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MEMORANDUM

August 13, 2004

TO: Clients

FROM: Groom Law Group

RE: IRS Issues Comprehensive HSA Guidance That Clarifies Many Issues and Sets Forth Several New Rules

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On July 23, the IRS released Notice 2004-50, which is the most comprehensive health savings account (HSA) guidance issued to date. The Notice resolves many issues in a manner that is generally favorable for employers, insurers, and trustees. However, the IRS position with respect to certain issues may result in increased cost and complexity of HSA administration. In Part I below, we provide a background of HSAs and previous guidance provided by the IRS and Department of Labor; in Part II, we summarize the major issues that the IRS resolved, both favorably and unfavorably, in this guidance; and in Part III, we offer some additional observations on the new rules.

I. Background

The "Medicare Prescription Drug, Improvement and Modernization Act of 2003" (Pub. L. No. 108-173, Dec. 8, 2003) created a new type of tax-favored savings vehicle for health expenses known as a Health Savings Account ("HSA"). The HSA legislation, contained in new section 223 of the Internal Revenue Code, became effective January 1, 2004. The HSA is a funded account, similar to an IRA, to which individuals under age 65 and/or employers may make annual contributions within specified limits. For 2004, the contribution limits are the lesser of (i) the annual deductible or (ii) $2,600 self-only or $5,150 family coverage. The earnings in the account grow on a tax-free basis, and, if used for medical expenses, may be withdrawn on a tax-free basis. When an individual becomes Medicare-eligible, or in the event of death or disability, amounts in the account may be used for any purpose without incurring a tax penalty (although these amounts must be included in income).

In order to participate in an HSA, an individual must be covered under a "high deductible health plan" ("HDHP") and may not participate in any other non-high deductible health plan, subject to certain exceptions. For 2004, an HDHP is defined as a plan with a minimum annual deductible of $1,000 for self-only or $2,000 for family coverage. The annual out-of pocket cap for the HDHP must not exceed $5,000 for self-only or $10,000 for family coverage.

The IRS and Treasury have already issued seven separate notices or rulings on HSAs, which clarify a number of key issues such as restrictions on the use of a health flexible spending arrangement and health reimbursement arrangement with an HSA.[1] The IRS has also issued model trust and custodial account agreements for use by trustees. In addition, the Department of Labor issued a Field Assistance Bulletin, which describes when an HSA will and will not be subject to ERISA. (F.A.B. 2004-01, (released April 7, 2004)).

II. Summary of Major Issues

A. Major Issues Resolved Favorably

Major issues that were resolved in Notice 2004-50 in a manner favorable to employers, insurers and trustees (i.e., a manner that does not generate additional cost or complexity, and provides maximum flexibility with respect to plan design) are as follows:

- An Employee Assistance Program (EAP), disease management, and wellness program are generally not health plans under Code section 223, and therefore, participation in these programs does not affect HSA eligibility; (See III. A., below)

[1] Notice 2004-2 (released Dec. 22, 2003) (answers basic questions about HSAs); Notice 2004-23 (released March 30, 2004) (provides safe harbor definition of "preventive care"); Notice 2004-25 (released March 30, 2004) (assists individuals who have not yet established HSAs in 2004); Rev. Rul. 2004-38 and Rev. Proc. 2004-22 (released March 30, 2004) (describe how prescription drug coverage may effect HSA eligibility); Rev. Rul. 2004-45 (released May 11, 2004) (describes how coverage under a FSA or an HRA may effect HSA eligibility); Notice 2004-43 (released June 21, 2004) (provides transition relief for individuals who live in states where high deductible health plans are not available).

- Trustees do not have an obligation to determine whether contributions to an HSA exceed the maximum annual contribution for a particular account beneficiary or to allow the return of mistaken distributions to the HSA, (but do have an obligation to make sure that contributions do not exceed the statutory maximum); (See III. B., below)

- Lifetime limits on benefits generally or on specific benefits under an HDHP are permissible;

- The preventive care exception under Code section 223 allows treatment of a condition that is "incidental" or "ancillary" to a preventive care service or screening, as long as it would be unreasonable or impracticable to perform another procedure to treat the condition; (See III. C., below)

- Drugs or medications that are taken by a person who has risk factors for a disease that has not yet manifested itself or not yet become clinically apparent, or to prevent the reoccurrence of a disease from which person has recovered, will now satisfy the definition of preventive care; (See III. C., below)

- "Any" individual (not just a participant, employer or family member) is able to make an HSA contribution on behalf of an eligible individual.

- Fiscal year health plans are able to make cost-of-living increases upon the renewal date of the plan; and

- Administrative fees may be paid from or outside the HSA without adverse tax consequences.

B. Major Issues Resolved in Manner that Will Result in Increased Cost and Complexity

- Employers are allowed to make matching contributions and incentive payments, but only through a Code section 125 cafeteria plan (where the nondiscrimination rules that apply to cafeteria plans will apply); (See III. D., below)

- Employers may not limit the use of the HSA to medical expenses; (See III. E., below)

- Employers may not recoup amounts contributed to an HSA from the HSA; (See III. E., below) and

- There is a new test for determining the contribution limit allowed when the HDHP has an embedded deductible. (See III. F., below)

III. Discussion

Below, we briefly discuss significant aspects of the above guidance, focusing on those issues where the IRS was more or less flexible than anticipated, departed from a previous position, or adopted a novel approach.

A. EAP, Disease Management and Wellness Programs

Notwithstanding the general rule under Code section 223 that a person may not participate as an eligible individual in an HSA if that person has coverage under a non-high deductible health plan, Notice 2004-50 ("the Notice") (Q&A-10) contains a broad exception allowing a person to participate in an HSA along with an Employee Assistance Program (EAP), disease management program or wellness program. The Notice provides that these programs are not health plans under Code section 223 as long as the programs do not "provide significant benefits in the nature of medical care or treatment." For purposes of making this determination, screening and other preventive care services (as described in Notice 2004-23) are disregarded. The general description of these programs in the Notice is quite broad, and does not contain a bright line test such as, with respect to an EAP, a limit on the number of counseling sessions that a person may receive. Accordingly, it appears that the majority of EAPs, disease management and wellness programs will likely qualify under this exception.

B. Trustee Responsibilities

The Notice is favorable from a trustee perspective, as it limits the obligations of trustees with respect to tracking and accepting HSA funds. Under the Notice (Q&A-74), a trustee is not required to determine whether contributions to an HSA exceed the maximum annual contribution for a particular account beneficiary. In addition, there is no obligation on the part of the trustee to allow for the return of mistaken distributions to the HSA (Q&A-76), and a trustee or custodian may place reasonable restrictions on both the frequency or minimum amount of account distributions (Q&A-80).

Finally, a trustee may, but is not required to, accept rollover contributions. These rules should minimize the administrative complexity associated with being a trustee.

The Notice does prohibit a trustee from accepting a deposit (other than a rollover contribution) that would exceed the maximum family coverage deductible set forth in Code section 223 (i.e., $5,150 for 2004) plus catch-up contribution applicable to a participant age 55 or over (i.e., $500 for 2004) (Q&A- 73). In addition, the Notice requires a trustee to track an account beneficiary's age, but provides that the trustee may rely on the account beneficiary's representation as to the date of his or her birth (Q&A-75). However, it should be relatively easy to comply with these requirements.

C. Preventive Care

Under Code section 223, an item or service that satisfies the criteria for "preventive care" may be covered under an HDHP even if a person has not yet satisfied the minimum deductible. In Notice 2004-23 the IRS set forth a safe harbor for preventive care, providing that preventive care generally does not include treatment for an existing illness or injury.

In the Notice, the IRS modifies this safe harbor in two ways. First, the Notice provides a new test, under which any treatment that is "incidental or ancillary" to a preventive care service or screening falls within the safe harbor for preventive care, if it would be "unreasonable or impracticable" to perform another procedure to treat the condition (e.g., polyp removal during colonoscopy) (Q&A-26). Second, with respect to prescription drugs, the Notice provides that "drugs or medications are preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself (i.e., asymptomatic) or not yet become clinically apparent, or to prevent recurrence of a disease from which a person has recovered." (Q&A-27). In addition, the Notice provides that drugs or medications used as part of procedures for preventive care services (e.g., weight loss and tobacco cessation programs) are also preventive care. (Q&A-27).

These positions expand the circumstances under which an item can be considered preventive care, and should therefore be viewed favorably by employers, insurers, and participants. However, it may be difficult under the IRS rule for an HDHP to determine whether a procedure or drug fits within these exceptions. For example, the same prescription drug may not always be

prescribed for the same reason, and the determination may therefore vary based on individual circumstances.

D. Matching Contributions, Incentive Payments & Cafeteria Plans

In general, the "comparable contribution" rule under Code section 4980G imposes a 35 percent excise tax upon employers who make contributions to employees' HSAs in varying amounts, with limited exceptions. Notice 2004-50 provides that, if an employer structures a contribution as an employer match, the comparable contribution rule generally will be violated. If, however, the employer matching contributions are structured to flow through a Code section 125 cafeteria plan, the comparable contribution rule does not apply. The same conclusion is reached with respect to employer contributions that are conditioned upon an employee's participation in a health assessment, disease management or wellness program (i.e., incentive payments).

The Notice (Q&A-47) specifically provides that all HSA contributions, including matching contributions, are subject to the Code section 125 nondiscrimination rules. Thus, by requiring employer matching contributions to flow through a cafeteria plan, the IRS is attempting to ensure that employers will not make HSA contributions disproportionately to highly compensated or key employees. Unfortunately, given the lack of guidance concerning the proper application of the Code section 125 nondiscrimination rules, this position increases the administrative burden of employers and has the potential to discourage employers from adopting a plan design that offers matching contributions or incentive payments.

E. Limitation On Use of HSA Account or Recoupment by Employer Prohibited

The Notice (Q&A-79) makes clear that a trust agreement may not contain a limitation on the use of the HSA account only for medical expenses. Accordingly, employers who had an interest in incorporating this feature into their HSA plan design to ensure that employer dollars are actually used for medical expenses do not have that option.

In addition, the Notice (Q&A-82) makes clear that employers may not recoup from an HSA amounts that the employer paid into the HSA when an employee terminates before the end of the year for which the contribution is

made. The Notice does not address how the employer should recoup the contribution (e.g., withholding amounts from an employee's last paycheck), but specifies that in certain circumstances, recoupment is required. For example, the Notice (Q&A-60) gives the employer flexibility to fund an HSA offered under a cafeteria plan on an employee's behalf, up to the amount that the employee elects to contribute to the HSA for the year, but specifies that the employee must repay the employer by the end of the plan year. This rule requires that the employer make such advancement available to all HSA participants, on the same terms.

F. Embedded Deductible

The Notice (Q&A-30) establishes a new rule to determine the HSA maximum contribution where the HDHP has both an individual and family deductible. This arrangement, which is referred to as an "embedded deductible," was approved in Notice 2004-2, provided that the individual deductible satisfies the minimum deductible for family coverage (i.e., $2,000 for 2004), but Notice 2004-2 did not address what contribution limit applied in this circumstance. Under the new rule, the HSA contribution amount is the least of three figures: (i) the statutory maximum contribution for family coverage (i.e., $5,150 for 2004), (ii) the actual family deductible under the HDHP, or (iii) the individual deductible multiplied by the number of family members covered under the HDHP.

Because the statute does not address an embedded deductible arrangement, it was necessary for the IRS to clarify the appropriate contribution level for this type of arrangement. However, it would have been simpler from an administrative perspective to simply base the contribution level on the lower of the statutory maximum for family coverage, or the actual family deductible. Instead, the rule now requires each HSA eligible individual to calculate his or her own maximum contribution. The burden of educating individuals regarding this calculation will likely fall on employers or insurers, resulting in increased administrative complexity. Further, if individuals miscalculate, withdrawals of excess contributions at year end will occur more frequently, resulting in an increased burden on trustees.

III. Conclusion

This summary does not address all of the issues that the IRS tackled in Notice 2004-50. There are many other technical clarifications, such as how to calculate out-of-pocket expenses in different scenarios, and how the cafeteria

plan rules impact HSAs. Overall, the guidance is very useful, and as noted above, is flexible in many places. Unfortunately, in those areas where the guidance does not offer the desired flexibility, there is a small likelihood that the rules will be modified in the near future. The IRS has stated that no further guidance will be issued for at least a year. At that time, it is possible that a formal regulation project will be opened, with proposed regulations, a public comment period, and eventually, final regulations.

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Groom Law Group has substantial experience designing and drafting defined contribution (DC) health plan arrangements for both active and retired employees, including in-depth knowledge of the new HSA rules. Our DC health plan team includes Tom Fitzgerald, Chris Keller, Lou Mazawey, Mike Thrasher and Brigen Winters. Please contact us if you have questions or comments in this area or we may otherwise be of assistance.