ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: Practical Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

IRS Clears the Air as to Tax Treatment of Benefits Under Traditional Health Fixed Indemnity Coverage

Background

Employers are constantly searching for new ways to offer additional valued benefits to employees while keeping benefit costs down. Oftentimes, this includes offering supplemental health fixed indemnity coverages alongside a more traditional medical benefit plan. While the tax attributes of such coverage have long been settled, previous IRS guidance created some confusion when addressing several abusive arrangements that purport to reduce taxable income through the use of a variation of fixed indemnity coverage. As we discuss below, the IRS has now cleared the air with regard to traditional health indemnity coverage.

As we have addressed in prior columns, there are a number of abusive tax arrangements marketed (primarily to small employers) that utilize a so-called wellness program that purport to provide tax advantages similar to the classic double dip arrangements first prohibited by the IRS in the early 2000s. In a Chief Counsel Memorandum dated December 12, 2016 (the "December 2016 CCM"),[1] the IRS exposed the fatal defects under a recent iteration of the wellness program scheme involving a self-insured health indemnity program that lacked economic substance.

However, some overly broad statements in the December 2016 CCM appeared to be contrary to established law with regard to more traditional fully-insured health indemnity plans. As we discussed in a prior column,[2] our belief was that these statements were limited to the abusive arrangements and could not as a matter of law impact taxation of traditional fully-insured fixed indemnity benefits as laid out in controlling authority. Nevertheless, the December 2016 CCM generated some confusion. In a new CCM dated April 24, 2017 (the "April 2017 CCM),[3] the IRS has made it clear that nothing has changed with respect to the federal tax treatment of fully-insured fixed indemnity coverage.

This article focuses on this aspect of the April 2017 CCM. [Note: The vast majority of employer wellness arrangements provide meaningful incentives to employees to encourage healthy behavior. We do not take issue with such programs. Rather, the "fatal defect" arises with respect to the incorrectly represented tax treatment of certain programs as described in more detail herein and in the CCMs and related IRS rulings.]

The Applicable Law

For decades, the issue of how benefits paid under health fixed indemnity policies are taxed has been settled based on the statutory provisions in Code Section 105, regulations, and IRS rulings. If the coverage was paid for on a pre-tax basis (i.e., by the employer or through employee salary reduction), 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.

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

> 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.**
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> 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 Rev. Rul. 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.

The December 2016 CCM

The IRS unintentionally created some confusion with respect to the well-settled law as described above in the December 2016 CCM. In the "wellness plan" arrangement discussed in the December 2016 CCM, 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. Situations 4 and 5 in the December 2016 CCM provide further details on the underlying structure of the arrangements.

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.** These broad statements were inconsistent with the regulations and Rev. Rul 69-154. While our analysis was that the December 2016 CCM was limited to the self-insured scheme under consideration, the broad statements generated some confusion.

The April 2017 CCM

The April 2017 CCM again addresses abusive self-funded arrangements and concludes that benefits under such arrangements are taxable if the average amounts received by employees for participating in a health-related activity predictably exceed the after-tax contributions by the employees.

The IRS lists two reasons for this conclusion: (1) the employer self-funded health plan in question does not have the effect of insurance; and/or (2) the ratio of the average amounts received by the employees for participating in health-related activities to the after-tax contributions by the employees demonstrates that the amounts received by the employees are attributable to contributions by the employer (and not employee after-tax contributions) so that the exclusion under section 104(a)(3) does not apply.

Importantly, the April 2017 CCM also eliminates the confusion generated by the prior CCM with respect to fixed indemnity arrangements. In particular, the April 2017 CCM states that the December 2016 CCM was "intended to address situations in which no medical expenses were incurred or reimbursed, and should not be read to modify the analysis or result in Rev. Rul. 69-154."

The April 2017 CCM also includes the following helpful example:

> For example, assume a traditional fixed indemnity health plan that pays fixed amounts on unpredictable health events such as a medical office visit or a hospital stay and receives premium payments on an after-tax basis, and that, unlike the arrangements presented in the situations described above [in the CCM], the fixed indemnity health plan provides insurance or has the effect of insurance. If that plan pays an individual $200 for a medical office visit and the covered individual's unreimbursed medical costs as the result of the visit were $30, the $200 would be excluded from income.
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> The exclusion under section 104(a)(3), however, does not apply to the extent that amounts paid are attributable to contributions by the employer which were not includable in the gross income of the employee, or paid by the employer. Thus, if a fixed indemnity health plan with premiums paid on a pre-tax basis through a section 125 cafeteria plan paid $200 for a medical office visit and the covered individual's unreimbursed medical costs as the result of the visit were $30, $30 would be excluded from gross income under section 105(b) and the excess amount of $170 would be included in gross income.

Conclusion

The IRS has now re-confirmed the income tax treatment to employees of benefits paid under fully-insured health fixed indemnity plans and that IRS Rev. Rul. 69-154 and the regulations under Code Section 105 continue to control. 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.** 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. ■

References

1 https://www.irs.gov/pub/irs-wd/201703013.pdf

2 John Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor, "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," The Self-Insurer (March 2017)

3 https://www.irs.gov/pub/irs-wd/201719025.pdf