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Nonqualified Deferred Compensation Plans Must Be Amended by December 31, 2020, to Remove Mandatory Payment Delays due to 162(m) Nondeductibility

J. MARC FOSSE

OCTOBER 2020

The amendments to section 162(m) of the Internal Revenue Code ("Code") under the Tax Cuts and Jobs Act (TCJA) can create a payment trap for nonqualified deferred compensation plans with a mandatory payment delay of amounts that are not deductible under Code section 162(m). The proposed Treasury Regulations under Code section 162(m) permit employers to remove these provisions from a plan by December 31, 2020, and the removal amendment will not be treated as causing an accelerated payment under the Code section 409A regulations.

Permitted Payment Delay

Treasury Regulation § 1.409A-2(b)(7)(i), provides an employer with discretion to delay payment from a nonqualified deferred compensation plan past the

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designated payment event or date if the employer reasonably anticipates that the scheduled payment would not be deductible. Under Code section 162(m), a payment to a covered employee in excess of $1,000,000 is not deductible. In general, a covered employee is the CEO, CFO and other top three highest paid executives at a publicly traded company. If the nondeductible payment is delayed, it must be paid no later than the first taxable year in which the deduction of such payment will not be barred by the application of Code section 162(m).

Pre-TCJA Treatment

Before the Tax Cuts and Jobs Act, a covered employee in one taxable year was not necessarily a covered employee in a subsequent taxable year and was no longer treated as a covered employee for a taxable year once the employee terminated employment. Therefore, a nondeductible payment delayed under Code section 409A would eventually become deductible, and payable, when either the payment no longer caused the executive to have compensation in excess of $1,000,000 in a single tax year or the executive was no longer a covered employee. Based on those rules, it was certain that at some point in the future the delayed payment would become deductible and payable.

Post-TCJA Potential Payment Trap

The TCJA amendments to Code section 162(m) changed the definition of "covered employee" so that once a person becomes a covered employee, the person remains a covered employee for all subsequent years. After this amendment, there is the potential that a nondeductible payment delayed under a nonqualified deferred compensation plan would never become deductible, or payable, because the employee will always be a covered employee. Consistent with the Code section 409A regulations, most nonqualified deferred compensation plans give the employer discretion to decide whether or not to delay payment of an amount that was not deductible under Code section 162(m). These plans do not need to be amended because the company can simply elect not to delay the payment timing. However, some plans provide for mandatory payment delays if the payment is not deductible under Code section 162(m). These plans should be amended to avoid the potential payment trap described above.

Limited Regulatory Relief

The preamble to the proposed 162(m) regulations states that a nonqualified deferred compensation plan may be amended to remove a mandatory payment delay for payments that are not deductible under Section 162(m). Generally, such an amendment would cause a payment acceleration under Code section 409A. However, the preamble states that the amendment will not be treated as causing an accelerated distribution if the amendment is made on or before December 31, 2020.

Next Steps

Employers should review their nonqualified deferred compensation arrangements to determine if the plan mandates a payment delay for distributions that the employer anticipates will not be deductible under Code section 162(m). If so, the plan must be amended by December 31, 2020, to avoid the potential payment trap for payments that may not become deductible under Code section 162(m).

New Proposed Rule Regarding Grandfathered Plans

SARAH KANTER

OCTOBER 2020

A new proposed rule (the "Proposed Rule"), released by the Departments of Treasury, Labor, and Health and Human Services (HHS) (the "Departments") on July 10, 2020, would permit grandfathered group health plans and grandfathered group health insurance coverage ("grandfathered plans") to make greater increases to certain types of cost-sharing requirements without resulting in a loss of grandfathered status. This article provides an overview of the current rules regarding grandfathered plans (including how grandfathered status is lost), and a description of the Proposed Rule. This article also discusses a recently issued FAQ regarding how certain coverage provided by grandfathered plans during the COVID-19 public emergency period impact a plan's grandfathered status.

Grandfathered Plans – An Overview

The Patient Protection and Affordable Care Act (ACA) dramatically transformed the healthcare landscape in America, impacting both access to health plan coverage and the rules regarding health plan coverage. With regard to the latter, the ACA ushered in a broad array of consumer protections including (among others): the elimination of pre-existing condition exclusions; coverage of dependent children up to age 26; and the elimination of annual and lifetime limits on benefits.

In an effort to mitigate some of the resulting disruption for plan sponsors and insurers, the ACA also generally provides that certain group health plans and health insurance coverage existing as of March 23, 2010 (the date of the enactment of the ACA — i.e., grandfathered plans) are subject to some of these consumer protections (such as the three listed above), but not all. As is explained in greater detail below, grandfathered plans can lose their grandfathered "status" in a number of ways (mainly related to eliminating benefits or increasing cost-sharing). Once grandfathered status is lost, it cannot be regained.

The expectation was that, over time, more and more plans lose grandfathered status, and this has indeed been borne out by experience. A report by the Kaiser Family Foundation estimates that in 2011, 56% of covered workers were enrolled in a grandfathered plan.[1] As of 2019, this percentage had decreased to only 13%, with 22% of firms that offer health benefits offering at least one grandfathered plan. A 2018 survey by the International Foundation of Employee Benefit Plans (IFEBP) estimated that 57% of multiemployer plans were grandfathered, compared with 20% of private sector plans,[2] and 30% of public sector plans.

Current Rules

Grandfathered plans are required to comply with many of the ACA's requirements (e.g., coverage of dependent children up to age 26, prohibition on annual and lifetime limits). However, they are not required to comply with other provisions such as (this is a non-exhaustive list):

- Coverage of preventive service without cost-sharing (e.g., contraceptive coverage);
- Annual limitation on cost-sharing;
- Coverage for individuals participating in approved clinical trials;
- Additional requirements for internal claims procedures, and external review of certain adverse benefit determinations; and

- Prohibition of prior authorization or increased cost-sharing for out of-network emergency services.

In 2015, the Departments released a final rule regarding grandfathered plans (the "2015 Final Rule"). Under the 2015 Final Rule, a group health plan or group health insurance coverage is considered grandfathered if it has continuously provided coverage for someone (not necessarily the same person, but at all times at least one person) since March 23, 2010, and if it has not taken certain actions. Grandfathered status is determined separately for each benefit package under a group health plan. The actions that can cause a plan to lose grandfathered status include the following:

- The elimination of all or substantially all benefits to diagnose or treat a particular condition;
- Any increase in a percentage cost-sharing requirement (such as co-insurance);
- Any increase in a fixed-amount cost-sharing requirement (other than a copayment) such as a deductible or out-of-pocket maximum that exceeds certain thresholds (explained below);
- Any increase in a fixed-amount copayment that exceeds certain thresholds (explained below);
- A decrease in contribution rate by an employer or employee organization toward the cost of coverage of more than five percentage points below the contribution rate for the coverage period that includes March 23, 2010; or
- The imposition of annual limits on the dollar value of all benefits for group health plans and insurance coverage that did not impose such a limit prior to March 23, 2010.

A grandfathered plan will lose its grandfathered status if there is an increase in a fixed amount cost-sharing requirement (other than a copayment) since March 23, 2010 that is greater than the "maximum percentage increase." The maximum percentage increase is defined as "medical inflation" from March 23, 2010 plus 15%. For this purpose, "medical inflation" is defined by reference to the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted (CPI-U) published by the Department of Labor using the 1982–1984 base of 100.[3]

A grandfathered plan will lose its grandfathered status if there is an increase in a copayment amount that exceeds the greater of: (1) the maximum percentage increase (as defined above); or (2) five dollars increased by medical inflation.

Under the 2015 Final Rule, grandfathered plans are required to include a statement in any summary of benefits provided under the plan that it believes the plan or coverage is a grandfathered health plan. Failure to provide this disclosure results in a loss of grandfathered status.

The Proposed Rule

The Proposed Rule would amend the 2015 Final Rule in two ways that are described below:

I. Special Rule for Grandfathered Plans That Are HDHPs

The Proposed Rule would permit grandfathered plans that are high deductible health plans (HDHPs) to make changes to fixed amount cost-sharing requirements that would otherwise cause a loss of grandfathered status, without causing a loss of grandfathered status, but only to the extent those changes are necessary to comply with the requirements for HDHPs under Section 223(c)(2) of the Code.

Section 223 of the Code permits "eligible individuals" to establish and contribute to Health Savings Accounts (HSAs). HSAs are tax-favored accounts established for the purpose of providing tax benefits to pay for qualified medical expenses on behalf of the account beneficiary, his or her spouse and dependents. Among the requirements for an individual to qualify as an "eligible individual" under the Code is the requirement that an individual be covered under a "high deductible health plan" (HDHP). An HDHP is a health plan that meets certain requirements

with respect to minimum deductibles and maximum out-of-pocket expenses, both of which increase annually with cost-of-living adjustments. The minimum deductible and maximum out-of-pocket limit for an HDHP is adjusted annually for cost of living based on changes in the CPI-U and is published annually by the Internal Revenue Service (IRS).[4]

Because a grandfathered plan loses its grandfathered status if an increase to any fixed-amount cost-sharing requirement (such as a deductible or out-of-pocket maximum) exceeds the maximum percentage increase (i.e., medical inflation plus 15%), plan sponsors of grandfathered plans that are HDHPs were concerned that the average cost of living increase for the minimum deductible and out-of-pocket maximum required to qualify as an HDHP could potentially exceed the maximum percentage increase. This would result in plan sponsors being required to choose between preserving the plan's status as a grandfathered plan or its status as an HDHP. Interestingly, as the preamble to the Proposed Rule notes, the annual cost-of living adjustment to the required minimum deductible for an HDHP has not yet exceeded the maximum percentage increase that would cause an HDHP to lose grandfathered status. Nevertheless, the Departments stated that they wanted to "provide assurance" to grandfathered plan sponsors that, in the future, they would not be faced with a choice between a plan's HDHP status and grandfathered status.

II. Revised Definition of "Maximum Percentage Increase"

A grandfathered health plan will lose its grandfathered status if there is an increase in a fixed amount cost-sharing requirement since March 23, 2010 that is greater than the "maximum percentage increase." As explained above, this currently means medical inflation plus 15% — and, as noted, medical inflation means the increase since March 2010 in the overall medical care component of the CPI-U.

The Proposed Rule would define "maximum percentage increase" to be the ***greater*** of (1) medical inflation plus 15% (i.e., the current rule); or (2) the portion of the "premium adjustment percentage" that reflects the relative change between 2013[5] and the calendar year prior to the effective date of the increase. The premium adjustment percentage is a measure of premium growth that is set by the Secretary of Health and Human Services and used to set the rate increase for three parameters detailed in the ACA.[6] According to *Health Affairs*, the premium adjustment percentage will be about three percentage points higher than medical inflation in 2026, meaning that if the Proposed Rule were adopted, fixed-amount co-pays, deductibles and out-of-pocket limits could, in 2026, be three percentage points higher than would otherwise be permitted under the current rule, without causing a loss of grandfathered status.[7]

In the Departments' view, the premium adjustment percentage better reflects the increase in underlying costs for grandfathered plans, since the overall medical care component of CPI-U reflects changes for private insurance, self-pay patients and Medicare — none of which would be reflected in in those underlying costs. The Departments also stated that because the premium adjustment percentage is a measure with which plan sponsors are already familiar, it would result in administrative simplicity.

Written comments were required to have been submitted by August 14, 2020. The Departments received 12 comments, primarily from industry groups and associations, the bulk of which urged the Department to withdraw the Proposed Rule.

Whether or not the Proposed Rule is ever released as a final rule will likely hinge on the results of the 2020 presidential election, as it is unclear whether a Biden Administration would have an appetite for this kind of change. Additionally, the Proposed Rule may become moot if the Supreme Court determines that the ACA is unconstitutional in its upcoming case, *California v. Texas*. Oral arguments for this case are scheduled to be heard on November 10, 2020, and a decision is expected in 2021.

FAQ Regarding Coverage of Coronavirus Treatment, Testing, and Telehealth — Impact on Grandfathered Status

Under the Families First Coronavirus Response Act (the FFCRA) and the Coronavirus Aid, Relief and Economic Security Act (the "CARES Act"), group health plans (including grandfathered plans) are required to cover certain items and services related to diagnostic testing for the diagnosis of COVID-19, without cost-sharing, prior authorization or other medical management requirements. Plans must comply with this requirement during the public health emergency related to COVID-19. Additionally, as a result of COVID-19, many group health plans have been amended to provide treatment for COVID-19 without cost-sharing (or with reduced cost-sharing), and to promote the use of telehealth or other remote care services through the addition of benefits, or the reduction or elimination of cost-sharing.

As a result, many plan sponsors of grandfathered plans are questioning whether their plan can be amended to eliminate these benefits without losing grandfathered status once the COVID-19 public health emergency is over. (One of the ways a grandfathered plan can lose its grandfathered status is by the elimination of all or substantially all benefits to diagnose or treat a particular condition.)

In an FAQ released on June 23, 2020, the Departments have now answered this question. The FAQ provides that: To the extent that a plan or issuer added benefits, or reduced or eliminated cost-sharing requirements, for the diagnosis and treatment of COVID-19 or for telehealth and other remote care services during the public health or national emergency period related to COVID-19, the plan or coverage would NOT lose its grandfathered status solely because those changes are later reversed, thereby restoring the terms of the plan or coverage that were in effect prior to the applicable emergency period.[8]

If you have any questions regarding this article please contact the author.

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[1] Available at www.kff.org/report-section/ehbs-2019-section-13-grandfathered-health-plans/

[2] IFEBP Employee Benefit Plans Survey 2018 Results.

[3] The CPI is a measure of the average change overtime in the prices paid by urban consumers for a market basket of consumer goods and services. It is published by the U.S. Bureau of Labor Statistics (BLS) on a monthly basis. Most CPI index series have a 1982–84=100 reference base. This means that BLS sets the average index level (representing the average price level) for the 36-month period covering the years 1982, 1983, and 1984 equal to 100; then measures changes in relation to that figure. The medical care component of the CPI-U is a measure of the average change over time in the prices paid by urban consumers for medical care.

[4] For example, in 2020, a HDHP is a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage, for which the annual out-of-pocket expenses (deductibles, copayments and other amounts, but not premiums) do not exceed $6,900 for self-only coverage, and $13,800 for family coverage.

[5] The premium adjustment percentage does not capture growth from 2010 to 2013.

[6] These include: the maximum annual limitation on cost-sharing; the required contribution percentage used to determine eligibility for certain exemptions under Code Section 5000A; and the employer shared responsibility payment amounts.

[7] "New Proposed Rule On Grandfathered Plans; Court Strikes Abortion Double Billing Rule," Health Affairs Blog, July 13, 2020. Available at www.healthaffairs.org/do/10.1377/hblog20200713.885651/full/

[8] FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act, Part 42, Q&A 15.

FIRM NEWS

On September 18, **Tiffany Santos** presented a webinar, *Cobra Compliance in the New COVID-19 Legal Environment,* to the Golden Gate Chapter of the Association of Legal Administrators (ALA). Tiffany discussed how the COVID public health crisis has engendered significant new legislation, impacting employers' obligations in the administration of employee benefits.

On October 28, **Katuri Kaye** will moderate a panel discussion at the Pension & Investments DCW Series, *Striving for Success — Plan Administration Best Practices*. Panelists will share tips on managing plan document maintenance, such as Form 5500 reporting and nondiscrimination testing, how to better manage multiple tasks and deadlines that an employer needs to complete on a timely basis, and utilizing DC service providers in a more efficient manner. Katuri will also be a speaker during the roundtable.

On November 19, **Marc Fosse** will join a panel of speakers on a Strafford live webinar, *IRC 83(i) Election Qualified Equity Grants: Deferral Opportunities for Stock Options and RSUs*. The panelists will discuss adopting a qualified equity grant plan, employee eligibility and inclusion, taxation of the deferred transfer, risks of the election, practical administrative issues, and other significant concepts.

On November 13–16, **Freeman Levinrad** will present the following sessions for the American Society of Pension Professionals & Actuaries at ASPPAs ALL ACCESS:

- Friday, November 13, 2-2:50 p.m. ET:
  Correcting DB Plan Errors — EPCRS Part I
  Take a close look at how EPCRS covers defined benefit issues, including certain rules only applicable to DB plans. We'll highlight common plan errors and corrections.
- Friday, November 13, 3-3:50 p.m. ET:
  DB EPCRS Case Studies Part II
  With real-life case studies and examples, learn about the self-correction and VCP submission process. Review applicable EPCRS case studies as they apply to Defined Benefit Plans.
- Monday, November 16, 3-3:50 p.m. ET:
  Watch Out! — Trends in DOL and IRS Audits
  Help your clients be ready when the DOL or IRS comes knocking. DOL investigations and IRS audits are on the rise. This session will look at examination trends and initiatives, and provide real life examples that can help TPAs be better prepared to guide clients through the investigation/audit process.

The Trucker ✦ Huss *Benefits Report* is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

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