K. Reimbursement Must Satisfy Code § 105(h) Nondiscrimination Rules

A health FSA must comply with the nondiscrimination rules for self-funded medical reimbursement plans under Code § 105(h). Simply stated:

- a health FSA must not discriminate in favor of highly compensated individuals as to eligibility to participate; and
- health FSA benefits must not discriminate in favor of participants who are highly compensated individuals.[211]

Note that a health FSA offered under a simple cafeteria plan will be treated as meeting the health FSA nondiscrimination rules; for more information, see Section XXXIII.

Nondiscrimination issues will largely be a matter of plan design, rather than arising on a case-by-case basis in an administrator's reimbursement decision. However, administrators often have to use some discretion in deciding whether a participant's request meets the Code requirements for reimbursement. It is not unusual for administrators to feel uncomfortable denying a request made by a senior executive. Keep in mind that failing to administer a plan uniformly and consistently on behalf of all participants can trigger discrimination (as well as other) problems when those benefiting from unusually favorable treatment are highly compensated.

Section XXXI discusses how the Code § 105(h) nondiscrimination rules apply to health FSAs. For a full discussion of the nondiscrimination rules for health FSAs, see Sections XXVIII through XXXI.

L. Health FSA Expenses That Are Difficult to Administer

There are several reasons why an expense may be difficult to administer. It may be unclear whether the particular type of expense is reimbursable (e.g., there may be no guidance or the guidance is vague). The expense may be hard to substantiate (or the participant may have submitted inadequate substantiation). The expense may be one that an administrator has not seen before—because health FSAs reimburse medical expenses that have not been reimbursed by other health plans, administrators often must adjudicate unusual items. Or the expense may have a high potential for participant abuse (e.g., expensive capital items).

> **Administration Tip: Developing Solutions for Difficult Expenses.** Administrators should keep track of how they resolve the expenses that cause them difficulties. Not only will this help them to be uniform and consistent in future adjudications, it will help them resolve similar issues more quickly in the future.* One approach is to exclude the difficult expenses from the plan by amendment. This should be done on a prospective basis at open enrollment, making sure that all plan documents and employee communications are consistent. Also, such exclusions should comply with other applicable laws (e.g., health care reform, ADA, ADEA, and Title VII).†

* ERISA plans are required to maintain reasonable procedures governing benefit claims that ensure consistency in the claims approval process. See Section XXII.

† See Section XXII.

In this subsection L, we address certain expenses that are difficult to administer because of one or more of the above reasons, including the following:

- procedures directed at improving appearance, such as cosmetic surgery;
- prescription and over-the-counter (OTC) medicines and drugs;
- vitamins, natural medicines, and nutritional and herbal supplements;
- special foods;
- weight-loss programs;
- exercise programs and health club membership dues;
- naturopathic, holistic, and alternative treatments;
- travel expenses, meals, and lodging;
- capital expenditures;
- long-term care expenses;
- plan administration costs;
- local, sales, service, and other taxes;
- infertility expenses;
- special schools; and
- expenses that could be for personal as well as medical reasons.

211 *See* Code § 105(h)(2).

Expenses Often Fall Into More Than One Category. Many expenses can fall into more than one "difficult" category, each of which has its own special rules. For example, one IRS information letter considered the implications of using cayenne pepper to treat a medical condition.* The analysis raised concerns about alternative healers, personal-use items, drugs and medicines, special foods, and vitamins. Administrators should consider all possible categories into which an expense might fall.

* IRS Information Letter 2001-0297 (Dec. 31, 2001).

If you cannot find information on the difficult or unusual expense you are looking for in subsection L or in the table in subsection M, here are some additional places to search:

- Code § 213(d) and Treas. Reg. § 1.213-1;
- IRS revenue rulings, revenue procedures, and notices;[212]
- U.S. Tax Court decisions;[213]
- IRS information letters and private letter rulings;[214]
- IRS Publication 502 (Medical and Dental Expenses);[215]
- frequently asked questions on the IRS website;[216] and
- informal comments by IRS officials (conferences, telephone calls) (note that these comments are not binding).[217]

1. Procedures Directed at Improving Appearance, Such as Cosmetic Surgery

Code § 213(d)(9)(A) provides that medical care "does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease." The primary requirement is the existence of a procedure—Code § 213(d)(9)(B) defines "cosmetic surgery" to be "any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease." At least one IRS official has noted that the IRS generally uses the term "cosmetic procedure," not "cosmetic surgery."[218] Consequently, we call Code § 213(d)(9) the "cosmetic-procedure exception" from medical care.

The cosmetic-procedure exception addresses concerns about the overly broad application of the Code § 213(d) definition of medical care. Specifically, Code § 213(d)(1)(A) includes, in the definition of medical care, amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease, *or for the purpose of affecting any structure or function of the body.*"[219] Legislative history for the cosmetic-procedure exception notes that "the IRS has interpreted 'medical care' as including procedures that permanently alter any structure of the body, even if the procedure generally is considered to be an elective, purely cosmetic treatment (such as removal of hair by electrolysis and face-lift operations)."[220] Consequently, Congress added the exclusion to ensure that unnecessary cosmetic procedures would not constitute medical care under Code § 213.

a. Procedures That Generally Are Cosmetic (and Thus Are Not for Medical Care)

Examples of procedures that generally would fall under the cosmetic-procedure exception (and thus not be for medical care) include face-lifts, electrolysis, hair removal, hair transplants, and teeth whitening (but see the discussion of teeth whitening below). Although such procedures affect a structure or function of the body, they generally are performed for elective, cosmetic purposes.

212 These can be accessed at http://www.irs.gov/ (as visited Aug. 30, 2011).

213 These can be accessed at http://www.ustaxcourt.gov/ (as visited Aug. 30, 2011).

214 These can be accessed at http://www.irs.gov/ (as visited Aug. 30, 2011). Note that they are not binding and cannot be cited as precedent.

215 Note that IRS Publication 502 should be used with great caution, as it can be misleading in some instances and can be out-of-date—see subsection D.

216 These can be accessed at http://www.irs.gov/ (as visited Aug. 30, 2011).

217 For telephone numbers of IRS officials who answer questions about cafeteria plans in general and Code § 213 expenses in particular, see the list of Phone Numbers of Government Contacts behind Appendix Tab 11.

218 Informal, nonbinding remarks of John Sapienza, IRS, Office of Chief Counsel, May 2002 ECFC Teleconference.

219 Emphasis added.

220 H.R. Conf. Rep. No. 964, 01st Cong., 2d Sess., 1030-1041, 1031 (Oct. 27, 1990).

b. Procedures That Generally Are Considered to Be for Medical Care (Even Though They Have Cosmetic Effects)

In contrast, expenses for orthodontia and radial keratotomy generally do not fall within the cosmetic-procedure exception, so long as they correct a physical defect.[221] In other words, although these procedures have cosmetic effects, they more importantly promote the proper function of the body.[222]

c. Procedures That Are Necessary to Ameliorate a Deformity (and Thus Are for Medical Care)

Some procedures can be "saved" from the cosmetic-procedure exception (i.e., can still be considered medical care under Code § 213(d)) if they meet certain requirements. Under Code § 213(d)(9)(A), the cosmetic-procedure exception does not apply to surgeries or procedures that are "necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury arising from an accident or trauma, or disfiguring disease." Consequently, to qualify for the safe harbor, the procedure must first treat a condition that is a deformity (presumably from the perspective of society in general, not just from the perspective of the individual). Second, the deformity must be caused by one of the three specified types of events (congenital abnormality, personal injury, or disfiguring disease).

How has the cosmetic-procedure exception been applied to specific expenses? As an example, breast reconstruction for an individual who has had a mastectomy as part of treatment for cancer is an expense for medical care because the surgery ameliorates a deformity directly related to a disease.[223] In another example, the IRS held that a cosmetic-procedure treatment to correct a facial deformity that originated from numerous surgeries designed to correct a congenital abnormality qualified as a medical care expense because the facial deformity arose from or was directly related to congenital abnormalities.[224] (In other words, the relationship between the cosmetic-procedure treatment and the congenital abnormality that was needed to qualify for the safe harbor existed, although there were intervening procedures.)

In contrast, teeth whitening to correct discoloration as a result of age does not treat a disease or promote the proper function of the body but is instead directed at improving appearance.[225] Because the discoloration is not a deformity and is not caused by a disfiguring disease or treatment, the cost of whitening teeth in that circumstance is purely cosmetic and is not an expense for medical care. (One IRS official, however, has indicated that expenses for teeth whitening for blackened teeth that were the result of a disfiguring disease may qualify as medical care.)[226]

Subtle variations in the facts underlying submitted claims might lead to different conclusions about whether a procedure falls under the safe harbor (and is thus for medical care despite its cosmetic effects). For example, a health FSA might be able to reimburse a 20-year-old woman who undergoes treatment to restore all her hair after losing it as a result of alopecia areata (a disease that causes sudden hair loss), but it might reject a claim from a 50-year-old man who has simply experienced male pattern baldness (typically arising from the aging process). In the first situation, there is probably a deformity arising from a disfiguring disease; in the second case, even if there were a deformity (which seems unlikely), aging is not considered a disfiguring disease.[227]

Special issues arise with respect to how the cosmetic-procedure exception from medical care applies to medicines and drugs. See subsection L.2.b.

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221 *See, e.g.*, Rev. Rul. 2003-57, 2003-22 I.R.B. 959 ("Eye surgery to correct defective vision, including laser procedures such as LASIK and radial keratotomy, corrects a dysfunction of the body.").

222 *See* Priv. Ltr. Rul. 200226003 (Mar. 7, 2002); IRS Publication No. 502; and Priv. Ltr. Rul. 9625049 (June 21, 1996) (radial keratotomy is not a cosmetic procedure and would qualify as a medical expense under Code § 213). *See also* IRS Information Letter (Feb. 19, 1997) (implying that orthodontia expenses are reimbursable under a health FSA).

223 Rev. Rul. 2003-57, 2003-22 I.R.B. 959. The IRS did not address whether surgery and reconstruction of the other breast "to produce a symmetrical appearance," as may be required under the Women's Health and Cancer Rights Act (WHCRA), would also be considered a medical expense.

224 Priv. Ltr. Rul. 200344010 (Mar. 27, 2003).

225 Rev. Rul. 2003-57, 2003-22 I.R.B. 959.

226 Informal, nonbinding remarks of Donna Crisalli, IRS, Office of Chief Counsel, May 2002 ECFC Teleconference.

227 Rev. Rul. 2003-57, 2003-22 I.R.B. 959.

Sex Reassignment Surgery and Related Expenses. The Tax Court has held that a taxpayer's hormone therapy and sex reassignment surgery treated a disease within the meaning of Code § 213(d); therefore, these procedures were for medical care and were not cosmetic surgery. The court found that the taxpayer suffered from gender identity disorder (GID), a widely recognized and serious medical condition, and that mental health professionals consider hormone therapy and sex reassignment surgery to be appropriate and effective treatment for GID. However, the court concluded that the taxpayer's breast augmentation surgery was cosmetic surgery and not for medical care, because her breasts were "within a normal range of appearance" before the surgery, and surgery was not needed "for comfort in the social gender role."*

* *O'Donnabhain v. Comm'r*, 134 T.C. No. 4 (2010). The holding in this case differed from the conclusion previously reached by the IRS with respect to the taxpayer in Chief Counsel Advice 200603025 (Oct. 14, 2005). However, the IRS later announced that it would follow the Tax Court's decision and would no longer take the position reflected in its earlier Chief Counsel Advice. *See* Action on Decision 2011-3, I.R.B. 2011-47 (Nov. 21, 2011). Neither the Chief Counsel Advice nor the Action on Decision can be used or cited as precedent.

2. Medicines and Drugs (Over-the-Counter and Prescription)

Medicines and drugs are reimbursable if they are Code § 213(d) medical care expenses and meet other Code requirements, whether they can be acquired only with a prescription or are available over the counter (i.e., without a prescription). Under Code §§ 213(a) and (b), which allow an itemized deduction for medical expenses, medicines that do not require a prescription (like aspirin) are not deductible. For many years, the IRS also interpreted this provision to mean that such items were not reimbursable under a health FSA.[228] In Revenue Ruling 2003-102 (the 2003 OTC Ruling), however, the IRS announced that OTC drugs purchased to alleviate or treat personal injuries or sickness of the employee or the employee's spouse or dependents could be reimbursed by health FSAs and other employer-provided health plans.[229] This rule was short-lived and has since been modified by the health care reform law, under which expenses for OTC medicines and drugs (other than insulin) incurred after December 31, 2010 are only reimbursable if the medicines or drugs are prescribed (determined without regard to whether a prescription is necessary to acquire the drug).[230]

Shortly after the enactment of health care reform, the IRS issued guidance on the prescription requirement in the form of IRS Notice 2010-59 (the 2010 OTC Notice).[231] Further clarification as to the requirement's impact on electronic payment card programs was provided in IRS Notice 2011-5.[231.1] The IRS also declared the 2003 OTC Ruling obsolete as of January 1, 2011.[232] The 2010 OTC Notice addresses several questions arising under health care reform's prescription requirement, including the following:

- When is a medicine or drug considered to be prescribed?
- What substantiation is required to show that an OTC drug has been prescribed?

228 *See, e.g.*, IRS Information Letter 2000-0080 (May 23, 2000).

229 Rev. Rul. 2003-102, 2003-38 I.R.B. 559. The OTC Drug Ruling applied not only to health FSAs, but to any employer-provided health plans that were subject to the income exclusion under Code § 105(b) for medical care expenses, including HRAs, insured medical plans, and self-insured medical reimbursement plans. The same rules also applied to HSAs. For more information on HRAs and HSAs, see *Consumer-Driven Health Care* (Thomson Reuters/EBIA, 2004-present, updated quarterly).

230 Code § 106(f), as added by PPACA, Pub. L. No. 111-148 (2010). Note that this restriction also applies to other employer-sponsored health plans (e.g., HRAs and major medical plans). A similar restriction applies to HSAs and Archer MSAs under Code §§ 223(d)(2)(A) and 220(d)(2)(A), as amended by PPACA, Pub. L. No. 111-148 (2010). HRAs, HSAs, and Archer MSAs are covered in *Consumer-Driven Health Care* (Thomson Reuters/EBIA, 2004-present, updated quarterly).

231 IRS Notice 2010-59, 2010-39 I.R.B. 396.

231.1 IRS Notice 2011-5, 2011-3 I.R.B. 314. See Section XXI for a detailed discussion of health FSA card programs, including the impact of the prescription requirement and IRS Notice 2011-5.

232 *See* Rev. Rul. 2010-23, 2010-39 I.R.B. 388.

- How does the prescription requirement's January 1, 2010 effective date affect non-calendar-year plans and calendar-year plans with grace periods?
- How does the prescription requirement affect health FSA debit card programs?

These issues are discussed in more detail in this subsection L.2.

> **What's a Prescription Drug? What's an Over-the-Counter (OTC) Drug?** A "prescription drug" is "a drug that can be obtained only by means of a physician's prescription."* We use the term "OTC drug" to refer to a drug that is sold lawfully without a prescription (i.e., a drug that can be sold "over the counter").

* U.S. National Library of Medicine, MEDLINEplus: Medical Dictionary, available at http://www.nlm.nih.gov/medlineplus/mplusdictionary.html (as visited Mar. 11, 2013).

Most health FSAs cover OTC drugs, but there are many issues regarding how to administer this benefit, especially in light of the changes made by the health care reform law. This subsection L.2 addresses the additional restrictions on OTC drugs under the health care reform law, as well as the other legal requirements that must be met for medicines and drugs to be reimbursable. We also discuss how plan documents should be written to cover (or not cover) OTC drugs, and we provide other practical tips to help employers administer medicine and drug coverage under their health FSAs.

> **OTC Drugs Are Still Not Deductible.** Amounts paid for medicines or drugs that may be purchased without the prescription of a physician are not taken into account when determining an individual's medical expense deduction under Code § 213.* Consequently, individuals may not deduct OTC drugs (other than insulin) on their federal income tax returns (that is, on Schedule A of Form 1040). Health care reform did not change the nondeductible nature of OTC medicines and drugs under Code § 213.

* *See* Code § 213(b).

a. OTC Medicines or Drugs Must Be Prescribed to Be Reimbursable

Health care reform allows health FSAs to reimburse expenses for medicines or drugs only if the medicine or drug (1) requires a prescription, (2) is available without a prescription (i.e., an OTC drug) and the individual obtains a prescription, or (3) is insulin.[233] The health care reform law's "grandfather" provisions do not apply to this requirement, so all health FSAs must comply.[234] The statutory language provides that the restrictions apply to expenses incurred in taxable years beginning after December 31, 2010.[235] IRS guidance in the form of the 2010 OTC Notice clarifies that the change is effective for expenses incurred after December 31, 2010, and that the effective date of the restriction is the same for all plans, regardless of plan year and regardless of any grace period provided under a health FSA.[236]

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233 Code § 106(f), as added by PPACA, Pub. L. No. 111-148 (2010); IRS Notice 2010-59, 2010-39 IRB 396. *See also* Rev. Rul. 2010-23, 2010-39 IRB 388 (declaring that Rev. Rul. 2003-102, 2003-38 IRB 559, in which the IRS announced that employer-provided accident and health plans could reimburse OTC drugs purchased to alleviate or treat personal injuries or sickness of the employee, spouse or dependents, is obsolete as of January 1, 2011).

234 Under the health care reform law, group health plans that had at least one participant on March 23, 2010 and meet certain requirements are "grandfathered health plans" and are not subject to some of the law's requirements. PPACA, Pub. L. No. 111-148, § 1251 (2010); Treas. Reg § 54.9815-1251T; DOL Reg § 2590.715-1251; HHS Reg. § 147.140. Grandfathered plans are covered in Section VI of *Health Care Reform for Employers and Advisors* (Thomson Reuters/EBIA, 2010-present).

235 PPACA, Pub. L. No. 111-148, § 9003(d)(2) (2010) (the statute refers to expenses incurred "with respect to" taxable years beginning after 2010).

236 IRS Notice 2010-59, 2010-39 IRB 396. *See also* Technical Explanation Of The Revenue Provisions Of The "Reconciliation Act Of 2010," As Amended, In Combination With The "Patient Protection And Affordable Care Act" (JCX-18-10), 70 (Mar. 21, 2010), available at http://www.jct.gov/publications.html?func=startdown&id=3673 (as visited Mar. 11, 2013) (stating that the OTC drug restriction "is effective for expenses incurred after December 31, 2010"). The guidance also confirms that OTC drugs purchased without a prescription before 2011 can be reimbursed at any time to the extent allowed under then-applicable law and permitted under the plan's terms. So while the restriction will apply to expenses incurred during the post-2010 grace period under a calendar-year health FSA, it will not apply to expenses that are incurred in 2010 and submitted during a post-2010 claims run-out period.

(i) Which OTC Items Are Medicines or Drugs Subject to the Prescription Requirement?

By its terms, the prescription requirement applies only to medicines and drugs—it does not extend to items other than medicines or drugs that are available over-the-counter (e.g., equipment, supplies, and medical devices). The rules for reimbursing these "non-medicine" items remain unchanged (e.g., they must be for medical care and not merely beneficial to an individual's general health). Thus, items such as crutches, bandages, and blood-sugar test kits are not subject to the prescription requirement.[237] However, not all OTC items will fall neatly into one category or the other, and guidance is needed on what constitutes a medicine or drug for purposes of the restrictions. As discussed later in this subsection L.2, the Code does not offer a useful general definition of either term. The difficulty with defining these terms is illustrated by Treas. Reg. § 1.213-1(e)(2), which circularly defines the term "medicine and drugs" as including "items…which are generally accepted as falling within the category of medicine and drugs." The Treasury Department's 2012-2013 Priority Guidance Plan lists regulations under Code § 213 on medical and dental expenses as a project that the IRS intends to work on.[238] Perhaps further guidance on the definition of a medicine or drug will be included in these regulations.

> **Caution: Status of Certain OTC Items Is Unclear.** Can health FSAs continue to reimburse OTC items with a "medication" component, such as medicated bandages, or are they considered to be medicines or drugs that must be prescribed in order to be reimbursable? The answer is unclear. One approach would be to consider whether the item's medication component is de minimis or incidental to an otherwise allowable OTC item. If the medication component is incidental, the item could be reimbursed without a prescription (assuming other applicable requirements are met). Under such an approach, for example, the primary purpose of a medicated bandage likely would not be as a medicine or drug. While a Treasury Department official has informally indicated that such a "primary/incidental purpose test" should apply,* formal IRS guidance on the status of this and other OTC items with a medication component would be helpful.

* Informal, nonbinding remarks of Kevin Knopf, Attorney-Advisor, Office of Tax Policy of the Treasury Department, Mar. 4, 2011 ECFC Annual Conference.

(ii) What Is a Prescription for an OTC Medicine or Drug?

IRS Notice 2010-59 indicates that for purposes of the prescription requirement, a "prescription" for a medicine or drug is a written or electronic order that satisfies the legal requirements for a prescription in the state in which the expense is incurred, including that it be issued by someone who is legally authorized to issue a prescription in that state.[239] In subsequent guidance regarding the prescription requirement's application to electronic payment card programs, the IRS indicated that a prescription could be presented to the pharmacist "in any format."[240] This modification was made in order to clarify the status of orders that state law allows to be given orally (e.g., by telephone), and was intended to acknowledge that prescriptions may take any form permitted under applicable state law (whether or not an electronic payment card is used).[241] An OTC drug is considered to be prescribed if the individual obtains a prescription for it (even though a prescription is not legally required to obtain it).

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237 IRS Notice 2010-59, 2010-39 IRB 396. *See also* Affordable Care Act: Questions and Answers on Over-the-Counter Medicines and Drugs, available at http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs (as visited Mar. 11, 2013).

238 Treasury Department 2012-2013 Priority Guidance Plan, available at http://www.irs.gov/uac/Priority-Guidance-Plan (as visited Mar. 11, 2013).

239 IRS Notice 2010-59, 2010-39 I.R.B. 396.

240 IRS Notice 2011-5, 2011-3 I.R.B. 314.

241 Informal, nonbinding remarks of Kevin Knopf, Attorney-Advisor, Office of Tax Policy of the Treasury Department, Mar. 4, 2011 ECFC Annual Conference.

