

**AMERICAN BAR ASSOCIATION  
SECTION OF TAXATION**

**EMPLOYEE BENEFITS COMMITTEE**

**2004 Fall CLE Meeting**

**Boston, Massachusetts  
September 30 to October 2, 2004**

**Mini-Program: HSAs and Health Plan Design**

*Medicare Reform, Health Savings Accounts and  
the Future of Consumer Directed Health Care*

Alden J. Bianchi, Esq.  
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.  
One Financial Center  
Boston, Massachusetts 02111  
[abianchi@mintz.com](mailto:abianchi@mintz.com)

# Medicare Reform, Health Savings Accounts and the Future of Consumer Directed Health Care

Alden J. Bianchi, Esq.\*

## I. Introduction

President Bush signed the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*<sup>1</sup> (the “Act”) on December 8, 2003. Among other things, the Act makes sweeping changes to the underlying structures of Medicare, adds a Medicare prescription drug benefit, and establishes a special subsidy to encourage employers to provide prescription drug coverage. But from the employer’s perspective, the Act’s most important feature is the introduction of a new type of account—the “Health Savings Account” or “HSA”<sup>2</sup>—the purpose of which is to provide individuals with a tax-advantaged, participant-owned vehicle that allows them to accumulate funds for health care and other purposes.

Congress established HSAs at least in part to facilitate “consumer driven health care” (or CDHC). CDHC arrangements seek to lower the cost of health care by involving individuals in their own health care and providing monetary incentives in the form of tax-advantaged savings. Sustained, double digit increases in employer-based health coverage have left employers desperate for ways to constrain runaway medical cost increases. CDHC—i.e., arrangements that encourage greater employee participation in health care purchasing decisions—is being touted as the mechanism that can collar spiraling health care costs by encouraging and empowering previously passive plan participants to choose health care wisely and in a manner that is cost efficient. The statutory and regulatory mechanisms that existed before the Act, however, such as medical flexible spending accounts and health reimbursement accounts, were not seen as conducive to the adoption and maintenance of CDHC arrangements. This is no longer the case because of the HSA provisions of the Act.

## II. CDHC Overview

CDHC plans begin with the premise that participants will make better and more informed health care purchasing decisions if they are involved in the process, are provided with the proper tools and support, and have a stake in the outcome. In a traditional insurance arrangement, either a loss occurs or it does not. This is referred to in insurance jargon as “pure risk,” which the CDHC approach rejects in favor of so-called “speculative risk.” In an arrangement based on speculative risk, there is a third possibility—a gain that inures to the participant. CDHC plans are designed to motivate participants to make prudent health care choices with the aid of decision support tools

---

\* Alden J. Bianchi is a member in the law firm of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., Boston, Massachusetts and group leader of the Firm’s Employee Benefits and Executive Compensation practice.

<sup>1</sup> Pub. L. No. 108-173, 117 Stat. 2066 (2003).

<sup>2</sup> See Act § 1201 (re-designating I.R.C. § 223 as § 224 and adding a new I.R.C. § 223 establishing HSAs).

(typically, internet-based) that make available provider cost and quality data and information concerning health care treatment options.

HSAs are well suited to CDHC since, unlike medical flexible spending accounts<sup>3</sup>, HSA account balances can be carried forward from year to year. Amounts that accumulate over time can be applied free of tax to pay for COBRA or retiree health coverage. It is this feature that allows participants to realize a “gain” by limiting his or her health care expenditures.

While recognizing that managed care has brought about many improvements, CDHC proponents are critical of managed care in at least one important respect. They claim that managed care removes the patient from the health care equation. The commonly advanced complaint is that individuals have no idea of what a visit to the doctor’s office costs. One commentator cites an example involving the drug Claritin that moved to over-the-counter status. Consumers that complained about the price of the over-the-counter version were unaware that that price had been cut over 200% when compared with the prescription price.<sup>4</sup> At least in theory, participants will choose their health care options with greater care if they are aware of the underlying costs of each option. Of course, it helps if HSA participants understand their options. It is for this reason that CDHC plans include decision-support tools.

CDHC plans have not yet been widely adopted, so there is insufficient data to know whether they will work as advertised. And even where they have been adopted, they tend to be an option that is offered alongside traditional managed care plans. Critics claim that these arrangements will do little to help chronically ill individuals or those with routinely high medical costs. They also point out that the decision-support tools will likely require an unreasonably high degree of technical competence and sophistication—purchasing health care is, after all, not like purchasing a car or a television. But despite CDHC’s shortcomings, real or perceived, other cost containment options are in short supply. For this reason alone, CDHC will get a hearing.

The HSA is an ideal CDHC-enabling mechanism. Account balances can be rolled forward; they can be funded with employer contributions, employee contributions or both; and funds that accumulate can ultimately be used for medical care (on a tax-favored basis) and for other, non-medical purposes (on an after-tax basis). The HSA, therefore, meets all of the CDHC criteria.

### **III. HSA Precursor—The Archer Medical Savings Account**

HSAs are modeled after Archer Medical Savings Accounts (“Archer MSAs”), which were established as a pilot program in the Health Insurance Portability and

---

<sup>3</sup> See Prop. Treas. Reg. § 1.125-2, 54 Fed. Reg. 9460 (March 7, 1989) at Q&A 7 (subjecting medical flexible spending accounts to a “use-it-or-lose-it” rule that prevents the carryover to future years of amounts that are not used for medical expenses by the end of the year).

<sup>4</sup> S. Halterman and Pete Mailet, *The Consumer-Driven Approach: What Works, What Doesn’t*, *Journal of Compensation and Benefits*, 7, 10 (November/December 2003).

Accountability Act of 1996.<sup>5</sup> Archer MSAs are tax-exempt trust or custodial accounts established exclusively for the benefit of an account holder for the purposes of paying for medical expenses. Archer MSAs must be maintained in conjunction with a qualified high deductible health plan. While Archer MSAs would (for the reasons described below) appear ideally suited to the CDHC environment, they are subject to a numerical limit (i.e., no more than 750,000 taxpayers) and a sunset provision (i.e., no new contributions can be made after 2003 other than to the accounts of taxpayers who either made Archer MSA contributions or had them made by an employer on their behalf before then.) Accordingly, Archer MSAs are of little use if the goal is widespread adoption of CDHC plans.

#### A. *Eligibility*

Participation in an Archer MSA is limited: only self-employed individuals (and their spouses) and employees and owners of “small employers” that maintain a qualified high deductible health plan are eligible.<sup>6</sup> For Archer MSA purposes, self-employed individuals include more than 2% shareholders of S Corporations who are treated as partners for fringe benefit purposes.<sup>7</sup> Additionally, an individual is not eligible for an Archer MSA if he or she is covered under any other health plan that is not a qualified high deductible health plan or if he or she is entitled to Medicare. A small employer is defined as an employer that employs, on average, no more than 50 employees during either the immediately preceding or the second preceding year.<sup>8</sup> There are special rules that apply where the employer was not in existence throughout the preceding year. If an employer that sponsors Archer MSAs for its employees ceases to be a small employer, then Archer MSA contributions can continue until the year after the first year in which the employer has more than 200 employees.<sup>9</sup>

#### B. *Contributions and Deductions*

Contributions to an Archer MSA are deductible in arriving at adjusted gross income when made by an eligible individual, and they are excluded from wages for employment tax purposes. Earnings on amounts contributed to Archer MSAs are not included in income in the year earned (i.e., the inside build-up is not taxable).<sup>10</sup> Nor are distributions made for the purpose of paying qualified medical expenses included in income in the year distributed.<sup>11</sup> The term “qualified medical expense” is defined with reference to I.R.C. 213(d) but does not include expenses for health insurance other than long-term care insurance, COBRA premiums, and premiums for health care coverage while an individual is receiving unemployment compensation. Employee contributions

---

<sup>5</sup> See, Pub. L. No. 104-191, 110 Stat. 1936 (1996), adding a revised § 220 and re-designating former § 220 as § 221 (establishing “Medical Savings Accounts” which were renamed “Archer Medical Savings Accounts” by the Community Renewal Tax Relief Act of 2000, Pub. L. No. 106-554 § 202, 114 Stat. 2763 (2000)).

<sup>6</sup> I.R.C. § 220(c)(4) (2004).

<sup>7</sup> *Id.* at § 1372.

<sup>8</sup> *Id.* at § 220(c)(4).

<sup>9</sup> *Id.* at § 220(c)(4)(C).

<sup>10</sup> *Id.* at § 220(e)(1).

<sup>11</sup> *Id.* at § 220(f)(1).

and those made by individuals are deductible in arriving at adjusted gross income (i.e., they are an above-the-line deduction).<sup>12</sup> Similarly, employer contributions are excluded from the employee's gross income.<sup>13</sup> Archer MSA contributions may not be made available as an option under a cafeteria plan.<sup>14</sup> Contributions must be made in cash.<sup>15</sup>

A qualified high deductible health plan, for Archer MSA purposes, is a health plan that has an annual deductible of \$1,700 to \$2,500 and maximum out-of-pocket expenses up to \$3,350 for individual coverage, and, for family coverage, an annual deductible of \$3,350 to \$5,050, with maximum out-of-pocket expenses up to \$6,150. Out-of-pocket expenses include deductibles, co-payments, and other amounts (other than premiums) that the individual must pay for benefits. For this purpose, first-dollar coverage for preventive coverage mandated by state law is allowed.

### C. *Sources of Contributions*

Archer MSA contributions may be made either by employees, on a tax-deductible basis for Federal income tax purposes (and for some state income tax purposes), or by employers—but not both.<sup>16</sup> Contributions and earnings may be withdrawn at any time tax free for qualified medical expenses, and at age 65, or upon disability, taxable withdrawals may be made for any reason without a penalty. MSA contributions may not exceed the lesser of 65% of the deductible limit under the qualified high deductible health plan (75% in the case of family coverage) or 100% of earned income.<sup>17</sup> Where contributions exceed the applicable limits, the Internal Revenue Code imposes a 6% excise tax on the account holder.<sup>18</sup> But if the excess contributions (together with income) are distributed to the account holder before the last day prescribed by law, including extensions, for filing the account holder's tax return for the tax year, then the excise tax does not apply.<sup>19</sup>

### D. *Death of the Account Holder*

Upon the death of an Archer MSA account holder, the remaining account balance is included in his or her gross estate unless the account holder's surviving spouse is the named beneficiary (in which case the account becomes the property of the surviving spouse and the value of the account qualifies for the marital deduction). Where the beneficiary is not the account holder's spouse, the account ceases to be an Archer MSA and the beneficiary must include the date-of-death balance in income currently. The amount includible in income, however, is reduced by any amounts that are expended from the Archer MSA within one year following the death of the decedent to pay qualified medical expenses of the decedent.

---

<sup>12</sup> *Id.* at § 62(a)(16).

<sup>13</sup> *Id.* at § 106(b)(1); I.R.S. Notice 96-53, 1996-2 C.B. 219.

<sup>14</sup> I.R.C. § 125(f).

<sup>15</sup> *Id.* at § 220(d)(1)(A)(i).

<sup>16</sup> *Id.* at § 220(b)(5).

<sup>17</sup> *Id.* at § 220(b)(1)-(2).

<sup>18</sup> *Id.* at § 4973.

<sup>19</sup> *Id.* at §§ 220(f)(3), 4973(d).

### *E. Comparability Requirement*

Employers that sponsor an Archer MSA arrangement are subject to a “comparability” requirement. If an employer—determined on a controlled group basis—contributes to an Archer MSA for employees, the employer must make available a comparable contribution on behalf of all employees with comparable coverage during the same period.<sup>20</sup> Contributions are considered “comparable” if they are either (i) the same amount or (ii) the same percentage of the deductible under the high deductible plan.<sup>21</sup> This rule is applied separately to part-time employees. An employer that violates this comparability requirement is subject to a penalty equal to 35% of the employer’s aggregate Archer MSA contributions for the year.<sup>22</sup> But this penalty can be waived upon a showing of reasonable cause.<sup>23</sup>

### *F. Health Care Continuation Rights*

I.R.C. 106(b)(5) provides that amounts contributed by an employer to an Archer MSA are not considered part of a group health plan subject to I.R.C. 4980B. And Treas. Reg. Section 54.4980B-2, Q & A-1(f) clarifies that a plan is not required to make COBRA continuation coverage available with respect to Archer MSAs.

## **IV. Health Savings Accounts**

A Health Savings Account or “HSA” is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who is covered under a high-deductible health plan.<sup>24</sup> Earnings on HSA deposits accrue from year-to-year on a tax-deferred basis until distributed.<sup>25</sup> They are similar in this regard to Individual Retirement Plans or “IRAs.” Like IRAs, HSAs may be rolled over.

### *A. Eligibility and Eligible Individuals*

Beginning January 1, 2004, eligible individuals can contribute to an HSA. An “eligible individual”<sup>26</sup> is an individual who meets the following criteria:

1. He or she is covered under a “high-deductible health plan”<sup>27</sup> (HDHP) on the first day of a month,
2. He or she is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing certain limited types of coverage),

---

<sup>20</sup> *Id.* at § 4980E(a), (d).

<sup>21</sup> *Id.* at § 4980E(d)(2)(A).

<sup>22</sup> *Id.* at § 4980E(b).

<sup>23</sup> *Id.* at § 4980E(c).

<sup>24</sup> *Id.* at § 223(d)(1).

<sup>25</sup> *Id.* at § 223(d)(1)(E).

<sup>26</sup> I.R.C. § 223(c)(1); I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A2.

<sup>27</sup> I.R.C. § 223(c)(2).

3. He or she is not entitled to benefits under Medicare (generally, has not yet reached age 65), and

4. He or she may not be claimed as a dependent on another person's tax return.

IRS Notice 2004-50<sup>28</sup> provides further clarification on who is an eligible individual and under what circumstances. For example, an employee who has a choice between a non-HDHP and an HDHP is still an eligible individual if he or she elects coverage under the HDHP and forgoes coverage under the non-HDHP.<sup>29</sup> It is the actual coverage that controls, not the menu of available options. For purposes of item (3) (relating to Medicare), an individual is entitled to Medicare when he or she actually enrolls in Medicare Part A or Part B.<sup>30</sup> This means that an individual who works past age 65 and defers his or her Medicare enrollment can continue to fund an HSA.

State high-risk pools may also be HDHPs so long as they do not pay benefits below the HDHP thresholds,<sup>31</sup> and an individual who is eligible for medical benefits through the Department of Veterans Affairs is still an eligible individual so long as he or she is not actually receiving VA benefits.<sup>32</sup> Individuals covered by TRICARE (the health program for active duty and retired members of the uniformed services), on the other hand, are not eligible individuals for HSA purposes because TRICARE is not an HDHP.<sup>33</sup>

Notice 2004-50 makes clear that individuals who obtain discount cards that provide access to discounts for health care services and products are eligible individuals for HSA purposes.<sup>34</sup> The notice also advises that employers are responsible only for determining (i) whether an employee is covered under its employer-sponsored HDHP, and (ii) the employee's age (for purposes of catch-up contributions), with respect to which the employer may rely on the employee's representation as to his or her date of birth.<sup>35</sup>

#### *B. The High Deductible Health Plan*

An HDHP is a health plan that, for self-only coverage has an annual deductible of at least \$1,000 and annual out-of-pocket expenses (deductibles, co-payments and other amounts, but not premiums) not exceeding \$5,000. For family coverage, an HDHP must have annual deductible of at least \$2,000 and annual out-of-pocket expenses cannot not exceed \$10,000.<sup>36</sup> In the case of network plans, these limits are applied using the "in-

---

<sup>28</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1.

<sup>29</sup> *Id.* at Q&A 1.

<sup>30</sup> *Id.* at Q&A 2. (See also Q&A 3 relating to government retirees who enroll in Medicare Part B and who are not eligible individuals as a result).

<sup>31</sup> *Id.* at Q&A 13.

<sup>32</sup> *Id.* at Q&A 4.

<sup>33</sup> *Id.* at Q&A 5.

<sup>34</sup> *Id.* at Q&A 9.

<sup>35</sup> *Id.* at Q&A 81.

<sup>36</sup> I.R.C. § 223(c)(2)(A).

network” deductibles and co-payments.<sup>37</sup> There is an important exception under which a plan will not fail to be an HDHP merely because it does not have a deductible (or has a small deductible) for preventive care (e.g., first dollar coverage for preventive care).<sup>38</sup> An HSA may be either an insured or self-funded plan.<sup>39</sup> Self-funded HSAs are not subject to the non-discrimination requirement of I.R.C. 105(h).<sup>40</sup>

For purposes of determining whether the deductible has been satisfied in any year, credit can be provided under an HDHP for coverage under a non-HDHP where an employer changes plans mid-year.<sup>41</sup> Similarly, where an individual with self-only coverage changes to family coverage mid-year, the family coverage can take into account expenses incurred while the individual had self-only coverage.<sup>42</sup> Some plans base their deductible limits on a period that exceeds 12 months. While this is permissible for an HDHP, the HDHP deductibles must be adjusted based on a formula that spreads the statutory limit over the longer period of time.<sup>43</sup>

In the case of family coverage, a plan is an HDHP only if, under the terms of the plan, no amounts are payable from the HDHP until the family has incurred annual covered medical expenses in excess of the minimum annual deductible. Some plan designs involving family coverage have so-called “embedded deductibles.” An embedded deductible is a per-family member deductible, above which a plan will pay a benefit even before the plan’s overall deductible is reached. For a plan to be an HDHP, however, the embedded deductible may not be less than the threshold HDHP deductible. IRS Notice 2004-2,<sup>44</sup> Q&A 3, provides the following examples that illustrate how embedded deductibles can work in the HDHP environment:

Example (1): A Plan provides coverage for A and his family. The Plan provides for the payment of covered medical expenses of any member of A’s family if the member has incurred covered medical expenses during the year in excess of \$1,000 even if the family has not incurred covered medical expenses in excess of \$2,000. If A incurred covered expenses of \$1,500 in a year, the Plan would pay \$500. Thus, benefits are potentially available under the Plan even if the family’s covered medical expenses do not exceed \$2,000. Because the Plan provides family coverage with an annual deductible of less than \$2,000, the Plan is not an HDHP.

Example (2): Same facts as in example (1), except that the Plan has a \$5,000 family deductible and provides payment for covered

---

<sup>37</sup> *Id.* at § 223(c)(2)(D).

<sup>38</sup> *Id.* at § 223(c)(2)(D).

<sup>39</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 7.

<sup>40</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 83.

<sup>41</sup> *Id.* at Q&A 22.

<sup>42</sup> *Id.* at Q&A 23.

<sup>43</sup> *Id.* at Q&A 24; *See also id.* at Transition Relief (allowing plans with deductible periods of more than 12 months until January 1, 2006 to conform with the requirements of the notice).

<sup>44</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269.

medical expenses if any member of A's family has incurred covered medical expenses during the year in excess of \$2,000. The Plan satisfies the requirements for an HDHP with respect to the deductibles.

For HDHP purposes, embedded deductibles must not exceed the HDHP's out of pocket limits. By way of example, if an HDHP has a \$2,000 deductible for each family member, the plan will satisfy the \$10,000 out of pocket maximum if there are five or fewer family members covered under the plan. But if there are 6 or more covered family members, the annual out-of-pocket costs can exceed \$10,000, and the plan is not an HDHP as a result.<sup>45</sup>

There is a corresponding special rule that governs HSA contribution limits involving embedded deductibles. Under the special rule, contributions cannot exceed the least of (i) the maximum statutory contribution amount (\$5,150 for calendar year 2004), (ii) the umbrella deductible, or (iii) the embedded individual deductible multiplied by the number of family members. So, for example, if a married couple has family coverage under an HDHP that has an embedded deductible of \$2,000 per member, the maximum contribution for a family of 4 is \$8,000 unless the umbrella deductible is less.<sup>46</sup>

An HDHP's out-of-pocket limits include deductibles and co-payments but not premiums. Amounts incurred for non-covered benefits (including amounts in excess of usual-and-customary rates) and financial penalties are also not counted toward the deductible or out-of-pocket limit.<sup>47</sup> Similarly, discounts negotiated by the HDHP may be passed through to participants regardless of whether they have satisfied the deductible.<sup>48</sup>

A plan with no express limits on out-of-pocket expenses can qualify as an HDHP, but only if the plan by design cannot exceed the HDHP out-of-pocket maximums.<sup>49</sup> A plan that pays 100% of all charges in excess of HDHP deductible, for example, would qualify as an HDHP by design. But a plan that (i) provides self-only coverage with a \$2,000 deductible, (ii) imposes a lifetime limit on reimbursements for covered benefits of \$1 million, and (iii) reimburses 80 percent of the usual-and-customary costs, does not qualify as an HDHP. This is so because the out-of-pocket expenses are limited only by the cap and not by any express limit. Therefore, annual out-of-pocket expenses might exceed the \$5,000 annual limit for self-only coverage and the \$10,000 annual limit for family coverage, which are baseline HDHP requirements.

---

<sup>45</sup> *Id.* at Q&A 20.

<sup>46</sup> *Id.* at Q&A 30.

<sup>47</sup> *Id.* at Q&A 21.

<sup>48</sup> *Id.* at Q&A 25.

<sup>49</sup> *Id.* at Q&A 17; *See also id.* at Transition Relief (which provides transition relief under which plans (i) without express limits on out-of-pocket expenses, and (ii) with cumulative embedded deductibles have until January 1, 2005 to comply with the requirements of the notice.)

Flat dollar and other penalties imposed on participants who fail to obtain pre-certification for a specific provider or for certain medical procedures are generally allowed.<sup>50</sup>

## 1. The “No Other Coverage” Requirement

Under I.R.C. 223(c)(1)(A), an “eligible individual” for HSA purposes means an individual who is covered under an HDHP and is not, while covered under an HDHP, covered under any health plan (whether as an individual, spouse, or dependent) that is not a high deductible health plan, and which provides coverage for any benefit which is covered under the high deductible health plan.<sup>51</sup> In making this determination, “permitted insurance” and “permitted coverages” are not taken into account. Preventative care is also excluded for this purpose.

- “Permitted insurance” is coverage under which substantially all of the coverage provided relates to liabilities incurred under workers’ compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization.<sup>52</sup>
- “Permitted coverage” (whether through insurance or otherwise) is coverage for accidents, disability, dental care, vision care or long-term care.<sup>53</sup>
- Preventative care is defined in Notice 2004-23<sup>54</sup> to include (i) periodic health evaluations (such as annual physicals), including related tests and diagnostic procedures, (ii) routine prenatal and well-child care, (iii) child and adult immunizations, (iv) tobacco cessation and weight loss programs, and (v) screening services (which are described at length in an appendix). Preventive care also includes a service or screening for the treatment of a related condition, but it does not include any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications used to treat an existing illness, injury or condition. Treatment that is incidental or ancillary to a preventive care service or screening (e.g., the removal of polyps during a diagnostic colonoscopy) is also deemed to fall within the safe-harbor for preventive care. Preventative care also includes drugs or medications (i) taken by a person who has developed risk factors for a disease that has not yet manifested itself or has not yet become clinically apparent (i.e.,

---

<sup>50</sup> *Id.* at Q&As 18, 19.

<sup>51</sup> I.R.C. § 223(c)(1)(A).

<sup>52</sup> *Id.* at 223(c)(3). *See also* I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 8 (permitted insurance must generally be provided under a contract of insurance, except for self-funded workers’ compensation coverage furnished in satisfaction of a statutory requirement).

<sup>53</sup> I.R.C. § 223(c)(1)(B).

<sup>54</sup> I.R.S. Notice 2004-23, 2004-15 I.R.B. 725.

asymptomatic), (ii) to prevent the reoccurrence of a disease from which a person has recovered (e.g., the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease), and (iii) used as part of procedures providing preventive care services such as obesity weight-loss and tobacco cessation programs.<sup>55</sup>

## 2. Prescription Drug and Other Carve-Outs

There was some initial confusion over the extent to which an HDHP might co-exist with other coverage options or plans. The most common example is prescription drug coverage, but coverage for a broad range of medical conditions under a health FSA or an HRA is also affected. At issue is the language of I.R.C. 223(c)(1)(A), under which an “eligible individual” is limited to an individual who is covered under an HDHP and is not, while covered under an HDHP, “covered under any health plan *which is not a high deductible health plan, and which provides coverage for any benefit which is covered under the high deductible health plan.*” (Emphasis added.) Does this mean that one could design an HDHP with no prescription drug coverage, and then offer, say, first dollar prescription drug coverage under a rider or another plan? The IRS said “no” in Rev. Rul. 2004-38.<sup>56</sup> According to the Service, I.R.C. 223(c)(1)(B), which provides exceptions for permitted insurance and permitted coverage, sets out the only permitted exceptions. The Service cited the Act’s legislative history in support of its position:

“[a]n individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage.”<sup>57</sup>

The IRS recognized that its position concerning prescription drug carve-outs in Notice 2004-38 might cause problems in the short run for some plan sponsors. So it adopted a transitional rule in Rev. Proc. 2004-22<sup>58</sup> under which prescription drug coverage can be provided “under a separate health plan or rider” for 2004 and 2005 without sacrificing HDHP status for its health plan. This relief covers only prescription drugs and only if offered separately. So, for example, a self-funded HDHP with an integrated, low-dollar prescription drug deductible presumably does not qualify. But the relief is not limited to plans with existing prescription drug riders. It also applies to plans established after the rule was announced. Therefore, it might be possible to restructure existing arrangements to take advantage of this relief.

## 3. Annual and Lifetime Limits

---

<sup>55</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&As 26, 27. *See also* I.R.S. Notice 2004-43, 2004-27 I.R.B. 10 (establishing a transitional rule under which a group health plan that complies with state law coverage mandates will be deemed to be an HDHP until December 31, 2005 where the state mandates require coverage that does not qualify as preventative care within the meaning of I.R.C. § 223(c)(2)).

<sup>56</sup> 2004-15 I.R.B. 717.

<sup>57</sup> H.R. Conf. Rep. No. 108-391 (2003).

<sup>58</sup> 2004-15 I.R.B. 727.

One of the initial questions concerning HDHPs was whether lifetime or annual limits would be treated as out-of-pocket expenses. If so, the HDHP limits on out-of-pocket expenses might be easily exceeded, and the plan would no longer qualify as an HDHP. In Notice 2004-50, the IRS said that an HDHP may impose *reasonable* lifetime or annual limits on benefits provided under the plan.<sup>59</sup> Amounts paid by a covered individual above the limit will not be treated as out-of-pocket expenses in determining the annual out-of-pocket maximum. But limits designed to circumvent the maximum annual out-of-pocket limits would not pass muster. The IRS reaches a similar conclusion with respect to annual or lifetime limits on specific benefits.<sup>60</sup>

#### 4. Usual and Customary Charges

A related issue concerns amounts paid by individuals in excess of usual-and-customary (UCR) charges and whether they are included in determining the maximum out-of-pocket expenses paid. Here, again, the IRS said no. According to the Notice, “amounts paid by covered individuals in excess of UCR that are not paid by an HDHP are not included in determining maximum out-of-pocket expenses.”<sup>61</sup>

#### C. *Employee Assistance Plans, Disease Management Programs and Wellness Programs*

Notice 2004-50 clarified the interaction between HSAs and Employee Assistance Plans (or EAPs), disease management programs, and wellness programs. Prior to the issuance of the notice, there was concern that these arrangements would constitute “other coverage” for HDHP purposes. An individual covered under an EAP, disease management program or wellness program will still be an eligible individual for HSA purposes so long as these programs do not provide “significant benefits in the nature of medical care or treatment.” While the term “significant benefits” is not further defined, the Notice provides the following, useful example:<sup>62</sup>

An employer offers a program that provides employees with benefits under an EAP, regardless of enrollment in a health plan. The EAP is specifically designed to assist the employer in improving productivity by helping employees identify and resolve personal and work concerns that affect job performance and the work environment. The benefits consist primarily of free or low-cost confidential short-term counseling to identify an employee’s problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem. The issues addressed during the short-term counseling include, but are not limited to, substance abuse, alcoholism, mental health or emotional disorders, financial or legal

---

<sup>59</sup> See I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 15, examples 1 and 2 (a \$1,000,000 lifetime limit is reasonable but a \$10,000 annual limit is not).

<sup>60</sup> *Id.*

<sup>61</sup> *Id.* at Q&A 16.

<sup>62</sup> *Id.* at Q&A 10, example 1. See also, examples 2 and 3 (providing similar illustrations relating to disease management and wellness programs, respectively).

difficulties, and dependent care needs. This EAP is not a “health plan” under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

*D. Interaction with Health FSAs and HRAs—IRS Notice 2004-45*

In Rev. Rul. 2004-45, the IRS describes the coordination of HSAs with health FSAs or HRAs using 5 factual examples or situations. Situation 1 involves an individual covered by an HSA, and also covered under a health FSA and an HRA, each of which reimburse “all section 213(d) medical expenses that are not covered by the HDHP.”<sup>63</sup> This situation is intended to show what does *not* work. Individuals who participate in a general purpose HRA or health FSA are not “eligible individuals” for HSA purposes—i.e., they are not permitted to make tax deductible HSA contributions or to have contributions made on their behalf. This is so because these individuals are at the same time covered under an HDHP and another health plan (i.e., the HRA and/or health FSA), which is not a high deductible health plan and which provides coverage for benefits that are also covered under the HDHP (other than permitted insurance, permitted coverage or preventative care).

The remaining situations set out in Rev. Proc. 2004-45 illustrate four, IRS-approved design options under which an HRA or health FSA can coordinate with an HSA/HDHP such that affected individuals will continue to be “eligible individuals” for HSA purposes. These design options are:

1. Limited-Purpose Health FSA or HRA.

A “limited-purpose health FSA or HRA” is (i) an FSA that pays or reimburses benefits for permitted coverage (other than through insurance or long-term care services), (ii) an HRA that pays or reimburses benefits for permitted insurance or permitted coverage, or (iii) an FSA or HRA that pays or reimburses preventative care benefits. Situation 2 illustrates the features of this plan design. The facts are the same as in Situation 1 (i.e., coverage under an HSA, health FSA and HRA) except that the health FSA and HRA are limited-purpose arrangements that pay or reimburse only vision and dental expenses and preventative care (whether or not the minimum annual deductible of the HDHP has been satisfied).

2. Suspended HRA.

A “suspended HRA” is an HRA with respect to which an individual has elected, before the commencement of the coverage period, to forgo benefits other than permitted insurance, permitted coverage, or preventative care. Situation 3 illustrates how a suspended HRA works. The facts are again the same as Situation 1 except that the individual is not

---

<sup>63</sup> See I.R.S. Notice 2002-45, 2002-2 C.B. 93 (describing the requirements of a valid HRA and establishing ordering and other rules that apply when a health FSA and an HRA cover the same expenses). The arrangements described in Rev. Rul. 2002-45, 2004-22 I.R.B. 971 satisfy these rules.

covered by a health FSA. Under the employer's HRA, the individual elects, before the beginning of the HRA coverage period, to forgo the payment or reimbursement of medical expenses incurred during that coverage period. The decision to forgo the payment or reimbursement of medical expenses does not apply to permitted insurance, permitted coverage or preventive care.

### 3. Post-Deductible Health FSA or HRA.

A post-deductible health FSA or HRA is a health FSA or HRA that does not pay or reimburse any medical expenses incurred before the minimum annual HDHP deductible. In Situation 4, the health FSA and HRA pay or reimburse medical expenses (including the individual's coinsurance above the deductible) only after the minimum annual HDHP deductible has been satisfied. There is no requirement that the deductible under the HRA be the same as that under the HDHP. But where this is the case, the individual's HSA contribution limit is the lesser of the two.<sup>64</sup>

### 4. Retirement HRA.

A retirement HRA is an HRA that pays or reimburses only those medical expenses incurred after retirement. This approach is described in Situation 5 in which the individual is not covered by a health FSA, and the employer's HRA only reimburses those medical expenses incurred after the individual retires.

#### *E. Establishing the HSA*

Any eligible individual can establish an HSA with a qualified HSA trustee or custodian with or without involvement of the employer. No permission or authorization from the IRS is necessary, and individuals may have more than one HSA so long as the contributions in the aggregate do not exceed the amounts permitted by law.<sup>65</sup> Joint accounts are not permitted.<sup>66</sup> The IRS has adopted model HSA forms.<sup>67</sup> There is no requirement that the HSA custodian or trustee be the same as the HDHP vendor.<sup>68</sup>

Both employers and individuals can establish HSAs.<sup>69</sup> An employer, an employee (on an after tax basis or under a cafeteria plan), an individual, or even a state government<sup>70</sup> can make HSA contributions. Employer contributions to an HSA on an

---

<sup>64</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 33.

<sup>65</sup> *Id.* at Q&A 64.

<sup>66</sup> *Id.* at Q&A 63.

<sup>67</sup> *Id.* at Q&A 62 (Form 5305-B "Health Savings Trust Account" and Form 5305-C "Health Savings Custodial Account"). The model forms can be found at <<http://www.irs.gov/pub/irs-dft/d5305c.pdf>> and <<http://www.irs.gov/pub/irs-dft/d5305b.pdf>>.

<sup>68</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 10.

<sup>69</sup> I.R.C. § 223(a).

<sup>70</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&As 28, 29.

employee's behalf are treated as employer-provided coverage for medical expenses under an accident or health plan and are excludable from the employee's gross income.<sup>71</sup> The employer contributions are not subject to withholding from wages for income tax or subject to employment taxes.<sup>72</sup> Contributions to an employee's HSA through a cafeteria plan are treated as employer contributions.

Administration and account maintenance fees are not treated as taxable distributions, and they are not included in the account beneficiary's gross income. If administration and account maintenance fees are withdrawn from the HSA, the withdrawn amount does not increase the maximum annual HSA contribution limit. For example, if the maximum annual contribution limit is \$2,000, and a \$25 administration fee is withdrawn from the HSA, the annual contribution limit is still \$2,000, not \$2,025.<sup>73</sup>

#### *F. Trustees and Custodians*

Any insurance company or any bank (including a similar financial institution as defined in section 408(n)) can be an HSA trustee or custodian.<sup>74</sup> Other individuals or entities may request approval to be a trustee or custodian in accordance with existing procedures relating to IRA non-bank trustees.<sup>75</sup> Trustees and custodians of HSA funds are subject to annual contribution limits on amount that they can accept.<sup>76</sup> These limits are tied to the limits that apply generally to HSAs, but they do not apply to rollovers and transfers.

HSA trustees and custodians are not responsible for determining whether contributions to an HSA exceed the maximum annual contribution for a particular account beneficiary.<sup>77</sup> Rather, the account beneficiary is also responsible for notifying the trustee or custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution. And while the trustee or custodian is responsible for tracking the account beneficiary's age, it may rely on the account beneficiary's representation as to his or her date of birth.<sup>78</sup>

An HSA trust or custodial agreement cannot restrict HSA distributions to pay or reimburse only the account beneficiary's qualified medical expenses.<sup>79</sup> But trustees or custodians may place reasonable restrictions on both the frequency and the minimum amount of distributions from an HSA. For example, the trustee may prohibit

---

<sup>71</sup> I.R.C. § 106(d); Treas. Reg. § 1.125-1 at Q&A 7.

<sup>72</sup> I.R.C. § 3401(a)(22); I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 19.

<sup>73</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 70.

<sup>74</sup> *Id.* at Q&A 72.

<sup>75</sup> *See* Treas. Reg. § 1.408-2(e) (relating to IRA non-bank trustees).

<sup>76</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 73.

<sup>77</sup> *Id.* at Q&A 74.

<sup>78</sup> *Id.* at Q&A 75.

<sup>79</sup> *Id.* at Q&A 77.

distributions for amounts less than \$50 or only allow a certain number of distributions per month.<sup>80</sup>

### *G. Distributions for Qualifying Medical Expenses*

An individual can receive distributions from an HSA at any time. Distributions used exclusively to pay for qualified medical expenses of the individual, his or her spouse, or dependents, are excluded from gross income.<sup>81</sup> This is so even where a spouse or dependent is separately covered under a non-HDHP.<sup>82</sup> Where spouses each have separate HSAs, one spouse may apply distributions from his or her HSA to pay for medical expenses of the other spouse, although both HSAs may not reimburse the same expense.<sup>83</sup> There is no time limit on HSA distributions. An HSA account holder can defer distributions to later taxable years, but to do so he or she must keep sufficient records.<sup>84</sup>

Distributions that are not used exclusively to pay for qualified medical expenses of the individual, his or her spouse or dependents, are includable in the individual's gross income and subject to an additional 10% tax, except in the case of distributions made after the individual dies, becomes disabled or attains age 65.<sup>85</sup> For this purpose, "qualified medical expenses"<sup>86</sup> are medical care expenses as defined in I.R.C. 213(d). This includes certain expenditures for nonprescription drugs but only to the extent that the expenses are not covered by insurance or otherwise.<sup>87</sup> Amounts that would otherwise be treated as distributions are not taxed if they are rolled over into another HSA within 60 days.<sup>88</sup> Special rules apply where a distribution is made because of a mistake of fact. To qualify for this special rule, there must be clear and convincing evidence that the mistake resulted from reasonable cause and the mistakenly distributed amounts must be returned to the HSA. HSA trustees and custodians, however, are not required to accept the return of a mistaken expense.<sup>89</sup>

Qualified medical expenses must generally be incurred after the HSA has been established.<sup>90</sup> But out of concern that individuals would find it difficult to locate HSA trustees or custodians the IRS issued Notice 2004-25,<sup>91</sup> which provides a generous transitional rule. Under the transitional rule, for calendar year 2004 only, an HSA that is established on or before April 15, 2005 may pay or reimburse on a tax-free basis

---

<sup>80</sup> *Id.* at Q&A 80 ("[g]enerally, the terms regarding the frequency or minimum amount of distributions from an HSA are matters of contract between the trustee and the account beneficiary").

<sup>81</sup> I.R.C. § 223(f)(1).

<sup>82</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 36.

<sup>83</sup> *Id.* at Q&A 38.

<sup>84</sup> *Id.* at Q&A 39.

<sup>85</sup> I.R.C. § 223(f)(4).

<sup>86</sup> *Id.* at § 223(d)(2).

<sup>87</sup> Rev. Rul. 2003-102, 2003-38 I.R.B. 559.

<sup>88</sup> I.R.C. § 223(f)(5).

<sup>89</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 76.

<sup>90</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 26.

<sup>91</sup> I.R.S. Notice 2004-25, 2004-15 I.R.B. 727.

qualifying medical expenses that are incurred on or after the first day of the month on which an individual first becomes an eligible individual.

Health insurance premiums are not generally qualified medical expenses, except in the case of qualified long-term care insurance, COBRA health care continuation coverage, and health care coverage while an individual is receiving unemployment compensation.<sup>92</sup> Although I.R.C. 125(f) excludes long-term care coverage from coverage under a cafeteria plan, an HSA account-holder may pay long-term care premiums with HSA distributions even where the HSA is funded through a cafeteria plan. This is permitted since it is the HSA and not the cafeteria plan that is paying the premiums.<sup>93</sup> But there is an important restriction. I.R.C. 213(d)(10) limits the amount of the deduction for long-term care premiums to annually adjusted amounts based on age.<sup>94</sup> Excess amounts are included in income and may be subject to the 10% penalty under I.R.C. 223(f)(4).

I.R.C. 106(c) provides that employer-provided coverage for long-term care services under a flexible spending or similar arrangement is included in an employee's gross income. This rule does not apply, however, to distributions from an HSA that is funded by a health flexible spending account. This is so because the long-term care services in this instance are treated as being provided under the HSA and not under the medical flexible spending account.<sup>95</sup>

For individuals over age 65, premiums for Medicare Part A or B, Medicare HMOs, and the employee share of premiums for employer-sponsored health insurance, including premiums for employer-sponsored retiree health insurance, can be paid from an HSA.<sup>96</sup> Although the purchase of health insurance is not generally treated as a qualified medical expense,<sup>97</sup> there is an exception in this instance. This exception does not extend, however, to disabled individuals or individuals with end-stage renal disease.<sup>98</sup> Premiums for Medigap policies are not qualified medical expenses.<sup>99</sup>

#### *H. HSA Contributions and Deductions*

The Internal Revenue Code and applicable guidance describe who can make HSA contributions, when, in what amounts, and under what circumstances. Where spouses are covered under separate group health plans, special rules coordinate access to HSAs and the apportionment of deductions.

##### 1. Contribution and Deduction Limits

---

<sup>92</sup> I.R.C. § 223(d)(2)(A).

<sup>93</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 40.

<sup>94</sup> *Id.* at Q&A 41; *See* Rev. Proc 2003-85, 2003-49 I.R.B. 1184 at § 3.18 (describing the 2004 limits).

<sup>95</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 42.

<sup>96</sup> *Id.* at Q&A 43.

<sup>97</sup> I.R.C. § 223(d)(2)(B).

<sup>98</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 44.

<sup>99</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 27.

HSA contributions must be made in cash, and they may not exceed the lesser of (i) 100% of the annual deductible under the HDHP, or (ii) the maximum annual deductible permitted under an Archer MSA high deductible health plan as adjusted for inflation.<sup>100</sup> The maximum annual deductibles and out-of-pocket expenses are indexed for inflation using annual cost-of-living adjustments. Fiscal year plans have the option of applying any mid-year increases as of the renewal date next following the effective date of the increase (i.e., January).<sup>101</sup>

While these limits are expressed as annual limits, they are calculated on a monthly basis.<sup>102</sup> This treatment recognizes that individuals may not be “eligible individuals” throughout the year. For example, an individual may lose coverage under an HDHP midway through the year. For individuals under age 55, the maximum annual contribution to an HSA is the sum of the limits determined separately for each month based on status, eligibility, and health plan coverage as of the first day of the month. For calendar year 2004—

(a) The maximum monthly contribution for eligible individuals with self-only coverage under an HDHP is 1/12 of the lesser of 100% of the annual deductible under the HDHP (\$1,000 minimum) or \$2,600 (which is the \$2,250 Archer MSA limit adjusted for inflation since 1997).<sup>103</sup>

(b) The maximum monthly contribution for eligible individuals with family coverage under an HDHP is 1/12 of the lesser of 100% of the annual deductible under the HDHP (\$2,000 minimum) or \$5,150 (which is the \$4,500 Archer MSA limit adjusted for inflation since 1997).<sup>104</sup>

**Example:** X begins self-only coverage under an HDHP with a \$5,000 annual deductible on June 1, 2004 and continues to be covered under the HDHP for the rest of the year. X’s HSA 2004 contribution limit is the lesser of (i) \$5,000 (the annual deductible under the HDHP for the year) or (ii) \$2,600, which is \$216.67 per month times 7 months, or \$1,516.69 (i.e., 7 x \$216.67).<sup>105</sup>

The maximum annual HSA contribution is reduced dollar-for-dollar by amounts contributed to an Archer MSA in the same year.<sup>106</sup> Additional HSA catch-up contributions are permitted for individuals or employees who are age 55 or older. The catch-up contribution amount is \$500 in 2004, rising in annual increments of \$100 to

---

<sup>100</sup> I.R.C. § 223(b)(2).

<sup>101</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 86.

<sup>102</sup> I.R.C. § 223(b).

<sup>103</sup> *Id.* at § 223(g); I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 12.

<sup>104</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 12.

<sup>105</sup> *Id.* at Q&A 13.

<sup>106</sup> I.R.C. § 223(b)(4)(A).

\$1,000 in 2009.<sup>107</sup> But once the employee reaches and enrolls in Medicare at or after age 65, no further contributions are permitted.<sup>108</sup>

## 2. Correcting Excess Contributions

Annual contributions made to an HSA in excess of the prescribed contribution limits are subject to a 6% excise tax until they are either distributed or applied to the HSA funding limit in a subsequent year. An HSA account holder can correct excess contributions, and thereby avoid the 6% excise tax, by distributing excess amounts from the HSA account before the due date for the filing of his or her income tax return.<sup>109</sup> Net income attributable to the excess contribution must also be distributed.<sup>110</sup> It is for this reason that employers are unlikely to frontload HSA contributions since refunds would be required if an employee quits during the year. Individuals who have not made excess contributions may not treat an HSA withdrawal as a withdrawal of excess contributions.<sup>111</sup>

## 3. Dual Coverage

There are special rules where one or both spouses have family coverage. If either spouse has non-HDHP family coverage, both are treated as having family coverage. This means that an individual who is covered under his or her spouse's non-HDHP will be unable to make tax-deductible HSA contributions to an HDHP offered by his or her employer. This is so because he or she has "other coverage" that is not under an HDHP (and is not permitted coverage, permitted insurance or a preventative care benefit).

If both spouses have family coverage under separate HDHPs, then the contribution limit will be equal to that of the plan with the lowest deductible. Under a default rule, this amount is apportioned equally between the spouses. The spouses are free, however, to agree on a different allocation.<sup>112</sup>

If one spouse has HDHP family coverage and the other spouse has self-only coverage under a non-HDHP, then the maximum annual contribution for the married couple is the lesser of (i) the lowest family deductible under the HDHP, or (ii) the statutory maximum (\$5,150 in 2004).<sup>113</sup> In this case, the spouse with the family HDHP coverage can deduct the full amount allowable, and the other spouse may not make an HSA contribution. The spouse with the HDHP coverage is not penalized where the other spouse is not an eligible individual by reason of having self-only, non-HDHP coverage.

HSAs are also subject to certain other requirements. Contributions may not be invested in life insurance contracts, and assets may not be commingled with other

---

<sup>107</sup> I.R.C. § 223(b)(3).

<sup>108</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 3.

<sup>109</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 22.

<sup>110</sup> See I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 34 (which prescribes the manner in which the net income is determined for this purpose with reference to Treas. Reg. § 1.408-11).

<sup>111</sup> *Id.* at Q&A 34.

<sup>112</sup> *Id.* at Q&A 32; I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 15.

<sup>113</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 31.

property in a common trust fund. Also, HSA account balances must at all times be fully vested,<sup>114</sup> which among other things means that employers may not restrict or limit an employee's use amounts in of his or her HSA. HSA funds can be rolled over from an Archer MSA to an HSA, but rollovers from HRAs and FSAs are not allowed.<sup>115</sup>

Individual contributions within the limits described above are tax deductible as an above-the-line expense (which allows non-itemizers to benefit from the deduction).<sup>116</sup> An eligible individual can make contributions or have them made by a family member on his or her behalf even if he or she has no other compensation.<sup>117</sup> Of course, contributions, made by family members on an eligible individual's behalf would be treated as taxable gifts unless they qualify for the annual exclusion under I.R.C. 2053(b).<sup>118</sup> The deductible contribution can, therefore, be used to shelter such things as interest, pensions, and investment gains. An individual can make HSA contributions at any time during his or her tax year and at any time before the due date (without extensions) for the filing of the eligible individual's income tax return but not before the beginning of the year.<sup>119</sup>

### *I. Death of the Account Holder*

Upon the death of an HSA account holder, the remaining account balance becomes the property of his or her named beneficiary.<sup>120</sup> The account balance is included in the account holder's gross estate unless the account holder's surviving spouse is the named beneficiary (in which case the account becomes the property of the surviving spouse and the value of the account qualifies for the marital deduction). Where the beneficiary is not the account holder's spouse, the account ceases to be an HSA and the beneficiary must include the date-of-death balance in income currently.<sup>121</sup> The amount includable in income is reduced by any amounts that are expended from the HSA within one year following the death of the decedent to pay qualified medical expenses of the decedent. HSA transfers made in connection with a divorce are not taxable, and the transferred assets are thereafter treated as an HSA.<sup>122</sup>

---

<sup>114</sup> I.R.C. § 223(d)

<sup>115</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 23.

<sup>116</sup> *Id.* at Q&A 11.

<sup>117</sup> I.R.C. § 223(b)(7).

<sup>118</sup> *See also id.* at § 2503(e)(2)(B) (exempting from the gift tax amount paid by one individual on behalf of another individual directly to a provider of medical care as payment for the donee's medical care); Treas. Reg. § 25.2503-6(b)(3) (if the payment of the medical expense is reimbursed, e.g. by the HSA or under the donee's insurance company, the donor's payment for that expense is not eligible for the unlimited exclusion from the gift tax). Accordingly, contributions made for purpose of enabling a donee to fund an HSA will be subject to the annual exclusion.

<sup>119</sup> I.R.C. § 223(d)(4).

<sup>120</sup> *Id.* at § 223(f)(8).

<sup>121</sup> *Id.* at § 223(f)(8)(B).

<sup>122</sup> *Id.* at § 223(f)(7).

## J. Comparability Requirement

HSAs are subject to a comparability rule. While sometimes referred to as a nondiscrimination rule, the comparability rule does not operate to prevent discrimination in a traditional sense. By way of example, an employer could offer HSAs coupled with a fully insured HDHP to the employer's highly compensated management team and offer no health insurance or a more traditional, non-HDHP to its rank-and-file employees without running afoul of the comparability rule.<sup>123</sup> Rather, comparability testing is confined to, and tests only, the cohort that is covered by the HDHP.

Where an employer makes HSA contributions, the employer must make available comparable contributions on behalf of all "comparable participating employees" during the same period.<sup>124</sup> The comparability rules do not apply to contributions made through a cafeteria plan,<sup>125</sup> nor do they apply to employee, after-tax HSA contributions.<sup>126</sup> This has important consequences since it allows for plan designs that include employer-matching HSA contributions based on elective HSA deferrals by employees.<sup>127</sup> Matching contributions are otherwise barred by the comparability rule.

Similar rules apply in the case of employer contributions to an employee's HSA on account of an employee's participation in health assessment, disease management, or wellness programs. Under the general rule, if all eligible employees do not elect to participate in all these programs, the employer contributions fail to satisfy the comparability rules. But where these contributions are made through a cafeteria plan the result changes since the comparability rules do not apply to employer contributions to an HSA through a cafeteria plan.<sup>128</sup>

"Comparable participating employees" are eligible employees with comparable coverage. Contributions are considered comparable if they are either the same amount or the same percentage of the deductible under the HDHP. The comparability rule is applied separately to part-time employees (i.e., employees who are customarily employed for fewer than 30 hours per week).<sup>129</sup> In addition, amounts rolled over from an employee's HSA or Archer MSA are not subject to the comparability rule.

---

<sup>123</sup> See § 1151 of the Tax Reform Act of 1986, Pub. L. No. 99-514, 100 Stat. 2085 (1986) (adding § 89 which, among other things, imposed broad-based non-discrimination requirements on medical plans); See also § 203(b)(2) of the Debt Limit Extension Act, Pub. Law. No. 101-140, 103 Stat. 830 (1989) (repealing § 89). (For reasons that are largely historical, no benefits-related, non-discrimination rules currently apply in the case of insured accident and health plans).

<sup>124</sup> I.R.C. § 4980G.

<sup>125</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 32.

<sup>126</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 54.

<sup>127</sup> *Id.* at Q&A 47 ("The conference report for the Medicare Prescription Drug, Improvement and Modernization Act of 2003 states that the comparability rules do not apply to contributions made through a cafeteria plan . . . Thus, where matching contributions are made by an employer through a cafeteria plan, the contributions are not subject to the comparability rules of section 4980G. However, contributions, including 'matching contributions', to an HSA made under a cafeteria plan are subject to the section 125 nondiscrimination rules . . .").

<sup>128</sup> *Id.* at Q&A 49.

<sup>129</sup> I.R.C. § 4980E(d)(4); I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 51.

If employer contributions do not satisfy the comparability rule during a period, the employer is subject to an excise tax equal to 35% of the aggregate amount contributed by the employer to HSAs for that period.

*K. Cafeteria Plans and HSAs*

Prior to the issuance of Notice 2004-50, the interaction between the HSA rules and medical health savings accounts was the subject of a great deal of speculation among the regulated community. Would HSAs funded through a health FSA be treated more like health plans (which are subject to all of the cafeteria plan rules) or more like 401(k) plans (which are treated more liberally)? The answer is the latter. According to Notice 2004-50, the following rules that apply to medical FSAs do not apply to HSAs:<sup>130</sup>

- (i) The prohibition against a benefit that defers compensation by permitting employees to carry over unused elective contributions or plan benefits from one plan year to another plan year;
- (ii) The requirement that the maximum amount of reimbursement must be available at all times during the coverage period; and
- (iii) The mandatory twelve-month period of coverage.

Nor do the “change in status” rules (that limit mid-year election changes under cafeteria plans) apply to elections of HSA contributions through a cafeteria plan.<sup>131</sup>

Since the mandatory period-of-coverage rules do not apply to HSAs that are funded under a medical FSA, mid-year election changes are allowed. But the final medical FSA regulations governing mid-year election changes also apply,<sup>132</sup> and they will have the effect of limiting an employee’s options. Specifically, under Treas. Reg. I.R.C. 1.125-4(f)(1), a participant may not change a medical FSA election in connection with the addition or improvement of a benefit package option. As a result, an employee who has previously elected coverage under his or her employer’s general purpose medical FSA cannot be an “eligible individual” unless he or she has exhausted his or her FSA balance.

Where an employee elects to make contributions to an HSA through the employer’s cafeteria plan, the employer may (but is not required to) contribute amounts to an employee’s HSA to cover qualified medical expenses incurred by an employee that exceed the employee’s current HSA balance.<sup>133</sup> Contributions that are accelerated in this manner must be available to all participating employees on the same terms, and any advances must be structured so that advances will be repaid by the end of the cafeteria

---

<sup>130</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 57.

<sup>131</sup> *Id.* at Q&A 58.

<sup>132</sup> Treas. Reg., § 1.125-4.

<sup>133</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 60.

plan's plan year. An employer may not, however, recoup any amounts from an employee's HSA.<sup>134</sup> Negative HSA elections are also allowed.<sup>135</sup>

#### *L. Rollovers*

The rules that govern rollovers and transfers to and from HSAs are similar to those governing Individual Retirement Accounts. HSA account holders may roll over their account balances once per year, and the amount that is rolled over must be paid over within 60 days following the receipt of the HSA distribution.<sup>136</sup> There is no limit on the number of HSA trustee-to-trustee transfers allowed during a year.<sup>137</sup>

#### *M. Reporting*

Employer contributions to an HSA must be reported on box 12 of the employee's Form W-2.<sup>138</sup> The IRS expects that information reporting for HSAs will be similar to information reporting for Archer MSAs, and it expects to release forms and instructions for this purpose. As is the case with Archer MSAs, HSAs are not subject to COBRA continuation coverage under I.R.C. 4980B.<sup>139</sup> Nor are HSA contributions by an employer subject to the rules under I.R.C. 419 relating to welfare benefit funds.<sup>140</sup>

#### *N. Impact of ERISA*

In Field Assistance Bulletin 2004-1, the U.S. Department of Labor essentially exempted HSAs from ERISA coverage so long as certain criteria are satisfied. Accordingly, HSAs will not be subject to ERISA's reporting and disclosure requirements, among others. The Department also noted that the HDHP that is paired with an HSA is generally subject to ERISA—which should surprise no one.

The Department looked to its prior guidance relating to employee-pay-all arrangements with limited employer involvement.<sup>141</sup> These programs will not be subject to ERISA where (i) there are no employer contributions, (ii) employee participation is voluntary, (iii) the employer does not endorse the program, and (iv) the employer receives no consideration in connection with the program, other than reasonable compensation for administrative services actually rendered in connection with payroll deductions. Based on this precedent, an HSA funded entirely with employee contributions and that meets the other safe harbor requirements is not subject to ERISA.

---

<sup>134</sup> *Id.* at Q&A 82.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.* at Q&A 55; *See* I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 23 (setting out additional requirements that apply to HSA rollovers).

<sup>137</sup> I.R.S. Notice 2004-50, 2004-33 I.R.B. 1 at Q&A 56.

<sup>138</sup> I.R.S. Notice 2004-2, 2004-2 I.R.B. 269 at Q&A 34.

<sup>139</sup> *Id.* at Q&A 35.

<sup>140</sup> *Id.* at Q&A 36.

<sup>141</sup> 29 C.F.R. § 2510.3-1(j). *See also* 29 C.F.R. § 2509.99-1 (relating to payroll deduction IRAs).

The Department also exempted from ERISA HSAs that are funded either entirely or partially with employer contributions. In arriving at this position, the Department explained that—

“HSAs are personal health care savings vehicles rather than a form of group health insurance. For example, funds deposited in an HSA generally may not be used to pay health insurance premiums, and the beneficiaries of the account have sole control and are exclusively responsible for expending the funds in compliance with the requirements of the Code. Because of these differences, we regard court precedent on the significance of employer contributions to group or group-type insurance arrangements as inapposite to HSAs. In the group health insurance context, the employer, whether by choosing an insurance policy or creating a self-funded program, typically establishes the type of benefits provided, the conditions for their receipt, and the manner in which claims will be adjudicated. In the context of HSAs, however, the employer may be doing little more than contributing funds to an account controlled solely by the employee.” (Footnotes omitted)

For an HSA to be exempt from coverage under ERISA, the establishment of HSAs must be voluntary on the part of employees and the employer must not:

1. Limit the ability of eligible individuals to move their funds to another HSA beyond restrictions imposed by the Internal Revenue Code;
2. Impose conditions on utilization of HSA funds beyond those permitted under the Internal Revenue Code;
3. Make or influence the investment decisions with respect to funds contributed to an HSA;
4. Represent that the HSAs are an employee welfare benefit plan established or maintained by the employer; or
5. Receive any payment or compensation in connection with an HSA.

## **V. Comparison to Other CDHC Funding Vehicles**

Recall that one of the key features of any workable CDHC plan is that it must permit (and ideally encourage) plan participants to realize a net gain by taking advantage of the plan’s design-based incentives. Before the Act, there were three CDHC platforms—(i) FSAs, (ii) Archer MSAs and (iii) Health Reimbursement Accounts. Each of these suffered from drawbacks, which HSAs appear to have addressed.

### *A. Health Flexible Spending Accounts*

Prop. Treas. Reg. Section 1.125-2, Q&A 7(c) defines an FSA to mean, generally,

“a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant’s coverage.”

Where a health FSA complies with the applicable statutory and regulatory requirements, neither contributions nor benefits are subject to tax.

The proposed regulations also require FSAs to satisfy other requirements, including a “use-it-or-lose-it” rule under which any unused FSA balance remaining in a participant’s account at the end of a plan year must be forfeited.<sup>142</sup> The problem, of course, is that the “use-it-or-lose-it” rule is antithetical to the realization of gain that can be carried forward from year to year. Therefore, the FSA is a nonstarter in the CDHC marketplace.

#### *B. Health Reimbursement Accounts or HRAs*

Before the Act, most CDHC plans were HRA-based. An HRA is an arrangement that (i) is paid for solely by the employer and not provided pursuant to a salary reduction election or otherwise provided under a cafeteria plan, (ii) reimburses the employee for medical care expenses incurred by the employee and the employee’s spouse and dependents, and (iii) provides reimbursements up to a maximum dollar amount for a coverage period, with any unused portion of the maximum dollar amount at the end of a coverage period carried forward to increase the maximum reimbursement amount in subsequent coverage periods. For this purpose, “medical care expenses” is defined with reference to I.R.C. 213(d).

Importantly, HRAs can only be funded with employer contributions, and there is no requirement that assets be held in trust. An unfunded HRA, like an FSA, is simply a notional account. An HRA can be maintained alongside a health FSA. Notice 2002-45<sup>143</sup> imposes additional requirements, however, to ensure that the HRA is not being indirectly funded with employee monies.

HRAs (and FSAs) rely on I.R.C. § 105 to permit the reimbursement of medical expenses on a tax-excludable basis. Where amounts are paid out for non-medical purposes, all payments from the account (including those for medical purposes) become taxable. HSAs, on the other hand, can pay for qualifying and non-qualifying medical expenses. The former are tax-exempt; the latter are taxable and are subject to a modest excise tax where the distributee is under age 65. I.R.C. 105 also requires that payments be substantiated. This is not the case with Archer MSAs or HSAs, which are self-substantiating.

---

<sup>142</sup> Prop. Treas. Reg. § 1.125-2, 54 Fed. Reg. 9460 (March 7, 1989) at Q&A 7(a).

<sup>143</sup> 2002-2 C.B. 93.

### C. Archer MSAs

As noted above, widespread adoption of Archer MSAs is prohibited by statute. But attractive as they might have been for CDHC purposes, HSAs are more useful and flexible.

1. HSAs are not limited to just self-employed individuals and certain small employers; rather, they are widely available to individuals and employers of all sizes,
2. HSA deductibles are higher than those permitted under Archer MSAs—\$ 1,700 (self-only coverage)/\$3,450 (family coverage) vs. \$1,000 (self-only coverage)/\$2,000 (family coverage),
3. Unlike Archer MSAs that can only be funded by either employer or employee contributions (but not both), HSAs can be funded by a combination of the two.

## VI. The Future of CDHC

While HSAs have cleared most if not all of the regulatory hurdles to the widespread adoption of CDHC plans, it remains to be seen whether the concept will gain acceptance. Proponents of CDHC point out that managed care was slow to catch on and that CDHC is today where managed care was in the mid-1980s. But there may be a skunk at the CDHC garden party: If (as is likely) only healthy individuals opt for HSAs, it could drive up the costs of coverage for everyone else. Of course, if the CDHC plan is the only available plan, then the problem disappears—to the detriment of anyone with high or recurring medical expenses.

For CDHC to make good on its promise, there also needs to be a shift in the locus of participant choice. In the managed care environment, employers typically offer a choice of plan options. Employees may have the luxury of choosing among an array of options that include HMOs, PPOs and even plans with pure indemnity features. But if CDHC is offered as an option among other more traditional coverage, then the healthy individuals will be inclined to choose the former and everyone else would be inclined to choose the latter. If this were to occur, then CDHC would be unable to demonstrate its effectiveness. Accordingly, the point of choice in the CDHC environment must be at the point of service rather than at the point of enrollment. This will make it difficult for employers and other plan sponsors to adopt an incremental approach to CDHC.

Will CDHC find acceptance by employers? Of course, much will depend on whether the CDHC plan offerings reward the efficient use of health care at a cost the employers and employees are willing to pay. If employees feel that the CDHC is nothing more than mechanism to shift costs to them and away from the employer, then they will not choose it unless forced to. But employers impatient to contain rising health care costs might well embrace CDHC just for this purpose. This result would only fuel employee cynicism. Just as 401(k) plans shifted the burden of saving for retirement from the employer to the employee, CDHC will be viewed as further shifting the burden of

healthcare from the employer to the employee. The critical issue is whether the cost-saving promise of CDHC is real and meaningful or simply illusory.

HSAs have other problems unrelated to CDHC. While the tax penalties associated with HRAs and FSAs might be unnecessarily high, the 10% excise tax might prove too tempting to some participants for whom a 10% haircut is a small price to pay for access to funds that are intended for medical costs. But given that the HSA tax structure is mandated by statute, it appears that the IRS will be relatively powerless to address any “abuses” by regulation.

HSAs are at bottom a legislative response to concerns over rising health care costs, and as the enabler of CDHC there is a great deal riding on them. Employers cannot continue to sustain double-digit medical cost increases. Something, as they say, must give. If this experiment fails, then what? Elected officials, policymakers and concerned individuals at both ends of the political spectrum would prefer that employers get out of the business of offering health care entirely. On the left are the proponents of universal health care; on the right are those that advocate for individual insurance coverage. If CDHC falters, one side might well get its wish.