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HSAs and Health Plan Design: Beyond the Basics

Coordination with Other Tools

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On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("Act"). The landmark legislation made significant changes with respect to access of prescription drugs for seniors and people with disabilities under Medicare. The Act also amended the Internal Revenue Code ("Code") to permit eligible individuals to establish a health savings account ("HSA") for taxable years beginning after December 31, 2003. Since December of 2003, the federal government has issued a flurry of additional guidance intended to clarify the provisions of the Act with respect to HSAs.

Issues with respect to HSAs are discussed in Notice 2004-50, ____ IRB ____ ("Notice 2004-50") issued July 23, 2004; Revenue Ruling 2004-45, 2004-22 I.R.B. 971 ("Rev. Rul. 2004-45") issued May 11, 2004; Revenue Ruling 2004-38, 2004-15 I.R.B. 717 (Rev. Rul. 2004-38") issued March 30, 2004; Revenue Procedures 2004-22, 2004-15 I.R.B. 727 ("Rev. Proc. 2004-22") issued March 30, 2004; Notice 2004-43, 2004-27 I.R.B. 10 ("Notice 2004-43) issued June 18, 2004; Notice 2004-25, 2004-15 I.R.B. 727 ("Notice 2004-25") issued March 30, 2004; Notice 2004-23, 2004-15 I.R.B. 725 ("Notice 2004-23") issued March 30, 2004; and Notice 2004-2, 2004-2 I.R.B. 269. ("Notice 2004-2") issued December 22, 2003.

An individual may only contribute to an HSA for a particular month if the individual is covered by a high deductible health plan ("HDHP") at the beginning of such month. Many of the other health coverages normally provided by an employer will prohibit the individual from making a contribution to an HSA because those other coverages are not HDHPs. This outline will examine the interaction between HSAs and other tools used by employers to provide health coverage to their workforce.

I. Contributions to a Health Savings Account.

A. Eligible Individual. An individual is considered an "eligible individual" and may make a contribution to an HSA if: (i) the individual is covered under an HDHP as of the first day of the month; (ii) is not enrolled in Medicare (Notice 2004-2 originally stated "is not eligible for Medicare," but the language was changed in Notice 2004-50); (iii) is not claimed as a dependent on another person's tax return; and (iv) is not, while covered under an HDHP, covered under any other health plan which is not an HDHP (with certain exceptions).

B. Employees. For an HSA established by an eligible individual that is an employee, the employee, the employee's employer or both may contribute to an HSA in a given year. Notice 2004-2, Q&A 11. Notice 2004-50 expanded on Notice 2004-2 by stating that any person (an employer, a family member, *or any other person*) may make contributions to an HSA on behalf of an eligible individual. Notice 2004-50, Q&A 28.

C. Employer Contributions.

(1) Tax Treatment of Employer Contributions. The employer contributions are not subject to withholding from wages for income tax or subject to the Federal Insurance Contributions Act, the Federal Unemployment Tax Act or the Railroad Retirement Act. Notice 2004-2, Q&A 19.

(2) Discrimination Rules. If an employer makes HSA contributions, the employer must make available comparable contributions on behalf of all eligible employees with comparable coverage during the same period. Contributions are considered comparable if they are either the same amount or 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). The comparability rule does not apply to amounts rolled over from another HSA or Archer Medical Savings Accounts ("MSA"), or to contributions made through a cafeteria plan (see below). 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. Code section 4980G and Notice 2004-2.

Example: Employer X offers its collectively bargained employees three health plans, including an HDHP with self-only coverage and a $2,000 deductible. For each employee electing the HDHP self-only coverage, X contributes $1,000 per year on behalf of the employee to an HSA. X makes no HSA contributions for employees who do not elect the HDHP. X's plans and HSA contributions satisfy the comparability rule.

II. High Deductible Health Plan.

A. Definition. A "high deductible health plan" is a health plan that has an annual deductible of at least $1,000 and annual out-of-pocket maximum (including deductibles, co-payments and other amounts not including premiums) not to exceed $5,000. For family coverage, an HDHP has an annual deductible of at least $2,000 and annual out-of-pocket maximum not to exceed $10,000 (Code section 223 requires that both amounts are double self-only coverage). The dollar amounts are indexed for inflation to the nearest multiple of $50. Code section 223(g).

An individual may contribute to an HSA although such individual has an option to participate in a plan that is not an HDHP. The determination of whether the individual is an eligible individual is based on not what the individual could have elected, but what the individual actually elected. Notice 2004-50, Q&A 1.

Although an HDHP has an annual out-of-pocket expense not exceeding $5,000 ($10,000 for family), an HDHP may impose a reasonable lifetime limit on

benefits provided under the plan. The limit, however, may not be imposed as a way to circumvent the maximum out-of-pocket amount. Notice 2004-50, Q&A 14.

B. Family Coverage.

(1) Annual Deductible. For an HDHP with family coverage, no amounts may be payable from the HDHP until the family has incurred annual medical expenses in excess of the minimum annual deductible. For purposes of Code section 223, family coverage means any HDHP covering the eligible individual and at least one other individual (whether or not the individual is an eligible individual).

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 medical 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 and no HSA contribution may be made for the benefit of the individual.

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

(2) Rule for Married Couples. For married couples, if either spouse has family coverage, both spouses shall be treated as having family coverage (and if such spouses each have family coverage under different plans, having the family coverage with the lowest annual deductible). Internal Revenue Code section 223(b)(5).

C. Network Plans.

(1) Out-of-Pocket maximum. A "network plan" does not fail to be treated as an HDHP by reason of having an out-of-pocket limit for out-of-network services exceeding the applicable limitation set forth under the definition of HDHP. A "network plan" is a plan that generally provides more favorable benefits for services provided by its network of providers than for services provided outside of the network.

(2) Annual Deductible. A health plan's annual deductible for services provided outside of the network shall not be taken into account for purposes of determining if the health plan is an HDHP. Rather, the annual contribution limit is determined by reference to the deductible for in-network services. Internal Revenue Code section 223(d).

D. Permitted Insurance. A health plan is not an HDHP if substantially all of the health plan's coverage is for any benefit provided by "permitted insurance" or coverage is provided for accidents, disability, dental care, vision care and long term care. Code section 223(c)(2)(B).

(1) Definition. Permitted Insurance is insurance if substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, or such other similar insurance as the Secretary of the Treasury may specify by regulations. Permitted insurance must be fully insured unless the benefits (such as workers' compensation benefits) are provided in satisfaction of a statutory requirement and any resulting benefits for medical care are secondary or incidental to other benefits. Notice 2004-50, Q&A 8. Additionally, permitted insurance includes coverage for a specified disease or illness and insurance paying a fixed amount per day (or other period) of hospitalization.

(2) Insurance for Specific Diseases. There is apparently no limit to the amount of insurance that an eligible individual may have for specific illnesses as long as the HDHP provides the principal health coverage. Notice 2004-50 states that "an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma, or congestive heart failure, as long as the principal health coverage is provided by the HDHP." Notice 2004-50, Q&A 7. The Internal Revenue Service did not provide any additional guidance on when an HDHP provides "principal health coverage."

E. Preventative Care.

(1) Definition. Although an HDHP cannot provide first dollar coverage for most medical benefits, an HDHP is not required to have a deductible for preventative care (within the meaning of Section 1871 of the Social Security Act, except as otherwise provided by the Secretary of Treasury). Code section 223(c)(2)(C). The Internal Revenue Service further defined preventative care in Notice 2004-23 as including but not limited to the following:

(a) Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals;

(b) Routine prenatal and well-child care;

(c) Child and adult immunization;
(d) Tobacco cessation programs;
(e) Obesity weight-loss programs; and
(f) Screening services. Screening services include:

- Cancer screening,
- Heart and Vascular Disease Screening,
- Infection Disease Screening,
- Mental Health Conditions and Substance Abuse Screening,
- Metabolic, Nutritional, and Endocrine Conditions Screening,
- Musculoskeletal Disorders Screening,
- Obstetric and Gynecologic Conditions Screening,
- Pediatric Conditions Screening, and
- Vision and Hearing Disorders.

(2) Treatment Incident to Screening. Notice 2004-23 states that preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition. However, any treatment that is incidental or ancillary to a preventive care service or screening as described in Notice 2004-23 also falls within the safe-harbor for preventive care. For example, removal of polyps during a diagnostic colonoscopy is preventive care that can be provided before the deductible in an HDHP has been satisfied. Notice 2004-50, Q&A 26.

(3) Prescription Drugs or Medications as Preventative Care. Drugs or medications are preventive care when used by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic), or to prevent the reoccurrence of a disease from which a person has recovered. For example, the treatment of high cholesterol with cholesterol-lowering medications (e.g., statins) to prevent heart disease or the treatment of recovered heart attack or stroke victims with Angiotensin-converting Enzyme (ACE) inhibitors to prevent a reoccurrence, constitute preventive care. In addition, drugs or medications used as part of procedures providing preventive care services specified in Notice 2004-23, including obesity weight-loss and tobacco cessation programs, are also preventive care. The safe harbor does not include any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications. Notice 2004-50, Q&A 27.

(4) State Mandated Health Coverage. The Internal Revenue Service also ruled in Notice 2004-23 that state insurance law required coverages for health plans are not necessarily considered preventative care. In contrast to the MSA rules, which consider state mandated coverages to be considered preventative care, the Internal Revenue Service ruled that, with respect to

HSAs, the determination of whether state mandated coverages would be considered preventative care would be determined in accordance with the guidance in Notice 2004-23 and other guidance issued by the Internal Revenue Service. However, the Internal Revenue Service has provided transitional relief for such individuals that would be participating in an HDHP, but for the state mandated coverages which are not considered preventative care. Such individuals will be able to make contributions to an HSA prior to January 1, 2006. Notice 2004-43.

III. Coordination with Other Employer Plans or Programs

A. Prescription Drug Program. The Internal Revenue Service ruled on whether an individual covered under an HDHP and a separate prescription drug plan that did not meet the deductible requirement as an HDHP would prohibit the individual from making contributions to an HSA. Rev. Rul. 2004-38. The Internal Revenue Service held that the individual could not make a contribution to an HSA because he was covered by a health plan that was not an HDHP and the prescription drug coverage was not "permitted insurance" nor was it "permitted coverage" under Code section 223. The Internal Revenue Service also stated that the "result is the same if this prescription drug benefit is provided as a benefit under a health plan (and not separately)" or a benefit for the individual under a spouses plan. However, if the prescription drug program met the deductible requirements of an HDHP, then the individual could make a contribution to an HSA while covered under such prescription drug program.

The Internal Revenue Service has provided transitional relief for an individual that participates in an HDHP and a separate prescription drug plan that is not an HDHP. Such individuals may contribute to an HSA while covered by the separate prescription drug plan up through January 1, 2006. The individual will be able to make an HSA contribution prior to January 1, 2006 if still covered by a prescription drug program that does not qualify as an HDHP. See Rev. Proc. 2004-22.

B. Cafeteria Plans. Employees may make contributions to an HSA through a cafeteria plan and both HSAs and HDHPs may be offered as options under the cafeteria plan. An employee may elect to have amounts contributed to an HSA and an HDHP on a salary reduction basis with such contributions treated as employer contributions.

(1) Discrimination Rules. Employer contributions to an employee's HSA are typically subject to the comparability rules of Code section 4980G. But employer contributions through a cafeteria plan are not subject to the comparability rules of Code section 4980G. Notice 2004-2, Q&A 32. However, contributions, including "matching contributions", to an HSA made under a cafeteria plan are subject to the Code section 125 nondiscrimination

rules. See Code section 125(b), (c) and (g) and Proposed Treasury Regulations § 1.125-1, Q&A 19.

(2) Nonforfeitability. All employer contributions to an HSA are nonforfeitable. Code section 223(d)(1)(E). Even if an employer pre-funds an HSA for an employee for the full year and the employee leaves before the end of the year, the amounts cannot revert to the employer. Notice 2004-50, Q&A 82. However, if the former employee ceases to be an eligible individual (*i.e.*, not covered by an HDHP), the amounts funded by the employer during the period the former employee was no longer an eligible individual will be treated as an excess contribution.

(3) Change in Status. A cafeteria plan may permit an employee to revoke an election during a period of coverage with respect to a qualified benefit and make a new election for the remaining portion of the period only as provided in Treasury Regulations section 1.125-4. The eligibility requirements and contribution limits for HSAs are determined on a month-to-month basis. An employee who elects to make HSA contributions under a cafeteria plan may start or stop the election or increase or decrease the election at any time as long as the change is effective prospectively (i.e., after the request for the change is received), normally prior to the beginning of the month. Because the change in status rules are permissive, if an employer places additional restrictions on the election of HSA contributions under a cafeteria plan, the same restrictions must apply to all employees. Notice 2004-50, Q&A 58.

An employer may permit employees to elect an HSA mid-year if offered as a new benefit under the employer's cafeteria plan if the election for the HSA is made on a prospective basis (prior to the first days of the month for which the employee wants to make a contribution). However, the HSA election does not permit a change or revocation of any other coverage under the cafeteria plan unless the change is permitted by Treasury Regulations section 1.125-4. While an HSA may be offered to and elected by an employee mid-year, the employee may have other coverage under the cafeteria plan that cannot be changed, (e.g., coverage under a health FSA that does not meet the requirements of an HDHP), which may prevent the employee from being an eligible individual. See Rev. Rul. 2004-45.

(4) Negative Elections. Employers may provide negative elections for HSAs if offered through the cafeteria plan. Notice 2004-50, Q&A 61, See also Revenue Ruling 2002-27, 2002-1 C.B. 925. Although allowed, using negative elections would be difficult, at best, to administer because there are so many types of coverage that would make an individual ineligible to make HSA contributions and the employer may not have knowledge of such other coverage. For example, the employee could be covered by a spouse's non-

HDHP health plan, be receiving treatment from the Veteran's Administration, or have a Health Care Reimbursement Account from a previous employer.

C. Health Reimbursement Accounts (HRA) and Healthcare Flexible Spending Accounts (FSA). Generally, an individual may not make contributions to an HSA if the individual is participating in a health plan that does not qualify as an HDHP. Both an HRA and an FSA are health plans that normally do not qualify as an HDHP because each typically provides first dollar health benefit coverage to participants. Rev. Rul. 2004-45, however, discusses how an employer can design HRAs and FSAs to fit them within the definition of an HDHP.

(1) Limited Purpose FSA or HRA. A limited purpose FSA pays or reimburses for "permitted coverage" (but not through insurance or long-term care services) and a limited purpose HRA pays or reimburses benefits for "permitted insurance" (for a specified disease or illness or that provides a fixed amount per day (or other period) of hospitalization) or "permitted coverage" (but not for long term care services). For example, an FSA or HRA could be set up to only reimburse dental and vision expenses, but not medical expenses. In addition, the limited purpose health FSA or HRA may pay or reimburse preventative care benefits. Ultimately, the HRA or FSA is designed only to cover those amounts which are permitted without regard to whether the arrangement is an HDHP.

(2) Suspended HRA. A suspended HRA, pursuant to an election made before the beginning of the HRA coverage period, that does not pay or reimburse, at any time, any medical expense incurred during the suspension period except preventive care, permitted insurance and permitted coverage (if otherwise allowed to be paid or reimbursed by the HRA). When the suspension period ends, the individual is no longer an eligible individual because the individual is covered by a health plan that is an HDHP. An individual who does not forgo the payment or reimbursement of medical expenses incurred during an HRA coverage period, is not an eligible individual for HSA purposes during that HRA coverage period. If an HSA is funded through salary reduction under a cafeteria plan during the suspension period, the terms of the salary reduction election must indicate that the salary reduction is used only to pay for the HSA offered in conjunction with the HRA and not to pay for the HRA itself. The mere fact that an individual participates in an HSA funded pursuant to a salary reduction election does not necessarily result in attributing the salary reduction to the HRA.

(3) Post-Deductible Health FSA or HRA. A post-deductible health FSA or HRA that does not pay or reimburse any medical expense incurred before the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied. The deductible for the HRA or health FSA ("other coverage") need not be the same as the deductible for the HDHP, but in no event may the

HDHP or other coverage provide benefits before the minimum annual deductible under Code section 223(c)(2)(A)(i). Where the HDHP and the other coverage do not have identical deductibles, contributions to the HSA are limited to the lower of the deductibles. In addition, although the deductibles of the HDHP and the other coverage may be satisfied independently by separate expenses, no benefits may be paid before the minimum annual deductible under Code section 223(c)(2)(A)(i) has been satisfied. With respect to an FSA, this option would likely not be appealing to employees because unused portions of the FSA would be forfeited at the end of the plan year and the individual would be unable to use the amounts to pay for medical coverage until deductibles are reached.

(4) Retirement HRA. A retirement HRA that pays or reimburses only those medical expenses incurred after retirement (and no expenses incurred before retirement). Here, the individual is an eligible individual for the purpose of making contributions to the HSA before retirement but loses eligibility for coverage periods when the retirement HRA may pay or reimburse medical expenses. Thus, after retirement, the individual is no longer an eligible individual for the purpose of the HSA.

In addition, combinations of these arrangements would not disqualify an individual from making HSA contributions. For example, if an employer offers a combined post-deductible health FSA and a limited-purpose health FSA, this would not disqualify an otherwise eligible individual from contributing to an HSA. An individual may not be reimbursed for the same medical expense by more than one plan or arrangement. However, if the individual has available an HSA, a health FSA and an HRA that pay or reimburse the same medical expense, the health FSA or the HRA may pay or reimburse the medical expense first, so long as the individual certifies to the employer that the expense has not been reimbursed and that the individual will not seek reimbursement under any other plan or arrangement covering that expense (including the HSA).

D. Employee Assistance Programs (EAPs), disease management programs, or wellness programs. An individual may be eligible to make HSA contributions even though the individual is covered under an EAP, disease management program or wellness program if the program does not provide significant benefits in the nature of medical care or treatment, and therefore, is not considered a "health plan" for purposes of Code section 223(c)(1). To determine whether a program provides significant benefits in the nature of medical care or treatment; screening and other preventive care services as described in Notice 2004-23 will be disregarded. Notice 2004-50, Q&A 10 lists the following examples of plans not considered health plans under Code section 223:

Example 1. 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 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.

Example 2. An employer maintains a disease management program that identifies employees and their family members who have, or are at risk for, certain chronic conditions. The disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan. Typical interventions include monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks. This disease management program 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.

Example 3. An employer offers a wellness program for all employees regardless of participation in a health plan. The wellness program provides a wide-range of education and fitness services designed to improve the overall health of the employees and prevent illness. Typical services include education, fitness, sports, and recreation activities, stress management and health screenings. Any cost charged to the individual for participating in the services are separate from the individual's coverage under the health plan. This wellness program 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.

Many of these programs still may be considered as a health plan under the Code or as an employee welfare plan under ERISA. The exception to the program as a health plan is only for Code section 223.