Compliance Alert

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Employee Benefits Compliance

Agencies Issue Proposed Rule on Fixed Dollar Indemnity Plans and Request Comment on Level Funded Plans

Introduction

On July 7, 2023, the Departments of Labor, the Treasury, and Health and Human Services (the Departments) issued Proposed Rules that would amend the definition of short term, limited-duration insurance, formalize and amend requirements for hospital indemnity or other fixed dollar indemnity insurance to be considered an excepted benefit in the group and individual health insurance markets, amend and clarify the tax treatment of certain benefit payments in fixed amounts received under fixed dollar indemnity plans, and request comments regarding level-funded plan arrangements. The focus of this Alert is on elements of the proposed rule that affect group health plans (as opposed to individual insurance). Importantly, some of the more significant elements of the proposed rule, including the excepted benefit status of fixed dollar indemnity plans, are not entirely new. Although the proposed rule does include new significant plan design restrictions related to combining indemnity plans with other plans, policies or products, this portion of the Proposed Rule largely codifies and clarifies existing sub-regulatory guidance.

The Proposed Rule

Fixed Dollar Indemnity Plans in the Group Market

Background:

The Affordable Care Act (ACA) market reform mandates, as well as HIPAA portability rules, do not apply to any group health plan that qualifies as an excepted benefit. This makes excepted benefit status very important for certain medical plans and policies that cannot satisfy ACA market reform rules, such as the required coverage of preventive care or the prohibition against lifetime and annual limits on essential health benefits. This issue has become increasingly important in recent years with new vendors offering employer plan sponsors different approaches and designs for a host of different benefits. Excepted benefit status can, but will not always, apply to: (1) coverage only for a specified disease or illness (for example, cancer-only policies); or (2) hospital indemnity or other fixed indemnity insurance. The coverage must satisfy the following conditions:

- the coverage is provided under a separate policy, certificate, or contract of insurance (no self-funded plans);
- no coordination exists between the provision of such benefits and any exclusion under any plan maintained by that employer; and
- benefits are paid for an event regardless of whether benefits are provided for the same event under any group health plan maintained by the same plan sponsor.

Fixed dollar indemnity insurance is considered an excepted benefit if it meets the statutory and regulatory criteria because its primary purpose is not to provide major medical coverage but to provide a cash-replacement benefit for those individuals with other health coverage. In addition, hospital or other fixed dollar indemnity insurance must pay a fixed dollar amount per day (or other time-related period) of hospitalization or illness, regardless of the amount of expenses incurred. This exception includes most traditional hospital indemnity policies (e.g., $100 per day of hospitalization regardless of medical expenses incurred or availability of other health coverage), as well as specific illness policies (which pay a flat dollar amount if a person is diagnosed with the specified illness).

In 2013, the Departments jointly issued FAQ guidance emphasizing that coverage that pays benefits for specified services generally will not qualify for this exception since benefits are not paid on a per-period basis. The FAQs expressly provide that where a health insurance policy is advertised as fixed dollar indemnity coverage, but then covers doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and/or prescription drugs at $15 per prescription it is not an excepted benefit. It concludes that when a policy pays on a per-service basis as opposed to on a per-period basis, it is in practice a form of health coverage instead of an income replacement policy and does not meet the conditions for excepted benefits.

Proposed regulations issued in June 2016 echo this FAQ guidance highlighting that group policies purporting to provide fixed dollar indemnity coverage but paying benefits based on the type of items or services (instead of per period) are not excepted benefits. Specifically, a policy that provides benefits in a different amount per day depending on the type of service, rather than one specific dollar amount per day regardless of the type of service, is not hospital indemnity or other fixed dollar indemnity insurance that is an excepted benefit. These requirements were not addressed in the 2016 final regulations but the prior FAQ guidance has remained in force.

Clarification and Examples in the Proposed Rule:

The Proposed Rule codifies important elements from its prior FAQ guidance and re-introduces concepts from the 2016 proposed rule. Specifically, to be an excepted benefit, plans must only pay a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example,

$100/day) 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 other characteristics particular to a course of treatment received by a covered participant or beneficiary, and not on any other basis (such as on a per item or per-service basis).

The Proposed Rule also would prohibit certain relatively common plan designs where a fixed dollar indemnity plan is paired with other more limited coverage such as a Minimum Essential Coverage only plan or skinny MEC plan (sometimes referred to as a limited medical plan). This reflects the Departments' understanding that these pairings do not meet the requirement that hospital indemnity and other fixed dollar indemnity insurance must offer only "non-coordinated" benefits to be considered an excepted benefit.

The Proposed Rule provides the following examples:

> **Example 1**. An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only related to hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.
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> **Conclusion**. Because benefits are paid based on a percentage of expenses incurred rather than a fixed dollar amount per day (or per other time period, such as per week), the policy does not qualify as an excepted benefit. This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.
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> **Example 2**. An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits when a person receives certain specific items and services in a fixed amount, such as $50 per blood test or $100 per visit. The fixed amounts apply to each specific item or service and are not paid per day or per other time period of hospitalization or illness.
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> **Conclusion**. The policy does not qualify as an excepted benefit because the benefits are not paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness, and are not paid without regard to the services or items received. The conclusion would be the same even if the policy added a per day (or per other time period) term to the benefit description (for example, "$50 per blood test per day"), because the benefits are not paid regardless of the services or items received.
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> **Example 3**. An employer sponsors a group health plan that provides two benefit packages. The first benefit package includes benefits only for preventive services and excludes benefits for all other services. The second benefit package provides coverage through an insurance policy that pays a fixed dollar amount per day of hospitalization for a wide variety of illnesses

that are not preventive services covered under the first benefit package. The two benefit packages are offered to employees at the same time and can be elected together but are not subject to a formal coordination of benefits arrangement.

Conclusion. The second benefit package's insurance policy does not qualify as an excepted benefit because the benefits under the second benefit package are coordinated with an exclusion of benefits under another group health plan maintained by the same plan sponsor (that is, the preventive-services-only benefit package). The conclusion would be the same even if the benefit packages were not offered to employees at the same time or if the second benefit package's insurance policy did not pay benefits associated with a wide variety of illnesses.

Additional Notice Requirement:

Under the Proposed Rule either the plan or issuer must display a new notice or disclaimer regarding fixed dollar indemnity insurance prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage: The following language is required in at least 14-point font:

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:

The Departments propose that the amendments related to group fixed dollar indemnity excepted benefit coverage would apply to existing coverage that is sold or issued before the effective date of the final rules with respect to plan years that begin on or after January 1, 2027. It would apply to newly issued coverage for plan years beginning on or after the effective date of the final rules. The new group market notice would be required only for plan years beginning on or after the effective date of the final rules. Note, however, that many of the requirements for indemnity plans to be excepted benefits are not new but reiterate prior sub-regulatory guidance. We would, therefore, encourage plan sponsors to review any existing fixed dollar indemnity offerings and request a formal

legal statement of excepted benefit status from any vendor partners offering these products. Plan designs that do not meet the criteria of the 2013 FAQ guidance should be amended as soon as practicable.

Tax Treatment of Indemnity Payments

The Proposed Rule provides that it largely codifies existing guidance under Revenue Ruling 69-154 that was latter muddied by a series of 2016/2017 opinion letters addressing the taxability of payments from fixed dollar indemnity plans when paired with other complex plan designs, including wellness plans, that likely created a tax issue commonly known as "double dipping" (see CCM 201703013 and CCM 201719025).[1] The Proposed Rule recognizes that there is still considerable confusion with respect to whether fixed dollar indemnity payments are taxable to participants. Specifically, many fixed dollar indemnity plan administrators have provided tax favored reimbursements where premiums were paid post tax and the amount of the reimbursement did not exceed the cost of actual medical care. The Proposed Rule clarifies that any amounts received under a fixed indemnity plan treated as an excepted benefit, or any plan that pays amounts regardless of the amount of medical care expenses actually incurred, are not payments for medical care and must be included in the employee's gross income. In light of this Proposed Rule, employer plan sponsors that have implemented or are interested in fixed indemnity plan designs that offer significant tax savings to both the employer and employee closely review those designs and consult with their tax advisors, if necessary.

With respect to an effective date, the Departments propose that plans make any necessary adjustments for proper taxation by the later of the date of publication of Final Regulations or January 1, 2024.

Request for Comment on Level Funding

The Proposed Rule also discusses the uptake of level funded plans and increasing concerns around the use of those plan designs among smaller employers. Notably, the Proposed Rule describes level funded plans as self-funded, but there are many fully insured designs that are marketed as or labeled as level funded. It is not uncommon for an employer plan sponsor entering into a level funding arrangement to actually not know whether they are purchasing an insured plan or creating a self-funded plan, which is a necessary threshold issue for all group health plan compliance-related requirements. We discuss how critically important understanding the funding behind these products

[1] Note that double dipping arrangements, often pairing a fixed dollar indemnity plan with a wellness plan, remain problematic and are an IRS enforcement priority.

is for a host of compliance requirements, including HIPAA and required reporting under the Affordable Care Act, in our Alliant Insight, Partial Self-Funding.

The Proposed Rule focuses on limits to benefits and coverage when a level funded plan is self-funded because self-funded plans are not subject to state insurance code regulations or coverage mandates. The Departments express concern that participants will be left with little coverage or denied claims when these designs are paired with stop loss that has a low attachment point in part because stop loss is not heavily regulated. Specifically, stop loss is not subject to state insurance codes that govern medical care, it is not subject to ERISA, and is not covered by Federal consumer protection laws. Lastly, the Departments caution that if the contributions of multiple plan sponsors are not properly segregated from other funds held by the plans' service providers, or if those service providers are pooling risk among multiple employers, those vendors are inadvertently establishing multiple employer welfare arrangements, which would result in the plans being subject to a wide range of State regulation and additional requirements under ERISA.

The Proposed Rule requests comment on topics including but not limited to; What kinds of level funded benefit options are generally made available to plan sponsors? How do the benefit packages differ from fully insured plans? Do level funded plans offer robust benefits similar to the comprehensive coverage offerings of fully insured plans? How do plans' service providers manage plan sponsors' contributions for level funded plans, including amounts that exceed actual plan costs (that is, costs for claims, administrative fees, and stop-loss premiums)? How are the amounts of any refunds paid to plan sponsors by stop loss providers determined? Are refunds remitted to participants and beneficiaries who have made contributions under the plan?

Conclusion

As discussed above, these are proposed rules and the Departments are requesting comment on this guidance. However, as noted above many of the requirements for indemnity plans to be excepted benefits are not new so plan sponsors should revisit existing fixed dollar indemnity plan designs. It will be important to build a strategy to unwind any plan offerings that pair fixed dollar indemnity benefits with limited benefit plans, like skinny MEC. Plan sponsors should also work with issuers to make sure indemnity payments are taxable to the participant as soon as possible and likely no later than January 1, 2024.

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