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INTERNAL REVENUE SERVICE RELEASES MEMORANDUM ON SELF-FUNDED FIXED PAYMENT PROGRAMS THAT CLAIM TO HAVE NO IMPACT ON EMPLOYEE TAKE-HOME PAY

The Internal Revenue Service (IRS) released a Memorandum (Memo) on May 12, 2017. As a reminder, IRS Memoranda do not act as binding authoritative writings, and therefore may not be treated as precedence, so employers should not rely on the contents of the Memo. However, IRS Memoranda are often used to guide employers in the area of tax compliance. The Memo addresses one outstanding question on amounts received by employees for health-related activities:

- If an employee receives payments for participating in a health-related activity under an employer sponsored self-funded fixed payment program, and those payments are greater than the amounts an employee has paid on an after-tax basis towards that benefit, should these excess payments be included as income/wages to that employee?

Background

Currently, promoters (e.g., product developers or insurance brokers) are selling self-funded health programs to employers that are promoted as a program that has little or no cost to an employer or employee, because the premiums do not affect the net take-home pay of an employee. Essentially, the promoters of these programs claim that these benefits received by employees do not constitute income or wages to the employee. An example of a program the IRS addresses in their Memo is included below:

- An employer provides a program whereby an employee voluntarily participates in making pre-tax contributions to a health program, in addition to making a post-tax contribution to a self-funded health plan. A significant amount of the pre-tax contributions are “refunded” back to the employee as a cash payment from the self-funded health plan or a reward through the wellness program, and these refunded amounts are not being included as income to the employee.
- Because the pre-tax contributions made to the health program are excluded from payment of the Federal Insurance Contributions Act (FICA) taxes by both the employee and employer, an employee’s **net take-home pay** remains unchanged after having made contributions to this health program.
- The employer pays a fee to the promoter for administration of the program, which is a reduced amount of the FICA taxes that would have been paid had the contributions to the health program been made on a post-tax basis. This creates the perception that the program is being provided at little or no cost to the employer/employee.

The Memo provides responses to two different scenarios that apply to the above benefit offering.

IRS Releases Memorandum on Fixed Payment Programs That Claim to Have No Impact on Employee Take-Home Pay (continued)

A Self-Funded Fixed Payment Plan that does not Involve Insurance Risk

In general under the IRS Code, an **employee** that purchases a policy using that **employee's** own after-tax funds, payments received by the employee under that policy are excludable from that employee's gross wages. However, this is contingent upon the employee purchasing a valid "insurance" plan. In summary, if an employee is able to purchase a **valid** policy on a **post-tax basis**, that employee may also receive any payments from that policy without being taxed on those amounts received.

However, the Memo calls into question whether certain employee paid programs are valid in allowing employees to receive payments from certain fixed-payment plans without taxation. The IRS describes two scenarios below:

Situation 1

An employer provides all employees (regardless of enrollment in major medical coverage), the ability to enroll in a self-funded fixed premium plan. Employees who elect into the self-funded fixed premium plan pay a small, **after-tax** employee contribution to the program of **$60 per month**. The self-funded fixed premium plan then pays a fixed cash payment benefit to employees for participating in certain activities related to health (e.g., calling a toll-free telephone number or participating in a seminar that provides general health-related information, participating in biometric screening). Employees are not charged for participating in the activities. The amount an employee receives for completion of the activity is **$1,425 per activity**, with the ability to only participate in one activity per month during a 12 month period. Under an actuarial analysis of the program, employees receive benefit payments that far exceed their after-tax contribution to the program.

Situation 1 Conclusion
The Memo states that the above arrangement, although it may include engagement in certain activities related to health, does not involve a risk of economic loss or a fortuitous event. Therefore, because the plan does not have the effect of "shifting risk" to the plan, it would not be considered "insurance" or considered to have the "effects of insurance." The IRS takes the position that the amounts received by the employee in this situation should **not** be excluded from that employee's income. Therefore, the employee would pay taxes (i.e., employment and income taxes) on any amounts received through the self-funded fixed premium payment plan, which would be any excess amounts above the original after-tax employee contribution. Therefore, in the above *Situation 1*, if an employee had successfully completed all of the required activities, that employee would pay taxes on the payments they received in the amount of $16,380 ($17,100 ($1,425 activity payments X 12 months) - $720 ($60 premium X 12 months) = $16,380 as income).

A Wellness Plan in Combination with a Self-funded Fixed Premium Plan

Situation 2

An employer provides all employees (regardless of enrollment in major medical coverage), the ability to enroll in a self-funded fixed premium plan. Employees who elect into the self-funded fixed premium plan pay a small, **after-tax** (i.e., excludes employment taxes) employee contribution to the program of **$60 per month**. The self-funded fixed premium plan pays a fixed cash payment benefit to employees for participating in certain activities related to health (e.g., calling a toll-free telephone number or participating in a seminar that provides general health-related information, participating in biometric screening). Employees are not charged for participating in the activities. The amount an employee receives for completion of the activity is **$1,425 per activity**, with the ability to only participate in one activity every 12 months. Under an actuarial analysis of the program, employees receive benefit payments that far exceed their after-tax contribution to the program.

Further, the employer offers employees the ability to enroll in a wellness plan, in addition to the above self-funded fixed premium plan. Employees who participate in the wellness plan pay a pre-tax employee contribution of **$1,500 per month** through a valid cafeteria plan. The wellness plan provides employees with health-related wellness activities at no charge to the employees. If an employee's net-take home pay – after taking into account the employee's contribution to both the wellness plan and the fixed indemnity plan and payment from the self-funded fixed premium plan - **exceeds** his/her net-take home pay, those excess monies would be paid into the wellness plan as flex credits for the employee to purchase benefits under the Section 125 cafeteria plan.

Situation 2 Conclusion
The Memo states that the above arrangement would still be treated as taxable income to the employee for any payments made by the self-funded fixed premium plan to the employee. Therefore, because the plan does not have the effect of the "shifting risk" to the plan, it would not be considered "insurance" or considered to have the "effects of insurance." However, any flex dollars that were added to the wellness plan would not be considered income to the employee, so long as the employee used those flex dollars to buy benefits that were included in the employers Section 125 cafeteria plan.

Memo Conclusion

Employers offering fixed payment plans that may be sold as "little or no cost plans" to the employer/employee because monies are being used for health related activities should be cautious in offering these plans due to tax complications. If the plan is not considered a true "health insurance" plan, employers and employees may be subject to taxes for offering and/or participating in these plans. This may be true even if the plan is offered in conjunction with a wellness plan.

IRS Releases Memorandum on Fixed Payment Programs That Claim to Have No Impact on Employee Take-Home Pay (continued)

Action Required

Employers offering self-funded fixed premium plans should ensure that they are offering true "risk shifting" insurance plans, or they could expose themselves and employees to future taxes. Employers should carefully review any plan offerings that may be sold as "low cost/no cost" self-funded fixed payment plans.

For the complete details, see:

Office of Chief Counsel, IRS Memorandum 201719025: https://www.irs.gov/pub/irs-wd/201719025.pdf

SAN FRANCISCO PROVIDES GUIDANCE FOR PAID PARENTAL LEAVE ORDINANCE

The San Francisco Office of Labor Standards Enforcement (OLSE) recently released Frequently Asked Questions for San Francisco Paid Parental Leave Ordinance (the FAQs), which requires that certain employers provide Supplemental Compensation to employees receiving California Paid Family Leave (PFL) benefits to bond with a new child. The Ordinance went into effect on January 1, 2017 for employers with fifty (50) or more employees, and will be phased in for smaller employers (for employers with thirty-five (35) or more employees, the Ordinance is effective **July 1, 2017**, and for employers with twenty (20) or more employees, the Ordinance is effective **January 1, 2018**). Highlights of the new FAQs are discussed below.

Covered Employers

Covered employers are those that employ a threshold number of employees (i.e., twenty (20) or more on January 1, 2018), regardless of whether the employer is headquartered in San Francisco.

Determining Employer Size

To determine employer size for the phase-in effective date, the employer must count their seasonal, permanent, temporary, full-time employees, part-time employees, independent contractors, and employees working within and outside of San Francisco.

If the number of employees employed varies each week, then the employer must use a PPLO Lookback Period (twelve (12) weekly pay periods, six (6) bi-weekly pay periods, or three (3) monthly pay periods preceding the first day of PFL leave) and count the number of employees employed during this time to determine whether they qualify as a covered employer.

Covered Employees

Covered employees are those who:

- started working for the employer at least 180 days before their PFL started;
- work for the covered employer for at least eight (8) hours per week;
- work at least forty (40) percent of their weekly hours in San Francisco for the covered employer; and
- have applied for, and receive, PFL benefits.

The FAQs clarify that covered employees exclude government workers.

San Francisco Provides Guidance for Paid Parental Leave Ordinance (continued)

Employees Must Apply for State and City Paid Leave Benefits

The FAQs clarify that there are two different sources of paid parental leave benefits—the PFL program, administered by the California Employment Development Department (EDD), and the San Francisco Paid Parental Leave Ordinance (PPLO), paid by covered employers. Employees must apply for both in order to receive paid leave benefits under the PPLO.

Amount of Supplemental Compensation Available

The PPLO requires employers to provide employees receiving PFL with "Supplemental Compensation" equal to the difference between the employee's normal weekly wages, and the employee's PFL benefits (i.e., 40%, or 30% for some employees in 2018). Currently, the PFL provides eligible employees with up to 55% of their weekly wages for up to six (6) weeks to bond with a new child, up to a weekly maximum benefit amount. The FAQs explain that this rate will increase to 60% (or 70%, depending on income), in 2018. For additional information on this topic, please see the February 2017 issue of our Legislative Compliance Monthly Newsletter for an article titled: Maximum Weekly Benefit Increases for California and San Francisco Paid Parental and Family Leave.

Payment of Benefits and Waiting Period

The FAQs explain that employers do not need to pay Supplemental Compensation during the employee's one (1) week waiting period under the PFL. This waiting period will be eliminated in 2018, and the employer is obligated to pay Supplemental Compensation for the six (6) weeks that an employee is entitled to, and receives PFL benefits (without a waiting period).

Use of PTO or Vacation Time

Employers may, upon employee consent, apply up to two (2) weeks of an employee's accrued vacation time to cover the cost of the Supplemental Compensation. However, if an employee works for an employer with ten (10) or more employees (our belief is that this is a typographical error, and this should state twenty (20) employees - we are currently seeking clarification from the City on this issue), and if an employee has accumulated PTO/vacation time in **excess** of 72 hours, an employer may **require** the employee to apply those **excess** hours (above 72 hours) of PTO/vacation time to cover the cost of their Supplemental Compensation. The FAQs provide the following example, illustrating an employer who requires an employee's PTO in excess of seventy-two (72) hours to be applied to the cost of their Supplemental Compensation:

> If a covered employee accrued eighty-two (82) hours of paid time off for an employer with twenty (20) or more employees, the employee **must** agree to allow the employer to apply up to ten (10) hours of paid time off to cover the cost of the Supplemental Compensation.

Employers who choose to require employees to use up to two weeks of an employee's PTO/vacation time (i.e., without employee consent), which an employer is allowed to do under California PFL, an employer would not receive credit towards the required six (6) weeks of time under the SF PPLO for any time that the employee was required to use his/her PTO/vacation time.

More importantly, an employer may not use an employee's accrued **sick time** to cover the cost of the Supplemental Compensation, and may only use the employee's **PTO/vacation time** to satisfy its requirement under the SF PPLO.

Action Required

Employers with employees in San Francisco should review the FAQs and revise their leave policies if necessary to ensure compliance with the Paid Parental Leave Ordinance in light of these clarifications.

For the Frequently Asked Questions and Ordinance, see:

http://sfgov.org/olse/paid-parental-leave-ordinance

TEXAS PASSES LEGISLATION EXPANDING TELEHEALTH SERVICES

Background

On May 27, 2017, Texas Governor Greg Abbott signed Senate Bill 1107 (SB 1107) into law. SB 1107 was passed in order to rectify previous regulations that restricted patients from having access to physicians through telemedicine services, and to clarify the permissible uses of telemedicine services for Texas physicians. Although the bill expands the use of telemedicine services for Texas physicians, the bill also provides that the Texas Medical Board (TMB) has discretion to adopt additional regulations regarding the administration of telemedicine services, which may result in modification of this law in the future. Highlights of SB 1107 are detailed below.

SB 1107 Provisions

Establishing the Physician-Patient Relationship

Physicians are now permitted to establish the physician-patient relationship with a new patient using telehealth services, without conducting an in-person examination or having another healthcare provider be physically present with the patient during a telehealth visit.

Using Telehealth for Treatment

SB 1107 allows Texas physicians to practice telemedicine through a variety of telehealth platforms, including real-time audio and video, and asynchronous (store-and-forward) platforms. Physicians are permitted to treat patients using these various telehealth platforms, so long as:

1. The physician provides appropriate follow-up care;
2. The physician has access to, and uses, relevant photographic or video images, or other relevant medical records (e.g., lab reports, medication histories, and pathology records) during the patient's course of treatment; and
3. The physician forwards to the patient's primary care physician, if applicable, (and the patient consents), a record or report of the telemedicine treatment (including evaluation, analysis, and/or diagnosis) within seventy-two (72) hours of the encounter.

These regulations do not apply to mental health services.

Prescribing Medications using Telehealth

SB 1107 allows physicians to prescribe medication based on a telemedicine consultation with a patient, but requires that the TMB, Texas Board of Nursing, and the Texas Board of Pharmacy develop and implement regulations regarding what prescriptions may be prescribed based on a telemedicine consultation.

However, physicians are not permitted to prescribe an abortion drug or device through telemedicine services.

Telemedicine Standard of Care

SB 1107 states that physicians treating patients through telemedicine services are subject to the same standard of care that would apply to other forms of heath care services or procedures provided in an in-person setting. SB 1107 prohibits an agency from imposing a higher standard of care on physicians providing telemedicine services.

Insurance Coverage for Telemedicine Services

According to SB 1107, insurers cannot exclude telemedicine services from coverage solely because the service is not provided in an in-person setting. However, telemedicine services may be excluded from coverage if the service is solely provided via **audio** interaction (synchronous or asynchronous), including an audio-only telephone consultation, text-only email, or a fax transmission.

A plan may impose copays, deductibles, and coinsurance for a covered health service or procedure delivered by a preferred or contracted provider of a telemedicine service.

Insurers must post their telehealth coverage policies and payment practices on their websites in a conspicuous manner.

Future Regulations

SB 1107 explicitly provides the TMB the discretion to adopt new regulations to address the following areas:

1. ensuring patients receive quality care through telemedicine services;
2. preventing fraud or abuse in the use of telemedicine services (e.g., claims and medical records);
3. supervision of non-physician healthcare professionals (e.g., physician assistants and nurse practitioners) who provide telemedicine services; and

Texas Passes Legislation Expanding Telehealth (continued)

4. establishing a maximum number of non-physician healthcare professionals a physician providing telemedicine services may supervise.

No Action Required

Employers with employees located in Texas should be aware that telemedicine services may now be offered as part of an employer's overall benefits strategy.

For Senate Bill 1107, see:

http://www.legis.state.tx.us/tlodocs/85R/billtext/pdf/SB01107F.pdf

COMPLIANCE REMINDER: PCORI FEE DUE TO IRS BY JULY 31, 2017

The Affordable Care Act (ACA) imposes a fee (PCORI fee) on health insurance carriers and sponsors of self-funded health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI) and support clinical effectiveness research. The PCORI fee is due annually and must be reported on IRS Form 720 by **July 31, 2017**.

The **PCORI fee due on July 31, 2017 is $2.26 per covered life for policy and plan years ending on or after October 1, 2016 and on or before December 31, 2016**. For plan years **ending** on or after **January 1, 2017**, the fee of $2.26 per covered life will be due by **July 31, 2018**. Also, for plans ending on or after **January 1, 2016** and before **October 1, 2016**, the per covered life fee is **$2.17**. For **self-funded plans**, the **employer/plan sponsor** will be responsible for submitting the fee and accompanying paperwork to the IRS. For **fully-insured plans**, the IRS collects this fee from the insurance carrier. Third-party reporting and payment of the fee is not permitted for self-funded plans.

The process for remitting payment by sponsors of self-funded plans is described in more detail below.

PCORI Fee Reporting and Payment

The IRS will collect the fee from the insurer or, in the case of self-funded plans, the plan sponsor, in the same way many other excise taxes are collected. The fees are reported and paid annually on IRS Form 720 by July 31st of the year following the last day of the plan year. This year, the fee is due by July 31, 2017.

The fee due on July 31, 2017 is $2.26 per covered life for plan years **ending on or after October 1, 2016 and on or before December 31, 2016**. For plan years **ending** on or after **January 1, 2016** and **before October 1, 2016**, the fee due on July 31, 2017 is $2.17 per covered life under the plan. IRS regulations provide three options for determining the average number of covered lives (actual count, snapshot, and Form 5500 method).

> **Example:** The Form 720 must be filed by July 31st of the calendar year immediately following the last day of the plan year. Calendar year plans in 2016 will owe a fee of $2.26 per covered life by July 31, 2017.

The **PCORI fee must be paid by the plan sponsor**; it is not permissible to pay this fee in whole or in part through participant contributions. The PCORI expense should not be included in the plan's cost when computing the plan's COBRA premium. The IRS has indicated the fee is, however, a tax-deductible business expense for employers with self-funded plans.

How to File IRS Form 720

The filing and remittance process to the IRS is straightforward and is largely unchanged from last year. On page two of Form 720, under Part II, the employer needs to designate the average number of covered lives under its "applicable self-insured plan". The number of covered lives is multiplied by $2.26 (for plan years ending on or after October 1, 2016) to determine the total fee owed to the IRS.

Part II

IRS No.	Patient - Centered Outcomes Research Fee (see instructions)	(a) Avg. number of lives covered (see inst.)	(b) Rate for avg. covered life	(c) Fee (see instructions)
133	Specified health insurance policies			
	(a) With a policy year ending before October 1, 2016		$ 2.17	
	(b) With a policy year ending on or after October 1, 2016, and before October 1, 2017		$ 2.26	
	Applicable self - insured health plans			
	(c) With a plan year ending before October 1, 2016		$ 2.17	
	(d) With a plan year ending on or after October 1, 2016, and before October 1, 2017		$ 2.26	

The **Payment Voucher** (720-V) should indicate the tax period for the fee is "2nd Quarter".

Form **720-V** (2017)

▼ Detach Here and Mail With Your Payment and Form 720. ▼

720-V Department of the Treasury Internal Revenue Service

Payment Voucher

► Do not staple or attach this voucher to your payment.

OMB No. 1545-0023

2017

1 Enter your employer identification number (EIN) (see instructions).

2 Enter the amount of your payment. ► Make your check or money order payable to "United States Treasury." | Dollars | Cents

3 Tax Period

- ○ 1st Quarter
- ○ 3rd Quarter
- ◉ 2nd Quarter
- ○ 4th Quarter

4 Enter your business name (individual name if sole proprietor).

Enter your address.

City or town, state or province, country, and ZIP or foreign postal code.

Please Note: Plan sponsors who are required to pay the PCORI fee but are **not** required to report any other liabilities on the second quarter Form 720 will be required to file the Form 720 only once a year. Failure to properly designate "2nd Quarter" on the voucher will result in the IRS's software generating a tardy filing notice, with all the incumbent aggravation on the employer to correct the matter with the IRS.

Action Required

Plan sponsors are required to submit the fee using Form 720, the Quarterly Federal Excise Tax Return, **available here:** https://www.irs.gov/pub/irs-pdf/f720.pdf

For instructions for Form 720, see: https://www.irs.gov/pub/irs-pdf/i720.pdf

QUESTION OF THE MONTH

Can a Qualified Transportation Plan Reimburse Employees' Expenses for Carpooling With Their Own Vehicles?

QUESTION: Some of our employees have organized carpools to commute to work, and we provide those carpools with parking benefits under our qualified transportation plan. Could our transportation plan also reimburse those employees for all or a portion of their other commuting costs as a vanpooling benefit? All of the carpools use employee-owned vehicles, and some of those vehicles are quite large (e.g., minivans and sport utility vehicles (SUVs)).

ANSWER: There are some circumstances in which the vanpooling rules can be used to reimburse the expenses of carpooling arrangements that use an employee's vehicle, but those circumstances are unusual. For purposes of the qualified transportation fringe benefit rules, "vanpooling" means transportation between the employee's residence and place of employment in a commuter highway vehicle. A "commuter highway vehicle" must have a seating capacity of six or more adults (not including the driver), and at least 80% of the vehicle's reasonably expected annual mileage must be used to transport employees between their residences and their place of employment. Commuting miles count toward the 80%, however, only if the number of employees transported to or from work is at least half of the vehicle's adult seating capacity (not including the driver). For example, miles driven on a commuting trip by a vehicle that holds a driver and six passengers will only count toward the 80% requirement if at least three employees in addition to the driver are using the vehicle to get to work or to go home. These usage rules are sometimes referred to as the "80/50 rule."

Because of the seating capacity and mileage-use requirements, most family vehicles used for carpooling cannot qualify as commuter highway vehicles and thus do not qualify for vanpooling benefits. Even if a family minivan or SUV satisfies the seating capacity requirement, a family vehicle generally cannot satisfy the 80% usage requirement. After considering the difficulty of determining whether an employee-owned vehicle could satisfy the commuter highway vehicle requirements, many employers decide not to offer vanpooling benefits to carpools that use employee-owned vehicles. Instead, some employers provide high-seating capacity vehicles that must be used exclusively for vanpooling, thus making it more likely the commuter highway vehicle requirements will be met. Alternatively, vanpooling benefits can be used to pay for private or public transit-operated vanpools, which are not subject to the 80/50 rule. (A private or public transit-operated vanpool is one owned and operated by public transit authorities or by any person in the business of transporting persons for hire.)

Source: EBIA

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