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TREASURY GUIDANCE CLEARS MUCH CONFUSION ON HSA ISSUES

Since Congress enacted the Health Savings Account (HSA) legislation in 2003, employers and health plan providers have been left to struggle with a host of implementation issues – e.g., will an employee assistance plan (EAP) or disease management program make an individual ineligible for HSAs; do the cafeteria plan rules apply to HSA elections, etc. On Friday July 23, 2004, the Treasury Department ("Treasury") and IRS issued its most comprehensive HSA guidance to date in the form of Notice 2004-50.[1] The guidance resolves many of the issues with which employers and health plan providers have been struggling. According to Treasury, Notice 2004-50 will "help providers to establish HSAs and consumers to enjoy their benefits". .

The guidance consists of 88 questions and answers that favorably address a wide array of outstanding HSA issues including the following:

- The effect of Medicare *eligibility* on "eligible individual" status. In a reversal from earlier guidance, Treasury has clarified that an individual who is eligible for Medicare, but not yet entitled to benefits (e.g., has not yet enrolled for Medicare or Social Security benefits) can continue to make contributions to an HSA;

- Whether employee assistance programs ("EAPs"), disease management programs and wellness programs adversely impact eligibility to make an HSA contribution. The guidance allows most current EAPs and wellness programs to co-exist in an HSA environment;

- The permissibility of common health coverage limitations (such as lifetime limits, caps on specific benefits, amounts in excess of usual and customary fees, pre-authorization penalties and excluded services or treatments) in a health plan intended to serve as qualifying high deductible health plan (HDHP) coverage. Basically, most common HDHP limitations will not disqualify an otherwise qualifying HDHP under Code Section 223;

[1] HSAs and Code Section 223 were created by Section XII of the Medicare Prescription Drug Improvement and Modernization Act of 2003. To date, Treasury and the IRS have issued the following pieces of HSA guidance to clarify Code Section 223: (a) Notice 2004-2 (a general discussion of the HSA requirements), (b) Notice 2004-23 (a safe harbor definition of preventive care) (c) Notice 2004-25 (transition relief for medical expenses incurred by eligible individuals) (d) Rev. Rul. 2004-38 (permissible scope of other non-high deductible health coverage) (e) Rev. Procedure 2004-22 (transition relief from Rev. Rul. 2004-38 for certain separately offered prescription drug plans) (f) Rev. Rul. 2004-45 (permissible Health FSA and/or Health Reimbursement Arrangement coverage) (g) Notice 2004-43 (transition relief in states where state law requires insurance coverage of services/treatments below the deductible) and (h) Model HSA custodian and trust account documents.

- Whether certain drugs can qualify as "preventive care" for HSA purposes.

- The extent to which cafeteria plan rules (e.g. benefit election change rules, cafeteria plan non-discrimination rules, etc.) apply to HSA contributions made through a cafeteria plan;

- The permissibility of employer "matching contributions" and health assessment and incentive program bonuses under the HSA "comparability" rules;

- The permissibility of withholding HSA account maintenance fees from the HSA and the impact on HSA contribution limits; and

- Whether HSA funds can be restricted to qualified medical expenses. As a general rule, no restrictions on the uses of distributions are permitted.

Our discussion below divides the guidance into the following categories: "eligible individual" status, HSA trusts and trustees, contributions to the HSA, and distributions from the HSA. We summarize the general rule related to each area, and then highlight the significant issues addressed by Treasury arising in each area. Note that the issues summarized below are not necessarily in the same sequential order as they appear in the guidance; however, to facilitate your review, we have referenced the applicable Q&A beside each issue.

ELIGIBLE INDIVIDUAL STATUS

General Rules

HSAs can only be established by or on behalf of an "eligible individual" and only eligible individuals can make or receive tax favored contributions. An eligible individual is any individual who satisfies all four of the following conditions:

- The individual is covered under a qualifying high deductible health plan ("HDHP")

- The individual has no other non-HDHP coverage that provides benefits other than "permitted coverage", "permitted insurance" and/or "preventive care".

- The individual cannot be claimed as a dependent under someone else's tax return and

- The individual is not "entitled" to Medicare.

An HDHP is a plan that generally does not provide any coverage below a statutory minimum deductible of $1000* for single coverage and $2000* for family coverage (collectively referred to as the "statutory minimum deductible") and does not require out of pocket expenditures, including the deductible, of more than $5000* for single

and $10,000* for family (collectively referred to as the "out of pocket expense limits"). The plan may, however, provide coverage below the deductible for "preventive care", "permitted coverage" and "permitted insurance".

These amounts are subject to cost of living adjustments beginning January 1, 2005.

Issues Addressed in the Guidance

- *Medicare Eligibility v. Medicare Entitlement*: Mere eligibility for Medicare will NOT disqualify an otherwise "eligible individual" from making or receiving tax favored contributions to the HSA so long as the individual is not *actually enrolled* in Medicare. Although an individual may become eligible for Medicare at age 65, an individual is not necessarily entitled to Medicare benefits simply by turning age 65 – in many cases enrollment for Medicare benefits may be required. Automatic enrollment in Medicare at age 65 only occurs where the individual has already enrolled in Social Security retirement benefits. If the person has not yet enrolled (e.g. they are not eligible for full Social Security benefits until age 67), then they must affirmatively apply for Medicare. Likewise, mere eligibility (but not entitlement) for Medicare will not disqualify an otherwise eligible individual from the "additional make-up contribution" available to individuals who have reached age 55 (Q-2, 3)

- *EAPs, Disease Management Programs and Wellness Programs.* The guidance confirms that participation in a traditional EAP, wellness program, or disease management program does not disqualify an otherwise "eligible individual". According to Treasury, such programs are not disqualifying "health plans" for HSA purposes if they do not provide "significant" benefits in the nature of medical care or treatment (excluding any benefits for "preventive care" services described in Notice 2004-23).

  Helpful examples clarify that the following programs would be permitted without affecting HSA eligibility:

  1) *EAP:* An "assessment and referral" based EAP that primarily provides free or low-cost confidential counseling – including counseling for mental health, emotional disorders, and substance abuse – and refers out for further treatment (if needed) is not a "health plan" for purposes of the HSA rules. Thus, it appears that an EAP could be a health plan for COBRA and related tax purposes – but not for HSA purposes. Plan sponsors have much leeway under this guidance to structure their EAP arrangements.

  2) *Disease Management Program*: If the Disease Management Program primarily provides evidence based information, disease specific support, education services and care oversight and management (i.e. the program oversees and coordinates medical care that is provided under the health

plan(s)) then it is likely not a "health plan" for HSA purposes. The ruling contemplates monitoring laboratory or other test results, telephone contacts or web based reminders of health care schedules, and providing information to help minimize health risk. Most programs for managing chronic diseases will be able to satisfy this standard.

3) *Wellness Program*: A wellness program that provides a wide range of education and fitness services designed to improve the overall health of the employee and prevent illness is likely not a "health plan" for HSA purposes. Under the considered program typical services would include education, fitness, sports, recreation activities, stress management, and health screenings. Any costs would be charged outside of the health plan. (Q-10)

- *Preventive Care service or screening that includes treatment of a related condition:* IRS Notice 2004-23 cleared the way for HDHPs to cover most preventive and screening procedures below the deductible. In some cases, an ancillary medical procedure may be appropriate as part of the screening. For example, removal of polyps may be appropriate during a diagnostic colonoscopy. The guidance clarifies that a preventive care service that includes a procedure that treats an existing condition is still within the preventive care safe harbor as long as the procedure is ancillary to the preventive care service AND it would be unreasonable or impractical to separate the procedure from the overall service. (Q-26)

- *Drugs or medications for preventive care*: There was some question following IRS Notice 2004-23 as to whether drugs can qualify as preventive care. The guidance provides that drugs or medications can be considered "preventive care" if :

    - The drug is taken by an individual who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., the individual is asymptomatic); or

    - To prevent the recurrence of a disease from which a person has recovered.

  Treasury cites statins taken to lower cholesterol and therefore prevent heart disease and the treatment of heart attack or stroke victims with ACE inhibitors as examples of drugs that fall within the preventive care safe harbor. Treasury also cites to drugs taken as part of a preventive care service or program, such as drugs provided as part of a weight loss program. However, drugs intended to treat an existing illness, injury or condition will not qualify as preventive care.

While the guidance sets forth a standard (current treatment of existing condition versus prevention for an asymptomatic individual), application of the preventive care rule will be difficult. Potential examples of such drugs would include:

- Drugs taken by HIV patients to prevent (or retard) the onset of AIDS
- Nicotrol, nicotine gum, or other similar drug or medicine taken to stop smoking.

The guidance does not appear to be limited to prescription drugs. Therefore, over the counter drugs that satisfy the same conditions (preventive for an asymptomatic individual) would also fall within the "preventive care" safe harbor. Thus, Health FSAs can continue to reimburse over the counter drugs that fall within the definition of preventive care without disqualifying an otherwise eligible individual (see Rev. Rul. 2004-45 where Treasury indicated that eligible individuals could participate in Health FSAs that were limited to, among other things, preventive care services). (Q-27)

- *Permitted Insurance*: An HSA eligible individual may also be covered under certain types of permitted insurance (e.g., disease specific health coverage) and permitted coverage (e.g., vision or dental coverage). The guidance indicates that permitted insurance must generally be provided pursuant to a commercial insurance contract and not on a self-insured basis. An exception exists allowing coverage required by state law (e.g., workers compensation coverage) to be provided on a self-funded basis. For example, high deductible health Plan A is a self-insured plan. No benefits are paid prior to satisfaction of the minimum statutory deductible with the exception of preventive care and cancer benefits, which are subject only to a co-pay. Plan A is not a qualifying HDHP because the cancer benefits are not provided pursuant to a commercial insurance contract . (Q-8)

- *The effect of having a choice between a low deductible option and an HDHP option:* The guidance confirms that an individual's status as an "eligible individual" for HSA purposes is determined based upon the benefits actually elected. Thus, merely having a choice between a low deductible option and a qualifying HDHP option does NOT disqualify an otherwise "eligible individual" so long as the individual does not choose an option other than the HDHP. For example, assume that Plan A has two options, a low deductible option and a high deductible option, either of which is available to employees who satisfy the eligibility requirements. Employee A, who meets the other "eligible individual" requirements listed above, chooses the HDHP option. Employee A is an eligible individual even though Employee A could have chosen the low deductible option. (Q-1)

- *Discount cards and negotiated discounted provider rates:* The guidance clarifies that an HSA eligible individual can also have a medical discount card as long

as the individual pays for the entire expense (taking into account the discount) until the minimum deductible has been satisfied. In other words, the discount provided as a result of having the card is not considered a plan benefit provided below the deductible even if the employer provides the discount card to an HDHP participant. Likewise, a plan does not fail to be an HDHP merely because participants are able pay negotiated discounted rates on expenses incurred before the deductible is satisfied. (Q-9, 25)

The following relate specifically to the statutory minimum deductible referenced above.

- *Carry over deductibles:* Albeit complicated, the guidance provides a method for otherwise qualifying HDHPs to accommodate carry over deductibles. As a general rule, the statutory minimum deductible relates to expenses incurred in a 12-month period. Many health plans reduce the deductible for a year by expenses incurred in the latter portion of the previous year under a "carry over" deductible provision. For example, in certain cases, expenses incurred in the last three months of 2004 may be applied toward the 2005 deductible. The deductible period in this example is greater than 12 months (in our example, the deductible period is a 15 month period-the 12 months of 2005 plus the last three months of 2004). The guidance provides an adjustment formula by which a plan with a carry-over provision can still qualify as an HDHP even though it takes into account expenses incurred in a period greater than 12 months. Under the guidance, a plan with a carry over deductible provision can qualify as an HDHP only if it satisfies an adjusted, increased minimum statutory deductible (even if the normal deductible under the plan otherwise satisfies the minimum statutory deductible referenced in the General Rules section above). The adjusted increased minimum statutory deductible is determined using the following formula:

    1) multiply the minimum statutory annual deductible by the number of months in the deductible period (e.g. if expenses incurred in the last 3 months of 2004 are applied toward the 2005 deductible, the deductible period is 15 months). The current minimum statutory deductible for single coverage is $1000. In our example, the Plan applies expenses incurred in the last 3 months of the prior towards the current year's deductible. This results in a 15-month deductible period. Thus, you would multiple $1000 by 15, which equals 15,000.

    2) Divide the amount in 1 by 12. This is the adjusted increased minimum statutory deductible. In our example, we would divide 15000 by 12, which comes out to $1250. The plan in our example must have a deductible that satisfies the adjusted minimum statutory deductible of $1250 (as opposed to $1000) to qualify as an HDHP.

The maximum contribution for a plan with a carry-over deductible is also adjusted (see the contributions section below). Treasury has provided transition relief for plans with carry over deductibles that will allow them to continue complying with the minimum statutory deductible (not the adjusted increased minimum statutory deductible) until January 1, 2006. (Q-24)

- *Deductible reduced by expenses incurred prior to a change in carriers*: In many cases a health plan adopted to replace an existing plan may give credit toward its deductible for expenses incurred under the prior health plan. The guidance confirms that a replacement plan may qualify as an HDHP even if it applies expenses incurred before the change toward the new deductible so long as the deductible period is the same 12 month period for both the current and replacement plan. For example, assume Insurer A imposes a deductible for the period January 1 through December 31. Insurer A is replaced by Employer with Insurer B on July 1, 2005. Insurer B also uses a January 1 through December 31 deductible year and Insurer B reduces the deductible in effect through December 31, 2005 by expenses incurred from January 1 through June 30, 2005. On January 1, 2006, a new deductible period starts. This arrangement would qualify as an HDHP (provided that the deductibles satisfied the minimum statutory requirements). (Q-22)

- *Effect of cost of living adjustments on plans with fiscal plan years:* A plan may wait to apply statutory minimum annual deductible and out of pocket expense limit that has been adjusted due to cost of living increases until the beginning of the fiscal year following the first day of the calendar year that the deductible and/or out of pocket limits have increased so long as the fiscal year is no longer than 12 months. For example, assume that the deductible limit increases on January 1, 2005 from $1,000/2,000 to $1250/2250. Assume further that Plan B renews each year on March 1 and operates on a March 1 through February 28 policy/plan year. Plan B may wait to apply the increase until March 1, 2005. (Q-86)

The following relate specifically to the out of pocket expense limit referenced above:

- *Lifetime limits:* Expenses paid by the employee after a "reasonable" lifetime limit has been satisfied do not count toward the annual out of pocket expense limit referenced above. Treasury does not define "reasonable" except to say that a plan's out of pocket expense maximum is not reasonable if it is has been designed specifically to circumvent the out of pocket max requirement. This guidance provides much flexibility for plan design.

Although not specifically stated, the following questions would presumably be relevant in determining reasonableness:

- Is the lifetime limit substantially similar to lifetime limits imposed by plans sponsored by employers of similar size in the same type of industry?
- Was the lifetime limited bargained for during a collective bargaining process?
- How long has the plan's lifetime limit been in effect? (Q-14)

- *Other traditional plan benefit limitations and caps:*

  - Expenses excluded by the plan after a "reasonable" benefit specific cap has been reached are not counted toward the out of pocket limit. A benefit specific cap is "reasonable" if significant other benefits remain available under the Plan in addition to the limited benefits. For example, a cap or annual limit for a specific condition or treatment may be reasonable. For example, a $10,000 lifetime limit on infertility treatments and a 26 per year visit limit related to substance abuse treatments imposed by the same plan are considered reasonable. However, an example in the guidance notes that an exclusion for amounts in excess of $10,000 on all benefits for any single condition is considered unreasonable because significant other benefits are not available under the plan. (Presumably the participant would not have significant other benefits available in this situation because the participant would have to have 100 different conditions in order to utilize the 1 million lifetime limit imposed under the Plan). (Q-15)
  - Expenses paid by the participant that are in excess of a "usual, customary, and reasonable" (UCR) limit are not counted toward the out of pocket expense limit. (Q-16)
  - A flat penalty imposed by a plan for failing to preauthorize benefits does not count toward the out of pocket maximum. Thus, a $100 penalty for failing to pre-authorize is not counted towards the out of pocket expense limit. Likewise, an increase in the co-insurance amount for failing to pre-authorize is not counted. For example, if a 20% coinsurance amount is increased to 30% when preauthorization is not sought, the additional 10% penalty is not counted toward the out of pocket expense limit. (Q-18, 19)

- *Plans with no out of pocket maximums*: A plan that does not impose an out of pocket expenditure maximum will not generally qualify as an HDHP. For example, a plan that has a $1000 deductible for single coverage and pays 80%

of all UCR expenses after the deductible has been satisfied is not an HDHP unless it specifically imposes a maximum consistent with the statutory OOP limit referenced above on the participant's potential out of pocket expenditures (e.g., 100% coverage after the deductible is satisfied). (see Q-17) However, the guidance provides transition relief for plans with no specific out of pocket expense maximum until January 1, 2005. (Q-17)

- *Cumulative Embedded Deductibles*: When a plan imposes a deductible on each family member, the out of pocket requirement is satisfied where the deductible for each family member multiplied by the number of family members cannot exceed the statutory OOP limit. For example, if a plan provides 100% coverage after a $2000 deductible on each family member, and there are 6 family members, the potential out of pocket expenses of the family (before any other coinsurance expenses that might apply) are $12,000, which exceeds the $10,000 statutory OOP limit for family coverage. However, if there is an umbrella deductible (a cap on the total family deductible), the potential out of pocket expenditure related to the deductible is the lesser of the umbrella deductible or the embedded deductible multiplied by the total number of family members covered under the Plan. (Q-20)

- *Participant Premiums:* The guidance confirms that premiums paid by participants are not counted toward the out of pocket limit. (Q-21)

- *Expenses for excluded benefits and expenses not applied toward the deductible*: Expenses for services or treatments that are excluded from the HDHP, such as amounts determined not to be medically necessary, or experimental or investigative treatments, are not counted towards the out of pocket limit. However, co-payments not applied toward the deductible (e.g. a $ co payment for preventive care) are counted toward the out of pocket expense limit. (Q-21)

- *Employer responsibility to determine eligible individual status of employee:* The guidance confirms that employers have only limited responsibility for determining HSA eligibility of their employees. Under the guidance, employers are only responsible for determining:

  - Whether the individual is covered under an HDHP sponsored by that employer. The employer is not responsible for collecting information concerning coverage maintained by the employee other than that provided by employer (e.g., through a spouse's employer).

  - Whether the individual is covered under any non-HDHP's sponsored by that employer.

  - The employee's age (for purposes of HSA contributions). (Q-81)

QUALIFYING HSA TRUSTS AND TRUSTEES

General Rules

An HSA is a trust or custodial account created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the HSA account beneficiary. The trust or custodial account must satisfy the following requirements:

- Contributions are limited to cash contributions, except for rollover contributions, and do not exceed the contribution limit for family coverage (plus the additional makeup contribution, if applicable).
- The trust or custodial account is maintained by a qualifying trustee.
- No part of the trust or custodial account is invested in life insurance contracts.
- The assets of the trust or custodial account are not commingled with other property except in a common trust fund or common investment fund. The interest of an individual in the balance in his account is nonforfeitable.

Only banks (and similar financial institutions), life insurance companies and non-bank custodians that have already been approved by the IRS to be an IRA or MSA trustee are automatically qualified to be an HSA trustee. Other entities must seek IRS approval.

If an account beneficiary engages in a prohibited transaction, the trust ceases to be an HSA.

Issues Addressed in the Guidance

- *Automatic Trustees/Custodians:* The guidance confirms that only life insurance companies are automatically approved to be HSA trustees. Health insurance companies must seek IRS approval to be an HSA trustee/custodian. Note that Treasury corrects Q/A 9 of Notice 2004-2 to reflect this clarification. (Q-72)
- *Permissible HSA investments:* HSA funds may be invested in investments approved for IRAs. The HSA custodial agreement may restrict investments to certain types of permissible investments. (Q-65)
- *Commingling HSA funds into a common trust fund.* Individual accounts maintained on behalf of individual HSA account beneficiaries may be held in a common trust or investment fund. (Q-66)
- *Combined Husband and Wife HSAs:* A husband and wife may not have a "joint" HSA. This does not mean that an account beneficiary cannot be reimbursed from an HSA for qualified medical expenses of a qualifying spouse, even if the

spouse is also an account beneficiary. It simply means that a spouse who is an eligible individual who wishes to make contributions to an HSA must establish his or her own HSA account. (Q-63)

- *Multiple HSAs maintained by a single Account Beneficiary:* An eligible individual may establish more than one HSA; however, the maximum contribution limit applies to all HSAs combined. (Q-64)

CONTRIBUTIONS TO THE HSA

General Rules

Tax favored HSA contributions may come from any one or a combination of the following four sources: a) the eligible individual (either on an after-tax basis or through the employer's cafeteria plan), b) the eligible individual's employer, c) any other person and/or d) rollover contribution from another HSA or MSA.

The maximum annual contribution amount from all sources (other than rollover contributions that were originally made to another HSA or MSA during a previous tax year) cannot exceed the sum of the "monthly limits" for each month during the year that the individual is an eligible individual. The monthly limit for any month is 1/12th of the following amounts (subject to the reductions described below):

- For those with single coverage on the first day of the month, the lesser of the actual annual deductible under the HDHP or $2600* in 2004; or

- For those with family coverage on the first day of the month, the lesser of the actual annual deductible under the HDHP or $5150* in 2004.

The general contribution limit (i.e., the lesser of the annual deductible amount or $2,600/self or $5,150/family) is increased by $500 in 2004 for individuals who have attained age 55 by the end of the taxable year. A married couple can each make the additional contribution amount as long as both spouses are at least 55. If both husband and wife have an HSA and either has family coverage, the contribution limit referenced is split evenly unless agreed otherwise. Contributions for a particular year may be made at any time before the due date of the individual's tax return for that year.

An employer is not required to make HSA contributions. However, if an employer makes HSA contributions, the employer is subject to a 35% excise tax on its contributions unless for a calendar year it makes available comparable contributions to the HSAs of all comparable participating employees for each coverage period during such calendar year." Comparable contributions are the same amount for each comparable participating employee or the same percentage of the deductible (which may result in different contributions amounts if comparable participating employees have different deductibles).

Comparable participating employees are all full-time employees with the same level of coverage (single or family). Part-time employees may be treated separately.

**These amounts are subject to cost of living adjustments*

Issues Addressed in the Guidance

- *Responsibility of Employer and/or Trustee to monitor contributions:* The employer is responsible for monitoring the employer's contributions to ensure that they do not exceed the maximum statutory contribution limit plus any applicable additional contribution based on age. Therefore, the employer is responsible for monitoring the individual's age. For example, if the plan's deductible is $1000, and the employee is age 56, the employer is responsible for ensuring its own contributions to the employee's HSA do not exceed $1500. The employer is not responsible for monitoring contributions that the employee makes on an after-tax basis with the employee's own funds.

  The trustee is only responsible for ensuring that the maximum amount that the trust can accept is not exceeded. That amount is currently $5150 plus $500 additional contribution where a single person is age 55 or over. Therefore, the trustee is required to monitor the employee's age. The trustee is not, however, responsible for ensuring that the contributions to the HSA do not exceed the individual's maximum contribution limit.

  In both cases, the employer and the trust may rely on the HSA account holder's certification regarding his or her age. (Q-74, 81)

- *Contributors to an HSA:* Contrary to the language in the statute, the guidance indicates that <u>any person</u>, regardless of family status, can make tax favored contributions to an HSA for an eligible individual. (Q-28)

- *Contribution limit for plans with carry over deductibles:* If a plan has a carry over deductible, the contribution limit for an individual covered under such plan is adjusted so that it is the lesser of: i) the statutory maximum ($2600 or $5150); or ii) the actual annual deductible divided by the number of months allowed to satisfy the deductible and then multiplied by 12. Consider the following example to illustrate this rule. Plan A imposes a $1250 deductible for single coverage and has a 15-month deductible period (expenses incurred in the current year plus the last three months of the previous year). Employee B has single coverage under Plan A and wishes to know what the maximum contribution limit is for 2004. Employee B must take the lesser of 1) $2600 (the statutory maximum) and 2) ($1250/15) x 12= $1000

- *Effect of embedded deductibles on the contribution limit:* The contribution limit for a family member covered under a plan with an embedded deductible is the lesser of the following:

  - The maximum annual contribution for family coverage ($5150)
  - The umbrella deductible (if any) or
  - The embedded deductible multiplied by the number of family members covered under the Plan.

  The following examples illustrate how this rule is applied:

  1) Employee A (who is under age 55) has an HSA and is covered under Plan A. Plan A imposes a $2000 deductible for each family member covered under the Plan. There are 3 family members covered under the Plan. Thus the family deductible is $6,000 ($2000 multiplied by 3 family members is $6,000). The maximum annual contribution to Employee A's HSA is $5150 (the lesser of the family contribution maximum and the embedded deductible multiplied by family members)

  2) Employee B has an HSA and is covered under Plan B. Plan B imposes a $2000 deductible for each family member covered under the Plan up to a maximum of $6000 (the "umbrella deductible"). There are 2 family members covered under the Plan. Thus, the family deductible is actually $4000 ($2000 multiplied by 2 family members). In this case, the maximum annual contribution to Employee A's HSA is $4000 (the lesser of the family contribution maximum, the umbrella deductible, and the embedded deductible multiplied by family members).

  3) Employee C has an HSA and is covered under Plan C. Plan C imposes a $2000 deductible for each family member covered under the Plan up to a maximum $5000 (the "umbrella deductible"). There are 3 family members covered under the Plan. Thus, the family deductible is actually $5000 (due to the umbrella deductible). In this case, the maximum annual contribution to Employee A's HSA is $5000 (the lesser of the family contribution max, the umbrella deductible, and the embedded deductible multiplied by family members). (Q-30)

- *Effect of payment of administration fees on contribution limits:* Administration fees paid by the employer directly to the trustee/custodian are not applied toward the contribution maximum. For example, Employee is subject to a $1000 deductible under Employer's plan; therefore, the maximum annual contribution amount from all sources is $1000. Employer contributes $1000 to Employee's HSA and also pays the $25 monthly trustee fee directly to the trustee. The maximum contri-

bution amount has not been exceeded. However, the maximum contribution is not increased where HSA fees are taken from the HSA. Thus, in the example above, the maximum contribution would be exceeded if the Employer makes a $1,025 contribution to an Employee's HSA to enable the trustee to withdraw the $25 fee from the account. (Q-69, 70)

- *How frequently may an Account Beneficiary make a trustee to trustee transfer or a rollover contribution:* There is no annual limit to the number of direct trustee to trustee transfers in which an account beneficiary may engage. However, rollovers from distributions to the account beneficiary are limited to once every 12 months. It is also significant to note that trustees may not restrict an account beneficiary's ability to rollover funds from an HSA; however, a trustee/custodian is NOT required to accept rollovers from other HSAs. (Q-55, 56, 77, 78)

- *The effect of the Code Section 125 change in status rules on HSA cafeteria plan elections:* An HSA election under the cafeteria plan can be changed at any time and for any reason so long as the change is prospectively effective no sooner than the first day of the month following the date the election change is made. For example, Employee A participates in an HDHP with a $3000 deductible. She elects to reduce her salary on a pre-tax basis by $100 each month ($1200) for the year for purposes of contributing to the HSA. On March 23, 2005, she learns that she is getting a pay raise and so she decides that she would now like to contribute $200 per month. She may change her monthly HSA salary reduction to $200 effective April 1, 2004.

  In addition, an individual may change his or her existing cafeteria plan election as result of adding an HSA mid-year; however, the HSA election may not permit a change to any other coverage unless a change to that other coverage is otherwise permitted by the cafeteria plan regulations. Thus, for example, an individual would not be able to terminate his or her election under the employer's general purpose Health FSA in order to enroll in an HSA because Health FSA election changes are not permitted as a result of cost or coverage changes. (Q-58, 59)

- *Applicability of the Code Section 125 nondiscrimination rules:* The Section 125 nondiscrimination rules (eligibility, contributions and benefits, and key employee concentration tests) apply to HSA contributions made through a cafeteria plan. (Q-47)

The following relate specifically to the comparability rule referenced above:

- *Matching contributions/Employer contributions made through the cafeteria plan:* The guidance reiterates the rule that contributions made through a cafeteria plan are not subject to the HSA comparability rule. Thus, pre-tax salary reductions made under the cafeteria plan are not subject to the comparability rule and it

appears that employer contributions that are "made through a cafeteria plan" are also not subject to the comparability rule. Consequently, the guidance clarifies that an employer's matching contributions that are made through the cafeteria plan are not subject to the HSA comparability rule. The following examples illustrate this rule:

1) Employer establishes an HSA for all full-time employees. Employees can make contributions to the HSA through the Employer's Code Section 125 cafeteria plan. The Employer further provides that it will contribute an amount equal to each employee's pre-tax salary reduction under the cafeteria plan up to $1000. John and Ashley each have single coverage. John elects to reduce his salary on a pre-tax basis by $400 and Ashley elects to reduce his salary on a pre-tax basis by $300. Employer contributes an additional $400 to John's HSA account and an additional $300 to Ashley's HSA account. Even though Employer's matching contributions are not the same for Ashley and John, the Employer does not violate the comparability rule because the matching contributions are directly associated with the employees' pre-tax salary reductions and are thus made through the cafeteria plan. Note that even though the comparability rules do not apply to the matching contributions in this situation, the cafeteria plan non-discrimination rules do (e.g., the key employee concentration test) and those rules may affect the excludability of contributions provided on a disproportionate basis to highly compensated employees and/or key employees.

2) Same example as above except that Employer does not maintain a Code Section 125 cafeteria plan. Thus, John's and Ashley's HSA contributions are after-tax. In this situation, Employer's contributions are subject to the comparability rule. Since the Employer's matching contributions are not the same amount for Ashley as they are for John, the Employer violates the comparability rule. (Q-46, 47)

Query: When exactly are employer contributions made through the cafeteria plan? Consider an example where Employer will make an HSA contribution (other than a "matching" contribution) for employees who elect the employer's HDHP coverage. Assume further that employees must contribute toward the HDHP coverage on a pre-tax basis through the cafeteria plan. Is Employer's non-elective contribution still "made through the cafeteria plan" even though the participant is not contributing to the HSA or is not contributing to the HSA through the cafeteria plan? Arguably it is still a contribution made through the cafeteria plan because the HSA contribution is conditioned on the employees electing the HDHP and contributing to it through the cafeteria plan. Such a "but-for the cafeteria plan" analysis applies for other purposes (e.g., determining the scope of employer contributions to include in the key employee concentration test under Section 125). Although this will result in most employers being able to avoid

the comparability rules, they will not be able to avoid the Code Section 125 nondiscrimination rules, which provide a “backstop, if you will, where the comparability rules do not apply.

- *Variations in employer contributions based on service:* Employers are not required to contribute the same amount of annual contributions to the HSAs of employees who are employed for part of a year. Contributions must only be comparable when determined on a month to month basis. For example, assume that the Employer agrees to contribute $100 per month to each individual's HSA account for as long as they are employed during the year. Employee A is employed January 1, 2005 through December 31, 2005. Consequently, she receives $1200 in HSA contributions. Employee B is employed January 1, 2005 through March 31, 2005. Employee B only receives $300. This is not a violation of the comparability rule referenced above, even though Employee B received fewer contributions than Employee A, because they each received the same contribution amount when viewed on a month to month basis. (Q-51)

- *Effect of comparability rule on catch up/additional contributions:* It is a violation of the comparability rule to increase the employer HSA contribution for those ages 55 and older due to the makeup contribution rule. (Q-50)

- *Effect of the comparability rule on health assessments and incentives:* If an employer conditions employer contributions to an HSA on participation in health assessments, disease management programs and/or wellness programs and all eligible employees do not participate, then the comparability rule is violated because all eligible employees (subject to the permissible variations) will not receive the same HSA contribution amount. Likewise, it would violate the comparability rule if only those employees with a specific disease were offered an HSA contribution for participating in a disease management program. However, if the additional contribution is made through a cafeteria plan (as discussed above), the comparability requirement for HSAs is not violated. (Q-48, 49)

- *Effect of comparability rules on employer's decision to contribute only to employees with HDHP coverage maintained by the employer:* An employer can limit HSA contributions to employees that participate in its HDHP. However, if the employer contributes to the HSA of even one employee who does not have coverage under the employer's HDHP, the employer must contribute to all comparable employees without regard to whether they are covered under the employer's HDHP. (Q-53)

DISTRIBUTIONS

General Rules

Distributions from an HSA are generally excluded from an account beneficiary's gross income to the extent the distributions are for qualified medical expenses as defined by Code § 213(d). HSA funds can also be withdrawn for non-medical reasons, but such non-medical distributions are includable in gross income and generally subject to an additional 10% excise tax.[2] The additional 10% excise tax does not apply in certain situations such as payments made after death, disability, or attaining the age of 65 (i.e., the Medicare eligibility date) and for "rollovers" that meet certain statutory requirements. Since it is the account beneficiary's account, it is the account beneficiary's responsibility to report on his or her tax return whether distributions are includable in gross income or not.

Issues Addressed by Guidance

- *Mistaken distributions:* Account beneficiaries may return a mistaken distribution (due to a mistake of fact due to reasonable cause) without imposition of income or excise taxes provided that the following conditions are satisfied:

    - There is clear and convincing evidence that a mistake of fact due to reasonable cause occurred. No guidance is provided as to what constitutes a clear and convincing mistake; however, it would seem that excess distributions due to miscalculations of cost and after-service re-pricing would qualify. Moreover, it appears to be the account beneficiary's responsibility, not the trustee's or employer's, to make that determination.

    - The mistaken distribution is repaid no later than April 15 following the first year that the account beneficiary knew or should have known that the distribution was a mistake.

  The trustee is not required to accept a return of a mistaken distribution; however, if the trustee or custodian does allow for a return of mistaken distributions, they may rely on the account beneficiary's certification that there was a mistaken distribution. (Q-37, 76)

- *Timing of distributions from HSAs:* There is no time limit on when a distribution must occur to reimburse a particular expense. Thus, a distribution can be taken in the current year to reimburse expenses incurred in prior years (provided the expenses were incurred after the HSA was established and have not since been reimbursed or taken as a deduction). The account beneficiary must be able

[2] Code § 223(f)(2) and (4)

to document that the expenses were not previously reimbursed from another source and were not previously deducted. (Q-39)

- *Restrictions by employers and/or trustees on the reasons for distributions:* Employers and/or trustees may not impose restrictions on HSA distributions that limit use of distributions to reimbursement of medical expenses. The guidance makes it clear that only the account beneficiary may determine how HSA distributions will be used. While not specifically addressed by the guidance, presumably an HSA may utilize an electronic payment card limited to medical providers as long as HSA funds can be accessed through other means (e.g., check) for non-medical uses without significant restrictions. Such a restriction would seem to be consistent with the rules allowing trustees to limit the frequency of distributions discussed below. (Q-79)

- *Restrictions by trustees/custodians on the frequency of distributions:* Trustees/custodians may place reasonable restrictions on the frequency of distributions as well as the minimum amount of distributions from HSAs. (Q-80)

- *Distributions for qualified long term care premiums:* The guidance confirms that HSAs may reimburse qualified long term care premiums even if the HSA contributions are made through the cafeteria plan. Code Section 125 specifically prohibits the payment of qualified long term care premiums with cafeteria plan contributions. Treasury indicates that it is permissible to pay qualified long term care premiums through the HSA, even though the HSA contributions are made through the cafeteria plan, because it is the HSA and not the qualified long term care insurance contract that is offered under the cafeteria plan. In addition, excludable distributions from the HSA for qualified long term care premiums are subject to the limits on deductions for qualified long term care premium. (Q-40,41)

- *Withdrawals from HSA for administration fees:* Withdrawals from the HSA for administration fees are not counted as distributions for non-medical expenses; therefore, they are not included in gross income and not subject to the 10% excise tax. (Q-69)

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