THE ECFC FLEX REPORTER

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The ECFC FLEX Reporter provides in-depth coverage of developments affecting the administration of cafeteria plans, flexible spending arrangements (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs). Articles in The ECFC FLEX Reporter are authored by nationally recognized attorneys and consultants, and edited by John R. Hickman, a partner in the Employee Benefits Practice Group of Alston & Bird, LLP.

WHAT'S INSIDE

Important Note: The information contained herein is not intended to be legal, accounting or other professional advice. We assume no liability whatsoever in connection with your use or reliance upon this information. This information does not address specific situations. If you have questions about your specific situation, we recommend that you obtain independent professional advice.

The Difficult Process of Developing the Replacement for "Obamacare"

Last year Donald Trump and Republicans running for Congress stated that they would repeal and replace "Obamacare." Donald Trump is now the President, Republicans maintained control of the House of Representatives and Senate and now they all must deliver on this important promise. But campaigning on an issue and actually developing legislation are very different things. The Trump campaign had very few specifics on what his replacement would be. Although Congressional Republicans voted to repeal Obamacare may times over the past few years, they never had to actually craft legislation to provide a replacement. Now comes the hard part of legislating. This article will provide an overview of efforts to repeal and replace Obamacare which may give you an understanding on why this process is so difficult.

Repealing the Affordable Care Act

Complete repeal of the Affordable Care Act (the real name of the legislation that is referred to as Obamacare) is not as easy as it seems. Many provisions of the ACA are popular with Americans, (such as the prohibition on denying or limiting coverage due to pre-existing conditions and letting children stay on their parent's health insurance until they attain age 26), and eliminating those provisions would not be popular. Another concern is the impact of repeal on the individual insurance market; there are concerns that insurance premiums will increase drastically if the mandate for purchasing insurance is lifted while the pre-existing condition prohibition remains in place. And finally, the politics surrounding repeal means that Democrats will most likely oppose repeal legislation. This means that in the Senate, Democrats can filibuster any repeal legislation since Republicans will not have 60 votes to overcome the filibuster. To move any repeal legislation through the Senate, the legislation must be under budget reconciliation authority in order for the legislation to pass the Senate with a simple majority. (Previous repeal legislation was passed under budget reconciliation authority.) However, under the rules, a budget reconciliation bill can only have provisions that increase or decrease government spending (this would include increases or decreases in taxes), so not all of the provisions in the ACA could be repealed under a budget reconciliation bill.

In the discussion about use of the budget reconciliation process to repeal the ACA, it is important to remember that most of the ACA was not passed using budget reconciliation. The majority of the ACA was passed under regular order when the Democrats held 60 seats in the Senate and were able to overcome any threat of a Republican filibuster of the bill. Part of the ACA was passed under budget reconciliation because the Democrats lost one seat in the Senate when, in the election to fill Senator Kennedy's seat, Republican Scott Walker was elected so Senate Democrats could not overcome a filibuster attempt by Republicans. Therefore, repealing all of the ACA will not be possible unless enough Senate Democrats cross over and vote for repeal --- something that is very hard to imagine.

Common Thread in Health Care Reform for Republicans

I don't think that there is any Republican in Congress who doesn't support Health Savings Accounts (HSAs). If you remember, HSAs were enacted as part of the Medicare Modernization Act of 2003 which extended drug coverage under Medicare and, for many conservative Republicans, the HSA provisions were the only reason that they voted for a law that they thought was expanding government spending in the healthcare arena. In the years since enactment of the HSA provisions, Republicans have been tinkering with the law to try to increase the number of people covered by HSAs. The Trump campaign did not provide many details on how they would replace the ACA, but President Trump did say that HSAs would be part of the replacement.

President Trump, in his first State of the Union Address touted replacement of the ACA and again mentioned HSAs. The proposal for replacing the ACA advanced by Speaker of the House of Representatives Paul Ryan, entitled "The Better Way," includes provisions that would increase the maximum contribution amount to HSAs to equal the maximum deductible and out-of-pocket expense limits and expand eligibility for HSAs. In the Senate, Chairman of the Committee on Finance, Orrin Hatch, has introduced the Health Savings Act of 2017 (S. 403) that addresses numerous issues that many have been advocating for over the years. This legislation will likely be in any health care reform legislation coming from the Senate. A companion bill to Hatch's bill was introduced in the House of Representatives by Rep. Eric Paulsen (H.R. 1175).

Other bills have been introduced to increase the availability of HSAs and they are likely to be included in any health care reform discussion. For example, Senator Rand Paul introduced legislation (S. 222) which would provide for unlimited contributions to HSAs while Senator Jeff Flake's legislation (S. 28) would only increase the maximum contribution limit to $9,000 for single coverage and $18,000 for family coverage. Taking a different tact, Senators Bill Cassidy and Susan Collins introduced legislation (S. 191) which would phase out HSAs under current law and replace them with "Roth HSAs" with the current tax credits available under PPACA to fund these new Roth HSAs.

Prospects for Legislation

As of March 3, 2017, it has been reported that mark-up of health care reform legislation will be held on Thursday, March 9, 2017 in both the Ways and Means Committee and the Energy and Commerce Committee in the House of Representatives. The text of the legislation to be marked up in the Committees has not yet been released, so we don't know how the Committees will deal with the repeal of the ACA and what they will put forward as a replacement. Usually, the Committee Chair will not release the text of a bill to be marked up without knowing that it will be approved by the Committee. Consequently, I would anticipate that the March 9 mark-up date may be postponed as the Chairs of the Committee negotiate with Committee members to get the votes needed to pass the bill through Committee. In addition, the Congressional Budget Office and the Joint Committee on Taxation need to score the bills to be marked up and that might delay the process.

While we don't have a bill text, there was a draft of a "repeal and replace" bill leaked to *Politico* which posted it on February 24, 2017. This leaked document had a draft date of February 10, 2017. (A copy of this leaked draft bill was sent to the ECFC membership on February 24, 2017.) Many of the provisions in this draft followed the principles set out in Speaker Ryan's Better Way proposal. Some provisions in the proposal are:

- The individual and employer mandates under ACA were eliminated
- Other ACA taxes were eliminated, including the excise tax on high cost health plans (commonly referred to as the "Cadillac Tax");
- Provisions to expand the use of HSAs, based on provisions in the Hatch/Paulsen Health Savings Act of 2017;
- Subsidies for insurance purchased on an exchange were eliminated and replaced with refundable tax credits available to all with the amount of the credit based on the individual's age;
- Medicaid expansion was phased out, but states could continue to offer coverage under the Medicaid expansion with less funding from the federal government; and
- A cap on the employee tax exclusion for employer-provided health care was included which will help pay for the bill. The dollar amount of the cap was not specified in the draft bill but it will be at the 90th percentile of current premiums.

A number of conservative Congressmen – including members of the House Freedom Caucus and the Republican Study Committee -- have stated that they would not vote for this draft bill because it includes

refundable tax credits which they consider to be another new entitlement program. House leadership disavowed the leaked draft, although such a disavowal would seem to be suspect since the provisions in the draft were similar to Chairman Ryan's Better Way proposal. In addition, President Trump in his first State of the Union Address appeared to be supportive of the principles in the Better Way proposal. It will be interesting to see what the new Trump Administration will do to promote or change the legislation. As of March 3, 2017, there is new draft legislation prepared but it has not yet been unveiled. As for now, we must wait to see what the final legislative product is that will go before the Committees.

Advocates of consumer directed health care will have a mixed reaction to the proposals in the leaked draft. Expansions to HSAs will be welcome. A cap on the tax exclusion for employer-provided health insurance could be as problematic to account-based health plans as the Cadillac Tax which will be repealed. ECFC has been speaking with Congress and their staffs about the impact of cap on the tax exclusion suggesting that employee contributions to FSAs not be counted toward the cap. Once the legislative process on health care reform starts, it will be a very busy time and ECFC hopes to have its membership's voice heard in the debate.

ECFC Requests QSEHRA Clarification

Reproduced below is the request for clarification prepared by Bill Sweetnam and the Government Relations Committee for ECFC and submitted February 23rd.

February 23, 2017

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Re: Qualified Small Employer Health Reimbursement Arrangements under the 21st Century Cures Act

Dear Mr. Neis and Ms. Judson:

The recently enacted 21st Century Cures Act (the "Cures Act") amended the Internal Revenue Code (the "Code"), the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to establish a new type of health reimbursement arrangement for small employers, the Qualified Small Employer Health Reimbursement Arrangement ("QSEHRA"). Since this new arrangement is effective as of the beginning of 2017, the Employers Council on Flexible Compensation ("ECFC") requests that the Department of the Treasury and the Internal Revenue Service (collectively, the "Agencies") provide guidance under the Code on certain urgent issues relating to this new arrangement as soon as possible.

ECFC is a membership organization dedicated to promoting and protecting the availability of benefit choices for working Americans through account-based benefit plans which provide benefits in areas such as health care, child care, and commuting. ECFC's members include employers who sponsor employee benefit plans, including flexible spending arrangements, health reimbursement arrangements and health savings accounts, as well as third party administrators, health plan providers, payers, providers, payment networks, processors, financial institutions, and accounting, consulting, and actuarial companies that design or administer employee benefit plans. ECFC member companies assist in the administration of cafeteria plan and health benefits for over 33 million employees.

Many ECFC member companies will administer these new QSEHRA or advise employers about the establishment of these arrangements. Consequently, we believe that it is imperative that the Agencies provide guidance as soon as possible to assist employers in determining whether they should establish a QSEHRA and plan administrators in designing procedures for the administration of these arrangements. This letter sets out the issues regarding QSEHRAs where our members believe that immediate guidance or further information by the Agencies is warranted in order for employers to offer a QSEHRA program to their employees. Many of these issues have come to our attention as ECFC members review the statutory provisions and answer questions from small employers that currently sponsor similar arrangements that reimburse employees for health insurance purchased on the individual market and other qualified medical

expenses or are considering sponsoring such arrangements. Consequently, we request guidance on the following issues:

Employers Eligible to Offer a QSEHRA

Only "eligible employers" may offer a QSEHRA to its employees. Code § 9831(d)(2) of the Code. An eligible employer is an employer that is not an applicable large employer as defined in Code section 4980H(c)(2) and does not offer a group health plan to any of its employees. Code § 9831(d)(3)(B).

Group Health Coverage. The term "group health plan" in Code section 9831(d)(3)(B)(ii) does not reference any other Code section as a definition of that term, so guidance is needed for employers to understand whether they are currently offering a disqualifying group health plan. The term group health plan is defined in the Code, but when that term is used for other purposes in the Code, the definition is modified by the excepted benefit provisions. We believe that, since the term "group health plan" is often modified by the excepted benefit provision, an employer that offers a plan that provides only excepted benefits would be eligible to offer a QSEHRA.

A "group health plan" is defined extremely broadly in Code section 5000(b) as a plan of an employer to provide health care (directly or otherwise) to the employees, former employees or their families and a group health plan must comply with various requirements. This broad definition is modified for certain purposes under the Code in that certain non-major medical ancillary and supplemental benefits (referred to as excepted benefits) are not subject to the ACA requirements for a group health plan. Code §9832(c). Excepted benefits include separate coverage for accident or disability insurance, workers' compensation insurance, automobile medical payment insurance, and coverage for on-site medical clinics. Code §9832(c)(1). Also included as an excepted benefit if offered separately are limited scope dental or vision benefits and long-term care benefits. Code §9832(c)(2). In addition, coverage for a specified disease or illness or hospital indemnity or other fixed indemnity insurance will be considered excepted benefits if offered as an independent, non-coordinated benefit. Code §9832(c)(3).

Strict application of the Code Section 5000(b) definition for QSEHRAs would lead to perverse results. By way of example, an employer that offered dental coverage or an EAP to employees would be unable to sponsor a QSEHRA. We believe that Congress did not intend that coverage of excepted benefits would be considered group health coverage causing an employer to be unable to offer a QSEHRA to its employees. The requirement that no employee had employer-provided health coverage was a means of ensuring that the employer did not offer major medical coverage to some employees through a group plan and let other high risk employees purchase their coverage on the individual market – thereby driving up costs of coverage on the individual market. Coverage for excepted benefits poses no such risks. We would appreciate guidance from the Agencies confirming a small employer that only offered coverage of excepted benefits would be considered an eligible employer that could offer a QSEHRA.

Applicable Large Employer Determination. Only an employer that is not an applicable large employer as defined in Code section 4980H(c)(2) will be eligible to offer a QSEHRA to its employees. The rules for determining whether an employer is an applicable large employer subject to the shared responsibility payment under Code section 4980H should be applicable in determining whether an employer is an applicable large employee that is not eligible to establish a QSEHRA and we request that the Agencies provide confirmation. The coordination of the definition of applicable large employer

for both application of the shared responsibility payment provisions and the ability to offer a QSEHRA is appropriate so that an employer that is not subject to the shared responsibility payment provisions would be eligible to offer a QSEHRA. In addition, using the look-back rules in determining whether an employer is an applicable large employer would be helpful to employers in case they become an applicable large employer at some time during the year so that they may offer the QSEHRA through the full year.

Reimbursements from a QSEHRA

Reimbursements from a QSEHRA may only be made for eligible expenses for medical care (as defined in Code section 213(d)) for the eligible employee and the employee's family members after an employee has provided proof of coverage. Code § 9831(d)(2)(B)(ii). The maximum amount of reimbursement permitted under a QSEHRA is $4,950 or $10,000 in the case of an arrangement that also provides for payments or reimbursement for family members of the employee. Code §9831(d)(2)(B)(iii). Reimbursements must be made on the same terms to all eligible employees of the eligible employer. Code §9831(d)(2)(A)(ii). The QSEHRA will be treated as providing reimbursements on the same terms to all employees if the benefit varies in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market based on (i) the age of the eligible employee or the employee's family members if covered, or (ii) the number of family members covered. Code §9831(d)(2)(C). In addition, the reimbursement of qualified medical expenses will be excluded from an employee's income only if the employee has minimum essential coverage ("MEC") at the time the medical expense is incurred. Code §106(g).

Proof of Coverage. The term "proof of coverage" is not defined in the statute. We would like confirmation that reimbursement by the QSEHRA of medical insurance premiums of a policy that provided MEC would be considered proof of coverage for this purpose. Further, if the reimbursement is for a qualified medical expense that is not a reimbursement of health insurance premiums and the QSEHRA already provided a reimbursement of medical insurance premiums during that month, we believe that no additional proof of coverage would be needed. However, if the QSEHRA has not provided a reimbursement of medical insurance premiums (either because the employee does not choose to get reimbursement from the QSEHRA or because the QSEHRA does not provide for the reimbursement of medical insurance premiums) *and* the employee has medical coverage from another source (such as, individual insurance purchased without using the QSEHRA, spousal coverage or coverage under TRICARE or Medicare), guidance should confirm that attestation by the employee that he or she has coverage is sufficient proof to verify that the employee has coverage. Self-attestation has been permitted by the Agencies in other circumstances, such as employee certification any expense paid through a health flexible spending arrangement has not been reimbursed and that the employee will not seek reimbursement from any other plan coverage. Proposed Treas. Reg. §1.125-6(b)(3)(ii).

Premium-Only Reimbursements. We believe that a QSEHRA can limit reimbursements to only premiums for health insurance. We would like confirmation that an employer could, in fact, offer a QSEHRA that limits reimbursements to premiums for health insurance. Similarly, an employer can limit the types of qualified medical expenses that the QSEHRA would reimburse. This would facilitate, for example, an arrangement that would allow the purchase of a qualified HDHP and preserve HSA eligibility for a QSEHRA participant. We request guidance confirming that an employer could offer a QSEHRA that limited the types of reimbursements permissible.

Employer Discretion in Plan Design. Since the statute does not state how reimbursements under the QSEHRA must be made, the current rules applicable to HRAs should apply to QSEHRAs, and an employer should be able to design its plan to provide reimbursements in the manner that it desires as long as reimbursements are limited to qualified medical expenses under Code section 213(d) and the employee provides proof of coverage. We request Agency guidance that would confirm this position.

Variations in Reimbursement Amounts. Variations in the amount that a QSEHRA will reimburse are permissible under the statute as long as the variation is in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market. Given that the statute states that the maximum contribution is $4,950 for individual coverage and $10,000 for family coverage, we believe that a QSHRA that reimburses at the maximum for individual and family coverage should be considered as providing coverage under the same terms for all eligible employees regardless of the difference in price between a health policy with single coverage and one with family coverage. We would like confirmation of our position in Agency guidance. In addition, guidance from the Agencies is necessary in order for employers to understand how to determine whether a variation in reimbursements is permissible under the new law and what documentation would be required in order to support that determination.

Allowance for After-Tax Payroll Deductions to Supplement HRA Funds. In some areas, the cost of individual medical insurance may far exceed the statutory amounts that can be paid or reimbursed under a QSEHRA. In some cases, the QSEHRA will be established to reimburse the employee for the employees' direct payment of insurance premiums. In other cases, the employer may facilitate the premium payments through a "list bill" payroll deduction arrangement. Such an arrangement may result in a premium discount for participating employees. An employer's involvement with after tax payroll deduction for any excess cost of a QSEHRA funded policy (i.e., amounts in excess of the statutory limits) should not cause the employer to become ineligible to offer a QSEHRA, and we request confirmation of that in guidance.

Taxation of Reimbursement. The statute provides that the taxability of any reimbursement from a QSEHRA will depend on whether the employee has MEC at the time that the medical expense is incurred. We contend that any reimbursement (within statutory limits) of health insurance premiums for insurance that provides MEC would automatically be excluded from the employee's income without any further documentation. In addition, any other qualified medical expenses incurred during the time the QSEHRA has provided reimbursement for health insurance premiums would automatically be excluded from the employee's income without further documentation. We believe that an employee can attest to the plan administrator that they have MEC and the plan administrator would not have to request or review any additional documentation. As noted previously, the Agencies has accepted self-attestation in other circumstances regarding health plans and guidance should confirm that self-attestation is appropriate in this situation. We request guidance confirming this interpretation.

Reporting and Withholding on Taxable Reimbursements. If it is determined that a reimbursement from the QSEHRA is not excluded from income because the employee does not have MEC in the month in which the medical expense was incurred, the reimbursement must be included in the employee's income as supplemental wages. It would be helpful if guidance would detail how these amounts should be reported and withheld upon.

Annual Notice to Employees

An employer funding a QSEHRA must provide a written notice to eligible employees that states (i) the amount of the benefit available under the QSEHRA for the year, (ii) that the employee should provide the information about the amount of the benefit to any health insurance exchange the employee applies to for subsidized coverage and (iii) a statement that if the employee does not have MEC for any month the employee may be subject to the individual mandate tax and reimbursements from the QSEHRA may be includible in gross income. Code §4931(d)(4)(B). This written notice must be given to an employee no later than 90 days prior to the beginning of the year of the arrangement or, if the employee is not eligible to participate as of the beginning of the year, on the date the employee first becomes eligible to participate in the QSEHRA. Code §4931(d)(4)(A). Failure to provide this notice will result in a tax of $50 per employee per incident of failing to provide the notice. Code §6652(o).

- Model Notice. The contents of this notice will be the same for all employers sponsoring a QSEHRA with the only difference being the amount of the benefit provided. It would be helpful to employers establishing these plans for the Agencies to provide a model notice that will satisfy the requirements for the notice.

- Notice and Establishment of a New QSEHRA. The statute states that a notice must be given to an on the date that the employee first becomes eligible to participate in the QSEHRA. For an employer that establishes a new QSEHRA, it would follow that the notice to be given to employees no later than the first day that the QSEHRA is established. In the years after the QSEHRA is initially established, the notice would be given 90 days prior to the beginning of the plan year. Confirmation of that interpretation would be helpful so that employers may make reimbursements from a QSEHRA as soon as possible after the QSHRA is established.

ECFC appreciates this opportunity to alert the Agencies on issues of concern to those employers who will establish QSEHRA and for those organizations that will administer these plans. If you have any questions and would like to discuss these issues in more detail, please feel free to contact me via e-mail at wsweetnam@ecfc.org or by telephone at 202-465-6397.

Sincerely,

William F. Sweetnam, Jr.

William F. Sweetnam, Jr.
Legislative and Technical Director

Whack-a-Mole – IRS Takes Aim at Latest Wellness Program Scheme, But Overly Broad Language Can Be Taken Too Far As Applied to Traditional Coverage

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Background

As we addressed in a prior column, there are a number of abusive tax arrangements marketed (primarily to small employers) that utilize a wellness program to provide tax advantages similar to the classic double dip arrangements first prohibited by the IRS in the early 2000s. One recent manifestation sought to convert otherwise taxable wages to tax-free "reimbursements" under a hybrid health indemnity plan/wellness program combination. Under the program, employees paid pre-tax "premiums" and received disproportionally large "benefits" (which often corresponded to the amount of wages sought to be sheltered) and received payment for non-traditional triggering events. Whereas most health indemnity policies are fully insured[1], with benefits triggered solely by an accident or sickness (as required under the Internal Revenue Code), benefits under the self-funded health indemnity plan lacked economic substance in that payments could be made for merely completing a health risk assessment or calling a health coach. The IRS issued a Chief Counsel Memorandum (CCM) on this arrangement in early 2016, and in a recent follow-up CCM,[2] the IRS exposed the fatal defects under the self-insured program. As discussed herein, however, some overly broad statements in the most recent CCM appear to be contrary to established law with regard to more traditional fully insured health indemnity plans. Our primary focus in this article is on that topic.[3]

The Classic "Double Dip"

The classic double dip arrangement involved two steps. First, employees would make a salary reduction election to pay for their portion of the cost of an excludable employer health plan on a pre-tax basis. Next, employees were reimbursed for a portion of their salary reduction contribution purportedly on a tax-free basis. These arrangements were touted as a win-win: employers and employees get to pocket tax savings generated by the pre-tax salary reduction, while employees have no reduction in take-home pay due to the purported tax-free reimbursement. If it seems too good to be true, it probably is. While the pre-tax salary reduction for the employee health coverage was permissible, the so-called tax-free "reimbursement" to employees for the premiums used to pay for the health coverage was not!! There simply is no basis in the tax code for tax-free reimbursements of premiums paid by the employee with pre-tax salary reductions, and the IRS made that clear in 2002 in Revenue Ruling 2002-3.

Recent "Wellness Plan" Arrangements and IRS Response

[1] We seldom see self-funded health indemnity plans, as an indemnity policy that is not fully insured would not qualify as a HIPAA excepted benefit. In the present case the promoters apparently argued that the health indemnity program was integrated with ACA compliant coverage.

[2] https://www.irs.gov/pub/irs-wd/201703013.pdf . The CCM from last year addressing abusive wellness programs can be found at https://www.irs.gov/pub/irs-wd/201622031.pdf

[3] Note: The vast majority of employer wellness arrangements provide meaningful incentives to employees to incent healthy behavior. We do not take issue with such programs. Rather, the "fatal defect" arises with respect to the incorrect tax treatment of certain programs as described in more detail herein.

Fast forward to some fifteen years later where there has been a resurgence of similar health benefit schemes, this time characterized as "wellness plans." In the arrangement addressed in our prior column, purportedly tax-free "wellness benefits" were funded with pre-tax salary reduction wages. Under a recent iteration of the arrangement, tax-free "premium" contributions are funneled through a self-funded health indemnity plan that purportedly pays a substantial tax-free indemnity benefit when the participant engages in certain wellness activities provided by the arrangement (e.g., participating in a health fair, contacting a wellness coach, etc.). Unlike more traditional fixed indemnity health insurance, the plan is self-funded, and the purportedly tax-free benefit payments are not triggered by events that result in medical expenses for the participant. As described by the IRS:

> *Situation 4*. An employer provides all employees, regardless of enrollment in other comprehensive health coverage, with the ability to enroll in coverage under a "wellness plan" that qualifies as an accident and health plan under § 106. Employees electing to participate in the wellness plan pay an employee contribution by salary reduction through a § 125 cafeteria plan (and therefore the amount of the salary reduction is not included in compensation income at the time the salary would otherwise have been paid). The wellness plan pays employees a fixed indemnity cash payment benefit of $100 for completing a health risk assessment, $100 for participating in certain prescribed health screenings, and $100 for participating in other prescribed preventive care activities, without regard to the amount of medical expenses otherwise incurred by the employee.
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> *Situation 5*. An employer provides all employees, regardless of enrollment in other comprehensive health coverage, with the ability to enroll in coverage under a wellness plan that qualifies as an accident and health plan under § 106. Employees electing to participate in the wellness plan make an employee contribution by salary reduction through a § 125 cafeteria plan (and therefore the amount of the salary reduction is not included in compensation income at the time the salary would otherwise have been paid). The wellness plan pays employees a fixed indemnity cash payment benefit each pay period (for example, equal to a percentage of the salary payable for the pay period) for participating in the wellness plan, without regard to the amount of medical expenses otherwise incurred.

The IRS had little difficulty concluding that benefits paid under the purported wellness programs were taxable. However, as background to the wellness rulings they were trying to address, the IRS went even further, seemingly concluding that benefits under ***any*** fixed indemnity health policy would be taxable ***because the amount of payment does not correlate to the amount of medical expense incurred.*** The CCM states:

> The value of coverage by an employer-provided wellness program that provides medical care (as defined under § 213(d)) generally is excluded from an employee's gross income under § 106(a), and any reimbursements or payments for medical care (as defined under § 213(d)) provided by the program is excluded from the employee's gross income under § 105(b). However, any reward, incentive or other benefit provided by the medical program that is not a payment for or reimbursement of medical care (as defined under § 213(d)) is included in an employee's compensation income, unless excludible as an employee fringe benefit under § 132. That is because under § 1.105-2, the exclusion under § 105(b) does not apply to amounts, which a taxpayer would be entitled to receive irrespective of whether or not the taxpayer incurs expenses for medical care, ***including amounts paid irrespective of the amount of expense incurred by a taxpayer.***
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> A fixed indemnity health plan is a plan that pays covered individuals a specified amount of cash for the occurrence of certain health-related events, such as office visits or days in the hospital. The amount paid is not related ***to the amount of any medical expense incurred or coordinated with other health coverage***. Consequently, while the payment by the employer for coverage by a fixed

indemnity health plan is excludible from gross income under § 106, any payments by the plan are not excluded under § 105(b).

The CCM, which by its terms is not controlling law and cannot be cited as precedent, is inconsistent with current controlling law under Code Section 105, which would allow amounts paid under a pre-tax funded health indemnity policy to be received tax-free, but only up to the amount of otherwise unreimbursed medical expenses. Indeed, at the time Section 105 was enacted, many employer-funded health plans paid benefits on a fixed indemnity basis, without necessarily coordinating coverage from other sources. The IRS specifically addressed such situations in a 1969 Revenue Ruling,[4] which clarified that any "excess" fixed indemnity benefits would be included in gross income. If fixed indemnity payments are never (as seems to be suggested by the CCM) considered to be a reimbursement for medical expenses—even when the payment is triggered by a health care related event that likely triggers medical expenses, such as hospitalization or an office visit—the Revenue Ruling would be unnecessary, and not make sense.

The Applicable Law

The federal tax laws start from the premise (in Code Section 61) that all income is taxable unless a specific exception applies. *If* the wellness and fixed indemnity payments are excludable from gross income, they would be excludable under either Code Section 105 or 106; however, Code Sections 105 and 106 do not support the conclusion that **all** wellness and fixed indemnity payments are excluded. Rather, as discussed below, any exclusion is limited to the amount of unreimbursed medical expense. Section 105 and 106 work together to provide an exclusion from income for both the value of employer provided *health coverage* (regardless of amounts received) and the *benefits* received by the employee through such coverage but only to the extent such benefits reimburse otherwise unreimbursed medical expenses.

For example, with regard to the value of *coverage*, if an insurance carrier charges the employer $300 per month to provide self-only coverage, the value of that coverage is $300. If the employer chooses to pay $200 for that coverage, then the $200 is excluded from income under Code Section 106. Amounts that the employee elects to reduce from his or her compensation on a pre-tax basis through a Code Section 125 cafeteria plan to pay for health coverage are also considered "employer" contributions. See Prop. Treas. Reg. § 1.125-1(r)(2). Thus, the value of the coverage paid for with pre-tax salary reductions is also considered provided by the employer and excluded from income by virtue of Code Section 106. In the example above, if the employee pays for the remainder of the $300 premium not paid by the employer through salary reduction, that $100 would also be excluded from income under Code Section 106.[5]

Section 105 determines the extent to which *benefits* received through employer-provided accident or health coverage are excluded from income. If the coverage was paid for on a pre-tax basis, then the general rule in Code Section 105(a) is that benefit payments received under the coverage are taxable. However, Code Section 105(b) provides an important exception to this general rule. Under Section 105(b), benefit payment amounts received under such coverage are excludable from income if such amounts represent direct or indirect reimbursements for expenses actually incurred for medical care (as defined in Code Section 213(d)) that if paid directly by the employee would give rise to a deduction under Section 213.

The applicable IRS regulation (Treas. Reg. 1.105-2) provides as follows:

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[4] Rev. Rul. 69-154 https://www.irs.gov/pub/irs-drop/rr-69-154.pdf

[5] What if the value of the coverage was $300 but the salary reduction for that benefit was $1,000? Would the cost of the coverage still be excluded from income? The IRS did not specifically address this issue in the CCM but we note that such excessive cost of coverage may not even qualify for exclusion under 106 in that instance. If not, the benefit would not constitute a qualified benefit that can be offered under the cafeteria plan—thereby jeopardizing the tax status of the cafeteria plan.

> Section 105(b) provides an exclusion from gross income with respect to the amounts referred to in section 105(a) (see section 1.105-1) which are paid, directly or indirectly, to the taxpayer to reimburse him for expenses incurred for the medical care (as defined in section 213(e)) of the taxpayer, his spouse, and his dependents (as defined in section 152). . . . Section 105(b) applies only to amounts which are paid specifically to reimburse the taxpayer for expenses incurred by him for the prescribed medical care. ***Thus, section 105(b) does not apply to amounts which the taxpayer would be entitled to receive irrespective of whether or not he incurs expenses for medical care.*** For example, if under a wage continuation plan the taxpayer is entitled to regular wages during a period of absence from work due to sickness or injury, amounts received under such plan are not excludable from his gross income under section 105(b) even though the taxpayer may have incurred medical expenses during the period of illness. . . . . ***If the amounts are paid to the taxpayer solely to reimburse him for expenses which he incurred for the prescribed medical care, section 105(b) is applicable even though such amounts are paid without proof of the amount of the actual expenses incurred by the taxpayer, but section 105(b) is not applicable to the extent that such amounts exceed the amount of the actual expenses for such medical care.***

Thus, as long as an amount is ***triggered by a medical event giving rise to an expense,*** some portion may be excludable, even if it is paid ***without proof of the amount of the actual expense incurred by the taxpayer.*** Because most traditional insured health indemnity policy benefits are only paid when a medical event has resulted in a medical expense being incurred, it cannot be said that such benefits are paid "***irrespective of whether an expense is incurred for medical care***."

Further support for this position can be found in IRS Revenue Ruling 69-154. In that ruling, the IRS looked at several situations in which health indemnity benefits exceeded the amount of medical expenses incurred. As with traditional insured health indemnity benefits today, the health indemnity policies in the ruling did not coordinate with other coverage or otherwise reduce benefits because the medical expense had been fully reimbursed. Yet the IRS concluded that the health indemnity coverage in the ruling would provide tax-free benefits to the extent of any unreimbursed medical expenses.

Conclusion

As noted above, we understand that the CCM was intended to address certain abusive practices associated with the hybrid wellness/self-funded health indemnity coverage arrangement that was under review. We stress that traditional health indemnity policies are fully insured and only pay benefits in the event of a medical event that triggers medical expenses. In light of the foregoing, we believe that to the extent traditional health indemnity benefits are examined, IRS Rev. Rul. 69-154 and the regulations under Code Section 105 control. See also, Tech. Adv. Mem. 199936046 (May 19, 1999), FN 1 ("...Although it is possible that a portion of the proceeds of the insurance policies under discussion may be taxable to the employees under section 105(a) (e.g., in the event that the proceeds exceed the taxpayer's medical expenses, see Rev. Rul. 69-154, 1969-1 CB 46), such inclusion would have no bearing on the application of section 106").

Thus, amounts payable under such health indemnity policies should be excludable from an employee's income to the extent of any otherwise unreimbursed medical care expenses.[6] Any claim payments (combining the total from all health and medical policies/plans) that exceed the amount of unreimbursed Section 213 medical expenses would be taxable.

In informal conversations, the IRS confirmed our interpretation, and indicated that additional guidance clarifying these issues may be coming.

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[6] Note that if the employee paid the entire premium on an after-tax basis, then all of the amounts payable under the policy would be excluded from income under Code Section 104(a)(3).

The IRS has long recognized various items and services relating to reproduction and childbearing (or its prevention) as medical care and therefore reimbursable from an FSA. The regulations specify that obstetrical services are medical care. Revenue and private letter rulings going back at least to the 1970s have allowed abortions (after legalization), birth control pills, infertility treatments, in-vitro fertilization procedures (including preparatory expenses such as to obtain an egg from a donor), lactation assistance, Lamaze classes, pregnancy tests, and vasectomies. The IRS has weighed in informally on doulas and birthing coaches.

With the exception of infertility procedures, none of these expenses relate to a disease (and whether procedures such as the use of egg donors or in-vitro fertilization treat or mitigate a disease is debatable), but they all are allowed because they affect a function of the body. In recent years taxpayers have claimed two reproduction-related expenses for which the IRS says (or would say) no: pregnancy surrogates and long term egg storage.

Pregnancy Surrogates

As we all know, to be deductible or reimbursable, medical expenses must be for medical care provided to a taxpayer, spouse, or dependent. The IRS has long adhered to the position that the medical expenses a taxpayer pays for a pregnancy surrogate is not an allowable medical expense because the medical care is not provided to the taxpayer, spouse, or dependent. See, for example, Info. Letter 2002-0291 (Dec. 31, 2002). I use "pregnancy surrogate" as shorthand for expenses that may include the medical expenses of a "gestational carrier" to carry and give birth to a child, medical expenses of an egg donor, charges for in-vitro fertilization procedures, fees for legal services, and fees charged by the gestational carrier, egg donor, and agencies.

In recent years three male taxpayers have made claims for expenses related to pregnancy surrogates that have resulted in litigation and court opinions favorable to the IRS.

- Magdalin (2005): A divorced man with two children and no medical issues that prevented him from fathering children. Apparently he wanted more children, and being without a spouse he hired two pregnancy surrogates and claimed legal fees, egg donor fees and expenses, surrogate fees and expenses, and IVF clinic charges.

- Longino (2013): Deducted expenses for IVF treatments for his fiancee.

- Morrissey (2016): A gay man who paid expenses for a pregnancy surrogate, egg donor, and agency fees.

Magdalin and Morrissey argued that the denial of the deductions violated their civil and constitutional rights. Magdalin claimed that he should be able to choose his method of reproduction and that allowing women but not men to choose how they will reproduce was sex discrimination. Morrissey claimed that denying him a deduction for his expenses when he and his partner were incapable of having children discriminated against him on the basis of sexual orientation. (Unfortunately, the IRS revenue agent apparently told Morrissey that his sexual orientation was a choice.) It's not clear why Longino thought he

should be able to deduct the expenses. As far as appears from the opinions, none of these taxpayers made a plausible argument for how pregnancy surrogate expenses fit into the definition of medical expenses. Morrissey claimed that the impregnation of a surrogate using his sperm affected his own reproductive function.

Unfortunately in *Magdalin* (and apparently in *Longino*) the IRS chose to argue that the taxpayer was not entitled to a deduction because he had no physical or mental defect or illness that prevented him from procreating the usual way, and the procedures were not medically indicated. (They didn't ask me first.) In *Magdalin* the court held that the taxpayer was not entitled to a deduction because the expenses were not related to a disease or illness, which is the part of the holding commentators tend to focus on, but also that the procedures did not affect the functioning of the *taxpayer's* body. In *Longino* the court stopped at the first point, holding that a taxpayer may not deduct the IVF expenses of an unrelated person if the taxpayer does not have a defect that prevents him or her from conceiving children.

The emphasis on the whether the taxpayer suffered from a disease or illness missed the point and left the door wide open for the next, more difficult case. What if these taxpayers had been women with fertility issues who hired pregnancy surrogates because they themselves were unable to carry children? Sure enough, the next case was an infertile woman. Is the expense of a pregnancy surrogate an expense to treat, diagnose, cure, mitigate, or prevent the taxpayer's disease or illness, or to affect a structure or function of that taxpayer's body? (The case has not been decided, status unknown.)

Clearly, expenses related to a pregnancy surrogate do not affect the *taxpayer's* body. If the taxpayer is an infertile woman, is there an argument that the expenses are to treat, cure, mitigate, prevent, or diagnose the infertility? After *Magdalin* was decided, a law professor published an article espousing the "substitute for normal functioning" theory—that is, that an expense that substitutes for an activity a taxpayer can't perform because of a medical condition should qualify as a medical expense because it *mitigates* the medical condition. Thus, according to this theory, medical expenses for a pregnancy surrogate should qualify for a taxpayer who cannot have a child as the result of a disease, because the surrogate is a substitute for the taxpayer's normal functioning.

Under this reasoning, anything a taxpayer pays someone to do that the taxpayer can't do because of a medical condition would qualify as medical care--someone to clean house for a physically disabled taxpayer, for example, or a driver to take the taxpayer to work. The same reasoning was behind an actual private letter ruling request from a taxpayer claiming that that baby formula qualified as a medical expense because his wife had had a mastectomy and couldn't breast feed.

Although the IRS has not issued guidance directly addressing the definition of mitigation, it is unlikely that it will embrace this reasoning. Expenses for a pregnancy surrogate, housecleaner, driver, etc., are examples of expenses that deal with the *consequences* of a medical condition. In contrast, a service or item that mitigates an illness helps a taxpayer to overcome or compensate for the effect of the illness on the taxpayer's body, and to assist the taxpayer to perform basic personal functions such as mobility. Paying someone else to function *for* the taxpayer is not mitigating the taxpayer's illness.

Although it did not expressly address the "substitute for normal functioning" theory or the definition of "mitigation," the court in *Morrissey* finally got to the right place. It held that the expenses were not allowable because they were not for the diagnosis, cure, mitigation, or treatment of a disease or to affect a structure or function of the body of the taxpayer, spouse, or dependent. The procedures affected the body of only the surrogate. The court noted that pregnancy surrogate expenses would not be allowable to any taxpayer, regardless of gender, sexual orientation, or fertility. The court properly distinguished situations in which the IRS has allowed expenses for an infertile female taxpayer to obtain eggs from a donor, noting

that the procedure was preparatory to implanting an embryo into the *taxpayer's* body, which is medical care provided to the taxpayer.

Much has been made of the sexual orientation issue raised in *Morrissey*, but as the court noted, it is irrelevant. Gay, straight, fertile, infertile, the bottom line is that expenses related to a pregnancy surrogate are not medical care to a taxpayer, spouse, or dependent.

Magdalin v. Commissioner, T.C. Memo 2008-293, *aff'd* No. 09-1153 (1st Cir. 2009) (unpub. op.), *cert. denied* 559 U.S. 1093 (2010).

Longino v. Commissioner, T.C. Memo. 2013-80.

Morrissey v. Commissioner, No. 8:15-cv-2736-T-26AEP (E.D. Fla. 2016).

Long Term Egg Storage

Technological advances in recent years have improved the success rate for achieving pregnancy using eggs that were frozen, stored for a period of time, and thawed (oocyte cryopreservation). According to news reports, women may take advantage of these possibilities to delay childbearing until an age when egg viability may be problematic. Women may have many reasons for freezing their eggs, including an impending medical treatment such as chemotherapy that may damage their eggs, the immediate lack of an appropriate mate, or to concentrate on their careers.

An article in the Washington Post got our attention at the IRS because it noted that some employers are adding "egg freezing to their list of fertility benefits." "Want to freeze your eggs? Only a few firms, such as Facebook and Apple, help pay for it" (Dec. 23, 2014). Actually, the article presented these figures: "Forty-five percent of high-tech companies cover in vitro fertilization, and 27 percent cover other advanced reproductive procedures such as egg freezing, for example. The comparable figures for non-high-tech companies were 26 percent and 14 percent, respectively." It noted that Facebook will pay up to $20,000 for egg freezing for medical or nonmedical reasons.

As we all know, if those expenses are not qualified medical expenses, the employer's payment or reimbursement is taxable to the employee. As far as I know, no one has asked the IRS, formally or informally, whether egg freezing and storage qualifies as medical care. The IRS has been asked, many times, about long term storage of cord blood, however. Based on the IRS position on cord blood, the answer for long term egg (or sperm, or embryo, for that matter) storage is likely to be no.

Cord blood is derived from an umbilical cord at birth and contains stem cells that may be used to treat certain diseases. Taxpayers sometimes store, or bank, cord blood as a precaution in case the child later develops such a disease. The IRS has generally viewed the expense of extracting the cord blood, but not the cost of long term storage, as allowable. Thus, in Info. Letter 2010-0017, the IRS advised that "[E]xpenses for banking cord blood to treat an existing or imminently probable disease may qualify as deductible medical expenses. However, banking cord blood as a precaution to treat a disease that might possibly develop in the future does not satisfy the existing legal standard that at a minimum a disease must be imminently probable."

In other words, the IRS does not view an expense for something that may or may not ever be used for medical care at some time in the future as allowable. The existence of a medical reason is irrelevant if the future use is speculative. Additionally, the IRS is likely to consider expenses for long term egg storage a matter of personal convenience, rather like paying a fee for a concierge medical practice that gains the patient better access to a doctor. Apple and Facebook are warned.

Postponement of the ERISA Fiduciary Rules on ERISA Investments
Background and Possible Impact

This article is about the recent actions taken by the U.S. Department of Labor (DOL) to postpone the effective date of the DOL's final fiduciary regulations that have an initial implementation date of April 10, 2017[7] and a full implementation date of January 1, 2018.

Employee Retirement Income Security Act of 1974 (ERISA) was enacted when the retirement world consisted primarily of defined benefit plans. These programs are quickly disappearing and for many years now defined contribution retirement plans and individual accounts like Individual Retirement Accounts (IRAs) have become the norm.

Recognizing this huge shift in how retirement savings are invested and that IRAs are not subject to ERISA's fiduciary rules, the DOL embarked on a multi-year project to protect the assets being held in defined contribution plans and individual accounts such as IRAs. In April, 2016, final regulations defining "fiduciary" were issued by the DOL (colloquially referred to as the conflict of interest rules). Health Savings Accounts (HSAs) also may be subject to these rules. Specifically, these new fiduciary rules, modify the standard of care for individuals and institutions who provide investment advice and/or recommendations to defined contribution plans, IRAs, and HSAs, provide a private cause of action for a breach of that standard of care, and, absent compliance with the requirements of specific prohibited transaction exemptions, can result in the imposition of excise taxes for violation of the prohibited transaction rules under Internal Revenue Code of 1986, as amended (Code) Section 4975. (Please refer to "The New ERISA Fiduciary Rules on HSAs and HSA Service Providers" by Dan S. Brandenburg, Esquire and Dasha Brockmeyer, Esquire that was published in the July issue of this publication, for more background.

On February 3, 2017, the White House issued a **Presidential Memorandum on Fiduciary Duty Rule,** which directed the Secretary of Labor to review the fiduciary regulations issued in 2016 to determine if it meets the goals the new Administration.[8] If a determination is

[7]Until April 10, 2017, the current definition of fiduciary investment advice remains in effect. On April 10, 2017 the bulk of the new regulations are scheduled to become effective. Applicable on January 1, 2018, the transition Period for the Best Interest Contract Exemption (*i.e.,* participant disclosures; new documents, forms, and contracts) expires. Grandfathering allows compensation to advisers based on investments that were made prior to April 10, 2017.

[8] "Section 1. Department of Labor Review of Fiduciary Duty Rule. (a) You are directed to examine the Fiduciary Duty Rule to determine whether it may adversely affect the ability of Americans to gain access to retirement information and financial advice. As part of this examination, you shall prepare an updated economic and legal analysis concerning the likely impact of the Fiduciary Duty Rule, which shall consider, among other things, the following:

made that any changes are appropriate, the Secretary of Labor is directed to publish for notice and comment a proposed rule revoking or revising the Rule.

On March 1st, the Department of Labor issued a News Release that reads as follows:

> The U.S. Department of Labor has announced a proposed extension of the applicability dates of the fiduciary rule and related exemptions, including the Best Interest Contract Exemption, from April 10 to June 9, 2017.
>
> The announcement follows a presidential memorandum issued on Feb. 3, 2017, which directed the department to examine the fiduciary rule to determine whether it may adversely affect the ability of Americans to gain access to retirement information and financial advice.
>
> The proposed extension is intended to give the department time to collect and consider information related to the issues raised in the memorandum before the rule and exemptions become applicable.
>
> The department will accept public comments on the proposed extension for 15 days following its publication. Comments on issues raised in the presidential memorandum will be accepted for 45 days.
>
> The proposal will be published in the March 2, 2017, edition of the *Federal Register* and can also be viewed on the Employee Benefits Security Administration's website, www.dol.gov/ebsa/.

The Proposed rule and extension of the applicability date can be found at https://www.federalregister.gov/documents/2017/03/02/2017-04096/definition-of-the-term-fiduciary-conflict-of-interest-rule-retirement-investment-advice-best.

At this point, the most important issue may be that the end of the comment period will not occur until approximately June 2, which is after the effective date of the original Fiduciary regulation. Stay tuned on whether legally the DOL can and will provide any relief from the overlap in effective dates. The Administration and the DOL may choose not to enforce any violations that may occur during the gap period. However private plaintiffs may not be forestalled/barred by the Administration's actions. Given that the guidance literally was published only a few days

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(i) Whether the anticipated applicability of the Fiduciary Duty Rule has harmed or is likely to harm investors due to a reduction of Americans' access to certain retirement savings offerings, retirement product structures, retirement savings information, or related financial advice;

(ii) Whether the anticipated applicability of the Fiduciary Duty Rule has resulted in dislocations or disruptions within the retirement services industry that may adversely affect investors or retirees; and

(iii) Whether the Fiduciary Duty Rule is likely to cause an increase in litigation, and an increase in the prices that investors and retirees must pay to gain access to retirement services."

before this article was written, all of us will need to work at digesting the impact and follow any developments.

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[i] Seth Gaudreau, an associate in The Wagner Law Group assisted with this article.

EEOC v. Flambeau, Inc.: The Road Ends But The Uncertainty Continues

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On January 25, 2017, the U.S. Court of Appeals for the Seventh Circuit affirmed the lower court's dismissal of the case filed by the EEOC against Flambeau, Inc. regarding the company's wellness program on the grounds that the case was moot or the relief sought by the EEOC was not available. Employers were disappointed by this decision as they had hoped for some clarification regarding the interaction between employer wellness programs, the prohibition on involuntary medical exams set forth in the Americans with Disabilities Act (ADA), and the ADA's "insurance safe harbor."

This case began in September 2014 when the EEOC filed suit against Flambeau, alleging that the company's wellness program violated the ADA's prohibition on involuntary medical exams. The wellness program required employees to complete a health risk assessment and biometric screening as a condition of enrolling in the company's health plan. In December 2015, the federal district court found that the program did not violate the ADA, and dismissed the EEOC's case. The district court relied on a provision in the ADA known as the "insurance safe harbor" which exempts employer activities to the extent they relate to the establishment or administration of "the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks." The *Flambeau* court followed *Seff v. Broward County*, an earlier decision in which the court allowed an employer to rely on the ADA insurance safe harbor in defending its wellness program. The *Flambeau* court rejected the EEOC's argument that applying the insurance safe harbor to employer wellness programs would gut the ADA requirement that employer wellness programs be voluntary. (For a further discussion of this case, see our article, "EEOC v. Flambeau, Inc.: Just What the Doctor Ordered for Employer Wellness Programs," in the March 2016 ECFC Flex Reporter.) The EEOC appealed.

The Seventh Circuit Court of Appeals affirmed the lower court's dismissal of the EEOC's complaint on the grounds that the relief sought by the EEOC was no longer available or the case was moot. As support, the appellate court pointed to the fact that the single employee who lost coverage on account of not complying with the terms of the program did not incur any compensatory damages or emotional distress. The EEOC argued that punitive damages should be awarded because Flambeau acted with reckless indifference with respect to the employee's rights under ADA, but the appellate court disagreed, citing the legal uncertainty on this issue. ("An employer's or its attorney's disagreement with EEOC guidance does not by itself support a punitive damages award, at least where the guidance addresses an area of law as unsettled as this one.") Finally, the appellate court found that the EEOC's claim for injunctive relief was moot because Flambeau terminated its program for substantiated cost reasons before the EEOC filed suit. In short, "neither party to this case has any longer a serious stake in its outcome" and "[t]he genuine statutory issues should be decided by a court in a case where the answer will matter to the parties."

The Seventh Circuit also pointed to the fact that the EEOC filed its appeal before the EEOC issued final rules establishing the requirements for a "voluntary" wellness program under the ADA. (These rules were issued in May 2016 and are discussed in our article "The Wait is Over: The EEOC Issues Final ADA and GINA Regulations Regarding Employer-Sponsored Wellness Programs" in the June 2016 ECFC Flex Reporter.) In the final rules, the EEOC states expressly its position that the ADA insurance safe harbor does not apply to employer wellness programs. Citing these new rules, the appellate court concluded that it would not be appropriate for it to address the application of the insurance safe harbor based on the "outdated legal landscape" before it on appeal.

The important question now is where do things go from here? Questions remain as to whether the courts will allow employers to rely on the insurance safe harbor in defending their wellness programs or will they defer to the EEOC's interpretation on this issue. At least one federal district court, in the case of the *EEOC v. Orion Energy Systems*, has sided with the EEOC on this issue. It remains to be seen whether other courts will follow.

At the same time, there is a broader question of what impact the Trump administration will have on the regulation of employer wellness programs generally. The EEOC's final ADA wellness program rules went into effect on January 1, 2017 (to the extent not already effective). As a result, they are not subject to President Trump's freeze on new or pending regulations. However, we expect the EEOC to take a cautious approach to enforcement of these rules given the current political environment, and could see the EEOC amend these rules in the future.

In addition, the House Blueprint issued last June identifies the EEOC's wellness program rules as an area of change. ("Legal challenges and burdensome regulations have undermined employers' ability to offer wellness programs, leaving them in a perpetual state of uncertainty.") In the Report, House Republicans propose to eliminate the EEOC's rules under the ADA and GINA and allow employers to offer wellness programs that provide a participation incentive as long as the program complies with the existing HIPAA wellness program rules. ("Our proposal would provide much-needed certainty, protect workplace wellness programs from costly litigation, and ensure employers can continue to make crucial benefit decisions that have a large impact on their daily operations and health care resources.") Legislation to this effect was proposed this past week as the "Preserving Employee Wellness Act". Given this, employers should stay tuned to developments coming from Washington.

While Transgender Coverage is Under Scrutiny, Plan Sponsors Need to Pay Attention to the Rights of Those with Disabilities or who are not proficient in English

In *Franciscan Alliance, Inc. v Price, et al*, several plaintiffs challenged regulations issued by the Department of Health and Human Services (HHS) implementing Section 1557 of the Affordable Care Act (ACA). Plaintiffs included eight states (Texas, Wisconsin, Nebraska, Kansas, Louisiana, Arizona, Mississippi, and the Commonwealth of Kentucky) and three private health care providers. On December 31, 2016, Judge Reed O'Connor of the US District Court for the Northern District of Texas issued a nationwide preliminary injunction enjoining HHS from enforcing the regulation's prohibition against discrimination on the basis of gender identity or termination of pregnancy.

Although HHS cannot enforce the prohibition against discrimination on the basis of gender identity, the court did not enjoin enforcement of the other portions of Section 1557. This article addresses the decision and how plan sponsors should address compliance with Section 1557 going forward.

Background

Section 1557 of the ACA prohibits group health plans from discriminating on the basis of race, color, national origin, sex, age, or disability in health programs, consistent with existing federal laws, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; and Sections 504 and 508 of the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 (ADA). Group health plans (e.g., retiree medical plans that receive RDS payments as well as most insured health benefit plans) and employers (e.g., health care providers) that accept federal funding from HHS are covered entities under the law.

The Section 1557 regulations defined discrimination on the basis of "sex" to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity. Plaintiffs challenged this interpretation as being an impermissible definition of the term "sex." Plaintiffs claimed that the regulation violated the Administrative Procedure Act by contradicting existing law and exceeding statutory authority, and also violated the Religious Freedom Restoration Act (RFRA) as applied to the private health care providers. Judge O'Connor agreed with this conclusion and enjoined enforcement of the regulation's prohibition against discrimination on the basis of gender identity or termination of pregnancy, which would have been effective for plan years beginning on or after January 1, 2017.

While the Obama Administration did not appeal the decision, several private parties have attempted to intervene in the case. Consequently, the courts are still addressing some of the procedural aspects of the decision. In the meantime, however, the Trump Administration has rescinded guidance, issued by the U.S. Departments of Education and Justice, on the use of school bathrooms and locker rooms by transgender students.

https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201605-title-ix-transgender.pdf In that guidance, the federal government had also interpreted prohibited sex discrimination to include discrimination based on a student's transgender status, and required schools to "treat transgender students consistent with their gender identity." In addition, on March 6, 2017, the United States Supreme Court vacated and remanded *Gloucester County School Board v. G.G.,* a case addressing enforcement of the guidance, to the United States Court of Appeals for the Fourth Circuit for further consideration.

Application to group health plan sponsors

The court's decision in *Franciscan Alliance, Inc. v Price,* addressed only discrimination on the basis of gender identity or termination of pregnancy. Consequently, the court did not overturn the other prohibited discrimination under Section 1557, including race, color, national origin, sex (unrelated to gender identity), age, or disability.

Until either the courts or HHS take further action, plan sponsors should continue their efforts to comply those portions of Section 1557. In addition, in implementing Section 1557, plan sponsors should consult with legal counsel, because individuals have a right to file a lawsuit seeking benefits under Section 1557 or other federal or state civil rights laws.

1. Based on the nationwide injunction currently in place, plan sponsors that are Section 1557 covered entities may retain a categorical exclusion of transition-related health treatment after the original effective date (plan years beginning on or after January 1, 2017) without violating Section 1557.
    a. For those plan sponsors that did not revise their plan as of 1-1-17, they may retain current language without violating Section 1557.
    b. Plan sponsors that amended their plan in 2016 to cover treatment services for gender dysphoria as of the plan year beginning on or after 1-1-17 should consult with their plan advisors and legal counsel as to next steps. Plans could simply continue to provide coverage for gender dysphoria. If a plan sponsors decides to remove the coverage, plan language that has been adopted and implemented cannot be changed unless certain steps are taken (e.g., plan amendments and certain notices may be required, and other legal considerations may apply if this coverage is removed mid-year).

2. The Section 1557 notice obligations (including the full notice, the statement, and taglines) remain intact. Plan sponsors that are covered entities are still required to issue and post the notices in the same manner as before the lawsuit.

3. The obligation for covered entities with more than 15 employees to have a compliance coordinator and grievance policy continues.

4. The obligations to provide accommodations to disabled individuals and language accessibility services continue undisturbed. Plan sponsors that are covered entities should be developing a compliance plan that includes the following actions:

a. Provide meaningful access to each individual with limited English proficiency eligible for the health program.
b. Communicate with individuals with disabilities as effectively as with others in health programs by providing auxiliary aids and services, such as assistive listening systems and devices; captioning; screen reader software; and other voice, text, and video-based telecommunications products. When choosing an auxiliary aid or service, covered entities should consider the choice of aid or service requested by the person who has a communication disability.
c. Assure that health programs provided through electronic information technology (e.g., websites, electronic dashboards) are accessible to individuals with disabilities, unless doing so would result in an undue financial or administrative burden.

5. Plan sponsors that are affiliated with a religious entity should consult with legal counsel as to the implication of the decision, as the court found that the regulation likely violates the RFRA as applied to private entities.