans that constitute “grandfathered plans” within the meaning of PPACA section 1251 and related tri-agency regulations. To be a grandfathered plan, a plan generally must (i) have provided coverage to at least one covered individual on March 23, 2010, and (ii) not undertake any actions (or fail to take any actions, such as with respect to certain notice and recordkeeping requirements that apply to grandfathered plans) that would cause the plan to lose grandfathered status, as set forth in the tri-agency regulations. Significantly, the regulations issued by Labor, Treasury and HHS are very restrictive and provide little flexibility for plan sponsors in terms of making changes or modifications to their plans.¹ Nonetheless, to the extent a fully insured plan qualifies as a grandfathered plan for purposes of PPACA section 1251, it is excepted from the new nondiscrimination rules.

HIPAA-Excepted Benefits are Not Covered – Unlike section 105(h), which applies broadly to all self-insured plans that reimburse medical expenses, the PPACA version of section 105(h) does not apply to HIPAA excepted benefits, including limited scope dental or vision benefits offered separately. Similarly, long-term care benefits that qualify as excepted benefits are not subject to the new nondiscrimination requirements.

Treatment of Former Employees – Although not perfectly clear, it appears that the nondiscrimination rules may not be applicable to group health plans that provide benefits only to former employees. In this regard, notwithstanding the absence of an exemption in the PHSA, the relevant agencies have taken the position that the group market reforms in the PHSA, including

¹ This is perhaps best evidenced by the statement in the preamble to the regulations that a “mid-range” estimate is that 66 percent of small employer plans and 45 percent of large employer plans will relinquish their grandfather status by the end of 2013.

section 2716, do not apply to a group health plan that covers fewer than two participants who are employees.² Note, however, given that section 105(h) clearly applies to former employees, it seems somewhat anomalous that section 2716 would be inapplicable to group health plans covering former employees.

Governmental Plans – Although governmental plans are excepted from the new nondiscrimination rules as contained in ERISA and the Code, there is no similar exception in the PHSA. Thus, HHS has authority to enforce the nondiscrimination rules against insured non-federal governmental plans. For a number of reasons, it seems possible that HHS will avoid enforcement of these new rules against non-federal governmental plans. Most notably, state and local government entities have historically been exempt from the various Code nondiscrimination rules. They are, for example, explicitly exempt from all nondiscrimination testing in the retirement plan context.

THE SECTION 105(h) NONDISCRIMINATION TESTS

When applicable, section 105(h) involves two separate and complex tests – somewhat mislabeled as (1) an eligibility test and (2) a benefits test. Both tests depend on whether the plan disproportionately favors “highly compensated individuals” relative to other employees.

Highly Compensated Individuals Defined – For purposes of the section 105(h) tests, highly compensated individuals are defined to include the following.

- The 5 highest paid officers;
- A 10% or more shareholder; and
- An individual who is among the highest paid 25% of all employees (other than excludable employees discussed below).

Note that this definition is much broader than the class that is taken into account under other nondiscrimination testing regimes, including the cafeteria plan rules and the tax-qualified plan rules. Any employee in the top quarter of the employee population will be considered a highly compensated individual. There is no minimum dollar threshold, such as the current \$110,000 for highly compensated employee status under the cafeteria and retirement plan rules.

Excludable Employees – Certain employees may be disregarded in performing the eligibility test (as discussed below), including employees who have not completed 3 years of service, part-time employees whose customary weekly employment is less than 35 hours, seasonal employees, employees subject to a collective bargaining agreement, employees who have not attained age 25, and nonresident aliens. These employees are not taken into account in the denominator in determining whether the employer’s plan has satisfied the eligibility test.³

² Preamble to Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under PPACA.

³ There is a substantial unanswered issue with respect to excludable employees. At times, the IRS has informally suggested that an otherwise excludable employee may not be excluded if the employer benefits some otherwise excludable employees. Thus, for example, if the employer provides group health plan coverage to some part-time

The Eligibility Test – A plan satisfies the eligibility test if it satisfies any one of the following three tests:

- The plan benefits at least 70% or more of all employees,
- 70% of all employees are eligible to benefit under the plan, and at least 80% or more of those eligible in fact benefit; or
- The plan benefits a nondiscriminatory class of employees (the “nondiscriminatory classification test”).

Although there is at least some ambiguity, the eligibility tests appear to apply based on who is actually *benefitting* under the plan, not on mere eligibility to participate. As a result, if a group health plan provides that employees must pay a portion of premiums, it appears that only employees who elect to pay their share of the premiums and, therefore, benefit under the program are taken into account in the numerator. Thus, to the extent that an employer designs a group health plan that results in a substantial portion of its population opting out, the plan may have an eligibility problem. This may become an even greater issue if, for example, a substantial number of employees opt out to obtain coverage through a health insurance exchange or decide to obtain coverage from a spouse's employer.

Also, the eligibility test depends on numeric testing of the employer's workforce. The data gathering aspect of the tests alone could represent a substantial new burden for some employers. Moreover, the eligibility test applies on a controlled group basis. That is, all employers who share a common parent (generally based on 80% ownership) are treated as a single employer. There is no provision for separate testing of different entities, divisions, or lines of business.

Finally, by far the most flexible test is the nondiscriminatory classification test. It is, however, also by far the most complicated to apply. The section 105(h) regulations incorporate the nondiscriminatory classification test under section 410(b) for tax-preferred retirement plans.⁴ The 410(b) test requires that the eligibility class satisfy (i) a subjective standard that the classification is reasonable and established under objective business criteria and (ii) an objective standard that it is a nondiscriminatory classification under a numeric test that is based on covering a specified percentage of non-highly compensated individuals. The required percentage of non-highly compensated individuals that must be covered varies based on the percentage of highly compensated individuals who are covered and the extent to which the employer has a higher or lower concentration of highly compensated individuals overall. A table in the section 410(b) regulations specifies the relevant ratios for different concentrations of non-highly compensated employees in an employer's workforce. Based on the coverage of highly compensated employees relative to non-highly compensated employees in the workforce, the employer will either fit within a numeric safe harbor nondiscriminatory classification or, if the

employees but not all part-time employees, it is possible that all part-time employees must be taken into account in testing.

⁴ Note that the section 105(h) regulations were published before the current 410(b) regulations were finalized. Thus, at the time the 105(h) regulations were published a different set of 410(b) regulations was in effect. It is fairly clear that a plan may rely on the current nondiscriminatory classification test under the 410(b) regulations. There is also an argument that the old law test – referred to as the fair classification test – is applicable.

percentage is in a gray area, then the employer may be able to demonstrate that the classification is a nondiscriminatory classification based on the facts and circumstances.

An example in the section 410(b) regulations only begins to illustrate the complexity of the test:

Example: Employer A has 200 nonexcludable employees, of whom 120 are non-highly compensated employees and 80 are highly compensated employees. Employer A maintains a plan that benefits 60 non-highly compensated employees and 72 highly compensated employees. The employer's non-highly compensated employee concentration percentage is 60 percent (120/200). Employer A's safe harbor percentage is 50 percent and its unsafe harbor percentage is 40 percent.⁵ The plan's ratio percentage is 55.56 percent $[60/120]/[72/80]=50\%/90\%=0.5556$. Thus, in this case the plan's ratio percentage is greater than the safe harbor percentage and the plan is deemed to be a nondiscriminatory classification.⁶

The Benefits Test – In contrast to the eligibility test, the benefits test is on its face quite simple, albeit strict. It states simply that all benefits provided for participants who are highly compensated individuals must be provided for all other participants. This test applies based on benefits subject to reimbursement, not to actual payments of claims. The benefits test, for example, precludes a lower deductible or co-pay for highly compensated individuals. It is not, however, affected by whether the actual utilization rate is higher for highly compensated individuals. The express language in the regulations requiring that each benefit be tested separately appears to preclude the use of actuarial equivalence as a means to comply with the benefits test (for example, by establishing that two distinct policies have an equivalent value of benefits).

The Treasury regulations do provide a special rule for a plan that provides optional benefits that potentially softens the strict general benefits test. Under the special rule, an optional benefit will not run afoul of the rule requiring that all non-highly compensated individuals get the same benefits as highly compensated individuals if all eligible participants may elect the benefit and the required employee contributions are the same amount. Thus, for example, a plan may offer an indemnity option and an HMO option under the same plan without running afoul of the nondiscrimination rules, provided that both options are universally available and the employee's share of the premium is the same for all employees.

In contrast to retirement plans which generally permit benefits to vary relative to the compensation earned by a participant, Treasury regulations interpreting section 105(h) expressly provide that a plan discriminates if the benefits subject to reimbursement under the plan vary in proportion to compensation.

Interaction Between The Eligibility Test and the Benefits Test – The line between the eligibility test and the benefits test may blur in certain circumstances. In a private letter ruling issued in the

⁵ This number is derived from the table in the IRS regulations.

⁶ If the facts had been different and the plan's ratio percentage was between 40% and 50%, then the plan could still satisfy the nondiscriminatory classification test under all the facts and circumstances. If the plan's ratio percentage were below 40%, then it would not satisfy the nondiscriminatory classification test.

early 1980s, the IRS took the position that a plan which made certain highly compensated individuals immediately eligible for participation but imposed a 90-day waiting period for other employees ran afoul of the benefits test. That is, even though a waiting period is arguably an eligibility feature, the IRS tested it under the inflexible benefits test. As a result, the plan could not satisfy section 105(h) even if it passed the numeric coverage requirements during the waiting period.

This notion that eligibility features may be tested under the stringent benefits test of section 105(h) raises the specter that different employees may not be required to pay different shares of the premium obligation. It suggests, for example, that an employer may not fully subsidize premiums for highly compensated individuals while requiring that rank-and-file employees pay a portion of the premiums.

Operational Compliance – The benefits tests must be satisfied in both form and in operation. It is not enough for a plan document to merely include provisions that satisfy section 105(h). The arrangement must be operated in a manner that is nondiscriminatory. A closely related issue has to do with the timing of amendments or plan changes. Treasury regulations provide that a plan change may cause the arrangement to run afoul of section 105(h) if the timing of the change, for example, a plan termination (or the elimination of a benefit under the plan) has the effect of discriminating in favor of highly compensated individuals.

Aggregation and Disaggregation – An employer is largely free to define the “plan” subject to nondiscrimination testing. That is, the employer may aggregate and disaggregate arrangements into component plans. An employer may, for example, treat two different populations covered by a single written plan document as two separate plans for nondiscrimination testing purposes. This is sometimes done because differences in benefits would otherwise cause an arrangement to fail to satisfy section 105(h) but the plan is able to satisfy the eligibility requirements if each benefit structure is tested separately.⁷ Similarly, two or more plans may be aggregated for testing purposes, although this is done less frequently simply because differences in benefit structures may make aggregation impracticable. To the extent that an employer chooses to aggregate two plans together for testing purposes, it must do so for both the eligibility and benefits test.

Former Employees – As mentioned above, it appears that PPACA's nondiscrimination rules do not apply to a retiree-only plan. However, to the extent that a fully insured group health plan covers both current and former employees, the rules will apply. There is, however, very little guidance on how section 105(h) applies to former employees. The regulations absolve a plan from performing numeric coverage testing with respect to a “retired employee” but provide that all benefits provided to a retired highly compensated individual must be provided to all retired employees. There is, however, no definition of retired employee. This could, for example, raise

⁷ For example, assume an employer offers one insured arrangement to employees in its New York office and a second insured arrangement to employees in its Florida office. Given the mechanics of the benefits test under Code section 105(h), the employer likely will need to treat each insured arrangement as a separate plan for purposes of section 105(h).

a question about whether an employer may pay COBRA premiums for former highly compensated individuals but not other individuals.⁸

SOME IMPLICATIONS FOR INSURED PLANS

In general, fully insured benefits provided solely to highly compensated individuals will now run afoul of the new nondiscrimination requirements to the extent they apply (e.g., the plan is not grandfathered). As a result, fully insured executive medical plans will generally be prohibited. There is, however, an exception from the requirements of section 105(h) for “reimbursements paid under a plan for medical diagnostic procedures” for an employee, but not a dependent. This carve-out generally allows for executive physicals and the reimbursement of related transportation expenses.

Treatment of After-Tax Premiums – One approach to section 105(h) problems affecting self-insured plans is to provide that premiums paid on behalf of highly compensated individuals are paid with after-tax dollars. This generally has the effect of making the arrangement one that is taxed under section 104(a)(3) of Code, which has no nondiscrimination requirements. It appears, however, that this approach will not be effective under the PPACA for insured plans. That is, it appears that employee after-tax payments to a fully insured group health plan, and related benefits, will be subject to nondiscrimination testing. In this regard, there is nothing analogous to section 104(a)(3) under the section 105(h) rules as incorporated in the PHSAs, ERISA, and the Code by the PPACA.

Interaction with Cafeteria Plan Nondiscrimination Rules – There is substantial overlap between the nondiscrimination requirements under Code section 125 for cafeteria plans and section 105(h). In this regard, for example, both sections impose an eligibility test that may be satisfied using the nondiscriminatory classification test. There are, however, substantial differences. For example, the two sections define highly compensated individuals differently, and the cafeteria plan rules include a key employee concentration test, which is often problematic.

Significantly, PPACA section 9022 provides “eligible small employers” who sponsor a “simple cafeteria plan” with a special safe harbor from both the cafeteria plan nondiscrimination rules and also certain nondiscrimination requirements under the Code, including section 105(h) with respect to self-insured medical plans. It does not appear that a plan sponsor of a simple cafeteria plan can avoid the application of the new nondiscrimination rules under Code section 105(h) to their insured plans. This is because the new nondiscrimination rules for insured plans are set forth in new PHSAs section 2716 and by reference, in Code section 9815, and are not included in the enumerated list of nondiscrimination rules that are deemed satisfied by a safe harbor simple plan. As discussed in greater detail below, however, in order to qualify as a simple cafeteria plan, a plan sponsor must meet a host of requirements, including a universal eligibility and universal benefits test, in addition to having to make certain minimum dollar contributions to the plan. These requirements appear to be as strict as the requirements under new PHSAs section 2716 for fully insured plans. Thus, an employer’s act of establishing and maintaining a simple cafeteria

⁸ More generally, it is not clear how COBRA elections will be taken into account, although presumably a plan will not fail the nondiscrimination rules solely because former highly compensated individuals elect COBRA coverage at a higher rate.

plan is likely to mean that the employer will also be found to be in compliance with PHSA section 2716.

Under the terms of the new safe harbor for simple cafeteria plans, an eligible employer must satisfy the following criteria in connection with its sponsorship of a simple cafeteria plan: (i) universal eligibility, (ii) universal availability, and (iii) minimum contribution requirements. For purposes of this new provision, an “eligible small employer” is generally defined to mean employers with less than 100 employees for the preceding two years. The provision does, however, include a special rule that allows employers that cross the 100-employee threshold to remain eligible to provide a simple cafeteria plan unless and until an employer employs on average 200 or more employees.

With respect to the universal eligibility requirement, PPACA section 9022 provides that all employees with at least 1,000 hours of service for the preceding plan year (other than certain excludable employees) must be eligible to participate in the simple cafeteria plan. Thus, a plan cannot limit access to a specific qualified benefit (such as a higher-value medical plan) to a subset of employees. For purposes of satisfying the universal eligibility rule, the following classes of employees may be excluded: those who (1) have not attained the age of 21 (or a younger age provided in the plan) before the close of a plan year, (2) have fewer than 1,000 hours of service for the preceding plan year, (3) have not completed one year of service with the employer as of any day during the plan year, (4) are covered under an agreement that the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or (5) are nonresident aliens working outside the United States.

PPACA section 9022 also imposes a universal availability requirement on simple cafeteria plans. Specifically, section 9022 requires that each eligible employee must be eligible to elect any benefit provided under the cafeteria plan. Notably, the statute does not expressly address whether an employer premium subsidy paid by an employer with respect to health coverage made available through a simple cafeteria plan must be treated as a benefit for purposes of the universal availability requirement. Nonetheless, given the significant economic value that can be delivered vis-à-vis employer premium subsidies, it seems quite reasonable to expect the regulators to characterize employer premium subsidies as a separate benefit for purposes of the new safe harbor.

In addition to the foregoing, the safe harbor rules require eligible employers to provide a minimum contribution for each nonhighly compensated employee in addition to any salary reduction contributions made by the employee to the simple cafeteria plan. Specifically, the eligible small employer must make a minimum contribution amount on behalf of all eligible employees equal to one of the following:

- A uniform percentage of at least 2 percent of each eligible employee’s compensation for the plan year. (Note: The contribution must be determined without regard to whether an eligible employee makes any salary reduction contribution under the cafeteria plan.)

- An amount that is not less than the lesser of (i) six percent of the employee’s compensation for the plan year, or (ii) “twice the amount of the salary reduction contributions”⁹ of each eligible employee.

Regardless of which of the above approaches is used, the minimum contribution must be available for application toward the cost of any qualified benefit (other than a taxable benefit) offered under the cafeteria plan.

As the foregoing discussion demonstrates, the simple cafeteria plan safe harbor may be a helpful tool for small employers that currently provide for meaningful premium subsidies on a broad basis to their employees. This is because such employers may be able to arrive at the same or similar economic result for themselves and their employees by reallocating existing premium contributions among and between qualified benefits (such as major medical) and the simple cafeteria plan, while avoiding the costs associated with complying with the myriad of nondiscrimination rules that might otherwise apply. Moreover, for certain employers, the ability to bypass the key employee concentration test under the cafeteria plan nondiscrimination rules is likely to be of significant value. However, small employers that seek to avoid the financial outlay necessary to fit within the safe harbor, or large employers that are ineligible to sponsor a simple cafeteria plan, will likely find themselves having to test for compliance with Code section 105(h) with respect to their insured plans for the upcoming plan year.

Penalties for Failure to Satisfy Nondiscrimination Rules – As outlined in recent IRS Notice 2010-63, the consequences associated with a failure to satisfy section 2716 of the PHSa are not the same as those associated with a failure to satisfy section 105(h). Under section 105(h) generally, highly compensated individuals in a discriminatory self-insured plan are taxed on medical expense reimbursements actually paid. However, a failure to satisfy PHSa section 2716 will, depending on the size of the plan sponsor, involve a different set of penalties under the Code, ERISA, and the PHSa.

As mentioned above, PPACA merely utilizes the nondiscrimination standards of section 105(h) of the Code without incorporating its penalties for failure. Instead, the employer sponsoring a fully insured group health plan that fails to satisfy section 105(h) is subject to an excise tax under section 4980D of the Code. Significantly, there is an exception from the excise tax for a group health plan maintained by a small employer, which is generally defined as an employer employing an average of at least 2 but not more than 50 employees on business days during the preceding calendar year. However, it is our understanding from speaking with Treasury representatives that the Department is likely to read the exception to only apply where the prohibited discrimination results from the underlying insurance policy itself versus employer plan design or related employer activity (such as discriminatory plan eligibility rules or employer premium subsidies).

⁹ On its face, the statutory language regarding “twice the amount of the salary reduction contributions” appears to require that an eligible employer contribute an amount equal to 200% of the eligible employee’s salary reduction contributions. Notwithstanding the statutory language, the technical explanation provided by the Joint Committee on Taxation states that the amount must only be “100 percent of the amount of the salary reduction”. Thus, there is some uncertainty regarding whether the amount is in fact 100% or 200% of the salary reduction contributions by an eligible employee.

The excise tax under Code section 4980D is \$100 per day during the noncompliance period with respect to “each individual to whom the failure relates”, not to exceed the lesser of 10% of the group health plan costs or \$500,000. There is, however, no penalty if the failure is not discovered exercising reasonable diligence, or if the failure is due to reasonable cause and corrected within 30 days of discovery.

In terms of identifying the individuals “to whom the failure relates”, it seems quite likely that the sponsor and/or issuer may need to look to different classes of persons depending on the nature of the failure. Take for example a failure related to excluding individuals from coverage generally. In this instance it would seem to be that appropriate individual to look to is not with respect to an enrollee, but rather to those participants who are being excluded from coverage. On the other hand, take for example a failure with respect benefits provided under the plan. In this instance, the correct approach would appear to be to look to the participants in the plan who subject to reduced benefits.

In addition, PPACA nondiscrimination requirements are included in ERISA and also the PHSa. With respect to the former, it appears likely that a participant (or the Department of Labor) is permitted to bring a lawsuit utilizing ERISA’s remedial provisions to compel compliance with the nondiscrimination standards. These remedies would be available with respect to both large and small group health plans.

With respect to the latter, there is some lack of clarity regarding whether issuers may be subject to penalty under the PHSa with respect to a discriminatory fully insured plan. In general the PHSa applies only to issuers and non-federal governmental plans. The basis for the lack of clarity is that new PHSa section 2716 states only that a fully insured “group health plan” shall not discriminate; there is no express reference to issuer (as included in various other PPACA insurance reforms). The absence of any reference to “issuer” leaves unclear whether issuers may be subject to penalty under the PHSa. Given that issuers are unlikely to know whether a plan is in fact discriminatory, this would seem to counsel against subjecting issuers to liability.

To the extent the nondiscrimination rules contained in PHSa section 2716 apply to issuers, the penalty regime is fairly similar to that provided under the Code (as set forth above), with several notable differences. As under the Code, the maximum amount of the penalty is \$100 per day with respect to each individual to whom the failure relates. However, unlike with regard to the excise tax under the Code, no maximum penalty applies for the tax year at issue; thus the penalty could exceed the \$500,000 threshold that applies for purposes of the Code. In determining the amount of the penalty, the statute provides that the HHS Secretary will consider the previous record of compliance of the entity and the gravity of the violation. The statute also provides that the penalty shall not apply (i) where the failure was not discovered despite the exercise of reasonable diligence, and (ii) where the failure was due to reasonable cause (and not willful neglect) and is corrected during the 30-day period beginning on the first day that any of the entities against which the penalty is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

IMPLICATIONS FOR SELF-INSURED PLANS

Although PPACA's nondiscrimination requirements are applicable only to certain fully insured group health plans, it is possible that the new requirements could ultimately have a material impact on self-insured plans. As mentioned above, Treasury/IRS has for many years avoided issues related to the interpretation of section 105(h). At some point, we anticipate that the responsible agencies could publish more substantive guidance interpreting the PHSA provisions and that guidance could (and most likely would) also have implications for the application of the currently vague rules of section 105(h).

NEXT STEPS

Employers and providers of insured group health plans other than grandfathered plans should be reviewing their demographics and plan design with an eye to the requirements of section 105(h). There will be a number of features where it is unclear how the new nondiscrimination requirements will apply. While the responsible agencies may issue interim guidance in the near future, it does not appear likely that such near-term guidance will address many of the uncertainties in application of the section 105(h) rules.

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