Employee Benefit Nondiscrimination Basics

There are four main regulations that employers should consider when they are ensuring their employee benefit plans are not discriminatory in design, participation or operation.

Regulation: HIPAA Nondiscrimination on the Basis of Health Factors

General Rules

- Prohibits group health plans and health insurers from discriminating regarding eligibility or benefits based on certain "health factors" when enrolling in a plan.
- Prohibits "actively at work" waiting period provisions.
- Participants may not be charged more than similarly situated individuals based on any health factor.[1]

[1]Employers may vary contributions among similarly situated individuals only by way of offering a HIPAA-compliant bona fide wellness program in conjunction with the group health plan. Wellness programs are beyond the scope of this paper.

Group health plans are subject to HIPAA. With very few exceptions, almost all employer group health plans are subject to HIPAA.

Application

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Test

No specific test. Employers may vary eligibility, benefits and contributions based on non-health-related factors.

Definitions

SIMILARLY SITUATED INDIVIDUALS

Determined based on "bona fide employee employment-based classifications" consistent with the employer's usual business practice. For example, part-time and full-time employees, employees working in different geographic locations and employees with different dates of hire or lengths of service can be treated as different groups of similarly situated individuals. A plan may draw a distinction between employees and their dependents. Plans may also make distinctions between beneficiaries themselves if the distinction is not based on a health factor. For example, a plan may distinguish between spouses and dependent children, or between dependent children age 26 and older, based on their age or student status.

HEALTH FACTORS INCLUDE:

- Health status, including vaccination or tobacco usage
- Medical conditions, including physical and mental illnesses
- Claims experience
- Receipt of healthcare
- Medical history
- Genetic information
- Evidence of insurability
- Disability

Practical Impact

Employers cannot exclude individuals who participate in dangerous activities or have a history of high health claims, and they cannot base eligibility on evidence of insurability or "passing" a physical exam.

Employers cannot exclude individuals from the plan for refusing to receive vaccinations, quit smoking or receive their annual physicals/exams.

Employers cannot exclude coverage related to specific disease treatments for individuals who are noncompliant with known therapies or who decline vaccinations for specific diseases.

Employers cannot charge individuals different premiums based on the existence or absence of health factors, unless they do so in conjunction with a bona fide wellness program that meets all regulatory requirements.

Example: An individual who uses tobacco (a health factor) cannot be charged more in premiums unless the employer offers a proper tobacco-cessation wellness program.

Employers cannot limit an offer of coverage to those who are "actively at work" at the time of their waiting period[2].

Employers cannot keep high claimants off the plan and in turn pay for a "better" or comparable plan in the individual market.

Employers cannot offer a "special" plan to employees with a risk of high health claims to keep them off the main group health plan, even if the alternative plan is richer.

Penalties

Violating HIPAA nondiscrimination requirements can trigger numerous potential penalties, including an ACA-related excise tax penalty of $100 per day per affected plan participant.

[2]Stop-loss contracts should be reviewed for "actively at work" provisions.

Some self-funded plans will also be considered a covered entity by the nature of their business. Because health insurance carriers are covered entities, all fully insured plans are subject to these rules.

Regulation: ACA Section 1557

General Rule

ACA Section 1557 provides that individuals shall not be excluded from participation, denied the benefits of or be subjected to discrimination under any health program or activity that receives federal financial assistance from HHS, based on race, color, national origin, sex, age or disability. Consistent with the Supreme Court's Bostock decision, the Office of Civil Rights (OCR) interprets Section 1557's prohibition on discrimination on the basis of sex to include: (1) sexual orientation; and/or (2) gender identity.

Application

The rule applies to any program administered by HHS or any health program or activity administered by an entity established under Title I of the ACA, which are considered covered entities. The rule also applies to any health program or activity that receives federal financial assistance from HHS, which will include all fully insured plans. Some self-funded plans will also be considered a covered entity by the nature of their business. Because health insurance carriers are covered entities, all fully insured plans are subject to these rules.

Test

No specific test.

Definitions

Covered entities include, but are not limited to:

- Hospitals
- Nursing homes
- Home health agencies
- Laboratories
- Community health centers
- Therapy service providers (physical, speech, etc.)
- Physicians' groups
- Health insurers
- Ambulatory surgical centers
- End stage renal dialysis centers
- Dental practices
- Schools or universities with health programs receiving federal financial assistance through grant awards.

Practical Impact

Blanket, categorical or automatic exclusions for coverage of care associated with gender dysphoria or associated with gender transition are prohibited.

The regulations do not preclude neutral standards that govern the circumstances under which coverage will be offered.

Medical examinations (such as pelvic, prostate and breast exams) cannot be denied based on a person's sex assigned at birth, gender identity or recorded gender, if the classification is medically appropriate.

Penalties

Section 1557 rules are being litigated in various courts across the country. Anticipate additional guidance from HHS. Employers who wish to exclude services must seek guidance from legal counsel on these regulations, particularly if they are a covered entity. Risks of categorical exclusions for treatment of gender dysphoria include regulatory oversight and civil lawsuits brought by plan participants. This risk was heightened by the Supreme Court ruling in Bostock v. Clayton County, which found that under Title VII, sex includes sexual orientation and gender identity, and ruled that discrimination on the basis of sex under employment law is not permissible – which includes health benefits as a term and condition of employment.

Regulation: Internal Revenue Code Section 125 Cafeteria Plan Nondiscrimination

General Rule

Section 125 prevents employers from favoring or disproportionately offering pre-tax benefits to certain groups of highly paid or key employees. This prohibition applies to the plan design, operation of the plan and the actual utilization of the plan.

Note: Certain components of Section 125 plans — notably health flexible spending accounts (FSAs) and dependent-care flexible spending accounts (DCAPs/DCFSAs) — have additional non-discrimination tests.

Application

Any employer offering benefits on a pre-tax basis must do so through a Section 125 plan (commonly called a cafeteria plan) and the 125 plan must undergo annual testing.

Best Practice: Perform the test(s) mid-year so corrections can be made timely if the plan is trending towards failure.

Test

A cafeteria plan must pass the following three tests, unless a safe harbor applies:

- Eligibility test
- Contributions and benefits test
- Concentration test.

Definitions

A highly compensated individual (HCI) includes:

- Officer
- 5% shareholders
- Highly compensated employee (HCEs)
- Spouse or dependent of any of the preceding individuals.

Highly compensated means any individual or participant who — for the prior plan year, or the current plan year in the case of the first year of employment — had annual compensation from the employer more than the compensation amount specified in the Internal Revenue Code and, if elected by the employer, was also in the top-paid group of employees for the year.

For 2023, the applicable compensation amount is $150,000. For 2022, the applicable compensation amount was $135,000.

A key employee is a participant who, at any time during the plan year, is one of the following:

- An officer with annual compensation greater than an indexed amount ($215,000 for 2023)
- A 5% owner of the employer
- A 1% owner having compensation in excess of $150,000.

Executive plans cannot be provided on a pre-tax basis because they cannot be run through a 125 plan and pass the testing by the nature of their plan design.

Practical Impact

Cafeteria plans must be open to all similarly situated eligible employees and must give each similarly situated participant a uniform opportunity to elect qualified benefits.

Highly compensated participants must not disproportionately elect qualified benefits. The plan cannot provide more than 25% of its nontaxable benefits to key employees.

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Employers are given flexibility when offering benefits across locations or positions within a company, provided they can pass the testing. This means a plan design with different premium structures or benefit offerings based on tenure, location or job title might be discriminatory for Employer A but pass the testing and not be discriminatory for Employer B. Employers should be aware that changes in their workforce could cause a nondiscriminatory plan to become discriminatory.

Plan designs in which an employer pays 100% of the premium for employees or a group of employees exclude those employees from the testing. Practically speaking, employers can pay 100% of the premium on a fully insured plan for highly compensated employees and will not fail nondiscrimination testing for that reason, because those employees will be excluded from the testing. Employers should keep in mind that state law might prohibit paying 100% of the premium for some employees and not others.

Penalties

A highly compensated participant or key employee in a discriminatory cafeteria plan must include the value of the taxable benefit (with the greatest value that the employee could have elected to receive) in their gross income. This requires both the employer and the affected employees to amend past tax filings to account for undeclared gross income, unpaid Social Security, FICA, FUCA, etc. There is no impact on participants who are not highly compensated or key employees.

Regulation: Internal Revenue Code Section 105(h)

General Rule

Section 105(h) prevents employers from favoring or disproportionately offering benefits to certain groups of highly paid or key employees.

Application

Any self-insured medical plan, including self-funded major medical plans, health reimbursement arrangements (HRAs) and medical expense reimbursement plans (MERPs).

Note: The ACA directs that the Section 105(h) prohibitions extend to fully insured plans; however, regulations have yet to be proposed and likely never will be.

Test

A self-insured plan must pass the following two tests:

1. Eligibility test, which determines whether there are enough regular employees benefiting from the plan. Section 105(h) has three methods of passing the eligibility test:
   - The 70% test — 70% or more of all employees benefit under the plan.
   - The 70%/80% test — At least 70% of employees are eligible under the plan, and at least 80% or more of those eligible employees participate in the plan.
   - The nondiscriminatory classification test — Employees qualify for the plan under a classification set up by the employer that is found by the IRS not to be discriminatory in favor of highly compensated individuals.
2. Benefits test, which determines whether all participants are eligible for the same benefit(s).

Definitions

A highly compensated individual (HCI) is an individual who is:

- One of the five highest-paid officers
- A shareholder who owns more than 10% of the value of stock of the employer's stock
- Among the highest-paid 25 percent of all employees (other than excludable employees who are not participants)

The following employees may be excluded from the highest-paid 25 percent of all employees, unless they are eligible to participate in the plan:

- Employees who have less than three years of service
- Employees who are not 25 years old
- Part-time employees (defined as customary weekly employment of fewer than 35 hours) or seasonal employees (defined as customary annual employment of fewer than nine months)
- Collectively bargained employees
- Nonresident aliens who receive no earned income from U.S. sources.

Practical Impact

Self-funded plan sponsors should be cautious of plan designs that create separate plans for different employee groups, that do not cover all employees, or base employer contributions or benefits on employees' years of service or compensation level. Unlike the similar rules under Section 125, employers sponsoring self-funded plans cannot pay 100% of the premium for certain employees to avoid including those employees in the testing. Employers cannot offer self-funded executive health plans as a result.

HRAs are subject to 105(h), so any plan design in which an HRA is not accessible to all employees equally (or to all employees enrolled in a particular plan) would be at a risk of failing the testing.

Penalties

If the plan fails the Section 105(h) nondiscrimination tests, highly compensated individuals' excess reimbursements are treated and reported as taxable income.

The excess reimbursement calculation differs based on which test failed.

Unlike the similar rules under Section 125, employers sponsoring self-funded plans cannot pay 100% of the premium for certain employees to avoid including those employees in the testing. Employers cannot offer self-funded executive health plans as a result.

Your Contact

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