Benefits Counselor – July 2023

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HEALTH AND WELFARE PLAN DEVELOPMENTS

Hospital Pays $240,000 for Security Guards' HIPAA Violations

The U.S. Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) recently announced a $240,000 settlement with Yakima Valley Memorial Hospital, a community hospital located in Washington. In May 2018, OCR began investigating the hospital after a breach notification report indicated that 23 security guards working in the emergency department used their login credentials to access 419 patients' medical records. According to OCR Director Melanie Fontes Rainer, "Data breaches caused by current and former workforce members impermissibly accessing patient records are a recurring issue across the healthcare industry. Healthcare organizations must ensure that workforce members can only access the patient information needed to do their jobs." The advice applies equally to other types of HIPAA covered entities, such as group health plans, and business associates. In addition to the $240,000 settlement, the hospital agreed to monitoring by OCR for two years and to take other corrective measures, including a risk analysis and workforce training.

This settlement serves as an important reminder to plan sponsors that if they receive protected health information (PHI) from their health plans, to ensure the PHI is available only to authorized employees to perform plan administrative functions.

Proposed Regulations Would Bring Changes for STLDI and Health Indemnity Insurances

STLDI Changes

On July 7, HHS, the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (collectively, the Departments) proposed rules that would amend the definition of "short-term, limited-duration insurance" (STLDI). Under the revised definition, the phrase "short-term" would mean that STLDI policies would need to expire at most three months after the original effective date. The phrase "limited-duration" would also be revised; the maximum duration for an STLDI policy would be four months, including any renewals, extensions or new STLDI policies issued by the same insurer to the same policyholder within a 12 month period. The Departments proposed these amendments to better distinguish STLDI from

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individual health insurance coverage, which is subject to additional federal requirements. These regulations also represent a return to the similar less-than-three-month maximum term in the federal definition of STLDI adopted in final regulations issued in 2016. If finalized, these rules would apply to new STLDI policies, certificates and insurance contracts sold or issued on or after the final rules' effective date. However, existing policies sold or issued before a final rule's effective date, including any renewals or extensions, could still have an initial contract term of less than 12 months and a maximum duration of 36 months.

Indemnity Insurance Changes

In addition, the Departments' proposed rules would amend the requirements for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit in the group and individual health insurance markets. This type of insurance qualifies as an excepted benefit—meaning it is exempt from many federal requirements—if it is offered independently, on a "noncoordinated" basis, from other major medical coverage.

Under the proposed rules, to qualify as an excepted benefit, the benefits would need to be paid: (1) as a fixed dollar amount per day (or per other time period) of hospitalization or illness, not on any other basis (such as on a per-item or per-service basis); and (2) regardless of the actual or estimated amount of expenses incurred, services or items received, severity of illness or injury experienced by a covered participant or beneficiary, or any other characteristics particular to a course of treatment received by a covered participant or beneficiary.

The proposed regulations would also clarify the prohibition on coordination between fixed indemnity excepted benefits coverage and any group health plan maintained by the same plan sponsor. In essence, the fixed indemnity coverage would be an excepted benefit only if the plan sponsor does not "take into account" the benefits under the fixed indemnity insurance to fill gaps in another group health plan.

Further, under the proposed regulations, the exclusion from gross income under Code section 105(b) would not apply to amounts received from accident or health insurance paid for on a pre-tax basis that pays a benefit without regard to the actual amount of medical expenses incurred. This interpretation would apply, for example, to benefit payments under fixed indemnity excepted benefits coverage and to benefit payments under specified disease excepted benefits coverage that pays benefits without regard to the amount of medical expenses incurred if these

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types of coverage were paid for on a pre-tax basis. These non-excludable indemnity-type benefit payments would be considered wages subject to FICA, FUTA and income tax withholding. In contrast, hospital indemnity and other fixed indemnity insurance and coverage only for a specified disease or illness benefit payments would still be excluded from a taxpayer's gross income if the premiums are paid on an after-tax basis.

Additionally, regulations under Code section 105(b) would also be amended to clarify that, for amounts to be excluded from income under Code section 105(b), the payment or reimbursement must be substantiated.

These amendments would apply when final regulations are published or January 1, 2024, if later.

The Departments also requested comments regarding coverage solely for a specified disease or illness that qualifies as excepted benefits and level-funded plan arrangements.

Wellness Indemnity Policy Payments Might Be Wages Subject to Employment Taxes

The IRS has provided guidance regarding wellness indemnity programs being pitched to employers to reduce their FICA taxes. The guidance in IRS Office of Chief Counsel Memorandum 202323006 is not binding, but it does indicate how the IRS would examine one of these wellness indemnity programs in an audit.

The program that the IRS examined involved a fixed indemnity insurance policy for which employees paid the entire $1,200 premium pretax through a cafeteria plan. Each month, the policy would pay out $1,000 if the employee completed certain health or wellness activities, such as receiving preventive care under the employer's major medical plan with no associated out-of-pocket cost, or other health-related activities that were free for the employee. The insurance company paid the $1,000 monthly benefit to the employer, which in turn paid the benefit to its employees tax-free.

The IRS concluded that these wellness indemnity payments are includible in employees' gross income if there are no unreimbursed medical expenses related to the payments. The IRS explained that the income exclusion under the Code that the insurer represented would apply is limited to amounts paid to reimburse medical care expenses. The exclusion does not apply to amounts the employee can receive regardless of whether he or she incurs medical expenses. In other words, if the employee has no unreimbursed medical expenses, whether because

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the activity that triggers the payment is free to the employee or because other coverage reimburses the employee for its cost, the benefit payment is not excludable from income.

The IRS went on to explain that because the payment was provided in connection with the employee's employment, it needed to be treated as wages for employment tax purposes. Therefore, the employer and employee should have been paying employment taxes on these benefit payments. Employers that sponsor one of these types of arrangements risk penalties for under-reporting, under-withholding, filing incorrect Form W-2s, and any uncollectable FICA taxes owed by the employees.

FAQ Guidance Clarifies Interaction Between No Surprises Act and ACA

On July 7, the Departments published guidance in the form of Frequently Asked Questions about the No Surprises Act (NSA) and the Affordable Care Act (ACA). The guidance clarified that if a provider is a "nonparticipating" provider under the NSA (for purposes of the balance billing and cost-sharing protections for emergency services, non-emergency services by nonparticipating providers at participating facilities, and air ambulance services), the provider is considered an "out-of-network" provider for purposes of the ACA's maximum limit on out-of-pocket cost sharing. In addition, if a plan or insurer has any sort of contract with a provider, that makes the provider "participating" for NSA purposes and "in-network" for purposes of the ACA's out-of-pocket limit rules. In short, a plan or insurer cannot treat a provider as "participating" for purposes of the NSA and "out-of-network" for purposes of the ACA.

Separately, the guidance confirmed that facility fees are "items and services" for purposes of the ACA's Transparency in Coverage final rules and the NSA's good faith estimate requirements. Therefore, plans and insurers must make price information for facility fees available to covered persons through their online cost estimator tools.

HDHP Pre-Deductible Coverage for COVID-19 Testing and Treatment Ending in 2024

The IRS recently modified prior guidance regarding coverage for COVID 19 testing and treatment under a high deductible health plan (HDHP) in Notice 2023-37. Currently, HDHPs can cover testing and treatment for COVID-19 before an individual satisfies their deductible. Now that the COVID-19 national emergency has ended, HDHPs may continue covering COVID-19 testing and treatment pre-deductible only for plan years ending on or before December 31, 2024. For

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subsequent plan years, an HDHP cannot provide testing and treatment for COVID-19 before satisfaction of the deductible or with a deductible below the minimum deductible (for self-only or family coverage).

The IRS also confirmed that testing for COVID-19 would not be included in the preventive care safe harbor, which allows HDHPs to pay for screenings for certain infectious diseases before the deductible is met. Notably, this guidance does not apply to vaccines for COVID-19 as the vaccines are specifically listed as a preventive care service.

In addition, the guidance confirmed that items and services recommended with an "A" or "B" rating by the U.S. Preventive Services Task Force (USPSTF) on or after March 23, 2010, are treated as preventive care for purposes of HDHPs under the Code and can be covered pre-deductible. This treatment is available regardless of whether these items and services must be covered, without cost sharing, under the ACA due to the district court ruling in *Braidwood Management Inc. v. Becerra*. The IRS noted that if the USPSTF ever recommends COVID-19 testing with an "A" or "B" rating, testing would requalify for pre-deductible HDHP coverage.

RETIREMENT PLAN DEVELOPMENTS

PBGC Issues Final Rule on Terminated Single-Employer Plans

On July 10, 2023, the Pension Benefit Guaranty Corporation (PBGC) made available a final rule that revises its regulations on benefits payable in terminated single-employer plans and the allocation of assets in single-employer plans. The changes clarify and codify policies involving payment of lump sums, changes to benefit form and valuation of plan assets.

The changes under the final rule will apply to plan terminations initiated on or after August 10, 2023. However, the amendments generally represent policies and practices that PBGC has followed for years and will continue to follow before August 10.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

All Benefit Plans

Summary of Material Modifications for Calendar Year Plans

A Summary of Material Modifications (SMM) must be distributed within 210 days of the close of the plan year in which a material amendment was adopted. For calendar year plans, all required SMMs describing amendments adopted during

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the 2022 plan year must be distributed by July 29, 2023.

Summary Annual Report

Plan administrators whose plans must provide summary annual reports generally must distribute them within nine months after the plan's year-end (e.g., for plan years that ended December 31, 2022, the deadline is September 30, 2023). However, if a plan has received an extension for filing its Form 5500, the nine month deadline is extended by two months.

2021 Form 5500 for Calendar Year Plans

Plan administrators generally have seven months after the end of a plan year to file a Form 5500, including applicable schedules and attachments. For plan years ending December 31, 2022, the Form 5500 filing deadline is July 31, 2023. However, by filing Form 5558 by July 31, 2023, plan administrators can request a deadline extension to October 16, 2023.

Retirement Plans

Annual Funding Notice

Calendar year defined benefit plans with 100 or fewer participants (i.e., small plans) must provide an annual funding notice to required recipients by the earlier of the Form 5500 due date or the date of the Form 5500 filing, including extensions. Calendar year defined benefit plans with 100 or more participants (i.e., large plans) must provide an annual funding notice to required recipients within 120 days after the close of the plan year.

Health Plans

PCORI Fee

Plan sponsors of self funded plans must report and pay the annual Patient-Centered Outcomes Research Institute (PCORI) fee to the IRS by filing the second quarter Form 720 by July 31, 2023. For plan years that ended in 2022 but before October 1, 2022, the fee due this July is $2.79 per covered life. For plan years that ended between October 1, 2022, and December 31, 2022, the fee due this July is $3.00 per covered life.

Reinhart's Employee Benefits Practice is one of the largest and most tenured in the country:

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