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Employee Benefits & Executive Compensation ADVISORY ■

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Post-*Roe* Issues for Health Plan Sponsors: Navigating the Rapidly Changing Legal Landscape

On June 24, 2022, in *Dobbs v. Jackson Women's Health Organization*, the U.S. Supreme Court overruled *Roe v. Wade* and *Planned Parenthood v. Casey*. States are now able to regulate abortion. As plan sponsors consider potential coverage options, they will need to coordinate their plan coverage with a patchwork of state laws that span from outright bans (with limited exceptions) to mandatory coverage of abortion (for fully insured plans in some states). In some states both civil and criminal laws may be relevant, and states may attempt to enforce their laws for actions that extend across their borders. There are also federal laws that may apply, which may preempt state law, at least to some extent.

In the wake of *Dobbs*, some employers are considering covering travel benefits for abortions that are legal in the state where they are provided. This advisory focuses primarily on issues under ERISA and the Internal Revenue Code for self-insured group health plans. Employers considering such benefits also need to examine state law. Tracking state laws and their possible effects on providing abortion benefits under a group health plan is a complex analysis. This advisory provides a high-level summary of state-law issues but does not address specific state laws. The legal landscape is expected to rapidly change, and the issues will need to be worked out on a state-by-state basis. Further litigation on many issues may be forthcoming. Plans sponsors should consult with their legal counsel on the state-law issues, which may include criminal laws.

The Pregnancy Discrimination Act

The Pregnancy Discrimination Act (PDA) is a federal law that was enacted in 1978 after the U.S. Supreme Court held that excluding pregnancy-related disabilities from an employee benefit plan did not constitute sex discrimination under Title VII of the Civil Rights Act. The PDA amended Title VII to clarify that discrimination based on pregnancy, childbirth, or related medical conditions is a prohibited form of sex discrimination. The PDA specifically states that employers do not have to pay for health coverage for abortions "except where the life of the mother would be endangered if the fetus were carried to term." The PDA also requires plans to cover complications arising from abortion (even if abortion is not covered by the plan), such as excessive hemorrhaging. The PDA also does not preclude an employer from providing abortion benefits. As with Title VII generally, the PDA applies to employers with 15 or more employees and is enforced by the Equal Employment Opportunity Commission (EEOC).

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The effect of the *Dobbs* opinion on the PDA requirements for health plans is not clear. As a federal law, it may preempt inconsistent state law, but the EEOC has not yet commented. States with abortion restrictions appear to have an exception for abortions necessary to protect the life of the mother. The scope of such an exception under particular state laws may not be clear and may create uncertainty for health care providers and plans as to which conditions would meet the standard under state law. Plans have their own procedures in place for reviewing the medical necessity of any covered service, but whether a plan's determination of medical necessity for an abortion will be consistent with a state's limited exception, and whether the plan can simply rely on the provider's determination, is not yet known.

Medical Travel Benefits: Tax Treatment and Plan Design Questions

Both the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code define "medical care" to include amounts paid for "transportation primarily for and essential to" medical care. Code Section 213(d) governs the scope of medical expenses that are excludable from employees' income and payroll taxes. The medical care itself also has to be legal in order for the tax-favored treatment to apply. Many plans already provide travel benefits, such as to centers of excellence (COEs), for specified surgery or for transplants.

With certain limitations, travel expenses for abortion should be excludable from income and payroll taxes under the federal tax rules as long as the abortion is legally obtained. Lodging is capped at $50 per night per person (this limit is not adjusted for inflation). The cost of meals is not taxable if the meal is obtained within the hospital (or similar facility) where the procedure is performed. If traveling by automobile, reimbursement is permitted for actual expenses (not including depreciation, insurance, general repair, or maintenance expenses) or, alternatively, the current medical mileage rate, plus tolls and/or parking fees. The mileage rate is normally adjusted annually by the IRS for inflation. The cost of other modes of travel (train, plane, bus, etc.) is also excludable if covered by the plan, but in all cases the transportation must be primarily for medical care and not for non-medical purposes. Travel expenses for medically necessary travel companions are also considered excludable medical care.

There are a number of different ways plan sponsors can structure travel benefits. Providing coverage through the employer's traditional medical plan is likely the least complicated option, with the fewest compliance risks. Other paths that have emerged (each with compliance questions) are health reimbursement arrangements (HRAs), excepted benefit health reimbursement arrangements (EBHRAs), employee assistance programs (EAPs), and stand-alone travel benefit plans. In order to avoid disqualifying health savings account (HSA) eligibility, any travel benefits need to conform to the high deductible health plan (HDHP) requirements, such as no plan coverage until the deductible is met. We discuss each option in turn below.

Practice Pointer: ***Any reimbursement for medical travel exceeding federal tax limits is subject to taxation. This can create payroll challenges because taxable amounts are subject to income and employment tax withholding.***

Traditional Employer Group Health Plans

Medical travel expenses can be reimbursed directly through the employer's group health plan, provided that the plan includes such travel (or medical travel generally) as a covered service. The plan participant would need to submit documentation to the plan for substantiation in order to obtain reimbursement, which would

necessarily include information about the medical procedure itself. Substantiating these reimbursement requests would involve protected health information and thus require compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

Practice Pointer: ***Self-insured group health plans adding a medical travel benefit will need to develop a HIPAA-compliant substantiation process, or engage their third-party administrator (TPA) to handle the process. Also, before implementing any travel benefit, there should be a discussion with the TPA on whether it can manage the process administratively and how that process will be communicated to participants and beneficiaries.***

Because medical travel is medical care under Code Section 213(d), participants can also obtain reimbursement through their existing HRA, FSA, or HSA. Some employers have expressed an interest in providing medical travel benefits to employees who are not eligible for or enrolled in the employer's group health plan; this presents additional health plan compliance issues.

Practice Pointer: ***Review the plan document to determine whether an amendment is needed to add medical travel and whether to restrict the added benefit to specific services only. The amount and scope of the benefit should also be considered (e.g., "procedures, treatments, and services unavailable within a 100-mile radius").***

Other Reimbursement Arrangements

There are other reimbursement plans such as HRAs, EBHRAs, health FSAs, and possibly EAPs that may be used to reimburse medical travel expenses. Generally, plans that provide an ERISA benefit are subject to ERISA with the requirements of a plan document, summary plan description, Form 5500, etc. They are also subject to COBRA. Except for certain limited exceptions, these plans must likewise comply with the privacy and security provisions of HIPAA. As self-insured plans, they are subject to Code Section 105(h), which denies tax-favored status to plans that discriminate in favor of highly compensated individuals.

The one important feature of these plans is that, if designed correctly, they will not be subject to aspects of the Affordable Care Act (ACA) that they could not otherwise meet—such as covering all required preventive services. This can be done either through integration with a traditional group health plan (for an HRA) or their status as an "excepted benefit" under the ACA.

HRAs and health FSAs

Medical travel can be reimbursed through either an HRA or a health FSA, subject to the rules governing the specific arrangement or account.

For example, health FSAs are subject to annual contribution/benefit limits. Employer contributions to a health FSA are further limited in order to keep the health FSA an excepted benefit under the ACA. If an employee does not contribute to a health FSA, employer contributions are capped at $500. Health FSAs can, however, be offered to those who have been offered a traditional group health plan but declined coverage.

HRAs are not subject to contribution/benefit limits, but there are almost always limits based on plan design. HRAs must be "integrated" with a traditional group health plan in order to avoid application of certain aspects of the ACA. This means the employee must be enrolled in other group health plan coverage in order to be enrolled in the HRA.

If the plan design is that the HRA or FSA will cover any Code Section 213(d) expense, then medical-related travel expenses are currently covered absent an express exclusion for certain types of services/travel.

If an HRA or FSA does not cover all Code Section 213(d) expenses, one decision if travel benefits are added is whether reimbursements will be restricted to travel for certain types of services or whether other broader medical travel will be included. In both cases, substantiation of the medical services received will be required.

For employers that want to offer travel benefits to employees who are not enrolled in the employer's group health plan, employers may consider offering an EBHRA; however, this type of HRA has additional compliance concerns under the Code and ERISA.

EBHRAs

One possible way to structure a travel benefit for employees who are eligible for, but who do not enroll in, the group health plan is through an EBHRA, which is a relatively new benefit option available since 2020. EBHRAs are flexible in that they can be used by employers of any size and can be used by employees not enrolled in the employer's traditional medical group health plan. EBHRAs are another form of "excepted benefit" under the ACA. To obtain that excepted benefit status, however, several requirements need to be met:

- EBHRAs must be available under the same terms and conditions to all similarly situated individuals. HIPAA nondiscrimination rules are used for purposes of defining "similarly situated."
- The employer must make other nonexcepted, non-account-based group health plan coverage available to the EBHRA participants for the plan year. The participants do not have to enroll in such primary coverage to be eligible for the EBHRA.
- Dollar limits for EBHRA accruals are $1,800 for 2022 and $1,950 for 2023.
- Reimbursements can generally be made for any out-of-pocket Code Section 213(d) medical expenses, subject to certain restrictions on reimbursement for health insurance. Reimbursement is not permitted for premiums for individual health coverage, Medicare, or non-COBRA group coverage.
- Non-federal governmental EBHRAs have some notice requirements relating to conditions of eligibility, annual/lifetime caps, and other limits on benefits and a summary of the benefits.

An employee's participation in an EBHRA can impact other account-based benefits, like other existing HRAs, FSAs, and HSAs. EBHRA participation can disqualify a person from participating in an HSA because the EBHRA provides a benefit below the HDHP deductible.

HSAs

Because medical travel is a Code Section 213(d) expense, travel for a legally obtained abortion should be a qualifying medical expense. Third-party adjudication is not required for distributions from an HSA. The individual is responsible for maintaining their own records to show that their expenses are qualified medical expenses. The employer plays no role in substantiating HSA distributions.

EAPs

In order for an EAP to qualify as an excepted benefit:

- The EAP cannot provide "significant benefits in the nature of medical care." Currently, there is limited guidance on what constitutes "significant" medical benefits. Even if medical travel alone would not be significant, there remains some question of whether adding this benefit to an existing EAP that provides some medical benefits could tip the balance from insignificant to significant.
- EAP benefits cannot be coordinated with benefits under a group health plan. This means that eligibility for the EAP cannot be conditioned on being enrolled in the group health plan.
- Participants cannot be charged any premium or cost sharing to participate in the EAP. The employer must fully fund the EAP. Although cost sharing is not defined in the EAP rules, cost sharing typically does not include amounts exceeding plan limits. Thus, it should be possible to impose some limits on the amount of covered travel expenses.

If, however, medical travel benefits are viewed as significant, the EAP would not be an excepted benefit and therefore would be subject to ACA mandates, which the EAP could not meet. In designing an EAP, plan sponsors should also consider the cost of travel and how likely (in the absence of clarifying guidance) it would be for the cost of a plane ticket *not* to be significant.

Stand-Alone Travel Plans

Some employers may be considering ways to extend medical travel benefits to all employees, even those who are not enrolled in or eligible for the group health plan outside what is discussed above. Offering such a benefit has several risks under ERISA and the Code. Because medical travel benefits are medical care, even a benefit that covers only medical travel could be considered a group health plan under ERISA and COBRA. That plan would also need to comply with the ACA. Under the ACA, group health plans must cover all required preventive services, which is typically beyond an employer's intended scope of coverage for a travel benefit. Sanctions for a noncompliant plan under the ACA include a $100 per day per participant excise tax under the Code.

Substantiation

Tax-favored arrangements for medical travel also require substantiation to confirm that the travel was for medical care, which would raise HIPAA compliance requirements. For health FSAs, HRAs, and EBHRAs, substantiation includes providing documentation from an independent third party describing the transportation service provided, the date of the service, and the amount of the expense, as well as a statement from the participant that the travel expense has not been reimbursed and that the participant will not seek reimbursement for the travel expense under any other health plan coverage. There must be substantiation that the medical services and treatment for which the travel expenses were incurred were provided.

ERISA Preemption of State Laws

ERISA may preempt some state abortion laws that relate to employee benefit plans, but the analysis is complicated and would need to be on a state-by-state basis. For example, before the opinion in *Dobbs*,

lawmakers in Texas signaled that they may craft legislation banning in-state employers that pay for out-of-state abortions from doing business in Texas. Whether such a law would be closely related to the employee benefit plan would be significant for purposes of an ERISA preemption analysis, and the actual text of the as-yet-to-be-drafted law would need to be reviewed.

A high-level explanation of ERISA preemption is as follows:

- ERISA generally preempts state laws that relate to employee benefit plans, with some exceptions for laws regulating banking, securities, and insurance. The exception for laws regulating insurance is important for fully insured plans (which remain subject to state insurance laws) but not for self-insured plans.
- ERISA does not preempt any *generally applicable* criminal law.
- Federal common law has a presumption against preemption of a civil statute if a state is exercising general police powers, which may include public safety.

Broad bans on abortions generally are not as likely to be preempted by ERISA because such laws do not relate to employee benefit plans. State criminal laws that target employee benefits plans by banning plans from covering services or treatments that are legally obtained in other states might face not only preemption challenges but other challenges as well. In his concurring opinion in *Dobbs*, Justice Brett Kavanaugh stated that barring a resident from travel from one state to another to obtain an abortion would violate the constitutional right to interstate travel. We also note that the Biden Administration's Executive Order on Protecting Access to Reproductive Healthcare Services and related actions from the Administration may come into play as well. States can also pass civil statutes that restrict abortion access under traditional exercise of police powers, but again, the purpose and scope of the state statute would need to be reviewed in order to evaluate the likelihood of a successful preemption challenge.

ERISA preemption favors self-insured plans because the ERISA "savings clause" allows state insurance regulators to control the policies issued to fully insured plans. Self-insured ERISA group health plans may still be able to cover the procedure if it is legally obtained out of state, depending on the provisions of the state law itself. For fully insured ERISA plans, state insurance law may control whether abortion and related travel can be covered. It is possible that even reimbursements from HRAs integrated with a fully insured plan could be limited by state insurance laws.

Criminal laws will need to be examined *very* closely, especially those that contain language on aiding or abetting abortions or "accomplice" liability, to determine whether paying for abortion-related travel expenses is a crime under these laws. As mentioned above, ERISA does not preempt *generally applicable* criminal laws, and it is unclear which laws will be generally applicable (and saved from preemption) and which will be considered targeted at employee benefit plans (and therefore preemption may still be a viable argument). Legal counsel should always be consulted on criminal laws generally, but especially any "aiding and abetting" law.

Telehealth

Even before the *Dobbs* opinion, access to and methods for abortion were changing. Over half of all abortions in the United States are "medication" abortions. Medication abortions involve the use of medication (mifepristone followed by misoprostol) to induce abortion without the use of surgery or anesthesia. Until recently, access

to such medication still required visiting a clinic and picking up the pills in person. The COVID-19 pandemic made such in-person encounters more difficult, and on December 16, 2021, the Food and Drug Administration permanently removed dispensing restrictions on these drugs, allowing the medications to be shipped by mail. As a result, it is now legal under federal law for abortion medication to be prescribed through a telehealth visit and mailed to the patient.

How to resolve conflicts of state restrictions and bans with various federal laws and other mandates is currently under scrutiny. Before the *Dobbs* opinion, several states had laws that require at least one visit to a clinic for an in-person evaluation or pre-abortion counseling before receiving any abortion services, and some specifically banned the use of telehealth for medication abortion. A few states, including Arizona, Indiana, Ohio, Montana, Oklahoma, and Texas, had already passed laws to ban mailing abortion medication before *Dobbs*. The legality of prescribing abortion medication through telehealth and mailing abortion medication, and the restrictions on and criminalization of abortion itself, have created a maze of legal challenges that will continue to evolve in the coming months.

Other Issues

Returning abortion regulation back to the states will create numerous challenges for national employer plan sponsors, many of which may not yet be apparent as the legal landscape rapidly evolves. Some of the other issues that plan sponsors will be watching include the effect of state laws on pharmacy benefit managers (PBMs), infertility benefits, "aiding and abetting" type provisions in state laws, and the need to expand provider networks to states that provide legal abortion.

Conclusion

This advisory has focused on key issues that plan sponsors face under ERISA and the Code if they are considering options for covering travel benefits for legal abortions. Understanding state law is also critical, and before adopting such benefits, employers should review state law, including criminal laws, "aiding and abetting" laws, and laws that reach actions outside the state. Employers should continue to consult with their legal counsel on these complex issues as the legal landscape continues to change.

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