Compliance Monthly Update: June 2023

A brief update on what happened the prior month in group health plan compliance at the federal level, organized chronologically. If you would like additional information, please reach out to the GBS Compliance Team.

Reminder that PCORI fee and filing is due by July 31. The annual ACA Patient-Centered Outcomes Research Institute (PCORI) filing and fee on insurers and sponsors of self-funded medical plans (including HRAs) is coming up. The filing and payment due July 31, 2023, is required for policy and plan years that ended during the 2022 calendar year. For plan years that ended January 1, 2022 – September 30, 2022, the fee is $2.79 per covered life. For plan years that ended October 1, 2022 – December 31, 2022 (including calendar year plans that ended December 31, 2022), the fee is $3.00 per covered life. The PCORI fee is reported and paid using IRS Form 720. See the Form 720 Instructions for more information and instructions on reporting and paying the fee. As a reminder:

- Insurers report and pay the fee for fully insured group medical plans.
- For self-funded plans, the plan sponsor (e.g., the employer) reports and pays the fee.
- An employer that sponsors an HRA along with a fully insured medical plan must pay the PCORI fee based on the number of employees (dependents are not included in this count) participating in the HRA, while the insurer pays the PCORI fee on the individuals (including dependents) covered under the insured plan.
- Where an employer maintains an HRA along with a self-funded medical plan and both have the same plan year, the employer pays a single PCORI fee. Each person covered by both plans is only counted once. If the HRA covers anyone who is not also covered under the self-funded medical plan, the sponsor counts those individuals using the one life per participant rule.

CMS guidance on the elimination of the MHPAEA opt-out for self-insured non-federal governmental plans. CMS released guidance on June 7 addressing legislation that eliminated the ability of self-insured non-federal governmental health plans to opt-out of complying with the Mental Health Parity and Addiction Equity Act (MHPAEA). The Consolidated Appropriations Act, 2023, provided that new MHPAEA opt-out elections may not be made on or after December 29, 2022, and that elections expiring 180 or more days after that date may not be renewed. The guidance confirms that elections expiring on or after June 27, 2023, may not be renewed but explains a special rule for certain collectively bargained plans. A self-insured, non-federal governmental plan that is subject to multiple collective bargaining agreements (CBAs) of varying lengths and that has an MHPAEA opt-out election that was in effect on December 29, 2022, and expires on or after June 27, 2023, may extend the election until the last CBA expires. After current elections expire, self-insured non-federal governmental plans may only opt-out of three group health plan mandates: standards related to newborns and mothers, reconstructive surgery following mastectomies, and Michelle's Law (now obsolete for most plans due to the Affordable Care Act's requirement to cover dependent children to age 26).

IRS again addresses double-dipping wellness schemes. On June 9, the IRS released a Chief Counsel Advice memo addressing the tax treatment of an employer-funded fixed-indemnity insurance policy promoted as providing tax-free wellness indemnity payments.

- The memo concludes 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 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, 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 IRS has previously addressed these types of double-dipping tax schemes (that attempt to utilize various IRS Code sections to claim employee contributions and subsequent employer payments are not taxable). The IRS has repeated struck down these "too good to be true" arrangements. The designs of these schemes vary, but the programs typically are funded with employee salary reduction contributions through a Section 125 plan, and then the program makes cash payments as a tax-free "reward" (or indemnity payment) for employee participation in certain wellness or other activities. Employers should be especially wary of arrangements that require employee pre-tax salary reductions and purport to leave the employee with "the same" or "better" take-home pay than if no salary reduction had occurred.

ACA preventive care requirements continue while *Braidwood* case is on appeal. On June 13, the 5th Circuit issued a new ruling in the *Braidwood* case (following up on the temporary injunction discussed last month). The new order allows the PSTF preventive health services recommendations and the corresponding coverage mandate to remain in effect while the appellate court decides the case. As background, the ACA requires health plans to cover preventive care with no cost-sharing for participants, and the ACA empowers three agencies—the U.S Preventive Services Task Force (PSTF), the Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices (ACIP)—to determine what kinds of preventive care fall within each category of mandatory coverage by issuing guidelines or recommendations. But, this past March a district court ruled in the *Braidwood* case that the ACA requirement to provide preventive care as recommended by the PSTF is unconstitutional. That district court ruling has been stayed pending the outcome of the appeal. It is expected that, regardless of the outcome of the 5th Circuit appeal decision, the *Braidwood* case will ultimately reach the U.S. Supreme Court.

IRS guidance on expenses related to COVID and for preventive care—for purposes of HSA eligibility. Under prior guidance, COVID testing/treatment benefits could be provided without cost-sharing and would not impact HSA eligibility. IRS Notice 2023-37 (that was issued on June 23) provides that due to the end of the COVID emergency, the prior guidance is no longer needed and will apply only for plan years ending on or before December 31, 2024. After that date, COVID testing/treatment cannot be provided under a HDHP at no cost or reduced cost prior to satisfying the HDHP minimum deductible. IRS Notice 2023-37 also reiterates that COVID testing/treatment does not satisfy the definition for preventive care, and that screenings for common and episodic illnesses, such as the flu, are also not included in the preventive services safe harbor.