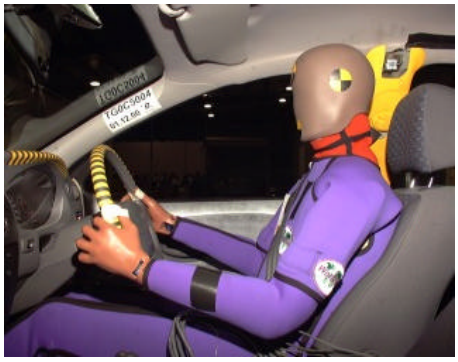
Everything You Wanted To Know About HSAs (and Then Some)



A Crash Course in Health Care Consumerism

September 2004

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Everything You Need to Know About HSAs, But Were Afraid to Ask

The Fun and Easy Way to Learn About Consumer-Directed Health Care – Now Covers Latest Q/As

What to Do to Keep Bad Things From Happening – Written in Plain Legalese

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"This book will help vault you over your benefits hurdles and navigate the Snake River Canyons of the benefits world and still come through in one piece" – former stunt motorcyclist

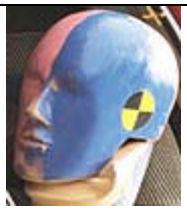
"Thanks Dad, for turning me on to this book. Now I can thrill and amaze my friends and really make my mark on the world" – son of famous stunt motorcyclist

"I sure could have used this book a few weeks ago. It's the hottest thing I've encountered in years." – famous race car driver

"This book shatters all illusions about benefits. If we all had lessons like this earlier in our careers, we would not worry about crashing into other people's glass houses" – famous piano man

The testimonials above are merely a fiction of the imaginations of the authors. Any resemblance to any real person should be ignored.

Symbols You Need To Know

	Alerts you to basic HSA concepts we all need to know.
	Alerts you to new HSA concepts and interpretations.
	Alerts you to potential traps and perils to avoid.
	Alerts you to important HSA concepts and information relating to family coverage.
	Alerts you to ivory-towered discussions that only an ERISA attorney would enjoy.

John R. Hickman

John Hickman is a partner with Alston & Bird (an Atlanta, New York, Charlotte, and Washington, DC based law firm) where he has been a member of the Employee Benefits Practice Group since 1989. Mr. Hickman is also an adjunct professor of law at Emory University School of Law. Mr. Hickman's practice focuses primarily upon health and welfare benefit plan matters and the tax, ERISA, and other compliance issues that arise in connection with such arrangements. He represents employers, insurers, and third-party administrators, assisting them with plan design and compliance issues.

Mr. Hickman is listed in *The Best Lawyers in America* (Woodward/White) and has lectured widely and published articles on HIPAA, ERISA litigation, cafeteria and health plan issues. He is co-author of the *Cafeteria Plans Manual, HIPAA Portability and Privacy,* and *Consumer-Driven Health Care & Fringe Benefits* (published by the Employee Benefits Institute of America). Mr. Hickman is also on the editorial advisory board of the *Benefits & Compensation Law Alert,* is a past member of the editorial board of the *Benefits Law Journal*, is chair of the Employers Council on Flexible Compensation (ECFC) Technical Advisory Committee, and is on the *Publications Committee* of the Self Insurance Institute of America. He received his law degree from Emory University School of Law, graduating with distinction, where he received the *Order of the Coif* Award. Mr. Hickman has been called upon by benefits and trade associations to testify before the IRS and DOL on issues affecting health and welfare benefit plans including HIPAA, cafeteria plan regulations, DOL claims procedures, and the recent DHHS health care privacy regulations.

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Everything You Wanted To Know About HSAs (And Then Some)

It has been nine months since Congress enacted the Medicare Prescription Drug Improvement and Modernization Act (the "Act") which gave us health savings accounts ("HSAs") under Section 223 of the Internal Revenue Code. Since then, Treasury and the IRS have worked tirelessly to fill in the gaps left by the Act. We have also received helpful guidance from the DOL and the Employee Benefits Security Administration ("EBSA").

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] 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. For detailed information on the latest guidance, see our summary "Treasury Guidance Clears Much Confusion on HSA Issues" included with your presentation materials.

Our primary goal in this article is to provide an integrated discussion of the myriad sources of guidance -- i.e., legislative history, the statute and agency releases.

The PDQ on HSAs

If you are looking at HSAs from 30,000 feet above, here is what you would see.

- ? *HSAs may only be established by or on behalf of an "eligible individual."* An individual can only be an HSA "eligible individual" if he or she is covered under one or more "qualifying high deductible health plans" ("HDHPs") and is not also covered under a non-high deductible health plan ("non-HDHP") unless the non-HDHP coverage is limited to "preventive care", "permitted coverage" and/or "permitted insurance". In addition, an individual cannot be an eligible individual if he or she is eligible to be claimed as a dependent on someone else's tax return or is *entitled* to Medicare.
- ? *HSA contributions must be held in a "qualified trust" (or custodial account) maintained by a "qualified trustee".* Not just any type of trust will suffice and not just any type of trustee will suffice. Both the HSA trust (or custodial account) and the trustee (or custodian) of that account must satisfy certain requirements. Once established, the HSA trust account belongs to the individual for whom the

[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.

trust account was established ("Account Beneficiary") and the Account Beneficiary's interest in that HSA trust account is non-forfeitable.

- ? *Contributions to the HSA are tax favored to the extent certain conditions are satisfied.* Contributions to the HSA may come from anyone. Contributions to an HSA by an HSA Account Beneficiary or any other person are deductible "above the line" by the Account Beneficiary and employer contributions are excluded from the Account Beneficiary's gross income so long as two conditions are satisfied: 1) the contributions are made by or on behalf of an "eligible individual" and 2) the contributions from all sources during the year do not exceed the sum of the "*monthly limits*" for that year. Eligible individuals may contribute to their HSA with pre-tax contributions under their employer's Section 125 cafeteria plan if the cafeteria plan has been amended to include HSAs. Interest earned on HSA contributions is generally tax-free.
- ? *Distributions from the HSA for eligible medical expenses are generally tax-free.* A distribution from an HSA is tax-free so long as the distribution is for "qualified medical expenses", even if the Account Beneficiary has ceased to be an eligible individual. Distributions from the HSA for non-medical reasons are also permitted, but such distributions are subject to income and excise taxes.

TMI – Too Much Information

Now, for the details. The HSA rules logically divide up into three parts: implementation, contributions, and distributions. The "implementation" section describes how to establish a tax-favored HSA. In the "contributions" section, we discuss the rules governing tax-favored contributions as well as the maximum annual amount of tax-favored HSA contributions. Finally, in the "distributions" section we set forth the conditions for tax-free distributions from the HSA and the consequences that arise when those conditions are not satisfied.

I. Implementation

Any "eligible individual" can establish an HSA, which is a qualified trust or custodial account maintained by a "qualified trustee". As discussed in more detail below, not every entity can be a qualified trustee. Eligible individuals could begin establishing HSAs on January 1, 2004; however, many individuals and employers wishing to establish HSAs on behalf of their eligible employees have found it difficult to find trustees who provide HSA products and administration, likely due to the wait and see approach of many would be trustees/custodians caused by the ambiguity of the statute and the period issuance of guidance by Treasury. Consequently, Treasury provided transition relief that allows an individual who is otherwise an "eligible individual" in 2004 to establish an HSA for 2004 as late as April 15, 2005.

As a general rule, tax-free distributions cannot be taken for medical expenses incurred prior to the date the HSA is established; however, the transition relief allows tax free reimbursement of medical expenses incurred before the HSA is established so long as (i) the expense was incurred on or after the later of January 1, 2004 or the date the

individual became an eligible individual and (ii) the HSA is established by April 15, 2005.

A. Only an eligible individual may establish an HSA

An individual may only be an HSA "eligible individual" if he or she satisfies all four of the following conditions on the first day of each month:

- The individual is covered under a qualifying high deductible health plan (HDHP).
- The individual is not covered under any non-HDHP that provides coverage other than for "permitted coverage", "permitted insurance" and/or "preventive care" (see below for a more detailed discussion of these types of permissible coverage). Examples of impermissible *other* non-HDHP coverage include coverage under individual health insurance policies and coverage under the spouse's employer's plan (e.g. where the spouse has family coverage or the spouse participates in a general purpose Health FSA that reimburses expenses of dependents).
- The individual is not eligible to be claimed as a dependent on anyone else's tax return.
- The individual is not entitled to Medicare (due to age or disability). An individual who is age 65 or older but not yet enrolled in Medicare (e.g., has not applied for Medicare or Social Security benefits) may still qualify as an "eligible individual" provided the individual satisfies all of the other conditions.

As indicated above, the determination of "eligible individual" status is made on a monthly basis. Thus, an individual who does not meet all four of the above mentioned conditions until June 15, 2004 does not become an "eligible individual" until July 1, 2004. Likewise, an individual who satisfied all four of the eligibility conditions on June 1, 2004 but ceased to be covered under a HDHP on June 15 would likely not cease to be an eligible individual until July 1, 2004.

Section 223 does not address whether the employer or the HSA trustee must verify whether an individual is an "eligible individual". Recent IRS 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-HDHPs sponsored by that employer.
- The employee's age (for purposes of HSA contributions).

NOTE: Although an Account Beneficiary must be an "eligible individual" to make or receive tax favored contributions to an HSA, an Account Beneficiary need not be an "eligible individual" to receive tax-free distributions from the HSA. The requirements for tax-free distributions are discussed in more detail below.

B. What is a High Deductible Health Plan (HDHP)?

An HDHP is any health plan (self-funded or insured) that meets both of the following requirements:

- The HDHP has an annual deductible of not less than $1,000 for self-only coverage, and $2,000 for family coverage (collectively referred to as the "statutory minimum deductible"). These amounts are subject to cost of living adjustments (COLA) beginning January 1, 2005. Plan sponsors that wish to modify their health plan to qualify as an HDHP in 2005 should plan to have annual deductibles slightly higher than $1000 and 2000 as these amounts will go up. Recent guidance from Treasury allows plans that operate on a fiscal year to wait until the beginning of the fiscal year following the cost of living adjustment to apply the adjustment (so long as the fiscal year is not longer than 12 months). See our summary "Treasury Guidance Clears Much Confusion on HSA Issues" included with your presentation materials for more information on Treasury's recent guidance.
- The sum of the plan's annual deductible and other annual out-of-pocket maximums (other than premiums, expenses) cannot exceed $5,000 for self-only coverage and $10,000 for family coverage. These amounts will also increase based on COLA adjustments. Recent IRS guidance confirms that reasonable plan limitations and exclusions need not be counted toward the OOP limits. However co-payments (e.g., for preventive care or above the deductible) must be counted.

If the HDHP is a network plan, the plan's annual deductible and out-of-pocket maximums for out-of-network expenses are disregarded when determining whether the HDHP satisfies the statute's requirements.

In addition, an HDHP may not generally cover anything below the deductible except for permitted coverage, permitted insurance, and/or preventive care. Although HDHP coverage can be self funded or fully insured, insured plans may run into problems if state mandates require benefits below the statutory deductible. However, a special transition rule applies until January 1, 2006 for state mandates in effect on January 1, 2004. We describe permitted non-HDHP coverage in more detail below.

There are also special rules for family coverage. "Family" coverage is any coverage other than self-only coverage. Thus, categories such as "employee plus one", "employee plus spouse" and "employee plus family" all qualify as "family" coverage subject to a minimum annual deductible of at least $2000. The IRS has clarified that for individuals with family coverage, no amounts can be paid for any family member from the HDHP (other than for exempt permissible coverage identified below) until the *statutory minimum deductible* for family coverage has been satisfied. Thus, a high

deductible health plan is not an HDHP in 2004 if there is an individual (or "embedded") deductible lower than $2,000 (however, an embedded deductible is permissible so long as the deductible is equal to or above the statutory minimum deductible for family coverage). For example, a health plan that has a $2000 deductible for family coverage but provides for reimbursement of covered expenses of any single member of a family once that family member has incurred $1000 in expenses is not a qualifying HDHP because the plan will begin paying expenses for someone covered with family coverage before the statutory minimum deductible ($2000 as indexed) has been satisfied.

C. What other non-high deductible health coverage can an eligible individual have?

An individual generally cannot have other non-high deductible health plan coverage (other than the HDHP and HSA) unless that coverage is permitted coverage, permitted insurance, and/or preventive care.

"Permitted coverage" is any of the following types of coverage, whether provided through insurance or otherwise: accident, disability, dental care, vision care, or long-term care. Thus, for example, automobile medical coverage or a school or sports accident policy should be permissible even if some medical expenses are covered.

"Permitted insurance" is insurance coverage for which substantially all of the coverage relates to liabilities incurred under workers' compensation law; tort liabilities; liabilities relating to ownership or use of property (e.g., homeowner or auto insurance); insurance for a specified disease or illness (e.g., cancer insurance); and insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance). With the exception of certain state mandated benefits (e.g., workers' compensation coverage) permitted insurance cannot be self-funded.

"Preventive Care" is for HSA purposes: periodic health evaluations (and the tests and diagnostic procedures ordered in conjunction with such evaluations); well-baby and/or well-child care; immunizations for adults and children; tobacco cessation and obesity weight loss programs; screening devices (IRS provided a list of permissible screening devices in Notice 2004-23). Preventive care does *not*, however, generally include services or treatments intended to treat an existing condition. Recent IRS guidance confirms that drugs and ancillary treatments associated with a screening may, under certain circumstances, be preventive care. See our summary "Treasury Guidance Clears Much Confusion on HSA Issues" included with your presentation materials for more information.

Some noted exceptions to the "no other coverage requirement" are employee assistance plans (EAPs), disease management, and wellness programs. IRS has clarified that typical EAP, disease management, and wellness program benefits will not generally be considered impermissible non-high deductible coverage provided that they do not provide "significant" benefits in the nature of medical care or treatment. Also, until January 1, 2006, individuals covered by both a HDHP and a separate plan or rider *that provides prescription drug benefits* below the minimum annual deductible can be eligible for an HSA -- even though benefits (including prescription drug benefits) cannot generally be paid on a co-pay basis.

D. How does the "no other coverage" requirement impact Health FSA and HRA benefits?

Treasury specifically addressed the impact of Health FSAs and HRAs on HSA eligibility in Rev. Rul. 2004-45. Not surprisingly, Treasury held that an individual is not an HSA eligible individual if the individual is covered under a general purpose FSA or HRA – i.e., an HRA or FSA that covers most unreimbursed medical expenses. This includes the plan of the individual's employer as well as the individual's spouse's employer. Thus, an individual may inadvertently be disqualified because his or her spouse is covered under the spouse's employer's FSA. This may cause employers to consider offering an "employee only" option for FSAs and HRAs. Such an arrangement would be permissible under applicable statutory and regulatory authority; however, it may be administratively difficult under current systems to identify who has single coverage and who has family coverage.

An individual may, however, continue to qualify as an HSA eligible individual and maintain Health FSA/HRA coverage at the same time if one or more of the following applies:

1. Limited Purpose FSA or HRA. An individual is still an "eligible individual" if he or she is covered under a Health FSA and/or HRA to the extent the coverage is limited to one or more of the following:

- Preventive care (as defined in IRS Notice 2004-23);
- Permitted coverage expenses such as dental or vision expenses. (Code Section 125 prohibits a Health FSA from reimbursing dental or vision insurance premiums; however, HRAs may reimburse dental or vision insurance premiums. Code Section 106 prohibits Health FSAs and HRAs, to the extent the HRA is a "flexible spending arrangement" as defined in 106, from reimbursing long term care expenses); or
- For an HRA only, benefits for permitted insurance (e.g., insurance for a specified disease or illness, or that provides a fixed amount per day (or other period) for hospitalization) provided such coverage qualifies as deductible medical coverage under Section 213. IRS has concluded that "permitted insurance" benefits must be provided through an insurance contract and Section 125 rules prohibit an FSA from reimbursing insurance premiums. This rule seems to suggest that an HRA cannot reimburse the actual expenses (as opposed to the insurance premiums) covered under the permitted insurance exception (e.g., expenses for a specified disease or illness or an amount for each day of hospitalization).

The ruling also confirms that such benefits could be provided under the HDHP, without regard to the statutory deductible for HSAs. Unfortunately, over-the-counter ("OTC") drugs are not on this list of permitted coverage items (unless such drugs constitute preventive care and satisfy the Code Section 213(d) requirements)

2. ***High deductible FSAs and HRAs for general expenses are permitted.*** An individual covered under a general purpose FSA or HSA is still an eligible individual if

the FSA and HRA do not pay benefits until the statutory deductible for the HDHP is satisfied. Three special rules apply:

- ? It is not necessary that the FSA and/or HRA have the same deductible limits as the HDHP. However, where the FSA/HRA have different deductible limits than the HDHP, the HSA contribution is limited to the arrangement with the lowest deductible;
- ? While the deductible under the HDHP and HRA/FSA may be satisfied by separate expenses, no benefit can be paid until the at least the statutory minimum deductible is satisfied; and
- ? If substantially all of the coverage in a health plan that is intended to be an HDHP is provided through an FSA or HRA, the health plan is not an HDHP. Therefore, the high deductible FSA and/or HRA would have to be offered in conjunction with a traditional HDHP in order to maintain eligible individual status.

An interesting issue arises with respect to the minimum deductible for FSAs and HRAs. Generally, FSAs (and to a lesser extent HRAs) typically cover expenses incurred by all eligible dependents (i.e. you don't have to affirmatively enroll your spouse and/or children in order to receive reimbursement for their expenses under the FSA). In essence, an FSA provides "family" coverage for the individual who has any eligible dependents. Presumably, in that case, the Health FSA deductible must satisfy the statutory minimum deductible for family coverage ($2000 in 2004) for an individual with any dependents -- even if the individual has single coverage under the HDHP. As we note above, employers may begin offering single only FSAs so that individuals can avoid disqualifying their spouse from HSA eligibility.

3. ***Suspended HRAs.*** An individual can still be an HSA eligible individual and be covered under a general purpose HRA to the extent the HRA participant elects to suspend coverage under the HRA for expenses other than preventive care, permitted coverage, or permitted benefits. This rule is beneficial for those individuals that already have an HRA because it allows HRA participants to receive tax-free HRA contributions from the employer for current permissible expenses and/or future general medical expenses and it also provides a way for the HRA participant to avoid losing previously accrued HRA funds. To take advantage of this exception, an election must be made "prior to the beginning of the coverage period" to suspend the use of funds for general 213(d) medical purposes and limit reimbursement only to expenses constituting permitted coverage (dental or vision), permitted insurance (specified disease) and/or preventive care. Per informal comments by Treasury officials, the election may be made at any time so long as the election is prospective. Whether such an election can be made will also depend on the terms of the plan (i.e. plans will have to be amended to allow such a suspension).

4. ***Retiree HRAs.*** An HSA eligible individual can accrue HRA benefits for an HRA that limits coverage of general medical expenses to those incurred after retirement. Under this scenario, no expenses incurred prior to retirement can be reimbursed. While the definition of "retirement" is unclear, presumably any "retirement option" (including early retirement) under an employer's qualified plan would qualify. Treasury officials

commented that such an HRA could reimburse expenses for pre-Medicare retirees. Presumably former employees who terminate prior to retirement eligibility, but who have a vested balance, may qualify upon ultimate retirement (i.e. the individual does not necessarily have to retire from employment with the plan sponsor). Also, once the individual retires and the funds become eligible for general medical expenses, the individual will cease to be an HSA eligible individual.

II. HSA Trust and Contributions

A. HSA contributions must be held in a qualified trust (or custodial account) maintained by a qualified trustee.

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 account beneficiary, and the written governing instrument creating the trust meets the following requirements:

- ? The HSA contributions are in cash (except for rollover contributions, which are discussed in more detail below).
- ? The trustee of the trust is a bank, a life or health insurance company, or another person who demonstrates to the satisfaction of the Secretary of the Treasury that the manner in which such person will administer the trust will be consistent with the HSA requirements.
- ? No part of the trust is invested in life insurance contracts.
- ? The assets of the trust 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.

Except as noted above, the statute does not specify the terms that must be included in an HSA document. However, Treasury has issued a prototype HSA document that can serve as a "safe harbor" setting forth the necessary HSA provisions.

Once established, the HSA trust or custodial account belongs to the Account Beneficiary and the Account Beneficiary's interest in the account is non-forfeitable. For example, assume Acme contributes $1200 to Employee A's HSA on January 1, 2005. On February 1, 2005, Employee A terminates employment. Acme could not take back the funds deposited to former Employee A's HSA.

B. Limits on HSA Contributions

1. Source and Timing of HSA Contributions

HSA contributions may come from anybody, including but not limited to, the eligible individual's employer and/or the eligible individual, so long as they are made by or on behalf of an eligible individual and do not, in the aggregate, exceed the annual contribution limit. Eligible individuals may contribute with after-tax contributions or with pre-tax contributions under their employer's cafeteria plan (to the extent the employer's cafeteria plan permits it).

In addition, an HSA may accept "rollover contributions" from another HSA or Archer Medical Savings Account (MSA) (but they are generally not counted toward the annual contribution limit). No amounts may be rolled over from a Health FSA and/or HRA. Also, direct trustee to trustee rollovers (from one HSA to another) will be allowed.

Contributions for a particular year may be made at any time before the due date of the individual's tax return for that year (not including extensions). Consequently, contributions may be made monthly, semi-annually, once at any time during the year (as early as the beginning of the year and as late as April 15 of the following year) or on any other schedule. It is important to remember, though, that the HSA cannot reimburse an HSA account beneficiary for more than the HSA account balance.

Employer contributions are excluded from income and employment taxes while contributions by eligible individuals and other persons are deductible by the eligible individual above the line to the extent the contributions from all sources (other than rollover contributions) do not exceed the annual contribution limit. In addition, as stated above, the employee may contribute with pre-tax contributions.

2. Contribution Limits

The annual contribution limit (excluding rollover contributions arising from contributions made in a previous tax year) is the sum of all "monthly limits" for the year. The monthly limit for any month is $1/12^{th}$ of the following amounts:

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

The general contribution limit is increased for individuals who have attained age 55 by the end of the taxable year. This "additional contribution amount" is $500 for 2004, and increases by $100 each year, up to $1,000 for taxable years beginning in 2009 and thereafter.

Although it seems complicated at first glance, determining the amount that may be excluded from gross income is not that difficult. Consider the following example:

Employee A is covered under Employer A's qualifying HDHP with a $1200 deductible. Employee A also has an HSA. Employer makes a $1200 contribution on January 1, 2004. Employee terminates employment with Employer on June 15, 2004 and does not elect COBRA or any other qualifying HDHP coverage. On April 14, 2005, Employee A sits down to file her tax return. She wants to know how much of the HSA contributions made during 2004 are excludable from her 2004 income. You tell her to take the following steps:

Step One: Determine the number of months Employee A was an eligible individual. Employee A was an eligible individual from January 1, 2004 through June 30, 2004 (6 months). Although she was not covered under a HDHP after June 15, 2004, Employee A was an eligible individual on the first day of June so she is considered an eligible individual for the entire month of June.

Step Two: *Determine the monthly limit for 2004*. The monthly limit for 2004 is 1/12 of the lower of the annual deductible ($1200) or $2600. Thus, in this case, the monthly limit is $100 (1/12 of 1200).

Step Three: Multiply the number of months Employee A was an eligible individual by the monthly limit to get the maximum annual HSA contribution. Employee A was an eligible individual for 6 months. Multiply that by the monthly limit of $100 and you get a maximum annual contribution of $600. Employee A can exclude $600 of the $1200 HSA contribution from gross income for 2004.

3. Special Rules for Married Couples?

Although an employee and spouse cannot have combined HSAs, there is a special rule for determining the amount that each eligible individual who is married may contribute to his or her HSA if both spouses maintain an HSA. For married individuals, if either spouse has family coverage, then both spouses are treated as having that family coverage. If both spouses have family coverage, the lowest annual deductible is used for purposes of determining eligibility and the monthly limitation. Thus, for example, non-HDHP family coverage (such as an HMO or low-deductible plan) on the part of *either* spouse would make both individuals ineligible for an HSA. The applicable contribution limits are divided equally between the spouses, or as they otherwise agree. This rule is illustrated in the following examples:

Example #1: Employee A has single coverage under her employer's plan with a $500 deductible. Employee A's spouse has family coverage under his employer's plan with a deductible of $3000 coverage. In this example, the special married rule does not apply because Employee A cannot have an HSA since Employee A is covered under disqualifying non-high deductible health coverage. However, the spouse could open an HSA and make the full $3,000 contribution.

Example #2: Employee A has single coverage under her employer's plan with a $1000 deductible. Employee A's spouse has family coverage under his employer's plan with a deductible of $3000. Both Employee A and Employee A's spouse can have an HSA. Both are treated as having Employee A's spouse's family coverage for purposes of determining contribution limits. Unless they agree otherwise, Employee A may contribute up to $1500 to her HSA (which ironically is higher than she could otherwise contribute but for this rule) and Employee A's spouse may contribute up to $1500 to his HSA (which is less than he could otherwise contribute but for this rule).

Example #3: Employee A has family coverage under her employer's plan with a $3000 deductible. Employee A's spouse has family coverage under his employer's plan with a deductible of $2000. Both Employee A and Employee A's spouse have an HSA. Both are treated as having coverage under Employee A's spouse's plan because his has the lower deductible. Unless they agree otherwise, Employee may contribute $1000 to her HSA and Employee A's spouse may contribute $1000 to his HSA.

4. Excess Contributions

Excess contributions are subject to a 6% excise tax unless the excess contributions (and any net earnings attributable to the excess contributions) are returned to the individual before the last day of the period for filing the individual's tax return (including any extensions). If excess contributions are distributed after the tax-filing deadline, both regular income tax on employer contributions and earnings and the excise tax will apply. In the example, Employee A had an excess contribution of $600.

C. Employer Contributions

1. What are the tax advantages of an HSA for an employer?

Employers may make an excludable contribution to the HSA subject to the above limits and a non-discrimination requirement. Such contributions are exempt from FICA and FUTA taxation to the extent the employer had reason to believe that the contribution would be excludable from income when they were made. Treasury has confirmed that, except with regard to the employer's own coverage, that neither the employer nor the trustee is required to confirm eligibility status.

2. Are there any discrimination rules related to employer contributions?

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 all of its HSA contributions made during the calendar year unless it "makes available comparable contributions to the [HSAs] of all comparable participating employees for each month during such calendar year."

Generally, if an employer makes contributions to HSAs, it must contribute the same amount or the same percentage of the deductible to all employees who are eligible individuals, and who have the same coverage category (self-only or family). The employer may, however, restrict its contributions to those eligible individuals covered under the employer's HDHP provided that the employer makes no contributions to any employee not covered under the employer's HDHP. The test may be run separately for "part-time employees", which is statutorily defined as those who customarily work fewer than 30 hours per week. .

The HSA comparability rule does not apply when employer contributions (including matching contributions and bonuses for disease management and wellness programs) are "made through a Section 125 cafeteria plan". Much remains to be developed on when exactly a benefit is offered "through a cafeteria plan."

III. Distributions

A. Distributions from the HSA for medical expenses are generally tax-free.

Distributions from the HSA are excluded from income to the extent that they are for "qualified medical expenses" incurred after the establishment of the HSA. A "qualified medical expense" is generally an amount for medical care, as defined in Code § 213(d), for the account beneficiary, the account beneficiary's legal spouse (in accordance

with state law but consistent with the federal Defense of Marriage Act), or the account beneficiary's tax dependents (as defined by Code § 152) to the extent such amounts are not reimbursed by insurance or otherwise. Thus, as with employer-funded arrangements, generally OTC medicines qualify as an eligible medical expense.

With certain exceptions, qualified medical expenses do not include payments for health insurance premiums. Therefore, neither the account beneficiary nor his or her spouse or dependent can generally pay for HDHP coverage or other health coverage from the HSA. The following are permitted as a qualified medical expense notwithstanding the general proscription on insurance premiums:

- ? COBRA coverage;
- ? A qualified long-term care insurance contract (subject to the 213 maximum amount);
- ? Any health plan maintained while the individual is receiving unemployment compensation under federal or state law; or
- ? For those age 65 or over (i.e., those eligible for Medicare), any health insurance including Medicare premiums other than a Medicare supplemental policy.

Neither the HSA custodian/trustee nor a contributing employer is required to determine whether HSA distributions are used for qualified medical expenses or is permitted to require substantiation. Thus, unlike health FSAs, third party adjudication is not required for HSA distributions. HSA distributions are self adjudicated and reported as taxable or not by the HSA account beneficiary. Recent IRS guidance allows for the re-deposit of certain mistaken distributions. The guidance also confirms that distributions may be deferred until many years after a claim is incurred (i.e., a "shoebox" rule) as long as adequate records are maintained.

Furthermore, expenses must be incurred after the HSA is established in order to be a qualified medical expense. However, for 2004, transition relief allows an individual who is an "eligible individual" in 2004 to establish a 2004 HSA as late as April 15, 2005.

B. Taxable Distributions

Unlike other health arrangements (e.g., FSAs) amounts in an HSA can be withdrawn on a taxable basis even though no medical expense has been incurred. If a distribution is made from the HSA for other than a qualified medical expense, the distribution is included in the account beneficiary's taxable income and is generally subject to an additional 10% tax. The 10% additional tax does not apply to any distributions from the HSA that are made in the following instances (however regular income tax does still apply):

- ? Payments made following the HSA Account Beneficiary's death.
- ? Payments made after the HSA Account Beneficiary becomes eligible for Medicare. This gives Medicare Eligible Individuals the option to use accrued HSA funds for medical expenses on a tax-free basis or to receive the funds in cash without the additional 10% tax.

? Payments made after the Account Beneficiary becomes disabled as defined in Code § 72.

? The return of excess contributions to the extent returned prior to the individual's tax return due date in accordance with the statute's requirements

An exception to taxation for non-qualified medical expenses exists for "rollover" distributions. A rollover distribution is any amount distributed from an HSA to an account beneficiary that is deposited into an HSA for the benefit of that beneficiary within 60 days after the distribution is received. An account beneficiary may take advantage of this rollover exception only once every rolling twelve month period. While the statute does not address the issue, trustee to trustee transfers will be allowed without regard to the once every twelve month restriction.

C. Transfer of HSA Upon Death or Divorce

An account beneficiary's interest in an HSA can be transferred under a divorce or separation instrument to an HSA established for the spouse (or ex-spouse). In the event of such a transfer the distribution is not subject to taxation or the excise tax, and the spouse (or ex-spouse) becomes an Account Beneficiary in a newly created HSA.

Upon the death of an HSA account beneficiary any amounts remaining in the HSA transfer to the beneficiary of the HSA named in the HSA instrument. If the beneficiary is the Account Beneficiary's spouse, the spouse becomes the Account Beneficiary of the HSA and the transfer is not subject to taxation. If the interest is transferred to someone other than the beneficiary's spouse upon death, the account ceases to be an HSA and an amount equal to the fair market value of the account assets as of the date of the beneficiary's death is taxable income. Unless the transferee is the decedent's estate, the includable amount is reduced by any payments from the HSA made for the decedent's qualified medical expenses, if paid within one year after death. Whether the amount is subject to income or estate tax depends upon whether the interest is transferred to the beneficiary's estate.

IV. ERISA

In addition to the tax issues discussed above, HSAs may, under some circumstances be subject to ERISA requirements. ERISA coverage could bring with it potential baggage under HIPAA and COBRA as well.

Prior to April 2004, it was not clear whether HSAs would be subject to ERISA. ERISA application would create a substantial administrative burden for employers. Not only would Forms 5500 be required in all instances (irrespective of size) but also financial schedules would be required and an auditor's report would be required if 100 or more participants. Instead of a simple communication packet, employers would be required to prepare summary plan descriptions that comply with ERISA's comprehensive SPD content requirements. Fortunately, in April 2004, the Employee Benefits Security Administration (EBSA) issued guidance in the form of FAB 2004-1, which details when HSAs would be subject to ERISA.

Prior to FAB 2004-1, there was concern that employer contributions to the HSA would cause ERISA applicability. However, EBSA concluded that in the HSA context, employer contributions to an HSA do not automatically result in ERISA applicability. EBSA reasons that HSAs are personal savings accounts over which the account holder/employee has sole responsibility for using funds in accordance with the requirements of Code Section 223. In the words of the EBSA, the "employer may be doing little more than contributing funds to an account controlled solely by the employee".

The EBSA indicates that it would not find that employer contributions to an HSA give rise to ERISA applicability so long as the following conditions are satisfied:

1) *Establishment of the HSA must be completely voluntary*. FAB 2004-1 does not define "voluntary" for purposes of determining ERISA applicability to HSAs. Many plan sponsors may establish HSAs and contribute to them automatically for employees who elect the HDHP coverage. Presumably, under this type of plan design, participation in the HSA is still "voluntary".

2) *The employer does not limit the ability of the employee to move funds to another HSA beyond that permitted by the Code*. The EBSA also indicates that employers may, without violating this condition, limit the forwarding of contributions through its payroll system to a single HSA provider so long as the employees can still move the funds to another HSA provider. This facilitates a centralized contribution scheme and eliminates the possibility that the employer will be required to make contributions to multiple HSA vendors, depending on who the employees choose to ultimately use for their HSA deposits. Recent IRS guidance confirms that HSA trusts must allow for transfers out to other trustees. Thus, in some situations, the employer-funded HSA may be a temporary or transitional account where funds are placed until ultimately moved by the participant.

3) *The employer does not impose conditions on the utilization of HSA funds beyond that permitted by the Code.* Under the Code, HSA funds may be distributed to the HSA account holder for any reason -- non-medical distributions are subject to income tax and an excise tax. Recent IRS guidance confirms that distributions cannot be restricted to medical expenses.

4) *The employer does not make or influence investment decisions with respect to funds contributed to the HSA.* Presumably, limiting contributions through the payroll system to a single HSA provider that invests in a single deposit vehicle or limited set of funds would not (in and of itself) result in ERISA applicability. Remember, the employee is free to move funds to another HSA.

5) *The employer does not represent that the HSAs are established or maintained by the employer.* Plan sponsors should have legal counsel review communications to participants to ensure that HSA arrangements are not inadvertently "endorsed" by

employers as their own plan. In fact, plan communications should clearly reflect that HSAs are NOT part of the ERISA plan.

6) *The employer does not receive any payment or compensation in connection with the HSA.* Generally, under other DOL ERISA safe-harbors, employers may receive reasonable compensation for expenses incurred in connection with the payroll functions it performs. Read literally, the guidance would prevent a contributing employer from receiving any compensation, even for reasonable payroll administrative expenses.

The EBSA guidance is great news for employers – especially small and medium size employers that were on the fence with regard to HSA adoption because of potential regulatory costs due to ERISA reporting, disclosure, and fiduciary requirements that may have applied. Careful planning with benefits counsel is required to avoid these requirements.

V. How do HSAs Stack Up With HRAs and FSAs ?

With the introduction of HSAs, employers now have a wide variety of tax-advantaged arrangements from which to choose: traditional health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) and HSAs. Each has its own peculiar set of rules and restrictions – so different employers may select different arrangements.

FSAs enable employers (or employees through salary reduction) to set aside funds on a tax-favored basis in a notional bookkeeping account to pay for future medical expenses. However, unused FSA funds are forfeited each year if they remain unused. FSAs require claims adjudication and tax free reimbursement is allowed for all Code Section 213(d) expenses except for a) premiums and b) qualified long term care services.

An HRA allows employers to provide tax-advantaged funds for otherwise unreimbursed medical expenses and to carry-over unused funds from one year to the next. The HRA must be funded exclusively by the employer, and HRA funds generally are not portable (i.e., they are forfeited upon termination of employment). HRAs require claims adjudication and tax free reimbursement is allowed for all Code Section 213(d) expenses except qualified long term care services.

The HSA, as noted above, is a portable tax-favored account that can be funded by either the employer, the employee or any other person. However, only individuals with a qualifying HDHP (and no other coverage) are eligible. Many employers (and employees) will find the HDHP coverage requirement (e.g., no benefits below the mandatory HDHP deductible) to be too restrictive. HSAs are portable, and claims adjudication is neither required nor permitted for HSA fund distribution. Tax free reimbursement is allowed for Code Section 213(d) expenses except for certain premiums (as discussed above); however, distributions may be made for non-medical expenses, subject to income and excise tax on that distribution, without jeopardizing the tax free status of past and future medical distributions.

Ultimately, many employers will make a menu of coverage options available to their employees including traditional PPO, HMO, and HSA/HDHP options. Recent IRS

guidance confirms that offering such a menu will not adversely impact the eligibility of employees that select the HSA/HDHP.

The chart below compares some of the relative advantages and disadvantages of the various tax-favored benefit arrangements.

Plan Design or Compliance Issues	Health FSAs	HRAs	HSAs
Internal Revenue Code			
Pre-tax salary reduction funding	Permitted	Not permitted for HRA, but permitted for high deductible health plan (HDHP) offered in conjunction with HRA. HRAs are employer-funded.	Permitted for both HSA and HDHP. In addition, the HSA may be funded with deductible (after-tax) employee contributions.
Carryover of unused amounts	Not permitted	Permitted, but not required.	Permitted (an anti-forfeiture clause prohibits restrictions on account payout)
Medical expenses that are eligible for tax-free reimbursement	Otherwise unreimbursed Code § 213(d) medical expenses incurred during the coverage period. Cannot reimburse insurance premiums. Cannot reimburse qualified long-term care services.	Otherwise unreimbursed Code § 213(d) medical expenses incurred while coverage in effect, including premiums for eligible health insurance and long-term care insurance.	Otherwise unreimbursed Code § 213(d) medical expenses incurred while coverage in effect, but not expenses for insurance other than premiums for: COBRA, a qualified long-term care contract, or for a health plan while the individual is receiving unemployment compensation; or is age 65 or over (but not a Medicare supplement policy).
Cash-outs of unused amounts (if no medical expenses)	Not permitted.	Not permitted.]	Permitted but such amounts are taxable. Cash outs for non-medical expenses are also generally subject to a 10% excise tax..
Uniform coverage requirement – i.e., requirement that "annual amount" be available on first day of coverage	Applies—i.e., maximum amount of coverage must be available throughout coverage period (generally 12 months.)	Does not apply—i.e., coverage level may be prorated by plan design.	Does not apply. Generally, only funds actually in account are available.

Plan Design or Compliance Issues	Health FSAs	HRAs	HSAs
Portability	Cannot use unused amounts to pay for claims incurred after termination unless COBRA elected.	HRA can permit unused amounts to be used until depleted to pay for claims incurred after termination and COBRA rights will apply too.	Fund disbursement not tied to individual's employment. Unused amounts can be distributed on a tax-free basis for qualified medical expenses and subject to income and excise tax for non-qualified medical expenses regardless of the individual's status as an employee or "eligible individual."
Third party claims adjudication	Required.	Required.	Not permitted. Funds can be withdrawn for any purpose.
Limitations on having other health coverage (i.e., anti-coverage stacking rules)	None. Compatible with other health coverage of any type (e.g., other medical coverage, HRA, etc).	None. Compatible with other health coverage of any type (e.g., other medical coverage, FSA, etc).	Yes. In general, an individual is not eligible to have an HSA if she is covered as a participant, spouse, or dependent under any other non-high deductible health plan.

NOTE PAGES