

HSA, HRA, & FSA

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The Future



Standard Deduction

<u>Filing Status</u>	<u>Standard Deduction</u>
Married Individuals Filing Joint Returns and Surviving Spouses (§ 1(a))	\$11,400
Heads of Households (§ 1(b))	\$8,350
Unmarried Individuals (other than Surviving Spouses and Heads of Households) (§ 1(c))	\$5,700
Married Individuals Filing Separate Returns (§ 1(d))	\$5,700

Rev. Proc. 2008-66

Medical Insurance

(a) General rule

Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

§ 106(a)

COBRA Changes

Late Breaking Development

Employer Continues Coverage

Example. An individual is involuntarily terminated from employment on November 15, 2009. Health coverage in connection with the November 15, 2009, termination of employment would normally end on November 30, 2009. However, the individual is provided with severance benefits that include six months of health coverage for which no premium is required, running from December 1, 2009, through May 31, 2010. The employer considers no loss of coverage to have occurred until the six months of severance benefits have been exhausted. Under these facts, for purposes of Federal COBRA, the loss of coverage does not occur until May 31, 2010, which is after December 31, 2009. Although the individual's involuntary termination occurs during the required time period, the beginning of eligibility for COBRA continuation coverage does not. Consequently, the individual cannot become an assistance eligible individual. However, if the employer considered the payment of health coverage during the severance benefits period to be the provision of COBRA continuation coverage on behalf of the involuntarily terminated individual, for purposes of Federal COBRA the loss of coverage would be considered to have occurred on November 30, 2009, and thus the individual could become an assistance eligible individual.

Question 14

Divorce Then Let Go

Example 1. An employee is divorced after September 1, 2008, and before December 31, 2009. The divorce results in a loss of health coverage for the spouse of the employee. The spouse is eligible for and timely elects COBRA continuation coverage. After the divorce, and before December 31, 2009, the employee is involuntarily terminated and loses health coverage. The employee elects COBRA continuation coverage that begins before December 31, 2009. The spouse is not an assistance eligible individual because the qualifying event with respect to the spouse's COBRA continuation coverage is not an involuntary termination. The employee is an assistance eligible individual.

Question 15

Reduce Hours Then Let Go

Example 2. An employee experiences a reduction in hours in March 2009 that does not constitute (and is not in anticipation of) an involuntary termination. The reduction in hours results in a loss of coverage for the employee. The employee is eligible for and timely elects COBRA continuation coverage that begins as of April 1, 2009. In November 2009, the employee is involuntarily terminated from employment. The employee cannot become an assistance eligible individual in connection with the November 2009 involuntary termination because the qualifying event with respect to the COBRA continuation coverage is not involuntary termination.

Question 15

Calculate Credit

Example 1. The employer requires individuals electing COBRA continuation coverage to pay \$500 per month. An assistance eligible individual is entitled to COBRA continuation coverage upon the timely payment of \$175 (35 percent of \$500). The employer's resulting payroll tax credit is \$325 (65 percent of \$500).

Question 20

Calculate Credit

Example 2. The employer requires active employees to pay \$200 per month for health coverage. For involuntarily terminated employees, the severance benefits include continued health coverage at the cost of \$200 per month for six months after termination. After the six-month severance period, the terminated employee must pay \$1,000 per month for the remainder of the COBRA continuation coverage. The employer considers the loss of coverage to occur on the last day coverage is in effect before the severance benefits begin to take effect; that is, the employer considers the six-month severance period to be part of the terminated employee's COBRA continuation coverage period, during which the employer pays \$800 toward the cost of the terminated employee's COBRA continuation coverage.

For the first six months, an assistance eligible individual is entitled to COBRA continuation coverage upon the timely payment of \$70 (35 percent of \$200); for the next three months, the individual is entitled to COBRA continuation coverage upon the timely payment of \$350 (35 percent of \$1,000). The employer's resulting payroll tax credit is \$130 (65 percent of \$200) for the first six months and \$650 (65 percent of \$1,000) for the next three months.

Question 20

Calculate Credit

Example 4. The employer requires active employees to pay \$200 per month for health coverage. For involuntarily terminated employees, the severance benefits include continued health coverage for six months after termination at no cost. The employer considers that COBRA continuation coverage begins on the date of the involuntary termination. After the six-month severance period, the terminated employee would be required to pay \$1,000 per month (but for the ARRA premium reduction) for the remainder of the COBRA continuation coverage. Because the premium during the first six months is zero, the premium reduction is not available and no payroll tax credit is available to the employer. For the next three months after the severance period, the terminated employee is entitled to COBRA continuation coverage upon the timely payment of \$350 (35 percent of \$1,000) for coverage. The employer's resulting payroll tax credit is \$650 (65 percent of \$1,000). After the first nine months, no subsidy applies, so the terminated employee can be required to pay \$1,000 per month for any later month of COBRA continuation coverage.

Question 20
Implication-Employer Can't "Absorb" 35%

Planning Possibility

Example 1. Under a group health plan, 102 percent of the applicable premium for COBRA continuation coverage is \$1,000 per month. Prior to February 17, 2009, the plan charged \$400 per month for COBRA continuation coverage. Pursuant to section 54.4980B-8, Q&A-2(b)(1) and the applicable notice requirements, the plan charges \$1,000 per month for COBRA continuation coverage for periods of coverage beginning March 1, 2009. In addition, beginning March 1, 2009, the employer provides a taxable severance benefit of \$600 per month to employees who are assistance eligible individuals. The premium reduction is based on \$1,000 for the coverage beginning March 1, 2009, and thus the individual is entitled to COBRA continuation coverage upon the timely payment of \$350 (35 percent of \$1,000).

Example 2. Same facts as Example 1, except that, beginning March 1, 2009, instead of providing a taxable severance benefit, the employer reimburses employees who are assistance eligible individuals for the \$350 the employees pay for the coverage, and the employer excludes that amount from the employees' gross income under section 106. Consequently, the \$350 is treated as paid by the employer, and, because there is no non-employer payment, the premium reduction is not available, and no payroll tax credit is available to the employer.

Question 22-Compare Results

Cafeteria Plans

Module I

Example p. 1-2

An employee earns \$1,000 per week and spends \$100 per week to pay for medical insurance. The \$100 is deducted from net pay, after applicable taxes.

Pre Sec. 125 Plan

Gross Taxable Salary	\$1,000
Total Taxes 30% (including payroll taxes)	(<u>300</u>)
Adjusted Pay	\$ 700
Insurance Premium	(<u>100</u>)
Net Payroll check	\$ 600

Example p. 1-2

Post Sec. 125 Plan

Now, under the Sec. 125 plan, the insurance premium is paid pre-tax, reducing the gross taxable salary, which is now \$900.

Gross Taxable Salary	\$900
Total Taxes 30% (including payroll taxes)	(<u>270</u>)
Net Check	\$ 630
Previous Check	\$ 600
Net increase in pay	\$ 30
percent increase in net pay	5%
Equivalent increase in employee net pay	\$42.90
Equivalent gross percent increase in net pay	7%

Example 1-1

EXAMPLE 1-1

The Get Rich corporation offers a cafeteria plan that discriminates in favor of highly compensated employees in 2008. A highly compensated employee has the right to select \$5,000 in benefits. The plan document provides the following benefits are available:

- | | | |
|----|--------------------------------|-----------|
| a. | Health Insurance Plan Benefits | - \$3,000 |
| b. | Sec. 79 Insurance Benefits | - \$1,500 |
| c. | Dependent Care Program | - \$2,500 |
| d. | 401(k) Contribution | - \$2,000 |
| e. | Cash | - \$1,800 |

Example 1-1

The highly compensated employee elected the following benefits:

- | | | |
|----|------------------|-----------|
| a. | Health Insurance | - \$2,250 |
| b. | Dependent Care | - \$2,250 |
| c. | Cash | - \$ 500 |

The highly compensated employee would be taxable on the \$500 cash benefit selected. However, because the plan is discriminatory, the employee is taxable on an additional \$1,300 of benefits (the maximum taxable benefits (\$1,800) that could be selected. The additional taxable amount is allocated pro-rata to the benefits actually selected – in this case 50% to the Health Insurance benefit (\$650) and 50% to the Dependent Care benefit (\$650).

The taxable amount arising from a discriminatory plan will be included in the employee's income in the taxable year in which the Sec. 125 plan year ends.

Qualifying Events

The following are a list of typical qualifying events

- a. Voluntary termination of employment
- b. Involuntary termination of employment
- c. Strike or walkout, provided coverage is lost
- d. Death
- e. Reduction in hours not constituting a termination of employment (i.e. leaves of absence, being laid off, disability, etc.)
- f. Spouses and dependent children losing coverage as the result of a qualifying event. However, the spouse or dependent must be covered on the day before the qualifying event.
- g. Divorce or legal separation
- h. Family and Medical Leave Act absence where the employee doesn't return

Note Gross Misconduct Exception

FMLA Payment Options

- Pre-pay
- Pay-as-you-go
- Catch-up

Reg. Sec. 1.125-3 A3

Payment Option Example

Employer Y allows employees to pay premiums for group health coverage during an FMLA leave on an after-tax basis while the employee is on unpaid FMLA leave. Under the terms of Y's cafeteria plan, if an employee elects to continue health coverage during an unpaid FMLA leave and fails to pay one or more of the after-tax premium payments due for that coverage, the employee's salary after the employee returns from FMLA leave is reduced to cover unpaid premiums (i.e. the premiums that were to be paid by the employee on an after-tax basis during the FMLA leave, but were paid by the employer instead).

From Reg. 1.125-3 A3

Deferral Example

Employee A elects group health coverage under a calendar year cafeteria plan maintained by Employer X. Employee A's premium for health coverage is \$100 per month throughout the 12-month period of coverage. Employee A takes FMLA leave for 12 weeks beginning on October 31 after making 10 months of premium payments totaling \$1,000 (10 months x \$100 = \$1,000). Employee A elects to continue health coverage while on FMLA leave and utilizes the pre-pay option by applying his or her unused sick days in order to make the required premium payments due while he or she is on FMLA leave.

Because A cannot defer compensation from one plan year to a subsequent plan year, A may pre-pay the premiums due in November and December (i.e., \$100 per month) on a pre-tax basis, *but A cannot pre-pay the premium payment due in January on a pre-tax basis.* If A participates in the cafeteria plan in the subsequent plan year, A must either pre-pay for January on an after-tax basis or use another option (e.g., pay-as-you-go, catch-up, reduction in unused sick days, etc.) to make the premium payment due in January.

FSA Examples

Example 1.

(i) Employee B elects \$1,200 worth of coverage under a calendar year health FSA provided under a cafeteria plan, with an annual premium of \$1,200. Employee B is permitted to pay the \$1,200 through pre-tax salary reduction amounts of \$100 per month throughout the 12-month period of coverage. Employee B incurs no medical expenses prior to April 1. On April 1, B takes FMLA leave after making three months of contributions totaling \$300 (3 months x \$100 = \$300). Employee B's coverage ceases during the FMLA leave. Consequently, B makes no premium payments for the months of April, May, and June, and B is not entitled to submit claims or receive reimbursements for expenses incurred during this period. Employee B returns from FMLA leave and elects to be reinstated in the health FSA on July 1.

(ii) Employee B must be given a choice of resuming coverage at the level in effect before the FMLA leave (i.e., \$1,200) and making up the unpaid premium payments (\$300), or resuming health FSA coverage at a level that is reduced on a prorata basis for the period during the FMLA leave for which no premiums were paid (i.e., reduced for 3 months or 1/4 of the plan year) less prior reimbursements (i.e., \$0) with premium payments due in the same monthly amount payable before the leave (i.e., \$100 per month). Consequently, if B chooses to resume coverage at the level in effect before the FMLA leave, B's coverage for the remainder of the plan year would equal \$1,200 and B's monthly premiums would be increased to \$150 per month for the remainder of the plan year, to make up the \$300 in premiums missed (\$100 per month plus \$50 per month (\$300 divided by the remaining 6 months)). If B chooses prorated coverage, B's coverage for the remainder of the plan year would equal \$900, and B would resume making premium payments of \$100 per month for the remainder of the plan year.

FSA Examples

Example 2.

(i) Assume the same facts as Example 1 except that B incurred medical expenses totaling \$200 in February and obtained reimbursement of these expenses.

(ii) The results are the same as in Example 1, except that if B chooses to resume coverage at the level in effect before the FMLA leave, B's coverage for the remainder of the year would equal \$1,000 (\$1,200 reduced by \$200) and the monthly payments for the remainder of the year would still equal \$150. If instead B chooses prorated coverage, B's coverage for the remainder of the plan year would equal \$700 (\$1,200 prorated for 3 months, and then reduced by \$200) and the monthly payments for the remainder of the year would still equal \$100.

FSA Examples

Example 3.

(i) Assume the same facts as Example 1 except that, prior to taking FMLA leave, *B elects to continue health FSA coverage during the FMLA leave.* The plan permits B (and B elects) to use the catch-up payment option described in Q&A-3 of this section, and as further permitted under the plan, B chooses to repay the \$300 in missed payments on a ratable basis over the remaining 6-month period of coverage (i.e., \$50 per month).

(ii) Thus, B's monthly premium payments for the remainder of the plan year will be \$150 (\$100 + \$50).

POP Example

Schedule A

Krypton Industries

No Flexible Benefit (Cafeteria Compensation) Plan

PERSONNEL ENROLLMENT DATA

Prepared For:	Ben E. Fitts 585-00-0011
Department:	Male age 35
Payroll Freq.:	Monthly

CURRENT

ACTUAL GROSS COMPENSATION PER PAY PERIOD: \$ 1,500.00

TAXABLE COMPENSATION: \$ 1,500.00

LESS:

Federal Tax:	15.00%	\$ 225.00
State Tax:	5.00%	75.00
FICA	<u>7.65%</u>	<u>114.75</u>
Total Taxes:	27.65%	\$ 414.75

ADJUSTED NET PAY: \$1,085.25

AFTER-TAX EXPENSES PER PAY PERIOD:

Health Ins. Prem.: 150.00

PAYROLL CHECK: \$ 935.25

POP Example

Schedule B Krypton Industries

Flexible Benefit (Cafeteria Compensation) Plan

PERSONNEL ENROLLMENT DATA

Prepared For:	Ben E. Fitts 585-00-0011
Department:	Male age 35
Payroll Freq.:	Monthly

PROPOSED

ACTUAL GROSS COMPENSATION PER PAY PERIOD:	\$1,500.00
Cafeteria Eligible Reduction:	(\$150.00)

TAXABLE COMPENSATION:	\$1,350.00
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Federal Tax:	15.00%	202.50
State Tax:	5.00%	67.50
<u>FICA</u>	<u>7.65%</u>	<u>103.28</u>
Total Taxes:	27.65%	\$373.28

ADJUSTED NET PAY:	\$976.72
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NEW PAYROLL CHECK:	\$976.72
ORIGINAL PAYROLL CHECK (Schedule A)	<u>(935.25)</u>

EXTRA TAKE HOME PAY:	\$ 41.47
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POP Example

Schedule C Krypton Industries

Employee Data Summary

Employee Name		Start Plan	Gross Comp.	Reduction in comp.	New Comp.	FICA	Annual Savings to Organization
Last	First						
FITTS	BEN	1	\$1,500	\$150	\$1,350	7.65%	\$137.70

POP Example

Schedule D Krypton Industries

Flexible Benefit (Cafeteria Compensation) Plan

PERSONNEL ENROLLMENT DATA

Prepared For:	Ben E. Fitts 585-00-0011
Department:	Male age 35
Payroll Frequency:	Monthly

PROPOSED

ACTUAL GROSS COMPENSATION PER PAY PERIOD:	\$1500.00
Cafeteria Eligible Reduction:	(175.00)

TAXABLE COMPENSATION:	\$1325.00
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LESS:

Federal Tax:	15.00%	198.75
State Tax:	5.00%	66.25
FICA	7.65%	101.36
Total Taxes:	27.65%	\$366.36

ADJUSTED NET PAY:	\$958.64
ORIGINAL PAYROLL CHECK (Schedule A)	<u>(935.25)</u>

EXTRA TAKE HOME PAY:	\$ 23.39
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Note: The new payroll deduction has been increased by \$25 to \$175 but there still is EXTRA income of \$23.39 over the initial pre-cafeteria plan pay!

Health Reimbursement Arrangements

Module 2

Ineligible Beneficiary

Amounts paid to an employee under the reimbursement plan described in this ruling are not excludable from gross income under § 105(b) if the plan permits amounts to be paid as § 213(d) medical benefits to a designated beneficiary (other than the employee's spouse or dependents of the employee). None of the payments made from the reimbursement plan during the plan year to any person, including amounts paid to reimburse the medical expenses of an employee or the employee's spouse or dependents, is excludable from the gross income.

Rev Ruling 2006-36

Expense	Is the Expense for Medical Care as Defined in Code Section 213
Transportation of someone other than the person receiving medical care	Yes, in some cases. Transportation expenses of the following persons may be reimbursed. (1) a parent who must go with a child who needs medical care, (2) a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone; and (3) visits to see a mentally ill dependent if recommended as part of a treatment.
Treadmill	Generally, no UNLESS prescribed by a doctor to treat a medical condition. For example, if the individual can establish that the reason for the treadmill is to treat a medical condition (such as obesity), and the expense would not have been incurred "but for" that medical condition it might be reimbursable.
Tuition for special needs program	Probably not, unless primary purpose is for medical care. Including reading program for dyslexia.
Tuition including separate breakdown for medical expenses	Yes, charges for medical expenses that are separately broken down in a bill for tuition or a college or private school are reimbursable. If they are for specific medical services.
Usual and customary, charges in excess of	Yes. Medical expenses in excess of an insurance plan's usual, customary and reasonable charges are reimbursable if the underlying expense would be reimbursable.
Vaccines	Yes.
Varicose veins, treatment of	Generally no, if the procedure improves appearance and doesn't meaningfully promote the proper function of the body or prevent or treat illness or disease. May be reimbursable if the procedure promotes the proper function of the body, prevents, or treats an illness or disease.
Vasectomy	Yes.
Viagra	Yes. If prescribed by a physician to treat a medical condition.
Vision discount programs	Generally no.
Vitamins	No. For all over-the-counter vitamins. However, if vitamins are only available by prescription, they may be deductible if prescribed by a physician to treat a specific medical condition and if legal. Administrator should get a physician's certification of medical need.
Wheelchair	Yes. Expenses of buying, operating and maintaining the wheelchair are reimbursable if the wheelchair is needed to relieve sickness or disability.
Weight-loss program and/or	Yes, if the weight loss program is prescribed by a doctor to

drugs prescribed to induce weight loss (e.g., Phen-fen and Redux)	treat an existing disease (such as obesity, heart disease or diabetes) and is not simply to improve general health, then the expenses are reimbursable. However, the costs of food associated with a weight loss program such as special weight watchers-type dinners) would not be, since they just meet normal nutritional needs.
Wigs	Yes. The full cost of a wig purchased if prescribed by a physician for the mental health of a patient who has lost all of his or her hair from disease or treatment (e.g., chemotherapy or radiation).
X-ray fees	Yes. Expenses of X-rays received for medical reasons are reimbursable.

Expenses Before Coverage

Although claims incurred during one coverage period may be reimbursed in a later coverage period, an unreimbursed claim may be reimbursed in a later coverage period only if the individual was covered under the HRA when the claim was incurred. Additionally, the maximum reimbursement amount credited under the HRA in the future (not including amounts carried forward from previous coverage periods) may be increased or decreased.

Notice 2002-45

Differences with FSAs

Because an HRA is paid for solely by the employer and not pursuant to salary reduction, the following restrictions on health FSAs under § 125 are not applicable to HRAs:

- (1) the prohibition against a benefit that defers compensation by permitting employees to carry over unused elective contributions or plan benefits from one plan year to another plan year;
- (2) the requirement that the maximum amount of reimbursement must be available at all times during the coverage period;
- (3) the mandatory twelve-month period of coverage; and
- (4) except as otherwise provided in this notice, the limitation that medical expenses reimbursed must be incurred during the period of coverage.

As a result, the maximum reimbursement amount for a coverage period (not including amounts carried forward from previous coverage periods) need not be available at all times during the coverage period. Also, an HRA may specify a coverage period for a reimbursement amount that is less than a year.

Notice 2002-45

Cafeteria Example I

Assume an employer offers a reimbursement arrangement plus other specified accident or health plan coverage with the actual cost for family coverage for the specified accident or health plan being \$4,500 and the employee having a choice to salary reduce \$2,500 or \$3,500 to fund this coverage. An employee who elects family coverage and \$2,500 salary reduction receives a \$1,000 maximum reimbursement amount under the reimbursement arrangement for the coverage period and an employee who elects family coverage and \$3,500 salary reduction receives a \$2,000 maximum reimbursement amount under the reimbursement arrangement for the coverage period. In this case, although the maximum allowable salary reduction is not exceeded, a portion of the salary reduction is attributed to the reimbursement arrangement because the increase in salary reduction election is related to a larger maximum reimbursement amount in the reimbursement arrangement for the coverage period. This arrangement is not an HRA and is subject to the cafeteria plan rules.

Can't link HRA Reimbursement to FSA Deferral

Cafeteria Plan Example

2

Assume an employer provides a reimbursement arrangement in the reimbursement arrangement are reimbursed up to \$1,000 each year for substantiated medical care expenses and unused amounts remaining at the end of the year are carried forward for reimbursements in later years. The employee-share of the annual premium for the other accident or health plan is \$1,500. Employees have a choice either to use amounts in the reimbursement arrangement to pay for the premium for the other accident or health plan or to pay that premium pursuant to a salary reduction election. Under this plan, the reimbursement arrangement does not reimburse any portion of the premium paid by salary reduction. Because an employee may use the reimbursement arrangement to pay a portion of the premium in lieu of electing to salary reduce, the reimbursement arrangement is indirectly funded pursuant to salary reduction. This arrangement does not meet the definition of an HRA because it is funded by salary reduction and it is subject to the cafeteria plan rules.

Allowed payment via either mechanism is indirect funding

Distinguish from FSA

1. The HRA plan document, employee communications and forms clearly say that the HRA is 100% employer-funded and is offered outside of the cafeteria plan.
2. The employee's share of the premium for the major medical is less than what the carrier charges the employer for it.
3. If the employer offers several major medical options, the HRA amount remains fixed, regardless of which major medical option the employee elects (e.g., a \$500 HRA coupled with either a \$1,000, \$2,000, or \$3,000 deductible health insurance).
4. If an employee drops the major medical (e.g., at open enrollment the employee elects an HMO option instead), the employee's HRA coverage continues, at least for purposes of spending remaining amounts.
5. There is a longer waiting period for the HRA than for the major medical.
6. The HRA is provided to employees who have major medical through either the employer's or through a spouse's major medical plan.
7. Separate Form 5500's are filed for the HRA coverage.
8. Separate elections are made for the HRA coverage.
9. The HRA is treated as a separate plan for COBRA purposes.

TPA?

- HIPAA and Employer Liability suggest to use
- Suggestion for separate fund

Flexible Spending Accounts

Module 3

Employer Exposure

(1) Uniform coverage throughout coverage period-in general. The maximum amount of reimbursement from a health FSA must be available at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage). Thus, the maximum amount of reimbursement at any particular time during the period of coverage cannot relate to the amount that has been contributed to the FSA at any particular time prior to the end of the plan year. Similarly, the payment schedule for the required amount for coverage under a health FSA may not be based on the rate or amount of covered claims incurred during the coverage period. Employees' salary reduction payments must not be accelerated based on employees' incurred claims and reimbursements.

Proposed Reg. §1.125-5(d)(1)

12 Month Requirement

(e) Required period of coverage for a health FSA, dependent care FSA and adoption assistance FSA –

(1) Twelve-month period of coverage -- in general. An FSA's period of coverage must be 12 months. However, in the case of a short plan year, the period of coverage is the entire short plan year. See paragraph (d) in § 1.125-1 for rules on plan years and changing plan years.

(2) COBRA elections for health FSAs. For the application of the health care continuation rules of section 4980B of the Code to health FSAs, see Q & A-2 in § 54.4980B-2 of this chapter.

(3) Separate period of coverage permitted for each qualified benefit offered through FSA. Dependent care assistance, adoption assistance, and a health FSA are each permitted to have a separate period of coverage, which may be different from the plan year of the cafeteria plan.

Prop. Reg. 1.125-5(e)

Medical Expenses

(ii) Reimbursement exclusively for section 213(d) medical expenses. A cafeteria plan benefit through which an employee receives reimbursements of medical expenses is excludable under section 105(b) only if reimbursements from the plan are made specifically to reimburse the employee for medical expenses (as defined in section 213(d)) incurred by the employee or the employee's spouse or dependents during the period of coverage. Amounts paid to an employee as reimbursement are not paid specifically to reimburse the employee for medical expenses if the plan provides that the employee is entitled, or operates in a manner that entitles the employee, to receive the amounts, in the form of cash (for example, routine payment of salary) or any other taxable or nontaxable benefit irrespective of whether the employee (or the employee's spouse or dependents) incurs medical expenses during the period of coverage. This rule applies even if the employee will not receive such amounts until the end or after the end of the period. A plan under which employees (or their spouses and dependents) will receive reimbursement for medical expenses up to a specified amount and, if they incur no medical expenses, will receive cash or any other benefit in lieu of the reimbursements is not a benefit qualifying for the exclusion under sections 106 and 105(b). See § 1.105-2. This is the case without regard to whether the benefit was purchased with contributions made at the employer's discretion, at the employee's discretion (for example, by salary reduction election), or pursuant to a collective bargaining agreement.

Prop. Reg. 1.125-6(a)(3)(ii)

Experience Gains Uses

- (i) Retained by the employer maintaining the cafeteria plan; or
- (ii) If not retained by the employer, may be used only in one or more of the following ways --
 - (A) To reduce required salary reduction amounts for the immediately following planyear, on a reasonable and uniform basis, as described in paragraph (o)(2) of this section;
 - (B) Returned to the employees on a reasonable and uniform basis, as described in paragraph (o)(2) of this section; or
 - (C) To defray expenses to administer the cafeteria plan.

Limits on Return to Employees

(2) Allocating experience gains among employees on reasonable and uniform basis. If not retained by the employer or used to defray expenses of administering the plan, the experience gains must be allocated among employees on a reasonable and uniform basis. It is permissible to allocate these amounts based on the different coverage levels of employees under the FSA. Experience gains allocated in compliance with this paragraph (o) are not a deferral of the receipt of compensation. However, in no case may the experience gains be allocated among employees based (directly or indirectly) on their individual claims experience. Experience gains may not be used as contributions directly or indirectly to any deferred compensation benefit plan.

Can't use to effectively benefit the losers

Example

- (i) Employer L maintains a cafeteria plan for its 1,200 employees, who may elect one of several different annual coverage levels under a health FSA in \$100 increments from \$500 to \$2,000.
- (ii) For the 2009 plan year, 1,000 employees elect levels of coverage under the health FSA. For the 2009 plan year, the health FSA has an experience gain of \$5,000.
- (iii) The \$5,000 may be allocated to all participants for the plan year on a per capita basis weighted to reflect the participants' elected levels of coverage.
- (iv) Alternatively, the \$5,000 may be used to reduce the required salary reduction amount under the health FSA for all 2009 participants (for example, a \$500 health FSA for the next year is priced at \$480) or to reimburse claims incurred above the elective limit in 2010 as long as such reimbursements are made on a reasonable and uniform level.

Employee Termination

Example 3-5

Sarah is a single participant in an FSA. In 2008, she elected to have a maximum reimbursement of \$2,400. She pays for the reimbursement in four, equal quarterly installments of \$600 on January, April, July and October 1. In February, Sarah incurs medical expenses of \$2,400. She makes her required payments in January, April and July. However, on August 31, Sarah terminates her employment. Sarah is not required to make her October 1 contribution and she is entitled to a refund of \$200 from her July contribution (1/3 of the \$600), since she terminated on August 31. Note that the employer has a net deficit with her, since the employer paid out \$2,400, but only collected \$1,600.

**OVER-THE-COUNTER EXPENSES ELIGIBLE FOR REIMBURSEMENT
UNDER YOUR FLEXIBLE SPENDING ACCOUNT**

The following is a list of over-the-counter items the IRS has determined to be primarily for medical care and that can be reimbursed when purchased in reasonable quantities without a medical practitioner's note.

<ul style="list-style-type: none"> • Allergy medicine • Antacids • Bactine • Band-Aids/bandages • Anti-diarrhea medicine • Bug-bite medication • Calamine lotion • Carpal-tunnel wrist supports • Cold medicines • Cold/hot packs for injuries • Condoms • Contact-lens cleaning solution • Cough drops • Diaper rash ointments • First aid cream • First aid kits • Hemorrhoid medication • Incontinence supplies • Laxatives • Liquid adhesive for small cuts • Menstrual cycle products for pain and cramp relief 	<ul style="list-style-type: none"> • Motion sickness pills • Nasal sinus sprays • Nasal strips • Nicotine gum or patches for stop-smoking purposes • Pain reliever • Pedialyte for ill child's dehydration • Pregnancy test kits • Products for muscle or joint pain--BenGay and Tiger Balm, for example • Reading glasses • Rubbing alcohol • Sinus medications • Sleeping aids used to treat occasional insomnia. • Special ointment or cream for sunburn • Spermicidal foam • Thermometers (ear or mouth) • Throat lozenges • Visine and other eye products • Wart remover treatments
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Ineligible expenses - Some OTC items will not be reimbursed under any circumstances since they are toiletries or cosmetics or likely to be primarily for general health and well-being.

<ul style="list-style-type: none"> • Chapstick • Face cream, moisteners • Medicated shampoos and soaps 	<ul style="list-style-type: none"> • One-a-day vitamins • Suntan lotion
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Dual purpose - Some dual purpose OTC items can be reimbursed if they are used for a medical purpose. They must be accompanied by a medical practitioner's note stating that the person has a specific medical condition and the doctor recommends the OTC drug to treat it and the treatment is not a cosmetic procedure.

Note: This list does not include all reimbursable items.

<ul style="list-style-type: none"> • Acne treatment (Retin A)--only to treat a specific medical condition such as acne vulgaris. • Dietary supplements or herbal medicines to treat a specific medical condition in narrow circumstances. • Glucosamine/chondroitin for arthritis or other medical condition, • Orthopedic shoes and inserts (for orthopedic shoes, you can be reimbursed only for the extra cost over buying non-orthopedic shoes). 	<ul style="list-style-type: none"> • Fiber supplements under narrow circumstances. • OTC hormone therapy and treatment for menopause for symptoms such as hot flashes and night sweats, • Pills for persons who are lactose intolerant. • Prenatal vitamins. • St. John's Wort for depression. • Sunscreen. • Weight-loss drugs to treat a specific disease (including obesity).
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Source: American Fidelity Assurance Company, Oklahoma City, Oklahoma, www.afadvantage.com/flex-list-otc.shtml. Prepared by Edward L. Hobbs, CPA, assistant professor of accounting at Southeastern Oklahoma State University in Durant, and Theresa J. Hrcir, CPA, PhD, associate professor of accounting at Southeastern Oklahoma State University.

Substantiation Rules

(2) All claims must be substantiated. As a precondition of payment or reimbursement of expenses for qualified benefits, a cafeteria plan must require substantiation in accordance with this section. Substantiating only a percentage of claims, or substantiating only claims above a certain dollar amount, fails to comply with the substantiation requirements in § 1.125-1 and this section.

Prop Reg 1.125-6(b)(2)

Third Party Substantiation

(3) Substantiation by independent third-party. (i) In general. All expenses must be substantiated by information from a third-party that is independent of the employee and the employee's spouse and dependents. The independent third-party must provide information describing the service or product, the date of the service or sale, and the amount. Self-substantiation or self-certification of an expense by an employee does not satisfy the substantiation requirements of this paragraph (b). The specific requirements in sections 105(b), 129, and 137 must also be satisfied as a condition of reimbursing expenses for qualified benefits. For example, a health FSA does not satisfy the requirements of section 105(b) if it reimburses employees for expenses where the employees only submit information describing medical expenses, the amount of the expenses and the date of the expenses but fail to provide a statement from an independent third-party (either automatically or subsequent to the transaction) verifying the expenses. Under § 1.105-2, all amounts paid under a plan that permits self-substantiation or self-certification are includible in gross income, including amounts reimbursed for medical expenses, whether or not substantiated. See paragraph (m) in § 1.125-5 for additional substantiation rules for limited-purpose and post-deductible health FSAs.

Prop Reg 1.125-6(b)(3)

Debit Card Example

In Situation 1 of the ruling, the employer establishes the following procedures for substantiating claimed medical expenses after the card is used. First, if the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the accident or health plan covering the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review (i.e., co-payment match). Second, the employer permits automatic reimbursement without further review of recurring expenses that match expenses previously approved as to amount, provider, and time period (i.e., recurring expenses). Third, if the merchant, service-provider, or other independent third-party (e.g., Pharmacy Benefit Manager), at the time and point-of-sale, provides information to verify to the employer (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review (i.e., real-time substantiation).

CASE STUDY: KRYPTON INDUSTRIES

Jane Sinclair, is a senior officer of this new company. Jane has assembled a group of 12 employees including herself. Because this is a new organization, each of the employees came from different professional backgrounds representing both the private and public sector. Jane has interviewed each one and fully understands that some of her employees had employee benefit programs completely paid for by the previous employer. Others had a dental program and disability income. Some did not.

One company paid 100% of the benefits for both the employee and her non working dependent, others did not. Some of the employees received benefits they couldn't care about, others did not receive reimbursement for a medical condition which was extremely costly but, unfortunately not covered in full.

Because of the rush to set up this new company, a benefit plan has, in fact, already been installed which Jane admits did not completely address the needs of all the people just described.

It consists of the following:

1. Group Major Medical underwritten by Acme Medical - Only ten employees elected Major Medical coverage. Two are covered elsewhere.
2. Dental Coverage-Eight employees are covered. Dental Coverage did include the two employees not covered under the Major Medical, but only six of the remaining ten employees.
3. Life Insurance - Equal to \$10,000 for all twelve eligible employees.
4. Additional Group Term for Jim Smith and Mary Gonzalez which, although purchased on a group basis, is part of their employment contract and therefore is not part of this discussion.
5. Group Disability Income-Formula (Family Social Security Offset) - 50 percent of salary to \$2,500 of benefit per month. Mr. Smith would like a higher limit but understands that (\$5,000 of salary) amount is top for the insurance carrier. Also, an individual policy would be quite expensive.

Premium Commitment - Jane and the finance department previously decided to pay 60% of both the single and dependent premium rates.

MONTHLY PREMIUMS FOR THE FOLLOWING PLANS

	# of Employees	Single	# of Dependents	Dependent	Gross Cost	Company Cost 60%
Group Major	10	\$500.00	4	\$495.00	\$6,980.00	\$4,188.00
Dental	8	\$30.00	6	\$60.00	\$600.00	\$360.00
Life Insurance	12	\$38.00	-	-	\$456.00	\$274.00
Group Long Term Disability	12	\$30.00	-	-	\$360.00	\$216.00
Total Cost of Plans		\$598.00			\$8,396.00	\$5,038.00

Summary of Plan – total employees 12; cost to employer annually \$5,038

Jane has been confronted by two employees, both of whom are single. They feel that they are being economically discriminated against because the company is providing more allowance for employees with dependents.

Another employee is concerned that her chiropractic care is covered but with limited benefits. Ben Fitts, another employee, is concerned that the counseling care for his son also has limited coverage.

Mary Gonzalez's husband needs constant physical therapy for his degenerative illness and most of that is not covered. Mary also claims that she is spending too much time reviewing benefit programs which is not her specialty, and not her interest.

Jane has admitted (to herself) that employee benefit planning is not her specialty either.

In the first two months of operation, the company has experienced rapid growth. They might even have to expand and add another mid-level executive and secretary.

Jane has been informed by her financial people that the amount of money currently spent on employee benefits is the maximum allowed for their current employees.

DETERMINATION OF EMPLOYEE BENEFIT ALLOWANCE

In this situation, we simply added the current nonqualified (excluding 401(K) contributions, etc.) and divided it by the number of eligible employees.

Total Monthly Cost \$5,038 divided by 12 = \$420 per month.

Note: The company could have selected \$380 as the allowance, thus saving 10% from its budget.

THE ALLOWANCE

Each employee will now have \$420 per month or \$5,040 per year of benefit credits to spend on a menu of benefits.

If an employee, for example, is already covered by a spouse's employer, or through Indian Health Services or the VA, and they have unreimbursed medical or dependent day care expenses, they may use the \$5,040 allowance to purchase other benefits.

Previously, each employee received the same benefits. The cost to the company to provide benefits for each employee was different.

Now, each employee will receive the same amount of benefit allowance credit.

The benefit now is chosen by the employee. Benefit packages may be different for each employee.

MENU OF BENEFITS

Each employee is provided the opportunity to select the mix of benefits that best suits their needs and desires. No employee has to choose a particular mix or amount of benefits, it's entirely an individual choice.

SELECTION OF BENEFITS

COMPLETED EXAMPLE

Assume we have a married female employee, age 40, earning \$2,000 per month. Also assume the available benefit credit is \$400 per month. The actual choice could be as follows:

Jane Halstead 01/06/08 Married with 2 children

Allocation available \$420

Section 1--Major Medical

Monthly Premium

A--\$ 100 deductible	\$450
B--\$ 250 deductible	\$375
C--\$ 500 deductible	\$320
D--\$1,000 deductible	\$275

Choice \$320

Section 2--Life Insurance

Monthly Premium

E--\$ 25,000 face amount	\$ 10
F--\$ 50,000 face amount	\$ 25
G--\$100,000 face amount	\$ 60

Choice \$ 25

Section 3--Disability Income

Monthly Premium

H--30 day elim/2 years	\$ 6
I--60 day elim/5 years	\$10
J--90 day elim/to age 65	\$25

Choice \$ 25

Section 4--Other Deductions

Monthly Premium

R--Dependent Day Care	\$25
L--Unreimbursed Medical	\$25

Choice \$50

TOTAL \$420

Health Savings Accounts

Module 4

HSA Guidance

1. Announcement 2004-2, 2004-1 C.B. 322
2. Notice 2004-2, 2004-1 C.B. 269
3. Notice 2004-23, 2004-1 C.B. 725
4. Notice 2004-50, 2004-2 C.B. 196
5. Notice 2005-8, 2005-1 C.B. 368
6. Notice 2005-83, 2005-2 C.B. 1075
7. Notice 2005-86, 2005-2 C.B. 1075
8. Rev. Proc. 2004-22, 2004-1 C.B. 727
9. Rev. Proc. 2006-53, 2006-48 IRB 1
10. Rev. Rul. 2004-38, 2004-1 C.B. 971
11. Rev. Rul. 2004-45, 2004-1 C.B. 971
12. Rev. Rul. 2005-25, 2005-1 C.B. 971
13. Notice 2008-59, 2008-30 IRB 1

HSA Limits

HSA

Self only	Not less than \$1,100	Annual "out-of-pocket" \$5,600
Family	Not less than \$2,200	Annual "out-of-pocket" \$11,200

2009 HDHP limits (Rev. Proc. 2008-29, 2008-22 IRB)

Self only	Not less than \$1,150	Annual "out-of-pocket" \$ 5,800
Family	Not less than \$2,300	Annual "out-of-pocket" \$11,600

Catch up \$900 for 2008, \$1,000 for 2009

Eligible Individuals

1. Is covered under a high-deductible health plan (HDHP) on the first day of such month;
2. Is not also covered by any other health plan that is not an HDHP (with an exception for plans providing certain limited types of coverage);
3. Is not enrolled in Medicare (generally, has not yet reached age 65); and
4. May not be claimed as a dependent on another person's tax return.

Example 4-1

EXAMPLE 4-1

HDHP

Jack and Jill work for a company that has instituted a HDHP. The plan provides for a limit on participant payments of \$7,500 per year. Jack and Jill fund an HSA for \$5,800 in 2008. Also in December 2008, Jack has heart surgery that costs \$55,000. Jack and Jill draw the \$5,800 from the HSA (ignore any earnings on that contribution), tax-free and add \$1,700 of their own funds to pay the \$7,500 deductible. The health plan then pays \$47,500 (\$55,000 - \$7,500). Jack and Jill's 2008 AGI is \$100,000 and they are in the 25% bracket.

Payment of deductible	\$7,500
Tax Savings on HSA Contribution	<u>(1,450)</u>
Net Medical Expenses	\$6,050

If Jack's stay in the hospital carries over into 2009, Jack and Jill will still be responsible for another \$7,500 before the insurance steps in to cover any excess. However, they will also be entitled to contribute and withdraw another \$5,800 to their HSA (the contribution will likely be higher, since it is adjusted annually for inflation).

Example 4-2

EXAMPLE 4-2

NON-HDHP

Jack and Jill are covered by their employer's health plan. It provides a \$100 initial co-pay for any hospital stay, then a 20% co-pay for the first \$50,000 of expense. After that, the insurance covers all other expenses. In December 2008, Jack has heart surgery that costs \$55,000. Jack and Jill's 2008 AGI is \$100,000 and are in the 25% bracket. Under this scenario, Jack and Jill will have the following medical bills in 2008:

Initial co-pay	\$ 100
20% co-pay of hospital bill	<u>10,000</u>
Total out-of-pocket	\$10,100
Tax Savings on Medical (((\$10,100 - \$7,500 (7.5% of 100,000) X .25)	<u>(650)</u>
Net Medical Expenses	\$ 9,450

Compare this to the net outlay of \$6,050 in the HDHP example under an HSA. The difference comes from the limitation on the participant's part after reaching the deductible limit as well as from a shifting of the medical deduction (or a portion of it) to an above-the-line deduction. If the maximum out-of-pocket expense had been \$7,500 in the last example, the HSA would still save Jack and Jill \$1,450, which is the tax benefit of the HSA deduction of \$5,800.

Example 4-3a

EXAMPLE 4-3a

PLAN COVERAGE

A Plan provides coverage for Bill and his family. The Plan provides for the payment of covered medical expenses of any member of Bill's family if the member has incurred covered medical expenses during the year in excess of \$1,100 even if the family has not incurred covered medical expenses in excess of \$2,200. If Bill incurred covered medical expenses of \$1,500 in a year, the Plan would pay \$400. Under these provisions benefits are potentially available under the Plan even if the family's covered medical expenses do not exceed \$2,200. Accordingly, because the Plan provides family coverage with an annual deductible of less than \$2,200, the Plan is not an HDHP.

Family coverage has to impose family deductible

Example 4-3b

EXAMPLE 4-3b

PLAN COVERAGE

Assume the same facts as above, except that the Plan has a \$5,500 family deductible and provides payment for covered medical expenses if any member of Bill's family has incurred covered medical expenses during the year in excess of \$2,200. Now, the Plan satisfies the HDHP requirements.

Personal limit now at family minimum, so OK

Example 4-4

EXAMPLE 4-4

LIFE-TIME COVERAGE

A health plan has an annual deductible that satisfies the minimum annual deductible for self-only coverage and for family coverage. After satisfying the deductible, the plan pays 100 percent of covered expenses, up to a lifetime limit of \$1 million. The lifetime limit of \$1 million is reasonable and the health plan is not disqualified from being an HDHP because of the lifetime limit on benefits.

Reasonable lifetime/annual limits allowed

Example 4-5a

EXAMPLE 4-5a

COVERED BENEFITS LIMIT

In 2008, a self-only health plan with a \$1,100 deductible includes a \$1 million lifetime limit on covered benefits. The plan provides no benefits for experimental treatments, mental health, or chiropractic care visits. Although the plan provides benefits for substance abuse treatment, it limits payments to 26 treatments per year, after the deductible is satisfied. Although the plan provides benefits for fertility treatments, it limits lifetime reimbursements to \$10,000, after the deductible is satisfied. Other than these limits on covered benefits, the plan pays 80 percent of major medical expenses incurred after satisfying the deductible. When the 20 percent coinsurance paid by the covered individuals reaches \$4,000, the plan pays 100 percent. Under these facts, the plan is an HDHP and no expenses incurred by a covered individual other than the deductible and the 20 percent coinsurance are treated as out-of-pocket expenses.

**OK for limits on limited set of specific expenses
so long as still significant other coverage**

Example 4-5b

EXAMPLE 4-5b

COVERED BENEFITS LIMIT

In 2008, a self-only health plan with a \$1,100 deductible imposes a lifetime limit on reimbursements for covered benefits of \$1 million. While the plan pays 100 percent of expenses incurred for covered benefits after satisfying the deductible, the plan imposes a \$10,000 annual limit on benefits for any single condition. The \$10,000 annual limit under these facts is not reasonable because significant other benefits do not remain available under the plan. Under these facts, any expenses incurred by a covered individual after satisfying the deductible are treated as out-of-pocket expenses.

Limit on every potential benefit makes it not a true cap on expenses, not an HDHP

Example 4-6a

EXAMPLE 4-6a

OUT-OF-POCKET

A plan provides self-only coverage with a \$2,000 deductible and pays 100 percent of covered benefits above the deductible. Because the plan pays 100 percent of covered benefits after the deductible is satisfied, the maximum out-of-pocket expenses paid by a covered individual would never exceed the deductible. Thus, the plan does not require a specific limit on out-of-pocket expenses to insure that the covered individual will not be subject to out-of-pocket expenses in excess of the maximum limit.

No way to exceed maximum out of pocket so
no explicit limit needed

Example 4-6b

EXAMPLE 4-6b

OUT-OF-POCKET

A plan provides self-only coverage with a \$2,000 deductible. The plan imposes a lifetime limit on reimbursements for covered benefits of \$1 million. For expenses for covered benefits incurred above the deductible, the plan reimburses 80 percent of the UCR costs. The plan includes no express limit on out-of-pocket expenses. This plan does not qualify as a HDHP because it does not have a limit on out-of-pocket expenses.

Would need an explicit limit-would clear maximum well before hitting \$1 million

Example 4-6c

EXAMPLE 4-6c

OUT-OF-POCKET

Assume the same facts as Example 4-6b, except that after the 20 percent coinsurance paid by the covered individual reaches \$3,000, the plan pays 100 percent of the UCR costs until the \$1 million limit is reached. For the purpose of determining the individual's out-of-pocket expenses, the plan only takes into account the 20 percent of UCR paid by the individual. This plan satisfies the out-of-pocket limit.

Now can't hit limit again, so is an HDHP

Example 4-7

EXAMPLE 4-7b

HSA DEDUCTIBLE LIMIT

In 2008, John and Marsha are married and neither qualifies for catch-up contributions. John and Marsha have family HDHP coverage with a \$5,000 deductible. John is an eligible individual and has no other coverage. Marsha also has self-only coverage with a \$200 deductible. Marsha, who has coverage under a low-deductible plan, is not an eligible individual. John may contribute \$5,800 to an HSA.

Key fact-Marsha is single person coverage, no spill-over to John even Marsha may be only family also covered

Example 4-7c

EXAMPLE 4-7c

HSA DEDUCTIBLE LIMIT

Assume the same facts as Example 4-7b above, except that, in addition to the family HDHP with a \$5,000 deductible, Marsha has self-only HDHP coverage with a \$2,200 deductible rather than self-only coverage with a \$200 deductible. Both John and Marsha are eligible individuals. They are treated as having only family coverage. Thus, the maximum HSA contribution will be \$5,800.

Again, Marsha's coverage doesn't spill over

Example 4-7d

EXAMPLE 4-7d

HSA DEDUCTIBLE LIMIT

Assume the same facts as Example 4-7b above, except that, in addition to the family HDHP with a \$5,000 deductible, Marsha has family HDHP coverage with a \$3,000 deductible rather than self-only coverage with a \$200 deductible. Both John and Marsha are eligible individuals. John and Marsha are treated as having family HDHP coverage with the lowest annual deductible - \$3,000. For 2008, the maximum deduction is \$5,800.

**Both with HDHP, limited to lower because
Marsha's coverage spills over onto John**

Example 4-7e

EXAMPLE 4-7e

HSA DEDUCTIBLE LIMIT

Assume the same facts as Example 4-7b, except that, in addition to family coverage under the HDHP with a \$5,000 deductible, Marsha has family coverage with a \$500 deductible rather than self-only coverage with a \$200 deductible. Now John and Marsha are treated as having family coverage with the lowest annual deductible. Accordingly, neither is an eligible individual and neither may contribute to an HSA.

Spillover strikes again

Example 4-7f

EXAMPLE 4-7f

HSA DEDUCTIBLE LIMIT

Assume the same facts as Example 4-7b, except that, in addition to the family HDHP with a \$5,000 deductible, Marsha is enrolled in Medicare rather than having self-only coverage with a \$200 deductible. She is not an eligible individual. John may contribute \$5,800 to an HSA while Marsha may not contribute to an HSA.

Marsha's Medicare coverage doesn't spill over

Example 4-7g

EXAMPLE 4-7g

HSA DEDUCTIBLE LIMIT

Grace is a single individual who does not qualify for catch-up contributions and has a dependent. Grace and her dependent have family HDHP coverage with a \$5,500 deductible. The dependent also has self-only coverage with a \$200 deductible. Grace may contribute \$5,800 to an HSA while the dependent may not contribute to an HSA.

Again, issue is what covers Grace

Example 4-8

EXAMPLE 4-8

EMPLOYEE WELLNESS PROGRAM

An employer offers a wellness program for all employees regardless of participation in a health plan. The wellness program provides a wide-range of education and fitness services designed to improve the overall health of the employees and prevent illness. Typical services include education, fitness, sports, and recreation activities, stress management and health screenings. Any cost charged to the individual for participating in the services is separate from the individual's coverage under the health plan. This wellness program is not a "health plan" because it does not provide significant benefits in the nature of medical care or treatment and thus does not disqualify an HSA.

**Not considered significant benefits so not
a health plan**

Example 4-9

EXAMPLE 4-9

DISCOUNT CARD

An employer provides its employees with a pharmacy discount card. For a fixed annual fee, paid by the employer, each employee receives a card that entitles the holder to choose any participating pharmacy. During the one-year life of the card, the card holder receives discounts of 15 percent to 50 percent off the usual and customary fees charged by the providers, with no dollar cap on the amount of discounts received during the year. The cardholder is responsible for paying the costs of any drugs (taking into account the discount) until the deductible of any other health plan covering the individual is satisfied. This benefit alone will not disqualify the HSA.

Discount card OK for this purpose

Example 4-10a

EXAMPLE 4-10a

MEDICARE ELIGIBILITY

Susan, age 66, is covered under her employer's HDHP. Although Susan is eligible for Medicare, Susan is not actually entitled to Medicare because she did not apply for benefits under Medicare, (i.e., enroll in Medicare Part A or Part B). Since she hasn't enrolled in Medicare, Susan may contribute to an HSA. Note, however, that because Susan failed to enroll in Medicare at age 65, her Medicare premium will be higher.

**If not enrolled, even though eligible, can contribute
but note negative effect on Medicare in future**

Example 4-10b

EXAMPLE 4-10b

MEDICARE ELIGIBILITY

In August 2008, Alan attains age 65 and applies for and begins receiving Social Security benefits. Alan is automatically enrolled in Medicare. As of August 1, 2008, Alan is no longer an eligible individual and may not contribute to an HSA.

Automatic enrollment triggers lack of eligibility

Example 4-10c

Example 4-10c

Failed Testing Period

Greg joins a family HDHP and becomes eligible for an HSA on November 30, 2008. On December 3, 2008 he contributes \$5,800 to his HSA. He ceases to be an eligible individual in June 2009.

The testing period for Greg's 2008 HSA contributions ends on December 31, 2009. Since Greg ceases to be an eligible individual during the testing period, he must include in gross income \$5,316.67, the amount contributed to the HSA for 2008 minus the sum of the monthly contribution limits – one month (December 2008 (\$5,800.00 - \$483.33)). Further, the 10% penalty will apply to the deemed distribution.

For calendar year: must have coverage by 12/1
Testing period always 13 months ending next December

Example 4-10d

Example 4-10d

Receipt of Disqualified Benefits

Sarah, age 30, is eligible for medical benefits through the Department of Veterans Affairs (VA) in January through April of 2008 and again in October of 2008. Sarah is an eligible individual with self-only HDHP coverage in May through September 2008. Because of the 3 preceding month rule, Sarah is not an eligible individual on December 1, 2008. Thus, the full contribution limit does Sarah's 2008 contribution limit is determined under the sum of the monthly contribution limits and is \$1,208.33 ($5/12 \times \$2,900$), reflecting her eligibility from May 1 through September 30.

**VA Benefits have 3 month lookback to actual use
for disqualification**

Example 4-11 (Partner)

EXAMPLE 4-11


PARTNERSHIP HSA CONTRIBUTION

The Profit Partnership is a limited partnership with three equal individual partners, Tyler (a general partner), Kyle (a limited partner), and Carol (a limited partner). Carol is to be paid \$500 annually for services rendered to Partnership in her capacity as a partner and without regard to Partnership income (a guaranteed payment). Profit has no employees. Tyler, Kyle and Carol are eligible individuals and each has an HSA. During 2008, Profit makes the following contributions: a \$300 contribution to each of Tyler's and Kyle's HSAs which are treated by Partnership as distributions to them; and a \$500 contribution to Carol's HSA in lieu of paying C the guaranteed payment directly.


The partnership's contributions to Tyler's and Kyle's HSAs are not deductible by Profit and, therefore, do not affect Profit's calculation of its taxable income or loss. The distributions to Tyler's and Kyle's individual HSAs are reported as cash distributions to them on their Schedule K-1 (Form 1065). The distributions to their HSAs are not includible in their net earnings from self employment, because distributions don't affect a partner's distributive share of the partnership's income or loss.

The partnership's contribution to Carol's HSA that is treated as a guaranteed payment for services rendered to the partnership is deductible by Profit under IRC Sec. 162, if the requirements of that section are otherwise satisfied, and is includible in Carol's gross income. The payment to Carol's HSA should be reported as a guaranteed payment on Schedule K-1 (Form 1065). Because the contribution is a guaranteed payment that is derived from the partnership's trade or business and is for services rendered to the partnership, the contribution constitutes net earnings from self-employment, which would be reported on Schedule SE (Form 1040). Carol is also entitled to deduct as an adjustment to gross income the amount of the contribution made to her HSA.

Not for services
treated as
§721 distribution



For services
treated as
§707(c)
guaranteed
payment.



Example 4-12 (Catch Up)

EXAMPLE 4-12

DEDUCTION COMPUTATION

An HDHP has an annual deductible of \$4,800 for a family. An individual starts in the HDHP on August 1, 2008 and opens an HSA. In 2008, the individual (assuming family coverage) will be able to contribute \$5,800, the maximum HSA contribution. If the employee was 57, the employee could deduct an additional \$900 as a catch-up.

**Age 55 by year end (§223(b)(3))
For 2009 addition is \$1,000**

Spousal Rules

EXAMPLE 4-13a

SPOUSAL COVERAGE

Tom has HDHP self-only coverage and no other health coverage, is not enrolled in Medicare and may not be claimed as a dependent on another taxpayer's return. Although Natalie, his wife, has non-HDHP family coverage, Tom is not covered under that health plan. Tom is therefore an eligible individual. The special rules for married individuals do not apply because Natalie's non-HDHP family coverage does not cover Tom. Thus, Tom remains an eligible individual and may contribute \$2,900 to an HSA for 2008.

Contribution can only go in HSA for eligible spouse-in this case 100% to Tom

Spousal Rules

EXAMPLE 4-13b

SPOUSAL COVERAGE

Fred (56) and Ethel (53) are married. Both have family coverage under separate HDHPs. Fred's HDHP has a deductible of \$3,000 and Ethel's HDHP has a \$2,200 deductible. In 2008, Fred and Ethel can deduct a total of \$5,800. The presumed allocation is 50/50, so Fred and Ethel can each deduct \$2,900, unless they agree otherwise. In addition, Fred can deduct an additional \$900 as a catch-up contribution.

Divide normal, catch up to eligible spouse account

Delayed Repayment

EXAMPLE 4-14

DEFERRED PAYMENT OF MEDICAL EXPENSES

Kenny, an eligible individual, contributes \$1,500 to an HSA in 2008. On December 1, 2008, Kenny incurs a \$2,500 qualified medical expense and has a balance in his HSA of \$1,525, including earnings. On January 3, 2009, Kenny contributes another \$1,500 to the HSA, bringing the balance in the HSA to \$3,025. In June, 2010, the Kenny receives a distribution of \$2,500 to reimburse him for the \$2,500 medical expense incurred in 2008. Kenny can show that the \$2,500 HSA distribution in 2008 is a reimbursement for a qualified medical expense that has not been previously paid or otherwise reimbursed and has not been taken as an itemized deduction. The distribution is excludable from Kenny's gross income.

Must have records and expense incurred after established an HSA

FSA/HRA Transfer

Generally, under the new rules, all of the following conditions must be satisfied in order to receive the favorable tax treatment. By plan year-end:

- a. The plan must be amended as appropriate;
- b. The employee must elect the rollover; and
- c. The year-end balance must be frozen

In addition, the funds must be transferred within two and a half months after the end of the plan year and result in a zero balance in the health FSA or HRA.

Notice 2007-22

FSA Timing Problem

Remember, unused amounts remaining at the end of a health FSA's plan year must be forfeited in the absence of a grace period. Thus, if a health FSA does not have a grace period, unused amounts remaining at the end of the plan year are forfeited and cannot be transferred to an HSA after the end of the plan year. Although the unused amounts can be distributed to an HSA before the end of the plan year, because the health FSA coverage continues until the end of the plan year, an individual covered by the health FSA is not an eligible individual immediately after the qualified HSA distribution. Any such qualified HSA distribution is included in income and subject to an additional 10 percent excise tax. Similarly, an individual without HDHP coverage after a distribution is not an eligible individual after the distribution and thus the qualified HSA distribution is included in income and subject to an additional 10 percent excise tax. Another problem is that unless a participant has a change in status health FSA elections may not be changed during a plan year.

HRA Coverage Fix

1. Effective on the first day of the immediately following HRA plan year, the employee elects to waive participation in the HRA, or
2. Effective on or before the first day of the following HRA plan year, the employer terminates the general purpose HRA with respect to all employees, or
3. Effective on or before the first day of the following HRA plan year, with respect to all employees, the employer converts the general purpose HRA to an HSA compatible HRA.

FSA Grace Period Issues

1. The employer amends the health FSA or HRA written plan effective by the last day of the plan year to allow a qualified HSA distribution,
2. A qualified HSA distribution from the health FSA or HRA has not been previously made on behalf of the employee with respect to that particular health FSA or HRA,
3. The employee has HDHP coverage as of the first day of the month during which the qualified HSA distribution occurs, and is otherwise an eligible individual,
4. The employee elects by the last day of the plan year to have the employer make a qualified HSA distribution from the health FSA or HRA to the HSA of the employee,
5. The health FSA or HRA makes no reimbursements to the employee after the last day of the plan year,
6. The employer makes the qualified HSA distribution directly to the HSA trustee by the fifteenth day of the third calendar month following the end of the immediately preceding plan year, but after the employee becomes HSA-eligible,
7. The qualified HSA distribution from the health FSA or HRA does not exceed the lesser of the balance of the health FSA or HRA on (a) September 21, 2006, or (b) the date of the distribution, and
8. After the qualified HSA distribution there is a zero balance in the health FSA or HRA, and the employee is no longer a participant in any non-HSA compatible health plan or (b) effective on or before the date of the first qualified HSA distribution the general purpose health FSA or general purpose HRA written plan is converted to an HSA-compatible health FSA or HRA, as described in Rev. Rul. 2004-45, for all participants.

FSA Rollover

EXAMPLE 4-15

FSA ROLLOVER

In 2008, Stooges, Inc. has a calendar year general purpose health FSA with a grace period ending on March 15, 2009. Stooges offers employees the option of electing HDHP coverage for the plan year beginning January 1, 2009. Before January 1, 2009, Stooges amends the health FSA to allow for qualified HSA distributions. The amended plan allows an employee electing HDHP coverage to also elect to have any health FSA balance at year-end contributed directly to an HSA trustee. Under the amendment, if an employee elects the qualified HSA distribution, the employee cannot submit any additional claims after December 31, 2009, regardless of when the underlying expense was incurred nor are any claims paid after December 31, even if submitted prior to December 31, 2008.

Larry has a balance of \$950 in the health FSA on September 21, 2006, and a balance of \$700 on December 31, 2008. On or before December 31, 2008, Larry elects HDHP coverage beginning January 1, 2009 and also elects to have a qualified HSA distribution of the \$700 remaining in the health FSA on December 31, 2008. Stooges contributes \$700 to an HSA on Larry's behalf on or before March 15, 2009. Larry is otherwise an eligible individual as of January 1, 2009.

Curly has a balance of \$850 on December 31, 2008. On or before December 31, 2008, Curly elects HDHP coverage for 2009. Curly does not elect to have a qualified HSA distribution of the \$850 remaining in the health FSA on December 31, 2008. As with Larry, Curly is otherwise an eligible individual.

Under these facts, Larry does not fail to be an eligible individual as of January 1, 2009 because after the qualified HSA distribution Larry has a zero balance in the health FSA. Curly is an eligible individual on April 1, 2009.

Zero at 12/31



Covered until
3/31



HRA Rollover

EXAMPLE 4-16a

HRA ROLLOVER

For 2008, Eastwood, LLC has a calendar year general purpose HRA. Eastwood offers employees the option of electing HDHP coverage for the plan year beginning January 1, 2009. Before January 1, 2009, Eastwood amends the HRA to allow for qualified HSA distributions. The amended HRA allows an employee electing HDHP coverage for the plan year to also elect to have the lesser of the balance in the HRA on September 21, 2006 or the HRA balance at year-end contributed directly to an HSA. Under the amendment, if an employee elects the qualified HSA distribution, the employee cannot submit any additional claims after December 31, 2008, regardless of when the underlying expense was incurred, nor will the HRA reimburse any claim submitted but unpaid as of December 31, 2008. The amendment also provides that an employee who elects a qualified HSA distribution may also elect to waive participation in the HRA.

2008 Balance <
9/21/06

Clint has a balance of \$300 in the HRA on September 21, 2006, and a balance of \$175 on December 31, 2008. On or before December 31, 2008, Clint elects HDHP coverage for 2009. Clint also elects to have a qualified HSA distribution of the \$175 remaining in the HRA on December 31, 2008, and to waive participation in the HRA effective after December 31, 2008. Eastwood contributes \$175 to his HSA on or before March 15, 2009. Clint is otherwise an eligible individual as of January 1, 2009.

Harry has a balance of \$300 in the HRA on September 21, 2006, and a balance of \$550 on December 31, 2008. On or before December 31, 2008, Harry elects HDHP coverage for 2008. Harry also elects to have a qualified HSA distribution of the \$300 that was in the HRA on September 21, 2006. Eastwood contributes \$300 to his HSA on March 15, 2009. Harry is otherwise an eligible individual as of January 1, 2009.

2008 Balance >
9/21/06

Has to wait until
2009

Sandra has a balance of \$400 in the HRA on September 21, 2006. On or before December 31, 2008, Sandra elects HDHP coverage for 2009. On June 15, 2008, Sandra has a balance of \$275 in the HRA, and elects to have a qualified HSA distribution of the \$275. Eastwood contributes \$275 to her HSA on August 20, 2008. Sandra is otherwise an eligible individual as of January 1, 2009.

HRA Rollover Results

Clint does not fail to be an eligible individual as of January 1, 2009 because after the qualified HSA distribution he has a zero balance in the HRA and does not participate in any non-HSA compatible HRA. Harry fails to be an eligible individual after the qualified HSA distribution, because he has a balance exceeding zero in the HRA after the distribution. Harry must include \$300 in gross income in 2009, as well as pay an additional 10 percent tax. Sandra fails to be an eligible individual after the qualified HSA distribution, because she remains a participant in an HRA that is not HSA-compatible until the end of the HRA plan year. The result is the same regardless of whether she waived participation in the HRA after June 15, 2008. Thus, Sandra must include \$275 in gross income in 2008, as well as pay an additional 10 percent tax.

HSA Compliant HRA

EXAMPLE 4-16b

HRA ROLLOVER

Assume the same facts as in Example 4-16a, except Eastwood converted the general purpose HRA to an HSA-compatible retirement HRA for all employees effective January 1, 2009.

Chris has a balance of \$275 in the HRA on September 21, 2006, and a balance of \$700 on December 31, 2008. On or before December 31, 2008, Chris elects HDHP coverage beginning January 1, 2009 and is otherwise an eligible individual as of January 1, 2009. Chris also elects to have a qualified HSA distribution of the \$275 that was in the HRA on September 21, 2006. Eastwood contributes \$275 to his HSA on or before March 15, 2009. Chris has a balance of \$425 in a retirement HRA and remains an active employee. Chris is an eligible individual as of January 1, 2009, because the HRA Chris participates in is HSA-compatible.

Proprietorship and Comparability

EXAMPLE 4-17

PROPRIETORSHIP HSA

Joe, a sole proprietor is an eligible individual and contributes \$1,000 to his own HSA. Joe also contributes \$500 for the same calendar year to the HSA of each employee who is an eligible individual. The comparability rules are not violated by Joes's \$1,000 contribution to his own HSA.

Partnership and Comparability

EXAMPLE 4-18

PARTNERSHIP HSA

Tax Specialists is a limited partnership with three equal individual partners, Val (a general partner), Sue (a limited partner), and Jill (a limited partner). Jill is to be paid \$300 annually for services rendered to Tax Specialists in her capacity as a partner without regard to partnership income (an IRC Sec. 707(c) guaranteed payment). Oliver and Stan are the only employees of Tax Specialists and are not partners. Val, Sue, Jill, Oliver and Stan are eligible individuals and each has an HSA. During Tax Specialists' taxable year, which is also a calendar year, it makes the following contributions:

1. A \$300 contribution to each of Val's and Sue's HSAs that are treated as IRC Sec. 731 distributions to them;
2. A \$300 contribution to Jill's HSA in lieu of paying her the guaranteed payment directly; and
3. A \$200 contribution to each of Oliver's and Stan's HSAs, who are comparable participating employees.

Tax Specialists' contributions to Val's and Sue's HSAs are IRC Sec. 731 distributions, treated as cash distributions. Tax Specialists' contribution to Jill's HSA is treated as a guaranteed payment under IRC Sec. 707(c). Thus, it is not treated as compensation to an employee. Accordingly, Tax Specialists' contributions to the HSAs of Val, Sue and Jill are not subject to the comparability rules. Tax Specialist's contributions to Oliver's and Stan's HSAs are subject to the comparability rules because they are employees and not partners in Tax Specialists. Based on the facts, Tax Specialists' contributions satisfy the comparability rules.

No comparability issue



No comparability issue



Comparability applies



Outside HDHP Coverage

EXAMPLE 4-19a

COMPARABILITY

Notsohot, Inc. offers an HDHP to its full-time employees. Most full-time employees are covered under Notsohot's HDHP and Notsohot makes comparable contributions only to these employees' HSAs. Mark, a full-time employee and an eligible individual, is covered under his spouse's HDHP and not under Notsohot's HDHP. Notsohot is not required to make comparable contributions to Mark's HSA.

Can restrict to only HDHP coverage employer provides

Outside HDHP Coverage

EXAMPLE 4-19b

COMPARABILITY

Mainframe, Inc. doesn't offer an HDHP. Several full-time employees, who are eligible individuals, have HSAs. Mainframe contributes to these employees' HSAs. Mainframe must make comparable contributions to the HSAs of all full-time employees who are eligible individuals.

Can offer only to those with their own HDHP coverage

Outside HDHP Coverage

EXAMPLE 4-19c

COMPARABILITY

Notsure, Inc. offers an HDHP to its full-time employees. Most full-time employees are covered under Notsure's HDHP and Notsure makes comparable contributions to these employees' HSAs and also to HSAs of full-time employees not covered under Notsure's HDHP. Pat, a full-time employee and an eligible individual, is covered under his spouse's HDHP and not under Notsure's HDHP. Notsure must make comparable contributions to Pat's HSA.

If do both, must do so consistently

Comparable Categories

- Single coverage is one group
- Family coverage is another
 - Can also subgroup family coverage by number covered
 - But can't give better benefit to those with fewer family beneficiaries (though can skip single and still give family)

Differing Categories

EXAMPLE 4-19d

COMPARABILITY

Bigsales, Inc. maintains an HDHP and contributes to the HSAs of eligible employees who are covered under the HDHP. The HDHP has self-only coverage and family coverage. Bigsales contributes \$750 to the HSA of each eligible employee with self-only HDHP coverage and \$1,000 to the HSA of each eligible employee with family HDHP coverage. Bigsale's contributions satisfy the comparability rules.

Can differentiate between family and self-only

Differing Categories

EXAMPLE 4-19e

COMPARABILITY

Manymore LLC maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has the following coverage options:

1. Self-only;
2. Self plus spouse;
3. Self plus dependent;
4. Self plus spouse plus one dependent;
5. Self plus two dependents; and
6. Self plus spouse and two or more dependents.

The self plus spouse category and the self plus dependent category constitute the same category of HDHP coverage (self plus one) and Manymore must make the same comparable contributions to the HSAs of all eligible individuals who are in either the self plus spouse category of HDHP coverage or the self plus dependent category of HDHP coverage. Likewise, the self plus spouse plus one dependent category and the self plus two dependents category constitute the same category of HDHP coverage (self plus two) and Manymore must make the same comparable contributions to the HSAs of all eligible individuals who are in either of those categories.

Family grouping by numbers

Differing Categories

EXAMPLE 4-19f

COMPARABILITY

Lost profits maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has the following coverage options:

1. Self-only;
2. Self plus one;
3. Self plus two; and
4. Self plus three or more.

Lost profits contributes

1. \$500 to the HSA of each eligible employee with self-only HDHP coverage
2. \$750 to the HSA of each eligible employee with self plus one HDHP coverage
3. \$900 to the HSA of each eligible employee with self plus two HDHP coverage and
4. \$1,000 to the HSA of each eligible employee with self plus three or more HDHP coverage.

Lost profits' contributions satisfy the comparability rules.

Notice Language

Notice to Employees Regarding Employer Contributions to HSAs:

This notice explains how you may be eligible to receive contributions from [employer] if you are covered by a High Deductible Health Plan (HDHP). [Employer] provides contributions to the Health Savings Account (HSA) of each employee who is [insert employer's eligibility requirements for HSA contributions] ("eligible employee"). If you are an eligible employee, you must do the following in order to receive an employer contribution:

1. establish an HSA on or before the last day in February of [insert year after the year for which the contribution is being made] and;
2. notify [insert name and contact information for appropriate person to be contacted] of your HSA account information on or before the last day in February of [insert year after year for which the contribution is being made]. [Specify the HSA account information that the employee must provide (e.g., account number, name and address of trustee or custodian, etc.) and the method by which the employee must provide this account information (e.g., in writing, by e-mail, on a certain form, etc.)].

If you establish your HSA on or before the last day of February in [insert year after year for which the contribution is being made] and notify [employer] of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for [insert year for which contribution is being made] by April 15 of [insert year after year for which contribution is being made]. If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then we are not required to make any contributions to your HSA for [insert applicable year]. You may notify us that you have established an HSA by sending an [e-mail or] a written notice to [insert name, title and, if applicable, e-mail address]. If you have any questions about this notice, you can contact [insert name and title] at [insert telephone number or other contact information].

Timing of Notices

Example 4-19g

Comparability

Good Guy, Inc. contributes to the HSAs of current employees who are eligible individuals covered under any HDHP. For the 2009 calendar year, Good Guy contributes \$50 per month on the first day of each month, beginning January 1st, to the HSA of each employee who is an eligible employee on that date. For the 2009 calendar year, Good Guy provides a qualified written notice on October 16, 2008 to all employees regarding the availability of HSA contributions for eligible employees. For eligible employees who are hired after October 16, 2008, Good Guy provides such a notice on January 15, 2010. Good Guy satisfies the notice requirements.

**90 Day prior rule for existing
January 15 rule for new**

Excise Tax

EXAMPLE 4-20

EXCISE TAX

During 2008, Cheapskate, Inc., has 8 employees who are eligible individuals with self-only coverage under Cheapskate's HDHP provided by Cheapskate. The deductible for the HDHP is \$2,000. For the 2008 calendar year, Cheapskate contributes \$2,000 each to the HSAs of two employees and \$1,000 each to the HSAs of the other six employees, for total HSA contributions of \$10,000. Cheapskate's contributions do not satisfy the comparability rules. Therefore, Cheapskate is subject to an excise tax of \$3,500 (35% of \$10,000) for its failure to make comparable contributions to its employees' HSAs.

35% of all amounts contributed to all HSAs

Union vs. Nonunion

EXAMPLE 4-21a

CATEGORIZATION

The Good Company offers its employees an HDHP with a \$1,500 deductible for self-only coverage. Good has collectively bargained and non-collectively bargained employees. In the 2008 calendar year, Good contributes \$500 to the HSAs of all eligible non-collectively bargained employees with self-only coverage under its HDHP. Employer Good does not contribute to the HSAs of the collectively bargained employees. Good's contributions to the HSAs of non-collectively bargained employees satisfy the comparability rules. The comparability rules do not apply to collectively bargained employees.

**Collectively bargained employees and others
can be treated differently**

Union vs. Non-Union

EXAMPLE 4-21b

CATEGORIZATION

Highprofit, Inc. offers its employees an HDHP with a \$1,500 deductible for self-only coverage. Highprofit has collectively bargained and non-collectively bargained employees. Highprofit contributes to the HSAs of all eligible collectively bargained employees. Highprofit does not contribute to the HSAs of the non-collectively bargained employees. Highprofit's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules. Accordingly, Highprofit's failure to contribute to the HSAs of the non-collectively bargained employees does not violate the comparability rules.

Could exclude non-union even if covering unionized employees under the CBA

Outside Coverage

EXAMPLE 4-22a

COMPARABLE CONTRIBUTIONS

Healthful, LLC offers an HDHP to its full-time employees. Most full-time employees are covered under Healthful's HDHP and Healthful makes comparable contributions only to these employees' HSAs. Lisa, a full-time employee and an eligible individual, is covered under an HDHP provided by the employer of Lisa's spouse and not under Healthful's HDHP. Healthful is not required to make comparable contributions Lisa's HSA.

Can ignore outside coverage if ignore
it for all individuals

Outside Coverage

EXAMPLE 4-22b

COMPARABLE CONTRIBUTIONS

In 2008, Sleeper, Inc. does not offer an HDHP. Several full-time employees of Sleeper, who are eligible individuals, have HSAs. Sleeper contributes to these employees' HSAs. Sleeper must make comparable contributions to the HSAs of all full-time employees who are eligible individuals.

If recognize one employee's outside coverage will have to recognize all (subject to grouping rules)

Outside Coverage

EXAMPLE 4-22c

COMPARABLE CONTRIBUTIONS

Confused, LLC offers an HDHP to its full-time employees. Most full-time employees are covered under Confused's HDHP and Confused makes comparable contributions to these employees' HSAs and also to the HSAs of full-time employees who are eligible individuals and who are not covered under Confused's HDHP. Terri, a full-time employee and a comparable participating employee, is covered under an HDHP provided by the employer of Terri's spouse and not under Confused's HDHP. Confused must make comparable contributions to Terri's HSA.

Recognizing outside coverage can
create more consequences than expected

Spousal Confusion

COMPARABLE CONTRIBUTIONS

Greedy, Inc. offers an HDHP to its full-time employees. Most full-time employees are covered under Greedy's HDHP and Greedy makes comparable contributions only to these employees' HSAs. Ray and Debra are a married couple. Ray, who is a full-time employee and an eligible individual, has family coverage under Greedy's HDHP for Ray and Debra. Debra, who is also a full-time employee and an eligible individual, does not have coverage under Greedy's HDHP except as Ray's spouse. Greedy is required to make comparable contributions to Ray's HSA, but is not required to make comparable contributions to Debra's HSA.

Debra can be ignored since her coverage technically “our” plan providing to her as a employee (rather as a spouse)

Spousal Confusion

EXAMPLE 4-22e

COMPARABLE CONTRIBUTIONS

Trader, Inc. offers an HDHP to its full-time employees. Most full-time employees are covered under Trader's HDHP and Trader makes comparable contributions to these employees' HSAs and to the HSAs of full-time employees who are eligible individuals but are not covered under Trader's HDHP. Shannon and Ellen are a married couple. Shannon, who is a full-time employee and an eligible individual, has family coverage under Trader's HDHP for Shannon and his spouse Ellen. Ellen, who is also a full-time employee and an eligible individual, does not have coverage under Trader's HDHP except as the spouse of Shannon. Trader must make comparable contributions to Shannon's HSA and to Ellen's HSA.

Since we recognize “outside” coverage
have to contribute for Ellen

I Hate Families Option

EXAMPLE 4-23a

COMPARABILITY COMPUTATION

Wildman, LLC offers its full-time employees three health plans, including an HDHP with self-only coverage and a \$2,000 deductible. Wildman contributes \$1,000 for the calendar year to the HSA of each employee electing the self-only HDHP coverage. Wildman makes no HSA contributions for employees with family HDHP coverage or for employees who do not elect the employer's self-only HDHP. Wildman's HSA contributions satisfy the comparability rules.

**Beneficiary count rule doesn't extend between
family & self-only**

Families are OK

EXAMPLE 4-23b

COMPARABILITY COMPUTATION

Greatideas, Inc. offers its employees an HDHP with a \$3,000 deductible for self-only coverage and a \$4,000 deductible for family coverage. Greatideas contributes \$1,000 for the calendar year to the HSA of each employee electing the self-only HDHP coverage and contributes \$2,000 for the calendar year to the HSA of each employee electing the family HDHP coverage. Greatideas' HSA contributions satisfy the comparability rules.

Two Ways to Be Comparable

EXAMPLE 4-23c

COMPARABILITY COMPUTATION

Mainline, Inc. maintains two HDHPs. Plan A has a \$2,000 deductible for self-only coverage and a \$4,000 deductible for family coverage. Plan B has a \$2,500 deductible for self-only coverage and a \$4,500 deductible for family coverage. Mainline makes contributions to the HSA of each full-time employee covered under Plan A of \$600 for self-only coverage and \$1,000 for family coverage. Mainline satisfies the comparability rules, if it makes either of the following contributions to the HSA of each full-time employee covered under Plan B:

1. \$600 for each full-time employee with self-only coverage and \$1,000 for each full-time employee with family coverage; or
2. \$750 for each employee with self-only coverage and \$1,125 for each employee with family coverage (the same percentage of the deductible Mainline contributes for full-time employees covered under Plan A, 30% of the deductible for self-only coverage and 25% of the deductible for family coverage).

Can be % of deductible or absolute \$ amount

Still Can Segregate

EXAMPLE 4-23d

COMPARABILITY COMPUTATION

Mainline also makes contributions to the HSA of each part-time employee covered under Plan A of \$300 for self-only coverage and \$500 for family coverage. Mainline satisfies the comparability rules, if it makes either of the following contributions for the 2008 calendar year to the HSA of each part-time employee covered under Plan B:

1. \$300 for each part-time employee with self-only coverage and \$500 for each part-time employee with family coverage; or
2. \$375 for each part-time employee with self-only coverage and \$563 for each part-time employee with family coverage (the same percentage of the deductible Employer E contributes for part-time employees covered under Plan A, 15% of the deductible for self-only coverage and 12.5% of the deductible for family coverage).

Could do absolute \$ for full time, % of deductible for part timers, and vice versa

Funding

- Pay as you go
- Lookback method

Choosing Health Plan Design

Module 5