

**AMERICAN BAR ASSOCIATION
SECTION OF TAXATION**

EMPLOYEE BENEFITS COMMITTEE

2004 Joint Fall CLE Meeting

Boston, Massachusetts
October 2, 2004

**HSAs and Health Plan Design:
Beyond the Basics**
Major Issues and Impediments

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**HSAs and Health Plan Design:
Beyond the Basics**
Major Issues and Impediments

I. MAJOR ISSUES

- Economics and Feasibility
- Coordination with Other Laws
- Coordination with Other Tools
- The Future of HSAs

II. IMPEDIMENTS TO IMPLEMENTING HEALTH SAVINGS ACCOUNTS

A. General Concerns

- HSAs are very new so questions remained unanswered.
- They are complicated. The above-the-line tax deduction is great, but is it worth the effort?
- Many common insurance features run afoul of the HSA rules, for example, embedded deductibles, tracking of co-payments, payment of prescription drug benefits before satisfaction of the deductible, and state mandated benefits.

B. State tax treatment

- Many state tax laws mirror the federal tax treatment of HSAs.
- Others must be amended before HSAs receive the same favorable treatment.

C. High Deductible Health Plan Issues

1. General Concerns

An individual must be covered by a high deductible health plan (“HDHP”) to make contributions to an HSA.¹

- Most individuals are not currently covered by HDHPs so they are ineligible to make contributions unless they change to HDHP coverage.
 - No one likes change.

¹ I.R.C. § 223(c)(1)(A)(i).

- Many individuals may be wary of converting to an HDHP in order to be eligible because they do not like high deductibles.
- HMOs are not HDHP coverage.
- If an employer converts coverage to HDHP, employees will view it as a takeaway, even if employees are financially better off.
 - Communication will be key to a successful conversion.
- If all healthy employees switch to HDHP, it could cause adverse selection issues for non-HDHP coverage.
 - Underwriters for non-HDHP coverage may want to increase premiums.
- If employers do not offer an HDHP option, younger, healthier employees might drop employer coverage altogether for an individual HDHP. This could result in higher premiums for the employer health plan.
- How do you find an HDHP?
 - How do you know if meets all the requirements of an HDHP?

2. Embedded Deductibles

An individual deductible within a family deductible, commonly called an embedded deductible, may cause coverage to fail as HDHP coverage.²

- *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.³

² I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, Q&A 3.

³ I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, Q&A 3, Example (1).

- Embedded deductibles are very common so beware.

3. Out-Of-Pocket Maximums

A health plan's out-of-pocket maximum includes deductibles, co-payments and other amounts, but not premiums.⁴

- If a plan does not take co-payments into account in determining whether the deductible has been satisfied, the co-payments must still be taken into account in determining if the out-of-pocket maximum has been exceeded.⁵
- Many insurers do not count co-payments towards out-of-pocket maximums. This could cause a plan to fail to be an HDHP.
 - *Example:* In 2004, a health plan has a \$1,000 deductible for self-only coverage. After the deductible is satisfied, the plan pays 100% of the usual, reasonable and customary fee for covered benefits. In addition, the plan pays 100% for preventative care, minus a \$20 co-payment per screening. The plan does not take into account co-payments in determining if the \$1,000 deductible has been satisfied. The co-payments must be included in determining if the plan meets the out-of-pocket maximum. Unless the plan includes an express limit on out-of-pocket expenses taking into account the co-payments, or limits the co-payments to \$4,000, the plan is not an HDHP.⁶

4. State Mandates

Some state laws require health plans to provide certain benefits without regard to a deductible or below the deductible required by Section 223(c)(2) (e.g., first-dollar coverage or coverage with a low deductible). Such plans do not qualify as HDHPs.

- Due to the short period between the enactments of HSAs and the effective date of Section 223, the IRS has recognized that such states may have had insufficient time to modify their laws to conform to the HSA rules.

⁴ I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 21.

⁵ Id.

⁶ I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 21, Example.

- For months before January 1, 2006, a health plan which would otherwise qualify as an HDHP under Section 223(c)(2), except that it complies with state law requirements that certain benefits be provided without a deductible or below the minimum annual deductible of Section 223(c)(2)(A)(i), will be treated as an HDHP for purposes of Section 223(c)(2), if the disqualifying benefits are required by state law in effect on January 1, 2004.⁷
 - This relief is welcome, but will it give employers and employees peace of mind?
 - What if employers and employees revise health care plans but state insurance laws are not revised?
 - Employers and employees may take a wait-and-see approach.

5. Preventative Care

A plan will not fail to qualify as an HDHP if it does not have a deductible for preventative care.⁸

- In Notice 2004-23, the IRS provides a safe harbor definition of “preventative care.”⁹ It includes, but is not limited to:
 - periodic health evaluations,
 - routine prenatal and well child care,
 - child and adult immunizations,
 - tobacco cessation programs,
 - obesity weight-loss programs; and
 - screening services listed on the appendix thereto.
- Preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.¹⁰

⁷ I.R.S. Notice 2004-43, 2004-27 I.R.B. 10.

⁸ I.R.C. § 223(c)(2)(C).

⁹ I.R.S. Notice 2004-23, 2004-15 I.R.B. 725.

¹⁰ Id.

- Drugs or medications are preventative care when taken 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 an individual has recovered.¹¹
- Unless a prescription drug is preventative, providing prescription drug coverage before the HDHP deductible is met will cause a plan to fail to be an HDHP.
 - Employers may be leery of providing preventative services, treatments and drugs that do not clearly fall within the safe harbor.
 - If employers modify their plans in an effort to comply with the preventative care rules, employees will view it as a takeaway.

D. “Other Coverage” Issues

While covered by an HDHP, an individual cannot be covered by certain other health plans¹² but can have “permitted insurance” (i.e., coverage under which substantially all of the coverage provided relates to liabilities incurred under workers’ compensation, 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) and “permitted coverage” (i.e., whether through insurance or otherwise is coverage for accidents, disability, dental care, vision care, or long term-care).

1. Prescription Drug Benefits

Prescription drug benefits are not listed as “permitted coverage” or “permitted insurance.”¹³

- If an individual is covered by an HDHP that does not cover prescription drugs and by a separate prescription drug plan (or rider) that provides benefits before the minimum annual deductible of the HDHP has been satisfied, the individual is not an eligible individual under Section 223(c)(1)(A).¹⁴
- For months before January 1, 2006, an individual who would otherwise be an “eligible individual” under Section 223(c)(1)(A), but is covered by both an HDHP that does not provide benefits for

¹¹ I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 27.

¹² I.R.C. § 223(c)(1)(A)(ii).

¹³ Rev. Rul. 2004-38, 2004-15 I.R.B. 717.

¹⁴ Id.

prescription drugs and by a separate health plan or rider that provides prescription drug benefits before the minimum annual deductible of the HDHP is satisfied (i.e., the separate prescription drug plan is not an HDHP), will continue to be an “eligible individual” and may make contributions to an HSA based on the annual deductible of the HDHP.¹⁵

- Employees will be irate if employers take away or change their prescription drug coverage.

2. EAPs, Wellness and Disease Management Programs

EAPs, disease management programs, and wellness programs are not considered health plans for purposes of this rule if they do not provide significant benefits in the nature of medical care and treatment.¹⁶

- Although the above is welcome relief, this means that an employer offering an EAP, wellness program or a disease management program must analyze whether those programs provide significant benefits in the nature of medical care and treatment before establishing HSAs for employees covered by those programs.
 - If an employer provides such benefits, programs will have to be modified accordingly -- another potential takeaway.
 - What if the employer is wrong in its conclusion?

E. Contributions to HSAs Are Nonforfeitable

Contributions to an individual’s HSA must be nonforfeitable.¹⁷

- *Example:* On January 2, 2005, the employer makes the maximum annual contribution to the employees’ HSAs, in expectation that the employees would work for the entire calendar year in 2005. On February 1, 2005, one employee terminates employment. The employer may not recoup from that employee’s HSA any portion of the contribution previously made to the employee’s HSA.¹⁸
 - Employers may not be willing to make contributions to employee HSAs if they cannot subject those contributions to a vesting schedule.

¹⁵ Rev. Proc. 2004-22, 2004-15 I.R.B. 727.

¹⁶ I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 10.

¹⁷ I.R.C. § 223(d)(1)(E); See also I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 82.

¹⁸ I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 82.

- Employers do not like to treat new employees the same as longer-term employees.
- This requirement alone could cause many employers to avoid HSAs.

F. Distributions from an HSA May be Taken at Any Time For Any Reason

An individual must be permitted to take distributions from his or her HSA at any time.¹⁹ The HSA trust or custodial agreement may not impose a requirement that the HSA only be used for the payment or reimbursement of qualified medical expenses.²⁰

- Employers may not be willing to make contributions to employee HSAs if they cannot require that the contributions be used for the payment of medical expenses.
- Employers could end up paying for bass boats, jewelry and vacations if they cannot impose restrictions on distributions.
- This requirement alone could cause many employers to avoid HSAs.

G. Comparability Requirements

If an employer makes HSA contributions, the employer must make comparable contributions on behalf of all “comparable participating employees” (i.e., eligible employees with comparable coverage) during the same period. Contributions are comparable if they are either the same amount or the same percentage of the deductible under the HDHP.²¹

- An offer to make matching contributions in an amount equal to each employee’s HSA contributions or a percentage of each employee’s HSA contributions does not satisfy the comparability requirement unless each eligible individual contributes the same amount.²²
 - Matching contributions are not a viable form of HSA contribution unless the employer makes them through a cafeteria plan.²³
- If employer contributions do not satisfy the comparability rule during a period, the employer is subject to an excise tax of 35% of the

¹⁹ I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, Q&A 24.

²⁰ I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 79.

²¹ I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, Q&A 32.

²² I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 46.

²³ I.R.S. Notice 2004-50, 2004-33 I.R.B. 1, Q&A 47.

aggregate amount contributed to HSAs by the employer during that period.²⁴

- This could result in a huge penalty, so employers may shy away from making HSA contributions.

H. Eligible Individuals, Not Their Employers, Must Establish the HSAs

Beginning January 1, 2004, any eligible individual can establish an HSA with a qualified HSA trustee or custodian, in much the same way that individuals can establish IRAs or Archer MSAs. No permission or authorization from the IRS is necessary to establish an HSA. An eligible individual may establish an HSA with or without involvement of the employer.²⁵

- There is no indication that an employer may establish HSAs for its employees without their involvement.
 - If an employer wants to make comparable contributions to all its employees, the employer must convince all employees to establish HSAs.
 - Can one employee spoil it for all employees?
 - Small employers might be able to get all employees to establish HSAs, but how would a large employer?
- Will hospitals and providers be as willing to offer discounts when they are faced with collecting small amounts (i.e., amounts below the HDHP deductible) from eligible individuals rather than the employer's plan? Typically hospitals and providers offer volume discounts to plans because payment is assured.

²⁴ Id.; I.R.C. § 4980G.

²⁵ I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, Q&A 8.