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# Employee Relations

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# HSAs—The New Consumer Health Plan: Is this the Real Thing?

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Tucked into the closing pages of the Medicare Prescription Drug Improvement and Modernization Act of 2003<sup>1</sup> that was signed into law in December 2003, is authorization for new consumer-driven health accounts, called “health savings accounts” or HSAs. These accounts have been described by their proponents as a revolutionary change that gives medical care consumers more incentive to control certain health care costs that are discretionary in nature. This would be accomplished by having individuals pay for discretionary medical costs from their own accounts, thus making the costs of healthcare more transparent.

### *A Bit of History*

The establishment of HSAs is a continuation of attempts by Congress to steer American employees away from employer-paid health “insurance” plans under which the employer pays all or part of the premiums and absorbs a significant portion of any cost increases. Such plans, it is believed, hide the cost of coverage and provide little or no incentive to the employee (the ultimate user of health care services) to control costs. It puts any cost-conscious employer that denies payment or subsidized access to certain medical benefits in the role of cheapskate, at best, and murder accomplice, at worst. In addition, employer-provided healthcare creates a dangerous link between employment and medical care coverage. Under that system, employees who lose their jobs may also lose medical care for themselves and their families.

However, tax-incentive programs that help employees to choose and finance their own health care premiums or costs individually have

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always faced resistance from numerous policymakers and regulation writers who see such consumer accounts as new tax shelters available only to those who can afford them. As a result, such plans are either so limited in scope that they are unattractive to employees or so full of regulatory safeguards that they are shunned by employers.

For example, flexible spending accounts (FSAs) that encourage saving for incidental medical costs contain numerous rules that limit their utility—including the forfeiture or so-called “use-it-or-lose-it” rule contained in IRS regulations that requires that all such accounts be “spent down” and used to pay medical costs by year-end. Any excess amounts are forfeited. FSAs are popular, but because of the low individual account values that are elected due to the forfeiture rule, they generally cannot support all of a year’s ordinary medical costs for an individual or family. Moreover, because FSAs cannot build up over time, they cannot fund the cost of more significant health care needs.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorized a limited number of “medical savings accounts” (MSAs), which could be established with or without employer involvement. MSAs can roll over from year to year. Contributions to MSAs are deductible and grow tax-free. MSA distributions are not taxed, but the accounts cannot be established unless the individual account holder has a high-deductible health plan (a deductible of \$1,500 for single coverage; \$4,000 for family coverage). As a “pilot program,” MSAs were limited in number by statute to 750,000 and were also limited to self-employed individuals or employees of small businesses (fewer than 50 employees). The cap on the number of MSAs that could be established and the administrative procedures involved clearly limited the attractiveness of MSAs to financial institutions that might otherwise have offered them.

Policymakers have cited anecdotal evidence to suggest that MSAs were established largely by wealthier individuals because the high deductible could be borne more easily by the higher-paid and the ability of the MSA to grow tax-free was more valuable to those at higher income brackets. Interestingly, however, Internal Revenue Service Announcement 2002-90 reported that by 2002, there were about 98,500 taxpayers who reported MSA contributions in 2001 and early 2002 and over 60,000 of them were previously uninsured, which would unlikely be true in the case of a wealthy individual. One fact about MSAs was certain, however; they were *not* widely used.

Benefits professionals recently tried another approach to encourage more employee involvement in health care financing. They introduced health retirement accounts or HRAs, which provided for *employer* con-

tributions (not made through salary deferral) that could be carried over from year-to-year.<sup>2</sup> Quite often employers try to combine these with high-deductible plans. Despite technical concerns raised by certain government officials about the operations of these programs, the IRS did provide useful guidance that blessed some of the basic structures of HRAs. These plans, like MSAs, have yet to experience widespread growth.

Congress is trying again with HSAs; and in the process, has tried to eliminate some of the restrictions that restrained the growth of other consumer-driven health products. However, health policy and revenue cost concerns have continued to impose certain limits on HSAs similar to those on MSAs. Whether employers' desire to control costs can overcome the burdens of these limits and the natural reluctance to change the traditional operation of health plans remains to be seen.

### ***HSA Basics***

An HSA is a trust or custodial account established by an individual, with or without employer involvement, that is used to pay for "qualified" medical expenses for the individual and his or her dependents. As discussed further below, qualified medical expenses are medical expenses as defined in Section 213(d) of the Internal Revenue Code (Code), but they do not include premiums other than premiums for continued healthcare (COBRA), Medicare or long-term care, or premiums paid while an individual is unemployed. Very generally, an HSA account holder (an "eligible individual") must be someone who:

1. Is covered by a high-deductible health plan (HDHP);
2. Is not covered by another health plan; and
3. Is not a dependent of another taxpayer or eligible for Medicare benefits.

Contributions do not have to be made by the account holder; for example, they can be made by a family member for an eligible individual, but are only deductible by the eligible individual. Moreover, an individual does not have to have earnings to make contributions.

Like MSAs, HRAs, and FSAs, HSAs do not provide access to medical care; they only provide the funding for it. Banks, insurance companies, brokerage firms, and other financial institutions are qualified to establish HSAs for customers. Then, theoretically, the individuals shop for an appro-

appropriate high-deductible health plan (or their employer provides one).

It is important to note that although only "eligible individuals" can contribute to HSAs (or have contributions made on their behalf), if such persons cease to be eligible (for example, if they change jobs or become covered under a traditional health plan), they can still maintain the HSA and take distributions from the account for medical care.

### ***Tax Advantages of HSAs***

HSAs have significant tax advantages. Contributions up to stated limits that are made by or on behalf of an eligible individual are deductible (or, if made by the employer, excludable from income). These contributions are deductible by the individual account holder regardless of whether he or she itemizes; contributions made for another person are subject to gift tax if they exceed normal gift tax limits. The earnings of the account grow tax-free and can be invested at the account holder's direction. Distributions from the HSA are tax free if they are used for medical expenses as defined in Section 213(d) of the Code (but not for premiums, except for Medicare, COBRA, long-term care premiums, or premiums paid when the account holder is unemployed). Any other distributions are taxable and subject to a 10 percent additional tax; but if the account's funds are never used to pay for the costs of health care, they can be withdrawn without the 10 percent tax upon the account holder's death, disability or attainment of Medicare eligibility. Unlike flexible spending accounts, unused contributions in HSAs can be "rolled over" to another year and held until they are needed. HSA accounts can also be transferred to a spouse (or to a former spouse under a divorce agreement) tax-free.

### ***Specific Requirements of HSAs***

Contributions can be made to HSAs only if the account holder has a "high-deductible health plan" (HDHP). An HDHP is an insured plan or a self-insured medical reimbursement plan sponsored by an employer or other entity with (for 2004) a minimum annual deductible of at least \$1,000 for single coverage and \$2,000 for family coverage, and a maximum out-of-pocket limit of no more than \$5,000 for single coverage and \$10,000 for family coverage. However, if the HDHP offers a preferred provider network, the out-of-pocket expense limit can be exceeded for non-network services. Under current IRS guidance, a health plan will not satisfy the \$2,000 family deductible requirement if it pays benefits to any family member before the entire family incurs \$2,000 in claims.<sup>3</sup> Thus, for example, if plan has a per person deductible of \$1,000 and an

overall deductible of \$2,000 (a fairly common arrangement), it cannot pay benefits even if one person has expenses over \$1,000, until the aggregate \$2,000 limit is reached.

The health plan deductible limits must apply to all medical expenses covered under the plan. That is, the deductible must be met before *any* other expenses are reimbursed. Although the initial IRS guidance was silent on this issue, under an interpretation of the HSA rules as currently written, an account holder that has an otherwise HDHP but who also receives prescription drug benefits at a flat fee or subject to separate co-pay requirements (and thus actually receives in part the prescription drug cost) would likely not be eligible to establish an HSA. This is because under that arrangement, some amount would be payable before the deductible is met. The policy rationale for HSAs is that the deductible should be paid from the health savings account, so the individual participant can see the flow of "his" cash being used to pay expenses. As a practical matter, however, it may be hard to "sell" HSAs to the public if this remains the government's interpretation of the rule for prescription drug plans. Recognizing the need for quick guidance on this subject, the IRS recently issued Revenue Ruling 2004-38, which states that a person covered by a prescription drug coverage plan that provides benefits before the deductible is met is not eligible to contribute to an HSA, but the Service postpones enforcement of this rule until 2006 in Revenue Procedure 2004-22.

Another requirement is that the account holder cannot be covered under any plan other than the HDHP. Despite this restriction, however, individuals may have "permitted insurance" even if that insurance has no deductible or a very low deductible. "Permitted insurance" is insurance under which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (like car or home insurance), insurance for a specified disease or illness, and insurance for a fixed amount per day (or other period) of hospitalization. The eligible HSA holder may also have coverage for vision, dental, accident insurance, disability, and long-term care.<sup>4</sup> Read literally, entities could design "hospitalization" or another type of permitted insurance to avoid some of the requirements of HSAs, but as a practical matter that is unlikely to occur. Moreover, the IRS guidance states that a plan designed to provide substantially all of the insured's coverage through permitted insurance (*e.g.*, an accident plan designed primarily to provide medical insurance as opposed to one that has medical coverage as a part of a broader accident insurance plan) will *not* be treated as a high-deductible health plan..

In addition, an eligible individual contributing to an HSA can have “preventive care coverage.” Preventive care is defined in Section 1861(ww) of the Social Security Act, which appears to be the cross-reference Congress intended by its apparently erroneous cross-reference to Section 1871 in the statute as passed. Preventive services under Section 1861 include an initial physical examination, mammography services, vaccines against pneumonia, flu and hepatitis B, and pap smear and prostate and colon cancer, diabetes and glaucoma, and cardiovascular disease screening. The law allows the IRS to modify the definition of preventive services, and the IRS has done so in Notice 2004-3, in which it sets forth a “safe harbor” definition of preventive services that include periodic health evaluations, obesity weight loss and smoking cessation programs, immunizations, prenatal care, and certain listed screening services.

### ***Contribution Limits for HSAs***

Contributions to an HSA by or on behalf of an eligible individual can only be made with respect to a month in which the account holder is an eligible individual. The permitted amount for any month is 1/12 of the lesser of the HDHP’s annual deductible or a specified annual dollar amount, increased for COLA adjustments each year. For 2004, the specified dollar amounts are \$2,600 for single coverage and \$5,150 for family coverage.<sup>5</sup> Catch-up contributions are permitted for account holders 55 and older, but younger than 65; these amounts begin at \$500 in 2004 and increase to \$1,000 in 2009. These dollar limits are reduced by any amount contributed to the HSA by the individual’s employer or by any amount contributed to an individual’s MSA.<sup>6</sup> No contributions may be made for any month during a year in which an individual is claimed as a dependent on another person’s tax return, or beginning with the first month an individual is eligible for Medicare.<sup>7</sup>

Special rules apply to married couples. If either spouse has family coverage under an HDHP, both spouses are treated as having only family coverage. If spouses are covered under separate HDHPs with different deductibles, both spouses are treated as having family coverage with the lowest deductible. Thus, using these rules, the applicable minimum contribution family deductible limit—for 2004, the lesser of \$5,150 and the lowest HDHP deductible—is divided equally between the spouses unless they agree on a different division. Excess contributions exceeding these maximum limits are subject to a 6 percent excise tax unless distributed before the due date (with extensions) of the individual’s tax return.

### ***Employer Contribution Rules***

The discussion thus far has focused on the individual contribution rules and limits. If an employer wishes to accommodate the use of HSAs, additional rules apply. If an employer makes a contribution to an HSA, it must make “comparable contributions” for all “comparable participating employees” during the same period.<sup>8</sup> Contributions are comparable if they are either the same dollar amount or the same percentage of the annual deductible under the HDHP covering the employees. Contributions only must be made for employees that choose to participate in an HDHP; if an employer offers an HDHP along with other options, no contributions need to be made for the employees choosing other options. The “comparable contributions” rule is applied separately to full and part-time employees (defined as employees working less than 30 hours per week). Thus it appears that an employer need not provide any benefits to part-time employees who work fewer than 30 hours a week, if it chooses. Employers who do not meet the comparability rule will be subject to an excise tax of 35 percent of the aggregate contribution for the period of failure. The comparability rule does not apply to contributions made through a cafeteria plan or rolled over from an employee’s HSA or MSA. No income or FICA tax is imposed on employer contributions.

Contributions to HSAs can also be made through an employee’s section 125 cafeteria plan, and such contributions will be excluded from the employee’s income and wages. However, note that if an employee generally has a flexible spending account (FSA), which is a type of cafeteria plan arrangement that reimburses medical costs, and an HSA, the Service will take the position that in order for the employee to meet the requirements of an HDHP, FSA reimbursements can be made, if at all, only *after* the HDHP deductible has been met with employee payments outside the FSA. Such bookkeeping may be too onerous for employers and employees. An alternative would be to provide “dental” or “vision only” FSAs since dental and vision care can be offered with an HDHP.

Once an employer becomes involved with an HSA, the plan becomes potentially subject to the employee protection rules of ERISA and certain additional considerations apply. ERISA contains reporting and disclosure requirements, as well as rules requiring that plan assets be held in trust. If the HSA “plan” were subject to ERISA, for example, it would have to be reported as a health plan (or as part of an employer’s health plan) on Form 5500, summaries of the plan would have to be provided, a claims procedure would be needed (even though, as discussed below, the IRS has said that substantiation requirements are the responsibility of the account holder) and most importantly, the employer

might have fiduciary responsibility for monitoring the investment performance of the HSA accounts. ERISA bonding requirements would also apply.

ERISA applies to benefit plans “established or maintained” by an employer. Obviously, if an employee establishes an HSA and obtains high-deductible health plan coverage on his own, ERISA would not apply. If the employer establishes an HDHP that can be used with an HSA, ERISA would clearly apply to the HDHP, but logically it should not apply to the HSA unless the employer is somehow involved with the establishment or maintenance of the HSA. It could be argued that if in conjunction with the HDHP, the employer solicits bids for and offers a variety of investment vehicles for the HSAs, the employer is establishing or maintaining a “plan” for HSAs. One could argue to the contrary that under Labor Department regulations merely offering (and not endorsing) investment vehicles to employees who have a choice, and collecting any premiums through payroll deduction, would not constitute “maintaining a plan,” but an employer might want additional assurance from the Labor Department before proceeding forward on that basis.<sup>9</sup> The Labor Department has issued Field Assistance Bulletin 2004-1 stating that as long as employer involvement is otherwise limited, even HSA with employer contributions will not be subject to Title I of ERISA. Note that the statute clearly provides that the continued health coverage (COBRA) rules set forth in the Internal Revenue Code do not apply to HSAs;<sup>10</sup> COBRA still would apply, however, to any underlying FSAs or basic health plans that are used in conjunction with HSAs.

### ***Reporting and Substantiation***

Current IRS guidance states that employers must report HSA contributions on an employee’s W-2. Information reporting required of HSA trustees or sponsors will be similar to the reporting for MSAs.<sup>11</sup>

Unlike the rules governing FSAs, employers and trustees are not required to substantiate that distributions from HSAs are used for medical expenses. The IRS guidance states that *employees* must keep records to prove that expenses were incurred in accordance with HSA requirements if audited.<sup>12</sup> Current IRS guidance allows the use of debit/credit, or stored value cards for cafeteria plans, but also requires that the cafeteria plan substantiate that the expenses were for medical costs by a procedure for post-usage review of employee claims.<sup>13</sup> However, the IRS guidance on HRAs appears to provide that substantiation is not required for HSA holders that use these types of cards. This might make it easier for financial institutions to administer HSAs.

### ***Comparison of HSAs and Other Consumer Driven Health Plans***

As discussed earlier, it appears to be Congress' intent that the HSA structure avoid some of the more unruly requirements that applied to earlier consumer-driven health initiatives. First, HSAs do not require an employer's involvement—any eligible individual can establish one, as long as it is done in conjunction with an HDHP. The HDHP does not have to be obtained by an employer either. HSAs are also portable; an individual can establish an HSA and make contributions when permissible, and he or she can use the account to reimburse medical expenses throughout his or her life, even if he or she is no longer eligible to participate in an HSA (*e.g.*, because he or she is covered under another plan). Presumably, this portability is intended to encourage maximum efficiency and care with respect to such accounts, and avoid the tendency of individuals in an employer-driven health care system either to spend down medical accounts due to the "use it or lose it" requirement, or (as is often reported anecdotally with respect to employer accounts) to spend significant dollars on discretionary medical care just before retirement or loss of employer-subsidized medical benefits.

### ***Will HRAs Fly?***

Despite the significant tax advantages of HSAs, the key to whether HSAs can be widely used is: (a) whether financial institutions and insurance companies will design plans that work with HSAs; and (b) whether employers will adapt their current plans to accommodate HSAs. There still remain a number of unanswered questions that the IRS must address before the reaction from employers, insurers, and financial institutions can be measured. The Service issued Notice 2004-2 as quickly as possible in early 2004 and promises more guidance.

The most significant questions appear to deal with the proper design of an HDHP. These questions are significant because until third parties can establish health plans for use by employers and individuals, HSAs will not be widely used.

A major issue that is critical to determining how HSAs will work is the treatment of prescription drug coverage. As discussed above, currently the HSA rules do not anticipate that there will be an exclusion for prescription drugs from the requirement that the HDHP deductible be paid first, so participants will be unable to have a prescription drug plan with an HSA, unless it is very clear that prescription drug costs cannot be covered until the HDHP deductible is met. This would sig-

nificantly decrease the popularity of HSAs, because given the advances in science and the continued use of drugs to treat illnesses that were once treatable only by surgery, prescription drug use has become an increasingly large part of health care for people with chronic diseases.

The standard for defining “preventive care” still needs clarification. Some have suggested that preventive care be defined as anything that is preventive “within the standards of the industry.” This may be too broad a standard for the IRS to permit. Alternatively, the IRS could use the definition in section 1861 of the Social Security Act and either reduce or add to the provisions contained therein.

Finally, there are numerous transition rules to be addressed. Rollovers from HRA or FSA accounts (which are employer contributions) to HSAs are not permitted; it appears that employees would have to satisfy any HSA deductible under the “deductible first” rule for HSAs before using any excess HRA or FSA funds. This may cause difficulties for employers who recently introduced HRAs and now want to have HSAs, since HRA accounts will not be able to be used to pay the HSA deductible.

### **Summary**

HSAs present a new approach in the never-ending attempt to rationalize America’s employer-driven health care system. These accounts do seem useful for a more portable and more independent workforce of the future. But whether they will result in much change in the short run is uncertain. Regulatory guidance and flexibility may help somewhat, but the larger task involves convincing American workers that there is no “free lunch” when it comes to health care.

### **Notes**

1. P.L. 108-173.
2. See A. Moran, Hooray for HRAs: IRS Discusses Prototype Defined Contribution Health Plan, in 28 *Employee Relations Law Journal* 117 (Winter 2002).
3. See IRS Notice 2004-2, 2004-2 I.R.B. 269, at Q&A-3, Example 1.
4. See IRS Notice 2004-2 at Q&A-6.
5. This dollar amount appears to be adjusted for inflation, although the statute does not clearly authorize an inflation adjustment. See IRS Notice 2004-2 at Q&A-12.
6. Code § 223(b)(4).
7. Code § 223(b)(6) and (b)(7).
8. IRS Notice 2004-2 at Q&A-32.

9. *See* 29 C.F.R. § 2510.3-1(j).

10. Although the Internal Revenue Code was amended to make it clear that COBRA does not apply to HSAs, a technical correction to the Public Health Service Act and to ERISA may be needed to reflect this intent since those statutes impose COBRA requirements as well.

11. *See* IRS Notice 2004-2 at Q&A-34.

12. *See* IRS Notice 2002-4 at Q&A 29 and 30.

13. *See* IRS Rev. Ruling 2003-43, 2003-21 I.R.B. 814.