McGraw Wentworth

SPECIAL Alert

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In This Issue

In this fifth issue of the McGraw Wentworth Special Alert for 2005, we discuss recent guidance issued by the IRS on Health Savings Accounts. Health Savings Accounts were introduced by the Medicare Modernization and Improvement Act of 2003. The Medicare Act conceptually introduced Health Savings Accounts. The IRS has been issuing clarifying guidance on a regular basis to deal with administrative issues.

The new IRS guidance addresses state mandated benefits and HSAs coordinating with FSA plans that have added a grace period.

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

"More Guidance Released on HSAs"

The IRS recently released two notices that addressed administrative issues for Health Savings Accounts (HSAs):

- Notice 2005-83 provides additional transitional time for plans to meet high deductible health plan requirements when state mandates require a certain benefit be covered at a certain level.
- Notice 2005-86 addresses the ability for an individual to contribute to an HSA if the individual is also covered by a comprehensive medical flexible spending account that has adopted the newly permitted grace period.

The government continues to release guidance to clarify administrative issues relating to HSAs. The guidance is welcomed by organizations that have launched HSAs or are considering a Consumer Driven Health Plans with HSAs in the future.

Background

The Medicare Modernization and Improvement Act introduced the concept of HSAs in late 2003. HSAs are tax-exempt trusts or custodial accounts established for the purpose of paying qualified medical expenses in conjunction with a high deductible health plan (HDHP).

A number of requirements must be met for an individual to be qualified to contribute to an HSA. One requirement is that the individual must be covered by a HDHP and have no other comprehensive health coverage. The government does provide certain exceptions to this requirement, including permitted insurance and exempted coverage. Permitted insurance includes workers compensation, dread disease, fixed day hospital coverage or any other liability coverage. Exempted coverage includes vision coverage, dental benefits, long term disability and long term care plans.

A plan must meet a number of requirements to be considered a qualifying HDHP, including:

- In 2005, the plan must have a deductible of at least $1,000 self-only coverage and $2,000 for family coverage. In 2006, the minimum deductible requirements increased to $1,050 self-only and $2,100 for family.

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- In 2005, the plan must have an out-of-pocket maximum of no more than $5,100 for self-only coverage and $10,200 for family coverage. In 2006, the out-of-pocket limits increase to no more than $5,250 for self-only coverage and $10,500 for family coverage.
- The plan can cover only preventive care services prior to the satisfaction of the plan's deductible.

These are the key provisions a plan must meet to be considered a qualified HDHP.

One of the notices the IRS recently released addressed high deductible health plan requirements that may conflict with a state-mandated benefit requirement. The other notice addressed how contributions to an HSA should be handled when an employer sponsors a comprehensive FSA and adds the newly allowed grace period.

Notice 2005-83

Let's start by reviewing the guidance addressing state-mandated benefits. To fully grasp the issue, it is important to understand how the requirement that all benefits be subject to the deductible (with the exception of preventive care), was received by the market. Most plans did not have plan designs that could meet this requirement. Most notably, many plans paid prescription drugs in full after a member copay. The IRS immediately dealt with this issue by providing a transitional period where individuals could contribute to an HSA as long as a plan met all the requirements of an HDHP with the exception of having prescription benefits subject to the deductible. This transitional relief expires on January 1, 2006.

State-mandated benefits were another challenge to offering an HDHP-compliant plan design. For the most part, state-mandated benefits apply **only** to fully insured plans operating in each state. Some mandates not only dictated the type of service to be covered, but also the benefit level that needs to be provided. In some cases, the state-mandated benefit requires the plan to pay for some benefits before an individual meets the deductible. If the state mandate addressed a preventive care benefit, this would not be an issue. However, if the mandate addressed a benefit that was not considered preventive care and required that the benefit be paid prior to satisfying the deductible, an individual would never be able to purchase a fully-insured HDHP-compliant plan. Therefore, the individual would never have the opportunity to contribute to the HSA if a fully-insured option was the only option available for coverage.

This was quite a significant issue for individuals in some states and a big question when HSAs were initially introduced. States hoped the government would make exceptions for state-mandated benefits when determining the status of a qualified HDHP. Unfortunately, that was not the case. The IRS indicated they expected the states to change any state-mandated benefit requirement that conflicted with the requirements of an HDHP. As with prescription drugs, the IRS did recognize that it would take some time for states to identify any benefit mandate that would be affected, and then additional time to amend the mandate requirement. Therefore, they offered a transitional period similar to the one offered on prescription drugs. If a plan met all the requirements of an HDHP with the exception of a state-mandated benefit requirement, the health plan would be considered qualified for 2004 and 2005. However, as of January 1, 2006, the plan must meet all the requirements for an HDHP in order for the individual to make contributions to an HSA.

This most recent guidance extends the transitional period for some plans. Most states have modified any state-mandated requirement that conflicted with the HDHP requirements. However, if the change was approved by the state, for example, on November 15, 2005, the change in benefits would be implemented the first day of the first plan year following the change date. If a plan year was a calendar year, the change would be effective January 1, 2006 and not an issue. However, if the plan year falls after January

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Notable Thoughts

It is easier to do a job right than to explain why you didn't.

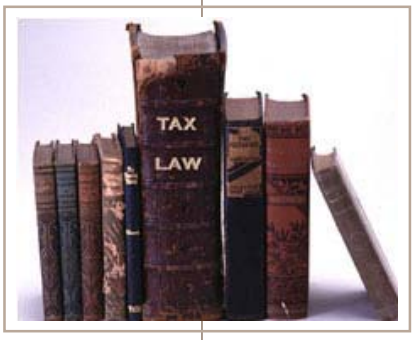
Martin Van Buren

1, there would be an opportunity for an individual to lose the ability to contribute to an HSA until the plan's renewal date.

The extension of the state mandate exception now applies to the first plan renewal following December 31, 2005. The transitional period expires as of December 31, 2006.

Notice 2005-86

This notice addressed the issue of medical flexible spending accounts and their impact on a participant's ability to contribute to an HSA. In 2004, the IRS issued guidance confirming that a traditional medical flexible spending account (FSA) would be considered other comprehensive group health coverage. If an individual was covered by a qualifying HDHP and also a comprehensive medical flexible spending account, the individual would be **ineligible** to contribute to an HSA as a result of FSA coverage. The guidance in 2004 offered alternatives to a comprehensive FSA that could be used in conjunction with an HDHP and an HSA. One option was creating a "limited scope" FSA that limited coverage to vision expenses, dental expenses, preventive services and expenses incurred once the high deductible was satisfied.



The IRS released guidance in May that allowed employers the option of adding a grace period to their spending account plan. The grace period would allow an extension of the plan year in which eligible expenses could be incurred. This new guidance discusses the impact of adding a grace period to your medical FSA and the ability for an individual to contribute to an HSA. This guidance surprised many as it is a bit more restrictive than expected. An individual who is covered by a comprehensive FSA with a grace period will generally not be able to contribute to an HSA (even when covered by a qualifying HDHP) until the expiration of the grace period. This applies even if the individual has exhausted all available benefits under the medical FSA by the end of the plan year. The ability to contribute to an HSA is determined on a month to month basis. All annual amounts are prorated by the number of months an individual is qualified to contribute. If an employer adds the two and a half month grace period to the FSA and also launches a HDHP with an HSA as of January 1, any FSA participant in the previous year would not be eligible to contribute to the HSA until the beginning of April. The individual could only contribute a maximum of 9/12ths of their actual contribution maximum for the first plan year.

This is definitely a drawback to launching HDHPs with HSAs. The government has offered an alternative to employers. Employers can amend their FSA plan design when they launch a CDHP with an HSA. The amendment would need to convert the comprehensive FSA to a limited scope FSA during the grace period. This will reduce the scope of services covered by the FSA during the grace period. Remember, limited scope plans would cover vision expenses, dental care, preventive service and services received after satisfying the plan deductible. The amendment must be made to the plan as a whole and for every participant in the plan; employers cannot limit the individuals to whom the amendment would apply.

The government has offered transitional relief to employers who may be in this situation for this year. For cafeteria plan years ending before June 5, 2006, an individual participating in a comprehensive medical FSA that provides coverage during the grace period, will be able to contribute to an HSA, if the following requirements are met:

- If not for coverage in a comprehensive FSA, the individual would be considered an eligible individual to contribute to an HSA during the grace period
- The individual's comprehensive FSA must have no benefit available at the end of the preceding cafeteria plan year or the employer can amend the plan to discontinue coverage during the grace period for any individual who elects coverage under a HDHP.

Conclusion

As the government continues to issue clarifying guidance on HSAs, the more complex HSA administration seems to become. These latest notices provide needed clarification on the role of state-mandated benefits and also medical FSAs with a grace period.

If you have any questions regarding this guidance, please feel free to contact your McGraw Wentworth Account Director. MW

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MCGRAW WENTWORTH TEAM

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MARKETING DEPARTMENT

McGraw Wentworth
3331 West Big Beaver Road, Suite 200
Troy, MI 48084
Telephone: 248-822-8000 Fax: 248-822-4131
www.mcgrawwentworth.com