November 4, 2010

CC:PA:LPD:PR (Notice 2010-63)
Courier's Desk
Internal Revenue Service,
1111 Constitution Avenue, NW
Washington, DC 20224
RIN 1210-AB44

Submitted electronically to Notice.Comments@irscounsel.treas.gov

Re: Comments Regarding the New Nondiscrimination Rules for Insured Group Health Plans as Set Forth in the Patient Protection and Affordable Care Act

Dear Sir or Madam:

I am writing on behalf of the American Benefits Council ("Council") in response to Notice 2010-63, issued on September 23, 2010 by the Department of Treasury ("Treasury") and the Internal Revenue Service ("IRS") (collectively, the "Department"), which requests written comments on what additional guidance is needed regarding the application of the nondiscrimination rules to insured group health plans.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

The Patient Protection and Affordable Care Act ("PPACA" or "Act"), as amended by the Health Care and Education Reconciliation Act ("HCERA"), in part, adds a new section 2716 to the Public Health Service Act ("PHSA"). New PHSA section 2716 generally provides that insured group health plans must satisfy the requirements of Internal Revenue Code ("Code") section 105(h)(2), and that "rules similar" to section 105, paragraphs (h)(3) (nondiscriminatory eligibility classification), (h)(4) (nondiscriminatory benefits), and (h)(8) (certain controlled groups) shall apply. New PHSA section 2716 (which does not apply to grandfathered health plans) is incorporated by reference into Code section 9815(a)(1) of the Internal Revenue Code

("Code") and section 715(a)(1) of the Employee Retirement Income Security Act ("ERISA").[1]

The Council appreciates the Department's issuance of Notice 2010-63 and the opportunity to provide written comments with respect to new PHSA section 2716, as the potential implications of new PHSA section 2716 to insured arrangements and to existing self-insured arrangements are substantial. Additionally, the complexity of the issues involved are significant and in many regards do not lend themselves to quick and easy solutions. Accordingly, we appreciate the Department's decision to seek written comment from all interested parties, including the employer community, prior to issuing new written guidance. As the Department continues down the path towards issuing additional guidance regarding new PHSA section 2716 or Code section 105(h), it is our hope that the Department will continue to involve all relevant parties, including the employer community.

In summary, we believe that:

- ***Future rulemaking needs to acknowledge the history of Code section 105(h)(2) and be mindful of existing self-insured arrangements.*** Given the lack of significant interpretive authority regarding existing Code section 105(h) and the likelihood that any future rulemaking regarding new PHSA section 2716 will implicate self-insured arrangements, we urge the Department to issue guidance both in terms and manner to ensure that existing self-insured arrangements are not harmed or otherwise unduly burdened.

- ***Current enforcement activity and rulemaking should be focused on executive-only plans***. In enacting new PHSA section 2716, we believe Congress was primarily concerned with discriminatory executive-only plans. Accordingly, the Department should focus its initial enforcement and rulemaking activity on discriminatory executive-only plans leaving undisturbed plans that provide coverage broadly to both highly compensated individuals ("HCIs") and non-HCIs.

- ***A series of transition rules should be issued for insured plans other than executive-only plans to preserve essential coverage for millions of American workers.*** Many insured arrangements, notwithstanding the absence of any discriminatory intent on the part of the plan sponsor, may not satisfy the rules as set forth in the section 105(h) regulations. To help ensure that current beneficiaries of these arrangements do not lose coverage and that employers do not find themselves subject to costly ERISA litigation, we urge the Department to issue the following set of transition rules that would apply for purpose of

[1] For purposes of this memorandum, unless expressly provided otherwise, all references to "PHSA section 2716" should be read to include the parallel provisions in Code section 9815(a)(1) and ERISA section 715(a)(1).

plan years beginning on or after September 23, 2010, unless and until final regulations are issued:

- *A non-enforcement rule for insured plans, other than executive-only plans* (similar to the rule issued by the Department along with the Departments of Labor and Health and Human Services on August 23, 2010, in connection with the new rules for internal claims and appeals and external review); and

- *Good faith transition relief* pursuant to which plans that use reasonable, good faith efforts in complying with new PHSA section 2716 shall be deemed in compliance; and

- *Safe harbor rules:* Notwithstanding a sponsor's nondiscriminatory intent, many plans are unlikely to satisfy the section 105(h) regulations under even the most expansive interpretation.[2] This is primarily due to the fact that Code section 105(h) and the section 105(h) regulations are particularly ill-suited to insured arrangements. Accordingly, the Council requests the following safe harbor rules for plan years beginning on or after September 23, 2010, unless and until final regulations are issued, that better takes into account the unique characteristics and limitations of insured coverage. Employers would be permitted to choose between either of the two following safe harbor rules:[3]

    (1) A safe harbor rule that allows employers to demonstrate that their group health plans do not discriminate in favor of HCIs based on all the facts and circumstances; and

    (2) A safe harbor rule that (i) allows for testing based on geographic location and benefit package, and (ii) determines a plan's nondiscriminatory status based on access to coverage (within a specified geographic area) and availability of benefits for non-HCIs, as opposed to actual utilization of benefits.

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[2] Inpatriate, expatriate and third country national plans are examples of such plans. These insured plans are commonly offered by employers with overseas operations and are designed to cover employees who work for extended periods of time in other countries. These employees may not be eligible for the national health plan of the country they are working in as a shorter term resident. Insured inpatriate, expatriate and third country national plans fill that gap. The population that they serve generally include higher paid individuals, as the employee category for overseas positions is typically more highly skilled and experienced. Without a safe harbor, these plans will have significant difficulty satisfying code section 105(h) regulations and the requirements of new PHSA section 2716 which could result in significant disruption and loss of coverage for impacted employees.

- ***Except for the requested transition relief, future rulemaking should be issued in proposed form with proposed effective dates; the Department should begin by issuing a request for information ("RFI").*** To ensure that all interested parties have a meaningful opportunity to provide crucial written comment, we urge the Department to issue any future rulemaking in proposed form and with prospective effective dates. Additionally, we urge the Department to begin such process by issuing an RFI to ensure that the Department is aware of all of the relevant issues with respect to insured arrangements and also Code section 105(h) more generally. This RFI should be structured to identify specific issues on which the Department will seek additional information on and could be followed by in-depth administrative hearings on these issues.

Any Future Rulemaking Needs To Acknowledge the History of Code Section 105(h)(2) And Be Mindful of Existing Self-insured Arrangements

The Council urges the Department to be mindful that any rulemaking with respect to insured plans is likely to have significant implications for existing self-insured arrangements.

As the Department is aware, notwithstanding that Code section 105(h) was added to the Code over 30 years ago, there is very little interpretive authority regarding Code section 105(h)(2). This is due in large part to the IRS's long-standing "no ruling" position with respect to Code section 105(h) generally. Accordingly, there exists only Treasury Regulation § 1.105-11 (the "Existing Regulations"), as well as a handful of private letter rulings dating back to the 1980s.

The limited interpretive authority regarding Code section 105(h) has left many employers confused regarding the scope and mechanics of the nondiscrimination rule. For example, the Existing Regulations make clear that plans can wholly exclude "excludable employees" for plan testing purposes, such as certain part-time and seasonal employees, among other individuals when testing for nondiscrimination eligibility. However, the existing Regulations are unclear as to whether a plan may voluntarily extend coverage to excludable employees that differs from that coverage provided to non- excludable employees, or whether excludable employees may or must be taken into account if they are enrolled in, or otherwise eligible for coverage, under the plan.

Additionally, the Existing Regulations are unclear as to how the nondiscrimination rules apply to retirees[4]. Depending on how one construes the Existing Regulations and defines a "plan" for this purpose, one can conclude that all retirees of an employer must receive the same benefit or that no retiree must receive the same benefit (thus, for example, allowing employers to provide different benefits based on a given reduction in force or specific severance arrangement).[5]

Another example of the many interpretative issues that exist with respect to Code section 105(h) and the Existing Regulations pertains to whether the nondiscriminatory eligibility test as set forth in the Existing Regulations incorporates a utilization requirement. Specifically, as set forth in Code section 105(h)(3)(A) and Existing Regulations, a self-insured arrangement generally must "benefit":

- 70% or more of all employees, or
- 80% or more of all eligible employees if 70% or more of all employees are eligible to benefit under the plan, or
- Employees of a nondiscriminatory classification.

The Existing Regulations leave open to interpretation whether, in applying the eligibility test, and particularly the nondiscriminatory classification component of the test), a plan may treat as "benefiting" under the plan an employee who is merely eligible to participate (similar to how the qualified retirement plan rules regarding cash or deferred arrangements determine whether a participant "benefits"[6]). Because of the IRS's continued "no ruling" position regarding Code section 105(h), employers have had to "fill in the holes" with respect to the meaning and application of Existing Regulation for over 20 years, including with respect to the mechanics of the eligibility test.

[4] As discussed below, the Council understands that new PHSA section 2716, like the other insurance reforms made part of PPACA, does not apply to plans with fewer than two active employees, which includes plans that only provide benefits to retiree, *i.e.*, retiree-only plans. Notwithstanding this, there are of course, plans that may not provide benefits only to retirees and thus would implicate new PHSA section 2716.

[5] We also note that there is a lack of clarity regarding what constitutes a "plan" for purposes of the retiree provisions of the 105(h) regulations.

[6] Treasury Regulation 1.410(b)-3(a)(2)(i). Treating an employee as "benefiting" if he or she is eligible for participation makes great sense in the context of a health plan, as it does in the context of a cash or deferred arrangement, where participation is voluntary. An employer is not penalized, then, in the testing process when an employee who is eligible for coverage simply declines that coverage because he or she does not want the coverage or perhaps because he or she is covered under a spouse's plan. We urge that any guidance on the Section 105(h) testing protocol specifically permit an employer to run the nondiscriminatory classification test by considering an employee as benefiting under the plan if he or she is eligible for coverage.

In addition to the lack of clarity regarding the scope and mechanics of Code section 105(h), the section 105(h) regulations have not been modified to take into account the fact that employer benefit plan offerings have evolved since 1978, including, for example, with respect to the rise of defined contribution health arrangements. Many employers have sought to introduce new health arrangements that control cost while providing employees with access to important resources for their use in financing current and future health costs. Given the continued absence of pertinent guidance, many employers have been unduly constrained by the section 105(h) regulations in their efforts to pursue and implement these types of arrangements. To the extent employers have succeeded in establishing such arrangements, such employers may have, in certain instances, left themselves vulnerable to future rulemaking and enforcement by the IRS.

In light of the foregoing, the Council urges the agencies to be mindful of the likely effect that any future rulemaking regarding new PHSA section 2716 will have with respect to existing self-insured arrangements. Employers who have established and maintain in good faith existing self-insured arrangements should not be unduly penalized by the issuance of future rulemaking with regards to new PHSA section 2716.

Crucial Transition Relief Is Needed For This Plan Year to Ensure That American Workers Do Not Lose Essential Health Coverage

Without transition relief, employers may feel compelled to discontinue possibly discriminatory coverages to avoid penalties and class action suits for expanded coverage. If non-HCIs lose coverage because employers are fearful of the consequences of discrimination, the new nondiscrimination requirements will prove counterproductive. Consequently, for arrangements that are nondiscriminatory in intent, the Council urges the Department to issue critical transition relief. Specifically, the Council requests a delayed effective date at least through the close of the first plan year beginning on or after September 23, 2010 for purposes of new PHSA section 2716. Such a rule will help ensure that all affected parties have time to analyze the application of these new rules to insured arrangements and respond appropriately.[7]

If the Department is unable to issue transition relief providing for a delayed effective date, the Council urges the Department to focus its initial rulemaking and enforcement efforts on executive-only plans. It is our understanding that in enacting new PHSA section 2716, Congress was concerned primarily with putting an end to discriminatory executive-only plans that by reason of prior law were able to escape the application of

[7] The Council notes that the Department recently provided for such relief in connection with PPACA section 9002, which, per the terms of Notice 2010-69, delays the mandatory application of the new Form W-2 reporting rule regarding employer-sponsored health coverage until the 2012 plan year.

nondiscrimination rules. Under prior law, executive-only arrangements could avoid any nondiscrimination rules to the extent they were fully insured.[8] Due in part to its desire to put an end to this practice, Congress enacted new PHSA section 2716. In light of this, we urge the Department to focus its rulemaking and enforcement activity on executive-only plans.[9]

In addition to the foregoing, we urge the Department to provide a set of transition rules to help ensure that insured plans[10] (other than executive-only plans) that have been established in good faith and without discriminatory intent will be deemed in compliance with new PHSA section 2716. Specifically, we request the following:

- *The Establishment of a Non-Enforcement Rule.* Given that insured plans have not been subject to Code section 105(h) nondiscrimination testing, many plan sponsors, especially small employers, may not have the knowledge and/or systems necessary to ensure compliance with these new rules for the first plan year beginning on or after September 23, 2010. To ensure that employers of insured arrangements do not feel compelled, out of an abundance of caution, to terminate or otherwise significantly curtail essential health coverage for their employees, we respectfully request the issuance of a non-enforcement rule that would remain in effect unless and until final regulations are issued.[11] [12]

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[8] We note that, under current regulations, executive-only plans that provide benefits limited to preventive and diagnostic care, commonly referred to as Executive Physical programs, are not subject to section 105(h) nondiscrimination testing. These rules should be preserved both with respect to insured and self-insured coverage for these diagnostic and preventive programs.

[9] We note that existing employment agreements subject to Code section 409A may provide for the provision of current or future insured executive-only coverage. Rules that operate to modify and/or preclude these arrangements (including a rule that taxes the value of insured coverage to an executive) could have significant implications under existing Code section 409A and administrative guidance thereunder. Accordingly, we urge you to take account of these issues as part of any future rulemaking or enforcement activity with respect to executive-only arrangements.

[10] Many employers use insured arrangements as part of their strategy to provide comprehensive and affordable health coverage to their employees, including, in many instances, their non-HCIs (such as with respect to more affordable managed care coverage, *e.g.*, Health Maintenance Organizations and other network-based coverage).

[11] A non-enforcement rule would also provide an important signal to courts that might be called upon to adjudicate ERISA claims with respect to new PHSA section 2716. As noted above, new PHSA section 2716 is incorporated by reference into ERISA section 715. Accordingly, as noted in IRS Notice 2010-63, an ERISA plan participant may bring suit for equitable relief with respect to a discriminatory plan. (Although the nature of such a claim remains a bit unclear, we suspect that such a claim could likely take the form of requesting injunctive relief or perhaps a claim for benefits owed).

[12] There is clear, recent precedent for establishing delayed effective dates with respect to PPACA provisions. PPACA Section 9002 provides generally that the aggregate cost of certain employer-sponsored coverage must be reported on Form W-2. In IRS Notice 2010-69, which was issued on October 12, 2010, the Department provided "interim relief to employers" by making the new reporting

- *The Provision of Good Faith Transition Relief.* In light of the many "open" questions that remain regarding Code section 105(h) and the Existing Regulations, we urge the Department to provide good faith transition relief for plan years beginning on or after September 23, 2010, unless and until final regulations apply. Pursuant to such a rule, plans that use reasonable, good faith efforts to comply with new PHSA section 2716 shall be deemed in compliance with the new nondiscrimination rules.[13] Like the requested non-enforcement rule, a good faith transition rule will help minimize the disruption to employer-sponsored insured coverage and help ensure that American workers continue to have access to essential health coverage.

- *The Establishment of a Substantive Transition Rule That Allows for Geographic Testing and Looks to Eligibility versus Actual Participation.* The need for a non-enforcement rule and good faith transition relief cannot be overstated. Nonetheless, for many existing insured plans, these rules, if issued, would be insufficient. This is because many plans, notwithstanding the absence of discriminatory intent, may be unable to satisfy the existing Code section 105(h) testing regime, even where construed in the most liberal, albeit reasonable, manner.[14] The primary reason for this because the section 105(h) regulations are especially ill-suited to testing insured arrangements. Most notably, many state insurance laws prohibit the use of extra-territorial insurance, *i.e.*, insurance that is underwritten in one state but applies to residents of another state. Yet, the Existing Regulations generally require testing on a controlled group basis (especially for purposes of satisfying the nondiscriminatory eligibility test). Insured arrangements, therefore, generally do not fare well under the Existing Regulations. Accordingly, we request the issuance of a substantive transition rule that better accounts for the unique characteristics and limitations of insured coverage. (For example, this could be accomplished by establishing a safe harbor rule that (i) allows for

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requirement optional for the 2011 tax year. The interim relief operates to provide a delayed effective date for employers.

[13] Thus, for example, a plan seeking to establish a nondiscriminatory classification for purposes of the nondiscriminatory eligibility test as set forth in paragraph (3) of Code section 105(h) and the Existing Regulations, could choose to apply the "old" Treasury Department regulations regarding Code section 410(b).

[14] As noted above, new PHSA section 2716 is incorporated by reference into the group health plan requirements of ERISA. This means that participants may bring suit for equitable relief with respect to insured arrangements that discriminate in violation of new PHSA section 2716. Unless the Department provides a substantive transition rule that would apply in the interim until final regulations are issued, plans and their sponsors may find themselves subject to costly litigation. We note that a facts and circumstances test is unlikely to be ideal in this regard because it provides insufficient certainty for plan sponsors in light of the ERISA litigation risk and because such a rule likely would require a trier of fact to engage in a costly and time consuming review of the facts and circumstances regarding the insured arrangement at issue.

geographic testing, and (ii) determines a plan's nondiscriminatory status based on access to coverage (within a specified geographic area) and availability of benefits for non-HCIs, as opposed to actual utilization of benefits.)

It is our understanding the Department is concerned that it may lack sufficient authority to issue rules, including the requested substantive transition rule, that diverge from those set forth in the Existing Regulations. Although we are fully appreciative of the Department's cautious approach to rulemaking, we believe that the express statutory language of new PHSA section 2716(b)(1) provides the Department with the needed flexibility to establish such rules.

When Congress enacted new PHSA section 2716, Congress expressly chose to <u>not</u> incorporate the rules of paragraphs (h)(3) (regarding the nondiscriminatory eligibility test) and (h)(4) (regarding nondiscriminatory benefits test) in their current form for purposes of new PHSA section 2716. Specifically, new PHSA section 2716(b)(1) states that:

> *Rules similar* to the rules contained in paragraphs (3) [regarding nondiscriminatory classification test], (4) [regarding nondiscriminatory benefits test], and (8) [regarding controlled group test] of section 105(h) of such Code shall apply. (Emphasis added.)

We read the reference to "rules similar" in PHSA section 2716(b)(1) to clearly provide the Department with sufficient authority to issue substantive rules that diverge, at least to some extent, from those set forth in Code section 105(h)(2) and the Existing Regulations, specifically with respect to the nondiscriminatory eligibility and benefits test.[15] For example, we believe that such language provides the Department with sufficient authority to allow for the establishment of nondiscrimination rules that allow for testing on a geographic basis (similar to the qualified separate lines of business ("QSLOB" rules) that apply for purposes of nondiscrimination testing under Code section 410(b)[16]). We also believe such language gives the Department sufficient authority to fashion a set of rules that, similar to the approach that currently applies

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[15] PHSA section 2716 expressly states that insured group health plans must satisfy existing Code section 105(h)(2). Section 105(h)(2) of the Code requires only that the plan "not discriminate in favor of highly compensated individuals as to eligibility to participate, and that "the benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals." Paragraph (h)(2) does not require the Department to establish an eligibility test that incorporates a utilization component, nor does it prohibit alternative testing approaches to those forth in existing regulations (such as testing on a geographic basis).

[16] *See* Code section 414(r); Treasury Regulation § 1.414(r)-4. We note that the QSLOB rules are quite difficult to apply in practice because of the many criteria that must be satisfied in order for a plan to avail itself of the QSLOB designation. To the extent the Department allows for testing on a geographic basis or by reference to a separate line of business, as requested, we urge the Department to adopt rules that are easy to administer. Rules that are unduly rigorous are effectively unavailable to plans.

under the qualified retirement plan rules for cash or deferred arrangements[17], determines a plan's nondiscriminatory eligibility and benefits based on broad access to coverage, *i.e.*, eligibility, versus actual participation.

Accordingly, the Council requests the following safe harbor rules for plan years beginning on or after September 23, 2010, unless and until final regulations are issued, that better takes account the unique characteristics and limitations of insured coverage. Employers would be permitted to choose between either of the two following safe harbor rules:

(1) A safe harbor rule that allows employers to demonstrate that their group health plans do not discriminate in favor of HCIs based on all the facts and circumstances; and

(2) A safe harbor rule that (i) allows for testing based on geographic location and benefit package, and (ii) determines a plan's nondiscriminatory status based on access to coverage (within a specified geographic area) and availability of benefits for non-HCIs, as opposed to actual utilization of benefits.

Given existing plan practices and the lack of clarity as to what constitutes a "benefit" under Code section 105(h) and new PHSA section 2716 we request, for purposes of these two safe harbor rules, that differential contributions for HCIs and non-HCIs be permitted unless and until final regulations are issued.

Any Future Rulemaking Should Be Issued in Proposed Form with Prospective Effective Dates And Should Allow An Opportunity For Meaningful Review And Written Comment.

Except for the transition relief described above, the Council urges the Department to issue any future rulemaking in proposed form and with prospective effective dates. Doing so will help ensure that all interested parties have a meaningful opportunity to file comments, which we believe will be especially helpful to the Department in formulating future guidance.

As noted above, there are many "open" issues about the existing self-insured plan nondiscrimination requirements. These issues have grown both in scope and sheer number over the course of the Department's 20+ year "no ruling" position regarding Code section 105(h). Now, add to this the fact that these rules – or more accurately "rules similar" to these – are to apply to insured arrangements, and we have before us a very long list of issues that must be considered as part of any future rulemaking project. For illustrative purposes, here are a few of these issues:

[17] *See* Treasury Regulation §§ 1.401(k)-1(g)(4) and 1.401(m)-1(f)(4).

- *Plan Documentation Requirements.* Existing Regulations appear to require plan sponsors to document each of their plans for section 105(h) testing purposes. This differs from the current rules for tax-qualified retirement and pension plans, which allow a sponsor to have one single written plan document and then to test based on nondiscriminatory classifications, etc., contained therein. Given the significant expense associated with having to document multiple Code section 105(h) plans (for multi-state employers this could mean one plan per state in which it sponsors an insured plan), we urge the Service to permit plan sponsors to disaggregate portions of plans (whether insured or self-insured) for testing purposes, without having to formally designate the separate "testing plans" in the plan documents.

- *Discriminatory "Benefits."* It is not entirely clear under the Existing Regulations as to what constitutes a discriminatory "benefit." For example, does the term "benefits" extend beyond the specific healthcare expenses that are reimbursable or payable by the plan to include waiting periods and the rate of employer contributions toward the cost of coverage?

- *Whether the Nondiscriminatory Eligibility Test Incorporates a Participation Component.* As discussed above, it is not clear that Code section 105(h)(3) mandates a participation test, or whether it should in light of post-PPACA circumstances, e.g., the individual mandate and the availability of coverage on a guaranteed issue basis through health insurance exchanges. PHSA section 2716 provides sufficient flexibility for the Department to issue a rule that looks instead at only access to coverage by non-HCIs versus actual utilization.[18]

- *Definition of HCI When Applying The Nondiscriminatory Eligibility Classification.* Code section 105(h)**(5)** and the Existing Regulations generally define an HCI to be : (i) the 5 highest paid officers; (ii) a 10% or more shareholder; and (iii) an individual who is among the highest paid 25% of all employees (other than excludable employees). This definition is generally much broader than the HCI definition that applies for purposes of the nondiscrimination rules for Code section 125 cafeteria plans tax-qualified retirement plans. Given that the Existing Regulations permit plans to establish a reasonable, nondiscriminatory classification based on the rules set forth in Code section 410(b) and the Treasury

[18] For smaller-size employers and for plans that cover only a small number of employees, a utilization component can be fatal to a plan passing nondiscrimination testing. This is because a decision by just one non-HCE to waive coverage (for example, where the non-HCE's spouse has "richer" or more heavily-subsidized employer-sponsored coverage) can result in a plan failing the eligibility test. To the extent the Department feels compelled by the statute to incorporate a utilization requirement, one possible solution to this issue would be to permit plans to count employees as participating in a given plan to the extent such employees are otherwise eligible to participate and certify in writing that they are waiving coverage.

Regulations, and Code section 410(b) uses a definition of highly compensated employee ("HCE") as set forth in Code section 414(q), can plans use the Code section 414(q) definition of HCE for purposes of determining their nondiscriminatory classifications?

- *Permissible Coverage for Excludable Employees.* As noted above, Code section 105(h) and the section 105(h) regulations make clear that employers can wholly exclude certain "excludable employees" for eligibility testing purposes, such as certain part-time and seasonal employees, among other individuals. The section 105(h) regulations, however, are unclear as to whether a plan will be treated as discriminatory if it supplies a benefit to an HCI that is not provided to an excludable non-HCI.

  Additionally, the section 105(h) regulations allow plans to use Code section 410(b) and the Treasury regulations thereunder for purposes of establishing a reasonable nondiscriminatory classification. When applying 410(b) for this purpose, can/should plans use the definition of excludable employee included in Code section 105(h) or, alternatively, should plans use the definition set forth in Code section 410(b)?

- *Ability to Discriminate Against HCIs*. It is not entirely clear under the Existing Regulations whether a plan may discriminate against HCIs in favor of non-HCIs. Under the nondiscrimination rules that apply to tax-qualified retirement plans, plans are generally permitted to discriminate in favor of non-HCIs. Further, if a plan covers only non-HCIs, can that plan elect to except the plan from required testing?

- *Multiple Employer Plans.* There has always been much uncertainty regarding how Code section 105(h) and the section 105(h) regulations apply to plans that allow for participation by employers outside a single controlled group (for example, whether one can test on control-group basis, or whether one must test at the plan level across all controlled groups). This is an important issue because many multiple employer plans are insured.

- *Ability to Avoid New Rules Through Use of After-Tax Coverage.* It is unclear that coverage provided to an HCI on an after-tax basis (or otherwise imputed as wages to the HCI) would be ignored in testing an insured health plan for discrimination. This approach generally works with respect to self-insured coverage because it generally has the effect of making the arrangement one that is taxed under section 104(a)(3) of Code, which has no nondiscrimination requirements.[19]

[19] *See supra* FN 7.

- *Application to Retiree Coverage.* It is the Council's understanding that the insurance reform provisions of the PPACA, including new PHSA section 2716, do not apply to plans with fewer than two active employees. Thus, it appears to be the case that insured retiree-only plans are not subject to the new nondiscrimination rules under PHSA section 2716, notwithstanding that the Existing Regulations include a set of provisions solely applicable to retiree coverage. Clarification of this interpretation would be helpful.

  Additionally, retiree coverage often would not qualify for this exception. As noted above, the section 105(h) regulations include a set of provisions that apply solely to retiree coverage. These provisions, however, are subject to much debate and interpretation regarding their scope and mechanics. It would be unfortunate if the section 105(h) regulations' murky retiree coverage provisions were to apply. Depending on how one construes the section 105(h) regulations and defines a "plan" for this purpose, one can conclude that all retirees of an employer must receive the same benefit or that no retiree must receive the same benefit. Clarification is needed regarding the scope and mechanics of these provisions.

- *Clarification of Penalties.* The penalty that applies for purposes of the Code is generally equal to $100 per day with respect to each individual to whom such failure relates, but is limited in the case of failures due to reasonable cause and not willful neglect to the lesser of (i) "10 percent of the aggregate amount paid or incurred by the employer" or (ii) $500,000. Specifically, with respect to new PHSA section 2716 there is a question as to who constitutes an "individual to whom such failure relates"; specifically, whether such term encompasses just the plan participant or is to be read more broadly to include individuals not participating in the plan. Additionally, the reference to the "aggregate amount paid or incurred by the employer" appears to indicate that only a plan's actual costs (*i.e.*, premiums paid) are taken into account, but clarification is needed.

This list demonstrates that a host of issues need resolution as to health plans for all types, especially insured plans.

To ensure that any future rulemaking takes into account all of the relevant issues, the Council urges the Department to issue an RFI as part of any future rulemaking. We recommend that the RFI be structured to identify specific issues on which the Department will seek additional information on and followed by in-depth administrative hearings on these issues. An issue-specific RFI will help ensure that the Department understands all of the relevant issues and, thus, has all of the data points to engage in sound and reasoned rulemaking.

In addition to the foregoing, the Council urges the Department to issue any future rulemaking in proposed form with a prospective effective date. This will help ensure that that all interested parties have a meaningful opportunity to provide crucial written comment. Any other approach risks the issuance of rules that are too strict or unclear, which could, in turn, lead employers to curtail or otherwise fully discontinue plans to the end detriment of non-HCIs.

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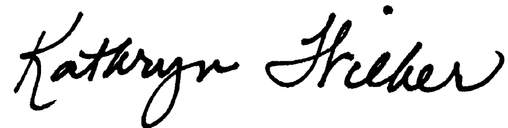
Thank you for the opportunity to comment and for considering our recommendations. Please contact me at kwilber@abcstaff.org or 202-289-6700 with any questions or if we can be of further assistance.

Kathryn Wilber



Senior Counsel, Health Policy