

## **HSA "Stacking" Guidance Includes Both Good and Bad News for HRA and FSA Plans**

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On May 11th, the Treasury Department issued yet another round of guidance regarding Health Savings Accounts ("HSAs"). This most recent round of guidance, Rev. Rul. 2004-45, identifies the circumstances under which HSA "eligible individuals" can make or receive tax-favored contributions to HSAs and also be covered under a Health Flexible Spending Account ("FSA") and/or Health Reimbursement Arrangement ("HRA"). The ruling generally concludes that an individual is not an HSA eligible individual if the individual is covered under a Health FSA and/or HRA. Thus, an HRA or FSA with an "open plan" design is not permitted. Limited exceptions exist allowing "stacking" of HSA coverage with an FSA or HRA in any combination of the following situations: i) coverage under the FSA or HRA arrangement is limited to "permitted coverage" or preventive care, and for HRAs only, "permitted insurance" benefits; ii) coverage under the FSA or HRA arrangement is limited to expenses incurred above the statutory minimum deductible (either its own high deductible or that of the HDHP); iii) coverage is provided through a "retiree HRA" whereby contributions made to an active employee's HRA who is also in an HSA cannot be used until after retirement; or iv) an election is made for coverage under an HRA to be "suspended" (except for benefits for preventive care, permitted insurance, or permitted coverage) during HRA coverage periods in which the individual makes or receives HSA contributions.

### **Background**

Code Section 223 indicates that an individual is not an "eligible individual" unless the individual is covered by a qualifying HDHP and is not also covered by a non-high deductible health plan ("Non-HDHP") that covers the same benefits as the HDHP except for "permitted coverage" or "permitted insurance". It was hoped that FSAs and HRAs that provided benefits for expenses not covered under the HDHP (e.g., over-the-counter expenses) would be permitted. However, in Rev. Rul. 2004-38, it was held that an individual cannot be an "eligible individual" and be covered by any other health plan that is not also a qualifying high deductible health plan ("HDHP") unless the other health plan is limited only to "permitted coverage" (e.g. dental or vision) or "permitted insurance" (specified disease, hospital indemnity). Although the fact pattern addressed in Rev. Rul. 2004-38 involved an HDHP and separate prescription drug plan, the holding applies generally to all health plans, presumably even Health FSAs and HRAs.

### **Health FSAs, HRAs, and eligible individuals after Rev. Rul. 2004-45**

Rev. Rul. 2004-45 addresses the Health FSA/HRA and "eligible individual" interaction issue through five (5) different scenarios. In the end, an individual is not an HSA eligible individual if the individual is covered under a general purpose FSA or HRA - i.e., an HRA or FSA that covers all medical expenses as defined in Section 213(d). This includes the plan of the individual's employer as well as the individual's spouse's employer. Thus, an individual may inadvertently be disqualified because his or her spouse is covered under the spouse's employer's FSA. This may cause employers to consider offering an "employee only" option for FSAs and HRAs. Such an arrangement would be permissible under applicable statutory and regulatory authority; however, it may be administratively difficult under current systems to identify who has single coverage and who has family coverage.

An individual may, however, continue to be an HSA eligible individual if one or more of the following applies:

(1). *Limited Purpose FSA or HRA*. An otherwise eligible individual may be covered under an FSA and/or HRA that covers one or more of the following:

- Preventive care (as defined in IRS Notice 2004-23);

- Permitted coverage expenses such as dental or vision expenses. (However, an FSA is constrained by Section 125 rules from reimbursing insurance or long term care services); or
- For an HRA only, benefits for permitted insurance (e.g., insurance for a specified disease or illness, or that provides a fixed amount per day (or other period) for hospitalization). The limitation to HRAs under this last category is puzzling. One interpretation is that a literal reading of the statute would limit the permitted insurance exception to benefits provided through a commercial insurance contract. And, as noted above, Section 125 rules prohibit an FSA from reimbursing insurance premiums. The reading seems to suggest that an HRA cannot reimburse the actual expenses (as opposed to the insurance premiums) covered under the permitted insurance exception (e.g., expenses for a specified disease or illness or an amount for each day of hospitalization).

The ruling also confirms that such benefits could be provided under the HDHP, without regard to the statutory deductible for HSAs. Unfortunately, over the counter ("OTC") drugs are not on this list in spite of the effort given by the IRS and Treasury to make OTC drug expenses reimbursable under FSAs and HRAs.

(2). *High deductible FSAs and HRAs for general expenses are permitted.* An individual covered under a general purpose FSA or HSA is still an eligible individual if the FSA and HRA do not pay benefits until the statutory deductible for the HDHP is satisfied. Three special rules apply:

- It is not necessary that the FSA and/or HRA have the same deductible limits as the HDHP. However, where the FSA/HRA have different deductible limits than the HDHP, the HSA contribution is limited to the lowest deductible under the HDHP or HRA/FSA;
- While the deductible under the HDHP and HRA/FSA may be satisfied by separate expenses, no benefit can be paid until the deductible is satisfied; and
- If substantially all of the coverage in a health plan that is intended to be an HDHP is provided through a FSA or HRA, the health plan is not an HDHP. Therefore, the high deductible FSA and/or HRA would have to be offered in conjunction with a traditional HDHP in order to maintain eligible individual status.

An interesting issue arises with respect to the minimum deductible for FSAs and HRAs. Generally, FSAs (and to a lesser extent HRAs) automatically cover expenses incurred by all eligible dependents (i.e. you don't have to affirmatively enroll your spouse and/or children in order to receive reimbursement for their expenses under the FSA). In essence, an FSA provides "family" coverage for the individual who has any eligible dependents. Presumably, in that case, the Health FSA deductible must be at least \$2000 (in 2004) for an individual with any dependents -- even if the individual has single coverage under the HDHP with only a \$1000 deductible. As we note above, employers may begin offering single only FSAs so that individuals can avoid disqualifying their spouse from HSA eligibility.

(3). *Suspended HRAs.* An individual can continue to maintain an HRA balance (and presumably receive accruals to his or her general purpose HRA) and continue to be an HSA eligible individual if an election is made to "suspend" coverage under the HRA for expenses other than preventive care, permitted coverage, or permitted benefits. This rule helps accommodate early HRA adopters by allowing a way for the HRA and HSA to co-exist. To take advantage of this exception, an election must be made "prior to the beginning of the coverage period" to suspend the use of funds for general 213(d) medical purposes and limit reimbursement only to expenses constituting permitted coverage (dental or vision), permitted insurance (specified disease) and/or preventive care. The guidance clarifies that, as long as the HSA salary reduction agreement specifies that it is for the HSA, salary reductions will not be attributed to the HRA arrangement. One ambiguity that arises with regard to the suspension rule relates to exactly when the "suspension" election must be made. Since the coverage period under an HRA may be the period during which the individual is an HRA participant and not necessarily a plan year, it is not clear

the date by which the election to suspend must be made. If the HRA does not operate on a plan year basis (i.e. funds may be reimbursed at any time so long as they were incurred while an HRA participant), must the election be made prior to the date the individual becomes an HRA participant or can it be made after the individual becomes a participant. Hopefully, Treasury officials will clarify that the election can be made prior to the beginning of any HRA plan year so long as it is prospectively effective.

(4). *Retiree HRAs.* An HSA eligible individual can accrue HRA benefits for an HRA that covers expenses incurred after retirement. Under this scenario, no expenses incurred prior to retirement can be reimbursed. While the definition of "retirement" is unclear, presumably any "retirement option" (including early retirement) under an employer's qualified plan would qualify. Treasury officials commented that such an HRA could reimburse expenses for pre-Medicare retirees. Presumably former employees who terminate prior to retirement eligibility, but who have a vested balance, may qualify upon ultimate retirement. Also, once the individual retires and the funds become eligible for general medical expenses, the individual will cease to be an HSA eligible individual.

### **Ordering of HSA and FSA/HRA Distributions**

The ruling also addresses the ordering of expense reimbursements for an HRA/FSA participant who also has an HSA account. The ruling clarifies that an individual may use the ordering rule applicable to HRAs (under Notice 2002-45, Part V) pursuant to which FSA funds (which are subject to the "use-it-or-lose-it" rule) may be paid prior to HRA funds. The individual must certify that he or she will not seek reimbursement under any other plan or arrangement (including the HSA). It would seem appropriate for FSA administrators to include such language in their claim reimbursement forms to accommodate the possibility of future HSA participation.

<sup>1</sup> Code Section 223(c)(1).

<sup>2</sup> Including a health plan of the individual's employer or the individual's spouse's employer.

<sup>3</sup> "Permitted coverage" is defined as accident, disability, dental, vision and long term care coverage. "Permitted insurance" is defined as one of the following: a) insurance for which substantially all of the coverage relates to workers' compensation, property or tort liabilities (i.e. liability coverage that happens to provide some medical coverage) b) insurance for a specified disease or c) insurance paying a fixed amount of hospitalization per day or other period.