



BENEFIT *Advisor*

In This Issue

In this ninth issue of the McGraw Wentworth Benefit Advisor for 2004, we discuss the latest guidance on Health Savings Accounts (HSAs) released by the Internal Revenue Service and the Treasury Department. The Medicare Act introduced HSAs with very limited detail about administrative process. This latest guidance provides very specific information regarding the operation and administration of HSAs.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

“IRS Issues More Health Savings Accounts Guidance”

In July, the Internal Revenue Service and the Treasury Department released additional guidance regarding Health Savings Accounts (HSAs). HSAs are tax-favored trust accounts that the Medicare Modernization and Improvement Act created. The Medicare Act spelled out the basic HSA requirements, but the administrative processes to implement them were unclear.

HSAs may be very attractive vehicles individuals can use to save for unreimbursed medical expenses and even retiree medical expenses. The IRS and Treasury Department have been busy in 2004 clarifying many administrative gray areas relating to account structure and management.

This latest effort is a comprehensive list of 88 administrative and procedural questions and answers about HSAs. These questions and answers are presented in 11 separate categories:

- Eligible Individuals
- High Deductible Health Plans (HDHPs)
- Preventive Care
- Contributions
- Distributions
- Comparability
- Rollovers

- Cafeteria Plans and HSAs
- Account Administration
- Trustees and Custodians
- Other Issues



This Benefit Advisor summarizes the key issues in each section. However, if your organization is considering HSAs, you can access the text from the latest guidance at <http://www.irs.gov/pub/irs-drop/n-04-50.pdf>.

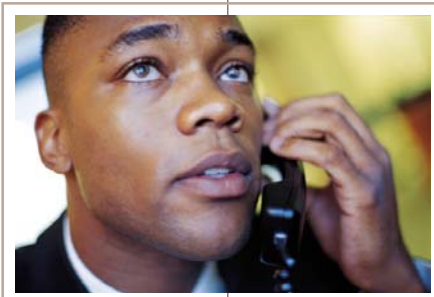
Eligible Individuals

This section clarifies HSA eligibility requirements. To be eligible an individual needs to be covered by an HDHP with no other coverage, unless the other coverage is permitted insurance. Individuals enrolled in Medicare cannot contribute to an HSA.

- An employee can choose an HDHP and contribute to an HSA even when the employer also offers other plan options, as long as the employee does not have other coverage. Remember a traditional FSA is considered other coverage. This point

is especially important for employers who may launch an HDHP with an HSA mid-year. Employees electing coverage under your medical FSA will not be able to contribute to an HSA while they are eligible to receive benefits under the full-scope medical FSA.

- The guidance clarified that only individuals enrolled in Medicare Part A, Part B or Medicare Advantage plans are ineligible for coverage. Individuals over age 65 that are still actively working and eligible for coverage under an employer sponsored HDHP may contribute to an HSA as long as they have not enrolled in Medicare.
- In general, permitted insurance (workers' compensation, dental, vision, critical illness, and so on) is generally fully-insured. However, if a benefit is self-funded, it is still considered permitted insurance. For example, workers' compensation can be self-funded and still be considered permitted insurance.
- Coverage under Employee Assistance Programs (EAPs), disease management plans or wellness programs may be considered other medical coverage and make an individual ineligible to contribute to an HSA. Eligibility depends on whether the program provides "significant" medical care benefits as defined in Section 223(c)(1). In determining whether a plan provides significant benefits,



disregard preventive care services. This section provides several examples, including:

- EAPs covering limited short-term counseling visits within the scope of the plan. These visits would not meet the definition of a health plan under Section 223 because benefits are not significant.
- Wellness plans offering various screenings the health plan does not cover will not typically be considered health plans.
- Disease management programs offering evidence-based information, disease specific support, case monitoring and care coordination would not be considered "significant" medical care.

High Deductible Health Plans

The initial regulations defining high deductible health plans (HDHPs), raised many questions. This section clarifies some key issues regarding the HDHP:

- Any coverage that includes more than one individual is considered family coverage. Some plans offer coverage for single, employee plus one and family. For the purposes of HSAs, single is considered "self only" coverage; any other category that covers more than one individual is considered family.

- The following internal plan limits are allowed within an HDHP:

- Reasonable lifetime benefit limits are permitted. For example, a plan with a \$1 million lifetime limit that meets all the other plan requirements can be considered an HDHP.
- Reasonable internal plan limits are permitted as long as significant benefits remain after the employee meets these limits. For example, a plan can have internal limits on mental health and counseling services, chiropractic services, infertility services, and so on, and still be considered an HDHP.

A \$10,000 limit for any single condition would not be considered reasonable because significant other benefits will not remain under the plan after the single condition limit is met. A plan with this type of limit would not meet the requirements of an HDHP.

- Restrictions for benefits based on reasonable and customary fee schedules are permitted.
- The plan must have an out-of-pocket maximum limit. The plan can cover expenses 100% after the deductible is met, even if the plan does not expressly define the deductible as the out-of-pocket maximum. If the plan pays 80% and has no out-of-pocket limit on the 20% the individual must pay,

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the plan will not be considered an HDHP.

- Out-of-pocket maximums include deductibles, copayments and other amounts paid for services received. Premiums paid for the HDHP, however, are not considered out-of-pocket expenses.
- Individuals will not be barred from contributing to an HSA if an employer establishes an HDHP mid-year but provides credit for any deductible met under the previous plan. This accumulation period for deductible expenses may not exceed 12 months.
- Fourth quarter deductible carry-over credits are permitted. Many plans contain a fourth quarter carry-over provision which allows any portion of the deductible met during the fourth quarter to be applied to the next year's deductible under the plan.

Your fourth quarter carry-over provision will affect whether your plan meets the definition of an HDHP. It also affects the maximum contribution that can be set aside in an HSA. The following example illustrates how these two provisions are affected. These examples assume an HDHP has a \$1,500 deductible:

Meeting the HDHP Deductible Requirement

1. Suppose your plan allows 15 months to accumulate the deductible. Multiply the 15 months by the \$1,000 minimum deductible = \$15,000. Divide \$15,000 by 12 = \$1,250. The minimum deductible for a plan that allows a

15 month accumulation is \$1,250.

2. Since the plan's \$1,500 deductible exceeds the \$1,250 adjusted minimum, this plan would still qualify as an HDHP.

Calculating the Maximum Contribution

1. An accumulation period longer than 12 months also affects the maximum contribution.
2. In this example, the maximum contribution is determined by taking \$1,500/15 months = \$100. Multiplying the \$100 x 12 = \$1,200, the maximum contribution.
3. The maximum contribution is calculated by dividing the deductible by the number of months used in the accumulation period and multiplying the result by 12. As long as this number falls below the contribution maximums, it is the maximum annual contribution amount.



tional clarifications regarding preventive care:

- Preventive services or screenings performed during treatment of related conditions will still meet the preventive care safe harbor. For example, the removal of polyps during a diagnostic colonoscopy is preventive care and services can be covered before satisfying the deductible. This is a unique situation and it will be interesting to see how plans provide this level of specificity as part of the claim paying process.

- Medications can fall under the preventive care safe harbor as well. Preventive care medications are medications prescribed for individuals who have developed risk factors for potential diseases or to prevent recurrences of a disease. These medications include statins to treat high cholesterol and ACE inhibitors to prevent heart disease or to aid recovery from heart attacks. They would also include medications used to treat obesity or to help stop smoking. For preventive medications to meet the safe harbor, they must not be intended to treat an existing illness, injury or condition.

Contributions

The contribution section clarifies who can contribute and how married couples should handle accounts:

Preventive Care

The only services that can be covered before satisfying the deductible are preventive care services. In March, the IRS released additional information regarding what type of services would be considered preventive care. This guidance includes the following addi-

- Anyone can contribute. Contributions are not limited to an individual or an employer. State governments can contribute on behalf of individuals covered under a high risk pool program providing the plan meets the HDHP requirements.
- This section provides a number of examples that outline how to determine maximum family contribution when an eligible individual has family coverage:
 - If an individual is covered under a family plan with an embedded deductible, the maximum contribution is the lesser of:
 - ♦ Maximum annual contribution which is \$5,150 for 2004.
 - ♦ The umbrella deductible.
 - ♦ The embedded deductible multiplied by the number of family members.

For example, if a plan has a \$10,000 family deductible, covering three individuals and no one individual needs to satisfy more than \$2,000 in deductible, the maximum contribution would be \$5,150 [the lesser of \$5,150; \$10,000; or \$6,000 (\$2,000 x3)].
- Part of the rule also allows spouses who are both covered under an HDHP to split the maximum HSA contribution between their two individually owned accounts. The maximum contribution is to be divided equally unless the couple agrees to a different arrangement.
- This section also clarifies excess contribution issues. An employee can withdraw excess

contributions before being assessed a 6% penalty, if the employee's contributions are high enough to result in excess contributions. Anyone who has not made excess contributions cannot treat an account withdrawal as a return of excess contributions.

Distributions

This section answers many questions regarding HSA account distributions:

- HSA distributions made for a qualified expense of an account beneficiary, an account beneficiary's spouse and dependents are excluded from income. It does not matter if the spouse and dependents are covered under the HDHP with the account beneficiary. To be considered qualified, an expense cannot be covered under any other health plan that covers the spouse or a child.
- If both an individual and a spouse have an HSA; eligible medical expenses can only be withdrawn from one account. The same expenses cannot be withdrawn from both HSAs (no double dipping is permitted).
- HSAs really don't have filing time limits. In order for a claim to be qualified, it must be incurred after the HSA is established. Transition relief published in March offers an exception to this requirement. In the transition relief, if you had difficulty securing an HSA vendor, then expenses incurred



in 2004 while covered under an HDHP may be claimed under an HSA as long as the HSA is established by April 15, 2005. If you choose to claim an expense that is several years old, it is your responsibility to maintain appropriate records verifying the funds were used for a qualified medical expense.

- If an account beneficiary receives a distribution intended for a qualified medical expense, but later discovers the expense does not qualify for tax-favored treatment, the individual can repay the account to avoid the 10% penalty and income tax applicability. This provision applies only if there is clear and convincing evidence that the mistake was reasonable.
- A retiree over age 65 can use the funds from an HSA to purchase employer-sponsored retiree medical coverage and fund any Medicare premium requirements. However, individuals totally disabled under social security cannot use the funds to purchase an individual Medicare supplement policy. This exception is due to the age requirement set forth in the rule as it applies to premium payments as an eligible medical expense.

Comparability

This section explains key administrative comparability issues related

to the contribution requirements in the initial legislation:

- Many employers were interested in offering their employees matching contributions for the HSAs, similar to a 401(k) type set up. The initial legislation discussed several comparability requirements that must be met for an employer to contribute to an HSA. A matching contribution plan would not meet the comparability requirements under this rule. However, the new guidance allows matching (or non-comparable) employer contributions if they are deducted under a cafeteria plan. The only requirement that needs to be met with this type of contribution strategy is making sure your plan meets Section 125 non-discrimination requirements.
- Under a cafeteria plan employers can require participation in disease management initiatives, wellness plans or a Health Risk Appraisal before they contribute to an HSA account.
- If an employer contributes a set amount annually for full-time employees, the employer does not need to be concerned about the comparability requirement for full-time employees hired mid-year. As long as the employer contributes monthly, the requirement can be met on a month by month basis.

Rollovers

This section provides a few more details regarding rollovers from these accounts:

- An account beneficiary may make one rollover contribu-

tion to an HSA during a one year period. The initial legislation defined which funds could be rolled into an HSA (funds in an Archer MSA or other HSA funds); HRAs and IRAs cannot be rolled over into an HSA.

- A rollover contribution must be paid to the HSA trustee within 60 days of the distribution.
- Transfers from one HSA trust to another HSA trust (referred to as “trust-to-trust” transfers) are permitted and not subject to the once a year plan limit.

Cafeteria Plans and HSAs

This section clarifies a number of issues regarding HSAs under cafeteria plans:

- Family status change requirements for cafeteria plans really don’t apply to HSAs because HSA eligibility is determined monthly. However, election changes must be made prospectively. Employers may want to add additional restrictions under the cafeteria plan to place some limits on the month to month flexibility of these arrangements. If restrictions are included, they must be applied uniformly to all participants who have contributions deducted under the cafeteria plan.
- If an employee incurs a large expense at the beginning of the plan year, the employer can contribute to the HSA in advance the amount the

employee expects to be funded under the cafeteria plan during that year. If an employee terminates in a situation where an employer has advanced funds, the employee can be required to repay the employer.

Account Administration

Additional administrative concerns addressed are:

- Spouses cannot establish joint HSAs. Individuals may have more than one HSA. Contributions can be made to multiple HSAs during the plan year. Cumulative contributions cannot exceed the contribution maximums permitted by law.
- Permissible HSA investments include investments approved for IRAs (bank accounts, annuities, certificates of deposit, stocks, mutual funds or bonds). HSAs may not invest in life insurance contracts or in collectibles. HSA custodians can limit investments to a certain type.
- HSA funds can be co-mingled only when they are in a common investment fund or a common trust fund.
- Account beneficiaries may not enter into “prohibited transactions” with an HSA custodian (an account beneficiary may not sell,



exchange or lease property, borrow or lend money, furnish goods, services or facilities, or pledge the HSA funds).

- Administration or account maintenance fees that the account beneficiary pays are treated as allowed disbursements not subject to tax or penalty. However, the maximum account balance cannot be increased to account for maintenance fees.

Trustees and Custodians

This section explains the requirements for managing HSA funds:

- Trustees may accept contributions only up to the maximum permitted by law. This maximum does not take into account any rollover funds that may have been deposited. It is the account beneficiary's overall responsibility to make sure contributions do not exceed the maximum according to their HDHP plan design.
- Trustees are responsible for tracking an account beneficiary's age.
- HSA trustees are not required to permit the return of mistaken distributions.
- Trustees or custodians cannot restrict distributions to pay or reimburse specific items on the plan. Therefore, employers cannot specify the benefits payable under an employer-sponsored HSA.
- Trustees may also limit the distribution frequency.

Other Issues

This section is a "catch all" for other issues regarding HSAs:

- For employer-sponsored HSAs, employers are required to determine only the following in regard to an employee's eligibility and contribution limits:
 - Whether the employee is covered under an HDHP or a low-deductible plan sponsored by the employer (including a full-scope FSA).
 - The employee's age to determine whether catch up contributions are permissible.
- Employers may not recoup any amounts paid to an employee's HSA when the employee terminates employment.
- HSA distributions are not subject to the non-discrimination requirements of Section 105(h).
- Many HDHP design requirements are indexed. A plan



sponsor has until the first plan anniversary following the announcement of an increase in an indexed provision to amend their plan to continue a qualified HDHP status.

Conclusion

This additional guidance covers a host of administrative issues that were not clear in the initial legislative and subsequent published guidance.

If your organization is seriously considering adding an HDHP with HSA opportunities, review this guidance carefully. Because these accounts are difficult to understand, any organization looking to offer these accounts must fully explain the requirements and restrictions to employees in a manner they can understand.

If you have any questions regarding HSAs or Consumer Driven Health Plans, please contact your Account Director. **MW**

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