Health Savings Accounts (HSAs)—High Deductible Health Plans

Health savings accounts (HSAs) are a popular type of tax-advantaged medical savings account available to individuals who are enrolled in high deductible health plans (HDHPs). Individuals can use their HSAs to pay for expenses that are covered under the HDHP until their deductible has been met, or they can use their HSAs to pay for qualified medical expenses that are not covered under the HDHP, such as dental or vision expenses.

Due to an HSA's potential tax savings, federal tax law imposes strict eligibility requirements for HSA contributions. Among other eligibility requirements, an individual must be covered under an HDHP for the months for which contributions are made to his or her HSA.

To qualify as an HDHP, a health plan must provide significant benefits and satisfy requirements for minimum deductibles and out-of-pocket maximums. As a general rule, an HDHP cannot pay benefits until the required minimum deductible has been satisfied—except for preventive care benefits.

Overview of Eligibility Rules

An individual's eligibility for HSA contributions is generally determined monthly, as of the first day of the month. The HSA contribution limit is calculated each month, and a contribution can only be made for the months in which the individual meets all the HSA eligibility requirements.

To be HSA-eligible for a month, an individual must:

- Be covered by an HDHP on the first day of the month;
- Not be covered by other health coverage that is not an HDHP (with certain exceptions);
- Not be enrolled in Medicare; and
- Not be eligible to be claimed as a dependent on another person's tax return.

The **full-contribution rule** that applies to individuals who are HSA-eligible on Dec. 1 is an exception to this general rule. Under this exception, an individual is treated as HSA-eligible for the entire calendar year for purposes of HSA contributions if he or she becomes covered under an HDHP in a month other than January and is HSA-eligible on Dec. 1 of that year. An individual who relies on this special rule must generally remain HSA-eligible during a 13-month testing period, with exceptions for death and disability.

HDHP Coverage Requirement

To be eligible for HSA contributions for a month, an individual must be covered under an HDHP as of the first day of the month and have no other impermissible coverage.

An HDHP is a health plan that provides "**significant benefits**" and satisfies requirements for **minimum deductibles and out-of-pocket maximums**. An HDHP can be insured or self-funded. Also, the HDHP coverage can be self-only coverage or family coverage. For this purpose, family coverage means any coverage other than self-only coverage.

Except for preventive care benefits, no benefits can be paid by an HDHP until the minimum annual deductible has been satisfied.

Special Exceptions - Minimum Deductible Requirement

COVID-19 Testing and Treatment

March 11, 2020, the IRS issued Notice 2020-15 to allow HDHPs to pay for **COVID-19 testing and treatment** before plan deductibles have been met, without jeopardizing their status. On June 23, 2023, the IRS issued Notice 2023-37 to update its guidance for HDHPs on expenses related to COVID-19 testing and treatment. Notice 2023-37 explains that because the COVID-19 federal emergency periods have ended, the relief provided by Notice 2020-15 is no longer needed. Thus, **for plan years ending after Dec. 31, 2024**, an HDHP is not permitted to provide benefits for COVID-19 testing and treatment without a deductible (or with a deductible below the minimum deductible for an HDHP).

Telehealth and Other Remote Care Services

The Coronavirus Aid, Relief and Economic Security Act (CARES Act) allowed HDHPs to provide benefits for **telehealth or other remote care services** before plan deductibles were met, for plan years beginning before Jan. 1, 2022. A spending bill signed into law on March 15, 2022, extended the ability of HDHPs to provide benefits for telehealth or other remote care services before plan deductibles have been met without jeopardizing HSA eligibility. This extension applied to any telehealth services from April 2022 through the end of 2022.

The Consolidated Appropriations Act, 2023, which was signed into law on Dec. 29, 2022, further extends the ability of HDHPs to provide benefits for telehealth or other remote care services before plan deductibles have been met without jeopardizing HSA eligibility. This extension applies for plan years beginning after Dec. 31, 2022, and before Jan. 1, 2025. HDHPs may choose to waive the deductible for any telehealth services for plan years beginning in 2023 and 2024, without causing participants to lose HSA eligibility. This provision is optional; HDHPs can continue to choose to apply any telehealth services toward the deductible. Note that there is a gap for non-calendar year plans from Jan. 1, 2023 (when the spending bill's extension expired) to the start of the 2023 plan year during which this temporary relief for telehealth services does not apply.

Significant Benefits

An HDHP must provide "significant benefits," although it may be designed with reasonable restrictions limiting the plan's covered benefits. The restrictions will be reasonable only if other significant benefits remain under the plan in addition to the benefits subject to the restrictions. For example, a plan that restricts benefits to expenses for hospitalization or in-patient care, and excludes out-patient services, is not an HDHP because it does not provide other significant benefits in addition to the benefits subject to the exclusion.

A plan will not qualify as an HDHP if substantially all its coverage is either "permitted insurance" or "permitted coverage" (for example, coverage for accidents, disability, dental care or vision care). Also, if substantially all the coverage that is intended to be an HDHP is provided through a health flexible spending account (FSA) or health reimbursement arrangement (HRA), the health plan is generally not an HDHP.

Cost-Sharing Limits

The minimum annual deductible and maximum out-of-pocket requirements for HDHPs for plan years beginning on or after Jan. 1, 2023, are as follows:

Type of Coverage	Minimum Annual Deductible	Annual Out-of-pocket Maximum
Self-only	**$1,500** ($1,600 for plan years beginning in 2024)	**$7,500** ($8,050 for plan years beginning in 2042)
Family	**$3,000** ($3,200 for plan years beginning in 2024)	**$15,000** ($16,100 for plan years beginning in 2024)

The minimum annual deductibles and the maximum out-of-pocket expense limits for HDHP coverage are adjusted for increases in the cost-of-living. By June 1 of each calendar year, the IRS publishes the cost-of-living adjustments that will become effective as of the next Jan. 1. For HDHPs with non-calendar plan years, IRS Notice 2004-50 clarifies that the adjusted limits for the calendar year in which the HDHP's plan year begins can be applied for that entire plan year.

Example—Non-calendar Year Plans: *An individual obtains self-only coverage under an HDHP on June 1, 2022, the first day of the plan year, with an annual deductible of $1,400. The cost-of-living adjustments require the minimum deductible amount to be increased from $1,400 for 2022 to $1,500 for 2023. The plan's deductible is not increased to comply with the increased minimum deductible amount until the plan's renewal date of June 1, 2023. The plan satisfies the requirements for an HDHP with respect to deductibles through May 30, 2023.*

Minimum Annual Deductible

For plan years beginning on or after Jan. 1, 2023, an HDHP must have a minimum annual deductible of $1,500 for self-only coverage and $3,000 for family coverage.

Family Coverage—Embedded Deductibles

When an individual has family coverage under an HDHP, no benefits can be paid under the HDHP (except for preventive care) until the minimum annual deductible for family coverage has been met. Some health plans administer family coverage in a way that includes an "**embedded deductible**." A plan that has an embedded deductible pays claims for a specific individual if he or she has met the individual deductible, even if the family as a whole has not met the family deductible.

An HDHP is not required to include, or prohibited from including, an embedded deductible. However, a health plan does not qualify as an HDHP if there is an embedded deductible that is lower than the required minimum annual deductible for family coverage. Also, the HDHP must be designed to ensure that the embedded individual deductibles do not cause the plan to exceed the out-of-pocket maximum expense limit for family coverage.

Example—Embedded Deductible: *Susan elected family coverage under a health plan for 2023. The plan year begins on Jan. 1 and includes a $1,500 individual deductible and a $3,000 family deductible. Susan incurs $2,000 in medical expenses on Jan. 15. Since the plan has an embedded deductible, Susan is required to pay $1,500 and the plan pays the remaining $500. Although the family deductible was not met, the plan will pay claims for Susan after she has met the individual deductible. Under the IRS rules, this plan does NOT qualify as an HDHP since claims were paid before the $3,000 HSA-required family deductible was met.*

Example—Embedded Deductible: *Susan elected family coverage under a health plan for 2023. The plan year begins on Jan. 1 and includes a $3,000 individual deductible and a $6,000 family deductible. Susan incurs $3,200 in medical expenses on Jan. 15. Since the plan has an embedded deductible, Susan is required to pay $3,000 and the plan pays the remaining $200. Although the plan's family deductible was not met, the plan will pay claims for Susan after she has met the individual deductible. In this example, the plan complies with the IRS rules and qualifies as an HDHP. The plan includes an embedded deductible, but its minimum individual deductible is equal to the minimum HSA-required family deductible.*

Deductible Carry-overs

Some health plans have a **deductible carryover feature** that allows expenses that are incurred below a participant's deductible during the last three months of a plan year to be applied to the participant's deductible in the following plan year. IRS Notice 2004-50 provides that a deductible carryover feature will not prevent a plan from being an HDHP if the required minimum annual deductible for the health plan is proportionately increased to account for the fact that expenses incurred over more than 12 months may be used to satisfy the plan's deductible.

To calculate the adjustment, a health plan must:

- Multiply the applicable required minimum annual deductible for self-only or family HDHP coverage by the number of months allowed in which to satisfy the deductible; and then
- Divide the resulting amount by 12.

The result of this is the adjusted **required minimum annual deductible**.

To qualify as an HDHP, the annual deductible under a health plan with a carry-over feature must be equal to, or greater than, the adjusted required minimum annual deductible. Also, the adjusted required minimum annual deductible cannot exceed the applicable (self-only or family) maximum out-of-pocket expense limit.

Discounted Prices

An HDHP may negotiate discounted prices for health care services from providers. A health plan will not fail to qualify as an HDHP if covered individuals, including those who have not satisfied the plan's deductible, receive health care services at discounted prices.

Prior Plan Coverage

If an employer changes health plans mid-year and the period during which expenses are incurred for purposes of satisfying the deductible is 12 months or less, IRS Notice 2004-50 confirms that the new health plan does not fail to qualify as an HDHP merely because it provides a credit toward the deductible for expenses incurred and not reimbursed during the previous health plan's short plan year. It does not matter whether the prior plan was an HDHP.

Example—Prior Plan Coverage: *An employer with a calendar year health plan switches from a non-HDHP plan to a new plan. Coverage under the new plan begins on July 1. The annual deductible under the new plan satisfies the minimum annual deductible for an HDHP and counts expenses incurred under the prior plan during the first six months of the year in determining if the new plan's annual deductible is satisfied. The new plan satisfies the HDHP deductible limit.*

In addition, if an individual changes coverage during the plan year from self-only HDHP coverage to family HDHP coverage, the family HDHP can take into account the expenses incurred by the individual during the portion of the plan year in which the individual had self-only coverage. This will not affect the plan's HDHP status.

Out-of-Pocket Maximum

To qualify as an HDHP, the sum of the plan's annual deductible and any other annual out-of-pocket expenses that the insured is required to pay, such as copayments and coinsurance (but not premiums), cannot exceed the annual out-of-pocket maximum. The IRS has clarified that copayments must be taken into account for purposes of an HDHP's out-of-pocket maximum, even if the plan does not apply copayments to the deductible.

Example—Copayments: *In 2023, a health plan has a $1,500 deductible for self-only coverage. After the deductible is satisfied, the plan pays 100% of UCR for covered benefits, minus a $20 copayment for doctor's visits and a $100 copayment for emergency room visits. The plan does not include copayments in determining if the $1,500 deductible has been satisfied. The copayments must be included in determining if the plan meets the out-of-pocket maximum. Unless the plan includes an express limit on out-of-pocket expenses of no more than $7,500 (including the copayments) the plan is not an HDHP.*

Special rules apply to health plans that use a **network of providers**. Network plans may qualify as HDHPs even if they have an out-of-pocket maximum for out-of-network services that exceeds the HDHP annual out-of-pocket maximum.

Also, many health plans provide coverage for services only up to the **usual, customary and reasonable (UCR) cost** for the service. When the UCR cost is exceeded, the covered individual is generally responsible for paying the excess, even after the plan's deductible has been satisfied. According to IRS Notice 2004-50, restricting benefits to UCR costs is a reasonable restriction on benefits. Thus, amounts paid by covered individuals in excess of UCR that are not paid by an HDHP are not included in determining maximum out-of-pocket expenses.

A health plan **without an express limit on out-of-pocket expenses** is generally not an HDHP, unless this limit is not necessary to prevent an individual from exceeding the required out-of-pocket maximum.

Example—No Out-of-pocket Maximum: *For the 2023 plan year, a health plan provides self-only coverage with a $3,000 deductible and pays 100% of covered benefits above the deductible. Because the plan pays 100% 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 ensure that the covered individual will not be subject to out-of-pocket expenses in excess of the HDHP maximum.*

Some health plans impose penalties or higher coinsurance payments on individuals who fail to obtain precertification for a specific provider or for certain medical procedures. According to the IRS Notice 2004-50, these penalties or increased copayments are not out-of-pocket expenses and do not count against the maximum out-of-pocket limit.

ACA Cost-sharing Limit

The Affordable Care Act (ACA) imposes an annual limit (or out-of-pocket maximum) on total enrollee cost-sharing for essential health benefits. The ACA's cost-sharing limit, which applies to all non-grandfathered health plans, is higher than the out-of-pocket maximum for HDHPs. For a health plan to qualify as an HDHP, the plan must comply with the lower out-of-pocket maximum limit for HDHPs.

ACA annual cost-sharing limits:

- For 2022, the ACA's out-of-pocket maximum is $8,700 for self-only coverage and $17,400 for family coverage.
- For 2023, the ACA's out-of-pocket maximum is $9,100 for self-only coverage and $18,200 for family coverage.
- For 2024, the ACA's out-of-pocket maximum is $9,450 for self-only coverage and $18,900 for family coverage.

The final rule on the ACA's 2016 benefit and payment parameters provides that the self-only annual limit on cost-sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage. This guidance embeds an individual out-of-pocket maximum in family coverage so that an individual's cost-sharing for essential health benefits cannot exceed the ACA's out-of-pocket maximum for self-only coverage.

In an FAQ, the Department of Health and Human Services (HHS) provides guidance on how this ACA rule affects HDHPs with family deductibles that are higher than the ACA's cost-sharing limit for self-only coverage. According to HHS, an HDHP plan that has a $10,000 family deductible must apply the annual limitation on cost-sharing for self-only coverage ($9,100 in 2023) to each individual in the plan, even if this amount is below the $10,000 family deductible limit. Because the $9,100 self-only maximum limitation on cost-sharing exceeds the 2023 minimum annual deductible amount for HDHPs ($3,000), it will not cause a plan to fail to satisfy the requirements for a family HDHP.

Preventive Care

An HDHP may apply a low deductible (or no deductible) to its coverage of preventive care. IRS Notice 2004-23 indicated that preventive care includes, but is not limited to the following:

- Periodic health examinations, such as annual physicals (including tests and diagnostic procedures ordered in connection with routine examinations);
- Routine prenatal and well-child care;
- Child and adult immunizations, including COVID-19 vaccinations;
- Obesity weight loss programs;
- Screening devices and tests (for example, cancer screening, heart and vascular diseases screening, infectious diseases screening, mental health conditions and substance abuse screening, and pediatric conditions screening); and
- Tobacco cessation.

Preventive care does not generally include any service or benefit intended to treat an existing illness, injury or condition. Also, IRS Notice 2023-37 clarifies that preventive care (as defined by IRS Notice 2004-23) does not currently include COVID-19 screening.

ACA Preventive Care Mandate

Under the ACA, non-grandfathered group health plans are required to provide coverage for preventive care on a “first-dollar basis” (that is, without any copayments, deductibles or other cost sharing). The ACA’s definition of “preventive care” is different from the IRS’s definition of “preventive care” for HSA eligibility purposes. For example, the ACA's definition includes evidence-based items or services that have, in effect, a rating of A or B in the current recommendations of the U.S. Preventive Services Task Fore (USPSTF).

IRS Notice 2013-57 provides that a health plan will not fail to qualify as an HDHP merely because it provides the preventive care services required by the ACA without a deductible.

In March 2023, the U.S. District Court for the Northern District of Texas struck down the ACA’s preventive care coverage requirements based on an A or B rating by the USPSTF on or after March 23, 2010. While the District Court’s ruling is currently on hold pending the case’s appeal, the future of this coverage requirement is uncertain. IRS Notice 2023-37 clarifies that HDHPs may continue to treat items and services with an A or B rating by the USPSTF on or after March 23, 2010, as preventive care that may be covered without a deductible, regardless of whether this coverage is required under the ACA

Care for Chronic Conditions

On July 17, 2019, the IRS released Notice 2019-45 to add care for a range of chronic conditions to the list of preventive care benefits that can be provided by a HDHP without a deductible. Notice 2019-45 provides that certain medical care services and items, including prescription drugs, for certain chronic conditions should be classified as preventive care under the HDHP rules for individuals with those chronic conditions.

These medical services and items are limited to the ones listed below for individuals with the corresponding conditions:

Preventive care for specified conditions For individuals diagnosed with Angiotensin converting enzyme (ACE) inhibitorsCongestive heart failure, diabetes and/or coronary artery disease Anti-resorptive therapyOsteoporosis and/or osteopenia Beta-blockersCongestive heart failure and/or coronary artery disease Blood pressure monitorHypertension Inhaled corticosteroidsAsthma Peak flow meter Insulin and other glucose-lowering agentsDiabetes Retinopathy screening Glucometer Hemoglobin A1c testing International normalized ratio (INR) testingLiver disease and/or bleeding disorders Low-density lipoprotein (LDL) testingHeart disease Selective serotonin reuptake inhibitors (SSRIs)Depression StatinsHeart disease and/or diabetes

Expanded Coverage of Insulin

The Inflation Reduction Act, which was signed into law on Aug. 16, 2022, expands the ability of HDHPs to cover insulin as a preventive care benefit, prior to the satisfaction of the annual deductible. Effective for plan years beginning on or after Jan. 1, 2023, an HDHP can cover selected insulin products prior to the deductible, regardless of whether the individual has been diagnosed with diabetes. “Selected insulin products” means any dosage form (such as vial, pump or inhaler dosage forms) of any different type (such as rapid-acting, short-acting, intermediate-acting, long-acting, ultra long-acting and premixed) of insulin.