COMPLIANCE ALERT

EMPLOYEE BENEFITS | JULY 31, 2023

Agencies Release Proposed Regulations on Fixed Indemnity Insurance, Seek Comments on Level Funded Plans

On July 12, 2023, the IRS, DOL and HHS (collectively, "the Agencies") released proposed regulations that modify the conditions for hospital indemnity and other fixed indemnity insurance to be considered an "excepted benefit." Maintaining "excepted benefit" status is important for fixed indemnity plans, as it exempts them from having to comply with the ACA's insurance mandates and market reforms, which is not feasible for these types of arrangements.

The proposed regulations also modify the definition of short-term limited-duration insurance ("STLDI") and clarify the tax treatment of certain benefit payments in fixed amounts received under employer-provided accident and health plans. Lastly, the Agencies solicit comments regarding specified disease or illness coverage and level-funded plan arrangements.

The Agencies released the proposed regulations in response to multiple executive orders released by the President to, among other things, protect and strengthen the ACA, improve the comprehensiveness of coverage, protect consumers from low-quality coverage, and help reduce the burden of medical debt on households.

While these regulations are merely proposed at this time, once finalized they may significantly impact coverage offerings available to employers, particularly those who do not offer comprehensive medical coverage. Moreover, they signal that the Agencies have level-funded plans on their radar and may soon seek to define and regulate them differently than traditional self-funded plans.

The proposed changes are described in more detail below:

Fixed-Indemnity Insurance

Under current law and regulations, the ACA's market reforms do not apply to individual or group health plan coverage that is an excepted benefit. For purposes of fixed indemnity and hospital indemnity coverage, to be an excepted benefit in the group market, the following requirements must be met: (1) the benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between these benefits and those under the employer's group health plan (including any exclusions under the plan); (3) the individual can access the benefits under the plan regardless of whether they obtain coverage under any of the employer's other group health plans (or by a policy issued by the same issuer for individual coverage); and (4) the plan must pay a fixed dollar amount per day (or other period) of hospitalization or illness and/or per

service, regardless of the amount of expenses incurred. Different requirements apply in the individual market.

The Agencies expressed concern over whether the marketing for these benefits misleads individuals into believing they have comprehensive coverage and whether these plans are being used as a substitute for comprehensive coverage without individuals fully understanding the limitations of these plans.

To address these concerns, the proposed rules modify the basis under which hospital indemnity or other fixed indemnity insurance will be considered excepted benefits. Essentially, these benefits will not be excepted unless they pay benefits in 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).

Further, the proposed regulations clarify in the examples how current regulations in the group market, which prohibit fixed indemnity insurance from coordinating between the provision of benefits and any exclusion of benefits under any other health coverage maintained by the same plan sponsor, may negate the ability of fixed indemnity coverage to maintain excepted benefit status. For example, coordination between fixed indemnity coverage and other coverage sometimes offered by employers, such as minimum essential coverage (MEC) plans (i.e., a plan that only covers ACA-recommended preventive care) will cause fixed indemnity coverage to lose its excepted benefit status as it would be considered to coordinate with the exclusions under the MEC plan, regardless of whether there is a formal coordination of benefits arrangement between the fixed indemnity insurance and the other coverage.

New notices have also been proposed for current and future plans or policies issued, though the content and form of the notice is not yet finalized.

Once the final rules are issued, these excepted benefits requirements will be effective at different times depending on the effective date of the policies. If the policy was sold prior to 75 days after the publication of the final rule, the new requirements will not apply until coverage periods beginning on or after January 1, 2027. If the policy is sold on or after 75 days after the date of publication of the final rule, it will apply at the time the policy is effective. Regardless of when the policy is sold, the notice requirements will be effective for any plan years beginning on or after the effective date of the final rule.

Taxation of Hospital Indemnity and Fixed Indemnity Insurance

The proposed rule clarifies that benefits paid from employer-provided hospital indemnity or other fixed indemnity benefits are not excluded from an employee's gross income if they are payable regardless of whether the covered individual incurs medical expenses or regardless of whether the plan has substantiated that the individual incurred qualified medical care expenses.

This will generally result in benefits under fixed indemnity policies being taxable to employees when premiums are paid pre-tax or the plan does not substantiate that the benefits are paid only for qualified medical expenses actually incurred.

These requirements will be effective on the ***later*** of:
(a) the date the final rules are published, or
(b) January 1, 2024.

Level-Funded Plans

In the preamble to the proposed rules, the Agencies recognize that many employers are utilizing level-funded plan arrangements. While "level-funded" is currently not a defined term under ERISA or other applicable federal law, the preamble describes these benefits as arrangements where the plan sponsor makes set monthly payments to a service provider to cover estimated claims costs, administrative costs, and premiums for stop-loss insurance for claims that surpass a maximum dollar amount beyond which the plan sponsor is no longer responsible for paying claims. The Agencies believe that a number of employers with level-funded plans utilize stop-loss insurance to limit the plan sponsor's financial responsibility.

The proposed regulations do not make any changes regarding level-funded plans, but pose a number of questions about level-funded plans for which they are seeking comments or information, some of which question how sponsors of level-funded plans are complying with applicable laws and regulations, including ACA filing requirements, consumer protection requirements under the ACA through stop-loss insurance, how refunds from stop loss providers are determined and distributed (to participants and/or the plan sponsor), and why these arrangements are becoming increasingly popular.

The goal appears primarily focused on information gathering so that the government may determine how and when to begin regulating these plans in the future.

STLDI

STLDI is a type of health insurance coverage primarily designed to fill a gap in coverage that occurs when someone transitions from one plan or coverage to another. It is typically not employer sponsored. STLDI has been the subject of prior regulations, including HIPAA portability regulations finalized in 2016 (which limited the duration of STLDI to a maximum coverage period of three months, which could be extended by participants, and required employers and issuers to provide certain notices to members, participants, and beneficiaries). In 2018 regulations, the maximum STLDI duration was extended to less than twelve months after the original date of the contract and allowed individual participants to elect to extend coverage for up to 36 months.

The new proposed regulations reduce the maximum duration of STLDI coverage from 12 months back to a contract term of no more than 3 months, and taking into account any renewals or extensions, a maximum duration of no more than 4 months. Moreover, only one policy can be issued by a carrier within the same 12-month period, which is intended to prevent "stacking" of multiple policies to avoid the duration limit.

Once finalized, the rule will not impact STLDI policies, certificates, or contracts of insurance sold or issued before the effective date of the final rule and will apply to all new STLDI policies sold on or after the effective date of the final rule, which will be 75 days after the date the final rule is publicized.

Both new and existing policies will have new notice requirements to inform participants that STLDI is not comprehensive coverage and is intended to be for a limited duration. The content of the revised notices will be released with the final rules, though a template

proposed notice and potential, alternative notice were included in the proposed regulations.

Conclusion

At this time, employers are not required to take any action. Comments to the proposed rules are due on or before September 10, 2023; however, the final rules will not be released until sometime after that date. Once regulations are finalized, employers with employer sponsored fixed indemnity plans should review their programs to confirm their status as an "excepted benefit."

The tax changes for hospital indemnity and other fixed indemnity benefits may be effective sooner, as they apply on the effective date of the final rules (or January 1, 2024 if the final rules are released before then).

This alert was prepared for Woodruff Sawyer by Marathas Barrow Weatherhead Lent LLP, a national law firm with recognized experts on the Affordable Care Act. Contact Stacy Barrow or Nicole Quinn-Gato at sbarrow@marbarlaw.com *or* nquinngato@marbarlaw.com.

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