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Permanent Standalone Telehealth Coverage Becomes a Possibility as Bill Advances

By Claire Martin

Earlier this year, a bipartisan group of lawmakers in the House of Representatives introduced H.R. 824, also known as the Telehealth Benefit Expansion for Workers Act of 2023 (the "Telehealth Bill"), in an effort to counter the upcoming expiration of certain health plan-related relief tied to the COVID-19 pandemic and national emergency declarations. This relief, most notably, includes the ability for employers to offer standalone telehealth coverage for employees who are not otherwise eligible for the employer's health plan.

As background, following the declaration of the COVID-19 public health emergency, the federal government (through the Department of Health and Human Services, the Department of Labor, and the Treasury Department) temporarily waived certain group health plan rules to allow applicable large employers (those with 50 or more full-time employees) to offer telehealth services to employees who are not eligible for any employer-sponsored group health plan. This means, on a temporary basis, qualifying employers could offer telehealth and remote care services as "excepted benefits" to certain employees, and such arrangements were exempt from having to satisfy certain group health plan mandates. This relief was limited to telehealth and remote care arrangements offered to employees who are otherwise ineligible for the employer's group health plan, like part-time, reduced-hour, and/or seasonal workers. Following the end of the public health emergency on May 11, 2023, this relief is set to expire at the end of the plan year that begins on or before May 11, 2023 (*i.e.*, December 31, 2024 for calendar year plans).

The Telehealth Bill aims to make permanent this temporary relief, which many employers and employees have come to rely on during the past few years. More specifically, the Telehealth Bill would permit employers to offer excepted-benefit standalone telehealth coverage, similar to dental and vision plans, to all employees, not just those employees who are otherwise ineligible for the employer's medical plans (in contrast to the temporary COVID-19 relief). Under this legislation,

standalone telehealth coverage could be offered alongside traditional health plans, like many vision and dental plans, and while it would not be a replacement for traditional health plan coverage, it would help provide employees, including those ineligible for traditional health coverage with a way to receive timely and affordable medical care. Moreover, such arrangements, as excepted benefits, will be able to avoid compliance with many federal rules and regulations applicable to group health plans.

Opponents of the Telehealth Bill argue that it allows such arrangements to skirt around important consumer protections under the ACA and other laws. Notably, however, the Telehealth Bill does attach some ACA protections to any standalone telehealth arrangements, including the prohibitions against preexisting condition exclusions and health status discrimination and protections against certain benefit rescissions. On the other hand, proponents of the Telehealth Bill argue that standalone coverage will help employees and employers alike. Specifically, proponents assert that such arrangements will reduce the need for employees to take time off work to seek medical care, while also providing more treatment options for employees, including those employees with mobility or transportation issues, and/or those employees who live in rural areas with limited provider options.

In June, the Telehealth Bill cleared a major legislative hurdle as it advanced through the Education and the Workforce Committee of the House of Representatives. This leads the way for consideration by the full House of Representatives later this summer or early fall.

Plan sponsors who have implemented the temporary standalone telehealth relief will need to monitor developments on the Telehealth Bill. If the Bill is not passed later this year, such plan sponsors will need to consider what to do going forward as they will no longer be able to offer such coverage on a standalone basis. Any plan sponsors that wish to continue to provide telehealth services on a similar basis will have to come into compliance with all laws applicable to major medical plans (unless the Telehealth Bill is passed and signed into law). In the event a plan sponsor must or chooses to wind down such relief, it should provide a communication to impacted employees at least 60 days prior to the expiration of coverage.

Fixed-Indemnity Wellness Plans: The IRS Clarifies Taxation of Wellness Payments

By Kate Belyayeva

On June 9, 2023, the IRS Office of Chief Counsel issued Memorandum No. 202323006 (the “Memorandum”) and addressed whether payments made under an employer-funded, fixed-indemnity wellness plan are includible in gross income of an employee if the employee has no reimbursed medical expenses related to the payments. This Memorandum was issued in response to a request for guidance about a particular employer’s wellness benefits.

Background

Many employers offer employer-sponsored programs to reward and encourage employees to participate. As a general matter, wellness incentives are subject to the same federal income tax treatment as typical employee rewards, which calls for inclusion of the amount of the reward (alternatively, its fair market value) in the employee’s gross income unless a specific tax exemption applies. As detailed herein, no such specific exemption has been expressly provided for fixed-indemnity wellness plans. Although coverage provided through an employer-funded wellness program is generally excluded from employees’ gross income, wellness payments to the employees are not.

These plans have been offered since 1970s; however, IRS guidance has been few and far between and only sparsely addressed particular iterations. For example, the IRS Office of Chief Counsel has previously addressed similar questions in Memorandums No. 201703013 and No. 201719025. Nevertheless, some consultants in

the industry contend that this wellness arrangement should not result in taxable income to the employees as it is a "win-win" plan for both the employer and employees—when the employees reduce their pay, the employer saves on employment taxes, which similarly results in the employees saving on both employment and income taxes. In the Memorandum, the IRS Office of Chief Counsel generally disagreed and further reinforced its prior position regarding the taxability of fixed-indemnity wellness plan payments when funded under a Section 125 cafeteria plan.

Employer Plan Design

The Memorandum addressed circumstances in which a certain employer provided employees comprehensive medical coverage through a group health insurance policy that included preventative care benefits without any cost-sharing. The employer also offered its employees an opportunity to enroll in a fixed-indemnity health insurance policy to supplement the employees' comprehensive health coverage with wellness benefits; however, enrollment in other health coverage was not required for participation in the fixed-indemnity coverage. The employees could enroll in such coverage by payment of monthly premiums of $1,200 by salary reduction on a pre-tax basis through a Section 125 cafeteria plan.

Among other things, the wellness plan provided wellness and nutrition counseling and telehealth visits at no additional cost. One of the wellness benefits under such policy was a payment of a specified amount ($1,000) once per month if the employee participated in certain health or wellness activities (*i.e.*, preventative care, such as vaccinations under the comprehensive health coverage). The insurance company would make these payments to the employer who, in turn, paid the wellness benefit to the employee through payroll.

As discussed in the April issue of *Benefitting You* (and in more detail below), the U.S. District Court for the Northern District of Texas (the "District Court") recently issued a ruling in the case *Braidwood Management Inc. v. Becerra*, wherein it vacated the implementation and enforcement of certain preventive service mandates under the Affordable Care Act ("ACA"). Following an appeal by the Department of Justice ("DOJ"), the U.S. Court of Appeals for the Fifth Circuit (the "Fifth Circuit") issued a temporary stay of the District Court's ruling on May 15, 2023. As a result, implementation and enforcement of the ACA's preventive services mandate will continue as normal while the Fifth Circuit considers the DOJ's appeal.

Taxability to Employees

Pursuant to the Internal Revenue Code (the "Code"), all employee compensation, including fees and fringe benefits, are taxable to the employees unless a specific exemption applies. In the Memorandum, the IRS Office of Chief Counsel concluded that no such exception applied in this case and stated that wellness payments under a fixed indemnity health insurance policy are includible in the gross income of the employee if the employee has no unreimbursed medical expenses related to the wellness payments.

The Memorandum explained that the Section 105(b) exclusion for medical expenses under the Code is meant to apply only to amounts limited to reimbursement of expenses incurred for medical care. This exclusion does not apply to amounts payable to the employee irrespective of whether expenses for medical care are incurred. The exclusion does not apply in such circumstances either because: (1) the activity that triggers the payment does not cost employee anything; or (2) the cost of the activity is reimbursed by other coverage. For instance, vaccinations may be covered as preventative care under the employee's comprehensive health coverage. Accordingly, the Memorandum confirms that wellness payments under a fixed-indemnity insurance policy are not related to the amount of any medical expenses incurred or coordinated with other health coverage and thus cannot be excluded from employees' gross income.

The Memorandum also discussed whether wellness payments that are includible in gross income are due to be considered wages for purposes of the Federal Insurance Contributions Act (“FICA”), the Federal Unemployment Tax Act (“FUTA”), and federal income tax withholding (collectively referred to in this article as “employment taxes”). The IRS Office of Chief Counsel clarified that the taxable wellness payments are considered wages for purposes of employment taxes because such payments are provided in connection with the employee’s employment.

Employer Impact

Although the Memorandum cannot be relied upon and is applicable only to the specific employer requesting this guidance, employers may nevertheless find it significant in navigating these types of plans as the Memorandum offers valuable insight into the IRS’s stance on this taxation issue. Notably, the Memorandum did not discredit all fixed-indemnity wellness plans across the board. However, any employer who currently sponsors a fixed-indemnity wellness plan or intends to implement one needs to consider both sides of the coin regarding various design options and the maintenance of these plans moving forward. Most importantly, employers need to be wary of the IRS knocking on their doors to assess penalties based on the employers’ alleged failure to remit taxes when due. Accordingly, some stakeholders suggested terminating such plans altogether to avoid IRS scrutiny and the possibility of audit activity. At a minimum, employers are advised to consult their benefits counsel to evaluate the risk of IRS penalties associated with unpaid employment taxes.

Proposed Legislation to Ease ACA Reporting Burdens Passes House

By Seth Capper

On June 21, 2023, the House passed H.R. 3801, also known as the Employer Reporting Improvement Act, which is intended to ease some of the burdens employers and insurance carriers face related to the annual Form 1094 and Form 1095 reporting requirements under the Affordable Care Act (“ACA”). The House also H.R. 3797, also known as the Paperwork Burden Reduction Act, which would allow reporting entities to provide notice of the availability of Forms 1095-C on its website rather than having to mail copies to every individual. While the bills have successfully passed the House, they still must pass the Senate and be signed into law by the President prior to becoming effective.

Background

Under the ACA’s employer shared responsibility rules, applicable large employers (“ALEs”) generally must offer the opportunity to enroll in minimum essential coverage (“MEC”) that meets the affordability or minimum value (“MV”) requirements to more than 95% of their full-time employees. If an ALE fails to do so and any of their full-time employees purchase health insurance through the marketplace and receive premium tax credits, then the employer will be subject to excise taxes under Code Section 4980H (also known as “Employer Shared Responsibility Payments” or “ESRPs”).

In order to avoid ESRPs, an ALE must use Forms 1094-C and 1095-C to report information required under Code Sections 6055 and 6056 about its offer of employer-sponsored health coverage to its full-time employees and the employees’ enrollment in such coverage. The IRS uses these forms to assess ESRPs. For fully insured plans, insurance companies use Form 1095-B to inform employees about their health coverage. ALEs that provide coverage solely through fully insured plans still must complete Forms 1094-C and 1095-C, but they need not complete Part III of Form 1095-C.

What Do the New Bills Provide?

H.R. 3801, if passed, would amend Code Sections 6055(b)(1) and 6056(c) to codify certain flexibilities that already exist under the regulations. One such flexibility allows reporting entities to substitute a covered individual’s date of birth in place of a missing SSN/TIN on Form 1095-B, and Part III of Form 1095-C. The other allows consent for electronic delivery of Forms 1095-B and 1095-C to be in place indefinitely, until revoked by the recipient. These changes would be effective for returns due after December 31, 2024.

H.R. 3801 also would give ALEs 90 days, rather than the current 30 days, to respond to a Letter 226-J from the IRS. Letter 226-J is the initial letter the IRS issues to ALEs to notify them that they may be liable for an ESRP. This would provide a more reasonable period for an employer to respond to a Letter 226-J. This change would be effective for ESRP assessments proposed in tax years beginning after the date of the bill's enactment.

Lastly, H.R. 3801 would establish a six-year statute of limitations for the IRS to assess ESRPs. The limitations period would begin to run on the due date for filing Forms 1094-C and 1095-C or, if later, the date the returns are actually filed. This would be effective for returns due after December 31, 2024. The IRS's current position is that there is no statute of limitations under Code Section 4980H. This would implement a clear cut-off point after which the IRS could no longer attempt to assess ESPRs, but it would mean that the limitations period might still be unlimited if an ALE fails to file returns for a given year.

H.R. 3797, if passed, would amend Code Sections 6055(c) and 6056(c) to allow for the use of an alternative method of furnishing Forms 1095-B and 1095-C. Currently, Forms 1095-B and Forms 1095-C that only report enrollment in Part III (*i.e.*, 1095-C forms that are coded 1G) do not have to be furnished annually. The new bill would codify and expand this flexibility to all Forms 1095-C to allow reporting entities to post a notice prominently on their websites notifying individuals that they may receive a copy of their form upon request rather than having to send written notices. The form must be furnished by January 31 of the year following the calendar year for which the return was required to be made or 30 days after the request.

What Does this Mean for Employers?

Although the bills still need to pass the Senate and be signed into law by the President before becoming effective, there appears to be bipartisan support for the changes, which suggests that they likely will be passed. While the changes are by no means monumental, they do provide some much-needed reforms to certain aspects of the ACA reporting requirements that employers have indicated are unduly burdensome, and they indicate that Congress is considering ways to ease the burdens of annual 1094 and 1095 reporting requirements.

This Month's Compliance Corner: Employee Assistance Program Compliance

By Claire Martin

Employer assistance programs ("EAPs") are not a new concept in the field of employer-sponsored health and welfare benefits; however, the COVID-19 pandemic created a greater push for employers to provide this benefit as employees have begun returning to work while still experiencing adverse health, personal, and financial effects of the pandemic. As detailed more below, EAPs provide employers with way to help their employees address their personal problems that may be impacting their work performance, including their mental health issues. The idea behind EAP programs is that if employees can successfully address stressful issues in their personal life, they will be happier and healthier and more focused at work, which will result in increased productivity, decreased absenteeism, and lower health care costs for the employee and the employer. When considering whether to implement an EAP, or expand services offered under an existing EAP, employers should consider not only if, and how, an EAP (or any additional EAP offerings) can benefit their workforce, but also the applicable legal requirements which may apply to the particular EAP based on its design and offerings.

What is an EAP?

An EAP is an employee benefit program designed to help employees improve their overall physical and mental health by providing services (*e.g.*, counseling, education) and/or referrals to help employees address certain personal problems they may be experiencing. EAPs can be designed differently and may provide services to address

varied issues or may focus on one particular type of issue. EAPs often provide counseling and/or referral services for one or more of the following types of issues: fitness and nutrition, stress management, mental health, grief, family-related issues (including childcare, elder care, and marital issues), substance abuse (including alcohol and drug use), and financial and legal concerns.

More recently, employers have utilized EAPs to help their employees cope with mental health issues associated with the COVID-19 pandemic, including but not limited to, the effects of social isolation, teleworking/returning to the office, lack of childcare, financial stress, and grief over illness or death of family members. During the pandemic, many employers expanded services offered under their EAPs to offer remote/online therapy and counseling services, which many employers have retained even after employees have returned to work due to the flexibility and convince remote care provides.

Legal and Compliance Considerations

An EAP's applicable legal requirements will generally depend on the design and structure of the EAP. Some benefits provided under an EAP may rise to the level of "medical care" or a "group health plan", which will subject the EAP to a greater level of federal regulation. Another consideration is whether the employer administers the EAP on its own or whether it contracts with third party service providers or other vendors to do so. The primary legal requirements to consider when designing or considering an EAP are set out below.

Employee Retirement Income Security Act ("ERISA"): If an EAP provides employees or their beneficiaries any "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services" it will be considered a "welfare benefit plan" under ERISA and will be subject to several compliance requirements thereunder. See 29 U.S.C. § 1002(1). While the statutory definition of "welfare benefit plan" is quite broad, the Department of Labor has tried to parse out what types of EAPs fall under ERISA's scope as welfare benefit plans. Generally, when an EAP offers counseling services beyond referrals, the EAP will likely be considered to be a welfare benefit plan under ERISA. For example, the DOL has found the following types of EAPs to be covered under ERISA as a welfare benefit plan providing "benefits in the event of sickness": (1) an EAP providing confidential, on-site counseling (including mental health counseling) one day a week with referrals to the appropriate agency or clinic; and (2) an EAP (with voluntary and involuntary participation) providing assistance, through an independent third-party EAP administrator, for employee personal problems like drug and alcohol abuse, stress, anxiety, depression, and marital, legal, and financial problems.

In contrast, the DOL has found that an EAP that provides only referrals from either a staff member with no specialized training in counseling, or from a national hotline, was not a welfare benefit plan covered by ERISA because it did not provide any benefits in the nature of "medical benefits" or "in the event of sickness." The program did not treat any issues (*e.g.*, drug abuse, stress, depression), did not employ any counselors, and did not provide any benefits in addition to the referrals that were free to the employees by virtue of their employment.

If an EAP is subject to ERISA, it will have to comply with ERISA's reporting and disclosure rules, including the requirement to have a written plan document and summary plan description. These documents must include certain information about the EAP including, among other things, information on eligibility, benefits, and claims procedures under the EAP. ERISA also applies certain fiduciary obligations on the employer plan sponsor and plan administrator, including but not limited to, the duty to act solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them. ERISA also has certain reporting requirements, including the annual Form 5500 (which is filed with the federal government) and summary annual report (which is provided to plan participants).

Affordable Care Act ("ACA") & Group Health Plan Coverage Rules: Employers should also consider whether their EAPs are "group health plans" under the ACA. Generally, if an EAP provides benefits for medical care, the EAP will be a group health plan unless the EAP is an "excepted benefit" (discussed in more detail below). If the EAP is a group health plan, it must satisfy certain rules under the ACA (*e.g.*, the requirement to provide minimal essential coverage, and the prohibition on annual dollar limits). Group health plans will also be subject to additional requirements under ERISA, including the DOL's expanded claims procedure requirements, and continued coverage requirements under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") (discussed below).

Similar to the ERISA determinations mentioned above, the DOL has also addressed when an EAP is a group health plan. EAPs that provide only referrals with no provision of medical services, including counseling services, will not be group health plans; however, EAPs that offer counseling services involving a form of medical care (*e.g.*, counseling for substance abuse or depression), will be considered group health plans, subject to the various group health plan requirements.

Consolidated Omnibus Budget Reconciliation Act ("COBRA"): If an EAP provides medical care and is a group health plan, it will be subject to COBRA's health plan continuation coverage requirements. In that case, the employer plan sponsor must offer COBRA beneficiaries the opportunity to continue their EAP coverage (at least, any portion of EAP coverage that provides medical care) following a qualifying event, in addition to providing all necessary COBRA notices (*e.g.*, an initial COBRA notice, a COBRA election notice).

Health Insurance Portability and Accountability Act ("HIPAA"): If an EAP provides medical care (which will generally be EAPs that provide direct counseling), the EAP must comply with HIPAA's Privacy and Security Rules (if the EAP comes into contact with employees' protected health information ("PHI")). If the EAP is self-insured by the employer, the employer will generally be responsible for the EAP's HIPAA compliance, which may, for example, require the creation and implementation of HIPAA policies and procedures that address when PHI may be used and disclosed.

EAPs as Excepted Benefits

As mentioned above, if an EAP is an "excepted benefit," it can avoid having to comply with many group health plan requirements (which are difficult for EAPs to do based on their limited scope). An EAP will be an excepted benefit (and will be considered supplemental to other coverage offered by the employer) if: (1) it does not provide significant benefits in the nature of medical care (considering the amount, scope and duration of covered services); (2) the benefits are not coordinated with benefits under another group health plan (which means participants in the other group health plan are not required to exhaust EAP benefits first, and eligibility for EAP benefits are not dependent on participation in another plan (*i.e.*, all employees can participate in the EAP)); (3) no employee premiums or contributions are required; and (4) there is no cost-sharing requirements under the EAP.

The applicable regulations provide examples of excepted benefit EAPs that do not provide significant benefits in the nature of medical care. This includes, for example: (1) an EAP with free or low-cost short-term counseling for mental health issues or emotional disorders and referrals for addressing the problems; and (2) a wellness program that provides fitness services designed to improve overall health and prevent illness and separates out costs charged to the individual for participating from the individual's coverage under health plan.

Notably, EAPs that are excepted benefits will not amount to coverage that is sufficient, on its own, to satisfy an employer's coverage responsibilities under the ACA's employer mandate. Moreover, excepted benefit EAPs will not be subject to the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"); however, EAPs can still impact an employer and its medical plan's compliance with the MHPAEA's parity requirements. The DOL has explained that a medical plan that requires

participants to exhaust benefits under an EAP (e.g., mental health counseling services) prior to being eligible for mental health benefits under the medical plan will violate the MHPAEA when the plan does not apply a comparable treatment limit to medical and surgical benefits offered under the medical plan.

Next Steps

When considering whether to implement an EAP or expand services offered under an EAP, employers should consider the goal of the EAP and the issues primarily affecting their workforce. Employers should consider polling or providing an anonymous survey to employees to determine what support they feel they need from an EAP. Employers may need to promote the EAP and educate their employees on what services are offered under the EAP to ensure employees are taking full advantage of the benefits provided to them through the EAP. Part of this education and promotion process should include focus on how their use of the EAP's services is confidential (subject to certain exceptions related to health and safety).

For most employers, structuring an EAP as an excepted benefit will be the most practical solution when taking into account applicable legal requirements and necessary compliance efforts. This structure generally allows the employer to offer some form of counseling to the employees, along with referral services, both of which can provide efficient and impactful assistance. Employers will need to consider whether they will administer the EAP internally or contract with a third-party administrator. Utilizing a third-party administrator allows the employer to take a more hands-off approach in terms of the day-to-day administration and employee confidentiality and privacy. Employers should ensure that any counselors or consultants utilized by the EAP are trained professionals and that any services provided are provided through a range of platforms, including in-person and remote counseling, to ensure that the assistance provided to employees is most effective. To determine if you should offer an EAP, or expand the services offered under an existing EAP, you should reach out to your benefits consultants or third-party administrators to further evaluate the needs of your workforce and the legal considerations.

2023 Deadline Reminders	
Anticipated End of COVID-19 "Outbreak Period" (assuming May 11, 2023 end to National Emergency)	July 10, 2023
PCORI Fee	July 31, 2023
Annual Medicare Part D Notice of Creditable (or Non-Creditable) Coverage to Eligible Individuals	October 14, 2023
Health Plans Must Submit Gag Clause Attestations	December 31, 2023
**While some deadlines are the same date for all plans ("fixed deadlines"), many important deadlines are different for each plan depending on, for example, when the plan year ends. The above is a snapshot of upcoming fixed deadlines that apply to many plans and plan sponsors. Contact your benefits consultant regarding important reporting and disclosure deadlines specific to your plan(s), including deadlines for the Forms 5500 and Summary Annual Reports.*	

STAY IN THE KNOW...

The Department of Labor released its 2023 Spring Regulatory Agenda for health and welfare plans, highlighting future rulemaking that could impact employer-sponsored plans. This includes, for example, the final rule for requirements concerning the disclosure of air ambulance services by plans and health insurance providers (scheduled for August 2023) and proposed rules for nondiscrimination requirements for plans and health insurance issuers, and reevaluation of the criteria for a group or association of employers to sponsor a multiple employer group health plan (scheduled for August 2023).

The Department of Homeland Security and the United States Citizenship and Immigration Services have announced that temporary relief for verifying I-9s of remote employees electronically ends on July 31, 2023, and employers have until August 30, 2023 to complete an in-person verification for all remote employees previously hired and verified via the remote verification flexibility rules. Effective August 1, 2023, employers must resume verification of I-9 documents in-person for all employees. With the recent boom in remote work, employers are expected to have to scramble to comply with these deadlines. Note that nothing about these changes requires creating a new E-Verify case for any employee who was previously E-Verified.

The federal agency attack on independent contractor relationships continues, with the National Labor Relations Board undertaking the latest effort to further narrow the use of legitimate independent contractors. In its June 13, 2023 decision in *The Atlanta Opera* case, the Board reinstated the narrower, common-law agency test for determining worker status under the National Labor Relations Act. While the context here is limited to which category of worker is eligible for the protections of the Act, including the right to form and join a union, the case is yet another instance to remind employers to strictly scrutinize their use of individual independent contractors and to seek regular review of such arrangements by their employment counsel.

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