Welcome! We will begin at 3:00 ET.

There will be no sound until we begin the webinar.

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July 20, 2023

Employee Benefit Regulatory Update

Presented by Benefit Comply

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Agenda

- End of Public and National Emergency Rules
- Braidwood Preventive Care Court Case
- Gag Clause Attestation Update
- PCORI reminder
- Questionable Wellness Programs/IRS Memo
- Regulatory Issues
  - New proposed Regs on indemnity

End of National & Public Health Emergencies

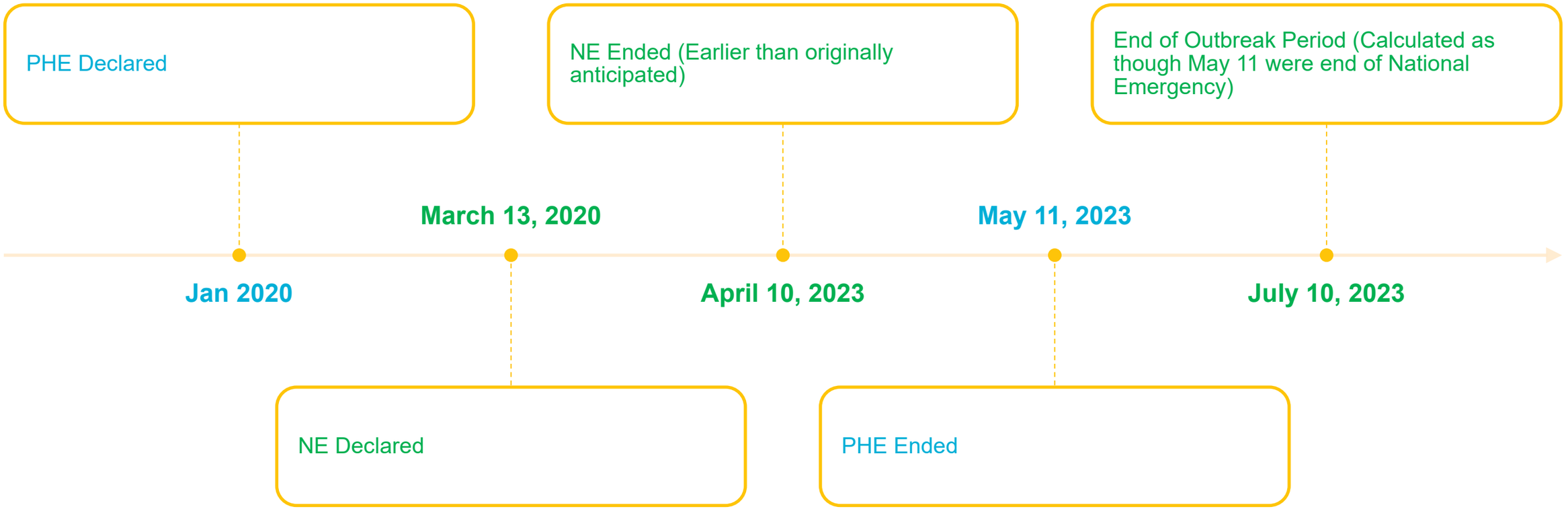
National Emergency & Public Health Emergency

- **Two Different Pandemic-Related "Emergencies"**
  - National Emergency (NE)
    - First Declared by President Trump March 2020 and renewed annually since then
    - Various benefit related deadlines suspended during Outbreak Period
    - Outbreak Period = National Emergency + 60 days
  - Public Health Emergency (PHE)
    - Declared by the Dept. of Health and Human Services January 2020 and renewed every three months
    - Plan coverage for COVID vaccination and testing, stand-alone telehealth, Medicaid rules

National Emergency – Extended Deadlines

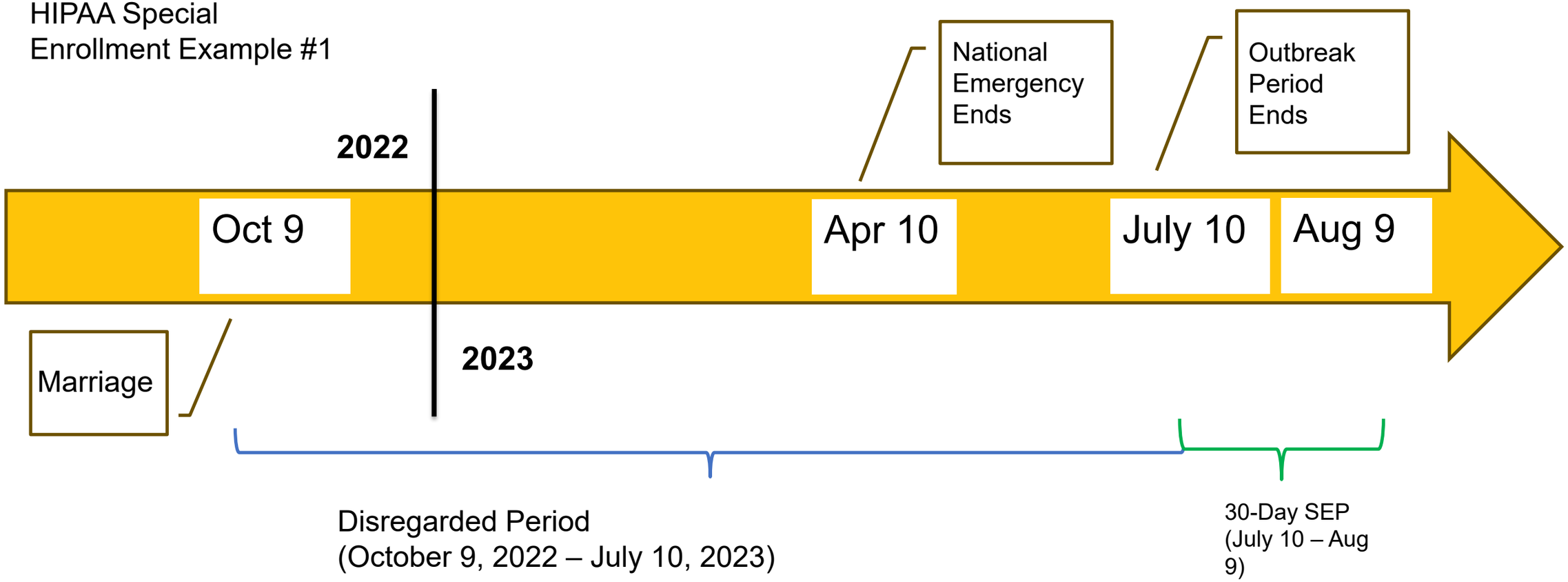
- From March 1, 2020 until 60 days after the National Emergency is over (i.e., the "Outbreak Period"), group health plans had to disregard this time period when administering plans and allowing employees and other plan participants to exercise certain rights
  - HIPAA Special Enrollment
  - COBRA Election
  - COBRA Premium Payment
  - Etc.
- Deadlines delayed until the earlier of:
  - 12 months from the original deadline; or
  - End of the outbreak period
- This structure ensured the "Disregarded Period" never lasted more than 1 year
- Original deadline period begins to run once the disregarded period is over

PHE and National Emergency Timelines



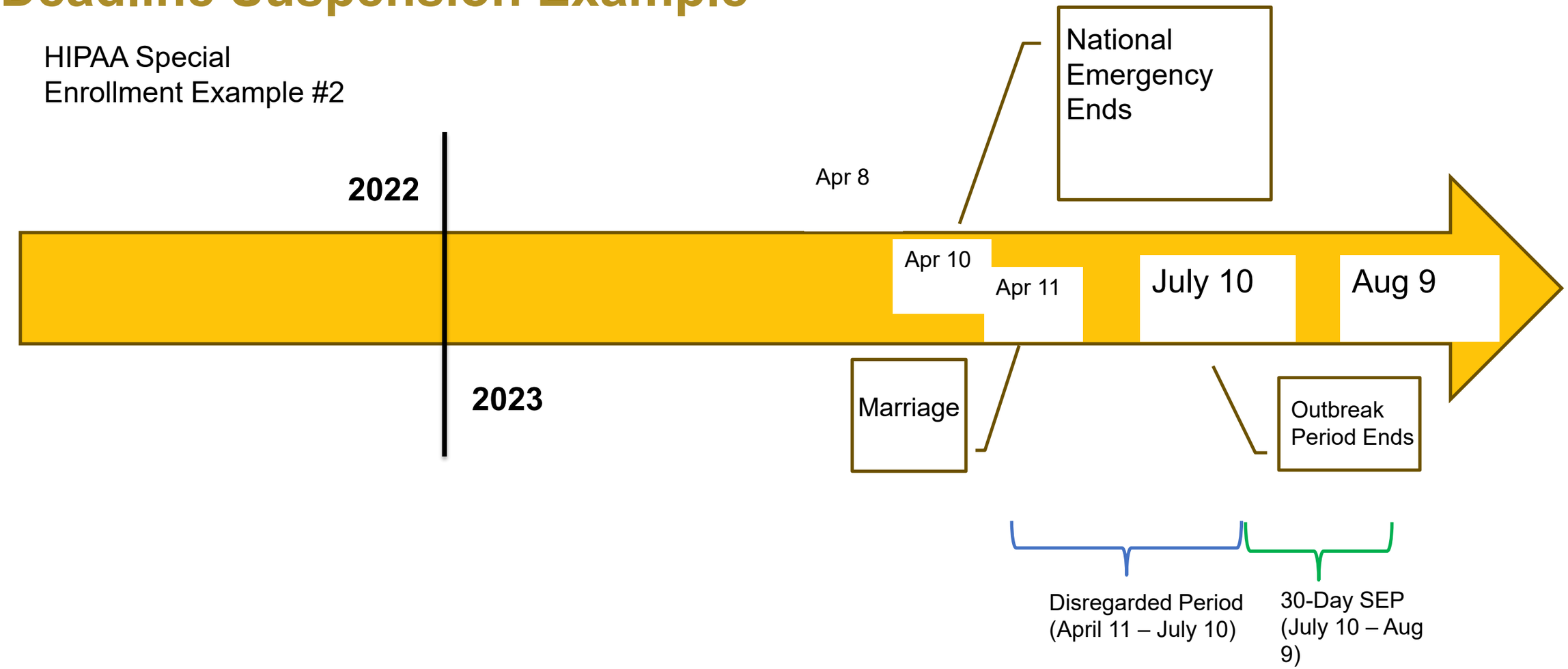
Deadline Suspension Example

HIPAA Special
Enrollment Example #1



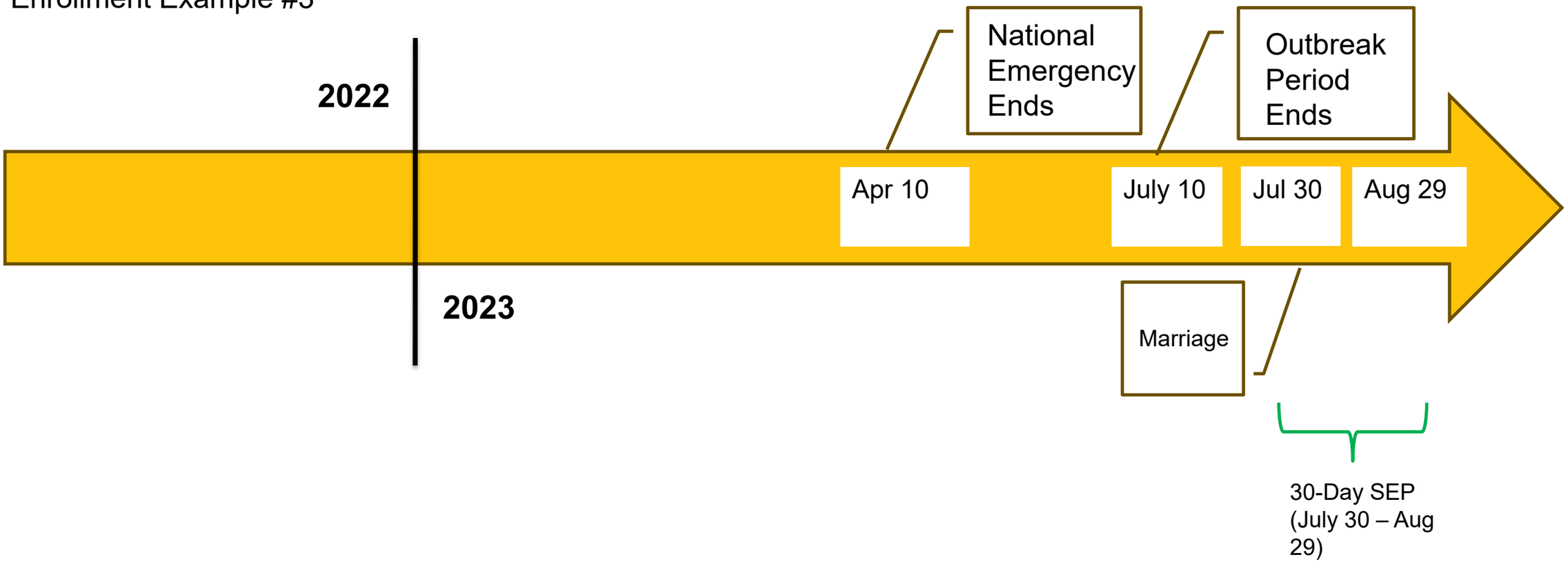
Deadline Suspension Example

HIPAA Special
Enrollment Example #2

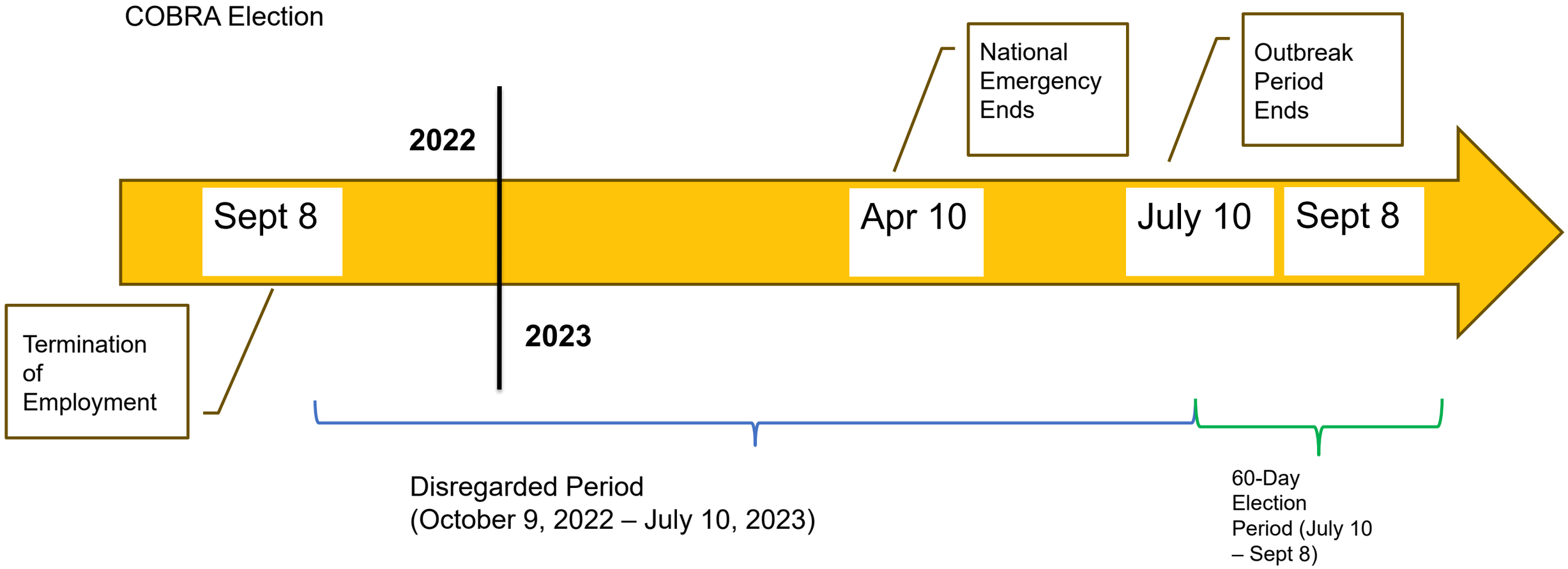


Deadline Suspension Example

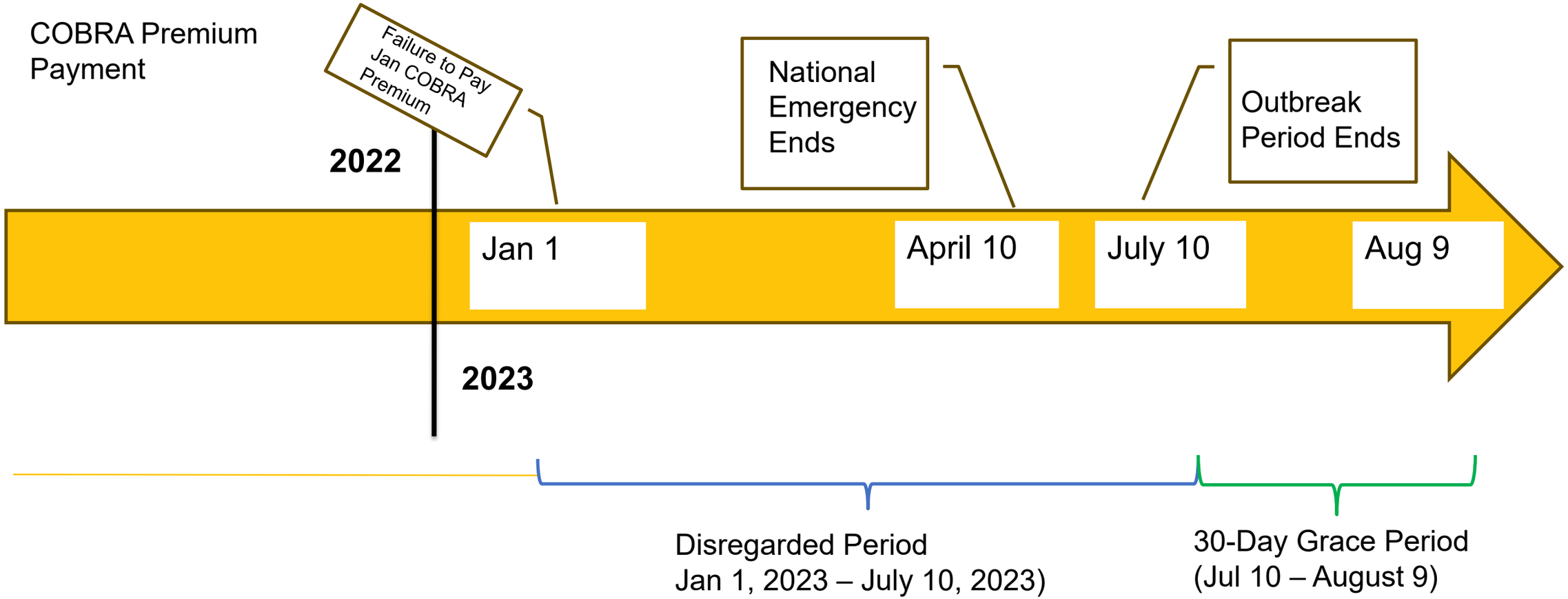
HIPAA Special
Enrollment Example #3



Deadline Suspension Example



Deadline Suspension Example



Braidwood – Preventive Care Case

Braidwood – An Overview

- Background of *Braidwood Management Inc. v. Becerra*
  - U.S District Judge Reed O'Connor of the US District Court in the Northern District of Texas ruled that parts of the ACA preventive coverage requirement are unconstitutional and violated the plaintiffs' religious rights
    - March 30, 2023 – Nationwide injunction issued preventing government from enforcing parts of ACA's preventive services mandate
- May 15, 2023 - Fifth Circuit Court of Appeals issued an administrative stay on the enforcement of district court's decision
  - For now, the ACA requirement for coverage of preventive care without cost-sharing is back in full force while the case continues to proceed in court
  - A final decision from the Fifth Circuit on this case is expected later this year

ACA Preventive Services Mandate – The Basics

- Non-grandfathered individual and group health plans are required to cover those items considered to be preventive under the ACA (PHSA §2713) without imposing any cost-sharing
  - Effective for plan years beginning on or after September 23, 2010
  - Coverage is required only for in-network services (if plan maintains a network)
  - Plans may use reasonable medical management techniques to determine coverage limitations (if they do not conflict with the recommendations)
  - Plans must cover items and services that are integral to the furnishing of a recommended preventive service, regardless of whether the item or service is billed separately

What Services are Considered Preventive?

1. Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF)
2. Immunizations for routine use recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention
3. Preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents
4. Preventive care and screenings for women not included in the USPSTF recommendations but provided for in comprehensive guidelines supported by HRSA

Impact of Braidwood Decision

- Departments' FAQ Part 59 Released April 13
  - If the Fifth Circuit Court of Appeals upholds the decision, it would prevent the Departments from enforcing PHS Act coverage requirements for items and services recommended with an "A" or "B" rating by the USPSTF on or after March 23, 2010
    - Items/services recommended before March 23, 2010 would continue to require coverage
  - The decision does not affect requirements related to immunizations recommended by ACIP and preventive care and screenings provided for in guidance supported by HRSA
  - State Insurance Laws
    - May continue to require fully-insured plans to continue coverage for these preventive services
  - Participant Notice Requirements for mid-year changes
  - A high deductible health plan (HDHP) may still provide pre-deductible coverage of preventive services with an "A" or "B" rating without adversely impacting an individual's HSA eligibility

Impact of Braidwood Decision (Cont.)

- Fully-insured employers
  - Will depend on the decisions made by their carrier
- Self-insured employers
  - Could change plans to impose copays or deductibles – or even choose not to cover preventive services impacted by the ruling
- Participant Notice Requirements
  - 60-day advance notice only required if a change is made to content of most recent SBC
  - Other reductions in coverage likely require a Summary of Material Modifications (SMM) and/or update of the Summary plan Description (SPD)

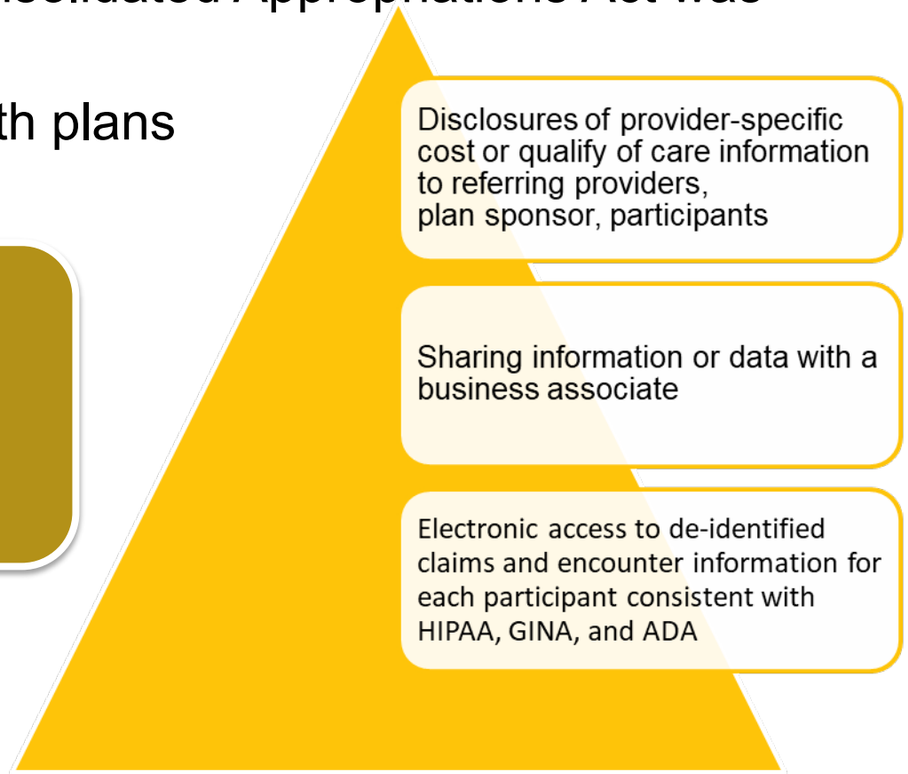
Gag Clause Attestation Update

Gag Clause Prohibitions

- The Prohibition – carriers and plans cannot enter into agreements with providers, TPAs, or other service providers that contain gag clauses
  - Effective as of December 27, 2020 when 2021 Consolidated Appropriations Act was passed
  - Applicable to virtually all employer-sponsored health plans
- What is a Gag Clause?

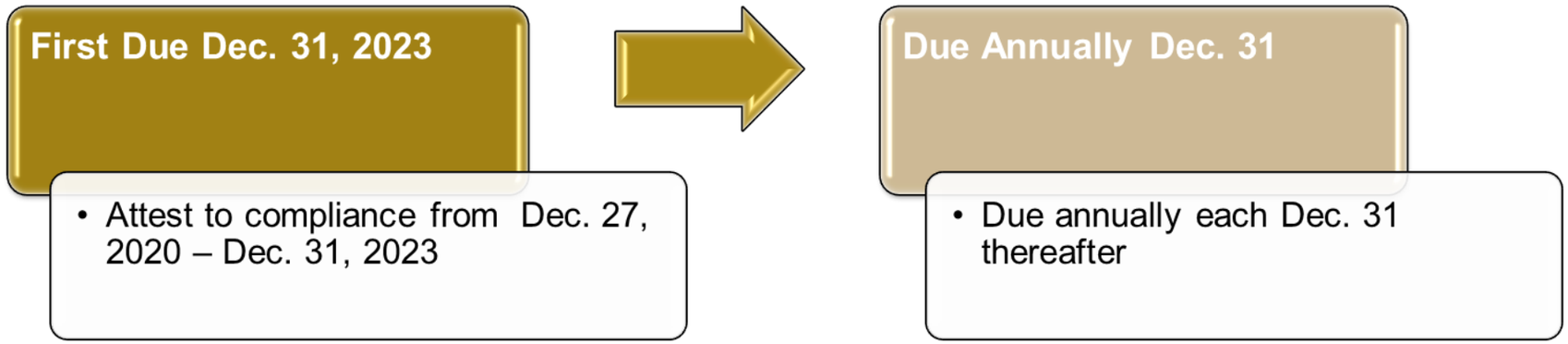
Contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party

Note: there is room for debate on what constitutes a gag clause for these purposes



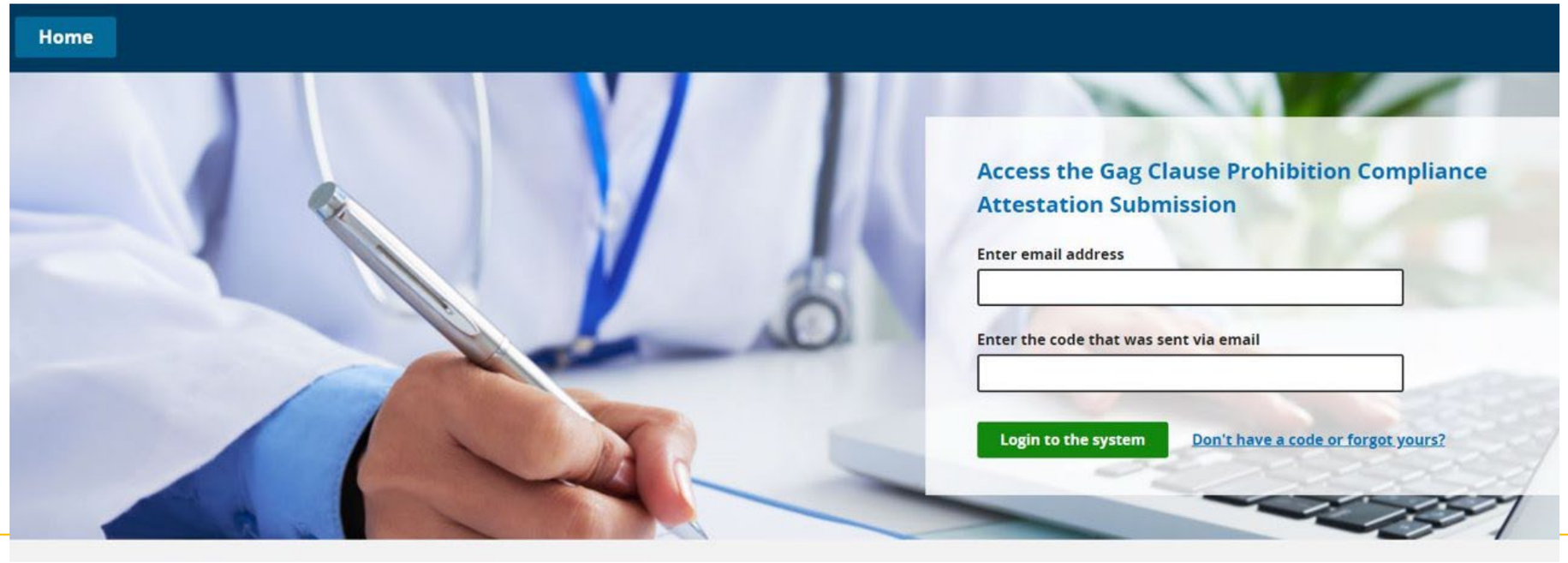
Gag Clause Attestation

- The Attestation - plans are required to attest to their compliance with the prohibition on gag clauses
- Applicable to virtually all employer-sponsored health plans
  - Including fully-insured, self-funded, grandfathered and grandmothered plans, regardless of employer/plan size
  - NOT applicable to excepted benefits or account-based plans (e.g., HRAs)



Gag Clause Attestation - Responsibility

- Most employers will be able to rely on their carrier or TPA to handle the attestation
  - Employers should have something in writing indicating the carrier/TPA's compliance
- Employers handling their own contracts will need to attest on their own
  - https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance



PCORI Fee Reminder

PCORI Fee Refresher

- A fee paid by insurers and sponsors of self-funded plans to help fund the Patient-Centered Outcomes Research Institute
  - Applies to most group health plans; NOT excepted benefits
    - Carriers will take care of the fee for fully-insured plans
- Reported on and paid for using Form 720 (a quarterly excise tax form)
  - Fee is calculated by multiplying the plan's average covered lives by the applicable fee
  - Deadline for PCORI payment: July 31 of the year following the last day of the plan year
    - Plan year of 2/1/2022-1/31/2023 - PCORI deadline is July 31, 2024
    - Plan year of 1/1/2022-12/31/2022 - PCORI deadline is July 31, 2023

PCORI Fee FAQs

- PCORI fee must be reported on/paid for in the second quarter Form 720 for the applicable year
  - IRS did not release the updated Form 720 for this year until mid-June; it is necessary to wait for that updated form each year
- For missed PCORI fees from previous plan years...
  - A separate Form 720 should be filed for each missed plan year – fees for multiple plan years generally should NOT be combined on the same Form 720
    - Unless multiple plan years have the same due date, e.g., if there is a short plan year
  - Use the Form 720 for the applicable missing year (or Form 720X, if it is an amendment)
    - https://www.irs.gov/prior-year-forms-and-instructions?find=720&items_per_page=200

IRS Office of Chief Counsel Memoranda - Tax Treatment of Questionable Wellness Programs

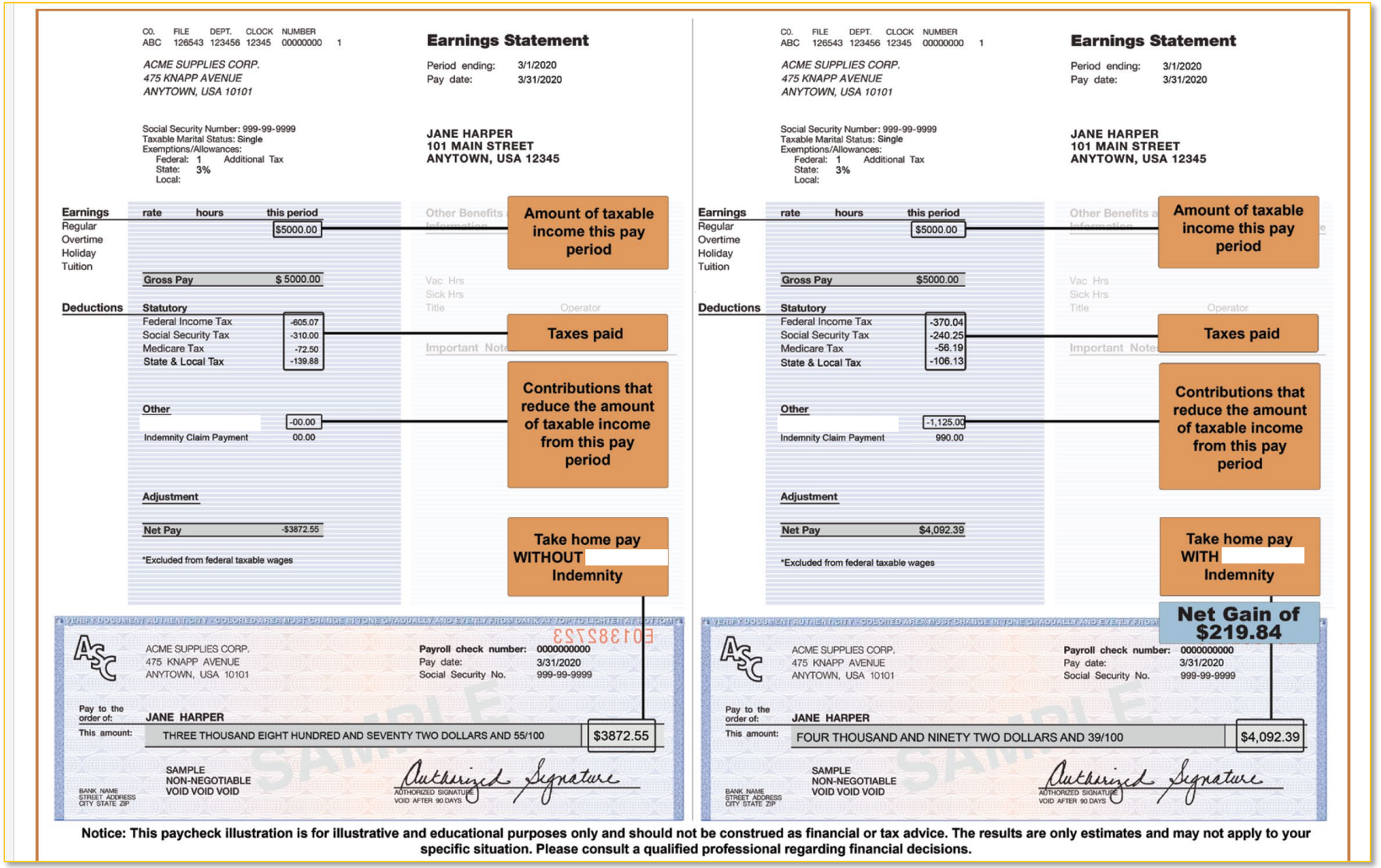
Office of the Chief Counsel Memorandum #202323006

- Overview
  - An arrangement that claimed significant tax savings and “free” benefits to employees through a “wellness plan” payment arrangement was not legitimate
- What is a Chief Counsel Memorandum?
  - Office of Chief Counsel memoranda are issued to provide legal opinions on certain matters to internal IRS staff. While they cannot be used or cited as precedent, they represent the Service’s interpretation regarding the specific legal issues addressed in the memo.

Office of Chief Counsel
Internal Revenue Service
memorandum

Office of the Chief Counsel Memorandum #202323006

- Basics of Plan Addressed by Memo
  - Employees paid $1,200/mo. for a fixed-indemnity health insurance policy pre-tax salary through a §125 cafeteria plan
  - The policy provided a “wellness benefit” payment of $1,000 per month if an employee participates in certain health or wellness activities
    - The fixed-indemnity policy provides wellness counseling, nutrition counseling, and telehealth benefits at no additional cost to employee
    - Use of preventive care under a health plan qualified the employee for the payment even though the care was covered by the employee’s health plan
  - The “plan” also included per day hospital indemnity benefit


CO. FILE DEPT. CLOCK NUMBER
ABC 126543 123456 12345 00000000 1
ACME SUPPLIES CORP.
475 KNAPP AVENUE
ANYTOWN, USA 10101
Earnings Statement
Period ending: 3/1/2020
Pay date: 3/31/2020
Social Security Number: 999-99-9999
Taxable Marital Status: Single
Exemptions/Allowances:
Federal: 1 Additional Tax
State: 3%
Local:
JANE HARPER
101 MAIN STREET
ANYTOWN, USA 12345
Earnings rate hours this period
Regular $5000.00
Overtime
Holiday
Tuition
Gross Pay $ 5000.00
Deductions Statutory
Federal Income Tax -605.07
Social Security Tax -310.00
Medicare Tax -72.50
State & Local Tax -139.88
Other -00.00
Indemnity Claim Payment 00.00
Adjustment
Net Pay -$3872.55
*Excluded from federal taxable wages
Amount of taxable income this pay period
Taxes paid
Contributions that reduce the amount of taxable income from this pay period
Take home pay WITHOUT Indemnity
ACME SUPPLIES CORP.
475 KNAPP AVENUE
ANYTOWN, USA 10101
Payroll check number: 0000000000
Pay date: 3/31/2020
Social Security No. 999-99-9999
Pay to the order of: JANE HARPER
This amount: THREE THOUSAND EIGHT HUNDRED AND SEVENTY TWO DOLLARS AND 55/100 $3872.55
SAMPLE
NON-NEGOTIABLE
VOID VOID VOID
Authorized Signature
CO. FILE DEPT. CLOCK NUMBER
ABC 126543 123456 12345 00000000 1
ACME SUPPLIES CORP.
475 KNAPP AVENUE
ANYTOWN, USA 10101
Earnings Statement
Period ending: 3/1/2020
Pay date: 3/31/2020
Social Security Number: 999-99-9999
Taxable Marital Status: Single
Exemptions/Allowances:
Federal: 1 Additional Tax
State: 3%
Local:
JANE HARPER
101 MAIN STREET
ANYTOWN, USA 12345
Earnings rate hours this period
Regular $5000.00
Overtime
Holiday
Tuition
Gross Pay $5000.00
Deductions Statutory
Federal Income Tax -370.04
Social Security Tax -240.25
Medicare Tax -56.19
State & Local Tax -106.13
Other -1,125.00
Indemnity Claim Payment 990.00
Adjustment
Net Pay $4,092.39
*Excluded from federal taxable wages
Amount of taxable income this pay period
Taxes paid
Contributions that reduce the amount of taxable income from this pay period
Take home pay WITH Indemnity
Net Gain of $219.84
ACME SUPPLIES CORP.
475 KNAPP AVENUE
ANYTOWN, USA 10101
Payroll check number: 0000000000
Pay date: 3/31/2020
Social Security No. 999-99-9999
Pay to the order of: JANE HARPER
This amount: FOUR THOUSAND AND NINETY TWO DOLLARS AND 39/100 $4,092.39
SAMPLE
NON-NEGOTIABLE
VOID VOID VOID
Authorized Signature
Notice: This paycheck illustration is for illustrative and educational purposes only and should not be construed as financial or tax advice. The results are only estimates and may not apply to your specific situation. Please consult a qualified professional regarding financial decisions.

Office of the Chief Counsel Memorandum #202323006

- IRS Conclusion
  - Payments (including those described as “wellness payments”) under a fixed-indemnity insurance policy, where the premium is paid by employee pre-tax salary reduction through a cafeteria plan should be treated as taxable income to the employee…
  - Employer cannot provide tax free benefits payments to employees:
    - When the taxpayer would be entitled to receive the payment irrespective of whether expenses for medical care are actually incurred
    - When the employee has no unreimbursed medical expense (either because the activity that triggers the payment does not cost the employee anything or because the cost of the activity is reimbursed by other coverage)

Not the First Time

- IRS has issued opinions on similar issues before…
  - Chief Counsel Memoranda 201622031 (05/27/2016) & 20170313 (01/20/2017)
    - *An employer may not exclude from an employee's gross income reimbursements of premiums for participating in a wellness program if the premiums for the wellness program were originally made by salary reduction through a section 125 cafeteria plan.*
  - 201719025 (05/12/2017)
    - *We understand that promoters…are selling self-funded health plans (often referred to by promoters as fixed indemnity health plans) and wellness plans to employers. The plans are promoted as a way to provide certain benefits to employees at no or little cost to the employer (&) employees… The promoters claim the benefits do not constitute income or wages and thereby reduce the employer and employee share of employment taxes with respect to employee remuneration.*
    - IRS memo even included a chart that looked much like what promoters often have in their marketing material…

Prior to Adopting the Plans	Each Employee	After Adopting the Plans
$4,000	Monthly Wage	$4,000
$0	Wellness Plan Contribution	<$1,500>
$4,000	Taxable Income	$2,500
<$600>	Income Taxes	<$375>
$3,400	Post-tax Income	$2,125
$0	Self-funded Health Plan Contribution	<$60>
$0	Fixed Cash Payment	$1,425
$3,400	Net Pay	$3,490
$0	Flex Credits	<$90>
$3,400	Net Take-home Pay	$3,400

Risk to Employer

- Employers could be subject to back taxes, penalties, and interest on unpaid payroll taxes

- Employer could face penalties based on the employer's incorrect W-2 filing

- Employer could also be required to restate these payments as taxable compensation to employees, subjecting them to additional tax liability

Regulatory Issues Update

Proposed Guidance for Short-term Health & Fixed Indemnity Plans

- IRS, DOL, and HHS have released new proposed guidance
  - Changes to definition of short-term limited duration insurance (STLDI)
  - Hospital and fixed indemnity policies as excepted benefits
  - Taxation of hospital and fixed indemnity policies
- 60-day comments period - final regulations later this year

Short-Term Limited Duration Insurance (STLDI)

- Background
  - Short-term plans are not subject to many individual health insurance plan rules
    - Can exclude pre-existing conditions
  - Length of Coverage
    - Was limited to 3 months for many years
    - In 2018 Trump administration expanded to 12 months with 3 renewals allowed for a total of 36 months
    - Many states impose limits on short-term plans
- New Proposed Rule
  - Coverage limited to 3 months (with a one-month extension allowed)
  - New notice requirements
  - Effective after publication of final rules

Hospital and Fixed Indemnity Plans

- Background
  - Plans that pay a fixed amount for a particular event and do not coordinate with other health coverage
  - If plan qualifies as an "excepted benefit" plans are not subject to most rules that apply to comprehensive group health insurance
    - No cost sharing for preventive care, no lifetime of annual max, no health underwriting or discrimination based on health status, etc.)

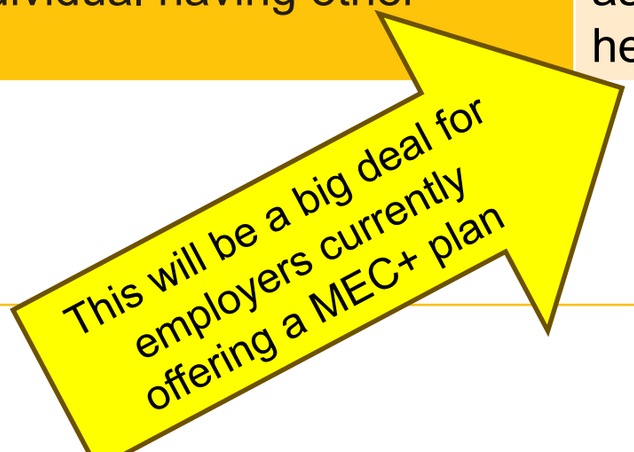
Hospital and Fixed Indemnity Plans

- Proposed Rules
  1. Plan must pay on a "fixed period" basis

Not allowed to pay on a per service basis	Addresses plans being sold as excepted benefit indemnity plans but contain a significant list of “per service” payments making it look more like comprehensive fee-for-service health insurance.

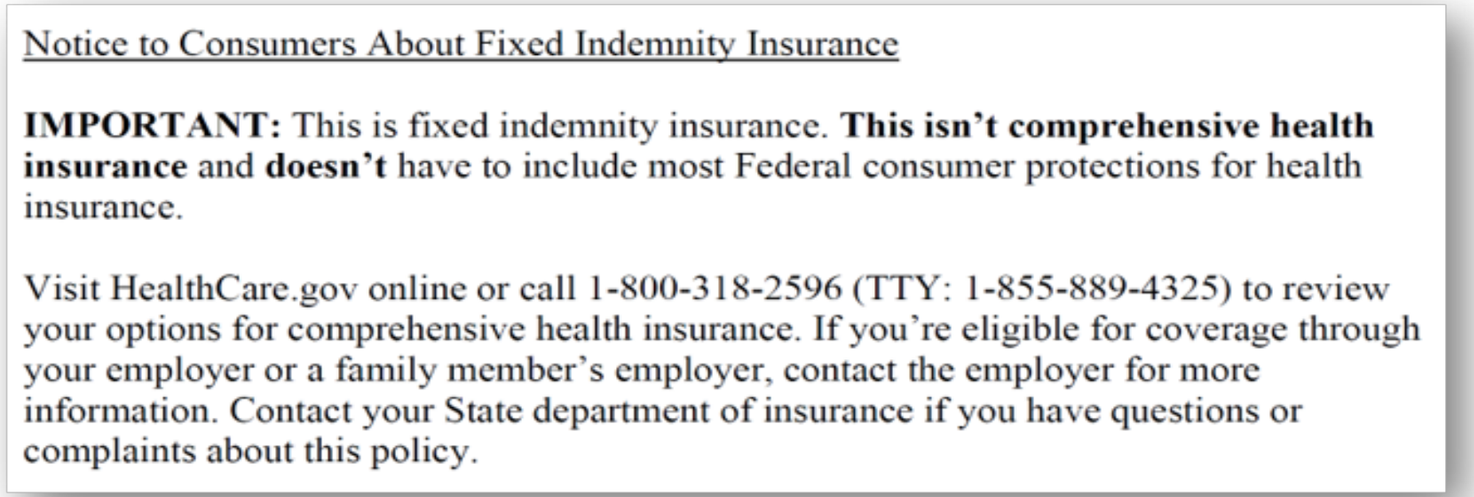
  2. Clarify the no coordination rule

Plan could not be offered in a conjunction with another medical plan that makes the indemnity plan payments contingent on the participant individual having other health coverage.	This change targets the proliferation of “preventive only MEC + indemnity coverage” plans that are being marketing as an alternative to comprehensive group health coverage.



Hospital and Fixed Indemnity Plans

- New Notice Requirement



Notice to Consumers About Fixed Indemnity Insurance

IMPORTANT: This is fixed indemnity insurance. **This isn't comprehensive health insurance** and **doesn't** have to include most Federal consumer protections for health insurance.

Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you're eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.

- Effective Date
  - New plans offered after publication of final rules
  - Existing group plans sold before publication of final rules
    - Plan years beginning January 1, **2027**!
    - Except notice requirement goes into effect after publication of final rules

Taxation of Hospital and Fixed Indemnity Plans

- Background
  - IRS proposing to amend regulations to reflect IRS existing interpretation of the tax treatment of these plans…
- Important Terminology
  - Tax-free = benefits that can be provided by employer not treated as taxable compensation to employees under Code rules (Sections, 104, 105, and 106)
  - Pre-tax = deductions that can be be taken from employee's pay to pay for certain benefits according to Section 125

Taxation of Hospital and Fixed Indemnity Plans

- Proposed Changes to IRS Regulations Consistent with Recent IRS Memorandum
  - Benefits paid by plan mut be treated as taxable compensation if:
    - Employee pays for the coverage using pre-tax deductions from pay through the employer's Section 125 plan or Employers pays and does not treat payments as taxable income
    - Payments made by the fixed indemnity plan are made without regard for an actual 213(d) medical expenses incurred by the employee
  - Effective Date
    - Later of publication of the final regulations or January 1, 2024

July, 20 2023

Employee Benefit Regulatory Update

Presented by Benefit Comply