

Agency Updates

Issue Date: June 18, 2020

In the last couple weeks, the government agencies (the EEOC, IRS, DOL and HHS) have held public meetings, released proposed and final rules, and updated forms and fees affecting employee benefit offerings. The following items are summarized below:

- PCORI Fee – Updated Form 720
- Qualifying Medical Expenses – Direct Primary Care & Health Care Sharing Ministries
- EEOC Wellness Rules – Notice of Proposed Rules
- §1557 Nondiscrimination Rules Modified

PCORI Fee – Updated Form 720

The PCORI fee for plan years ending in 2019 is due no later than July 31st, 2020.

The IRS provided indexed PCORI fees for plan years ending in October – December 2019 in IRS Notice 2020-44 (<https://www.irs.gov/pub/irs-drop/n-20-44.pdf>). The payment amounts are as follows:

- \$2.45 per covered life for plan years ending in January – September 2019.
- \$2.54 per covered life for plan years ending in October – December 2019.

The updated Form 720 can be found here - <https://www.irs.gov/pub/irs-pdf/f720.pdf>.

Qualifying Medical Expenses – Direct Primary Care & Health Care Sharing Ministries

The IRS released proposed rules indicating that most direct primary care (DPC) arrangements and health care sharing ministries will be considered “medical coverage” or “medical insurance” and thereby meet the definition of a qualifying medical expense under §213(d). While these IRS rules clarify some of the tax issues surrounding these arrangements, they do not address other compliance questions such as ERISA applicability, COBRA, ACA compliance, and others. Note that these rules will not take effect until after the final rules are published.

DPC Arrangement

In the proposed rules, a DPC arrangement is defined as “a contract between an individual and one or more primary care physicians under which the physician or physicians agree to provide medical care...for a fixed annual or periodic fee without billing a third party.” However, there are many different arrangements that fall under the category of a DPC arrangement, so the IRS guidance also requests comments on this definition, suggesting that it may need to be expanded to include individuals beyond just physicians (e.g. nurse practitioners, physician assistants or dentists).

Whether a DPC arrangement is considered “medical care” or “medical insurance” depends upon the specifics of the arrangement. It seems likely that the final rule will provide more guidance on how to categorize a DPC arrangement and will clarify whether the expenses are reimbursable only by an HRA, or by an HSA and health FSA as well. An HRA is permitted to reimburse any qualifying medical expenses, while HSAs and health FSAs are permitted to reimburse all qualifying medical expenses except for medical insurance premiums.

Health Care Sharing Ministry

The proposed regulations define a health care sharing ministry as an organization:

1. Which is described in section 501(c)(3) and is exempt from taxation under section 501(a);
2. members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs;
3. members of which retain membership even after they develop a medical condition;

4. which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999; and
5. which conducts an annual audit which is performed by an independent certified public accounting firm.

The proposed rules indicate that a health care sharing ministry is “medical insurance,” and therefore the costs are reimbursable by an HRA, but not by an HSA or health FSA (because HSAs and health FSAs are not permitted to reimburse insurance premiums).

HSA Eligibility

The proposed rules also clarify that participation in a DPC arrangement or health care sharing ministry will generally make individuals ineligible to contribute to an HSA. To be HSA-eligible, an individual must be enrolled in a qualifying HDHP and not have any other disqualifying coverage. A health care sharing ministry will always be considered disqualifying coverage, and most DPC arrangements (including those paid for by the employer) will also be disqualifying coverage.

EEOC Wellness Rules – Notice of Proposed Rules

Wellness programs involving disability-related questions (e.g. health risk assessment) or medical testing or examinations (e.g. biometric screening or annual physical) must comply with EEOC wellness rules to avoid violating the Americans with Disabilities Act (ADA). The original rules provided by the EEOC in 2016 indicated that an incentive limit of 30% or less was acceptable. However, following a court decision challenging whether the 30% limit was “voluntary,” the EEOC vacated the incentive limit without providing any definitive guidance in regard to what level of incentive, if any, could be provided with violating the ADA.

Just last week, the EEOC held a remote public meeting during which the Commission voted in favor of approving new proposed rules. The proposed rules will likely be released for public comment soon. During the public meeting, the Commission described two key components of the proposed rule:

1. Incentive Limits – The general EEOC rule is that only a de minimis incentive is permitted to encourage participation. However, there is a broad exception for any wellness programs that are part of an employer-sponsored group health plan and therefore subject to HIPAA wellness rules. Such wellness programs are permitted to follow the HIPAA incentive limit of 30%.
2. Confidentiality – There will be increased requirements for communication about the type of medical information collected and stored as part of the wellness program and consent for such collection and storage of information. There may also be some additional requirements that extend to third parties assisting in offering or administering the wellness program.

We will get more details once the proposed rules are officially released, but in the meantime, wellness programs with an incentive of 30% or less tied to the group health plan (e.g. reduction in cost-sharing or monthly premium) are likely acceptable. These rules will not be effective until after the proposed rules are released, time for public comment is provided, and the final rules are published.

§1557 Nondiscrimination Rules Modified

§1557, added by the ACA, prohibits covered entities from discriminating against individuals on account of race, color, national origin, sex, age, and disability.

Late last week, HHS finalized rules that roll back several of the requirements of previous agency guidance interpreting §1557 requirements. The following changes were made:

- Definition of Covered Entity: The definition of a “covered entity” previously included any organization providing health programs and activities that received federal funds administered by HHS, health programs and activities administered by HHS, and health programs and activities administered by entities established under Title I of the ACA (e.g. public Marketplaces/Exchanges). The final rules limited the application of §1557 to the portion of a business engaged in health programs or activities receiving HHS federal funding rather than applying broadly to the entire organization. This change means health insurers

are not covered entities except for operations or product lines that receive federal funding. And importantly, employer-sponsored plans are excluded unless they receive federal funding (e.g. Medicare Part D subsidies). The reality is that most employers were already excluded from the definition of covered entities and not directly subject to the rules, and this final rule limits §1557 application even further.

- Definition of Sex: The definition of “sex” for purposes of discrimination no longer includes termination of pregnancy or gender identity.
- Nondiscrimination Notices and Taglines: Previous guidance required covered entities to distribute nondiscrimination notices (including foreign language taglines). The final rule removed this requirement.
- Grievance Procedures and Retaliation Prohibition: Earlier rules required employers to maintain grievance procedures for those with §1557 discrimination claims and also prohibited retaliation for those making such claims. The final rule removed the requirement for employers to maintain grievance procedures and the prohibition on retaliation.

Employers sometimes question whether plans are required to provide coverage for conditions relating to gender identity such as gender dysphoria. To the extent that §1557 was previously interpreted to require such coverage by covered entities, that may no longer be the case. However, whether a plan is subject to §1557 requirements or not, employers considering excluding such coverage should consider whether doing so would violate broader federal and state nondiscrimination requirements (e.g. Title VII), especially in light of the most recent Supreme Court decision regarding the definition of sex for purposes of employment discrimination.

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