Table of Contents

I. Group Health Insurance… 6 items

A. Group Health Insurance is insurance on a group rather than on an individual. In order to qualify for group insurance, ***the group of individuals must NOT have come together for the sole purpose of securing group insurance.*** The most common type of group coverage is called an employee group or an employer sponsored group.

1. **The contract is a master policy.** In group insurance the contract is between a policyholder and the insurance company. The covered persons are those who have a specialized relationship with the group, i.e. employees of an employee or members of a labor union. The employer is the master policyholder and is responsible for all administration duties, enrolling employees, collecting premiums, and informing the employees of benefits.

2. **ERISA** is the Employee Retirement Income Security Act of 1974. The main purpose of ERISA is to protect the interests of employees (and their beneficiaries) who are enrolled in employee benefit plans, and to ensure that employees receive the pensions and group-sponsored welfare benefits that have been promised by their employers. It is a federal law that sets minimum standards for most voluntarily established pension and **health plans** in private industry to provide protection for individuals in these plans. ERISA explains the fiduciary responsibility of employers regarding health plans. e.g. *if an employer was late paying the premium for a health plan, the employer could be responsible for the medical costs incurred that would have otherwise been paid by the insurance company, they have the fiduciary responsibility.*

3. **Certificates of Insurance…** The enrollee will receive an individual certificate of insurance regarding their insurance benefits, rights and conditions under the plan.

4. **Eligible Groups…** A key point is that the group of individuals must not have come together for the sole purpose of securing group insurance. Beyond that, acceptable groups include employers, labor unions, associations, creditors, etc.

5. **Participation Requirement:**

   A ***contributory*** (a.k.a. participating) ***group*** is where the employee contributes some of the premium. With this type of group, the insurance company requires that at least ***75%*** of eligible employees and their dependents be enrolled in the group plan.

A ***noncontributory*** (a.k.a. nonparticipating) ***group*** is where the employer pays all of the premiums. With this type of group, the insurer requires that ***100%*** of eligible employees and their dependents enroll in the plan.

B. Employer Group Health Insurance

1. **Underwriting Criteria** The group product is underwritten on group averages: average age and gender (ratio of men to women), occupation, general physical and moral status of the group as a whole. An employer provides coverage for his employees. Since group policies are issued on a ***non-medical*** basis, adverse selection could be a problem. The following are steps taken to reduce or avoid adverse selection:

2. **Employment Probationary Period**(usually 60 days) is nothing more than a period of time established by the employer for all new employees before the employee will be eligible for any group benefits. It is an employer-imposed deductible measured in days rather than dollars. Once the probation period is over, the employee is eligible to enroll for benefits and must do so within the eligibility period. If they choose to not enroll immediately, they must wait for the open enrollment period, usually in November.

3. **Eligibility Period** is a specified period of time, usually 31 days, following the end of the "probation" period during which the employee is entitled to enroll in the group plan if they haven't signed up yet. The eligibility period is the same as a grace period. If a loss occurs during the eligibility period and the enrollee has not signed up for a plan, the minimum coverage available under the Master Policy will be provided.

4. **Open Enrollment** is a period of time, usually in November, where an employee may sign up for or change their benefit plans. Group plans are annual and so in order for everyone to have the proper benefits from January 1 through December 31, sign up occurs in November.

5. Coordination of Benefits Provision (COB)…

It is common for family members to be covered by more than one health care plan. This often happens when a husband and wife both work and choose to have family coverage through both employers, or when both employers offer non-contributory health plans.

The Coordination of Benefits Provision designates one insurer as **primary carrier** and the other insurer as **secondary** (excess) **carrier,** when a family is covered under two group plans. ***This provision prevents over insurance***.

- With a husband and wife, ***the primary insurer is the one that covers the claimant as an employee*.** The other spouse's insurer will be secondary or excess. This gives an insured 100% coverage.
    - ***The primary coverage for children that have duplicate coverage will be the plan of the parent whose birthday occurs first in the year***. (a.k.a. the "Birthday Rule")

6. Conversion of Coverage… If a person loses their coverage due to death or divorce or the child reaching the limiting age (currently 26), that person is eligible to convert to an individual policy.

- To obtain the conversion policy, a person must ***submit a written application*** and the first premium payment not later than **31 days** after the date the person's coverage ends. The conversion policy will become effective, without lapse of coverage, following termination of coverage under the previous policy.
- The insurer determines the premium for the conversion policy in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under the policy, and the type and amount of benefits.

C. COBRA

1. Eligibility for Insurance

COBRA, the Consolidated Omnibus Budget Reconciliation Act of '85, is a Federal Regulation that **requires** that group plans (of ***20 or more employees***) **give continuation privileges** (with the same

insurance company) to those who lose their group health coverage for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

- **Continuation rights** must be requested within ***60 days*** from the date of the qualifying event.

- COBRA **does not** apply if the employee is fired due to ***gross misconduct***, hasn't met his or her ***employment probationary period, or qualifies for other group health insurance.***

2. Duration of Coverage

- **Continuation** of benefits is **18 for loss due to termination of employment, *Being fired, resigning, or being laid-off would qualify an insured for 18 months of continued coverage*.**

- **Continuation of benefits is 36 months** if the **qualifying event** is the death or divorce of an employee, the employee signs up for Medicare and the spouse does not yet qualify, a child ages off the dependent status. In these events, the dependents will be offered 36 months of continued coverage.

3. Premium The employer keeps the employee and/or dependents on the group enrollment and pays the premium to the insurance company. The employer usually bills 100% of the premium to the enrollee. Premiums ***may not be increased*** except that an extra 2% administrative fee may be charged to cover the employer's costs.

II. Health Insurance for Senior Citizens and Special Needs Individuals

6 items

A. Medicaid (a.k.a. Welfare a.k.a. the Apple plan in WA) is a government-sponsored health care program for the financially needy (the poor) and certain other individuals. It helps pay for part or all of a person's medical expenses. It also covers the costs not covered by Medicare and helps pay for nursing home care, including home care and custodial care.

- **Medicaid is funded by State and Federal moneys**, but is ***administered by the States (Department of Social and Health Services [D.S.H.S.])***

- It is ***fraud*** for an agent or broker to write a Medigap or Long-Term Care policy on anyone who is currently on or applying for Medicaid.

- Medicaid pays secondary to Medicare benefits for a person who is eligible for Medicare. This replaces the coverage in a Medigap or Medicare supplement policy.

- In general, an individual must qualify financially as well as one of the following:
  - Be elderly (over 65)
  - Be eligible for welfare and in school up through high school graduation
  - Be blind (any age); or
  - Be totally and permanently disabled (any age)

- **TEFRA** is a federal law, the Tax Equity and Fiscal Responsibility Act, this allows states to extend Medicaid coverage to certain disabled children whose parents' income is too high to otherwise qualify for Medicaid.

- ***Medicare is Medical care for the elderly and certain other individuals. In contrast, Medicaid is Medical Aid for the financially needy. An individual may utilize both Medicare and Medicaid at the same time if they meet all qualifications.*

B. Medicare (www.medicare.gov) is national health insurance for the elderly and disabled. This is a Federal program which gives **hospital**, **medical,** and **prescription drug** benefits to those who are eligible.

People covered under Medicare are called "***beneficiaries***." Anyone who is eligible for Medicare has access to the exact same benefits. The difference is in the premium cost to the beneficiary.

Traditional Medicare (Part A and Part B) benefits are based on a ***fee-for-service approach*** which involves physicians and hospitals. The providers of care operate on a ***cost reimbursement system*** based on a charge for each item of service. This is not a comprehensive health plan as there are 4 separate plans involved and each may have separate premium, deductible and co-insurance costs.

Original Medicare

Part A Hospital	+	**Part B Medical**	+	**Part D RX**	+	**Medicare Supplement Plan**
No premium out of pocket costs		premium gold plan (deductible and 80/20 coinsurance)		premium coinsurance or copay		Premium

Or....

Part C

Medicare Advantage Plan

premium = part B + a small aount
managed care

1. **Medicare Enrollment** begins on the three months before your 65th birthday and continues for 7 months. If you are currently receiving Social Security you do not need to do anything, you will automatically be enrolled effective the 1st of the month that you turn age 65 in Medicare Part A. You will need to choose and sign up for B or C.

2. **Open Enrollment Period** (A.K.A. Annual Election Period A.K.A. Annual Coordinated Enrollment Period) runs each year from October 15th through December 7th. During this time a beneficiary may change plans, i.e. A and B to C

3. Medicare Eligibility:

- Persons age ***65 or older*** are ***automatically eligible if they are eligible for Social Security***. If not eligible for Social Security, persons age 65 or older may receive benefits by paying a monthly premium.
- Persons who have been receiving ***Social Security disability income benefits for 24 consecutive months***.
- Persons with ***end stage renal disease*** (kidney failure).
- Persons with Amyotrophic Lateral Sclerosis (ALS) commonly known as Lou Gehrig's disease are automatically enrolled the first month they receive SSDI.

4. Medicare Coverages Available

a) **Part "A" Hospital** pays reasonable **inpatient care in hospitals**, minus deductibles and co-payments. It also helps cover a stay in a skilled nursing facility, hospice, and home health care. Medicare Part A applies once a beneficiary has been ADMITTED to the hospital. ER visits or being held for observation are paid under Part B. No premium required if you are eligible for social security. If you are not eligible for Social Security, you may buy in to it by.

- ✓ Skilled Nursing Care is care that is required daily and must be performed by a skilled medical practitioner. A Registered Nurse must be on duty 24 hours a day
- ✓ Skilled Nursing Facilities are covered IF the beneficiary has been admitted to the hospital for 3 consecutive days. Note: *it is possible to be in a hospital and NOT be admitted.*

- ✓ Medicare pays primary (first) to other coverages such as Medicare Supplements, Long Term Care and/or Medicaid.

b) Part "B" Medical pays for doctor's services, out-patient hospital care, medical equipment, ambulance service, physical and occupational therapists and some limited home health care. There is a premium required. If you sign up for Part B when you are first eligible you can avoid a penalty. It is a Gold Plan. (The **deductible** is a flat $203 per year for 2021 and increases every year, with an **80-20% co-insurance, and no stop loss**. In 2021, Part B premiums range from $148 to $505, depending on the beneficiary's yearly income.)

c) Part "C" Medicare Advantage Plans are privately run, **government-paid,** health plans that a beneficiary can sign up for **instead of *the Traditional Medicare A & B***. **They can be in the form of an HMO, a PPO or a POS.**

- Medicare Advantage Plans are health plan options that provide hospital, medical and prescription coverage for the insured beneficiary, and are part of the Medicare Program. Generally, these plans offer extra benefits and lower copayments than the Traditional Medicare Plan, and ***often offer drug coverage and such extra benefits as eye or hearing care, dental care, wellness classes or health-club memberships.***

- When a beneficiary signs up for a Medicare Advantage Plan, Medicare will send a premium to the plan for the beneficiary. Many plans are 100% paid for by Medicare, however, some plans will require a small premium to be paid by the beneficiary.

- If a beneficiary joins Medicare Advantage Plan, **he does not need a Medigap Policy**, because the plan usually covers many of the same benefits covered by a Medigap plan.

- **Managed Care**… The beneficiary may have to see the doctors and hospitals that belong to the plan to get services.

d) Part "D" Medicare Drug Coverage… Anyone on Medicare with either Part A or Part B is entitled to drug coverage, regardless of income. No physical exams are required, and nobody can be denied for health reasons. ***Enrollment is voluntary***. It helps cover the cost of outpatient prescription drugs. There are 2 ways to get Medicare prescription drug coverage:

ii. Medicare Prescription Drug Plans. These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) plans,

and Medicare Medical Savings Account (MSA) plans. You must have Part A and/or Part B to join a Medicare Prescription Drug Plan.

iii. **Medicare Advantage Plans** or other Medicare health plans that offer Medicare prescription drug coverage. You get all of your Part A, Part B, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs." Remember, you must have Part A and Part B to join a Medicare Advantage Plan, and not all of these plans offer drug coverage.

In either case, you must live in the service area of the Medicare drug plan you want to join

5. Blood...

How often is it covered? Medicare Part A (Hospital Insurance) covers blood you get as a hospital inpatient. Medicare Part B (Medical Insurance) covers blood you get as a hospital outpatient.

Who's eligible? All people with Medicare Part A and/or Part B are covered.

Your costs in Original Medicare, both part A and B, if the provider pays, the beneficiary pays but only for the first 3 units. If the provider is not charged, the beneficiary is not charged. Note: Blood can be paid for with a blood donation by any person naming the beneficiary.

6. Medicare… Duplicate Coverage… If an individual becomes eligible for Medicare while employed by a company which offers health insurance, federal law **(TEFRA)** states that the primary coverage benefits will be paid under the employer sponsored group plan and ***Medicare will act as the secondary coverage***.

C. Medicare Supplement Plans (a.k.a. Medigap) are sold by ***insurance companies*** to pay for what Medicare approves but does not pay for, i.e., deductibles and co-payments. These plans fill the gaps of Medicare, a.k.a. Medigap Insurance, meaning, ***Medicare Supplement plans pay secondary (excess) to what is paid by Medicare.*** Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap policy, they must also offer either Medigap Plan C or Plan F.

- ✓ To get a Medicare Supplement policy, the beneficiary must be ***covered under both Part A (Hospital) & B (Medical) of Medicare*** and be at least 65 years old. **Remember, a person covered under Medicare is called a beneficiary.**

- ✓ The Center for Medicare and Medicaid Services (CMS) requires that the states implement any updated amendments made by the NAIC.

Under the Omnibus Reconciliation Act of 1990 (and revised in 2010), Congress passed a law that authorized the NAIC to develop a standardized model for Medicare Supplement policies. This act requires that Medigap plans meet certain requirements. The purpose of this law was to eliminate questionable marketing practices, to provide consumers with a degree of protection, and to standardize the coverage available through the insurance industry.

The ***requirements include:***

1. **Exclusion for pre-existing conditions** is allowed for a ***maximum of 180 days***. A pre-existing condition is any condition the beneficiary had, advised to have treatment for or had treatment for in the past 180 days. Note: Washington State Law limits this to 90 days

   - ✓ Since a Medicare Supplement plan is NOT considered insurance, but a supplement, these plans can and do have exclusions for a pre-existing condition but only for a **limited** period of time.

   - ✓ **No exclusions** are permitted when ***replacing*** an in-force Medigap Policy. If an in-force Medigap Policy is replaced, a replacement form is required to be filled out, signed by the agent and the insured, and the original left with the beneficiary.

2. **Open enrollment** guarantees that for six (6) months following enrollment in **Part B**, persons age 65 and older cannot be denied Medigap insurance because of their health.

3. **Outline of Coverage** Must be provided by Insurers to all applicants at the time of application. If the supplement policy is issued other than how it was applied for, a substitute outline of coverage must accompany the policy.

   The outline must give:

   - ✓ A brief *specific* description of the benefits contained in *the policy.* ***The description of benefits must be stated clearly and concisely and must include a description of any deductibles or copayment provisions applicable to the benefits described****.*

   - ✓ *A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described.*

The Outline of Coverage ***is not the insurance contract (policy) itself.*** The policy itself sets forth in detail the rights and obligations of both the insured and the insurer, therefore, it makes clear that the insured needs to **read the policy carefully when received!**

4. Buyer's Guide:

- ✓ Insurance policies that provide any hospital or medical expense coverage to persons eligible for Medicare must provide the pamphlet "*Guide to Health Insurance for People with Medicare.*" The buyer's guide was developed jointly by the National Association of Insurance Commissioners and the Center for Medicare and Medicaid Services.

- ✓ ***Delivery of the guide must be made to the applicant at the time of application and acknowledgement of receipt of the guide must be obtained by the issuer.***

5. Miscellaneous

A producer may not sell a Medicare supplement (Medigap) policy when another policy is to remain in-force. **A beneficiary may not have two Medigap policies at once**. Both state and federal laws prohibit insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.

- ✓ No producer or other representative of an insurer may: **Complete the medical history portion** of any form or application for the purchase of a Medicare supplement policy (the medical history questions must be completed by the applicant, the applicant's spouse, relative, legal guardian, someone with power of attorney or a physician).

- ✓ No producer or other representative of an insurer may ***Knowingly sell a Medigap contract to any person who is receiving or applying for Medicaid.***

- ✓ Medigap policies must be guaranteed renewable **and** have a 31-day grace period.

- ✓ Free Look Period… Every individual and group Medicare supplement insurance policy must have prominently displayed on the ***first page of the policy*** or group certificate a notice stating that the person to whom the policy or certificate is issued will be permitted to ***return the policy or certificate within thirty days of its delivery to the purchaser*** and to have all the paid premium refunded if the purchaser is not satisfied with it for any reason.

- ✓ An additional ten percent penalty will be added to any premium refund due which is *not paid within thirty days of return of the policy to the insurer or insurance producer*.

- ✓ No Medigap policy may use waivers to exclude, limit, or reduce benefits for specifically named or described preexisting diseases or physical conditions. This means **no** restrictions in coverage or higher premium is allowed because of the beneficiary's health (once the initial 90/180 days has passed)

- ✓ A Medicare Supplement Policy may not provide benefits for outpatient prescription drugs. (Part D – RX will cover those needs)

6. Standardized Plan Benefits

- Do NOT memorize the chart, be aware that there is a chart.

This chart shows basic information about the different benefits that Medigap policies cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you must pay the rest. These plans will pay for what Medicare approves but does not pay for (fills the gaps). Remember, Insurance companies selling Medigap policies are required to make Plan A available.

Benefits	A	B	C	D	F	G	K	L	M	N
Part A	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part B	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part a hospice	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled Nursing Facility			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B Deductible			100%		100%					
Part B Excess Charges					100%	100%				
Foreign Travel Emergency			80%	80%	80%	80%			80%	80%

III. Federal Taxation of Benefits

4 items

1. Health Insurance Premiums and Benefits

Individuals Policies.....

	Tax Deductible?	Taxable?
	Premium	**Benefit**
Dividends	n/a	no
Disability Income. Personal	no	no
Disability Income. Employer paid	yes	yes
Medical Insurance. Personal	no	no
Medical Insurance. Employer paid	yes to employer	no
Medical Insurance. Employee paid	over 10% of AGI*	no
Medical expenses not covered by insurance	over 10% of AGI*	no

Business Owner Policies.....

	Tax Deductible?	Taxable?
	Premium	**Benefit**
Medical Insurance. Personal (business owner)	yes	no
Business Overhead Expense	yes	yes
Key Person/ Partner	no	no
Disability Income for a Buy/Sell	no	no

Savings Plans for Health Care Usage/ Consumer Driven Health Plans...

	Tax Deductible?	Taxable?
	Contribution	**Withdrawal**
Health Savings Account (HAS)	yes	No, if used for a qualified medical expense as defined by the IRS. Yes if used for other.
Health Reimbursement Account (HRA)	yes	
Flexible Spending Arrangement (FSA)	yes	

*AGI - Adjusted Gross Income

*amounts over 10% of the individuals AGI in 2019, 7.5% previous years

Dividends are not taxed when paid by a Mutual, Reciprocal or Fraternal company, they are a refund of excess premium.

Individuals Plans

Disability Income Benefits received by an insured are *not taxable* if the insured pays his/her own premiums.

Disability Income Insurance individual policy premiums are NOT tax deductible.

Disability Income Benefits premiums paid for by the employer are tax deductible to the employer.

Disability Income benefits, employer sponsored, will be taxed to *the employee*.

Medical Expense Premiums are not tax deductible to the individual.

Medical Expense Premiums are tax deductible to the employer.

Medical Expense Benefits (including dental) are not taxed as long as they do not exceed the expenses incurred. They are considered a reimbursement of expenses.

Medical expenses not covered by insurance are tax deductible to an individual if they exceed 10% of a persons AGI

Business Owners Policies

Medical Expense Premiums are tax deductible to the self-employed individual. Partnerships, S Corporations, and sole proprietors are self-employed individuals, not employees

Business Overhead Policies Premium is tax deductible since it is a business expense

Business Overhead Policies benefit is taxable

Key Person/ Partner Policy premium is not tax deductible

Key Person/ Partner Policy benefit is not taxable

Disability Income Policy to fund a Buy/Sell agreement Premium is tax deductible since it is a business expense

Disability Income Policy to fund a Buy/Sell agreement benefit is taxable

a) **Disability Income Benefits** received by an insured are ***not taxable*** if the insured pays his/her own premiums, because individual policy premiums are **NOT tax deductible**. This does not relate to Social Security disability income benefits. In general, benefits received under Social Security are NOT taxable to the recipient.

b) **Disability Income benefits** received by an insured ARE taxable if the employer pays the premium, the premium is tax deductible for the employer.

c) **Medical Expense Benefits** (including dental) are not taxed as long as they do not exceed the expenses incurred. They are considered a reimbursement of expenses.

d) **Deductibility of Premiums…** Premiums paid by *employers* are deductible to the business to the extent that they pay for employees' benefits.

e) **Premiums paid by *employees*** for group medical care may be deducted by the insured if they exceed 10% of the insured's adjusted gross income.

f) **Deductibility of Premiums for the Self-Employed** Partnerships, S Corporations and sole proprietors are self-employed individuals, not employees. The self-employed may deduct 100% of the premiums paid for insurance during a taxable year which provides **medical care** for the self-employed individual, his spouse and dependents.

- Premiums paid by individuals for disability income insurance are **not tax deductible**.

2. Consumer Driven Health Plans...

The following items are under the broad category of consumer driven health plan when in fact, there is only one health plan listed. Called a High Deductible Health Plan, the only identifying feature is a high deductible. The three other plans are variations on savings plans. The idea is to make the consumer aware of the costs and aid in the savings by offering tax advantages to those putting moneys into these plans. The main advantage is the money placed in the plans is tax deductible and remains tax free if, when taken out, the money is used for a qualifying medical expense according to the IRS. The benefit of savings plans

that are tax deductible include lowering your taxable income thereby lowering your taxes. In addition, this may put you in to a lower tax bracket saving you even more.

a) **Flexible Spending Accounts** (FSAs) allow employees to be reimbursed for medical expenses. ***FSAs are usually funded through voluntary salary reduction agreements with an employer***. No federal income taxes are deducted from the employee's contribution. The employer may also contribute.

The benefits of the FSA are:

- No employment or federal income taxes are deducted from the contribution.
- Withdrawals may be tax free if you pay qualified medical expenses.

Self-employed individuals are **NOT** eligible for a flexible spending arrangement.

"Use It or Lose It" Rule: Distributions from the FSA are paid only to reimburse for qualified medical expenses incurred during the period of coverage. This means that amounts in the account at the end of the plan year *cannot be carried over to the next year*. You must use the money in the calendar year and submit the claims by the annual deadline, **or the money remaining in the account goes back to the employer,** so, *use it or lose it*.

So where does that money go? *It remains in the general account to be used the following year. I cannot access, for credit, the money I did not spend last year. I can utilize any moneys in the account up to the limits of what I will contribute early, i.e. prior to putting the money in. A benefit of the FSA is an individual can use funds they have not yet put in. e.g. I can pay for new glasses or braces in January and fund my FSA the rest of the year. Basically an interest free loan.*

The "use it or lose it" rule is why a person should plan carefully, and conservatively, when making contributions into an FSA.

b) **High Deductible Health Plan/Policy (HDHP)** with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) provides a ***medical expense policy*** and a tax free way to help build savings to help the insured pay for future medical expenses and to pay the deductible if the need arises.

The HDHP with an HSA or HDHP with an HRA gives greater flexibility and discretion over how to use health care benefits. The participant can then personally manage healthcare dollars, making it possible to cut expenses and save money. The idea is: if you have a higher deductible, you have a lower premium. The premium savings can be put into a savings account to pay the deductible if needed. If this account is an HSA then the money going into the account is tax deductible as well, encouraging saving for medical needs.

Once the deductible has been met, the participant's health plan coverage begins.

A health plan will qualify as a high deductible health plan (HDHP) if it has an annual deductible of **at least** a certain dollar amount. This amount will change every year, as defined by the I.R.S.

c) Health Savings Account (HSA)… A Health Savings Account lets qualifying individuals save and pay for medical expenses using money that is tax deductible. As long as it is used for qualified medical expenses, the money also stays tax free when it is withdrawn. **There are annual contribution limits**.

A health savings account (HSA) is a tax-exempt trust or custodial account you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. You must be an eligible individual to qualify for an HSA. No permission or authorization from the IRS is necessary to establish an HSA. You set up an HSA with a trustee. A qualified HSA trustee can be a bank, an insurance company, or anyone already approved by the IRS to be a trustee of individual retirement arrangements (IRAs) or Archer MSAs. The HSA can be established through a trustee that is different from your health plan provider.

What are the benefits of an HSA? You may enjoy several benefits from having an HSA.

- You can claim a tax deduction for contributions you, or someone other than your employer, make to your HSA even if you do not itemize your deductions on Form 1040.
- Contributions to your HSA made by your employer (including contributions made through a cafeteria plan) may be excluded from your gross income.
- The contributions remain in your account until you use them.
- The interest or other earnings on the assets in the account are tax free.
- Distributions may be tax free if you pay qualified medical expenses.
- ***An HSA is "portable." It stays with you if you change employers or leave the work force.***

The HSA is simply a tax-free savings account that is designed to work together with a high-deductible health plan. The HSA covers routine medical expenses while the accompanying insurance policy protects against major medical or catastrophic events. *Should you choose to use the money in your HSA for an expense that is not considered a qualified medical expense as defined by the IRS, that amount spent on that item will be added to your gross income for the year and a 10% penalty may be imposed*.

d) Health Reimbursement Account (HRA)… This account is also referred to as a personal savings account, personal care account, defined contribution plan or consumer driven health care plan. A Health Reimbursement Arrangement (HRA) is an employer-funded account that helps employees pay for qualified medical expenses. HRAs are compatible with all types of health insurance plans and they are owned by the employer. A qualified expense can include the premium for an individual health insurance plan. If an employer wished to let the employees choose their own plan they can reimburse that premium through an HRA rather than run a group plan of their own.

Contributions to an HRA

HRAs are funded solely through employer contributions and may not be funded through employee salary deferrals under a cafeteria plan. These contributions are not included in the employee's income. You do not pay federal income taxes or employment taxes on amounts your employer contributes to the HRA.

Amount of Contribution

There is no limit on the amount of money your employer can contribute to the accounts. Additionally, the maximum reimbursement amount credited under the HRA in the future may be increased or decreased by amounts not previously used.

If any distribution is, or can be, made for other than the reimbursement of qualified medical expenses, any distribution (including reimbursement of qualified medical expenses) made in the current tax year is included in gross income. For example, if an unused reimbursement is payable to you in cash at the end of the year, or upon termination of your employment, any distribution from the HRA is included in your income. This also applies if any unused amount upon your death is payable in cash to your beneficiary or estate, or if the HRA provides an option for you to transfer any unused reimbursement at the end of the year to a retirement plan.

A health reimbursement arrangement (HRA) must be ***funded solely by an employer*** and not by an employee. The most common use of the HRA is in combination with a High Deductible Health Coverage (HDHC) Plan. ***Reimbursements from the HRA are not taxed to the employee, and are deductible by the employer***.

The benefits of the HSA and HRA are:

- **Tax deduction** for contributions made to your account.
- The contributions **remain in your account from year to year** until you use them.
- The interest or other earnings on the assets in the account are **tax free,** as long as the distributions are used to pay for **qualified medical expenses**.
- This can include premiums reimbursed by the employer

Quick Comparison Chart	Health Reimbursement Account (HRA)	Health Savings Account (HSA)	Flexible Spending Arrangement (FSA)
Tax Deductible	Yes, for the employer	Yes. Including deductions for contributions someone other than an employer put in through a cafeteria plan	Yes, money is taken out of gross income pre tax.
Contributors?	Employer only	Insured +++	Employee and employer(optional)
Annual limit	No	Yes	Yes
Must have an HDHP	Should	**Yes**	No
Rollover to next year	Yes	Yes	No, use it or lose it.
Tax on growth?	Only if used for something other than a qualified medical expense as defined by the IRS, otherwise it grows tax free		

Extras

FSA, can spend funds not yet put in account. For example, I need glasses in February, buy them and pay into the FSA the rest of the year to cover the cost. However, if I put money in to save for Lasik surgery and am laid off in July, I may get nothing back - that is up to the employer.

HSA, withdrawals for something other than a qualified medical expense results in that item amount being added to my gross income at the end of the year and a 10% penalty. For example, I go to the doctor, the pharmacy, and buy some ice cream ($5.99) with my HSA money because ice cream always makes me feel better. At the end of the year, $5.99 +10% will be added to my gross income because the IRS does not consider that to be an eligible medical expense.

HRA, withdrawals for something other than a qualified medical expense results in that item amount as well as any other moneys taken out to cover qualified medical expenses being added to my gross income at the end of the year and a 10% penalty. For example, I go to the doctor, the pharmacy, and buy some ice cream ($5.99) with my HRA money because ice cream always makes me feel better. At the end of the year, all the doctor's office visits totaling $15,000, the medications totaling $856.00 as well as the $5.99 for ice cream +10% will be added to my gross income because the IRS does not consider ice cream to be an eligible medical expense.