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Excise Taxes

Brad Schlozman of the Hinkle Law Firm writes that a growing number of employers are adding telemedicine benefits for employees—and that ''there is a broad array of legal pitfalls dotting the landscape of these telemedicine arrangements.'' The author warns that employers face potential excise tax liabilities if their plans are poorly structured, plus health savings accounts associated with high deductible health plans may be affected. Added concerns about ERISA, COBRA and HIPAA compliance make it critical to proceed with caution, Schlozman says.

Telemedicine Arrangements: Beware of Inadvertently Dialing Up an Excise Tax

BY BRAD SCHLOZMAN

In an effort to save money and provide employees with more convenient health care delivery options, a growing number of employers are adding telemedicine arrangements to their overall benefits package.

Telemedicine generally refers to the provision of medical care by physicians or other health care professionals via the Internet or phone-video system, rather than in-person. Patient consultations using a telemedicine vehicle operate like a virtual doctor's office visit, with the physician providing a diagnosis and treatment plan and even issuing a prescription if necessary.[1] There obviously is no opportunity for the doctor to palpate any part of the patient, but then again, the patient doesn't have to sit in a waiting room for hours on end reading three-year-old issues of Field and Stream.

As one might expect, there is a broad array of legal pitfalls dotting the landscape of these telemedicine arrangements. It is our understanding that most program sponsors have done a good job addressing issues like physician state licensure requirements and informed consent rules. Our primary concern, though, is for the sponsoring employers. Unless the telemedicine arrangement is structured in just the right way, employers may find themselves on the hook for excise taxes of $100 per day (or $36,500 per year) per participant.

Moreover, depending on how the program is offered, participants enrolled in both the telemedicine arrangement and a high deductible health plan may be precluded from making (or receiving) contributions to their health savings account.

Further, the employer must ensure that the arrangement is in full compliance with all of the intricate Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA) and Health Insurance Portability and Accountability Act (HIPAA) mandates.

In short, there is much that can go wrong. It is critical, therefore, that employers proceed with caution.

Potential Imposition of Excise Taxes Under the Affordable Care Act

One of the most significant concerns for employers offering telemedicine arrangements is the potential imposition of excise taxes. The basic problem is that a telemedicine program is, by definition, a ''group health plan'' under ERISA, the Internal Revenue Code and the Public Health Service Act (PHSA). Unless it is properly

[1] A comprehensive discussion of telemedicine arrangements can be found on the American Telemedicine Association's website. See http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.V2hljrf2a70.

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structured, the plan won't satisfy all of the market reform requirements of the Affordable Care Act (ACA), which in turn could trigger enormous excise taxes.

Legal Basis for the Potential Excise Taxes

Both ERISA and the PHSA define a ''group health plan'' as ''an employee welfare benefit plan . . . to the extent that the plan provides medical care . . . to employees or their dependents . . . directly or through insurance, reimbursement, or otherwise.''[2]

An ''employee welfare benefit plan,'' in turn, includes any plan established or maintained by an employer ''for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care.''[3] ''Medical care,'' is defined to include, among other things, ''the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.''[4]

Meanwhile, the tax code's definition of ''group health plan'' is even broader. Under the code, a group health plan doesn't depend on the existence of an ERISA welfare benefit plan. Instead, it is any ''plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.''[5]

Telemedicine clearly entails the ''diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.'' It unequivocally also involves the provision of health care. It is beyond serious dispute, therefore, that a telemedicine arrangement is a group health plan within the meaning of ERISA and the tax code.

This characterization is critically important because the ACA imposes on virtually all group health plans a series of coverage mandates, commonly referred to as ''market reforms.''[6] These include, for example, the prohibition on annual and lifetime limits, the maximum 90-day waiting period, the mandatory extension of dependent coverage through age 26, the prohibition on cost sharing (i.e., copayments, coinsurance or deductibles) for preventive health services, etc.[7]

The preventive services mandate is particularly problematic for telemedicine plans. Under the final regulations, preventive health services include immunizations, screenings and other tests that realistically can only be performed through an in-person visit to the doctor's office.[8] If such services are performed by an in-network provider, there can be no cost sharing. Moreover, if a plan doesn't have an in-network provider that can provide such services, then the plan can't impose any cost sharing for the services to be performed out-of-network.[9] It is difficult to see how any telemedicine arrangement can comply with this mandate on its own.

An employer whose group health plan fails to satisfy any of the ACA's market reforms is subject to excise taxes of $100 per day ''with respect to each individual to whom such failure relates.''[10] In other words, an unwitting plan sponsor could be exposed to excise taxes up to $36,500 per year for every single participant in the plan! That is enough to ruin not only Christmas, but every other holiday that falls on a day ending in the letter Y.

The market reform mandates apply to every group health plan that isn't a HIPAA-excepted benefit. A stand-alone telemedicine plan is no different.

The fact that the employer is offering to its employees some other fully compliant major medical plan doesn't, in and of itself, negate the telemedicine plan's obligation to meet all the ACA's market reform requirements. The market reform mandates apply to every group health plan that isn't a HIPAA-excepted benefit. A stand-alone telemedicine plan is no different.

The tax code does state that the excise tax doesn't apply where the employer's compliance failure wasn't discovered despite its exercise of reasonable diligence. Further, if the ''failure was due to reasonable cause and not to willful neglect,'' and the failure is promptly corrected, then the tax may be greatly reduced or even avoided altogether.[11] But it is a well settled legal doctrine that mere ignorance of the law is no excuse.[12]

Nor, technically, can an employer wait for the feds to come knocking before paying the excise tax. Indeed, the Internal Revenue Service treats the tax as a self-reporting obligation.[13] Employers are supposed to com-

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[2] ERISA Section 733(a)(1); PHSA Section 2791(a)(1).

[3] ERISA Section 3(1).

[4] ERISA Section 733(a)(2).

[5] I.R.C. Section 9832(a) (incorporating Section 5000(b)(1)); accord Treas. Reg. Section 54.9831-1(a)(1).

[6] Congress implemented the ACA's market reforms through a series of amendments to the PHSA. See PHSA Sections 2701-2728. Although the PHSA primarily applies only to non-federal governmental plans, see PHSA Section 2721, the ACA also added new provisions to ERISA and the tax code that incorporated the new PHSA mandates, thus making them applicable to a much broader swath of employer-sponsored group health plans. See ERISA Section 715(a)(1); I.R.C. Section 9815(a)(1). HIPAA-excepted benefits, however, aren't subject to the market reforms. See Preamble to Final Regulations on Market Reforms (issued jointly by the departments of Treasury, Labor, and Health and Human Services) (hereinafter, ''Final Market Reform Regulations''), 80 Fed. Reg. 72,192, 72,201 n. 45 (Nov. 18, 2015).

[7] Although the preventive services mandate doesn't apply to ''grandfathered'' plans, a plan is treated as grandfathered only if it was in existence on March 23, 2010. See Treas. Reg. Section 54.9815-1251(a). The universe of telemedicine arrangements with a rightful claim to such status is likely extremely small.

[8] See Treas. Reg. Section 54.9815-2713(a)(1).

[9] Id. Section 54.9815-2713(a)(3).

[10] I.R.C. Section 4980D(b)(1). The tax is imposed on the employer in the case of single-employer plans. Id. Section 4980D(e)(1). In the case of multi-employer plans, the tax is imposed on the plan. Id. Section 4980D(e)(2).

[11] Id. Section 4980D(c).

[12] See *United States v. Int'l Minerals & Chem. Corp.*, 402 U.S. 558, 563 (1971) (''The principle that ignorance of the law is no defense applies whether the law be a statute or a duly promulgated and published regulation.'').

[13] See Instructions for Form 8928, Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code, available at https://www.irs.gov/pub/irs-pdf/i8928.pdf.

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plete a Form 8928, Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code, by the due date for filing their personal tax returns. Penalties and interest await them if they don't.[14]

Even non-federal governmental employers can't bask in a penalty-free zone. While the tax code's excise tax provisions don't apply to such employers, the PHSA empowers the U.S. Department of Health and Human Services (HHS) to impose civil penalties of up to $100 per day ''with respect to each individual to whom such failure relates'' for a failure to comply with the ACA's market reforms.[15] The PHSA contains the same penalty limitations and relief as the code.

Non-federal governmental employers should tread even more lightly, though, because one would suspect that the HHS currently has more resources and agents to enforce this mandate than the IRS.

Is a Telemedicine Plan An Employee Assistance Program?

In an effort to avoid the market reform requirements, some telemedicine providers have sought to characterize their plans as an employee assistance program (EAP). An EAP is a HIPAA-excepted benefit and is thus exempt from the ACA's market reform mandates.[16]

But characterizing a telemedicine arrangement as an EAP is no slam dunk. The final regulations on excepted benefits issued by the departments of Treasury, Labor and HHS in October 2014 declared that, to be considered an EAP, the program must satisfy each of the following four requirements[17]:

- The EAP doesn't provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.
- The benefits under the EAP aren't coordinated with benefits under another group health plan—participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a gatekeeper) before an individual is eligible for benefits under the other group health plan, and participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan.
- No employee premiums or contributions are required as a condition of participation in the EAP.
- There is no cost sharing under the EAP.

As evidenced by the last two elements, if a telemedicine plan has any chance at being properly considered an EAP, it must be completely free to employees. No premium, deductible, copayment or any other form of cost sharing would be permitted.

The first element, though, is far more muddled. Federal regulators have offered little insight into what constitutes ''significant benefits in the nature of medical care.'' The preamble to the final excepted benefit regulations states that ''employers may use a reasonable good faith interpretation'' in defining this phrase.[18] In 2013 proposed regulations, federal agencies invited comments as to whether the following types of programs might constitute a valid EAP:

- a program providing no more than 10 outpatient visits for mental health or substance use disorder counseling;
- an annual wellness checkup; and
- immunizations and diabetes counseling with no inpatient benefits.[19]

Would a telemedicine arrangement in which employees can meet with a physician at any time (albeit over the Web or by phone) to discuss some physical malady they are experiencing and possibly even receive a prescription fall within this definition? We are skeptical, but without further guidance, it is impossible to say.

Assuming all of the other regulatory conditions are satisfied, it is perhaps possible that the telemedicine plan could be characterized as an employee assistance program.

Assuming all of the other regulatory conditions are satisfied, it is perhaps possible that the telemedicine plan could be characterized as an EAP. But employers opting to follow that path must understand that there is some risk to this decision if regulators end up adopting a more narrow interpretation.

Integration: The Path to Excise Tax Avoidance?

If the telemedicine plan can't be legitimately treated as an EAP, another possible fix to the market reform requirements would be to integrate the telemedicine arrangement with the employer's major medical plan. Because the major medical plan presumably satisfies all of the ACA's market reform mandates, the concern over excise taxes largely vanishes.

The problem we often see, though, is that the employer makes the telemedicine program available to employees who aren't participating in, or even eligible for, the medical plan. Some employers also give employees who are enrolled in the medical plan the opportunity to opt out of the telemedicine component (by, for example, not paying the extra premium associated with the telemedicine plan). This won't work.

If participants in the medical plan can decline coverage in the telemedicine plan, then the plans aren't integrated. Anything less than an ''all or nothing'' choice

[14] Id.
[15] PHSA Section 2723(b)(2).
[16] See I.R.C. Section 9831(c); ERISA Section 732(c); PHSA Section 2722(c); see also Preamble to Final Market Reform Regulations, 80 Fed. at 72,201 n. 45.
[17] Treas. Reg. Section 54.9831-1(c)(3)(vi); DOL Reg. Section 2590.732(c)(3)(vi); HHS Reg. Section 146.145(b)(3)(vi).
[18] Preamble to Final Regulations on Amendments to Excepted Benefits (issued jointly by the departments of Treasury, Labor, and Health and Human Services) (hereinafter, ''Final Excepted Benefit Regulations''), 79 Fed. Reg. 59,130, 59,133 (Oct. 1, 2014).
[19] Preamble to Proposed Regulations on Amendments to Excepted Benefits (issued jointly by the departments of Treasury, Labor, and Health and Human Services), 78 Fed. Reg. 77,632, 77,636 (Dec. 24, 2013).

Avoiding ACA Market Reform Rules

Options for avoiding application of Affordable Care Act market reform rules to telemedicine arrangements include:

■ qualification of the telemedicine plan as an employee assistance program;

■ integration of the telemedicine arrangement with the employer's major medical plan; or

■ under the so-called ERISA safe harbor, satisfaction of requirements to avoid employer plan sponsorship.

won't get the employer over the necessary threshold. It is the same basic reasoning that federal regulators use in treating a self-insured dental plan, which is offered in conjunction with a major medical plan, as ''not an integral part of the group health plan'' (and thus a HIPAA-excepted benefit) if participants can opt out of the coverage.[20]

If All Else Fails, Avoid Employer Plan Sponsorship

If an employer can't (or doesn't want to) integrate the telemedicine arrangement into its major medical plan, and the arrangement can't be accurately characterized as an EAP, it still may be possible for the employer to avoid the market reform mandates by adhering to the so-called ERISA safe harbor.[21]

In other words, the employer would simply not ''establish or maintain'' a telemedicine group health plan. The telemedicine plan would instead be treated as a voluntary plan.

To accomplish this objective, the employer would have to adhere strictly to each of the following requirements:

■ **No Employer Contributions.** All premiums must be paid entirely by the employee. The employer can't make any contribution toward the cost of the premium. This also means that employees would have to pay their premiums on an after-tax basis.

■ **Voluntary Participation.** Participation in the program must be completely voluntary for employees.

■ **No Employer Endorsement.** The employer can't endorse the program in any way. Its role is strictly limited to allowing the telemedicine provider to publicize the program to employees and remitting employees' after-tax premiums to the provider.

■ **No Employer Benefit.** The employer must not receive any cash or consideration from the telemedicine provider for allowing such provider to offer the program to the employer's employees.

If all of these conditions are satisfied, the telemedicine arrangement would be exempt from ERISA. The employer's total absence of any contribution to, or endorsement of, the plan also would mean that the employer didn't establish a group health plan for purposes of the tax code or the PHSA. That, in turn, would render the market reform requirements inapplicable.

Potential Impact Of Telemedicine Arrangement On Health Savings Account Contributions

Even if ACA excise taxes can be circumvented, there is another potential impediment to telemedicine arrangements: Depending on how they are structured, they may be incompatible with a health savings account (HSA).

As most readers know, in order to be eligible to contribute to an HSA during any particular month of the year, an individual must be covered under a high deductible health plan (HDHP) as of the first day of that month.[22] In addition, with only a handful of narrow exceptions, the individual can't have any coverage under a non-HDHP that provides benefits for medical care covered by the HDHP.[23]

The IRS has clarified this proscription to mean that any benefits under the non-HDHP coverage can't kick in until after the individual has met the HDHP's deductible.[24] Depending on the nature of the telemedicine plan, therefore, participants may be precluded from contributing to an HSA.

But this rule isn't absolute. Some non-HDHP coverage is disregarded. For example, the tax code recognizes certain ''permitted insurance''—defined as policies primarily relating to workers' compensation laws, tort liabilities, specified diseases or illnesses, fixed payments for periods of hospitalization, and liabilities relating to ownership or use of property.[25] The code also authorizes coverage for accidents, disability, dental care, vision care and long-term care.[26]

If the non-HDHP coverage can be legitimately characterized as an EAP, the IRS has said that such coverage would likewise be compatible with HSA contributions.[27] Further, the code carves out an exception for ''preventive'' services[28]; in other words, if the non-HDHP coverage is merely providing preventive care, then the HDHP participant can still contribute to an HSA notwithstanding the otherwise disqualifying coverage.

Is Integration a Solution to Compatibility?

Some employers have questioned whether integrating a telemedicine arrangement with their HDHP will make the joint plan compatible with HSA contributions. As noted earlier, this integration does allow the employer to avoid imposition of excise taxes for failure to

[20] See Treas. Reg. Section 54.9831-1(c)(3)(ii); see also Preamble to Final Excepted Benefit Regulations, 79 Fed. Reg. at 59,131-59,132.

[21] See DOL Reg. Section 2510.3-1(j).

[22] I.R.C. Section 223(c)(1)(A)(i).

[23] I.R.C. Section 223(c)(1)(A)(ii).

[24] See IRS Notice 2008-59, Q-A #7 (''[A]s long as the deductible of the other coverage equals or exceeds the statutory minimum HDHP deductible, the individual remains an eligible individual.'').

[25] I.R.C. Section 223(c)(1)(B)(i), (c)(3).

[26] I.R.C. Section 223(c)(1)(B)(ii).

[27] See IRS Notice 2004-50, Q-A #10.

[28] I.R.C. Section 223(c)(2)(C).

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adhere to all of the ACA market reforms. HSA compatibility, however, is a different story.

Unless the telemedicine plan can be characterized as an EAP or somehow limited to providing preventive services, it is hard to see how integrating the telemedicine plan with the HDHP negates the problem of disqualifying coverage. Absent such carve-outs, the telemedicine program would be providing non-preventive service medical care coverage before the participant's HDHP's deductible had been satisfied.

Endeavoring to get around this problem, some insurers that incorporate telemedicine arrangements into their HDHP policies require participants to pay for each virtual doctor's visit until the deductible has been satisfied. Whether these efforts are successful likely will depend on the exact details of the structure. Is a participant on the hook for the full cost of the visit, or is he or she responsible only for a copayment? If the latter, the HSA incompatibility issue may well still exist.

Particularly given the recognized utility of these programs, perhaps regulators will at some future date explicitly sanction this kind of dual coverage in tandem with HSA contributions. Until that day arrives, though, there is real risk that offering a telemedicine arrangement in conjunction with an HDHP will preclude participants from making (or receiving) contributions to their HSA.

Is Telemedicine 'Preventive' Care?

If the integration road is blocked, what about the "preventive" care path? It, too, looks less than promising. The big issue here is what exactly is meant by "preventive" care and does it capture the type of coverage provided by a telemedicine plan? The code's HSA rules look to the Social Security Act's definition of "preventive services."[29] The Social Security Act, which is as long as "War and Peace" and as penetrable as Kevlar, in turn defines preventive services to include all of the following:

- screening and preventive services;
- initial preventive physical examinations; and
- personalized prevention plan services.[30]

The "screening and preventive services" referenced in the Social Security Act all appear to encompass procedures that would have to be done in person at the doctor's office.[31] The same is likely true of "initial preventive physical examinations," which include height and weight measurements, blood tests, blood pressure exams and other physical screenings.[32]

To be sure, there are preventive services—especially the "personalized prevention plan services"—that clearly could be performed in a virtual setting.[33] But do physicians meeting with patients over the Internet as part of a telemedicine arrangement strictly confine themselves to the type of personalized prevention services set forth in the Social Security Act? It is doubtful.

This makes perfect sense. After all, one of the main benefits—if not the primary benefit—of telemedicine is to enable individuals to meet promptly with a doctor upon experiencing some sort of health concern. Sure, certain preventive care may be provided in the virtual visit, but those preventive services would represent only a small component of the overall arrangement.

Improper HSA Contributions Potentially Trigger Excise Taxes

This situation creates a serious dilemma for employers and employees alike. If the non-HDHP telemedicine coverage can't be properly characterized as an EAP or preventive care, then any individual covered under both the HDHP and the telemedicine plan will be unable to contribute (or have contributions made on his or her behalf) to an HSA.

Meanwhile, if improper contributions are made to the HSA, the HSA holder may be subject to an excise tax of 6 percent of the amount of the excess contribution.[34] This could be an even bigger punch to the gut because the excise tax is cumulative; that is, if the excess HSA contribution isn't distributed, a 6 percent tax will apply to the full amount of the excess contribution each and every year.[35] Although the responsibility for this excise tax technically rests with the employee, any employer who inadvertently subjects its employees to the tax will be about as popular as E. coli at the company barbecue.

Although health savings account contributions are non-forfeitable, the IRS has effectively carved out an exception in situations involving mistaken eligibility.

Fortunately, if the problem is caught early enough, the excise tax may be avoidable. If the employee's improper HSA contribution is discovered before the end of his or her tax filing deadline for that year (including extensions), then the employee can take a corrective distribution of the amount of the excess contribution (plus earnings).[36] The amount of the distribution will, of course, be taxable to the employee, but at least no excise tax will be owed.[37]

The corrective procedure is quite similar if the excess HSA contributions came from the employer. If the employee had never before been eligible to establish an HSA, but the employer mistakenly thought the employee was eligible and thus contributed funds to an

[29] Id.
[30] 42 U.S.C. Section 1395x(ddd)(3).
[31] See 42 U.S.C. Section 1395x(ww)(2) ("screening and other preventive services" include such things as vaccines, mammographies, Pap smears, prostate exams, colonoscopies, bone mass measurements, blood tests, glaucoma screenings, etc.).
[32] Id. Section 1395x(ww)(1).
[33] "Personalized prevention services" generally refers to individualized wellness plans. See id. Section 1395x(hhh).
[34] I.R.C. Section 4973(g).
[35] See H. Conf. Rept. No. 108-391, at 853 (2003).
[36] I.R.C. Section 223(f)(3); IRS Notice 2004-2, Q-A #22. This is true even if the individual timely filed a federal tax return without first withdrawing the excess contribution from the HSA. See Instructions to IRS Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts.
[37] I.R.C. Section 223(f)(3)(A).

HSA account on the employee's behalf, relief is available.

Although HSA contributions are non-forfeitable,[38] the IRS has effectively carved out an exception in situations involving mistaken eligibility. If the error is discovered before the end of the taxable year, the IRS allows the employer to recover the full amount of the contribution (plus earnings) from the HSA with no tax consequences to the employee.[39] If, on the other hand, the employer is unable to recoup the excess HSA contribution by the end of the taxable year, then the employer must prepare an amended Form W-2, Wage and Tax Statement, and the amount (plus earnings) must be included as gross income to the employee for the year in which the employer made the contribution.[40] The good news, though, is that no excise taxes would be owed.

The rules are murkier if the employee had previously been eligible to contribute to an HSA, and the employer subsequently makes improper contributions to the employee's account. The option for the employee to avoid excise taxes by taking a timely corrective distribution of all excess contributions during that year (plus earnings) would still apply. But it is unlikely that the employer could simply recoup its own improper contributions to the employee's HSA.

The reason why the IRS allows employers, under limited circumstances, to recover HSA contributions from the account of an employee who was never eligible to establish an HSA is because the IRS assumes that the HSA never technically existed in the first place.[41] (Sort of like my artistic talent. Or the Golden State Warriors' ability to deliver in the clutch. Sorry Golden State fans, still too soon?) Yet that legal fiction doesn't apply if the employee had previously set up an HSA. Indeed, the IRS has said that, if an employer contributes to the HSA of an employee who ceases to be eligible to make HSA contributions during the middle of the year, the employer is prohibited from seeking to recoup those erroneous contributions.[42]

Without further guidance, it is difficult to say what constraints the IRS might impose on employers trying to rescue their employees from this HSA thicket. The most prudent course of action, therefore, would seem to be to advise employees to take a corrective distribution from their HSA of any and all improper or excess HSA contributions, including those made by the employer on their behalf, prior to their tax filing deadline for that year (including extensions).

Conclusion

Clearly, fitting telemedicine plans into the complex regulatory environment governing employer-sponsored health care can be a tricky endeavor. These are uncharted waters, with potential dangers lurking behind every bend.

No doubt, employers will increasingly find themselves encountering similar challenges as the health care delivery system evolves and as they continue to seek novel approaches to control their escalating health care expenses. It is essential, therefore, that employers tread carefully to ensure that they don't unwittingly invite even greater costs by running afoul of obscure federal statutes and regulations.

Unlike, say, a Kardashian marriage, telemedicine may well be around for a long time. But taking refuge in a non-compliant arrangement could be a cure far worse than the disease.

[38] I.R.C. Section 223(d)(1)(E).
[39] IRS Notice 2008-59, Q-A #23.
[40] Id.
[41] Id.
[42] IRS Notice 2008-59, Q-A #25.

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