issue paper
American Staffing Association
277 South Washington Street, Suite 200 ▪ Alexandria, VA 22314-3675 ▪ 703.253.2020 ▪ 703.253.2053 fax ▪ americanstaffing.net

May 8, 2023

By Alden J. Bianchi, Esq.
Counsel
McDermott Will & Emery LLP
200 Clarendon St, Floor 58
Boston, MA 02116-5021
617-535-4152
abianchi@mwe.com

Edward A. Lenz, Esq.
Senior Counsel
American Staffing Association
277 S. Washington St., Suite 200
Alexandria, VA 22314
703-253-2020
elenz@americanstaffing.net

Buyer Beware: The Newest Wave of Hospital/Fixed Indemnity Programs Promising Payroll Tax Savings

In February 2021, ASA published the article *Section 125 Plans Offering Wellness Benefits Warrant Caution—Be Sure You Understand the Tax Rules* in its *Staffing Today* newsletter. The article cautioned members to beware of certain products and programs marketed and variously described as "wellness" or "hospital indemnity" plans that promised significant payroll tax and, in some instances, income tax savings.

Since publication of that article, members have been reporting with increasing frequency on the marketing of a new wave of these products and programs (herein, "programs"). While varying in their design features and terminology, the programs share one concept in common: reduction of employee salary or wages coupled with a restoration of the salary or wages and a claim of outsized payroll tax savings. This article is intended to provide updated guidance to ASA members that may be considering participating in such programs.

For the reasons explained below, the authors are of the view that *any* health program, however configured, that claims to achieve material payroll tax savings exposes adopting employers to a significant risk of violating federal tax and other laws. Specifically, the more than a half-dozen programs that have come to the authors' attention and been reviewed

- Confuse federal regulation of hospital/fixed indemnity insurance[1] with the state regulation of hospital/fixed indemnity insurance
- Misapply the relevant tax principles and corresponding Internal Revenue Code provisions on which medical benefits may be excluded from income
- Place undue reliance on the U.S. Treasury Department's proposal to clarify the rules relating to fixed indemnity payments in its so-called Green Book[2]

Background

Health benefits-based programs promising tax savings are not new. In a 2002 revenue ruling, the U.S. Internal Revenue Service considered and rejected a so-called double dipping arrangement under which employers were encouraged to reimburse employees, purportedly tax free, for health insurance premiums paid by the employees on a pretax basis. The arrangement first reduced an employee's pay on a pretax basis for health

1. The term "hospital indemnity or other fixed indemnity insurance" is the term used in the applicable federal statutes (principally, the Health Insurance Portability and Accountability Act of 1996 and the Patient Protection and Affordable Care Act of 2010). The term is also used in a model law issued by the National Association of Insurance Commissioners. For marketing purposes, many carriers variously refer to "hospital or other fixed indemnity insurance," "hospital indemnity insurance," or "fixed indemnity insurance." For convenience, this article refers to "hospital/fixed indemnity" insurance, policies, benefits, coverage, etc.

2. See "General Explanations of the Administration's Fiscal Year 2024 Revenue Proposals," also called the Green Book, which provides a detailed analysis of the tax policy proposals contained in the Administration's budget, available at *home.treasury.gov/system/files/131/General-Explanations-FY2024.pdf*.

insurance premiums, thus reducing the employee's taxable income and the employer's payroll tax liability. The employer then reimbursed the employee for part of the premium expenses deducted from salary, claiming the reimbursements as an employer expense that were not taxable income to the employee.

The IRS disagreed with the claimed tax treatment, pointing out that, for an employee to be reimbursed on a nontaxable basis for the insurance premiums, the employee must first incur the expense. Because the employee paid the premium with pretax dollars, and because the law treats the portion of the premium reimbursed as an expense paid by the *employer* and not the employee (more on this below), the employer was effectively taking the deduction twice, hence the "double dip." According to the IRS, the reimbursed amounts must be included in the employees' income and are also subject to payroll taxes. Later that same year, the IRS summarily rejected two other similar programs, involving advance reimbursements and loans.

In the decade that followed, promoters began to leverage combinations of hospital/fixed indemnity health plans and wellness plans with the same aim of generating material tax savings. A trio of IRS general counsel memoranda issued in 2016 and 2017 examined variations of the double-dipping arrangements. The promoters' focus on hospital indemnity plans was in response to these memoranda. Each new set of arrangements sought to overcome the specific objections voiced by the IRS. In one instance, for example, the proposed arrangement lacked the required risk shifting to qualify as insurance. Promoters responded to the lack of risk shifting by wrapping the benefit in a fixed indemnity policy issued by a licensed health insurance carrier.

Hospital Indemnity/Wellness Programs

The most recent crop of hospital/fixed indemnity/wellness programs come in two flavors, which this article will refer to as "integrated" and "bifurcated."

- In an integrated arrangement, all the program benefits are provided under a single hospital/fixed indemnity policy. There is no separate wellness component.
- Bifurcated arrangements separate the hospital/fixed indemnity policy from the wellness feature, which takes the form of a policy rider.

At first blush, these structures might seem wildly divergent. Integrated arrangements generally avoid the "wellness" label; bifurcated arrangements embrace it. Confusingly, arrangements of both stripes often adopt alternative labels, claiming to instead provide "health management" or "preventive" services. None of these various approaches, labels, or design features sidestep the ACA insurance market reforms and health coverage nondiscrimination rules or the other applicable legal rules explained below. Nor does the addition of a "direct primary care" benefit, like a preventative-services-only "minimum essential coverage" (MEC) plan, or an enhanced MEC plan that includes dental coverage, prescription drug discounts, or telehealth benefits, among others. Adding a MEC plan may help with ACA issues but does not change the underlying tax analysis or otherwise mitigate the authors' concerns.

Despite their design variations, all these programs hold out the promise of a substantial net payroll tax savings, a portion of which is paid to the promoter to cover the costs of administration. The premium cost of these programs is significant, and it is paid in all the

programs reviewed entirely by employees on a pretax basis under a cafeteria plan.[3] As a result, the premiums are treated for tax purposes (for the reasons explained below) as entirely *employer* paid.

Typically, a program might call for each covered employee to make a salary reduction of $1,200 per month (generally weekly for temporary employees). Of this amount, $1,000 is restored to the employee, with the remaining $200 used to cover the cost of a small traditional hospital/fixed indemnity policy (perhaps $100 per month); to provide access to nominal health-related services like telehealth care and wellness coaches; and to provide a fee to the promoter. The vendors that manage those service options are often owned by the promoter. While the employee receives only $1,000 in return for a $1,200 salary reduction, the employee receives greater take-home pay because of the tax savings.

After paying the $1,200 via a salary/hourly wage reduction, the employee engages in an activity that triggers the restoration payment. In addition to the traditional event that triggers the hospital/fixed indemnity benefit—a fixed dollar amount per day (or per other period) of hospitalization or illness—each program purports to require employees to engage in certain activities, such as participating in a health screening, calling a toll-free telephone number, checking a website that provides general health information, or attending a seminar or webinar that involves general health information. For engaging in the activity, the employee's salary reduction is substantially restored. In some instances, however, the restoration payment is made merely upon the *sending* of a text or email to the employee with a link that provides access to the featured activity. In other words, the notification itself triggers the payment. Although the employee's activity is assigned a medical Current Procedural Terminology code, the activity may or may not actually qualify as medical care eligible for a tax deduction or an exclusion from income.

Analysis

The term hospital/fixed indemnity insurance means two very different things depending on the regulatory context. Program promoters often tout that their hospital/fixed indemnity policy is approved by a state insurance regulator. A determination by a state regulator that a policy of insurance is "hospital indemnity or other fixed indemnity insurance" is not relevant for purposes of federal tax or other laws, however. It simply means the state will regulate the policy as hospital indemnity or other fixed indemnity insurance rather than as individual or group health insurance. For federal regulatory purposes, hospital/fixed indemnity insurance is **not** health insurance; it is rather similar in nature to disability insurance. Its purpose is income replacement in the event of hospitalization or illness. It is for this reason that true hospital/fixed indemnity coverage is not subject to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act. There is no health insurance coverage to continue.

Excepted Benefit Status of Hospital/Fixed Indemnity Coverage

For purposes of federal tax and benefits law, the status of hospital/fixed indemnity insurance as an "excepted benefit" looms large. To qualify as such, a policy only must pay a fixed dollar amount per day (or per other period) of hospitalization or illness. These triggers are wholly consistent with the need for income replacement. A policy that pays benefits only on these narrow triggering events is not subject to a laundry list of

3. While not a legal question, the reduction in employee's pay under the cafeteria plan would result in a corresponding reduction in employee Social Security contributions, which could reduce the employee's Social Security retirement benefits.

federal laws including the ACA's insurance market reforms.[4] If, however, a policy pays on some *other* trigger, involving medical or preventative services, as all these programs do, then the program is providing group health insurance or a wellness benefit, or both, in which case other laws would come into play.

By way of example, a program that reimburses a covered employee for viewing a monthly, no-cost health education video would be regulated as a wellness program for ACA purposes. Similarly, a program that reimburses a covered employee for engaging with a health screening or filling out a health risk assessment would likely be subject to the Americans With Disabilities Act rules governing voluntary wellness programs. While the ACA places no limits on the amount of the reward for participation in a wellness plan, these programs may not be able to satisfy all the other ACA-imposed requirements; and the amount of program reimbursements would likely exceed the limit on incentives under U.S. Equal Employment Opportunity Commission rules implementing the ADA's voluntary wellness standards. Although the precise contours of the EEOC's rules have been the subject of legal challenges, and their status is currently less than certain, the risk nevertheless remains.

Lastly, to qualify as an excepted benefit, hospital/fixed indemnity coverage must exhibit risk shifting. Here again, that a state insurance regulator has approved a policy does not establish that a program or arrangement shifts risk for purposes of federal law. While the traditional hospital/fixed indemnity portion of the policy ($100 per month in the example above) likely shifts risk in a manner that would satisfy the ACA requirement, it is unlikely that the same can be said for other triggering events. The authors are skeptical that these programs would be found to be insured (i.e., involving actual risk-shifting) with respect the entire restoration payment of $1,000 per period, period after period for engaging in activities—many of which have at best only marginal substance.

The Tax Deduction Rules

The Internal Revenue Code starts with the assumption that all income is taxable. Exclusions from income are the exceptions. Benefits under a traditional hospital/fixed indemnity arrangement are excluded from gross income where an individual purchases the policy with their own, after-tax funds. But if the employer is the sole contributor of the premiums or if premiums are paid pretax under a cafeteria plan, then this exclusion is not available.[5] Rather, amounts paid by or on behalf of an employer to an employee for personal injuries or sickness are excludable from income, if at all, only under the rules governing employer-funded group health plans.

Final Treasury regulations hold that, where coverage is paid for on a pretax basis, benefits are taxable to the extent that they exceed the individual's unreimbursed medical expenses (the "excess benefit"). While the program promotional materials are not always clear or consistent, for the most part, promoters concede that at least some portion of the amounts restored to employees as benefits are subject to income tax as an excess benefit. That concession, coupled with a clear Treasury rule, makes untenable the

4. The federal laws that may apply to wellness programs include the HIPAA portability and administrative simplification (privacy and security) rules; the ACA wellness and insurance market reforms; the Americans With Disabilities Act; the Genetic Information and Nondiscrimination Act ; and Consolidated Omnibus Budget Reconciliation Act. In addition, paying premiums under a cafeteria plan virtually ensures that these programs will be subject to the Erisa reporting and disclosure rules and fiduciary standards.

5. To the extent that programs "auto-enroll" employees, it could violate the cafeteria plan rules requiring voluntary election.

promoters' claim that the entire $1,000 restoration payment is not salary or wages but rather a benefit payment not subject to payroll taxes. Indeed, given the nominal medical expense triggers under the programs, income and payroll taxes likely are owed on most or *all* the payments.

Take away the insurance wrapper, and the programs look suspiciously like the arrangement described and rejected by the IRS in 2002. Simply because employers and carriers lack (or claim to lack) the ability to reliably determine what portion of the payment is wages as opposed to reimbursement for medical care should not relieve them of their obligation to comply with the underlying tax rules. That is the situation addressed in the Treasury Department's Green Book recommendations, discussed next.

The Green Book

The Treasury Department's annual Green Book explains the administration's budget proposals, including recommendations for improving the federal tax code provisions relating to employee benefits. The 2022 and 2023 Green Book reported (accurately) that only amounts paid to reimburse an employee's medical care expenses are not subject to payroll taxes.

The Green Book notes that "employers are increasingly offering employees insured fixed indemnity benefits, which provide the employees with a fixed payment upon the occurrence of a specified medical event, instead of or in addition to traditional medical expense-based coverage." (p. 204). The Treasury Department expresses concern that insurers, employers, and employees generally fail to track the amount of the employees' medical expenses tied to the medical event that triggered the fixed payment, despite the importance of these amounts for determining the amount that is properly excludable from employees' gross income. As a result

> "[E]mployers who fail to track expenses generally fail to include the amount of any fixed payment in excess of actual medical expenses in the employees' gross income for income tax purposes or in compensation (or wages) for FICA and FUTA tax purposes. This leads to an underpayment of taxes owed."

To address the underpayment of taxes, "[t]he proposal would amend [the tax code] to *clarify* that the exclusion from gross income for payments received through an employer-provided accident or health plan applies only to the amount paid directly or indirectly for a specific medical expense." [*emphasis added*]

Some promoters believe that the government's desire for clarification suggests ambiguity that supports the current programs until the rules are clarified. Perhaps, but if the Green Book's proposal on the subject were adopted, the tax benefits claimed by the programs would be unambiguously eliminated. At best, any ambiguity is likely to provide only a brief reprieve from that outcome. In the meantime, the more practical immediate question is the risk of audit, and that the IRS would require repayment of all under-withheld tax payments, plus penalties and interest—and what level of exposure is acceptable to the client?

Concluding Thoughts

The consequences of maintaining the sort of hospital indemnity/wellness programs that are the subject of this article are significant. The IRS would, on audit, likely require repayment of all under-withheld tax payments, plus substantial penalties, and interest. In

addition, employees might be required to refile taxes for the years in which their W-2 income understated applicable tax payments.

Promoters of the programs insist that their programs comply with applicable law. "Our program is different" is a common refrain. The authors are skeptical and urge caution. Staffing firms should tread carefully when presented with any sort of health plan, however described, promising major tax savings and should consult competent, independent advisers with a clear understanding of the law and the compliance risks before committing.

Alden Bianchi is counsel in the Boston office of McDermott Will & Emery LLP specializing in Erisa, employee benefits, executive compensation, and related tax law. Bianchi has long served as outside benefits counsel for ASA. He has advised many staffing firms and was instrumental in guiding the industry through the Affordable Care Act.