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MEMORANDUM TO CLIENTS

Re: HEALTH SAVINGS ACCOUNTS – FAVORABLE IRS AND DOL GUIDANCE

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 The earnings in the account grow on a tax-free basis, and, if used for medical expenses, may be withdrawn on a tax-free basis.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," and may not participate in any other non-high deductible health plan, subject to certain exceptions. For 2004, a high deductible health plan 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 high deductible health plan must not exceed $5,000 for self-only or $10,000 for family coverage.

In a strong Administration-backed effort to promote the use of HSAs by employers and individuals, the IRS and DOL have issued substantial helpful guidance within a relatively brief time frame. A summary of the IRS guidance, and the favorable DOL position that exempts most HSAs from ERISA regulation, follows.

I. IRS Guidance

The IRS and Treasury have already issued 5 separate notices or rulings on HSAs, including clarification of a number of key issues. These are summarized below. Guidance regarding the use of a health flexible spending arrangement and health reimbursement arrangement with an HSA, guidance on employer HSA matching contributions, and a model document for use by trustees, is expected in the near future.

A. Initial Guidance: Notice 2004-2

Notice 2004-2 (Dec. 22, 2003) provides basic clarification of statutory rules and addresses a handful of issues not covered by the statute. These issues include:

- Self-Substantiation: The notice clarifies that neither a trustee nor an employer is responsible for verifying whether an HSA is used for qualified medical expenses. Rather, an HSA participant is responsible for making this determination and maintaining appropriate records. (Q&A-29, 30)

- Not a "Welfare Benefit Fund": The notice clarifies that an HSA is not a welfare benefit fund within the meaning of section 419 of the Code. Accordingly, the rules under section 419(a) of the Code, which limit employer deductions, do not apply. (Q&A-36)

- Self-Insured: The notice clarifies that a high deductible health plan that accompanies an HSA may be self-insured. (Q&A-7)

- The notice clarifies that the HSA and the high deductible health plan provider need not be the same entity. (Q&A-10)

- Nonprescription Drugs: The notice clarifies that expenses for nonprescription drugs will be considered qualified medical expenses that are eligible for tax-free reimbursement from an individual's HSA. (Q&A-26)

- Use of Debit Cards: The notice clarifies that a debit card may be used with an HSA. (Q&A-37)

- Loss of Eligibility: The notice clarifies that if an individual who establishes an HSA ceases to be an eligible individual (e.g., because that individual ceases to maintain high deductible health plan coverage as required), the individual may continue to use the HSA, but may not make further contributions. (Q&A-28)

B. Preventive Care: Notice 2004-23

The HSA statute contains one exception to the general rule that all benefits provided under the high deductible health plan are subject to minimum deductibles of $1,000 (self-only) or $2,000 (family). This exception applies to any services that satisfy the definition of "preventive care." The HSA statute itself did not include a definition of preventive care. Accordingly, this guidance was necessary in order to determine which benefits may and may not be covered under the high deductible health plan before the deductible is satisfied.

Notice 2004-23 sets forth a safe harbor list of services that are included within the term "preventive care." This list includes periodic health evaluations with associated tests and diagnostic procedures, routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight-loss programs, and specifically identified screening services. Preventive care does not include any service or benefit intended to treat an existing illness, injury, or condition. In addition, the IRS does not recognize a separate exception for benefits that are required to be provided on a first dollar basis pursuant to state law. Instead, all benefits that are covered prior to satisfaction of the deductible must comply with the federal definition of preventive care.

The notice requests comments on whether any other preventive care services should be added to the list. In addition, the notice requests comments on the extent to which benefits provided by an employee assistance program, mental health program or wellness program may qualify as preventive care, including comments regarding the scope of treatments provided as benefits through counseling and health assessments. Finally, the notice requests comments on whether any drug treatments should be considered preventive care.

C. Prescription Drug Coverage: Rev. Rul. 2004-38/ Rev. Proc. 2004-22

Currently, many group health insurers offer prescription drug coverage as a separate rider to a high deductible health plan. The prescription drug benefits offered under these riders are typically not subject to a deductible. Accordingly, the issue of whether this type of prescription drug coverage would violate the HSA statutory prohibition against participation in a non-high deductible health plan has been of great concern to several companies and the subject of written comments to Treasury.

Rev. Rul. 2004-38 takes the position that any individual who has prescription drug coverage that is not subject to a minimum deductible of $1,000 self-only or $2,000 family coverage is disqualified from participating in an HSA. However, Rev. Proc. 2004-22 provides that, prior to January 1, 2006, non-high deductible prescription drug coverage may be provided through a rider or plan that is separate from a high deductible health plan without disqualifying a covered individual from contributing to an HSA. This exception only extends to prescription drug benefits under a separate plan or rider and not to prescription drug benefits that are provided as part of the same high deductible health plan.

D. Establishment of HSA: Notice 2004-25

An individual who is participating in a high deductible health plan in 2004 and wishes to participate in an HSA in 2004 has until April 15, 2005 to establish and contribute to an HSA. Once the HSA is established and funded, that individual may take tax-free distributions for all qualified medical expenses incurred after the later of:

- January 1, 2004; or
- the date the individual became covered under the high deductible health plan.

This rule applies for 2004 only, and is an exception to the general IRS rule described in Notice 2004-2, Q&A-26, that no tax-free distributions may be taken from an HSA for qualified medical expenses incurred before the date the HSA is established. The stated IRS rationale for this rule is that it has been difficult for individuals to locate trustees who will sponsor HSAs and it is therefore necessary to provide short-term relief.

II. Favorable DOL Guidance Exempts Most HSAs From ERISA Regulation

DOL guidance on the issue of when an HSA is considered an ERISA plan was issued last week in the form of a Field Assistance Bulletin. (A Field Assistance Bulletin is guidance that the Department of Labor issues to its enforcement staff to follow in conducting an audit.) The guidance provides that, although the high deductible health plan sponsored by an employer will be considered an ERISA plan, the HSA itself will generally not be considered an ERISA plan – even if the employer makes contributions to the HSA and selects only one HSA provider to which it forwards employer and employee contributions, as long as the employer does not:

1. require employees to establish an HSA (i.e., establishment must be completely voluntary);

2. limit the ability of participants to roll funds over to another HSA, if allowed by the Code;

3. impose conditions on the use of HSA funds (e.g., stating that HSA distributions may only be used for medical expenses);

4. make or influence the investment decisions with respect to funds contributed to an HSA;

5. represent that the HSAs are an employee welfare benefit plan established and maintained by the employer; and

6. receive any payment or compensation in connection with an HSA.

This guidance is a major departure from existing DOL safe harbor regulations that define when group insurance arrangements (or IRAs) will be exempt from ERISA. In order to be covered by those safe harbors, an employer may not make any contributions to those plans. In this guidance, DOL highlights differences between HSAs and group insurance arrangements, and concludes that even if an employer contributes to an HSA, the HSA is still not subject to ERISA as long as the factors described above are satisfied. Accordingly, if an employer follows this guidance, DOL will not bring an enforcement action against the employer for failure to file a Form 5500, provide an SPD, adopt a claims procedure, offer COBRA coverage, or comply with HIPAA portability rules with respect to the HSA. However, the HSA

will still be subject to the prohibited transaction rules under section 4975 of the Code. In addition, if an employer or insurer is sued in connection with an HSA, state law rather than ERISA will control, since ERISA preemption would not apply.

This DOL guidance is of special interest to employers who do not already offer health benefits to their employees, because employers may now make contributions to HSAs that employees establish without the added cost of ERISA compliance and liability. Employers that already maintain ERISA-covered health plans may also benefit, at least if the HSA is offered on a stand-alone basis.

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Groom Law Group has substantial experience designing and drafting defined contribution health plan arrangements, 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.