Summer 2023 Benefits Newsletter

MORETON & COMPANY

IRS Memo Addresses Taxation of Employer-funded, Insured, Fixed-indemnity Wellness Policy

In a Chief Counsel Advice (CCA) memorandum*, the IRS addressed the tax treatment of an employer-funded fixed-indemnity insurance policy promoted as providing tax-free wellness indemnity payments. The policy at issue supplemented employees' other health coverage by providing wellness benefits to employees who elected to make monthly $1,200 premium payments through cafeteria plan salary reductions. The policy provided employees with a $1,000 payment (limited to one payment per month) for participating in certain health and wellness activities, such as use of preventive care under a comprehensive health plan in which the employee was enrolled. In addition, the policy provided other benefits at no additional cost (e.g., wellness and nutrition counseling), as well as a benefit for each day that an employee was hospitalized. Employees were responsible for any costs associated with their health-related activities, although the activities were often provided at no cost or covered by other insurance. Wellness benefits were paid to employees via the employer's payroll system.

The CCA concluded that payments under the policy were includible in employees' gross income if the employee had no unreimbursed medical expenses related to the payment; these payments were also wages for purposes of FICA, FUTA, and federal income tax withholding. The income exclusion under Code § 105(b) is available only for amounts paid to reimburse expenses incurred for medical care and does not apply to amounts that are received, regardless of whether medical care expenses are incurred. In this scenario, however, employees received $1,000 per month regardless of whether they had any unreimbursed medical expenses (e.g., because the activity triggering the payment did not cost the employee anything or was reimbursed by other coverage). The CCA also noted that, per Code § 104(a)(3), gross income does not include amounts received through accident or health insurance (or through an arrangement having the effect of such insurance) for personal injuries or sickness. However, the exclusion does not apply to the extent that the amounts are attributable to employer contributions that were not includible in the employee's gross income (including cafeteria plan salary reductions) or paid by the employer.

CCAs, which are written by the IRS Office of Chief Counsel, cannot be used or cited as precedent but provide useful insight into the IRS's views. This is not the first CCA to address the tax consequences of wellness payments under "too good to be true" arrangements. The scenario addressed in this latest CCA emphasizes that taxation cannot be avoided by using fixed indemnity insurance to provide wellness rewards. Like another recent CCA, it is directed to the employment tax policy division, perhaps signaling direction for audit activity.

* https://www.irs.gov/pub/irs-wd/202323006.pdf

Court Orders Reevaluation of Child's Residential Treatment Claim Denial

A participant with coverage under two health plans sued both plans after they denied claims related to her child's residential treatment for depression, anxiety, lack of focus, and extreme hyperactivity. The court reviewed both denials under the arbitrary and capricious standard (which generally upholds an ERISA plan administrator's claim determination unless it was an abuse of discretion).

The court upheld one plan's denial, concluding that the plan terms clearly covered residential treatment centers only if they provided 24-hour onsite nursing services, which this facility did not. The participant also argued that this requirement violated the mental health parity rules because the plan did not expressly include a 24-hour onsite nursing requirement for analogous medical/surgical facilities such as skilled nursing facilities. The court dismissed this claim, finding that the plan covered skilled nursing facilities only if they were "duly licensed" and that 24-hour onsite nursing was a component of all applicable licensing requirements–thus, there was no disparity.

With respect to the other plan, the court analyzed a different issue: the participant's claim that the plan's denial for lack of medical necessity failed to specifically address the medical opinions of the child's treating physicians. Relying on a recent Tenth Circuit decision, the court explained that the plan administrator was required to "engage with and address" treating providers' recommendations in its denial letters, and its failure to do so in concluding that the child was medically and mentally stable was an abuse of discretion. The court sent the claim back for reevaluation, directing the plan administrator to specifically address the participant's arguments in support of coverage of the child's residential treatment. In light of the remand to the plan administrator, the court dismissed–at least for now–a separate mental health parity claim against this plan.

ERISA plans must provide claimants with full and fair review of claims and adverse benefit determinations. This decision reaffirms the importance of demonstrating that the plan has engaged with treating providers' opinions when denying claims based on medical necessity. And while the participant's mental health parity claims were thus far unsuccessful, compliance with the mental health parity requirements is a focus of agency enforcement and should be a priority for plans.

Proposed Regulations Would Limit STLDI, Curtail Fixed Indemnity as Excepted Benefits, Make Tax Treatment Clarifications

The DOL, HHS, and IRS have jointly proposed regulations that would limit the permissible duration of short-term, limited-duration health insurance (STLDI). The proposals would also modify the conditions for certain fixed indemnity insurance to be considered an excepted benefit and clarify the tax treatment of certain benefit payments in fixed amounts received under employer-provided accident and health plans. As background, STLDI is designed to fill temporary gaps in coverage when an individual is transitioning from one source of coverage to another. Individual STLDI typically has higher out-of-pocket costs and covers fewer services than traditional insurance, and is generally not subject to certain group health insurance mandates. Hospital indemnity or other fixed indemnity insurance is designed to pay a fixed cash amount after a health-related event. When certain requirements are met, it is considered independent, non-coordinated coverage that is an excepted benefit and is not subject to certain group health plan mandates. Here are highlights of the proposals:

- **STLDI:** The proposed regulations interpret "short term" to mean an initial coverage period of no more than three months and "limited duration" to mean a maximum coverage period of no more than four months (considering renewals). Current rules allow an initial coverage period of fewer than 12 months, with renewals permitted for up to 36 months. Insurers would be prohibited from issuing multiple STLDI policies to the same individual within a 12-month period. The notice requirements would also be revised and enhanced.
- **Fixed Indemnity Insurance:** To be considered an excepted benefit, hospital indemnity or other fixed indemnity insurance would have to pay benefits without regard to the actual or estimated amount of expenses incurred, services or items received, severity of illness or injury experienced, or other characteristics of a course of treatment; benefits could not be paid on any other basis, such as per-item or per-service. A proposed example clarifies that impermissible coordination occurs when fixed indemnity insurance is offered as a coverage option that is coordinated with an exclusion of benefits under the same employer's group health plan.
- **Tax Treatment:** The proposals clarify that payments from employer-provided fixed indemnity health insurance and similar plans are not excluded from a taxpayer's gross income if the payments are made without regard to the actual amount of incurred medical expenses and premiums for the coverage were paid pre-tax. In addition, the proposals would clarify the substantiation requirements that must be met for medical expense reimbursements from employer-provided accident and health plans to qualify for exclusion from gross income.

Although the STLDI and fixed indemnity proposals follow a 2022 executive order and come as no surprise, they would have far-reaching implications for some benefit designs. Also worth noting is a comment request on level-funded plan arrangements. These self-insured arrangements–with set monthly plan sponsor payments to a service provider to cover estimated claims and administrative costs–are reportedly increasing, and the agencies seek to better understand their designs and whether additional guidance is needed to clarify the plan sponsor's obligations.

IRS Modifies Guidance on COVID-19 Expenses for HDHPs, Provides Preventive Care Clarifications

In response to the end of the COVID-19 emergency, the IRS has issued a notice modifying its 2020 guidance regarding the COVID-19 testing and treatment benefits that can be provided by a high-deductible health plan (HDHP). Under the 2020 guidance, HDHPs can provide those benefits without a deductible or with a deductible below the applicable HDHP minimum deductible (self-only or family), thereby allowing individuals to receive coverage under HDHPs that provide such benefits on a no- or low-deductible basis without any adverse effect on HSA eligibility. Agency FAQs issued earlier this year indicated that the 2020 guidance would apply until further guidance was issued. This latest notice provides that, due to the end of the COVID-19 emergency, the relief described in the 2020 guidance is no longer needed and will apply only for plan years ending on or before December 31, 2024.

The notice also addresses the status of certain items and services as preventive care under the Code's HSA eligibility rules. According to the notice, the preventive care safe harbor under those rules does not include COVID-19 screening (i.e., testing), effective as of the notice's publication date. The notice acknowledges that the preventive care safe harbor includes screening services for certain infectious diseases but also observes that screenings for "common and episodic illnesses, such as the flu" are not included and concludes that COVID-19 differs from the types of diseases on the list. The notice further provides that–consistent with recent agency FAQs regarding the impact of the trial court's decision in the Braidwood case–items and services recommended with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF) on or after March 23, 2010, are treated as preventive care under the HSA eligibility rules, whether or not they must be covered without cost sharing under the preventive services mandate. Thus, if the USPSTF were to recommend COVID-19 testing with an "A" or "B" rating, then that testing would be treated as preventive care under the HSA eligibility rules, regardless of whether coverage without cost-sharing is required under the preventive services mandate.

Employers, HSA account holders, and HDHP providers will appreciate having more than a year's advance notice of the 2020 guidance's expiration. And while the clarification that COVID-19 testing does not qualify as preventive care under the HSA rules is effective immediately, the notice effectively provides a transition period by allowing HDHPs to continue to provide benefits for COVID-19 testing on a no- or low-deductible basis for a limited time.

This publication was written by Carolyn Cox, Moreton & Company General Counsel. Carolyn provides Moreton & Company clients with Compliance services. For additional questions, please contact her at 801-715-7110 or ccox@moreton.com.

Moreton & Company - Idaho
2501 East State Avenue, Suite 200
Meridian, ID 83642
208-321-9300

Moreton & Company - Utah
101 South 200 East, Suite 300
Salt Lake City, UT 84111
801-531-1234

Moreton & Company - Colorado
4600 South Ulster Street, Suite 610
Denver, CO 80237
303-385-2100

www.moreton.com