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# Executive Post-Termination Medical Benefits: The Shape of Things Today

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It is common for an employer to promise continued medical benefits to an executive and his or her dependents following the executive's termination of employment. Sometimes, medical benefits are provided under broad-based retiree medical arrangements that can cover voluntary or involuntary terminations of employment. In other cases, medical coverage continuation may be limited to involuntary termination or termination for ''good reason'' (i.e., constructive termination), or may be negotiated in connection with a separation event. Of course, executives are generally also subject to protections under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)[2] on the same terms as employees generally. Medical coverage continuation may be coordinated with COBRA benefits continuation, such as pursuant to an arrangement for the reimbursement of COBRA premiums paid by an executive. Historically, complications regarding the tax treatment of such post-termination medical benefits have been a function of compliance with §409A and, for employer self-insured arrangements, the nondiscrimination requirements of §105(h).[3]

More recently, the Patient Protection and Affordable Care Act (Affordable Care Act)[4] includes provisions and requirements that will penalize insured medical benefit arrangements that discriminate in favor of highly compensated employees, applying standards similar to those applicable to employer self-insured arrangements under §105(h).[5] The Treasury Department and Internal Revenue Service (IRS) have indicated in guidance also approved by the Department of Labor and Department of Health and Human Services that these nondiscrimination requirements for insured arrangements will not apply until sometime after the issuance of future guidance defining the nondiscrimination standards.[6] Accordingly, those restrictions and potential penalties are not yet being en-

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[2] P.L. 99-272.

[3] All section references herein are to the Internal Revenue Code of 1986, as amended (Code), and the regulations issued thereunder, unless otherwise specified.

[4] P.L. 111-148.

[5] The Affordable Care Act added §9815(a)(1) to the Code and §715(a)(1) to the Employee Retirement Income Security Act of 1974 (ERISA) to incorporate the provisions of part A of title XXVII of the Public Health Service Act into the Code and ERISA. Section 10101(d) of the Affordable Care Act added §2716 to the Public Health Service Act, which provides that a group health plan (other than a self-insured plan) must satisfy the requirements of §105(h)(2) and that ''rules similar to'' the rules applicable with respect to nondiscriminatory eligibility classification, nondiscriminatory benefits, and certain controlled groups of §105(h) will apply.

[6] Notice 2011-1, 2011-2 I.R.B. 259.


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forced. A potentially complicating feature of the development of these nondiscrimination standards under the Affordable Care Act is that, as discussed further below, the applicable rules with respect to the existing nondiscrimination requirements on which the new rules will be based have not historically been a focal point for the IRS, so it is possible that the development of the new rules could impact the interpretation of the existing rules for discriminatory self-insured arrangements.

The discussion that follows outlines the key federal income tax requirements and Affordable Care Act considerations that shape the design of post-termination medical benefit arrangements for executives, and suggests a way forward in preparing for and addressing these requirements as they develop more fully.

## KEY RULES IN PLACE PRIOR TO THE AFFORDABLE CARE ACT

Section 61 generally provides that gross income of a taxpayer includes income from whatever source derived. Accordingly, the value of medical coverage provided, or the value of medical benefits actually received (such as reimbursement of medical expenses), generally would be includible in gross income under §61 in the absence of an applicable exclusion. Applicable exclusions relating to medical insurance and medical benefits are provided under §§104, 105 and 106.

In this regard, §104(a)(3) provides an exclusion from income for amounts received from accident or health insurance (or an arrangement with the same effect) for personal injuries and sickness, other than amounts received under an arrangement whereby the benefits are attributable to contributions of the employer that were not included in the income of the employee or are paid by the employer. Accordingly, §104(a)(3) provides an exclusion from gross income for the medical benefits (expense reimbursements, etc.) received under a policy where the taxpayer pays the premiums (i.e., from personal funds with ''after tax'' dollars).

Section 105(a) generally provides that amounts received under an accident or health plan for personal injuries or sickness are includible in gross income to the extent attributable to employer contributions that are not includible in gross income or paid by the employer. Thus, §105(a) establishes a general rule that benefits provided by the employer are includible in income. However, §105(b) provides a major exception to the general rule of §105(a) with respect to amounts paid, directly or indirectly, to reimburse an employee for qualifying medical expenses under §213(d) (including for the employee's spouse and dependents). This can be thought of as the traditional exclusion for employer-provided medical benefits, with the proviso that §106(a) generally excludes the value of employer-provided medical coverage (i.e., the value of employer-paid premiums) under an accident or health plan from the employee's gross income. Thus, in a traditional employer provided insurance arrangement, the value of the premiums paid by the employer is eligible for exclusion from the employee's gross income under §106(a) and the value of the benefits actually received under the plan for eligible medical expenses is designed to be excludible from income under §105(b).

As described above, employer-provided medical benefits enjoy certain income tax exclusions, however, §105(h) eliminates the gross income exclusion available under §105(b) (for medical benefits received) for certain discriminatory employer self-insured arrangements. In general, an employer self-insured medical plan subject to this nondiscrimination requirement cannot provide impermissibly greater benefits to highly compensated individuals relative to the benefits provided to non-highly compensated individuals.

In this regard, medical benefits are typically either insured (i.e., the employer contracts with an insurance company and the insurance company provides the benefit) or self-funded (i.e., the employer pays for the benefit out of its general assets — a more typical funding method for large employers). Additional nondiscrimination rules apply, regardless of how a benefit is funded, when employees make employee contributions on a pretax basis through salary reductions.[7]

These nondiscrimination rules of §105(h) provide that, in order for all employees to qualify for the exclusion under §105(b) for medical expense reimbursements, a self-insured medical expense reimbursement plan may not discriminate in favor of ''highly compensated individuals'' (HCIs) as to eligibility to participate (Eligibility Test) and as to benefits (Benefits Test). If a self-funded plan fails to satisfy the nondiscrimination requirements, the benefits provided through the plan to highly paid employees are included in the highly paid employees' taxable compensation. Continuing coverage for a former executive on terms more favorable than other former employees is evaluated on equivalent terms, so benefits are not exempt from these rules merely because they are provided to former employees.

For purposes of §105(h), a highly compensated individual is an individual who is: (1) one of the em-

[7] Section 125 establishes cafeteria plans as the vehicle that allows employees to reduce their compensation (and exclude such amounts from income) for certain benefits.


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ployer's five highest paid officers; (2) a shareholder who owns more than 10% in value of the employer's stock; or (3) among the highest paid 25% of all eligible employees, including the five highest paid officers.[8]

To pass the Eligibility Test, a self-insured medical plan must benefit:[9]

- 70% or more of all employees (controlled-group concept applies); or
- 80% or more of all employees who are eligible to benefit under the plan, if 70% or more of all employees are eligible to benefit under the plan; or
- A "nondiscriminatory classification" of employees, which means it:
  - benefits a "reasonable" classification of employees as established by the employer. For these purposes, reasonable classifications may include specified job categories, hourly vs. salaried, geographic location, and other bona fide business criteria; and
  - benefits an *objective* mathematical percentage of employees or satisfies a *subjective* facts and circumstances test. The objective mathematical percentage test provides that the ratio of non-HCIs benefiting under the plan over the ratio of HCIs benefiting under the plan exceeds a set mathematical percentage. This mathematical percentage is no more than 50%, but potentially much lower if the plan covers a high concentration of non-HCIs. The subjective facts and circumstances test establishes a potentially lower threshold mathematical percentage, but the overall facts and circumstances must support the classification and not be discriminatory.

Employees who may be excluded from the percentage tests described above include employees who: (1) have not completed three years of service; (2) have not yet attained age 25; (3) are part-time or seasonal employees; (4) are nonresident aliens receiving no earned income from within the U.S.; or (5) are covered by a collective bargaining agreement between an employee representative and the employer if health and accident benefits were the subject of good faith bargaining.[10]

For purposes of the Eligibility Test, all of the employees in the employer's controlled group are counted. This means that all employees employed by companies who have 80% common ownership are treated as employed by a single employer.[11] The controlled-group concept is not used for purposes of the Benefits Test because this test is typically performed on a plan-by-plan basis. As long as the benefits under a plan are the same for all eligible employees the plan should pass the Benefits Test. An employer has broad discretion in defining and restructuring the nature and type of "plans" that will cover various groups of employees,[12] as long as each plan separately satisfies the Eligibility Test and Benefits Test.

To pass the Benefits Test, benefits provided under the self-funded plan must not discriminate in favor of HCIs and further, all benefits provided for participants who are HCIs must be provided for all other participants.[13] This test is typically conducted on a plan-by-plan basis, and as long as benefits are the same for all eligible employees the plan should pass this test.

The following rules apply in determining whether a self-insured plan provides nondiscriminatory benefits:[14]

(1) The presence or absence of discrimination is determined by considering the type and the amount of benefit subject to reimbursement to HCIs.

(2) If a plan covers HCIs, and the type or amount of the benefits subject to reimbursement is in proportion to employee compensation, then the plan discriminates as to benefits.

(3) The nondiscriminatory benefits test is applied to the benefits that would be subject to reimbursement if the health care expense were incurred rather than the actual amount of benefits paid. At the same time, a plan may not discriminate in operation. This is determined by the facts and circumstances in each case. A plan is not considered discriminatory merely because HCIs participating in the plan use a broad range of plan benefits to a greater extent than do other employee participants.

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[8] §105(h)(5); Regs. §1.105-11(d).

[9] §105(h)(3); Regs. §1.105-11(c)(2).

[10] §105(h)(3); *see also* Regs. §1.105-11(c)(2)(iii).

[11] Other common-control rules apply to brother-sister controlled-groups and to non-corporate control groups. *See* §414(a), (b), and (c).

[12] Regs. §1.105-11(c)(4)(i). For example, an employer could maintain separate plans for hourly and salaried employees, separate plans for employees in different geographic regions, etc.

[13] §105(h)(4); *see also* Regs. §1.105-11(c)(3)(i).

[14] *See* Regs. §§1.105-11(c)(3)(i), (ii).


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(4) A plan may establish a maximum limit for the amount that may be reimbursed to a participant for any single benefit or combination of benefits. But any maximum limit attributable to employer contributions must be uniform for all participants and for all dependents of employees who are participants and cannot be modified by reason of a participant's age or years of service.

The nondiscrimination requirements under §105(h) are designed to promote equitable benefits under plans of general applicability. The rules tend to ensure that customized or ''executive only'' employer self-insured medical benefits would not be excludible from income under §105(b). However, a traditional strategy for addressing this issue, and to avoid the inclusion in gross income of potentially huge amounts of employer-provided medical benefits for an affected executive, is to structure an ''executive only'' medical benefit as an ''employee pay all'' arrangement for post-termination medical benefits whereby the executive pays the full value of the premium from personal funds. Under this approach, the executive and the employer take the view that because the executive paid the full premium from personal funds, the medical benefits are excludible from income under §104(a)(3) and therefore application of §105(b) is unnecessary. Informally, representatives of the IRS have in the past agreed with this line of analysis, but it has not been confirmed in binding guidance.[15] Notably, key support for this analysis turns on the determination that the executive paid the full value of the premium, without any employer pre-tax contribution or subsidy. Traditionally, the COBRA premium rate (less the 2% administrative charge) has been used as a reference point for determining premium amounts to satisfy this concern. While still not confirmed in formal guidance, an approach based on COBRA premium rates finds additional support in recent provisions of, and guidance under, the Affordable Care Act. For example, under the so-called ''Cadillac tax'' provisions for high-value health plans effective in 2018, the statute indicates premium values are to be determined by reference to rules for determining COBRA premium rates.[16] The IRS also utilized COBRA premium rates as an acceptable valuation method for satisfying Form W-2 reporting requirements under the Affordable Care Act.[17]

It is common for employers to reimburse premiums paid by the executives in this context on a fully taxable basis (with or without tax supplement), and although such reimbursements tend to be direct and explicit, they also could be combined with other payments, such as severance and thus provided indirectly. It is also relatively common for employers to impute the value of the premium payment as taxable income to the executive, and to obviate the need to collect premiums and them reimburse them with a taxable payment. This approach is supportable by analogy based on guidance in Rev. Rul. 2004-55,[18] in which the IRS held that disability benefits could be excluded from income under §104(a)(3) where the employee had elected to have the employer pay the premium on an after-tax basis (i.e., premiums paid by the employer were included in the employee's income).

## COMPLIANCE WITH REQUIREMENTS FOR DEFERRED COMPENSATION

Where an executive post-termination medical benefit arrangement involves any potential payments that are includible in gross income, the arrangement generally should be designed and documented to comply with the requirements of §409A, which imposes strict requirements on nonqualified deferred compensation.[19] For purposes of §409A, nonqualified deferred compensation generally exists where a service provider obtains a legally binding right to compensation ''that, pursuant to the terms of the plan, is or may be payable to (or on behalf of) the service provider in a later taxable year.''[20] It is important to note that a legally binding right can exist even if the right to such compensation is subject to a substantial risk of forfei-

[15] *See* American Bar Association, Section of Taxation, May Meeting 2009, Committee on Employee Benefits, questions and answers based on an oral presentation made by IRS and Treasury officials on May 8, 2009, Q&A-1, available at http://www.americanbar.org/content/dam/aba/migrated/jceb/2009/IRS2009.authcheckdam.pdf. However, note also that the language of §104(a)(3) indicates that the exclusion does not apply to ''amounts . . . paid by the employer'' and the conclusion that the exclusion still applies presumably rests on the theory that where the employee has paid the full value of the premium, benefits should not be considered to be paid by the employer because the employee has simply purchased medical insurance for income tax purposes.

[16] §4980I(d)(2)(A).

[17] Notice 2012-9, 2012-4 I.R.B. 315, Q&As 24 and 27.

[18] 2004-26 I.R.B. 1081.

[19] Section 409A was added by the American Jobs Creation Act of 2004, P.L. 108-357. Section 409A was initially effective as of Jan. 1, 2005, but there were transition rules in place through Dec. 31, 2008. The Treasury Department and the IRS issued proposed regulations regarding the treatment of nonqualified deferred compensation under §409A in REG-158080-04, 70 Fed. Reg. 57930 (10/4/05). In Apr. 2007, the Treasury issued final regulations interpreting §409A. T.D. 9321, 72 Fed. Reg. 19234 (4/17/07). Prior to the issuance of the final regulations, the IRS issued Notice 2005-1, 2005-2 I.R.B. 274, which set forth initial guidance with respect to the application of §409A and supplied transition guidance. The final regulations became effective as of Jan. 1, 2009. Notice 2007-86, 2007-46 I.R.B. 990.

[20] Regs. §1.409A-1(b)(1).


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ture such as a vesting requirement (e.g., benefits provided only upon an involuntary termination of employment). Accordingly, nonqualified deferred compensation includes most promises by an employer to pay compensation to an employee, contractor, or director (referred to collectively as service providers) in the future. In particular, severance compensation to be paid under a severance arrangement is generally considered deferred compensation under this definition, which could include post-termination medical benefits, unless an exception applies.

The requirements under §409A specify the conditions under which nonqualified deferred compensation may be paid, and the time and form of payment of the nonqualified deferred compensation may be established or changed. In particular, §409A restricts the payment of nonqualified deferred compensation to a limited set of pre-specified payment triggers, including ''separation from service,'' a fixed date or schedule, death, ''disability,'' ''unforeseeable emergency,'' or a ''change in control'' of the employer (as such terms are specifically defined for purposes of §409A). Events other than those listed are generally not permissible payment triggers for nonqualified deferred compensation under §409A. Moreover, once the payment triggers are set, either at the time a nonqualified deferred compensation plan is established or a qualifying election is made, the ability to accelerate or further defer the timing of the payment is significantly restricted and subject to detailed rules under §409A.[21]

Section 409A imposes both operational and documentary requirements. The election and payment provisions under any arrangement providing deferred compensation subject to §409A must be documented to conform to the basic requirements of §409A. In particular, §409A requires that a plan include the amount (or the method or formula for determining the amount) of deferred compensation to be provided under the plan and the time and form of payment.[22] Accordingly, documents cannot include noncompliant terms or the arrangement will automatically violate the requirements of §409A.

The consequences of violating the requirements of §409A are harsh, including (1) accelerated and full income inclusion of all the amounts deferred under the plan in violation and all other plans of the same type, (2) an additional 20% income tax on the amounts so included (i.e., in addition to normal federal, state, and local taxes), plus (3) a further tax calculated as interest on the tax deferred under the arrangement.[23]

Section 409A does not apply to benefits that are excluded from gross income, and medical coverage for the COBRA period and other limited reimbursements (such as reasonable outplacement services).[24] Additionally, payments made pursuant to a ''separation pay plan'' may be excluded from the requirements of §409A up to the applicable §402(g) limit (i.e., $17,500 for 2014).[25] For this purpose, separation pay is defined under §409A as deferred compensation that will be paid only in the event of an employee's separation from service, whether voluntary or involuntary.[26] A separation pay plan generally does not include deferred compensation that an employee elects to receive after or upon separation from service if the employee could have elected to receive such amounts at a time other than separation from service.[27]

Severance pay is not categorically excluded from §409A, although severance pay programs that provide for severance upon an involuntary termination are not considered deferred compensation subject to §409A if and to the extent that the following conditions are satisfied: (1) payment is made only upon an ''involuntary termination'' (including certain resignations by the service provider for good reason); (2) the payments do not exceed two times the lesser of the service provider's annual compensation or the compensation limit under §401(a)(17) (currently $260,000 for 2014 which means a maximum cap of $520,000 for 2014); and (3) the payments must be completed by the end of the second calendar year following the year of termination.[28] For this purpose, an involuntary termination means a separation from service due to the employer's exercise of its unilateral authority to terminate the service provider's services, where the service provider was willing and able to continue performing services.[29] The regulations under §409A further provide that an involuntary termination includes a resignation by a service provider for ''good reason'' as long as the good reason trigger requires a material

[21] In general, an election to further defer amounts subject to §409A beyond the specified payment date must be made at least one year prior to such payment date and provide for an additional deferral of at least five years. *See* Regs. §1.409A-2(b).

[22] Regs. §1.409A-1(c)(3).

[23] §409A(a).

[24] Regs. §1.409A-1(b)(9)(v). Note that the medical benefits exemption generally would not extend to tax gross-up payments, so while COBRA premiums might be permitted to be paid or reimbursed during the 6-month delay period applicable to a §409A ''specified employee'' upon separation from service, the tax supplement payments would remain subject to the 6-month delay requirement unless covered by another exemption (such as for involuntary separation pay).

[25] Regs. §1.409A-1(b)(9)(v)(D).

[26] Regs. §1.409A-1(m).

[27] *Id.*

[28] Regs. §1.409-1(b)(9)(iii).

[29] Regs. §1.409-1(n)(1).


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negative change to the service provider in the employment relationship.[30]

To the extent that a reimbursement or in-kind benefit arrangement (such as premium or medical expense reimbursement coverage) does not qualify for an exemption from the requirements of §409A, the Treasury regulations specify the terms and conditions that must be specified and satisfied in order to comply with the payment timing requirements of §409A. These requirements include: (1) the arrangement provides an objectively determinable nondiscretionary definition of the expenses eligible for reimbursement or of the in-kind benefits to be provided; (2) the arrangement provides for the reimbursement of expenses incurred or for the provision of the in-kind benefits during an objectively and specifically prescribed period (including the lifetime of the service provider); (3) the arrangement provides that the amount of expenses eligible for reimbursement, or in-kind benefits provided, during a service provider's taxable year may not affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other taxable year; (4) the reimbursement of an eligible expense is made on or before the last day of the service provider's taxable year following the taxable year in which the expense was incurred; and (5) the right to reimbursement or in-kind benefits is not subject to liquidation or exchange for another benefit.[31]

Importantly, in order to meet the requirements for exemption or compliance with requirements of §409A, a right to exchange medical benefits for other compensation payable on a different schedule should not be included.

## IMPACT OF THE AFFORDABLE CARE ACT

Until recently, the Code did not impose nondiscrimination requirements on an insured medical plan. However, for plan years beginning on or after September 23, 2010, the Affordable Care Act imposes nondiscrimination requirements similar to those required for employer self-insured medical plans under §105(h) as described above. If a plan fails to satisfy the nondiscrimination requirements, the employer is subject to a $100 per day/per affected participant excise tax.[32] The application of these nondiscrimination requirements has been suspended pending the issuance of guidance describing the applicable rules.[33]

Section 10101(d) of the Affordable Care Act added §2716 to the Public Health Service Act, which provides that a group health plan (other than a self-insured plan) must satisfy the nondiscrimination requirements of §105(h)(2), applying "rules similar to" the §105(h) rules for nondiscriminatory eligibility, nondiscriminatory benefits, and controlled group entities treated as a single employer. Section 2716 also provides that the term "highly compensated individual" has the same meaning as under §105(h).

Section 2716 of the Public Health Service Act references the substantive nondiscrimination requirements of §105(h) but does not apply the gross income inclusion rule for medical expense reimbursements. Rather, an insured group health plan that fails to comply with these rules may be subject to: (1) an excise tax under §4980D of $100 for each day in the noncompliance period with respect to each individual to whom such failure relates; (2) in the case of a non-Federal governmental group health plan, civil monetary penalties up to $100 per day per individual for each day the plan does not comply with the requirement; or (3) a civil action to enjoin a noncompliant act or practice or for other appropriate equitable relief under ERISA. The penalties may be reduced in the case of failures due to reasonable cause, and abated in limited circumstances, such as where a failure is due to reasonable cause and not to willful neglect and is corrected within a specified time period. Thus, if a self-insured plan fails to comply with §105(h), highly compensated participants have medical benefits includible in gross income, but if an insured group health plan fails to comply with the similar nondiscrimination requirements under §2716 of the Public Health Service Act when they become applicable, the plan or plan sponsor may be subject to an excise tax, civil monetary penalty, or a civil action to compel it to provide nondiscriminatory benefits.

The IRS has requested public comments on guidance needed regarding §2716 of the Public Health Service Act and the implementation of rules "similar

[30] Whether good reason exists is primarily a facts and circumstances analysis; however, §409A includes a safe harbor definition for good reason. For the safe harbor definition to apply, the plan must, among other conditions, define good reason to include actions taken by the employer resulting in a material adverse change in the duties to be performed, the conditions under which such duties are to be performed, or the base compensation to be received for performing such services, and the avoidance of the requirements of §409A is not a purpose of the inclusion of these conditions in the plan or a purpose of the actions by the service provider in connection with the satisfaction of these conditions. Additionally, the service provider must provide the employer with notice of the good reason condition within 90 days of the initial existence of the condition and the employer must be provided with at least 30 days to cure such good reason trigger. Regs. §1.409A-1(n)(2).

[31] Regs. §1.409A-3(i)(1)(iv).

[32] §4980D(b)(1).

[33] Notice 2011-1, 2011-2 I.R.B. 259.


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to'' the rules under §105(h).[34] In order to provide insured group health plan sponsors time to implement any changes required as a result of the regulations or other guidance, the IRS has indicated that guidance regarding the nondiscrimination requirements of §2716 of the Public Health Service Act will not apply until plan years beginning a specified period after the issuance of that guidance.[35]

Two exceptions to the application of the nondiscrimination requirements under §2716 of the Public Health Service Act include the exception for grandfathered plans and the exception for ''retiree only'' arrangements. The requirements for qualification as a grandfathered plan are provided in Treasury regulations.[36] The requirements for grandfather status are relatively strict, applying to plans in which participants were enrolled on March 23, 2010. Because of the conditions that must be met to retain grandfathered status, and the fluid nature of medical insurance arrangements, it can be difficult over time to maintain grandfathered status. Significant changes in benefits or cost sharing will remove the grandfathering. In addition, although new participants may be added to a grandfathered plan without eliminating the grandfather, transfers of existing employee populations with existing coverage may be difficult to achieve without eliminating the grandfather. Because it is relatively easy to lose grandfathered status, and the penalties for having a discriminatory insured arrangement could be very large, reliance on grandfathered status alone to avoid discrimination problems will in many (if not most) cases be unattractive.

For arrangements limited to post-termination coverage, the ''retiree only'' exception is a much more viable alternative for providing executive-only coverage that is not subject to the nondiscrimination requirements of §2716 of the Public Health Service Act.[37] This exception applies to separate group health plans with fewer than two participants who are current employees. Thus, if a separate insured medical plan is maintained solely for former executives who are no longer employed by the employer, that plan would not be subject to the nondiscrimination requirements of §2716 of the Public Health Service Act and the associated excise taxes. It is critical in this regard to establish a separate plan. Evidence of a separate plan includes a separate plan document, summary plan description, and, if applicable, a separate Form 5500, *Annual Return/Report of Employee Benefit Plan*.[38]

## THE WAY FORWARD

Pending the issuance of guidance on the application of the nondiscrimination rules for insured group health plans under §2716 of the Public Health Service Act, employers have an opportunity to optimize the profile of post-termination medical benefit continuation arrangements to minimize potential discrimination issues. This process should begin with an inventory of potentially affected arrangements including, but not limited to, formal plan documents, severance arrangements, and employment agreements.

The next step should be to determine whether each separate arrangement is either insured or self-insured. For purposes of §105(h), the term ''self-insured medical reimbursement plan'' (i.e., the arrangements subject to §105(h)) is defined as a plan of an employer to reimburse employees for eligible medical expenses for which reimbursement is not provided under a policy of accident and health insurance.[39] However, this determination is not necessarily straightforward in all cases because the rules are not clear. For example, it is not clear the extent to which, if any, a stop-gap loss insurance policy under an otherwise self-insured arrangement may cause all or a portion of the arrangement to be considered insured. In addition, §2716 of the Public Health Service Act generally applies only to insured group health plans, but it is not clear whether the same principles for determining whether an arrangement is self-insured under §105(h) apply for purposes of determining whether an arrangement is insured under §2716 of the Public Health Service Act.

### Insured Arrangements

With respect to those arrangements that are insured, employers should strongly consider establishing one or more separate ''retiree or former employee only'' plans, with separate plan documents and separate summary plan descriptions, pursuant to which medical coverage continuation benefits may be provided without triggering the nondiscrimination rules. In addition, existing documents that promise medical cov-

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[34] Notice 2010-63, 2010-41 I.R.B. 420; Notice 2011-1, 2011-2 I.R.B. 259.

[35] Notice 2011-1. Accordingly, before the beginning of those plan years, sponsors of insured group health plans are not required to file Form 8928, *Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code*, with respect to excise taxes related to the nondiscrimination requirements under §2716 of the Public Health Service Act.

[36] Regs. §54.9815-1251T(c).

[37] ERISA §732(a).

[38] Certain ''top-hat'' welfare benefit plans and certain welfare benefit plans with fewer than 100 participants are exempt from filing Form 5500. *See* Instructions to Form 5500.

[39] §105(h)(6); *see also* Regs. §1.105-11(b) (providing generally that an arrangement is not considered insured unless it involves the shifting of risk to an unrelated third party).


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erage continuation under insured arrangements should be clarified to reflect that such benefits will only be provided under a retiree-or-former-employee-only arrangement.

## Self-Insured Arrangements

With respect to self-insured arrangements, employers should review each arrangement to determine the best position for addressing the §105(h) nondiscrimination requirements. Unless an employer is comfortable that the nondiscrimination requirements can be satisfied, the employer should consider structuring the arrangement so that it constitutes an actual (or deemed) employee-pay-all arrangement whereby the participant pays, or is deemed to pay, the full value of premiums with after-tax dollars. In addition, to the extent there are any binding rights to premium reimbursements and/or gross-up payments, the employer should make sure that they either meet an exemption from §409A or satisfy in form and operation the §409A requirements for reimbursement and in-kind benefit arrangements that are considered deferred compensation, including the rules for permissible payment triggers and reimbursement timing.

Unfortunately, until additional guidance is issued with respect to these issues, it remains unclear what options may be available in the future, which creates plan design and contract drafting issues for arrangements in place or being implemented now. This article has suggested some steps employers should consider taking to place their arrangements in a better position for addressing the potential nondiscrimination issues going forward. However, employers should understand that they may have to make changes or completely restructure their post-termination medical arrangements after the additional guidance is issued. In addition, depending on the terms of the existing arrangements and the nature of any transitional rules that may be provided, employers may be significantly limited in the options that may be available in the future to continue providing post-termination medical benefits.


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