Section 220.—Medical Savings Accounts

Definition of high-deductible health plan. Guidance is given concerning the definition of a ''high-deductible health plan'' under section 220(c)(2)(A) of the Code.

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ISSUE

In the case of family coverage, what constitutes a ''high-deductible health plan'' for purposes of section 220(c)(2)(A) of the Code?

FACTS

Situation 1

Plan A is a health plan that provides for the payment of medical expenses. Taxpayer X and her family are covered by Plan A. Plan A provides for payment of covered medical expenses for all members of the family after the family's total covered medical expenses exceed $3,000 for the year. Plan A does not provide for payment of covered medical expenses until the family's total covered medical expenses exceed $3,000 for the year, regardless of which family member or members incur those covered expenses. Plan A limits out-of-pocket expenses to $5,000 for any year.

Situation 2

Plan B is a health plan that provides for the payment of medical expenses. Taxpayer Y and his family are covered by Plan B. Plan B provides for payment of covered medical expenses for all members of the family after the family has satisfied a family deductible of $3,000 for the year. Plan B also provides for payment of covered medical expenses of any member of the family after that family member has satisfied an individual deductible by incurring covered medical expenses for the year of at least $1,500. Plan B limits out-of-pocket expenses to $5,000 for any year.

Neither of the special rules regarding the definition of a high-deductible health plan applies to Plan A or B (see section 220(c)(2)(B)).

LAW

The Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, added section 220 to the Code to permit eligible individuals to establish medical savings accounts (MSAs) under a pilot project beginning on January 1, 1997.

The section 220(c)(1) definition of an ''eligible individual'' includes, as one prerequisite for eligibility, the requirement that an individual be covered under a high-deductible health plan. Section 220(c)(2)(A) provides that ''[t]he term 'high-deductible health plan' means a health plan —

(i) in the case of self-only coverage, which has an annual deductible which is not less than $1,500 and not more than $2,250,

(ii) in the case of family coverage, which has an annual deductible which is not less than $3,000 and not more than $4,500, and

(iii) the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed —

(I) $3,000 for self-only coverage, and

(II) $5,500 for family coverage.''

Section 220(c)(5) defines family coverage as coverage that is not self-only coverage.

ANALYSIS AND HOLDING

Situation 1

Plan A provides coverage for Taxpayer X and other members of her family and is, therefore, family coverage within the meaning of section 220(c)(5). Because Plan A provides family coverage, Plan A is a high-deductible health plan only if, as required by section 220(c)(2)(A)(ii), it has an annual deductible that is not less than $3,000 and not more than $4,500. Plan A provides for the payment of covered medical expenses for Taxpayer X or her family members only after the family has incurred covered medical expenses during the year of $3,000. Accordingly, the deductible under Plan A is $3,000. Because Plan A has a deductible that is not less than $3,000 and is not more than $4,500, Plan A meets the requirement with respect to the minimum and maximum deductible for a high-deductible health plan under section 220(c)(2)(A)(ii). Because the annual out-of-pocket expenses required to be paid under Plan A can never exceed $5,000, which is less than $5,500, Plan A is a high-deductible health plan for purposes of section 220.

Situation 2

Plan B provides coverage for Taxpayer Y and other members of his family and is, therefore, family coverage within the meaning of section 220(c)(5). Plan B provides for the payment of covered medical expenses of any member of Taxpayer Y's family if the member has incurred covered medical expenses during the year in excess of $1,500, even if the family has not incurred covered medical expenses in excess of $3,000. For example, if Taxpayer Y incurred covered medical expenses of $2,000 in a year, Plan B would pay $500. Accordingly, depending on which family members incur the covered medical expenses, benefits are potentially available under Plan B even if the family's covered medical expenses do not exceed $3,000. Because Plan B provides family coverage with an annual deductible of less than $3,000, Plan B is not a high-deductible health plan as defined in section 220(c)(2).

CONCLUSION

In the case of family coverage, except as provided in section 220(c)(2)(B), a plan is a ''high-deductible health plan'' under section 220(c)(2)(A) only if, under the terms of the plan and without regard to which family member or members incur expenses:

(1) No amounts are payable until the family has incurred annual covered medical expenses in excess of $3,000,

(2) Amounts for covered benefits are always payable after the family has incurred annual covered medical expenses in excess of $4,500, and

(3) The annual out-of-pocket expenses required to be paid under the plan for covered benefits do not exceed $5,500.

APPLICATION OF SECTION 7805(b)

Section 7805(b) of the Code provides that the Secretary may prescribe the extent, if any, to which any ruling relating to the internal revenue laws shall be applied without retroactive effect.

Pursuant to section 7805(b), a health plan acquired before November 1, 1997 that provides family coverage that becomes effective before November 1, 1997 will not fail to be treated as a high-deductible health plan merely because the health plan provides for individual deductibles of at least $1,500 and

not in excess of $2,250 (the permitted range of deductibles for a high-deductible health plan providing self-only coverage). The relief provided in the preceding sentence will apply until the first renewal date on or after December 31, 1997 (in the case of a health plan that provides for renewal) or for the term of the health plan (in the case of a health plan that has a specified term and that does not provide for renewal). For purposes of this paragraph, a health plan that continues in force for an indeterminate period as long as premiums are paid and does not otherwise provide for renewal, will be treated as a health plan that provides for renewal and each premium due date (determined without regard to any grace period) will be treated as a renewal date. In no event will the relief provided in this paragraph terminate before December 31, 1997 or extend beyond December 31, 1998.

DRAFTING INFORMATION

The principal author of this revenue ruling is Felix Zech of the Office of the Associate Chief Counsel (Employee Benefits and Exempt Organizations). For further information regarding this revenue ruling contact Mr. Zech at (202) 622–4606 (not a toll-free number).