

Discrimination Rules

Self-Funded Plans In General

Now that IRC §89 has been repealed, self-funded plans fall back on IRC §105 (h), a section added to the code added in 1978. Because of its brevity, the code section is reproduced in its entirety.

Code Section 105(h)

Amount paid to highly compensated individuals under discriminatory self-insured medical expense reimbursement plan.

1. **In General.** In the amounts paid to a highly compensated individual under a self-funded medical reimbursement plan which does not satisfy the requirements of paragraph (2) for a plan year, subsection (b) shall not apply to such amounts to the extent they constitute an excess reimbursement of such highly compensated individuals.
2. **Prohibition of Discrimination.** A self-funded medical reimbursement plan satisfies the requirement of this paragraph only if-
 - A The plan does not discriminate in favor of highly compensated individuals as to eligibility to participate; and
 - B The benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals.
3. **Nondiscriminatory eligibility classifications.**
 - A In general. A self-funded medical reimbursement plan does not satisfy the requirements of subparagraph (A) or paragraph (2) unless such plan benefits-
 - i 70 percent or more of all employees, or 80 percent or more of all the employees who are eligible to benefit under the plan if 70 percent or more of all employees are eligible to benefit under the plan; or
 - ii Such employees as qualify under a classification set up by the employer and found by the Secretary not to be discriminatory in favor of highly compensated individuals.
 - B Exclusion of certain employees. For purposes of subparagraph (A), there may be excluded from consideration-
 - i employees who have not completed 3 years of service;
 - ii employees who have not attained age 25;
 - iii part-time or seasonal employees;

- iv employees not included in the plan who are included in a unit of employees covered by an agreement between employee representatives and one or more employers which the Secretary finds to be a collective bargaining agreement, if accident and health benefits were the subject of good faith bargaining between such employee representatives and such employer or employers; and
 - v employees who are nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861 (a)(3)).
4. **Nondiscriminatory benefits.** A self-funded medical reimbursement plan does not meet the requirements of subparagraph (b) of paragraph (2) unless all benefits provided for participants who are highly compensated individuals are provided for all other participants.
 5. **Highly compensated individual defined.** For purposes of this subsection, the term *highly compensated individual* means an individual who is-
 - A one of the 5 highest paid officers,
 - B a shareholder who owns (with the application of section 318) more than 10 percent in value of the stock of the employer, or
 - C among the highest paid 25 percent of all employees (other than employees described in paragraph (3) (B) who are not participants).
 6. **Self-funded medical reimbursement plan.** The term *self-funded medical reimbursement plan* means a plan of an employer to reimburse employees for expenses referred to in subsection (b) for which reimbursement is not provided under a policy of accident and health insurance.
 7. **Excess reimbursement of highly compensated individuals.** For purposes of this section, the excess reimbursement of a highly compensated individual which is attributable to a self-funded medical reimbursement plan is-
 - A in the case of a benefit available to highly compensated individuals but not to all other participants (or which otherwise fails to satisfy the requirements of paragraph (2)(b)), the amount reimbursed under the plan to the employee with respect to such benefit, and
 - B in the case of benefits (other than benefits described in subparagraph (a) paid to a highly compensated individual by a plan which fails to satisfy the requirements of paragraph (2), the total amount reimbursed to a highly compensated individual for the plan year multiplied by a fraction-
 - i the numerator of which is the total amount reimbursed to all participants who are highly compensated individuals under the plan for the plan year, and
 - ii the denominator of which is the total amount reimbursed to all employees under the plan for such plan year. In determining the fraction under subparagraph (B), there

shall not be taken into account any reimbursement which is attributable to a benefit described in subparagraph (A).

8. **Certain controlled groups, etc.** All employees who are treated as employed by a single employer under subsection (b), (c) or (m) of Section 414 shall be treated as employed by a single employer for purposes of this section.
9. **Regulations.** The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.
10. **Time of inclusion.** Any amount paid for a plan year that is included in income by reason of this subsection shall be treated as received or accrued in the taxable year of the participant in which the plan year ends.

Regulations

In General. Treasury Regulations set forth guidelines to see that a self-funded medical plan is not discriminatory. Self-funded plans exclude prepaid health care plans; they include plans governed by a 501(c)(9) trust; they include ASO arrangements; they exclude plans where the insurer sets its premium based upon the employer's prior claims experience; they include the cost-plus stop-loss and retrospective premium arrangements and that portion of the minimum premium arrangement below the trigger point, since with these plans the risk is shifted to the employer by the insurer; a plan underwritten by a policy of insurance issued by a captive insurance company is not considered self-funded if for the plan year the premiums paid by the companies unrelated to the captive insurance company equal or exceed 50% of the total premiums received and the policy of insurance is similar to policies sold to such unrelated companies. Discriminatory self-funded plans do not include payments *outside the plan*. These outside-the-plan payments are not contemplated by the regulations; these are simply taxable as income to the participant.

HMO's. If there is an HMO and self-funded dual-option plan the HMO is to be deemed self-funded for discrimination purposes provided two tests are both met:

- Employer's HMO contributions equal or exceed those to the self-funded plan.
- The plans are truly dual-option which means they are treated for disclosure purposes as a single plan.

Nondiscriminatory Eligibility Classifications. Certain percentage tests must be met:

- (1) 70% or more of all employees, or
- (2) 80% or more of all eligible employees if 70% or more of all employees are eligible to benefit under the plan, or
- (3) employees who qualify under a classification set satisfaction that such a classification is not discriminatory in favor of highly compensated individuals. IRS determination of whether a classification set up by the employer is discriminatory is made on the basis of the facts and circumstances of each case, applying the standards as under IRC § 410(b)(1)(B) (relating to qualified pension, profit-sharing, and stock bonus plans; without regard to the eligibility rules at IRC § 401(a)(5), concerning eligibility to participant.

For purposes of percentage tests in categories (1) and (2), employees are not counted if they have been employed for less than 3 years, or if they have not attained age 25, or if they are employed part-time or seasonally, or if they are covered by a collective bargaining agreement and accident and health benefits were the subject of good faith collective bargaining, or if they are nonresident aliens and have no earned income within the meaning of IRC §911(d)(2) from the employee which constitutes income from sources within the U.S. under IRC §861(a)(3). Where appropriate, IRS is to interpret the nondiscriminatory classification test as applied under the self-funded medical reimbursement plan nondiscrimination rules in a different manner than those rules that apply in the area of qualified retirement plans, even where the statutory requirements with respect to such benefits are similar.

Years of Service Test. Any method may be used to apply the three year rule so long as it is reasonable and consistent. Excluded from the three years are these:

- Service below age 25
- Service as a part-time or seasonal employee
- Service as a member of a collective bargaining unit
- Service as a non-resident alien.

Service with an affiliate counts as regular service.

Part-Time and Seasonal. Part time break is at 35 hours where 40 hours is the *norm*. Where *norm* is a full year, seasonal is deemed to be nine months or less. As a safe harbor, twenty-five hours for part-time and seven months for seasonal will be acceptable.

Nondiscriminatory Benefits. To be nondiscriminatory, the plan must give the same benefit to the highly compensated as to the *all other* group. Benefits extend to the dependents as well as the participants. Certain rules must be followed:

- The presence or absence of discrimination is determined by considering the type of benefit subject to reimbursement to highly compensated employees, as well as the amount of benefits subject to reimbursement.
- If a plan covers employees who are highly compensated individuals, and the type or the amount of the benefits subject to reimbursement under the plan are in proportion to employee compensation, the plan does not discriminate as to benefits.
- The nondiscriminatory benefits test is applied to the benefits subject to reimbursement under the plan rather than to the actual benefit payments or claims under the plan.
- A plan may establish a maximum limit for the amount of reimbursement which may be paid a participant for a single benefit or combination of benefits. However, any maximum limit attributable to employer contributions must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reasons of a participant's age or years of service.

Optional Benefits. Optional benefits are to be treated as part of the basic plan if these rules are met:

- Election is available to all participants.
- No required participant contributions or if required, the contributions, are uniform.

Operation of a Self-Funded Plan. The plan must be nondiscriminatory both on its face and its operation. Operational discrimination is a fact and circumstances matter. A plan is not considered discriminatory merely because highly compensated individuals participating in the plan use a broad range of plan benefits to a greater extent than do other employees participating in the plan. If a plan, or a particular benefit provided by a plan is terminated, such termination would cause the plan benefits to be discriminatory if the duration of the plan or benefit has the effect of discriminating in favor of highly compensated individuals. Therefore, the prohibited discrimination may occur where the duration of a particular benefit coincides with the period during which a highly compensated individual utilizes the benefit.

Retired Employees. Test is applied by testing benefits of *former* highly compensated employees. Generally, benefits from a self-funded medical reimbursement plan to a retired employee that are otherwise exempt are not discriminatory benefits.

Multiple Plans. Two or more plans may be designated as one plan for discrimination purposes. If the plan, as an aggregate fails, some of the individual plans may satisfy. What plans are to be aggregated will be set forth in the plan document. If the aggregate plan discriminates, the penalty will be applied to the aggregate plan.

Tax Penalty for Non-Discrimination. If the plan fails the discrimination tests, the highly compensated participants must include *excess reimbursements* in their gross income.

Excess Reimbursements. These excess reimbursements apply only to the highly compensated participants. Several illustrations may be helpful.

- **Illustration:** N Corporation maintains a self-funded medical reimbursement plan that covers all employees. The plan provides a broad range of medical benefits for which all employees could be reimbursed. However, only the 5 highest paid officers are entitled to dental benefits. During the year, Employee B, one of these officers, received dental payments of \$300. Since the plan discriminated by providing a type of benefit not available to all employees, the \$300 is an excess reimbursement to B.
If a self-funded medical reimbursement plan discriminates by providing highly compensated employees with an *amount* of benefits not available to other participants, then the excess reimbursement is the amount a highly compensated employee receives over the amount that any other participant could have received.
- **Illustration:** M Corporation maintains a self-funded medical reimbursement plan which covers all employees. The plan provides the following maximum limits on the amount of benefits subject to reimbursements: \$5,000 for officers and \$1,000 for all other plan participants, thereby providing discriminatory benefits. Employee A, a plan participant and a highly compensated individual,

received reimbursements of \$4,000. Because reimbursements over \$1,000 are not provided to all other participants, A received an excess reimbursement of \$3,000 (\$4,000-\$1,000).

If the benefits provided under a plan otherwise discriminate in favor of participants who are highly compensated employees, the excess reimbursement is the amount reimbursed to a highly compensated employee that is in excess of the lowest amount that another participant may receive under the plan.

- ***Illustration:*** Corporation R maintains a self-funded medical reimbursement plan which covers all employees. The type of benefits subject to reimbursement under the plan include all medical care expenses as defined in IRC § 213 (e). The amount of reimbursement available to any employee for any calendar year is limited to 5% of the compensation paid to each employee during the calendar year. The amount of compensation and reimbursement paid to Employees A-F for the calendar year is as follows:

Employee	Reimbursable Compensation	Amount Paid
A	\$10,000	\$5,000
B	25,000	1,250
C	15,000	750
D	10,000	500
E	10,000	500
F	8,000	400
		<u>\$8,400</u>

Because the amount of benefits subject to reimbursement under the plan is in proportion to employee compensation the plan discriminates as to the benefits. In addition, Employees A and B are highly compensated individuals. Benefits in excess of \$400 (Employee F's maximum benefit under the plan (5% x \$8,000)) are not provided for all other participants. Employees A and B received, respectively, an excess reimbursement of \$4,600 (\$5,000-\$400) and \$850 (\$1,250-\$400).

Plans Which Provide Discriminatory Coverage. Presume the plan fails the eligibility tests. What will be the basis of *excess reimbursements*? Under the formula, the highly compensated individual will be taxed on the total amount reimbursed to him by the plan for the plan year multiplied by a fraction, the numerator of which is the total amount reimbursed to all highly compensated participants under the plan for the plan year, and the denominator of which is the total amount reimbursed to all employees under the plan for such plan year.

- ***Illustration:*** XYZ Corp's self-funded medical reimbursement plan fails the nondiscrimination eligibility test. The plan pays out \$30,000 in medical reimbursements of which \$10,000 is paid to participants who are *highly compensated individuals*, which the president of XYZ receiving \$6,000. The amount taxable to the president under the formula is \$2,000 computed as follows:

$$\$6,000 \times \frac{\$10,000}{\$30,000} = \$2,000$$

Plans Which Provide Both Discriminatory Coverage and Discriminatory Benefits.

An illustration will demonstrate how *excess reimbursement* is to be determined:

From discriminatory coverage:

$$\$4,500 \times \frac{\$30,000\text{-discriminatory benefits}}{\$50,000\text{-discriminatory benefits}} = \$2,700$$

From discriminatory benefits \$300

Total includible in income \$3,000

How Discrimination is to be Reported. Income for plan year-ending during highly compensated participants' tax year determines.

Controlled Group of Employers. For discrimination testing, all controlled corporations under IRC § 414(b), 414(c) and 414(m) as one.

Cafeteria Plans. If a self-funded medical reimbursement plan is included in a cafeteria plan, then the nondiscrimination rules determine the status of a benefit as a taxable or nontaxable fringe benefit and the cafeteria plan rules determine whether an employee would be taxed as though he elected all available taxable benefits (including taxable benefits under a discriminatory medical reimbursement plan).

Medical Diagnostic Procedures. Reimbursements paid under a plan for medical diagnostic procedures are not treated as part of a self-funded medical reimbursement plan. This means that medical diagnostic procedures are exempt from the self-insured plan requirements discussed. Accordingly, employers could have provided for these procedures tax-free to employees even though they were self-funded and discriminatory. However, the exemption was limited to medical diagnostic procedures furnished to employees, and *not* to dependents. Medical diagnostic procedures are defined to include routine medical examination, blood tests, and X-rays but not expenses incurred for the treatment, cure or testing for a physical injury, complaint or specific symptom of a bodily malfunction. These procedures don't include any activity undertaken for exercise, fitness, nutrition, recreation or the general improvement of health unless they are for medical care deductible as medical expenses. The diagnostic procedures must be performed at a facility which provides no services (directly or indirectly) other than medical and ancillary services. Transportation undertaken merely for the general improvement of health, or in connection with a vacation are not exempt, nor are they incidental expenses for food or lodging.

Conclusion

The Code and Regulations show the self-funder how to treat a plan with discriminatory features. It should be noted that plan benefits paid outside *the plan* or a medical reimbursement plan for highly compensated participants only would be deemed 100% discriminatory and fully taxable to the participant.

Cobra And Flexible Spending Accounts

Under proposed Treasury Department regulations, health flexible spending accounts under IRC §125 must provide for annual risk shifting to the cafeteria plan. This requirement had caused some concern because a health FSA that requires employees to contribute monthly could be left with expense reimbursements that exceed the amount of monthly premiums the employee has contributed at the time of the employee's termination. Some plans have sought alternative methods of protecting against this adverse risk, one of which is to explore the possibility of collecting the remaining monthly premium contributions for the balance of the plan year from the employee's final paycheck.

The Internal Revenue Service position is that collecting the monthly premium contributions from a terminated participant's final paycheck would not violate the proposed IRC §125 regulations but probably would violate the COBRA rules by impermissibly accelerating the premiums required. Since COBRA applies to health FSAs, an employee must be permitted to elect to continue COBRA coverage and must be given the right to make those premium payments for the balance of the plan year. Accelerating such premium payments, under the Internal Revenue Service view, would appear to violate COBRA. In addition, under some state laws, mandatory withholding from pay in this fashion would not be permissible.

Participation Requirements

Problem

Typical facts found in arranging excess loss coverage for self-funded health care plans are these:

1. Employer pays 75% of employee costs and none of the dependent costs.
2. On payroll 400
Part-time and seasonal 20
In waiting period 60
Eligible-Definition No. 1 320
Covered under comparable plan 80
Eligible-Definition No. 2 240
Declining to participate 40
Actually participating 200

The normal and usual ratio for purposes of the excess loss 75% test is as follows:

$$\frac{200}{320} \text{ or } 62.5\%$$

With such a ratio, the excess loss carrier would provide a *decline to quote* response/

Solution

The health care plan with Eligible Definition No. 1 is denied excess loss. If it modifies its definition of eligibility as set forth below it should qualify.

Amendment. The plan will not deem any person eligible to participate who is covered by another employer-financed, group medical plan offering comparable benefits as evidenced by an employee-provided sworn statement.

With the definition of eligibility so amended the ratio for excess loss purposes becomes:

$$\frac{200}{240} \text{ or } 83.3\%$$

Caveat by the Author

The author asserts that at least some excess loss carriers will honor the revised definitions. It is not asserting that all excess loss carriers will so honor the revised definition, however.

Contrast with Traditional Insurer Position

The group insurer, as a group, have encouraged double coverage because when both man and wife are covered the insurers, collectively, have a substantial built-in profit because:

- Premium sufficient for 160%.
- Premium only used for 100%.

Where the employer, however, in a self-funded plan elects to not permit double coverage on their own employees only they *save* the full risk because the plan would be primary on these employees anyway.

Where an employee has been removed from the plan because of sworn statement two things should be done (or consider being done):

- Pay increase to the employee because the employer is saving plan costs by not covering the employee.
- Permit the employee to come back on the plan without a waiting period or preexisting conditions should the sworn statement be revoked.

Double coverage by the plan of dependents should be allowed. Consider these examples:

<u>Before Statement</u>		<u>After Statement</u>	
Employee's	Spouse's	Employee's	Spouse's

Employee	Spouse	<u>Plan</u>	<u>Plan</u>	<u>Plan</u>	<u>Plan</u>
A	B	A & B	A & B		A & B
A	B	A	A & B		A & B
A	B	A & B	B	A & B	B

Group Term Life Non-Discrimination Requirements

In General

The value of the first \$50,000 of employer-provided group term life insurance coverage will be excluded from the gross income of a covered employee if the plan meets the requirements of IRC Secs. 79(a) and Sec. 79(b). The value of amounts in excess of \$50,000 is includible in gross income under Table I, which is found in regulations for Sec. 79(c) and the \$50,000 exclusion is lost if the plan fails to meet the Sec. 79(a) and 79(b) requirements.

Sec. 79(a) provides the exclusion from gross income for life insurance paid for by the employee and for amounts of \$50,000 and less. Sec. 79(b) exempts the first \$50,000 in life insurance in cases of disability of where a charitable organization is named as the sole beneficiary. In addition, a plan of group term life must satisfy the nondiscrimination requirements of Sec. 79(d).

Sec. 79(d) was replaced by the nondiscrimination requirements of IRC Sec. 89 and enacted in Tax Reform Act of 1986. However, the Sec. 89 provisions did not become effective prior to their repeal by the 1989 debt ceiling extension (P.L. 101-140). The result of the 1989 repeal was to restore Sec. 79(d) as if the 1986 provisions had never been enacted, but certain amendments were added.

The first of these amendments states that the nondiscrimination rules of Sec. 79(d) do not apply to IRC Sec. 414(e) church plans.

Under a second amendment, group term life offered through an IRC Sec. 501(c)(9) trust will not be subject to the IRC Sec. 401(a)(17) \$200,000 compensation limit. In that case, the nondiscrimination tests of IRC Sec. 505(b) apply to the trust.

Sec. 79(d) Requirements

Under Sec. 79(d), as restored in 1989, a plan of group term life insurance will be considered discriminatory unless:

- a It covers 70% of all employees.
- b At least 85% of all participants are not key employees.
- c The Plan covers a nondiscriminatory classification of employees, as determined by the Internal Revenue Service.

The 70% test and the nondiscriminatory classification test are long-standing retirement plan tests under IRC Sec. 410(b)(1)(A).

Key Employee Defined

A *key employee* is a member of the top-heavy group as is defined at Sec. 416(i) as:

- a An employee owning more than a 5% interest in the employer, whether incorporated or not.
- b An employee owning more than a 1% interest and whose compensation or earned income from the employer exceeds \$150,000 per year.
- c An active employee-one receiving annual compensation-who is one of the ten employees owning the largest interest in the employer.
- d An officer of the employer whose annual compensation exceeds 50% of the IRC Sec. 415(b)(1) defined benefit plan limit of \$90,000, indexed.

Firms that have a great number of officers may have low-paid officers. Therefore, it is not necessary to recognize all officers for the purpose of identifying key employees. Only the most highly compensated 50 need to be considered as officers. If less than 50 employees are in the plan, only the most highly compensated 10%, but not less than three, are considered to be officers.

If more than three but less than 30 employees are in the plan, only the most highly compensated three need to be considered officers. If less than four officers are in the plan, all the officers must be considered to be officers. In all cases, officers in name only are excluded. The guidelines of Rev. Rul. 80-314, C.B. 1080-2, 152, are used to exclude *in name only* officers.

Once an employee becomes a key employee, it takes five years as a non-key employee before a new non-key status is recognized.

Who Can Be Excluded?

Employees with less than three years of service may be excluded from group life coverage, as well as part-time employees who are defined under IRC Reg. Sec. 1.79(c)(4)(ii) as those working less than 20 hours per week or five months per year. Nonresident aliens can be excluded.

Employees in a collective bargaining unit where group term life benefits have been the subject of good faith bargaining may also be excluded.

Nondiscriminatory Benefits

Group term life benefits must be nondiscriminatory as to:

- a Eligibility for coverage
- b Type of benefit
- c Amount of coverage.

This last is defined so as to permit a uniform multiple of compensation, such as 1½ times salary, or coverage brackets that reasonably reflect basic rates of compensation, or a single amount applicable to all covered employees.

Use of Sec. 501(c)(9) Trust

If group term life is provided under a Sec. 501(c)(9) trust or a similar arrangement, the nondiscrimination tests of Sec. 79(d) must be met, and the \$200,000 compensation limit (Sec. 401(a)(17)) will not apply, according to IRC Sec. 505(b)(7), as amended in 1989.

Thus, group term life coverage, whether provided through a trust or otherwise, can be a multiple of compensation without any limit on compensation. A highly compensated employee earning \$750,000, for example, can receive coverage as a multiple of that amount, rather than as a multiple of \$200,000. However, if post-retirement coverage is provided through the Sec. 501(c)(9) trust, the amount cannot exceed \$50,000 under IRC Sec. 419A(e)(2).

Church Plan Exclusion

A church plan as defined by Sec. 414(e), of group term life maintained for church employees is not subject to the requirements of Sec. 79(d). However, employees of a church-supported institution of higher education, other than a school for religious training, or a non-profit medical or hospital facility, are not considered *church employees*, and such a plan must meet the nondiscrimination tests, according to Sec. 79(d)(7)(B)(ii).

Discrimination In Medical Plans-Age, Sex, Etc.

In General

As discussed elsewhere, the Internal Revenue Code requires self-funded health care plans to be non-discriminatory. There are, however, other federal nondiscriminatory laws which must not be violated:

- Age Discrimination in Employment Act (ADEA)
- Title VII of the Civil Rights Act of 1964
- Equal Pay Act
- Early Civil Rights Acts
- Statutes Relating to Federal Financial Aid
- Statutes Governing Federal Contractors
- Statutes Dealing with Veterans

Age Discrimination in Employment Act

Employers may not discriminate against the older workers with respect to compensation, terms, conditions or privileges of employment. This includes benefits.

Certain key features of the law should be cited:

- Employers of 20 full-time employees or more.
- Employers under 40 do not have the protection.
- Independent contractors and partners and board members are excluded.
- Benefit is narrowly construed. An opinion within a plan may be a benefit.
- All types of benefits are covered by the Act.
- Government employees are covered.
- Certain benefits, life insurance, e.g., may be reduced at higher ages (35% at 65, e.g.) but within guidelines established by regulations.
- Plan administration rules which impact unduly upon older employees are not permitted unless such impact is justified for *business necessity*.
- Two significant exceptions to the Act:
 1. Exception for reasonable factors other than age.
 2. Exception which is not a subterfuge to invoke the purposes of the law.

Title VII of the Civil Rights Act of 1964

The subject is compensation, terms, conditions and privileges of employment (as with ADEA Act); discrimination by sex, race, color, religion or national origin is prohibited.

Significant features of the Act are these:

- Employers with 15 or more employees are covered.
- Government employees are covered.
- Any employment discrimination must be defensible on grounds of business necessity.
- Law is enforced by the Equal Opportunity in Employment Commission.

Sex Discrimination. Allocating benefits solely on the basis of sex is prohibited; limiting benefits to only employees who are *head of household* or *principal wage earner* is prohibited. J.C. Penny was able to use the *head of household* rule, though by regulations discriminatory, on the grounds of business necessity. Actuarial assumptions, where applicable in benefits plans, must be based upon unisex tables.

Pregnancy Related Issues. When the Supreme court held that the sex discrimination section of the Civil Rights Act did not protect the pregnant worker, Congress reacted by passing the Pregnancy Discrimination Act of 1978. In effect the Act said pregnancy was to be treated as any other illness, which is medically not the case. Plans did not have to cover voluntary abortions; female employees and dependent wives are to be treated equally for benefit purposes; pregnancy coverage to dependent children is not mandated. Where the employer lends administrative support to an employee-pay-all relief association, it may be held financially liable for any acts or discrimination done by the association.

Recipients of Federal Financial Aid

Civil Rights Act of 1964. Recipients of any federal financial aid may not discriminate on the basis of race, age, sex, or national origin. This portion of the Civil Rights Act is regulated not by the EEOC but rather by particular federal agency making the funds available and coordinated by the Department of Justice.

Rehabilitation Act of 1973. Handicap discrimination is not permitted by this Act by any employer involved in any programs receiving federal assistance. The Department of Justice coordinates this Act. Employment discrimination includes employee benefits.

Federal Contractors

Executive Order 11246. An equal opportunity clause must be in contracts of \$10,000 or more with the federal government. Opportunity forbids discrimination by age, sex, race and national origin but not handicaps. Certain federal contractors must implement affirmative action programs.

Rehabilitation Act of 1973. Contractors with contracts in excess of \$2,500 per year must have an affirmative action program to hire the handicapped.

Vietnam Era Veterans Readjustment Assistance Act of 1974. Federal contracts with contractors in excess of \$10,000 must have an affirmative action program for Vietnam veterans.

Antiselection With Dual Option Plans

In General

Employees and HMO's are each in some way the suffers of antiselection in a dual option plan. Each party has taken some steps to control or minimize such antiselection.

Antiselection

When a participant has a choice of A or B, the selection will reflect the participant's best financial need. The result of such antiselection will be increased plan costs.

Typically the scenario with a dual option plan is as follows:

- **Employer's Indemnity Plan**

Older, sicker participants with established physician relationships stay with the indemnity plan. The others go to the HMO. Result: employer's indemnity plan has increased costs.

- **HMO Plan**

HMO plan offers benefits not normally found in indemnity plans:

Preventive Care Immunizations Infertility Services
Well Child Care Family Planning

These benefits attract the young families who are high users. Result: HMO's costs exceeds their estimate because they were selected against.

Federal HMO Act

This federal law has certain requirements which affect antiselection. This act applies only to federally qualified HMO's and only to certain employers (25 or more employees). The principal requirement of the act is that a choice between an indemnity and an HMO plan must be given where there is an HMO, federally licensed, that serves the area.

Minimizing Effects of Antiselection

There are a number of methods currently in use which are aimed at controlling the antiselection.

Data Review. This method involves direct employer review of who are the high utilizers and for what reasons as between the indemnity and the HMO plan. Legal difficulties arise at once in that such analysis may be in violation of state privacy laws as well as federal HMO law on privacy. The review of data is acceptable, of course, but the naming of the person and the disease should be avoided.

Single Option. This method involves offering the participants only the indemnity plan as a group; or the HMO plan as a group.

Costing Methods. Indemnity plan cost sharing is helpful to the employer and is desired by the employer. Certain rules regarding contributions are acceptable:

- Employee contributions to the indemnity plan and the HMO are equal.
- Classifying participants into groups such as age, sex, family status, and health status and giving same amount for each group to both the HMO and the indemnity plan.
- If employees must contribute \$50 per month to the indemnity plan, then contribution to the HMO may not exceed 150% or \$75.
- Employer contributes X% of the cost to each plan.
- Employer negotiates premium for each of the HMO and the indemnity plan.

NOTE: Federal law may be met with the pricing formula and not state law.

Single Carrier Option. The single carrier has both an indemnity and an HMO plan which, as a goal, should reduce both administrative costs and anti-selection. Reason: one carrier bears the full risk. There are practical difficulties with this method: geographic restrictions, need to offer both staff model as well as an IPA model where available, e.g.. Employer sees only a single cost.

Shared-Risk and Multiple Carriers. A syndicate, so to speak, of carriers and HMO's may be formed to offer a single unified package. The result, as with the single option, is a single cost. The difficulty with a syndicate approach is that the insurers rate on experience while the HMO must rate, by law, with a community rate by an employer group on a prospectus basis.

Minimize Differences. The indemnity plan and the HMO plan may approach *look alike*s with these changes:

- **Indemnity Plan**
Add a PPO

- **HMO**
Permit participants to use non-HMO providers with regular copays and deductibles. There are limits (10%, e.g.) for which HMO's costs may be for non-member services.