Healthcare Insurance and its effects on Divorce, Custody, and Support

Including FSA's and HAS's

1/21/2014

Lea Anderson
Gail Calderwood
Judge Susan Evashavik
Timothy Gricks
Dan McIntyre
Sophie Paul
Robert Sebastian
David Slesnick
Sally Thomas
Jennifer Zofcin

Program Schedule

Musical introduction- Single Payer's painless; Original lyrics written and sung By Robert Sebastian to the theme music from "MASH"

Part I - Affordable Care Act

a. Purpose of Act- by Sally Thomas - http://obamacarefacts.com/obamacare-facts.php
b. Coverage, defining events and as replacement for Cobra by Gail Calderwood
c. Subsidies by Timothy Gricks
d. Tax Implications by Sophie Paul

MUSICAL BREAK: It's the law Jack; Original lyrics written and sung by by Robert Sebastian to the tune of "Hit the road Jack"

Part II – HSA's, FSA's and HRA's

a. HSA vs FSA by Jennifer Zofcin
b. Support Calculation Implications by Lea Anderson
c. Healthcare Questions addressed by David Slesnick

MUSICAL BREAK: I can't get no (Health Insurance); Original lyrics Sung by Robert Sebastian to the tune of "I can't get no" by the Rolling Stones

Part III – The HighMark UPMC Rift by Daniel McIntyre

MUSICAL FINALE: Your Mama is Broke (And Your Daddy Ain't Got No Dough); Original Lyrics written and sung by Ronert Sebastian to the tune of "Your Mama Can't Dance"

PROGRAM MATERIALS

Affordable Care Act (ACA) Materials

Highlights Outline By Gail Calderwood

ACA Tax Provisions impacting Family Law Professionals by Savran Benson

ACA by Campbell, Durrant & Beatty

Spouse are not Dependents under the ACA

Wellness Programs under the ACA

HSA'S AND FSA'S

HSA - Wikipedia Definition

Health Savings Account Specifics

Comparison of HSA's, FSA's, and HRA's

IRS Filing Instructions For Form 8889 - Healthcare Savings Accounts

IRS Publication 502 - medical and dental expenses

Workzone: IRS making waves Reprinted from the Pittsburgh Post Gazette

Consumer Health: Is an HSA right for you?

The Highmark / UPMC Rift

Miscellaneous

Song Lyrics by Robert Sebastian
Proposed Rules - Recommendation 127 Rule 1910.16-6
23 Pa.C.S.A. §4326

ACA – Patient Care and Affordable Care Act
Inns of Court by Gail Calderwood

I. Open Enrollment:

a. Currently enrollment through January 15th for February 1st start date
b. Presumably must enroll by Feb 15th for March 1st
c. Open enrollment ends on March 31st
d. After that, need a "qualifying event" to enroll
    i. Qualifying event will include:
        1. Divorce
        2. Marriage
        3. Job Loss

II. Support Office of Allegheny County and the ACA

a. Currently Hearing Officers at support hearings are not accepting legal argument that the other party can seek out ACA coverage, so the payor can be relieved of his/her responsibility to provide coverage (available through his/her employer).

b. If neither party has employer coverage at time of hearing, practitioners would be well advised to consider a Consent PACSES Order that states, in the Other Conditions, that the parties will each look into the cost of individual coverage versus family coverage under the ACA and shall use the cheapest approach. Obviously, the payor would still owe a percentage of the cost of the payee's coverage (and any of their children) but it could minimize costs.

c. There are a number of reports that there is a "marriage penalty" in the ACA, and that separate individuals receive more savings/lower premiums that married couples, so may be advisable to explore the individual options and any subsidies available.

III. Subsidies:

a. People with income lower than 400% of the poverty level can qualify for possible subsidies (not available in every state), and, in some cases, an individual may not owe a monthly premium as a result of the subsidies.

b. Currently, 400% of the poverty level for an individual is $45,000, so incomes less than that threshold may qualify for a subsidy.

c. Discuss with clients and opposing counsel in cases where one party has low income. Make sure eligible individuals have applied or explored that option to keep costs to the non-intact family down as much as possible. Bear in mind that some ACA plans has higher deductibles and out-of-pocket costs though, which may outweigh the anticipated savings in monthly premiums.

d. The Kaiser Foundation has a free subsidy calculator: http://kff.org/interactive/subsidy-calculator/

IV. COBRA vs. ACA enrollment:

a. It is predicted that ACA coverage will be more affordable in every (or early every) situation as compared to COBRA coverage.

b. Some predict COBRA will be replaced by the ACA: http://www.kaiserhealthnews.org/stories/2013/september/24/obamacare-cobra-businesses-marketplaces-exchanges.aspx

c. COBRA representatives are helping individuals apply for ACA coverage.

V. Tax Effects and Support:

a. Earned Income Additional Medicare Tax - .9% (.009)

i. Definition of "Earned Income" under the ACA

ii. Breakdown of filing status versus earned income threshold for additional tax:

Must pay the tax if your modified adjusted gross income is over:

Married Filing Separately	$125,000 AGI
Head of Household	$200,000 AGI
Single	$200,000 AGI
Married Filing Jointly	$250,000 AGI

iii. For a party filing MFS and $150,000 in "earned income": additional tax will be $1,350 per year → unlikely to change most monthly support amounts significantly.

iv. For a party filing MFS and $250,000 in "earned income": additional tax will be $2,250 per year → may change some monthly support amounts.

b. Net Investment Income Additional Medicare Tax – 3.8%

i. Section 1411 of Internal Revenue Code – must pay the additional 3.8% on Net Investment Income if your modified adjusted gross income is over certain threshold (same threshold chart as for the Earned Income Additional Medicare Tax - see above).

ii. Net Investment Income (NIII) defined as interest, dividends, rents (less expenses), capital gains (minus capital losses), pass through income from passive activity, and royalties.

iii. Does EXCLUDE distributions from 401(k)'s, IRA's and the like.

iv. Also applies to Trust income that is not distributed.

VI. Expanded Medicaid coverage:

a. Could be of assistance in some divorces, as the newly divorced spouse of low income may qualify;

b. However, Pennsylvania has not yet adopted the expended Medicaid coverage, although it appears PA has undertaken steps to do so.

VII. Getting Info:

http://kff.org/health-reform/video/youtoons-obamacare-video/
http://www.amazon.com/Health-Care-Reform-Necessary-Works/dp/0809053977

Affordable Care Act Tax Provisions Impacting Family Law

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Most Relevant Tax Changes:

- Additional Medicare tax assessed on income over a threshold:
  - Earned income (0.9% tax)
  - Investment income (3.8% tax)

- Other tax issues
  - Health insurance W-2 reporting
  - HSA penalties

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Family Law Calculations Impacted

Affordable Care Act tax provisions can impact:

- Net income available for support calculations
- Property division calculations

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Medicare Taxes - Current

- 1.45% on all earnings (2.9% on self-employment)
- No maximum earnings
- Includes such items as:
  - Group Term Life insurance
  - Nonqualified deferred compensation

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New Medicare Taxes - Earned Income

- Old Medicare taxes apply
  - 1.45% on all earnings
  - No maximum earnings
  - Includes earnings currently subject to Medicare tax

- But now with an additional tax

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New Medicare Taxes - Earned Income (Continued)

- Additional 0.9% on earned income over the following thresholds:

Tax Filing Status	Income Threshold
Single	$200,000
Head of household	$200,000
Married filing jointly	$250,000 (combined)
Married filing separately	$125,000
Qualifying widow(er)	$200,000

- Employer is required to withhold if the individual meets the threshold, but is not required to if the threshold is crossed as a married couple

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New Medicare Taxes - Net Investment Income

- Tax at rate of 3.8% will be applied to Net Investment Income (NII)/unearned income above a base level
- NII/unearned income includes:
  - Interest
  - Dividends
  - Rents (less expenses)
  - Capital Gains (less capital losses)
  - Royalties
  - Passthrough income from a passive activity
  - Reduced by investment expenses

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New Medicare Taxes - Net Investment Income (Continued)

- NII/unearned income EXCLUDES:
  - Tax-exempt municipal bond interest
  - Distributions from IRA, 403(b), 401(k), 457, pension, profit sharing stock bonus, or qualified annuity
  - All active income above the thresholds ("active" income has not been fully defined in this context, but has historically meant spending more than 500 hours a year at an activity)

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Section 1411 Applied to Real Estate Income

- NII does not apply to active trade or business income
- Both "Active" and "Trade or Business Income" are required to be met but are defined separately (or not defined at all except by case law)

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Active Income Defined by Sec 469

- Real Estate Professional Rules – more than 750 hours
- Grouping of entities to meet the hour requirement
- Grouping must stay the same
- One year temporary ability to adjust groupings in 2013

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Trade or Business Income Defined by Sec 162

- What is the active trade or business of real estate?
- Historically, Triple Net Lease properties do not qualify
  - Tenant manages property and upkeep, and pays all bills.
- Difference between TNL property and a passive stock investment if rent check is cashed and mortgage is paid with no other activity?

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Trade or Business Income Defined by Sec 162 (Continued)

- Defining additional activity done by the real estate professional for the property
  - Ongoing services
  - Physical improvements made
  - Amount of expenses paid
  - Substantiality of all services performed
  - Risk for expense

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Trade or Business Income Defined by Sec 162 (Continued)

- Difference between managing the property vs. managing the investment
  - Refinancing a mortgage
  - Tenant leases
- Land leases – tenant owns building and does all the improvements and upkeep

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Grouping of Business and Rental Activity

- Initial guidance is leaning towards not allowing the grouping to meet trade or business test for the passive rental activity (Section 469 Regulations)

- Possibilities to decrease NII rental income
  - Reduce Rent
  - More expenses paid by real estate entity

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Section 1411 Real Estate and Divorce

- For Schedule of Assets rental properties need to be tax affected (*Balicki*)
- Care needs to be taken in division – a real estate property in the ownership of Husband may be nonpassive, but given to Wife it may be passive. Therefore she is now subject to NII when previously the property was not.
- If there is passive activity loss carryover as a marital asset, this needs to have careful consideration. If there are outstanding passive activity losses associated with assets, the passive activity stays with titled spouse, but if asset transfers, the passive activity loss gets added to the basis.

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Section 1411 Applied to Trusts

- IRS position is that trustee must be active in their role as trustee (500 hours)
  - No grouping provisions for trusts
- Trustee's activity must be only in role as trustee, not including any work in the underlying business activity as an employee/owner
- Grantor Trusts look to activity of grantor

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Section 1411 Applied to Trusts (Continued)

- Case law has allowed for activity of beneficiary or employee hired by beneficiary, but this is a challenged position
- NII is imposed on the lesser of Undistributed Net Investment Income or the excess of the modified AGI over the threshold amount
- Is Trust a martial asset? Usually no, but undistributed income may be.

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Medicare Tax Impact on Property Division

- Assets must be evaluated with taxes taken into consideration
- Some states require listing of assets net of tax consequences
- The Medicare tax is now a factor when:
  - Calculating capital gain tax cost for assets (15%/20% current federal tax rate, state rate, and possible 3.8% Medicare tax)
  - Interest and dividends are reserved for equitable distribution
  - Credit calculations for one party that paid the income tax on marital interest, dividends, capital gains, etc.

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Other Tax Issues

- The employer match of health insurance will be easier to identify starting in 2012 as generally it is required of most employers to report this information on Form W-2

- Penalty tax on distributions from health savings accounts (HSAs) if the funds are not used for qualified expenses has increased from 10% to 20%

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Social Security Changes

- 2012
  - Rate - 4.2% employee and 6.2% employer (10.4% self-employed)
  - Maximum taxable earnings $110,100
- 2013
  - Rate - 6.2% employee and 6.2% employer (12.4% self-employed)
  - Maximum taxable earnings $113,700

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Medicare Tax Example 1

- Married couple
- $200,000 in earned income
- $350,000 in capital gains, dividends, and rentals
- Taxes:
  - Pre-2013
    - Federal income tax on all of their earnings ($550,000)
    - Medicare tax of 1.45% on earned income ($200,000)
    - Total Medicare tax = $2,900
  - New - 2013 and forward
    - Medicare tax of 1.45% on earned income ($200,000) – same as current
    - Medicare tax of 3.8% on $300,000 of unearned income (lesser of combined earnings over $250,000 or income subject to the Medicare tax)
    - Total Medicare tax = 1.45% on $200,000 plus 3.8% of $300,000 = $2,900 + $11,400 = $14,300

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Medicare Tax Example 2

- Married couple
- $325,000 in earned income
- $10,000 capital gains, dividends, and rentals
- Taxes:
  - Pre-2013
    - Federal income tax on all of their earnings ($335,000)
    - Medicare tax of 1.45% on earned income ($325,000)
    - Total Medicare tax = $4,713
  - New - 2013 and forward
    - Medicare tax of 1.45% on earned income ($325,000) – same as current = $4,713
    - 0.9% Medicare tax on $75,000 ($325,000 earned income - $250,000 threshold) = $675
    - 3.8% on $10,000 = $380
    - Total Medicare Tax = $4,713 + $675 + $380 = $5,768

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The Affordable Care Act

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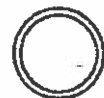
Three Key Parts of the Affordable Care Act



- Individual Mandate
- Employer Mandate ("Pay or Play" penalties)
- National Health Care Exchanges ("Health Insurance Marketplace")

- Federal Affordable Care Act website: www.healthcare.gov - can also go to sign up for Health Insurance

The Individual Mandate

- Starting on January 1, 2014, individuals must have "minimum essential coverage" or they will owe a penalty
- Minimum essential coverage includes Employer or government (e.g., Medicare) coverage
- Minimum essential coverage also includes Exchange coverage
- No penalty if short coverage gap (less than 3 months)

The Individual Mandate Penalties

- 2014: $95 per adult (up to 1.0% of income)
- 2015: $325 (2.0% of income)
- 2016: $695 (indexed after 2016) (2.5% of income)

- Penalty is ½ of adult rate for each uninsured dependent under the age of 18
- Total family penalty capped at 300% of the individual penalties
- No penalty if below threshold for filing tax return ($10,000 individual, $20,000 family for 2013)

The "Employer Mandate" Delay

- On July 5, 2013, the reporting requirements for plans and Large Employers were postponed until 2015.

- The "Pay or Play" penalty provisions applicable to Large Employers were also postponed until 2015.

- No other compliance deadlines are affected.

Department of Treasury Extension: What We Don't Know

- Whether there will be any more PPACA amendments in the interim?
- Whether yet-to-be-released guidelines and regulations will require any additional steps toward implementation?
- Whether there will be attempts to enforce "rights" to benefits separate from the government's penalties (private lawsuits)?

Changes That Affect All Employers

- All plans that provide dependent coverage must now cover dependents up to age 26.
- No lifetime or annual limits for essential benefits.
- Starting in 2014, all plans must guarantee coverage availability/renewal regardless of health status.
- Preventative services must be provided at no cost to the patient (unless grandfathered plan).
- External review/plan appeals procedures (unless grandfathered plan).
- FLSA "Notice to Employees of Coverage Options" (Exchange Notice) (starting October 1, 2013).

Changes That Affect Everyone: Maximum 90 Day Waiting Period

- All plans must limit waiting periods for eligible employees to a maximum of 90 days – may need to start early or mid-month.

- "Waiting period" is defined as "the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective."

- Beware! Pay or play penalties may still apply to the employer if coverage is not offered to full-time employees and their dependents within the first 3 calendar months of employment.

"Pay or Play" Critical Questions

- Is the Employer a Large Employer?
- If yes, who does the Employer have to offer coverage to (or does the Employer want to pay the "Pay or Play" penalties instead)?
- Who is Part-Time? (Throw out your old definition.)

Full time = 30 hours week employees

Are You a "Large Employer"?

- A "Large Employer" employed an average of at least 50 full-time employees on business days during the preceding calendar year. 26 U.S.C. § 4980 H(c)(2).

- "Full-time equivalents" are counted in addition to actual full-time employees (i.e., 100 employees working 15 hours/week = Large Employer).

Who Is Full-Time?

- For health insurance purposes **only**, PPACA defines "full-time employee" as any person "who is employed on average at least 30 hours of service per week." 26 U.S.C. § 4980H(c)(3).

- Stay tuned: "40 Hours is Full Time Act of 2013" (S. 1188, S. 701 & H.R. 2988) & "Save American Workers Act of 2013" (H.R. 2575) are pending in Congress.

Hours of Service

- Hours of Service – Under the proposed regulations, an employee's "hours of service" include not just hours worked, but every hour that an employee is paid for/entitled to payment (including paid vacation, holidays, sick leave, paid leaves due to incapacity/disability, paid jury duty, and other paid leaves of absence).

Determining Full-Time Equivalents

1) Count the number of full-time employees (including seasonal employees) who work on average 30 hours per week per month.

2) Calculate the number of full-time equivalents by adding the total number of hours worked in a month (up to a maximum of 120 per individual) by non-full-time employees (including seasonal employees) and divide by 120.

Determining Full-Time Equivalents

3) Add the number of full-time employees and full-time equivalents calculated in Step 1 & Step 2 for each month in the preceding calendar year.

4) Add the monthly totals and divide by 12.

If the average number is 50 or more, the employer is a "large employer" – unless the seasonal exception applies.

Large Employer Status

- Technically employers are not required to offer coverage even to full-time employees, but will be subject to the new “Pay or Play” penalties if they do not.
- Because the “Large Employer Mandate” takes effect on January 1, 2015, the first determination period is calendar year 2014.
- Before the delay, employers were permitted to use any consecutive 6 months in 2013, instead of the entire year, to determine Large Employer status for 2014 – what about 2015?

Seasonal Workers

- An employer is not considered to employ more than 50 full-time employees if (1) the employer's work force exceeds 50 full-time employees for no more than 120 days (or 4 calendar months) in a year, and (2) the employees over 50 during that period were seasonal workers.
- The 120 days/4 months can be non-consecutive (e.g., June, July, August, December).
- Any "reasonable, good faith interpretation of 'seasonal employee'" works through "at least 2014."

Fluctuating Hours Employees

- Because full-time status for the purpose of offers of coverage is determined by a monthly calculation, PPACA's new definition could create significant uncertainty and administrative difficulties regarding employees whose hours fluctuate (part-time, seasonal and temporary employees).

- Having employees drop in and out of coverage on a monthly basis would cause complications for both employers and employees.

The Three Periods for Determining Eligibility

3 time periods can be used in determining whether temporary/variable hour employees must be offered coverage:

- Measurement periods - people not expected to work full time 3 to 12 Months period
- Administrative periods time to get people covered - can be up to 90 days
- Stability periods - employed there previously New [illegible] hires - Date of hire

Measurement Period

- New Employees who are not expected to work full-time (variable hour or seasonal employees) can be employed without health insurance for an "Initial Measurement Period" of 3 to 12 months during which the employee's hours are tracked.

- New Employees reasonably expected to average 30 or more hours a week must be offered coverage before the end of the employee's initial 3 full calendar months of employment to avoid penalties.

Ongoing Employees v. New Employees

- Standard Measurement Period for evaluating current ("ongoing") employees (e.g., November 1, 2012 – October 31, 2013).
- Initial Measurement Period for evaluating new employees (runs from start date or any other day up to the start of the next calendar month).
- New Employees eventually transition to the Standard Measurement Period (there will be some overlap).

Administrative Period & Time Limit

- Employers are permitted up to 90 days for an "Administrative Period" before the stability period begins for determining eligibility, offering coverage and enrollment.
- Measurement Period + Administrative Period cannot extend beyond the last day of the first calendar month beginning on or after the 1 year anniversary of the employee's start date. **What???**

Measurement Period + Administrative Period Time Limit

- Employee starts working February 27, 2015.
- 1 year anniversary: February 27, 2016.
- Last day of the first calendar month beginning on or after the 1 year anniversary: March 31, 2016.
- The combined Measurement Period + Administrative Period cannot extend beyond March 31, 2016.

Stability Period

- If at the end of the "initial measurement period" an employee has been working an average of 30 hours a week or more, the employer must offer health insurance for a "stability period" of at least 6 months – or – the length of the initial measurement period (whichever is longer).
- Employees working an average of less than 30 hours a week during measurement period = part-time employees during the subsequent stability period, no offer of health insurance required.

Ongoing Employees v. New Employees

- Stability Period must be the same length for both (at least 6 months & at least as long as the Measurement Period).
- Stability Period for new employees denied coverage cannot be more than 1 month longer than Initial Measurement Period (can't measure for 3 months & lock out of coverage for 12 months) and cannot go past the end of the next Standard Measurement Period.

Transition from New Employee to Ongoing Employee

- Standard Measurement Period: November 1 to October 31 + 2 month Administrative Period + Calendar Year Stability Period.
- Employee hired February 27, 2015.
- Initial Measurement Period starts February 27, 2015 and ends February 26, 2016.
- Following an Administrative Period, Initial Stability Period for eligible employee: April 1, 2016 – March 31, 2017.
- Coverage for the rest of 2017 (or all of 2017 if employee was not initially eligible) determined by employee's hours during the November 1, 2015 through October 31, 2016 Standard Measurement Period.

The Two "Play or Pay" Penalties

- On January 1, 2015, Large Employers will be subject to Pay or Play penalties if even 1 full-time employee receives "a premium tax credit or cost-sharing reduction" for Exchange coverage and:
  - IRC § 4980H(**a**): employer failed to offer minimum essential coverage to full-time employees <u>and their dependents</u>; <u>or</u>
  - IRC § 4980H(**b**)(2): employer offered coverage that was not "affordable" or did not provide "minimum value".
- No penalties if no one goes to the Exchange for coverage.

"Dependent" Coverage

Under Section 4980H of the Affordable Care Act, employers must offer minimum essential coverage to full-time employees and their dependents to avoid pay or play penalties.

- A "dependent" is an employee's child under age 26.
- "Dependents" <u>do not</u> include spouses (or anyone else).
- Proposed Regulations indicate that the employee cost for dependent coverage does not need to be affordable.

Section 4980H(a) Penalty: Failure to Offer

- The annual Section 4980H(a) "Play or Pay" penalty is equal to the number of full-time employees (minus 30) multiplied by $2,000.

- Employer with 51 full-time employees:
  Fails to offer Minimum Essential Coverage
  1 goes into the Exchange to purchase coverage
  Receives a tax credit or subsidy for 1 month
  Penalty:
  $2,000 times 21 = $42,000 annually
  $42,000 divided by 12 = $3,500 per month

Section 4980H(b) Penalty: Unaffordable or No Minimum Value

- If coverage is offered, but it is unaffordable or does not provide minimum value (in general, pays less than 60% of the cost of covered services), a Section 4980H(b) penalty will be due for each employee who enrolls in the Exchange coverage and receives a premium subsidy or cost-sharing reduction.

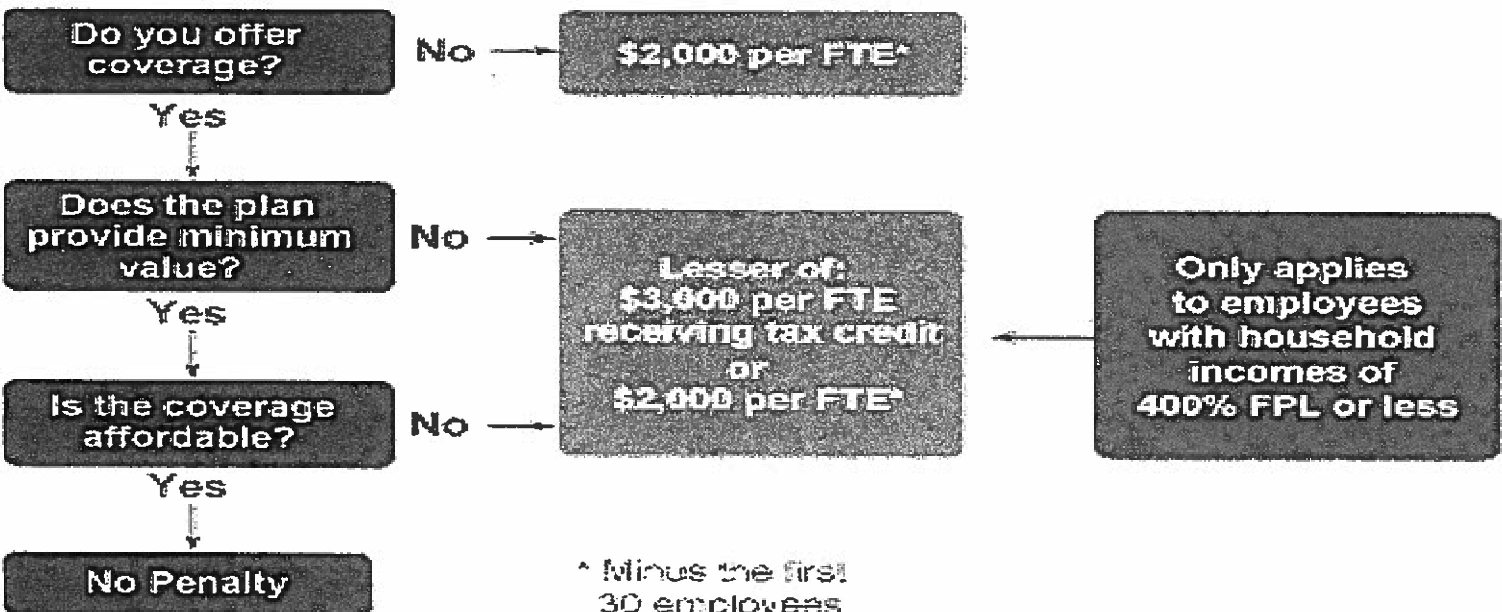
- Section 4980H(b) penalty amount: number of full-time employees who receive credits/subsidies for Exchange coverage, multiplied by $3,000.

- Maximum penalty is capped at the amount the 4980H(a) penalty would be ($2,000 multiplied by full-time employees minus 30) if you did not offer coverage -- but the $3,000 penalty will usually be significantly less than the cap.

How Will You Know If Someone Gets Exchange Coverage?

- IRS will send employers a "Section 1411 Certification" for each month any of their employees enroll in Exchange coverage and receive a premium tax credit or cost-sharing reduction.
- Employers will have a limited opportunity to respond before penalties are due.
- Subsidies for Exchange coverage are available for those with incomes up to 400% of the Federal Poverty Level (up to $45,960 for individuals and $94,200 for a family of 4 in 2013).

Large Employer Penalties



Minimum Value – Pays 60% of costs

The “Substantially All” or “95%” Standard

- Large Employers will be treated as offering coverage to all full-time employees (and dependents) if they offer coverage to all but 5% or 5 of their full-time employees (whichever is more).

- Subsection (a) “Play or Pay” penalty ($2,000 per full-time employee per year) will not apply.

- **BUT** if any of the 5% who are not offered coverage enroll in Exchange coverage and receive a premium tax credit/subsidy, a Subsection (b) Penalty applies ($3,000 per each such full-time employee).

What Will Employers Decide?

- It will often be cheaper to pay the penalties than to offer coverage (but be aware of retention, collective bargaining issues).
- Employer with 100 employees that provides coverage:

  50 on Individual coverage at $400/month (after employee contribution) = $20,000/month

  50 on Family coverage at $1200/month (after employee contribution) = $60,000/month

  Total Cost of Coverage: $80,000/month = $960,000/year
- Employer with 100 employees that does not provide coverage:

  Section 4980H(a) "Play or Pay" annual penalty: 100 employees – 30 = 70 multiplied by $2,000 = $140,000/year

Determining "Affordability"

In order to avoid the "Play or Pay" penalties, an employer-offered plan must provide "minimum value" and be "affordable."

Coverage is "not affordable" if an employee is required to pay more than 9.5% of his/her household income.

Does Your Employer Know Your Household Incomes?

Safe Harbors for Determining "Affordability"

3 Safe Harbor methods for determining whether the health coverage is affordable:

1) Form W-2 Wages
2) Rate of Pay
3) Federal Poverty Line

Form W-2 Safe Harbor

An Employer must offer full-time employees (and their dependents) minimum essential coverage, and the required employee contribution for self-only coverage for the lowest cost option providing minimum value must not exceed 9.5% of the employee's W-2 Wages (Form W-2, Box 1).

When do you know that?

Rate of Pay Safe Harbor

- An employer-offered plan will be considered "affordable" if the employee's monthly contribution amount is equal to or lower than 9.5% of his/her computed monthly wages.
- Hourly employees: multiply hourly rate of pay by 130.
- Salaried employees: monthly salary.

FPL Safe Harbor

- An employer-offered plan will be considered "affordable" if the cost of self-only coverage does not exceed 9.5% of the most recent Federal Poverty Line for individuals (on a monthly basis).
- Individual 2013 FPL = $11,490/year or $957.50/month.

9.5% of 2013 FPL = $90.97/month.

Health Care Exchanges

- **Exchanges** – By January 1, 2014, state insurance Exchanges (aka "Health Insurance Marketplaces") will permit individuals and certain "small employers" to obtain coverage through the purchase of a "qualified health plan."
- If a state does not establish its own Exchange (like Pennsylvania), a federal Exchange will be available.
- **Open Enrollment** – Open enrollment for Exchanges started October 1, 2013 and will run through March 31, 2014.

Notice of Coverage Options

- **FLSA Notice of Coverage (Exchange) Options**
  – By October 1, 2013, all employers covered by the FLSA were required to notify all employees of the availability of Exchange health insurance coverage.

- The Notice advises employees of potential premium tax credits and whether the share of plan coverage paid by their plan sponsor is less than 60% of total benefits.

Notice of Coverage Options

Manner of Notice

- Written notice must be provided in a manner that can be understood by the average employee.

- Notice can be sent by First Class mail or electronically (e-mail) if Department of Labor electronic disclosure safe harbor requirements are met.

Exchange Notices: Model Language

- Model Language for proper notice is on the U.S. Department of Labor website.
- There is a Model Notice for employers with employee health plans, and another one for those who do not.
- The Model Language may be modified as long as it still complies with the Notice requirements.

Notice of Coverage Options

Timing of Notice

- Starting on October 1, 2013, each new employee must receive notice at the time of hiring.
- Through the end of 2014, notice to new hires will be considered timely if provided within 14 days of the employee's start date.
- Current employees must receive notice on or before October 1, 2013, automatically and free of charge.

Cadillac Tax

2018

- In 2018, health plans that exceed Cadillac Tax thresholds will be subject to a 40% excise tax.
- The Cadillac tax will be paid by the plan issuers (or by employers, if a plan is self-insured), not the insured employees.
- Insurers are expected to either pass on the costs of the Cadillac tax or make plan design changes (increase co-payments, raise deductibles, etc.) to lower premiums.

Cadillac Tax

2018

- Cadillac Tax Thresholds: $10,200 for individual coverage and $27,500 for family coverage.
- For "High Risk" professions (firefighters, police, employees who repair/install electric lines etc.) the thresholds are increased to $11,850 and $30,950.
- Threshold includes total employer & employee premium costs (including contributions to Flexible Spending Accounts and Health Savings Accounts) but excludes dental and vision coverage.

Delayed Provisions

Affordable Care Act requirements delayed pending further regulations/guidance:

- (1) Automatic health care plan enrollment of all employees by employers with more than 200 full-time employees unless employee "opts out" (including notice of automatic enrollment and opt-out procedures).
- (2) Prohibition against discriminating in favor of highly compensated employees.

Wellness Programs

- Subject to new nondiscrimination requirements in Affordable Care Act

  effective for plan years beginning on or after January 1, 2014.

- Two types of wellness programs are permitted:
  - Participatory -screening
    - A participatory wellness program must be made available to all similarly situated individuals.
  - Health-Contingent (Potential Planning Opportunity) - Eg BMI level Financial Reward to get BMI level down. Same with cholesterol, etc.
    - A health-contingent wellness program must meet five requirements.

Wellness Programs (Health-Contingent): Five Requirements

1. Individuals must have the opportunity to qualify for the reward at least once per year.
2. Maximum reward is increased to 30% of total cost of coverage (or 50% if attributable to prevention/reduction of tobacco use).
3. Wellness program must be available to all similarly situated individuals. If unreasonably difficult (due to medical condition) or medically inadvisable, a reasonable alternative standard to obtain the reward must be made available.
4. Wellness program must be reasonably designed to promote health and prevent disease.
5. All materials describing the wellness program must disclose that for those who fail to meet the standards, another means of qualifying for a reward may be available.

Spouses Are Not Dependents Under New Proposed Affordable Care Act Regulations

By: David E. Mitchell, Esquire

The Patient Protection and Affordable Care Act of 2010 is approximately 900 pages in length. Despite its length, the Act leaves many issues regarding its implementation unclear. Some details regarding the application of the Act have been filled in by proposed regulations issued by the Internal Revenue Service and the U.S. Department of Health and Human Services in recent months. Although proposed regulations are subject to revision before they are issued in final form, they provide advance notice about issues employers need to be considering now.

One such issue relates to making coverage available to dependents. A section of the Act that will take effect in 2015 subjects "large employers" to the Act's "pay or play" penalties under certain circumstances if they fail to offer "full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan." 26 U.S.C.A. § 4980H. For the purposes of the Affordable Care Act, a full-time employee is one who works an average of 30 or more hours in a week. In general, a large employer is one that employs an average of at least 50 full-time employees and/or full-time equivalent employees (part-time employees whose hours, when combined, equate to full-time levels) on work days during the preceding calendar year. 26 U.S.C.A. § 4980H. Employers are also subject to penalties if the coverage offered does not provide minimum value (in general, pays less than 60% of the cost of covered services) or is not "affordable" (the premium share paid by the employee exceeds 9.5% of the employee's household income or fails to meet certain alternate safe harbor tests permitted by the proposed regulations).[1] Draft regulations have addressed the application of the minimum value and affordability standards as well as issues like the treatment of seasonal employees when determining large employer status.

Section 4980H does not provide a definition of the term "dependent." The omission of a definition and the wording of the Act gave rise to disagreement regarding who qualifies as a dependent under Section 4980H or even whether the Act requires large employers to offer coverage to dependents. New proposed regulations issued by the IRS on December 28, 2012, confirm that large employers will be required to offer coverage to dependents of employees or be potentially subject to the Act's penalties. However, the proposed regulations define "dependent" to include only an employee's children under the age of 26 and specifically state that the term dependent "does not include the spouse of an employee." No other categories of individuals are included in the proposed definition of the term dependent.

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[1] Recognizing the logistical difficulty in determining the household income of employees, the proposed regulations permit three "safe harbor" alternate tests. These safe harbor tests are based on 1) W-2 wages (the employee's required annual contribution for self-only coverage under the lowest cost option that provides minimum value does not exceed 9.5% of the employee's W-2 wages for the year); (2) rate of pay (the employee's required monthly contribution for self-only coverage under the lowest cost option that provides minimum value does not exceed 9.5% of the employee's monthly pay rate, as determined in accordance with the regulations); or 3) the Federal Poverty Line (the employee's required monthly contribution for self-only coverage under the lowest cost option that provides minimum value does not does not exceed 9.5% of the Federal poverty line, on a monthly basis, for a single individual).

Recognizing the fact that some large employers do not currently make coverage available to dependents of employees, the proposed regulations provided some transitional relief even before the "Pay or Play" penalty implementation was delayed until 2015, indicating that any employer that "takes steps during its plan year that begins in 2014 toward satisfying the section 4980H provisions relating to the offering of coverage to full-time employees' dependents" would not be liable for penalties under section 4980H solely based on "a failure to offer coverage to dependents for that plan year." Large employers currently offering only individual coverage will need to take steps to offer coverage to employees' children under the age of 26 (or potentially pay related penalties) in the near future.

That being said, a controversial aspect of the proposed regulations is that they evaluate affordability based only on the cost of the employee's self-only coverage, not on the cost of dependent coverage. Thus, under the proposed regulations, large employers will have to offer coverage to an employee's children up to the age of 26, but will not need to offer coverage to dependents that is "affordable" as defined by the Act. This is one area that can be expected to draw intense scrutiny while the proposed regulations are being considered.

<u>Wellness Programs under the Affordable Care Act</u>

David E. Mitchell, Esquire – Campbell Durrant Beatty Palombo & Miller, P.C.

In addition to increasing access to health care, containing health care costs is an underlying, if often overlooked, objective of the Patient Protection & Affordable Care Act of 2010. Wellness programs that encourage employees to participate in activities that reduce health risks and prevent disease have been used by many employers and insurers to achieve cost savings. In the wake of the Affordable Care Act regulations released earlier this year, which will take effect for plan years beginning on or after January 1, 2014, the role that wellness programs play in getting employees to act in ways that reduce (or at least slow the increase of) health care costs will expand.

Discrimination by group health plans based on health-related factors is generally prohibited by the Health Insurance Portability and Accountability Act ("HIPAA"). However, HIPAA wellness program standards, which were generally incorporated into and expanded by the Affordable Care Act and the recently released regulations, expressly permit employers to offer rewards to employees who participate in wellness programs that are intended to promote health and prevent disease. Rewards can take the form of incentives, such as premium discounts or rebates, or avoiding penalties like premium surcharges (although many wellness programs do not utilize penalties due to Americans with Disabilities Act concerns).

There are two categories of permissible wellness programs: participatory and health-contingent programs. In a participatory program employees receive a reward for engaging in an activity reasonably designed to improve health or prevent disease, but the reward is not linked to achieving any particular outcome or objective. Participatory wellness programs are generally permitted so long as they are available to all similarly situated individuals regardless of health status. Examples include reimbursement for fitness center membership or providing financial rewards for attending health-related seminars. A participatory program may also provide rewards for employees who voluntarily participate in health screenings, so long as the reward is not linked to the results of the screenings.

In contrast, a health-contingent wellness program takes a more aggressive approach by linking the financial incentive to attaining a particular objective, such as maintaining a certain body mass index ("BMI"), reducing cholesterol levels or reaching a goal such as running a particular distance. Health-contingent wellness programs must be open to all similarly situated employees and must be reasonably designed to promote health or prevent disease. Participants must have an opportunity to qualify for the reward at least once a year. If an individual has a medical condition that makes it unreasonably difficult or medically inadvisable to meet the designated standard, a reasonable alternative standard for obtaining the reward must be provided. In the alternative, the employer can waive the standard and provide the reward to such individuals. In addition, all materials that describe the wellness program must indicate that another means of qualifying for reward may be available for individuals who fail to meet the initial reward standards.

Rewards relating to health-contingent wellness programs are capped, but have been increased. Under HIPAA the maximum incentive was 20% of total premium cost. In conjunction with the Affordable Care Act, the recent regulations increased the maximum incentive to 30% of premium cost, effective in January 2014. In other words, if the annual premium cost for individual coverage is $4,800, the program can provide an incentive worth up to $1,440 for participating in its wellness program. Where the reward relates to refraining from tobacco use, the maximum limit is 50% of the total premium cost. Rewards are generally linked to the cost of employee only coverage, but if family members or dependents are eligible to participate in a wellness program, rewards can take their portion of the premium cost into account as well.

The recently released regulations also distinguish between two new subcategories of health-contingent wellness plans, activity-based programs and outcome-based programs. In the past, walking, exercise or diet programs that based incentives on mere participation rather than reaching a particular goal had been viewed as participatory programs, rather than health-contingent programs. Because certain individuals may have difficulty participating in such programs due to various health-related factors, they are now classified as activity-based health-contingent wellness programs and must meet the requirements that apply to health-contingent programs, including giving participants an alternate way to obtain the reward where it is unreasonably difficult or medically inadvisable for them to participate in the activity.

The other type of health-contingent wellness programs under the regulations are outcome-based programs. In an outcome-based program an employee can be rewarded for falling within the healthy range on a test for risk factors such as high glucose or high cholesterol levels or for taking steps to get to healthy levels if they are outside of that range. For outcome-based wellness programs, a reasonable alternative standard must be provided for all who fail the designated standard, not just those who have medical conditions that contributed to their inability to meet the standard. For example, if the standard is no tobacco use, smokers must be permitted an alternative means of qualifying for the reward, like participating in a program designed to help them stop smoking.

It should also be noted that wellness programs implicate issues under the Americans with Disabilities Act, the Genetic Information Non-Discrimination Act and other employment laws that must be considered when designing a wellness program. Meeting the requirements of HIPAA, the Affordable Care Act and related regulations does not guarantee that a plan complies with other employment related laws. Earlier this year the Equal Employment Opportunity Commission held hearings on wellness programs and may issue additional guidance on wellness programs and the ADA in the future. Designed the right way, a legally compliant wellness program has the potential to help employees get healthier, lower health care costs and reduce absenteeism.

Health savings account

From Wikipedia, the free encyclopedia

A **health savings account** (**HSA**) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP).[1][2] The funds contributed to an account are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), funds roll over and accumulate year to year if not spent. HSAs are owned by the individual, which differentiates them from company-owned Health Reimbursement Arrangements (HRA) that are an alternate tax-deductible source of funds paired with either HDHPs or standard health plans. HSA funds may currently be used to pay for qualified medical expenses at any time without federal tax liability or penalty. However, beginning in early 2011 OTC (over the counter) medications cannot be paid with HSA dollars without a doctor's prescription.[3] Withdrawals for non-medical expenses are treated very similarly to those in an individual retirement account (IRA) in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier. These accounts are a component of consumer-driven health care.

Proponents of HSAs believe that they are an important reform that will help reduce the growth of health care costs and increase the efficiency of the health care system. According to proponents, HSAs encourage saving for future health care expenses, allow the patient to receive needed care without a gatekeeper to determine what benefits are allowed and make consumers more responsible for their own health care choices through the required High-Deductible Health Plan.[1]

Opponents of HSAs say they worsen, rather than improve, the U.S. health system's problems because people who are healthy will leave insurance plans while people who have health problems will avoid HSAs. There is also debate about consumer satisfaction with these plans.

Health care in the United States

Government Health Programs

- Federal Employees Health Benefits Program
- Indian Health Service
- Veterans Health Administration
- Military Health System / TRICARE
- Medicare
- Medicaid / State Health Insurance Assistance Program (SHIP)
- State Children's Health Insurance Program (CHIP)
- Program of All-Inclusive Care for the Elderly (PACE)
- Prescription Assistance (SPAP)

Private health coverage

- Health insurance in the United States
- Consumer-driven health care
  - Flexible spending account (FSA)
  - Health Reimbursement Account
  - **Health savings account**
    - High-deductible health plan (HDHP)
    - Medical savings account (MSA)
  - Private Fee-For-Service (PFFS)
- Managed care (CCP)
  - Health maintenance organization (HMO)
  - Preferred provider organization (PPO)
- Medical underwriting

Health care reform law

- Emergency Medical Treatment and Active Labor Act (1986)
- Health Insurance Portability and Accountability Act (1996)
- Medicare Prescription Drug, Improvement, and Modernization Act (2003)
- Patient Safety and Quality Improvement Act (2005)
- Health Information Technology for Economic and Clinical Health Act (2009)
- Patient Protection and Affordable Care Act (2010)

State level reform

- Massachusetts health care reform
- Oregon Health Plan
- Vermont health care reform
- SustiNet (Connecticut)
- Dirigo Health (Maine)

Municipal health coverage

- Fair Share Health Care Act (Maryland)
- Healthy Howard (Howard Co., Maryland)
- Healthy San Francisco

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Contents

- 1 History
- 2 How they work
  - 2.1 Deposits
  - 2.2 Investments
  - 2.3 Withdrawals
- 3 HSAs vs. other medical savings plans
- 4 Benefits
- 5 Criticism
- 6 Consumer satisfaction
- 7 HSAs and health policy
- 8 See also
- 9 Notes and references
- 10 External links

History

HSAs were established as part of the Medicare Prescription Drug, Improvement, and Modernization Act which was signed into law by President George W. Bush on December 8, 2003. They were developed to replace the Medical Savings Account system.

A survey of employers published by the Kaiser Family Foundation in September 2008 found that 8% of covered workers were enrolled in a consumer-driven health plan (including both HSAs and Health Reimbursement Accounts), up from 4% in 2006. The study found that roughly 10 percent of firms offered such plans to their workers. Large firms were more likely to offer a high-deductible plan (18%), but enrollment was higher in small firms (8% of covered workers, versus 4% in larger firms).[4] As of 2012, these numbers had increased. Approximately 31% of firms offering health insurance offered an HSA (26%) or and HRA (5%) option. Large firms (38%) were somewhat more likely than small (31%) firms to offer such options. 11% of covered workers were in HSAs, while 8% were in HRAs. In small companies, 24% were in HDHPs vs 17% in larger firms.[5]

A survey of health insurers performed by America's Health Insurance Plans (AHIP) found that 4.5 million Americans were covered by HSA-qualified health plans as of January 2007. Of those, 3.4 million were covered through employer-sponsored plans, and 1.1 million were covered by individually purchased HSA-qualified plans. This represented an increase of 1.3 million since January 2006. In the individual market, 25% of new purchasers bought HSA-qualified plans. HSA-qualified plans represented 17% of new policies sold in the small group market and 8% of new policies sold in the large group market.[6] A follow-up survey by AHIP reported that the number of Americans covered by HSA-qualified plans had grown to 6.1 million as of January 2008 (4.6 million through employer-sponsored plans and 1.5 million covered by individually purchased HSA-qualified plans). HSA-qualified plans represented 27% of new purchases in the individual market, 31% of new enrollment in the small group market and 6% of new enrollment in the large group market.[7]

In January 2008, market research firm Celent moderated its earlier projections, citing the HSA market's "disappointing early showing", and projected 12.5 million accounts by 2012.[8] A survey published by AHIP in May 2009 found that 8 million people were covered by HSA/High-Deductible health plans in January 2009. Of those, 1.8 million were covered by individual policies and approximately 6.2 million were covered by a group plan.[9]

The Government Accountability Office (GAO) reported in April 2008 that many individuals enrolled in HSA-qualified health plans did not open tax-qualified HSA accounts, and individuals that had HSA accounts had higher incomes than others. According to the report, nationally representative surveys conducted by Blue Cross Blue Shield Association in 2005 to 2007 found that 42 to 49 percent of HSA-eligible plan enrollees did not open HSAs in those years. Based on an examination of Internal Revenue Service (IRS) data, GAO found that tax filers who reported HSA account activity had higher average incomes than other tax filers. Contributions into HSA accounts ($754 million in 2005) were roughly double withdrawals from the accounts ($366 million). Average contributions were also roughly twice average withdrawals ($2,100 versus $1,000). 41% of tax filers who made an HSA contribution did not make any withdrawals; 22% withdrew more than they contributed during the year.[10]

Data released in 2012 indicate that the use of HSAs is increasing. America's Health Insurance Plans (AHIP) reported in May 2012 that the number of people covered by an HSA-eligible HDHP more than doubled between January 2008 to January 2012 (going from 6.1 million to 13.5 million).[11] The split between group and individual plans was 11 million vs. 2.5 million, and the gender distribution of HSAs between male and female enrollees was an even 50%. Among individual plan holders, 51% were under age 40, and 49% were age 40 or over. The top five states with HSA/HDHP enrollment were California (1 million), Texas (0.76 million), Illinois (0.72 million), Ohio (0.66 million) and Florida (0.54 million). Also, a survey released in February 2012 by J. P. Morgan Chase of the 900,000 HSAs that it manages indicates that contributions to HSAs have been steadily increasing.[12] Between 2009 and 2011, the average Chase HSA balance rose by 11% annually, and the average employee contributions increased by 7% in 2011. Also, in 2011, 42% more dollars were transferred from HSA cash into HSA investment accounts than were transferred out.

How they work

Deposits

Deposits to an HSA may be made by any policyholder of an HSA-eligible high-deductible health plan or by their employer, or any other person. If an employer makes deposits to such a plan on behalf of its employees, non-discrimination rules still apply—that is, all employees must be treated equally. However, if contributions are made through a Section 125 plan, non-discrimination rules do not apply. Employers may treat full-time and part-time employees differently, and employers may treat individual and family participants differently. (The treatment of employees who are not enrolled in a HSA-eligible high-deductible plan is not considered for non-discrimination purposes.) Also, for 2007, employers may contribute more for non-highly compensated employees than highly compensated employees. Contributions from an employer or employee may be made on a pre-tax basis through an employer. If this option is not available through the employer, contributions may be made on a post-tax basis and then used to decrease gross taxable income on the following year's Form 1040. The main advantage of making pre-tax contributions is the Federal Insurance Contributions Act tax (FICA) and Medicare Tax deduction, which amounts to a savings of 7.65% (5.65% for the employee in 2011 due to Social Security rate holiday) each to the employer and employee (subject to limits of the Social Security Wage Base). The self-employed must pay self-employment tax on their contributions. Regardless of the method or tax savings associated with the deposit, the deposits may only be made for persons covered under an HSA-eligible high-deductible plan, with no other coverage beyond certain qualified additional coverage.

Initially, the annual maximum deposit to an HSA was the lesser of the actual deductible or specified Internal Revenue Service (IRS) limits. Congress later abolished the limit based on the deductible and set statutory limits for maximum contributions. For example, the 2012 statutory limits are $3,100 for an individual and $6,250 for a family.[13] All contributions to an HSA, regardless of source, count toward the annual maximum. A catch-up provision also applies for plan participants who are age 55 or over, allowing the IRS limit to be increased.[14]

All deposits to an HSA become the property of the policyholder, regardless of the source of the deposit. Funds deposited but not withdrawn each year will carry over into the next year. If the policyholder ends their HSA-eligible insurance coverage, he or she loses eligibility to deposit further funds, but funds already in the HSA remain available for use.

The Tax Relief and Health Care Act of 2006 signed into law on December 20, 2006, added a provision allowing a one-time rollover of IRA assets to be used to fund up to one year's maximum HSA contribution.

State tax treatment of HSAs varies. Three states—Alabama, California and New Jersey—do not allow deductions of HSA contributions for state income taxes, and Wisconsin did not prior to 2011.[15][16]

Contribution limits

According to IRS Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans (http://www.irs.gov/pub/irs-pdf/p969.pdf), you can generally make contributions to your HSA for a given tax year until the deadline for filing your income tax returns for that year, which is typically April 15. All contributions to an HSA from both the employer and the employee count toward the annual maximum.

Year	Contribution Limit (Single)	Contribution Limit (Family)	Catch-Up Contribution (55 or older) (Single and Family)
2004	$2,600	$5,150	$500
2005	$2,650	$5,250	$600
2006	$2,700	$5,450	$700
2007	$2,850	$5,650	$800
2008	$2,900	$5,800	$900
2009	$3,000	$5,950	$1,000
2010[17]	$3,050	$6,150	$1,000
2011[18]	$3,050	$6,150	$1,000
2012[19]	$3,100	$6,250	$1,000
2013[20]	$3,250	$6,450	$1,000
2014[21]	$3,300	$6,550	$1,000

Investments

Funds in an HSA can be invested in a manner similar to investments in an Individual Retirement Account (IRA). Investment earnings are sheltered from taxation until the money is withdrawn (and can be sheltered even then, as discussed in the section below).

While HSAs can be "rolled over" from fund to fund, an HSA cannot be rolled into an IRA or a 401(k), and funds from these types of investment vehicles cannot be rolled into an HSA, except for the one-time IRA transfer mentioned earlier. Unlike some employer contributions to a 401(k) plan, *all* HSA contributions belong to the participant immediately, regardless of the deposit source. A person contributing to an HSA is under no obligation to contribute to his or her employer-sponsored HSA, although employers may require that payroll contributions be made only to the sponsored HSA plan.

Withdrawals

HSA participants do not have to obtain advance approval from their HSA trustee or their medical insurer to withdraw funds, and the funds are not subject to income taxation if made for qualified medical expenses. These include costs for services and items covered by the health plan but subject to cost sharing such as a deductible and coinsurance, or co-payments, as well as many other expenses not covered under medical plans, such as dental, vision and chiropractic care; durable medical equipment such as eyeglasses and hearing aids; and transportation expenses related to medical care. Through December 31, 2010, non-prescription, over-the-counter medications were also eligible.[22][23] Beginning January 1, 2011 the Patient Protection and Affordable Care Act, also known as Health Care Reform, stipulates HSA funds can no longer be used to buy over-the-counter drugs without a doctor's prescription.

There are several ways that funds in an HSA can be withdrawn. Some HSAs include a debit card, some supply checks for account holder use, and some allow for a reimbursement process similar to medical insurance. Most HSAs have more than one possible method for withdrawal, and the methods available vary from HSA to HSA. Checks and debits do not have to be made payable to the provider. Funds can be withdrawn for any reason, but withdrawals that are not for documented qualified medical expenses are subject to income taxes and a 20% penalty. The 20% tax penalty is waived for persons who have reached the age of 65 or have become disabled at the time of the withdrawal. Then, only income tax is paid on the withdrawal, and in effect the account has grown tax deferred (similar to an IRA). Medical expenses continue to be tax free. Prior to January 1, 2011, when new rules governing HSAs in the Patient Protection and Affordable Care Act went into effect, the penalty for non-qualified withdrawals was 10%.

Account holders are required to retain documentation for their qualified medical expenses. Failure to retain and provide documentation could cause the IRS to rule withdrawals were not for qualified medical expenses and subject the taxpayer to additional penalties.[24]

There is no deadline for self-reimbursements of qualified medical expenses. High-income individuals can take advantage of this by paying for medical costs out of pocket, retaining receipts and allowing their accounts to grow tax-free. Money can then be withdrawn years later for any reason, up to the value of the receipts. [24]

When a person dies, the funds in their HSA are transferred to the beneficiary named for the account. If the beneficiary is a surviving spouse, the transfer is tax-free.

HSAs vs. other medical savings plans

Health savings accounts are similar to Medical savings account (Archer MSA) plans that were authorized by the federal government before HSA plans. HSAs can be used with some high-deductible health plans. HSAs came into being after legislation was signed by George W. Bush on December 8, 2003. The law went into effect on January 1, 2004.

HSAs differ in several ways from MSAs. Perhaps the most significant difference is that employers of all sizes can offer an HSA account and insurance plan to employees. MSAs were limited to the self-employed and employers of 50 or fewer people.

Benefits

The premium for an HDHP generally is less than the premium for traditional health insurance. A higher deductible lowers the premium because the insurance company no longer pays for routine healthcare, and insurance underwriters believe that Americans who see a relationship between medical cost and their bank accounts will consume less medical care, shop for lower-cost options, and be more vigilant against excess and fraud in the health care industry. Introducing consumer-driven supply and demand and controlling inflation in health care and health insurance were among the government's goals in establishing these plans.

With HSAs, in catastrophic situations, the maximum out-of-pocket expense liability can be less than that of a traditional health plan. This is because a qualified HDHP can cover 100% after the deductible, involving no coinsurance.

HSAs also give the flexibility not available in some traditional health plans to pay on a pretax basis for qualified medical expenses not covered in standard or HSA insurance plans, which may include dental, orthodontic, vision, and other approved expenses.[25][26]

HSA accounts also have an advantage over Flexible Spending Accounts (FSA) since deposits are not necessarily tied to expenses in a particular plan or calendar year. They are automatically rolled over for future medical expenses or may be used to reimburse qualified expenses from prior years as long as the expense was qualified under an HSA plan at the time that the expense was incurred.[27]

Over time, if medical expenses are low and contributions are made regularly to the HSA, the account can accumulate significant assets that can be used for health care tax free or used for retirement on a tax-deferred basis.

The HDHP plan, along with an HSA is the only health insurance plan option available that can possibly have a net gain of value during the year, provided the HSA funds are invested.

A recent industry survey found that in July 2007 over 80% of HSA plans provided first-dollar coverage for preventive care. This was true of virtually all HSA plans offered by large employers and over 95% of the plans offered by small employers. It was also true of over half (59%) of the plans which were purchased by individuals.

All of the plans offered first-dollar preventive care benefits included annual physicals, immunizations, well-baby and well-child care, mammograms and Pap tests; 90% included prostate cancer screenings and 80% included colon cancer screenings.[28]

Criticism

Some consumer organizations, such as Consumers Union, and many medical organizations, such as the American Public Health Association, oppose HSAs because, in their opinion, they benefit only healthy, younger people and make the health care system more expensive for everyone else. According to Stanford economist Victor Fuchs, "The main effect of putting more of it on the consumer is to reduce the social redistributive element of insurance."[29]

Critics contend that low-income people, who are more likely to be uninsured, do not earn enough to benefit from the tax breaks offered by HSAs. These tax breaks are too

modest, when compared to the actual cost of insurance, to persuade significant numbers to buy this coverage.[30]

One industry study matched HSA account holders to the neighborhood income ("neighborhood" was defined as their census tract from the 2000 Census) and found that 3% of account holders lived in "low-income" neighborhoods (median incomes below $25,000 in 1999 dollars), 46% lived in lower-middle-income neighborhoods (median incomes between $25,000 and $50,000), 34% lived in middle-income neighborhoods (median incomes between $50,000 and $75,000), 12% lived in upper-income neighborhoods (median incomes between $75,000 and $100,000) and 5% lived in higher income neighborhoods (median incomes above $100,000).[31]

In testimony before the US Senate Finance Committee's Subcommittee on Health in 2006, advocacy group Commonwealth Fund said that all evidence to date shows that health savings accounts and high-deductible health plans worsen, rather than improve, the US health system's problems.[32]

HSA funds that are not held in savings accounts insured by the Federal Deposit Insurance Corporation are subject to market risk, as is any other investment. While the potential upside from investment gains can be viewed as a benefit, the subsequent downside, as well as the possibility of capital loss, may make the HSA a poor option for some.[33]

Consumer satisfaction

Consumer satisfaction results have been mixed. While a 2005 survey by the Blue Cross and Blue Shield Association found widespread satisfaction among HSA customers,[34] a survey published in 2007 by employee benefits consultants Towers Perrin came to the opposite conclusion; it found that employees currently enrolled in such plans were significantly less satisfied with many elements of the health benefit plan compared to those enrolled in traditional health benefit plans.[35]

In 2006, a Government Accountability Office report concluded: "HSA-eligible plan enrollees who participated in GAO's focus groups generally reported positive experiences, but most would not recommend the plans to all consumers. Few participants reported researching cost before obtaining health care services, although many researched the cost of prescription drugs. Most participants were satisfied with their HSA-eligible plans and would recommend them to healthy consumers, but not to those who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible." [36]

According to the Commonwealth Fund, early experience with HSA-eligible high-deductible health plans reveals low satisfaction, high out-of-pocket costs, and cost-related access problems.[32] A survey conducted with the Employee Benefit Research Institute found that people enrolled in HSA-eligible high-deductible health plans were much less satisfied with many aspects of their health care than adults in more comprehensive plans.[37]

- People in these plans allocate substantial amounts of income to their health care, especially those who have poorer health or lower incomes.
- Adults in high-deductible health plans are far more likely to delay or avoid getting needed care, or to skip medications, because of the cost. Problems are particularly pronounced among those with poorer health or lower incomes.
- Few Americans in any health plan have the information they need to make decisions. Just 12 to 16 percent of insured adults have information from their health plan about the quality or cost of care provided by their doctors and hospitals.

Some policy analysts say that consumer satisfaction doesn't reflect quality of health care. Researchers at RAND Corporation and Department of Veterans Affairs asked 236 vulnerable elderly patients at two managed care plans to rate their care, then examined care in medical records, as reported in Annals of Internal Medicine. There was no correlation. "Patient ratings of health care are easy to obtain and report, but do not accurately measure the technical quality of medical care," said John T. Chan, UCLA, lead author.[38][39][40]

HSAs and health policy

According to a 2006 Zogby poll, seven in ten voters back Congressional action to allow HSA participants to pay for their insurance premiums using money in their savings plans.[41]

See also

- Direct primary care
- Health care in the United States
- Single-payer health care

Notes and references

1. ^ a b "Health Savings Accounts" (http://www.health401k.com/2011/09/health-savings-accounts-an-introduction/). Health401k.com. Retrieved 9 December 2010.
2. ^ "Health Savings Accounts (HSAs)" (http://www.ustreas.gov/offices/public-affairs/hsa/). U.S. Treasury. Retrieved 9 October 2010.
3. ^ "Affordable Care Act: Questions and Answers on Over-the-Counter Medicines and Drugs" (http://www.irs.gov/newsroom/article/0,,id=227308,00.html). IRS. 3 September 2010. Retrieved 9 December 2010.
4. ^ Employer Health Benefits 2007 Annual Survey (http://www.kff.org/insurance/7672), Kaiser Family Foundation, 2007-09-11, accessed 2007-10-28
5. ^ "Employer Health Benefits 2012 Annual Survey – Kaiser Family Foundation" (http://ehbs.kff.org/?CFID=570392658&CFTOKEN=68697502&jsessionid=603052be5c8bf60644407c455d! Ehbs.kff.org. Retrieved 2012-09-28.
6. ^ Hannah Yoo, January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans (http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf), America's Health Insurance Plans, April 2007
7. ^ Hannah Yoo, January 2008 Census Shows 6.1 Million People Covered by HSA/High-deductible Health Plans, (http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf) America's Health Insurance Plans, April 2008
8. ^ Press Release for Report Entitled "HSAs: Moving Beyond the Growing Pains," (http://www.celent.net/PressReleases/20080107/HSAGrowing.htm) Celent, January 7, 2008
9. ^ Hannah Yoo, January 2009 Census Shows 8 Million People Covered by HSA/High-deductible Health Plans, (http://www.ahipresearch.org/pdfs/2009hsacensus.pdf) America's Health Insurance Plans, May 2009
10. ^ John E. Dicken, Director, Health Care, U.S. Government Accountability Office, "Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes," (http://www.gao.gov/new.items/d08474r.pdf) Letter to Henry A. Waxman, Chairman of the House of Representatives Committee on Oversight and Government Reform and Pete Stark, Chairman of House of Representatives Subcommittee on Health Committee on Ways and Means, dated April 1, 2008
11. ^ Center for Policy Research, America's Health Insurance Plans, http://www.ahip.org/HSA2012/
12. ^ J. P. Morgan Chase, http://www.jpmorgan.com/visit/hsasnapshot
13. ^ "HSA Center 2012 Limits" (http://www.hsacenter.com/2012limits.html). hsacenter.com. Retrieved 2011-11-02.
14. ^ "2006 IRS Guidelines" (http://www.healthinsurance.com/hi/web/basics/hsa/irsGuidelines.aspx). healthinsurance.com. Retrieved 2006-08-11.
15. ^ "HSA State Income Tax – HSA for America" (http://www.health--savings--accounts.com/state-income-tax.htm). Health--savings--accounts.com. 2003-12-31. Retrieved 2012-09-28.
16. ^ "2011 Health Savings Accounts Fact Sheet" (http://www.revenue.wi.gov/taxpro/fact/hsa2011.pdf). Wisconsin Department of Revenue.
17. ^ IRS Rev. Proc. 2009-29 (http://www.irs.gov/pub/irs-drop/rp-09-29.pdf)
18. ^ IRS Rev. Proc. 2010-22 (http://www.irs.gov/pub/irs-drop/rp-10-22.pdf)

19. ^ IRS Rev. Proc. 2011-32 (http://www.irs.gov/pub/irs-drop/rp-11-32.pdf)
20. ^ IRS Rev. Proc. 2012-26 (http://www.irs.gov/pub/irs-drop/rp-12-26.pdf)
21. ^ IRS Rev. Proc. 2013-25 (http://www.irs.gov/pub/irs-drop/rp-13-25.pdf)
22. ^ "2006 IRS Publication 502" (http://www.irs.gov/publications/p502/). www.irs.gov. Retrieved 2007-10-21.
23. ^ HSA pdf (http://www.treasury.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-07.pdf)
24. ^ a b "IRS Publication 969" (http://www.irs.gov/publications/p969/index.html). www.irs.gov. Retrieved 2011-07-19.
25. ^ Department of Treasury – HSA FAQ (http://www.treas.gov/offices/public-affairs/hsa/faq_using.shtml#hsa2)
26. ^ HSA Basics (http://www.treas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-07.pdf)
27. ^ US Treasury Notice 2004-50 Q&A #39 (http://www.irs.gov/irb/2004-33_IRB/ar08.html#d0e1935)
28. ^ Thomas Wilder and Hannah Yoo, "A Survey of Preventive Benefits in Health Savings Account (HSA) Plans, July 2007," (http://www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf) America's Health Insurance Plans, November 2007
29. ^ Gladwell, Malcolm (2005-08-29). "The Moral Hazard Myth" (http://www.gladwell.com/2005/2005_08_29_a_hazard.html). *The New Yorker*. Retrieved 2007-06-28
30. ^ "Health Care Coverage in America: Understanding the Issues and Proposed Solutions" (http://web.archive.org/web/20071025150729/http://covertheuninsured.org/m (PDF). *Alliance for Health Reform*. Archived from the original (http://covertheuninsured.org/materials/files/2007/IssuesGuide.pdf) on 2007-10-25. Retrieved 2007-07-10.
31. ^ Hannah Yoo and Christelle Chen, Estimated Income Characteristics of HSA Accountholders in 2008, (http://www.ahipresearch.org/pdfs/HSAIncome2009.pdf) America's Health Insurance Plans, May 2009
32. ^ a b Testimony, Committee on Finance, September 26, 2006 CMWF.org (http://www.cmwf.org/publications/publications_show.htm?doc_id=405167)
33. ^ "Health Insurance Facts | Smarter Consumers of Healthcare" (http://www.healthharbor.com). Health Harbor. Retrieved 2012-09-28.
34. ^ "Surveys Indicate Consumers Are Happy With HSA Offerings, But Want Some Changes In Custodial Accounts" (http://web.archive.org/web/20070415053315/http://www.hsafinder.com/10-05_1.shtml). *HSA Finder.com*. Archived from the original (http://www.hsafinder.com/10-05_1.shtml) on 2007-04-15. Retrieved 2007-07-10.
35. ^ "Without the Correct Approach and Implementation, Long-Term Effectiveness of Account-Based Health Plans Could Be Undermined, Towers Perrin Research Shows" (http://www.towersperrin.com/tp/jsp/hrservices_webcache_html.jsp?webc=HR_Services/United_States/Press_Releases/2007/20070522/2007_05_22.htm&s (Press release). Towers Perrin. 2007-05-22. Retrieved 2007-07-10. "As compared to traditional health benefit plan participants, ABHP members are less comfortable with the level of financial risk their plan exposes them to, less likely to understand how the plan works, less favorable about how easy it is to use the plan, less favorable about the clarity of communication around benefit change and less satisfied with the basic elements of their plans."
36. ^ Health Savings Accounts: Early Enrollee Experiences with Accounts and Eligible Health Plans, GAO-06-1133T, September 26, 2006 (http://www.gao.gov/docsearch/abstract.php?rptno=GAO-06-1133T)
37. ^ Fronstin, Paul. "Findings from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey." EBRI Issue Brief no. 337, Dec. 2009 (http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2009_No337_CEHCS.pdf)
38. ^ Wessel, David Capital: In health care, consumer theory falls flat (http://online.wsj.com/article/SB115758434624755703.html) *Wall Street Journal*, 2006-09-07.
39. ^ RAND Corporation (http://www.rand.org/news/press.06/05.01.html), News Release, May 1, 2006, RAND study finds patients' ratings of their medical care do not reflect the technical quality of their care.
40. ^ Patients' Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care (http://www.annals.org/cgi/content/abstract/144/9/665), John T. Chang, et al., Ann Intern Med. 2006 May 2;144(9):665–72. [PMID16670136]
41. ^ Zogby International (http://www.zogby.com/news/ReadNews.dbm?ID=1105)

External links

- U.S. Treasury site on HSAs (http://www.treas.gov/offices/public-affairs/hsa/)
- HSA Contribution limits for 2007 (http://www.ustreas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml)
- HSA Contribution limits for 2008 (http://www.ustreas.gov/offices/public-affairs/hsa/pdf/rp-2007-36.pdf)
- HSA Contribution limits for 2009 (http://www.ustreas.gov/press/releases/hp975.htm)
- List of Eligible Medical Expenses (http://www.irs.gov/publications/p502/ar02.html#d0e630)
- Federal Tax Savings from HSA contributions made in 2007 (http://www.ustreas.gov/offices/public-affairs/hsa/pdf/hsa-examples_2007.pdf)
- IRS Forms for HSAs (http://www.ustreas.gov/offices/public-affairs/hsa/forms/)
- FAQs on HSAs: Frequently Asked Questions on Health Savings Accounts (http://www.actuary.org/pdf/health/hsa_oct07.pdf) from the American Academy of Actuaries (October 2007)

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HEALTH SAVINGS ACCOUNTS ("HSA")

WILL BE GROWING IN POPULARITY

- Increase in Cost of Health Insurance
- Employers Struggle to Meet ACA Compliance

WHAT IS THE HSA DESIGNED TO DO?

- Savings Account (Christmas Club!) of funds to pay the deductible

HOW TO QUALIFY FOR AN HSA

- High Deductible Health Insurance Plan
    - $1,250/yr for Single Person
    - $2,500/yr for Family
    - No Additional Prescription Plan
- Not Eligible for Any Other Non-High Deductible Health Insurance
- No Medicare
- You are not a Dependent (except a spouse)

ANYONE CAN CONTRIBUTE TO AN HSA

- Typical is Employer, Employee
- Third Parties can contribute, but not sure if this is on Pre-Tax basis

MAXIMUM CONTRIBUTIONS FOR 2014

- $3,300/yr for Individual
- $6,550/yr for Family
- After age 55, can contribute an additional $1,000/yr

BENEFITS OF AN HSA

- If the employer provides the plan, the employee can contribute to it on a Pre-Tax Basis.
- If the employee obtains a separate plan, the contributions are tax deductible.
- With some HSA plans, you can direct the investment of the account like an IRA.
- Funds grow tax-free, regardless whether growth is interest or investment.
- The funds roll-over from year to year.
- The funds are portable, if you leave your employment. However, the ability to contribute may not continue in your new job if you no longer have a High Deductible Plan.

WHAT CAN YOU PAY WITH AN HSA?

- Qualified Medical Expenses, see IRS Publication 502.
- Includes Dental, Orthodontic, and LASIK Expenses.
- Cosmetic Surgery if physician certifies medically necessary
- After the Affordable Care Act, over the counter medications no longer qualify
- Generally cannot be used for premiums, except for COBRA, long term care, premiums while on unemployment or age 65+

CAN YOU USE THE HSA FOR OTHER THINGS?

- You can withdraw funds at any time, but the funds will be subject to:
    - Income tax, and
    - Penalty of 20% until age 65 (This increased from 10% as part of Affordable Care Act).

EFFECT OF AFFORDABLE CARE ACT ON HSAs

- Many questioned whether they would still exist, but they do.
- Penalty for use other than Qualified Medical Expenses increased from 10% to 20%
- Elimination of Over the Counter Medications
- Children can stay on parent's HSA until age 26 (had been 18).

TWO CATEGORIES OF HSA USERS

1. "In and Outs"—Contribute to HSA with the intention of exhausting it each year. E.g. Large family or chronic health condition.

2. Long Term Investors—Contribute to HSA with the intention of allowing the funds to "ride." Remember that the 20% penalty expires at age 65. Therefore, in an HSA, the funds contributed are pre-tax and grow without tax until they are used. If not used until after age 65, there is only tax liability and no penalty.

Query: Whether these two classifications of HSA Users should be treated differently for family law purposes. It seems that for the "In and Outs"—those with legitimate medical needs who contribute and exhaust the benefits each year-- the contributions should be deducted from the payor's income and not counted as a marital asset. For the Long-Term Investors, the funds should be considered income for support and, if the account was built up at separation, then as a marital asset as well.

Query: Is it a double dip to consider it as income and as an asset? Think about it as if it was a 401(k).

MAJOR DIFFERENCES BETWEEN HSA AND FSA (FLEXIBLE SPENDING ACCOUNT)

- See detailed chart in the materials.
- Basic differences:
  - HSA owned by employee; FSA owned by employer
  - HSA funds rollover from one year to the next; FSA funds do not.
  - HSA funds are still owned by the employee after job termination; FSA funds are the employer's funds, so the employee loses them unless the employee uses the funds for COBRA.
  - Annual contributions limits are lower for FSA ($2,500) than HSA ($3300 individual; $6,550 family)

Comparison of Health Savings Accounts, Flexible Spending Accounts, and Health Reimbursement Arrangements

Updated May 20, 2013

	HSA	FSA	HRA
Account Ownership	Employee	Employer	Employer
Definition	A tax-exempt trust or custodial account set up with a qualified HSA trustee to pay or reimburse certain medical expenses incurred by eligible individuals.	Allows employees to be reimbursed for qualified medical expenses. Typically funded through voluntary pre-tax salary reduction agreements with employer.	Must be solely funded by an employer. Reimburses employees, tax-free, for qualified medical expenses up to a maximum dollar amount for a coverage period. May be offered with other health plans, including FSAs.
Eligibility	• Individual must be covered by a qualified High Deductible Health Plan and no other plan (that provides coverage for benefits covered by the HDHP) • Individual can not be claimed as a dependent on another person's tax return • Medicare entitled individuals are not eligible • Self-employed, partners and Sub S owners above 2% cannot receive pre-tax employer contributions	Owners, including sole proprietors, partners and Sub S owners above 2%, cannot participate; spouse of owner can participate if bona fide employee	Owners, including sole proprietors, partners and Sub S owners above 2%, cannot participate; spouse of partner and sole proprietor can participate if bona fide employee
Source of Contributions	• Employee, family member, employer or any other person can contribute to the account. • If Employer makes contributions, then Employer must make comparable contributions to all comparable participating Employees' HSAs. Failure to	Either employee or employer can contribute to the account.	Only employer can fund the account.

This Comparison only summarizes the legal rules and requirements for the health plans shown. Please check with Benecon or your legal counsel if you have any questions or need clarification or more information relating to a specific situation.

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	HSA	FSA	HRA
	meet this requirement will result in an excise tax of 35% of amount contributed. • One time rollover from HRA or FSA is permitted (amount is restricted)		
Tax Consequences	• Contributions, other than employer contributions are deductible on the eligible individual's tax return (except for those contributions that are made pre-tax through a cafeteria plan). • Employers may deduct their contributions. • Employer contributions are not included in employee's income.	Employer contributions can be excluded from employee's gross income, unless used to provide coverage for long-term care insurance.	Employer contributions can be excluded from employee's gross income.
Pre-Tax Contributions through Cafeteria Plan	Yes	Yes	No – employees cannot contribute
Annual contribution amount available at beginning of year	No	Yes	Not necessarily; employer can make funds available at beginning of year, or make a portion available each month (or other period)
Rollover of unused dollars at the end of the year	Yes. Interest or other earnings on the assets in the account are tax free.	No – however, funds may be available for health reimbursement during an additional 2½ month grace period following the end of the plan year	Only if permitted by employer in plan design.
Portability of unused dollars at termination of employment	Yes	No, except COBRA	• Usually no, except for COBRA • An ex-employee may have access at employer discretion as part of plan design

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	HSA	FSA	HRA
Applicability of HIPAA Privacy and Security	Only if the plan is subject to ERISA (see below)	• Privacy – yes (unless the employer pays the claims and there are fewer than 50 participants) • Security – yes if any protected health information is maintained on the computer system; limited compliance if none is maintained	• Privacy – yes (unless the employer pays the claims and there are fewer than 50 participants) • Security – yes if any protected health information is maintained on the computer system; limited compliance if none is maintained
Applicability of COBRA	COBRA applies only to the high deductible health plan and not the HSA	Yes	Yes
Applicability of ERISA	Yes, if the employer does any of the following: • Limits the ability of eligible individuals to move funds to another HSA beyond restrictions already in the IRC • Imposes conditions on the utilization of HSA funds beyond those contained in the IRC • Makes or influences investment decisions regarding funds in the HSA • Represents that the HSA is an employee welfare benefit plan established and maintained by the employer • Receives payment or compensation in connection with an HSA	Yes	Yes
Contribution Limits	For 2014 - $3,300 for individual and $6,550 for family coverage regardless of deductible in HDHP	$2,500 per year beginning January 1, 2013.	Employer determines contribution in plan design

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	HSA	FSA	HRA
Eligible Expenses	Any IRC §213(d) expenses; if employer limits the eligible expenses, the plan may be subject to ERISA. Non-prescription medicines (other than insulin) do not qualify as an eligible expense. Includes qualified medical expenses incurred by eligible individual, spouse, dependents (with limited exceptions). Adult children, that do not otherwise qualify as a tax-dependent of the parent, are not eligible for tax free reimbursements.	Any IRC §213(d) expenses, but employer can limit in plan design. Non-prescription medicines (other than insulin) do not qualify as an eligible medical expense. Eligible individuals must provide the FSA with a written statement from an independent third party stating that the medical expense had been incurred, the amount of the expense, and that the expense has not been paid or reimbursed under any other health plan coverage. Includes qualified medical expenses incurred by eligible individual, spouse, dependents (with limited exceptions).	Any IRC §213(d) expenses, but employer can limit in plan design (often covers only deductible expenses). Non-prescription medicines (other than insulin) do not qualify as an eligible medical expense. Reimbursements can be requested by eligible individual, spouse, dependents (with limited exceptions).
Insurance premiums eligible	Yes, but only COBRA, long term care, health insurance while unemployed, Medicare Parts B & D (but not a Medicare supplement policy)	No health or long term care premiums	Yes, but only if permitted by employer in plan design

This Comparison only summarizes the legal rules and requirements for the health plans shown. Please check with Benecon or your legal counsel if you have any questions or need clarification or more information relating to a specific situation.

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2013 Instructions for Form 8889

Department of the Treasury
Internal Revenue Service

Health Savings Accounts (HSAs)

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form 8889 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/form8889.

General Instructions

Purpose of Form

Use Form 8889 to:

- Report health savings account (HSA) contributions (including those made on your behalf and employer contributions),
- Figure your HSA deduction,
- Report distributions from HSAs, and
- Figure amounts you must include in income and additional tax you may owe if you fail to be an eligible individual.

Additional information. See Pub. 969, Health Savings Accounts and Other Tax-Favored Health Plans, for more details on HSAs.

Who Must File

You must file Form 8889 if any of the following applies.

- You (or someone on your behalf, including your employer) made contributions for 2013 to your HSA.
- You received HSA distributions in 2013.
- You must include certain amounts in income because you failed to be an eligible individual during the testing period.
- You acquired an interest in an HSA because of the death of the account beneficiary. See Death of Account Beneficiary, later.

If you (or your spouse, if filing jointly) received HSA distributions in 2013, you must file Form 8889 with Form 1040 even if you have no taxable income or any other reason for filing Form 1040.

Definitions

Eligible Individual

To be eligible to have contributions made to your HSA, you must be covered under a high deductible health plan (HDHP) and have no other health coverage except permitted coverage. If you are an eligible individual, anyone can contribute to your HSA. However, you cannot be enrolled in Medicare or be claimed as a dependent on another person's tax return. You must be, or be considered, an eligible individual on the first day of a month to take an HSA deduction for that month (see Last-month rule next).

Last-month rule. If you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered to be an eligible individual for the entire year.

Testing period. You must remain an eligible individual during the testing period. The testing period begins with the last month of your tax year and ends on the last day of the 12th month following that month (for example, December 1, 2013 – December 31, 2014). If you fail to remain an eligible individual during this period, other than because of death or becoming disabled, you will have to include in income the total contributions made that would not have been made except for the last-month rule. You include this amount in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. (See Part III.)

Account Beneficiary

The account beneficiary is the individual on whose behalf the HSA was established.

HSA

Generally, an HSA is a health savings account set up exclusively for paying the qualified medical expenses of the account beneficiary or the account beneficiary's spouse or dependents.

Distributions From an HSA

Distributions from an HSA used exclusively to pay qualified medical expenses of the account beneficiary, spouse, or dependents are excludable from gross income. (See the Line 15 instructions for information on medical expenses of dependents not claimed on your return.) You can receive distributions from an HSA even if you are not currently eligible to have contributions made to the HSA. However, any part of a distribution not used to pay qualified medical expenses is includible in gross income and is subject to an additional 20% tax unless an exception applies.

Qualified Medical Expenses

Generally, qualified medical expenses for HSA purposes are unreimbursed medical expenses that could otherwise be deducted on Schedule A (Form 1040). See the Instructions for Schedule A and Pub. 502, Medical and Dental Expenses. Expenses incurred before you establish your HSA are not qualified medical expenses. If, under the last-month rule, you are considered to be an eligible individual for the entire year for determining the contribution amount, only those expenses incurred after you actually establish your HSA are qualified medical expenses.

Note. Only prescribed medicines or drugs (including over-the-counter medicines and drugs that are prescribed) and insulin (even if purchased without a prescription) for the account beneficiary, the account beneficiary's spouse or dependent(s), are qualified medical expenses.

You cannot treat insurance premiums as qualified medical expenses unless the premiums are for:

1. Long-term care (LTC) insurance,
2. Health care continuation coverage (such as coverage under COBRA),
3. Health care coverage while receiving unemployment compensation under federal or state law, or
4. Medicare and other health care coverage if you were 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).

Coverage under (2) and (3) can be for your spouse or a dependent meeting the requirement. For (4), if you, the account

beneficiary, are under age 65, Medicare premiums for your spouse or dependents (who are age 65 or older) generally are not qualified medical expenses.

High Deductible Health Plan

An HDHP is a health plan that meets the following requirements.

	Self-only coverage	Family coverage
Minimum annual deductible	$1,250	$2,500
Maximum annual out-of-pocket expenses*	$6,250	$12,500

* This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses (such as copayments and other amounts, but not premiums) for services within the network should be used to figure whether the limit is reached.

An HDHP can provide preventive care and certain other benefits with no deductible or a deductible below the minimum annual deductible. For more details, see Pub. 969. An HDHP does not include a plan if substantially all of the coverage is for accidents, disability, dental care, vision care, or long-term care. An HDHP also cannot be insurance that you are permitted to have in addition to an HDHP. See Other Health Coverage, next.

Other Health Coverage

If you have an HSA, you (and your spouse, if you have family coverage) generally cannot have any health coverage other than an HDHP. But your spouse can have health coverage other than an HDHP if you are not covered by that plan. If you have a health flexible spending arrangement or health reimbursement arrangement, see Pub. 969.

Exceptions. You can have additional insurance that provides benefits only for:

- Liabilities under workers' compensation laws, tort liabilities, or liabilities arising from the ownership or use of property;
- A specific disease or illness; or
- A fixed amount per day (or other period) of hospitalization.

You can also have coverage (either through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

For information on prescription drug plans, see Pub. 969.

Disabled

An individual generally is considered disabled if he or she is unable to engage in any substantial gainful activity due to a physical or mental impairment which can be expected to result in death or to continue indefinitely.

Death of Account Beneficiary

If the account beneficiary's surviving spouse is the designated beneficiary, the HSA is treated as if the surviving spouse were the account beneficiary. The surviving spouse completes Form 8889 as though the HSA belonged to him or her.

If the designated beneficiary is not the account beneficiary's surviving spouse, or there is no designated beneficiary, the account ceases to be an HSA as of the date of death. The beneficiary completes Form 8889 as follows.

- Enter "Death of HSA account beneficiary" across the top of Form 8889.
- Enter the name(s) shown on the beneficiary's tax return and the beneficiary's SSN in the spaces provided at the top of the form and skip Part I.
- On line 14a, enter the fair market value of the HSA as of the date of death.
- On line 15, for a beneficiary other than the estate, enter qualified medical expenses incurred by the account beneficiary before the date of death that the beneficiary paid within 1 year after the date of death.
- Complete the rest of Part II.

If the account beneficiary's estate is the beneficiary, the value of the HSA as of the date of death is included on the account beneficiary's final income tax return. Complete Form 8889 as described above, except you should complete Part I, if applicable.

The distribution is not subject to the additional 20% tax. Report any earnings on the account after the date of death as income on your tax return.

Note. If, during the tax year, you are the beneficiary of two or more HSAs or you are a beneficiary of an HSA and you have your own HSA, you must complete a separate Form 8889 for each HSA. Enter "statement" at the top of each Form 8889 and complete the form as instructed. Next, complete a controlling Form 8889, combining the amounts shown on each of the statement Forms 8889. Attach the statements to your paper tax return after the controlling Form 8889.

Deemed Distributions From HSAs

The following situations result in deemed distributions from your HSA.

- You engaged in any transaction prohibited by section 4975 with respect to any of your HSAs, at any time in 2013. Your account ceases to be an HSA as of January 1, 2013, and you must include the fair market value of all assets in the account as of January 1, 2013, on line 14a.
- You used any portion of any of your HSAs as security for a loan at any time in 2013. You must include the fair market value of the assets used as security for the loan as income on line 21 of Form 1040 or Form 1040NR.

Any deemed distribution will not be treated as used to pay qualified medical expenses. Generally, these distributions are subject to the additional 20% tax.

Rollovers

A rollover is a tax-free distribution (withdrawal) of assets from one HSA or Archer MSA that is reinvested in another HSA of the same account beneficiary. Generally, you must complete the rollover within 60 days after you received the distribution. An HSA can only receive one rollover contribution during a 1-year period. See Pub. 590, Individual Retirement Arrangements (IRAs), for more details and additional requirements regarding rollovers.

Note. If you instruct the trustee of your HSA to transfer funds directly to the trustee of another of your HSAs, the transfer is not considered a rollover. There is no limit on the number of these transfers. Do not include the amount transferred in income, deduct it as a contribution, or include it as a distribution on line 14a.

Specific Instructions

Name and social security number (SSN). Enter your name(s) as shown on your tax return and the SSN of the HSA account beneficiary. If married filing jointly and both you and your

spouse have HSAs, complete a separate Form 8889 for each of you.

Part I—HSA Contributions and Deductions

Use Part I to figure:
- Your HSA deduction,
- Any excess contributions you made (or those made on your behalf), and
- Any excess contributions made by an employer (see Excess Employer Contributions, later).

Figuring Your HSA Deduction

The maximum amount that can be contributed to your HSA depends on the type of HDHP coverage you have. If you have self-only coverage, your maximum contribution is $3,250. If you have family coverage, your maximum contribution is $6,450.

Note. If you are age 55 or older at the end of your tax year, you can make an additional contribution of $1,000.

Your maximum contribution is reduced by any employer contributions to your HSA, any contributions made to your Archer MSA, and any qualified HSA funding distributions.

You can make deductible contributions to your HSA even if your employer made contributions. However, if you (or someone on your behalf) made contributions in addition to any employer contributions and qualified HSA funding distributions, you may have to pay an additional tax. See Excess Contributions You Make, later.

You cannot deduct any contributions for any month in which you were enrolled in Medicare. Also, you cannot deduct contributions if you can be claimed as a dependent on someone else's 2013 tax return.

How To Complete Part I

Complete lines 1 through 13 as instructed on the form. However, if you, and your spouse if filing jointly, are both eligible individuals and either of you have an HDHP with family coverage, you both are treated as having only the family coverage plan. Disregard any plans with self-only coverage.

Complete a separate Form 8889 for each spouse. Combine the amounts on line 13 of both Forms 8889 and enter this amount on Form 1040, line 25; or Form 1040NR, line 25. Be sure to attach both Forms 8889 to your paper tax return.

Line 1

If you were covered, or considered covered, by a self-only HDHP and a family HDHP at different times during the year, check the box for the plan that was in effect for a longer period. If you were covered by both a self-only HDHP and a family HDHP at the same time, you are treated as having family coverage during that period. If, on the first day of the last month of your tax year, December 1 for most taxpayers, you had family coverage, check the "family" box.

Line 2

Include on line 2 only those amounts you, or others on your behalf, contributed to your HSA in 2013. Also, include those contributions made from January 1, 2014, through April 15, 2014, that were for 2013. Do not include employer contributions (see line 9) or amounts rolled over from another HSA or Archer MSA. See Rollovers, earlier. Also, do not include any qualified HSA funding distributions (see line 10). Contributions to an employee's account through a cafeteria plan are treated as employer contributions and are not included on line 2.

Line 3

When figuring the amount to enter on line 3, apply the following rules.

1. Use the family coverage amount if you or your spouse had an HDHP with family coverage. Disregard any plan with self-only coverage.
2. If the last-month rule (see Last-month rule, earlier) applies, you are considered an eligible individual for the entire year. You are treated as having the same HDHP coverage for the entire year as you had on the first day of the last month of your tax year.
3. If you were, or were considered, an eligible individual for the entire year and you did not change your type of coverage, enter $3,250 for a self-only HDHP or $6,450 for a family HDHP on line 3. (See (6) in this list.)
4. If you were, or were considered, an eligible individual for the entire year and you changed your type of coverage during the year, enter on line 3 (see (6) in this list) the greater of:
   a. The limitation shown on the last line of the Line 3 Limitation Chart and Worksheet, later or
   b. The maximum amount that can be contributed based on the type of HDHP coverage you had on the first day of the last month of your tax year.

If you had family coverage on the first day of the last month, you do not need to use the worksheet; enter $6,450 on line 3.

5. If you were not an eligible individual on the first day of the last month of your tax year, use the Line 3 Limitation Chart and Worksheet, later to determine the amount to enter on line 3. (See (6) in this list.)
6. If, at the end of 2013, you were age 55 or older and unmarried or married with self-only HDHP coverage for the entire year, you can increase the amount determined in (3) or (4) by $1,000 (the additional contribution amount). For (5), the additional contribution amount is taken into account for each month you are an eligible individual.

Note. If you are married and had family coverage at any time during the year, the additional contribution amount is figured on line 7 and is not included on line 3.

See Pub. 969 for more information.

If you must complete the Line 3 Limitation Chart and Worksheet, and your eligibility and coverage did not change from one month to the next, enter the same number you entered for the previous month.

Line 6

Spouses who have separate HSAs and had family coverage under an HDHP at any time during 2013, use the following rules to figure the amount on line 6.
- If you are treated as having family coverage for each month, divide the amount on line 5 equally between you and your spouse, unless you both agree on a different allocation (such as allocating nothing to one spouse). Enter your allocable share on line 6.

Example. In 2013, you are an eligible individual and have self-only HDHP coverage. In March you marry and as of April 1 you have family HDHP coverage. Neither you nor your spouse qualify for the additional contribution amount. Your spouse has a separate HSA and is an eligible individual from April 1 to December 31, 2013. Because you and your spouse are considered to have family coverage on December 1, your contribution limit is $6,450 (the family coverage maximum). You and your spouse can divide this amount in any allocation to which you agree (such as allocating nothing to one spouse).

• If you are not treated as having family coverage for each month, use the following steps to determine the amount to enter on line 6.

Step 1. Refigure the contribution limit that would have been entered on line 5 if you had entered on line 3 the total of the worksheet amounts only for the months you were treated as having family coverage. When refiguring line 5, use the same amount you previously entered on line 4.

Step 2. Divide the refigured contribution limit from *Step 1* equally between you and your spouse, unless you both agree on a different allocation (such as allocating nothing to one spouse).

Step 3. Subtract the part of the contribution limit allocated to your spouse in *Step 2* from the amount determined in *Step 1*.

Step 4. Determine any other contribution limits that apply for the tax year and add that amount to the result in *Step 3*. Enter the total on line 6.

Example. In 2013, you are an eligible individual and have family HDHP coverage. In March you divorce and change your coverage as of April 1 to self-only. Neither you nor your ex-spouse qualify for the additional contribution amount. Your ex-spouse continued to have family HDHP coverage and was an eligible individual for the entire year. The contribution limit for the 3 months you both were considered to have family coverage is $1,612.50 ($6,450 × 3 ÷ 12). You and your ex-spouse decide to divide the family coverage contribution in the following manner: 75% to your ex-spouse and 25% to you. Your contribution limit for 9 months of self-only coverage is $2,437.50 ($3,250 × 9 ÷ 12). This amount is not divided between you and your spouse.

Because you are covered under a self-only policy on December 1, you will show $3,250 on line 6 (the greater of either (a) $2,840.62 ($1,612.50 family coverage + $2,437.50 self-only coverage – $1,209.38 spousal allocation) or (b) the maximum amount that can be contributed ($3,250 for self-only coverage). Your ex-spouse would show $6,450 on line 6 (the greater of either (a) $6,046.87 ($1,612.50 family coverage for the 3 months prior to the divorce + $4,837.50 family coverage maintained after the divorce – $403.13 spousal allocation) or (b) the maximum amount that can be contributed ($6,450 for family coverage).

Line 7

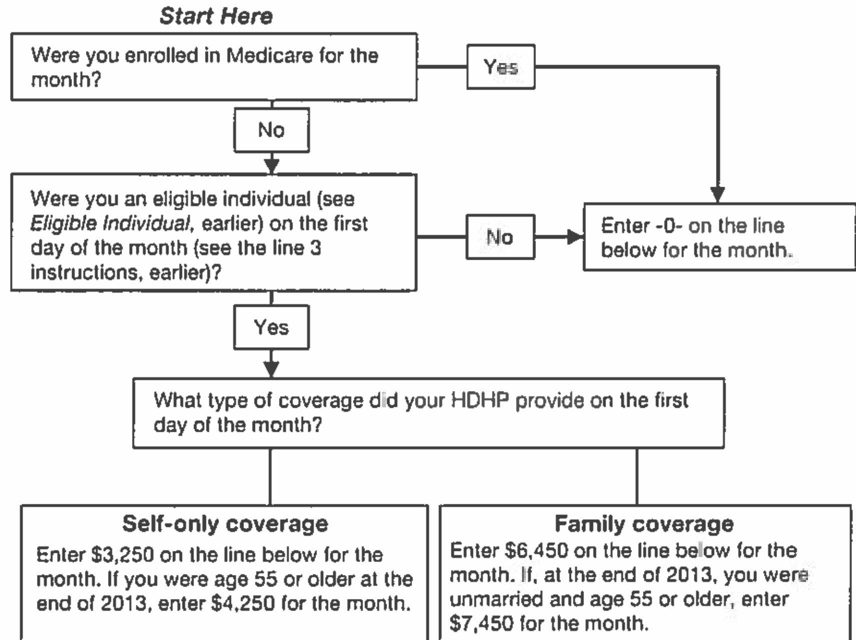
Additional Contribution Amount

If, at the end of 2013, you were age 55 or older and married, use the Additional Contribution Amount Worksheet, later, if both of the following apply.

1. You or your spouse had family coverage under an HDHP and were, or were considered to be, an eligible individual on the first day of the month.

Line 3 Limitation Chart and Worksheet

Before you begin: *See the instructions for line 3, earlier.*
Go through this chart for each month of 2013.
(Keep for your records)



Month in 2013	Amount from chart above
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	
Total for all months	
Limitation. Divide the total by 12. Enter here and on line 3	

Employer Contribution Worksheet

Keep for Your Records

1.	Enter the employer contributions reported in box 12 of Form W-2, with code W	1.	
2.	Enter employer contributions made in 2013 for tax year 2012	2.	
3.	Subtract line 2 from line 1	3.	
4.	Enter employer contributions made in 2014 for tax year 2013	4.	
5.	**Employer contributions for 2013.** Add lines 3 and 4. Enter here and on Form 8889, line 9	5.	

2. You were not enrolled in Medicare for the month.

Enter the result on line 7.

If items (1) and (2) apply to all months during 2013, enter $1,000 on line 7.

Additional Contribution Amount Worksheet

1.	$1,000 × number of months eligible	
2.	Divide line 1 by 12. Enter here and on line 7	

Example. At the end of 2013, you were age 55 and married. You had family coverage under an HDHP from January 1 through June 30, 2013 (6 months). You were not enrolled in Medicare in 2013. You would enter an additional contribution amount of $500 on line 7 ($1,000 × 6 ÷ 12).

Line 9

Employer Contributions

Employer contributions (including contributions through a cafeteria plan) include any amount an employer contributes to any HSA for you for 2013. These contributions should be shown in box 12 of Form W-2 with code W. If either of the following apply, complete the Employer Contribution Worksheet.

- Employer contributions for 2012 are included in the amount reported in box 12 of Form W-2 with code W.
- Employer contributions for 2013 are made in 2014.

If your employer made excess contributions, you may have to report the excess as income. See Excess Employer Contributions, later.

Line 10

Enter on line 10 any qualified HSA funding distribution made during the year. This is a distribution from your traditional IRA or Roth IRA to your HSA in a direct trustee-to-trustee transfer. This distribution is not included in your income, is not deductible, and reduces the amount that can be contributed to your HSA. This distribution cannot be made from an ongoing SEP IRA or SIMPLE IRA. For this purpose, a SEP IRA or SIMPLE IRA is ongoing if an employer contribution is made for the plan year ending with or within your tax year in which the distribution would be made.

The maximum amount that can be excluded from income is based on your age at the end of the year and your HDHP coverage (self-only or family) at the time of the distribution. You can make only one qualified HSA funding distribution during your lifetime. However, if you make the distribution during a month when you have self-only HDHP coverage, you can make another qualified HSA funding distribution in a later month in that tax year if you change to family HDHP coverage.

A qualified HSA funding distribution made during your tax year reduces the amount that can be contributed from other sources (including employer contributions) to your HSA. See the discussions under Line 13 for the treatment of excess contributions.

See Pub. 969 for more information.

Testing period. You must remain an eligible individual during the testing period. The testing period begins with the month in which the qualified HSA funding distribution is contributed to the HSA and ends on the last day of the 12th month following that month. For example, if the distribution is contributed on June 14, 2013, the testing period ends on June 30, 2014. If you fail to remain an eligible individual during this period, other than because of death or becoming disabled, you will have to include the qualified HSA funding distribution in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. (See Part III.)

Line 13

If you or someone on your behalf (or your employer) contributed more to your HSA than is allowable, you may have to pay an additional tax on the excess contributions. Figure the excess contributions using the following instructions. See Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts, to figure the additional tax.

Excess Contributions You Make

To figure your excess contributions (including those made on your behalf), subtract your deductible contributions (line 13) from your actual contributions (line 2). However, you can withdraw some or all of your excess contributions for 2013 and they will be treated as if they had not been contributed if:

- You make the withdrawal by the due date, including extensions, of your 2013 tax return (but see the Note under *Excess Employer Contributions*, later),
- You do not claim a deduction for the amount of the withdrawn contributions, and
- You also withdraw any income earned on the withdrawn contributions and include the earnings in "Other income" on your tax return for the year you withdraw the contributions and earnings.

Excess Employer Contributions

Excess employer contributions are the excess, if any, of your employer's contributions over your limitation on line 8. If you made a qualified HSA funding distribution (line 10) during the tax year, reduce your limitation (line 8) by that distribution before you determine whether you have excess employer contributions. If the excess was not included in income on Form W-2, you must report it as "Other income" on your tax return. However, you can withdraw some or all of the excess employer contributions for 2013 and they will be treated as if they had not been contributed if:

- You make the withdrawal by the due date, including extensions, of your 2013 tax return (but see the following Note),
- You do not claim an exclusion from income for the amount of the withdrawn contributions, and
- You also withdraw any income earned on the withdrawn contributions and include the earnings in "Other

income" on your tax return for the year you withdraw the contributions and earnings.

Note. If you timely filed your return without withdrawing the excess contributions, you can still make the withdrawal no later than 6 months after the due date of your tax return, excluding extensions. If you do, file an amended return with "Filed pursuant to section 301.9100-2" written at the top. Include an explanation of the withdrawal. Make all necessary changes on the amended return (for example, if you reported the contributions as excess contributions on your original return, include an amended Form 5329 reflecting that the withdrawn contributions are no longer treated as having been contributed).

Deducting an Excess Contribution In a Later Year

You may be able to deduct excess contributions for previous years that are still in your HSA. The excess contributions you can deduct in the current year is the lesser of the following two amounts.

- Your maximum HSA contribution limit for the year minus any amounts contributed to your HSA for the year.
- The total excess contributions in your HSA at the beginning of the year.

Any excess contribution remaining at the end of the tax year is subject to the additional tax. See Form 5329.

Part II—HSA Distributions

Line 14a

Enter the total distributions you received in 2013 from all HSAs. Your total distributions include amounts paid with a debit card that restricts payments to health care and amounts withdrawn by other individuals that you have designated. These amounts should be shown in box 1 of Form 1099-SA.

Line 14b

Include on line 14b any distributions you received in 2013 that qualified as a rollover contribution to another HSA. See *Rollovers*, earlier. Also include any excess contributions (and the earnings on those excess contributions) included on line 14a that were withdrawn by the due date, including extensions, of your return. See the instructions for line 13, earlier.

Line 15

Only include on line 15 distributions from your HSA that were used to pay you for qualified medical expenses (see Qualified Medical Expenses, earlier) not reimbursed by insurance or other coverage and that you incurred after the HSA was established. Do not include the distribution of an excess contribution taken out after the due date, including extensions, of your return even if used for qualified medical expenses.

In general, include on line 15 distributions from all HSAs in 2013 that were used for the qualified medical expenses (see *Qualified Medical Expenses*, earlier) of:

1. Yourself and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
   a. The person filed a joint return.
   b. The person had gross income of $3,900 or more.
   c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's return.

For this purpose, a child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether or not the custodial parent releases the claim to the child's exemption.

You cannot take a deduction on Schedule A (Form 1040) for any amount you include on line 15.

Lines 17a and 17b

Additional 20% Tax

HSA distributions included in income (line 16) are subject to an additional 20% tax unless one of the following exceptions applies.

Exceptions to the Additional 20% Tax

The additional 20% tax does not apply to distributions made after the account beneficiary—

- Dies,
- Becomes disabled (see *Disabled*, earlier), or
- Turns age 65.

If any of the exceptions apply to any of the distributions included on line 16, check the box on line 17a. Enter on line 17b only 20% (.20) of any amount included on line 16 that does not meet any of the exceptions.

Example 1. You turned age 63 in 2013 and received a distribution from an HSA that is included in income. Do not check the box on line 17a because you (the account beneficiary) did not meet the age exception for the distribution. Enter 20% of the amount from line 16 on line 17b.

Example 2. You turned age 65 in 2013. You received distributions that are included in income both before and after you turned age 65. Check the box on line 17a because the additional 20% tax does not apply to the distributions made after the date you turned age 65. However, the additional 20% tax does apply to the distributions made on or before the date you turned age 65. Enter on line 17b, 20% of the amount of these distributions included in line 16.

Part III—Income and Additional Tax for Failure to Maintain HDHP Coverage

Use Part III to figure any income and additional tax that must be reported on Form 1040 or Form 1040NR for failure to be an eligible individual during the testing period for:

- Last-month rule (see *Last-month rule*, earlier), or
- A qualified HSA funding distribution (see the instructions for line 10, earlier).

See the discussions indicated to determine the testing period for these items. Include the amount in income in the year in which you fail to be an eligible individual.

Line 18

You can use the *Line 3 Limitation Chart and Worksheet* for the year the contribution was made to determine the contribution you could have made if the last-month rule did not apply. Enter on line 18 the excess of the amount contributed over the redetermined amount. Examples of this computation are in Pub. 969.

Line 19

Enter the total of any qualified HSA funding distribution (see *Line 10*).

What Are Medical Expenses?

Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Medical expenses include the premiums you pay for insurance that covers the expenses of medical care, and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

What Expenses Can You Include This Year?

You can include only the medical and dental expenses you paid this year, regardless of when the services were provided. (But see Decedent under *Whose Medical Expenses Can You Include*, for an exception.) If you pay medical expenses by check, the day you mail or deliver the check generally is the date of payment. If you use a "pay-by-phone" or "online" account to pay your medical expenses, the date reported on the statement of the financial institution showing when payment was made is the date of payment. If you use a credit card, include medical expenses you charge to your credit card in the year the charge is made, not when you actually pay the amount charged.

If you did not claim a medical or dental expense that would have been deductible in an earlier year, you can file Form 1040X, Amended U.S. Individual Income Tax Return, for the year in which you overlooked the expense. Do not claim the expense on this year's return. Generally, an amended return must be filed within 3 years from the date the original return was filed or within 2 years from the time the tax was paid, whichever is later.

You cannot include medical expenses that were paid by insurance companies or other sources. This is true whether the payments were made directly to you, to the patient, or to the provider of the medical services.

Separate returns. If you and your spouse live in a noncommunity property state and file separate returns, each of you can include only the medical expenses each actually paid. Any medical expenses paid out of a joint checking account in which you and your spouse have the same interest are considered to have been paid equally by each of you, unless you can show otherwise.

Community property states. If you and your spouse live in a community property state and file separate returns or are registered domestic partners in Nevada, Washington, or California, any medical expenses paid out of community funds are divided equally. Generally, each of you should include half the expenses. If medical expenses are paid out of the separate funds of one individual, only the individual who paid the medical expenses can include them. If you live in a community property state and are not filing a joint return, see Publication 555, Community Property.

How Much of the Expenses Can You Deduct?

Generally, you can deduct on Schedule A (Form 1040) only the amount of your medical and dental expenses that is more than 10% of your AGI. But if either you or your spouse was born before January 2, 1949, you can deduct the amount of your medical and dental expenses that is more than 7.5% of your AGI.

Example.

You are unmarried and were born after January 2, 1949, and your AGI is $40,000, 10% of which is $4,000. You paid medical expenses of $2,500. You cannot deduct any of your medical expenses because they are not more than 10% of your AGI.

Whose Medical Expenses Can You Include?

You can generally include medical expenses you pay for yourself, as well as those you pay for someone who was your spouse or your dependent either when the services were provided or when you paid for them. There are different rules for decedents and for individuals who are the subject of multiple support agreements. See *Support claimed under a multiple support agreement*, later under *Qualifying Relative*.

Spouse

You can include medical expenses you paid for your spouse. To include these expenses, you must have been married either at the time your spouse received the medical services or at the time you paid the medical expenses.

Example 1.

Mary received medical treatment before she married Bill. Bill paid for the treatment after they married. Bill can include these expenses in figuring his medical expense deduction even if Bill and Mary file separate returns.

If Mary had paid the expenses, Bill could not include Mary's expenses in his separate return. Mary would include the amounts she paid during the year in her separate return. If they filed a joint return, the medical expenses both paid during the year would be used to figure their medical expense deduction.

Example 2.

This year, John paid medical expenses for his wife Louise, who died last year. John married Belle this year and they file a joint return. Because John was married to Louise when she received the medical services, he can include those expenses in figuring his medical expense deduction for this year.

Dependent

You can include medical expenses you paid for your dependent. For you to include these expenses, the person must have been your dependent either at the time the medical services were provided or at the time you paid the expenses. A person generally qualifies as your dependent for purposes of the medical expense deduction if both of the following requirements are met.

1. The person was a qualifying child (defined later) or a qualifying relative (defined later), and

2. The person was a U.S. citizen or national or a resident of the United States, Canada, or Mexico. If your qualifying child was adopted, see Exception for adopted child , later.

You can include medical expenses you paid for an individual that would have been your dependent except that:

1. He or she received gross income of $3,900 or more in 2013,
2. He or she filed a joint return for 2013, or
3. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2013 return.

Exception for adopted child. If you are a U.S. citizen or national and your adopted child lived with you as a member of your household for 2013, that child does not have to be a U.S. citizen or national, or a resident of the United States, Canada, or Mexico.

Qualifying Child

A qualifying child is a child who:

1. Is your son, daughter, stepchild, foster child, brother, sister, stepbrother, stepsister, half brother, half sister, or a descendant of any of them (for example, your grandchild, niece, or nephew),
2. Was:
   a. Under age 19 at the end of 2013 and younger than you (or your spouse, if filing jointly),
   b. Under age 24 at the end of 2013, a full-time student, and younger than you (or your spouse, if filing jointly), or
   c. Any age and permanently and totally disabled,
3. Lived with you for more than half of 2013,
4. Did not provide over half of his or her own support for 2013, and
5. Did not file a joint return, other than to claim a refund.

Adopted child. A legally adopted child is treated as your own child. This child includes a child lawfully placed with you for legal adoption.

You can include medical expenses that you paid for a child before adoption if the child qualified as your dependent when the medical services were provided or when the expenses were paid.

If you pay back an adoption agency or other persons for medical expenses they paid under an agreement with you, you are treated as having paid those expenses provided you clearly substantiate that the payment is directly attributable to the medical care of the child.

But if you pay the agency or other person for medical care that was provided and paid for before adoption negotiations began, you cannot include them as medical expenses.

You may be able to take a credit for other expenses related to an adoption. See the Instructions for Form 8839, Qualified Adoption Expenses, for more information.

Child of divorced or separated parents. For purposes of the medical and dental expenses deduction, a child of divorced or separated parents can be treated as a dependent of both parents. Each parent can include the medical expenses he or she pays for the child, even if the other parent claims the child's dependency exemption, if:

1. The child is in the custody of one or both parents for more than half the year,
2. The child receives over half of his or her support during the year from his or her parents, and
3. The child's parents:
   a. Are divorced or legally separated under a decree of divorce or separate maintenance,
   b. Are separated under a written separation agreement, or
   c. Live apart at all times during the last 6 months of the year.

This does not apply if the child's exemption is being claimed under a multiple support agreement (discussed later).

Qualifying Relative

A qualifying relative is a person:

1. Who is your:
   a. Son, daughter, stepchild, or foster child, or a descendant of any of them (for example, your grandchild),
   b. Brother, sister, half brother, half sister, or a son or daughter of any of them,
   c. Father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle),
   d. Stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law, or
   e. Any other person (other than your spouse) who lived with you all year as a member of your household if your relationship did not violate local law,
2. Who was not a qualifying child (see Qualifying Child, earlier) of any taxpayer for 2013, and

3. For whom you provided over half of the support in 2013. But see *Child of divorced or separated parents*, earlier, *Support claimed under a multiple support agreement*, next, and *Kidnapped child* under *Qualifying Relative* in Publication 501.

Support claimed under a multiple support agreement. If you are considered to have provided more than half of a qualifying relative's support under a multiple support agreement, you can include medical expenses you pay for that person. A multiple support agreement is used when two or more people provide more than half of a person's support, but no one alone provides more than half.

Any medical expenses paid by others who joined you in the agreement cannot be included as medical expenses by anyone. However, you can include the entire unreimbursed amount you paid for medical expenses.

Example.

You and your three brothers each provide one-fourth of your mother's total support. Under a multiple support agreement, you treat your mother as your dependent. You paid all of her medical expenses. Your brothers repaid you for three-fourths of these expenses. In figuring your medical expense deduction, you can include only one-fourth of your mother's medical expenses. Your brothers cannot include any part of the expenses. However, if you and your brothers share the nonmedical support items and you separately pay all of your mother's medical expenses, you can include the unreimbursed amount you paid for her medical expenses in your medical expenses.

Decedent

Medical expenses paid before death by the decedent are included in figuring any deduction for medical and dental expenses on the decedent's final income tax return. This includes expenses for the decedent's spouse and dependents as well as for the decedent.

The survivor or personal representative of a decedent can choose to treat certain expenses paid by the decedent's estate for the decedent's medical care as paid by the decedent at the time the medical services were provided. The expenses must be paid within the 1-year period beginning with the day after the date of death. If you are the survivor or personal representative making this choice, you must attach a statement to the decedent's Form 1040 (or the decedent's amended return, Form 1040X) saying that the expenses have not been and will not be claimed on the estate tax return.

Qualified medical expenses paid before death by the decedent are not deductible if paid with a tax-free distribution from any Archer MSA, Medicare Advantage MSA, or health savings account.

What if the decedent's return had been filed and the medical expenses were not included? Form 1040X can be filed for the year or years the expenses are treated as paid, unless the period for filing an amended return for that year has passed. Generally, an amended return must be filed within 3 years of the date the original return was filed, or within 2 years from the time the tax was paid, whichever date is later.

Example.

John properly filed his 2012 income tax return. He died in 2013 with unpaid medical expenses of $1,500 from 2012 and $1,800 in 2013. If the expenses are paid within the 1-year period, his survivor or personal representative can file an amended return for 2012 claiming a deduction based on the $1,500 medical expenses. The $1,800 of medical expenses from 2013 can be included on the decedent's final return for 2013.

What if you pay medical expenses of a deceased spouse or dependent? If you paid medical expenses for your deceased spouse or dependent, include them as medical expenses on your Form 1040 in the year paid, whether they are paid before or after the decedent's death. The expenses can be included if the person was your spouse or dependent either at the time the medical services were provided or at the time you paid the expenses.

What Medical Expenses Are Includible?

Following is a list of items that you can include in figuring your medical expense deduction. The items are listed in alphabetical order.

This list does not include all possible medical expenses. To determine if an expense not listed can be included in figuring your medical expense deduction, see *What Are Medical Expenses*, earlier.

Abortion

You can include in medical expenses the amount you pay for a legal abortion.

Acupuncture

You can include in medical expenses the amount you pay for acupuncture.

Alcoholism

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for alcohol addiction. This includes meals and lodging provided by the center during treatment.

You can also include in medical expenses amounts you pay for transportation to and from Alcoholics Anonymous meetings in your community if the attendance is pursuant to medical advice that membership in Alcoholics Anonymous is necessary for the treatment of a disease involving the excessive use of alcoholic liquors.

Ambulance

You can include in medical expenses amounts you pay for ambulance service.

Annual Physical Examination

See *Physical Examination*, later.

Artificial Limb

You can include in medical expenses the amount you pay for an artificial limb.

Artificial Teeth

You can include in medical expenses the amount you pay for artificial teeth.

Bandages

You can include in medical expenses the cost of medical supplies such as bandages.

Birth Control Pills

You can include in medical expenses the amount you pay for birth control pills prescribed by a doctor.

Body Scan

You can include in medical expenses the cost of an electronic body scan.

Braille Books and Magazines

You can include in medical expenses the part of the cost of Braille books and magazines for use by a visually impaired person that is more than the cost of regular printed editions.

Breast Pumps and Supplies

You can include in medical expenses the cost of breast pumps and supplies that assist lactation.

Breast Reconstruction Surgery

You can include in medical expenses the amounts you pay for breast reconstruction surgery, as well as breast prosthesis, following a mastectomy for cancer. See Cosmetic Surgery, later.

Capital Expenses

You can include in medical expenses amounts you pay for special equipment installed in a home, or for improvements, if their main purpose is medical care for you, your spouse, or your dependent. The cost of permanent improvements that increase the value of your property may be partly included as a medical expense. The cost of the improvement is reduced by the increase in the value of your property. The difference is a medical expense. If the value of your property is not increased by the improvement, the entire cost is included as a medical expense.

Certain improvements made to accommodate a home to your disabled condition, or that of your spouse or your dependents who live with you, do not usually increase the value of the home and the cost can be included in full as medical expenses. These improvements include, but are not limited to, the following items.

- Constructing entrance or exit ramps for your home.
- Widening doorways at entrances or exits to your home.
- Widening or otherwise modifying hallways and interior doorways.
- Installing railings, support bars, or other modifications to bathrooms.
- Lowering or modifying kitchen cabinets and equipment.
- Moving or modifying electrical outlets and fixtures.
- Installing porch lifts and other forms of lifts (but elevators generally add value to the house).
- Modifying fire alarms, smoke detectors, and other warning systems.
- Modifying stairways.
- Adding handrails or grab bars anywhere (whether or not in bathrooms).
- Modifying hardware on doors.
- Modifying areas in front of entrance and exit doorways.
- Grading the ground to provide access to the residence.

Only reasonable costs to accommodate a home to a disabled condition are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not medical expenses.

Capital expense worksheet. Use Worksheet A to figure the amount of your capital expense to include in your medical expenses.

Worksheet A. Capital Expense Worksheet

Instructions: Use this worksheet to figure the amount, if any, of your medical expenses due to a home improvement.			
1. Enter the amount you paid for the home improvement			1.
2. Enter the value of your home immediately after the improvement	2.		
3. Enter the value of your home immediately before the improvement	3.		

4.	Subtract line 3 from line 2. This is the increase in the value of your home due to the improvement	4.	
	• If line 4 is more than or equal to line 1, you have no medical expenses due to the home improvement; stop here.		
	• If line 4 is less than line 1, go to line 5.		
5.	Subtract line 4 from line 1. These are your medical expenses due to the home improvement	5.	

Operation and upkeep. Amounts you pay for operation and upkeep of a capital asset qualify as medical expenses, as long as the main reason for them is medical care. This rule applies even if none or only part of the original cost of the capital asset qualified as a medical care expense.

Improvements to property rented by a person with a disability. Amounts paid to buy and install special plumbing fixtures for a person with a disability, mainly for medical reasons, in a rented house are medical expenses.

Example.

John has arthritis and a heart condition. He cannot climb stairs or get into a bathtub. On his doctor's advice, he installs a bathroom with a shower stall on the first floor of his two-story rented house. The landlord did not pay any of the cost of buying and installing the special plumbing and did not lower the rent. John can include in medical expenses the entire amount he paid.

Car

You can include in medical expenses the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.

Special design. You can include in medical expenses the difference between the cost of a regular car and a car specially designed to hold a wheelchair.

Cost of operation. The includible costs of using a car for medical reasons are explained under *Transportation*, later.

Chiropractor

You can include in medical expenses fees you pay to a chiropractor for medical care.

Christian Science Practitioner

You can include in medical expenses fees you pay to Christian Science practitioners for medical care.

Contact Lenses

You can include in medical expenses amounts you pay for contact lenses needed for medical reasons. You can also include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner. See *Eyeglasses* and *Eye Surgery*, later.

Crutches

You can include in medical expenses the amount you pay to buy or rent crutches.

Dental Treatment

You can include in medical expenses the amounts you pay for the prevention and alleviation of dental disease. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments. But see *Teeth Whitening* under *What Expenses Are Not Includible*, later.

Diagnostic Devices

You can include in medical expenses the cost of devices used in diagnosing and treating illness and disease.

Example.

You have diabetes and use a blood sugar test kit to monitor your blood sugar level. You can include the cost of the blood sugar test kit in your medical expenses.

Disabled Dependent Care Expenses

Some disabled dependent care expenses may qualify as either:

- Medical expenses, or
- Work-related expenses for purposes of taking a credit for dependent care. (See Publication 503, Child and Dependent Care Expenses.)

You can choose to apply them either way as long as you do not use the same expenses to claim both a credit and a medical expense deduction.

Drug Addiction

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for drug addiction. This includes meals and lodging at the center during treatment.

Drugs

See *Medicines* , later.

Eye Exam

You can include in medical expenses the amount you pay for eye examinations.

Eyeglasses

You can include in medical expenses amounts you pay for eyeglasses and contact lenses needed for medical reasons. See *Contact Lenses* , earlier, for more information.

Eye Surgery

You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

Fertility Enhancement

You can include in medical expenses the cost of the following procedures to overcome an inability to have children.

- Procedures such as *in vitro* fertilization (including temporary storage of eggs or sperm).
- Surgery, including an operation to reverse prior surgery that prevented the person operated on from having children.

Founder's Fee

See *Lifetime Care—Advance Payments* , later.

Guide Dog or Other Service Animal

You can include in medical expenses the costs of buying, training, and maintaining a guide dog or other service animal to assist a visually impaired or hearing disabled person, or a person with other physical disabilities. In general, this includes any costs, such as food, grooming, and veterinary care, incurred in maintaining the health and vitality of the service animal so that it may perform its duties.

Health Institute

You can include in medical expenses fees you pay for treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.

Health Maintenance Organization (HMO)

You can include in medical expenses amounts you pay to entitle you, your spouse, or a dependent to receive medical care from an HMO. These amounts are treated as medical insurance premiums. See *Insurance Premiums* , later.

Hearing Aids

You can include in medical expenses the cost of a hearing aid and batteries, repairs, and maintenance needed to operate it.

Home Care

See *Nursing Services* , later.

Home Improvements

See *Capital Expenses* , earlier.

Hospital Services

You can include in medical expenses amounts you pay for the cost of inpatient care at a hospital or similar institution if a principal reason for being there is to receive medical care. This includes amounts paid for meals and lodging. Also see *Lodging* , later.

Insurance Premiums

You can include in medical expenses insurance premiums you pay for policies that cover medical care. Medical care policies can provide payment for treatment that includes:

- Hospitalization, surgical services, X-rays,
- Prescription drugs and insulin,
- Dental care,

- Replacement of lost or damaged contact lenses, and
- Long-term care (subject to additional limitations). See Qualified Long-Term Care Insurance Contracts under *Long-Term Care*, later.

If you have a policy that provides payments for other than medical care, you can include the premiums for the medical care part of the policy if the charge for the medical part is reasonable. The cost of the medical part must be separately stated in the insurance contract or given to you in a separate statement.

Health coverage tax credit. If, during 2013, you were an eligible trade adjustment assistance (TAA) recipient, alternative TAA (ATAA) recipient, reemployment TAA (RTAA) recipient, or Pension Benefit Guaranty Corporation (PBGC) pension recipient, you must complete Form 8885 before completing Schedule A. When figuring the amount of insurance premiums you can deduct on Schedule A, do not include:

- Any amounts you included on Form 8885,
- Any qualified health insurance premiums you paid to "U.S. Treasury–HCTC," or
- Any health coverage tax credit advance payments shown on Form 1099-H, Health Coverage Tax Credit (HCTC) Advance Payments.

Employer-Sponsored Health Insurance Plan

Do not include in your medical and dental expenses any insurance premiums paid by an employer-sponsored health insurance plan unless the premiums are included on your Form W-2, Wage and Tax Statement. Also, do not include any other medical and dental expenses paid by the plan unless the amount paid is included on your Form W-2.

Example.

You are a federal employee participating in the premium conversion plan of the Federal Employee Health Benefits (FEHB) program. Your share of the FEHB premium is paid by making a pre-tax reduction in your salary. Because you are an employee whose insurance premiums are paid with money that is never included in your gross income, you cannot deduct the premiums paid with that money.

Long-term care services. Contributions made by your employer to provide coverage for qualified long-term care services under a flexible spending or similar arrangement must be included in your income. This amount will be reported as wages on your Form W-2.

Retired public safety officers. If you are a retired public safety officer, do not include as medical expenses any health or long-term care insurance premiums that you elected to have paid with tax-free distributions from a retirement plan. This applies only to distributions that would otherwise be included in income.

Health reimbursement arrangement (HRA). If you have medical expenses that are reimbursed by a health reimbursement arrangement, you cannot include those expenses in your medical expenses. This is because an HRA is funded solely by the employer.

Medicare A

If you are covered under social security (or if you are a government employee who paid Medicare tax), you are enrolled in Medicare A. The payroll tax paid for Medicare A is not a medical expense.

If you are not covered under social security (or were not a government employee who paid Medicare tax), you can voluntarily enroll in Medicare A. In this situation you can include the premiums you paid for Medicare A as a medical expense.

Medicare B

Medicare B is a supplemental medical insurance. Premiums you pay for Medicare B are a medical expense. Check the information you received from the Social Security Administration to find out your premium.

Medicare D

Medicare D is a voluntary prescription drug insurance program for persons with Medicare A or B. You can include as a medical expense premiums you pay for Medicare D.

Prepaid Insurance Premiums

Premiums you pay before you are age 65 for insurance for medical care for yourself, your spouse, or your dependents after you reach age 65 are medical care expenses in the year paid if they are:

1. Payable in equal yearly installments or more often, and
2. Payable for at least 10 years, or until you reach age 65 (but not for less than 5 years).

Unused Sick Leave Used To Pay Premiums

You must include in gross income cash payments you receive at the time of retirement for unused sick leave. You also must include in gross income the value of unused sick leave that, at your option, your employer applies to the cost of your continuing participation in your employer's health plan after you retire. You can include this cost of continuing participation in the health plan as a medical expense.

If you participate in a health plan where your employer automatically applies the value of unused sick leave to the cost of your continuing participation in the health plan (and you do not have the option to receive cash), do not include the value of the unused sick leave in gross income. You cannot include this cost of continuing participation in that health plan as a medical expense.

Insurance Premiums You Cannot Include

You cannot include premiums you pay for:

- Life insurance policies,

- Policies providing payment for loss of earnings,
- Policies for loss of life, limb, sight, etc.,
- Policies that pay you a guaranteed amount each week for a stated number of weeks if you are hospitalized for sickness or injury,
- The part of your car insurance that provides medical insurance coverage for all persons injured in or by your car because the part of the premium providing insurance for you, your spouse, and your dependents is not stated separately from the part of the premium providing insurance for medical care for others, or
- Health or long-term care insurance if you elected to pay these premiums with tax-free distributions from a retirement plan made directly to the insurance provider and these distributions would otherwise have been included in income.

Taxes imposed by any governmental unit, such as Medicare taxes, are not insurance premiums.

Coverage for nondependents. Generally, you cannot deduct any additional premium you pay as the result of including on your policy someone who is not your spouse or dependent, even if that person is your child under age 27. However, you can deduct the additional premium if that person is:

- Your child whom you do not claim as a dependent because of the rules for children of divorced or separated parents,
- Any person you could have claimed as a dependent on your return except that person received $3,900 or more of gross income or filed a joint return, or
- Any person you could have claimed as a dependent except that you, or your spouse if filing jointly, can be claimed as a dependent on someone else's 2013 return.

Also, if you had family coverage when you added this individual to your policy and your premiums did not increase, you can enter on Schedule A (Form 1040) the full amount of your medical and dental insurance premiums.

Intellectually and Developmentally Disabled, Special Home for

You can include in medical expenses the cost of keeping a person who is intellectually and developmentally disabled in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living.

Laboratory Fees

You can include in medical expenses the amounts you pay for laboratory fees that are part of medical care.

Lactation Expenses

See Breast Pumps and Supplies , earlier.

Lead-Based Paint Removal

You can include in medical expenses the cost of removing lead-based paints from surfaces in your home to prevent a child who has or had lead poisoning from eating the paint. These surfaces must be in poor repair (peeling or cracking) or within the child's reach. The cost of repainting the scraped area is not a medical expense.

If, instead of removing the paint, you cover the area with wallboard or paneling, treat these items as capital expenses. See *Capital Expenses* , earlier. Do not include the cost of painting the wallboard as a medical expense.

Learning Disability

See *Special Education* , later.

Legal Fees

You can include in medical expenses legal fees you paid that are necessary to authorize treatment for mental illness. However, you cannot include in medical expenses fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that are not necessary for medical care.

Lifetime Care—Advance Payments

You can include in medical expenses a part of a life-care fee or "founder's fee" you pay either monthly or as a lump sum under an agreement with a retirement home. The part of the payment you include is the amount properly allocable to medical care. The agreement must require that you pay a specific fee as a condition for the home's promise to provide lifetime care that includes medical care. You can use a statement from the retirement home to prove the amount properly allocable to medical care. The statement must be based either on the home's prior experience or on information from a comparable home.

Dependents with disabilities. You can include in medical expenses advance payments to a private institution for lifetime care, treatment, and training of your physically or mentally impaired child upon your death or when you become unable to provide care. The payments must be a condition for the institution's future acceptance of your child and must not be refundable.

Payments for future medical care. Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule does not apply in situations where the future care is purchased in connection with obtaining lifetime care of the type described earlier.

Lodging

You can include in medical expenses the cost of meals and lodging at a hospital or similar institution if a principal reason for being there is to receive medical care. See *Nursing Home* , later.

You may be able to include in medical expenses the cost of lodging not provided in a hospital or similar institution. You can include the cost of such lodging while away from home if all of the following requirements are met.

1. The lodging is primarily for and essential to medical care.
2. The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.
3. The lodging is not lavish or extravagant under the circumstances.
4. There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount you include in medical expenses for lodging cannot be more than $50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included.

Do not include the cost of lodging while away from home for medical treatment if that treatment is not received from a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital or if that lodging is not primarily for or essential to the medical care received.

Long-Term Care

You can include in medical expenses amounts paid for qualified long-term care services and premiums paid for qualified long-term care insurance contracts.

Qualified Long-Term Care Services

Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative services, and maintenance and personal care services (defined later) that are:

1. Required by a chronically ill individual, and
2. Provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Chronically ill individual. An individual is chronically ill if, within the previous 12 months, a licensed health care practitioner has certified that the individual meets either of the following descriptions.

1. He or she is unable to perform at least two activities of daily living without substantial assistance from another individual for at least 90 days, due to a loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence.
2. He or she requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Maintenance and personal care services. Maintenance or personal care services is care which has as its primary purpose the providing of a chronically ill individual with needed assistance with his or her disabilities (including protection from threats to health and safety due to severe cognitive impairment).

Qualified Long-Term Care Insurance Contracts

A qualified long-term care insurance contract is an insurance contract that provides only coverage of qualified long-term care services. The contract must:

1. Be guaranteed renewable,
2. Not provide for a cash surrender value or other money that can be paid, assigned, pledged, or borrowed,
3. Provide that refunds, other than refunds on the death of the insured or complete surrender or cancellation of the contract, and dividends under the contract must be used only to reduce future premiums or increase future benefits, and
4. Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except where Medicare is a secondary payer, or the contract makes *per diem* or other periodic payments without regard to expenses.

The amount of qualified long-term care premiums you can include is limited. You can include the following as medical expenses on Schedule A (Form 1040).

1. Qualified long-term care premiums up to the following amounts.
   a. Age 40 or under – $360.
   b. Age 41 to 50 – $680.
   c. Age 51 to 60 – $1,360.
   d. Age 61 to 70 – $3,640.
   e. Age 71 or over – $4,550.
2. Unreimbursed expenses for qualified long-term care services.

Note. The limit on premiums is for each person.

Also, if you are an eligible retired public safety officer, you cannot include premiums for long-term care insurance if you elected to pay these premiums with tax-free distributions from a qualified retirement plan made directly to the insurance provider and these distributions would otherwise have been included in your income.

Meals

You can include in medical expenses the cost of meals at a hospital or similar institution if a principal reason for being there is to get medical care.

You cannot include in medical expenses the cost of meals that are not part of inpatient care. Also see Weight-Loss Program and Nutritional Supplements , later.

Medical Conferences

You can include in medical expenses amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your spouse, or your dependent. The costs of the medical conference must be primarily for and necessary to the medical care of you, your spouse, or your dependent. The majority of the time spent at the conference must be spent attending sessions on medical information.

The cost of meals and lodging while attending the conference is not deductible as a medical expense.

Medical Information Plan

You can include in medical expenses amounts paid to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician.

Medicines

You can include in medical expenses amounts you pay for prescribed medicines and drugs. A prescribed drug is one that requires a prescription by a doctor for its use by an individual. You can also include amounts you pay for insulin. Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed.

Imported medicines and drugs. If you imported medicines or drugs from other countries, see Medicines and Drugs From Other Countries , under *What Expenses Are Not Includible*, later.

Nursing Home

You can include in medical expenses the cost of medical care in a nursing home, home for the aged, or similar institution, for yourself, your spouse, or your dependents. This includes the cost of meals and lodging in the home if a principal reason for being there is to get medical care.

Do not include the cost of meals and lodging if the reason for being in the home is personal. You can, however, include in medical expenses the part of the cost that is for medical or nursing care.

Nursing Services

You can include in medical expenses wages and other amounts you pay for nursing services. The services need not be performed by a nurse as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient. These services can be provided in your home or another care facility.

Generally, only the amount spent for nursing services is a medical expense. If the attendant also provides personal and household services, amounts paid to the attendant must be divided between the time spent performing household and personal services and the time spent for nursing services. For example, because of your medical condition you pay a visiting nurse $300 per week for medical and household services. She spends 10% of her time doing household services such as washing dishes and laundry. You can include only $270 per week as medical expenses. The $30 (10% × $300) allocated to household services cannot be included. However, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses. See Maintenance and personal care services under *Long-Term Care*, earlier. Additionally, certain expenses for household services or for the care of a qualifying individual incurred to allow you to work may qualify for the child and dependent care credit. See Publication 503.

You can also include in medical expenses part of the amount you pay for that attendant's meals. Divide the food expense among the household members to find the cost of the attendant's food. Then divide that cost in the same manner as in the preceding paragraph. If you had to pay additional amounts for household upkeep because of the attendant, you can include the extra amounts with your medical expenses. This includes extra rent or utilities you pay because you moved to a larger apartment to provide space for the attendant.

Employment taxes. You can include as a medical expense social security tax, FUTA, Medicare tax, and state employment taxes you pay for an attendant who provides medical care. If the attendant also provides personal and household services, you can include as a medical expense only the amount of employment taxes paid for medical services as explained earlier. For information on employment tax responsibilities of household employers, see Publication 926, Household Employer's Tax Guide.

Operations

You can include in medical expenses amounts you pay for legal operations that are not for unnecessary cosmetic surgery. See Cosmetic Surgery under *What Expenses Are Not Includible*, later.

Optometrist

See Eyeglasses , earlier.

Organ Donors

See Transplants , later.

Osteopath

You can include in medical expenses amounts you pay to an osteopath for medical care.

Oxygen

You can include in medical expenses amounts you pay for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.

Physical Examination

You can include in medical expenses the amount you pay for an annual physical examination and diagnostic tests by a physician. You do not have to be ill at the time of the examination.

Pregnancy Test Kit

You can include in medical expenses the amount you pay to purchase a pregnancy test kit to determine if you are pregnant.

Prosthesis

See *Artificial Limb* and *Breast Reconstruction Surgery* , earlier.

Psychiatric Care

You can include in medical expenses amounts you pay for psychiatric care. This includes the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care. See *Psychoanalysis*, next, and *Transportation* , later.

Psychoanalysis

You can include in medical expenses payments for psychoanalysis. However, you cannot include payments for psychoanalysis that is part of required training to be a psychoanalyst.

Psychologist

You can include in medical expenses amounts you pay to a psychologist for medical care.

Special Education

You can include in medical expenses fees you pay on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous system disorders.

You can include in medical expenses the cost (tuition, meals, and lodging) of attending a school that furnishes special education to help a child to overcome learning disabilities. A doctor must recommend that the child attend the school. Overcoming the learning disabilities must be a principal reason for attending the school, and any ordinary education received must be incidental to the special education provided. Special education includes:

- Teaching Braille to a visually impaired person,
- Teaching lip reading to a hearing disabled person, or
- Giving remedial language training to correct a condition caused by a birth defect.

Sterilization

You can include in medical expenses the cost of a legal sterilization (a legally performed operation to make a person unable to have children). Also see Vasectomy , later.

Stop-Smoking Programs

You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Surgery

See *Operations* , earlier.

Telephone

You can include in medical expenses the cost of special telephone equipment that lets a person who is deaf, hard of hearing or has a speech disability communicate over a regular telephone. This includes teletypewriter (TTY) and telecommunications device for the deaf (TDD) equipment. You can also include the cost of repairing the equipment.

Television

You can include in medical expenses the cost of equipment that displays the audio part of television programs as subtitles for persons with a hearing disability. This may be the cost of an adapter that attaches to a regular set. It also may be the part of the cost of a specially equipped television that exceeds the cost of the same model regular television set.

Therapy

You can include in medical expenses amounts you pay for therapy received as medical treatment.

Transplants

You can include in medical expenses amounts paid for medical care you receive because you are a donor or a possible donor of a kidney or other organ. This includes transportation.

You can include any expenses you pay for the medical care of a donor in connection with the donating of an organ. This includes transportation.

Transportation

You can include in medical expenses amounts paid for transportation primarily for, and essential to, medical care.

You can include:

- Bus, taxi, train, or plane fares or ambulance service,
- Transportation expenses of a parent who must go with a child who needs medical care,
- Transportation expenses of 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
- Transportation expenses for regular visits to see a mentally ill dependent, if these visits are recommended as a part of treatment.

Car expenses. You can include out-of-pocket expenses, such as the cost of gas and oil, when you use a car for medical reasons. You cannot include depreciation, insurance, general repair, or maintenance expenses.

If you do not want to use your actual expenses for 2013, you can use the standard medical mileage rate of 24 cents a mile.

You can also include parking fees and tolls. You can add these fees and tolls to your medical expenses whether you use actual expenses or the standard mileage rate.

Example.

In 2013, Bill Jones drove 2,800 miles for medical reasons. He spent $500 for gas, $30 for oil, and $100 for tolls and parking. He wants to figure the amount he can include in medical expenses both ways to see which gives him the greater deduction.

He figures the actual expenses first. He adds the $500 for gas, the $30 for oil, and the $100 for tolls and parking for a total of $630.

He then figures the standard mileage amount. He multiplies 2,800 miles by 24 cents a mile for a total of $672. He then adds the $100 tolls and parking for a total of $772.

Bill includes the $772 of car expenses with his other medical expenses for the year because the $772 is more than the $630 he figured using actual expenses.

Transportation expenses you cannot include. You cannot include in medical expenses the cost of transportation in the following situations.

- Going to and from work, even if your condition requires an unusual means of transportation.
- Travel for purely personal reasons to another city for an operation or other medical care.
- Travel that is merely for the general improvement of one's health.
- The costs of operating a specially equipped car for other than medical reasons.

Trips

You can include in medical expenses amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You may be able to include up to $50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night can be included as a medical expense for lodging. Meals are not included. See *Lodging* , earlier.

You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or general improvement of health, even if the trip is made on the advice of a doctor. However, see *Medical Conferences* , earlier.

Tuition

Under special circumstances, you can include charges for tuition in medical expenses. See *Special Education* , earlier.

You can include charges for a health plan included in a lump-sum tuition fee if the charges are separately stated or can easily be obtained from the school.

Vasectomy

You can include in medical expenses the amount you pay for a vasectomy.

Vision Correction Surgery

See *Eye Surgery* , earlier.

Weight-Loss Program

You can include in medical expenses amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. You cannot include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

1. The food does not satisfy normal nutritional needs,
2. The food alleviates or treats an illness, and
3. The need for the food is substantiated by a physician.

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet. See also *Weight-Loss Program* under *What Expenses Are Not Includible*, later.

Wheelchair

You can include in medical expenses amounts you pay for a wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and maintaining the wheelchair is also a medical expense.

Wig

You can include in medical expenses the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease.

X-ray

You can include in medical expenses amounts you pay for X-rays for medical reasons.

What Expenses Are Not Includible?

Following is a list of some items that you cannot include in figuring your medical expense deduction. The items are listed in alphabetical order.

Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby

You cannot include in medical expenses amounts you pay for the care of children, even if the expenses enable you, your spouse, or your dependent to get medical or dental treatment. Also, any expense allowed as a childcare credit cannot be treated as an expense paid for medical care.

Controlled Substances

You cannot include in medical expenses amounts you pay for controlled substances (such as marijuana, laetrile, etc.), even if such substances are legalized by state law. Such substances are not legal under federal law and cannot be included in medical expenses.

Cosmetic Surgery

Generally, you cannot include in medical expenses the amount you pay for unnecessary cosmetic surgery. This includes any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. You generally cannot include in medical expenses the amount you pay for procedures such as face lifts, hair transplants, hair removal (electrolysis), and liposuction.

You can include in medical expenses the amount you pay for cosmetic surgery if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Example.

An individual undergoes surgery that removes a breast as part of treatment for cancer. She pays a surgeon to reconstruct the breast. The surgery to reconstruct the breast corrects a deformity directly related to the disease. The cost of the surgery is includible in her medical expenses.

Dancing Lessons

You cannot include in medical expenses the cost of dancing lessons, swimming lessons, etc., even if they are recommended by a doctor, if they are only for the improvement of general health.

Diaper Service

You cannot include in medical expenses the amount you pay for diapers or diaper services, unless they are needed to relieve the effects of a particular disease.

Electrolysis or Hair Removal

See Cosmetic Surgery , earlier.

Flexible Spending Account

You cannot include in medical expenses amounts for which you are fully reimbursed by your flexible spending account if you contribute a part of your income on a pre-tax basis to pay for the qualified benefit.

Funeral Expenses

You cannot include in medical expenses amounts you pay for funerals.

Future Medical Care

Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule does not apply in situations where the future care is purchased in connection with obtaining lifetime care or long-term care of the type described at Lifetime Care—Advance Payments or Long-Term Care, earlier under *What Medical Expenses Are Includible*.

Hair Transplant

See Cosmetic Surgery , earlier.

Health Club Dues

You cannot include in medical expenses health club dues or amounts paid to improve one's general health or to relieve physical or mental discomfort not related to a particular medical condition.

You cannot include in medical expenses the cost of membership in any club organized for business, pleasure, recreation, or other social purpose.

Health Coverage Tax Credit

You cannot include in medical expenses amounts you pay for health insurance that you use in figuring your health coverage tax credit. For more information, see Health Coverage Tax Credit , later.

Health Savings Accounts

You cannot include in medical expenses any payment or distribution for medical expenses out of a health savings account. Contributions to health savings accounts are deducted separately. See Publication 969.

Household Help

You cannot include in medical expenses the cost of household help, even if such help is recommended by a doctor. This is a personal expense that is not deductible. However, you may be able to include certain expenses paid to a person providing nursing-type services. For more information, see Nursing Services , earlier under *What Medical Expenses Are Includible*. Also, certain maintenance or personal care services provided for qualified long-term care can be included in medical expenses. For more information, see Long-Term Care , earlier under *What Medical Expenses Are Includible*.

Illegal Operations and Treatments

You cannot include in medical expenses amounts you pay for illegal operations, treatments, or controlled substances whether rendered or prescribed by licensed or unlicensed practitioners.

Insurance Premiums

See Insurance Premiums under *What Medical Expenses Are Includible*, earlier.

Maternity Clothes

You cannot include in medical expenses amounts you pay for maternity clothes.

Medical Savings Account (MSA)

You cannot include in medical expenses amounts you contribute to an Archer MSA. You cannot include expenses you pay for with a tax-free distribution from your Archer MSA. You also cannot use other funds equal to the amount of the distribution and include the expenses. For more information on Archer MSAs, see Publication 969.

Medicines and Drugs From Other Countries

In general, you cannot include in your medical expenses the cost of a prescribed drug brought in (or ordered shipped) from another country. You can only include the cost of a drug that was imported legally. For example, you can include the cost of a prescribed drug the Food and Drug Administration announces can be legally imported by individuals.

You can include the cost of a prescribed drug you purchase and consume in another country if the drug is legal in both the other country and the United States.

Nonprescription Drugs and Medicines

Except for insulin, you cannot include in medical expenses amounts you pay for a drug that is not prescribed.

Example.

Your doctor recommends that you take aspirin. Because aspirin is a drug that does not require a physician's prescription, you cannot include its cost in your medical expenses.

Nutritional Supplements

You cannot include in medical expenses the cost of nutritional supplements, vitamins, herbal supplements, "natural medicines," etc. unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician. Otherwise, these items are taken to maintain your ordinary good health, and are not for medical care.

Personal Use Items

You cannot include in medical expenses the cost of an item ordinarily used for personal, living, or family purposes unless it is used primarily to prevent or alleviate a physical or

mental defect or illness. For example, the cost of a toothbrush and toothpaste is a nondeductible personal expense.

In order to accommodate an individual with a physical defect, you may have to purchase an item ordinarily used as a personal, living, or family item in a special form. You can include the excess of the cost of the item in a special form over the cost of the item in normal form as a medical expense. (See *Braille Books and Magazines* under *What Medical Expenses Are Includible*, earlier.)

Swimming Lessons

See *Dancing Lessons* , earlier.

Teeth Whitening

You cannot include in medical expenses amounts paid to whiten teeth. See *Cosmetic Surgery* , earlier.

Veterinary Fees

You generally cannot include veterinary fees in your medical expenses, but see Guide Dog or Other Service Animal under *What Medical Expenses Are Includible*, earlier.

Weight-Loss Program

You cannot include in medical expenses the cost of a weight-loss program if the purpose of the weight loss is the improvement of appearance, general health, or sense of well-being. You cannot include amounts you pay to lose weight unless the weight loss is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). If the weight-loss treatment is not for a specific disease diagnosed by a physician, you cannot include either the fees you pay for membership in a weight reduction group or fees for attendance at periodic meetings. Also, you cannot include membership dues in a gym, health club, or spa.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs.

See Weight-Loss Program under *What Medical Expenses Are Includible*, earlier.

How Do You Treat Reimbursements?

You can include in medical expenses only those amounts paid during the tax year for which you received no insurance or other reimbursement.

Workzone: IRS ruling making waves

Red flags up at firms over changes targeting care saving plans

December 7, 2013 9:30 PM

By Len Boselovic / Pittsburgh Post-Gazette

Offering employees an option to avoid losing money that they've set aside for health care expenses may sound like a good thing, but employers might need to think twice before making the move, according to benefit consultants.

The Internal Revenue Service recently ruled that employers who offer flexible spending plans for health care expenses can allow employees to roll over up to $500 in unspent funds from one year to the next. That decision eliminates the "use it or lose it" provision that benefit consultants say has curbed participation in flexible spending accounts, or FSAs.

Such accounts allow participating employees to set aside up to $2,500 each year for deductibles, copayments and other qualified health care expenses. The money is deducted regularly from paychecks on a pretax basis, just like contributions to 401(k) accounts. (There are also FSAs for dependent care expenses, but the Oct. 31 IRS ruling does not apply to them.)

The change comes eight years after the IRS approved a two-and-a-half-month grace period that gives participants in health care FSAs a way around the "use it or lose it" issue. In 2005, the agency said participants could spend flexible spending account money from the prior year through March 15 of the next year.

The latest ruling allows employers to offer either the rollover or the grace period option -- but not both. If a company adopts either, the change must be written into documents governing the plan and explained to employees.

Flexible spending accounts: the basics

Flexible spending accounts (FSAs) allow workers to set aside up to $2,500 of their pay each year, on a pre-tax basis, to spend on health care and up to $5,000 of their pay per family to spend on dependent care. Workers can lose the money if they don't spend it. A look at companies with more than 500 employees:

	[illegible]	2012	2013
Employers offering health FSAs	83%	86%	85%
Eligible employees participating	22%	23%	22%
Annual voluntary contribution	$1,380	$1,484	$1,349
Percentage of contribution forfeited	4%	4%	5%

Source: Mercer National Survey of Employer Sponsored Health Plans

James Hilston/ Post-Gazette

"One of the biggest concerns employers have around this is whether employees understand that it's one or the other," said

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Tom Hricik, a principal in the Pittsburgh office of Buck Consultants.

PG graphic: Flexible spending accounts
(Click image for larger version)

Mr. Hricik said the IRS announcement came as many employers were already into the open enrollment season for benefit plans. That could make many of them think twice about taking advantage of the change this year, he said. Employers would have to make computer systems changes to process rollovers and educate employees who have been told to "use it or lose it."

But there are bigger complications than explaining the implications of the change to employees, according to Jay Savan, a partner in the Atlanta office of Mercer, a benefits consultant.

Mr. Savan said more employers are moving toward high-deductible health insurance plans that offer lower monthly premiums but require employees to pay more for the cost of their care. Employees covered by the high-deductible plans cannot have a health care FSA, but they are eligible for another tax-advantaged plan called a health savings account, or HSA.

"That was the red flag that shot up for me," he said. "I was more alarmed than appreciative of the change."

Employers who adopt the rollover provision by the end of this year would disqualify employees who carry unused FSA money into next year from contributing to an HSA.

Mr. Savan said that in order to make a health savings account contribution or receive one from an employer, a person must be covered by a high-deductible plan. Other requirements also apply and the existence of an FSA balance disqualifies someone from participating in an HSA, he added.

Moreover, in most circumstances, the spouse and dependents of an employee participating in an FSA are ineligible to have an HSA, Mr. Savan said.

HSAs are "much more flexible and durable" than FSAs, he said. They allow single employees to set aside up to $3,300 a year ($6,550 for families) and the money does not have to be used in the year contributed, he said.

Mr. Savan believes many employers won't jump at the chance to add the rollover feature to their flexible spending account plans this year.

"Most people are busy planning for Thanksgiving, Christmas and other things, and the last thing they want to do is sit down and understand the nuances between FSAs and HSAs," he said.

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Consumer health

Health savings accounts: Is an HSA right for you?

Health savings accounts are used to save money for future medical expenses. Discover how these plans work.

By Mayo Clinic staff

Health savings accounts (HSAs) are like personal savings accounts, but the money in them is used to pay for health care expenses. You — not your employer or insurance company — own and control the money in your health savings account. The money you deposit into the account is not taxed. To be eligible to open an HSA, you must have a special type of health insurance called a high-deductible plan.

Why were health savings accounts created?

HSAs and high-deductible health plans were created as a way to help control health care costs. The idea is that people will spend their health care dollars more wisely if they're using their own money. In addition, doctors and other health care providers will have an incentive to lower their rates because they're competing for business.

Is a health savings account right for me?

Like any health care option, HSAs have advantages and disadvantages. As you weigh your options, think about your budget and what health care you're likely to need in the next year.

If you're generally healthy and want to save for future health care expenses, an HSA may be an attractive choice. Or if you're near retirement, an HSA may make sense because the money in the HSA can be used to offset costs of medical care after retirement. On the other hand, if you think you might need expensive medical care in the next year and would find it hard to meet a high deductible, an HSA might not be your best option.

What are some potential advantages of health savings accounts?

- You decide how much money to set aside for health care costs.
- You control how your HSA money is spent. You can shop around for care based on quality and cost.
- Your employer may contribute to your HSA, but you own the account and the money is yours even if you change jobs.
- Any unused money at the end of the year rolls over (stays in your account) to the next year.
- You don't pay taxes on money going into your HSA.

Consumer health basics (12)
- Organ donation: Don't let these myths confuse you
- Health savings accounts: Is an HSA right for you?
- Palliative care: Symptom relief during illness
- see all in Consumer health basics

Alternative medicine (13)
- Mindfulness exercises: How to get started
- Pet therapy: Man's best friend as healer
- Herbal supplements may not mix with heart medicines
- see all in Alternative medicine

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What are some potential disadvantages to health savings accounts?

- Illness can be unpredictable, making it hard to accurately budget for health care expenses.
- Information about the cost and quality of medical care can be difficult to find.
- Some people find it challenging to set aside money to put into their HSAs. People who are older and sicker may not be able to save as much as younger, healthier people.
- Pressure to save the money in your HSA might lead you to not seek medical care when you need it.
- If you take money out of your HSA for nonmedical expenses, you'll have to pay taxes on it.

Who can set up a health savings account?

Your employer may offer an HSA option or you can start an account on your own through a bank or other financial institution. To qualify, you must be under age 65 and carry a high-deductible health insurance plan. If you have a spouse who uses your insurance as secondary coverage, he or she also must be enrolled in a high-deductible plan.

This high-deductible health plan must be your only health insurance — you can't be covered by any other health insurance. However, having dental, vision, disability and long-term care insurance doesn't disqualify you from having an HSA.

What is a high-deductible health plan and how does it work?

As its name implies, it's a health insurance plan that has a high deductible — the amount of medical expenses you must pay each year before coverage kicks in. While the deductible is high with this type of plan, the premium (the regular fee you pay to obtain coverage) is typically lower for high-deductible plans than for traditional plans.

High-deductible plans don't start paying until after you've spent at least $1,250 (for an individual) or $2,500 (for a family) of your own money on health care expenses. You can use your HSA to pay deductible expenses, as well as copays and other noncovered health care expenses.

Not all high-deductible plans work the same. For instance, plans may pay for preventive services, such as mammograms, before the deductible is met. It's critical to carefully review the plan's coverage details, including the out-of-pocket maximum — the limit on how much you would have to pay out of pocket for medical expenses in a year.

Next page
(1 of 2)

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Managing the cost of diabetes
Health literacy — What are you missing when talking with your provider?
Diabetes supplies: What does Medicare cover?
Triclosan: Is it safe?
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Blood donation
Kidney donation: Are there long-term risks?
Cosmetic surgery: What to know beforehand
Cancer causes: Popular myths about the causes of cancer

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April 13, 2013 GA00053

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Highmark / UPMC Consumer Questions

Questions and Answers: Highmark and UPMC

NOTE: *The following information represents the department's view of current conditions and may not reflect the positions or interpretations of Highmark or UPMC. The information provided below is subject to change. The department will continue to monitor this situation and provide additional information as conditions change. Please check back regularly for updates.* updated 09/20/13

What are the issues between UPMC and Highmark?
Highmark and UPMC started to air extensive advertising campaigns in late spring/ early summer 2013. The advertisements address the pending expiration of their commercial contract with one another on 12/31/14.The expiring contract controls the terms under which UPMC hospitals and physicians will provide services to Highmark members.

Highmark's ads call for an extension of the contract; UPMC's ads state that there cannot be an extension for competitive reasons now that Highmark has purchased its own health care provider system. Each has complained that the other's position constitutes anti-competitive behavior.

If the contract expires on 12/31/14, Highmark commercial subscribers (individuals who have Highmark insurance through their employer) will not have in-network access to most UPMC hospitals and physicians.

What is the current status of Highmark subscribers' access to UPMC facilities?
Highmark subscribers are generally eligible to be treated in UPMC's hospitals and by UPMC physicians on an "in-network" basis (see below) through 12/31/14. This means that UPMC will accept Highmark insurancecoverage, subject to any standard co-pay or deductible the Highmark policy provides for.

Highmark Community Blue subscribers have in-network access to all Highmark participating hospitals and physicians, five specific UPMC facilities (Children's Hospital of Pittsburgh of UPMC, UPMC Bedford Memorial, UPMC Northwest, Western Psychiatric Institute and Clinic and UPMC Altoona) and certain limited oncology services determined by UPMC on a case-by-case basis.

While some Community Blue products provide an out-of-network benefit, UPMC does not offer hospital or physician services on an out-of-network (see below) basis to Community Blue subscribers. After 12/31/14, UPMC will provide hospital and physician services to Community Blue subscribers on an out-of-network basis. Emergency services are available to Community Blue subscribers at any UPMC hospital at all times.

Medicare and Highmark Medicare Advantage beneficiaries have access to all Highmark and UPMC facilities. This will remain unchanged, regardless of whether Highmark and UPMC extend their commercial contract after 12/31/14.

CHIP beneficiaries currently have access to all Highmark and UPMC facilities. It is expected that this access will continue.

What happens if the Highmark/UPMC commercial contract does expire on 12/31/14 and how would it affect me?
Highmark subscribers will continue to have in-network access to:

- Children's Hospital of Pittsburgh of UPMC,

- UPMC Bedford Memorial,
- UPMC Northwest,
- Western Psychiatric Institute and Clinic,
- UPMC Altoona, and
- certain limited oncology services determined by UPMC on a case-by-case basis.

They will also have access to all other UPMC hospitals and physicians on an out-of-network basis. The out-of-network access will result in additional out-of-pocket costs for Highmark subscribers.

Community Blue subscribers may have access to certain UPMC hospitals and physicians on an out-of-network basis, depending on the specific terms of the contracts. They will also continue to have in-network access to the five UPMC hospitals and certain limited oncology services as explained earlier, as listed above.

Medicare and Highmark Medicare Advantage beneficiaries will experience no change in facility access because of the Highmark and UPMC contract dispute.

CHIP beneficiaries currently have access to all Highmark and UPMC facilities. It is expected that this access will continue.

What's the difference between an in-network and out-of-network benefit?

In-Network Benefit: Insurance companies contract with hospitals and physicians to form what is called a provider network. If you use your insurance policy and get medical treatment from an "in-network" hospital or physician, you may be responsible to pay a co-pay, a deductible and/or a co-insurance amount, depending on the terms of your insurance policy. Your insurance company will then pay a negotiated dollar amount to the hospital or physician. The hospital or physician will not be able to bill you for any difference between the negotiated rate and the actual cost of the services beyond your co-pay, deductible, and/ or co-insurance. This is generally the most cost effective way to obtain hospital or physician services.

Out-of-Network Benefit: Your hospital or physician is considered "out-of-network" if you get non-emergency medical treatment from a hospital or physician not participating with your insurance company. If your policy has an out-of-network benefit, your health insurance company agrees to pay a specified dollar amount towards the cost of the medical services by a hospital or physician even if the health insurance company does not have a contract with them. Not all health plans offer this benefit. More than likely, the health insurer will not cover the full cost of the medical services. The out-of-network hospital or physician may bill you the difference between the charges for the health care services rendered and the amount paid by your insurer - this is called balance-billing. Before you obtain medical services out-of-network, please carefully investigate the costs you may incur.

What is the Insurance Department's role?

We have asked both companies to act in a way that keeps the best interests of Western Pennsylvania consumers in mind. In addition, an Interagency Consumer Protection Task Force has been assembled between the Departments of Insurance and Health. This Task Force will work to address a number of consumer protection issues, such as making sure that consumers receive truthful and timely communications.

The Insurance Department does not have the authority under current law to force Highmark and UPMC to enter into a commercial contract.

Who should I contact?

The department recommends that you review your contract options carefully, and speak with a licensed health insurance agent. A consumer must make their own informed choices, by carefully weighing the costs and the potential benefits of any given plan with an insurance professional prior to purchasing coverage.

The department maintains a website, www.pahealthoptions.com to provide unbiased information about health insurance coverage options.

You may also call the department and speak to someone in our Consumer Services office. Please email us atra-in-commissioner@pa.gov or call us toll-free at 877-881-6388. Or, feel free to reach out directly to UPMC and Highmark to convey any concerns you may have.

http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/highmark___upmc_consumer_questions/1604935

UPMC, Highmark, health contract bout reaches Erie

By Alex Nixon, Pittsburgh Tribune Review

Published: Friday, Jan. 3, 2014, 12:01 a.m.

The contract battle between Pittsburgh's two biggest health organizations moved north to Erie on Thursday as hospital giant UPMC and insurer Highmark Inc. bickered over whether Highmark members in northwest Pennsylvania would be able to go to UPMC Hamot next year.

It is the latest front to open in the ongoing war for Western Pennsylvania's health care market. UPMC and Highmark have fought through dueling advertisements and in public hearings, courtrooms and the state General Assembly for the past three years.

UPMC, which has refused to renew a contract with Highmark covering UPMC hospitals in Allegheny County, said it wants Highmark insurance customers to have in-network access in Erie when the contract expires at the end of this year.

But Highmark, the state's largest health insurer, said it would include UPMC Hamot in its network only if UPMC negotiated a comprehensive contract covering all UPMC hospitals and doctors.

The two nonprofit institutions have been fighting since 2011 when Highmark said it would buy the five-hospital West Penn Allegheny Health System and convert it into a direct competitor with UPMC in the medical provider business. In addition to buying West Penn Allegheny last year, Highmark purchased Jefferson Regional Medical Center in Jefferson Hills and St. Vincent Health System in Erie.

The UPMC-Highmark contract, which gives Highmark members less-costly in-network rates for using UPMC medical services, expires at the end of this year for most of UPMC's 20 hospitals. The two organizations are negotiating standalone contracts for several UPMC hospitals in rural areas, such as Altoona, Bedford and Seneca, and for specialty hospitals such as Children's Hospital of Pittsburgh and Western Psychiatric Institute and Clinic.

Highmark spokesman Aaron Billger said UPMC was "toying with the community" by picking only certain hospitals to have contracts, rather than opening its entire system to Highmark's two million members in Western Pennsylvania.

"This is a blatant example of how UPMC is picking and choosing which communities it wants to have access to," Billger said.

UPMC spokesman Paul Wood said Highmark backed out of ongoing talks over a contract covering UPMC Hamot and was reneging on a commitment not to let the fight in Pittsburgh spill over into Erie.

"They indicated to us they fully intended to have a contract for Hamot, and now they've changed their minds," Wood said.

Billger said Hamot was mentioned by UPMC negotiators during contract talks on the rural and specialty hospitals, but Highmark has never said it would have a separate contract for the Erie medical center.

The rhetoric between the health giants is growing more fierce with the contract expiration less than 12 months away.

UPMC, which stands to lose millions of dollars a year from Highmark members, has been trying to persuade employers and individuals to drop Highmark as their insurer and switch to a plan that will offer full in-network access to UPMC.

Highmark, which is trying to hold onto its members, has lobbied for lawmakers in Harrisburg to get involved in the dispute and pass legislation that would force UPMC into a contract.

Alex Nixon is a staff writer for Trib Total Media. He can be reached at 412-320-7928 or anixon@tribweb.com.

Read more: http://triblive.com/business/headlines/5349556-74/upmc-highmark-contract#ixzz2qTVShAUX
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Highmark, UPMC prepare for end of contract December 30, 2013

By Steve Twedt, Pittsburgh Post Gazette

The prospective UPMC-Highmark divorce is now a year away, but preparations already have begun for a post-contract afterlife.

Earlier this month, Highmark sent letters to 86 local independent physicians who refer a significant number of patients to UPMC facilities to let them know the insurer "will soon be contacting your commercial patients who have Highmark coverage" about what's to come if there's no contract, including the loss of in-network access to UPMC specialists.

"Ultimately, our goal is to help our members plan ahead to avoid the stress and hardship of last-minute transfer of care, or worse, significant out-of-pocket financial liability," wrote Thomas J. Fitzpatrick, Highmark vice president of provider contracting and relations, in a copy of the letter to doctors obtained by the Pittsburgh Post-Gazette.

The letter, in bold-faced type, also suggests that the physicians contact UPMC board members: "Your concerns regarding the impending disruption to your Highmark patients and to your practice's revenue are valid and should be heard."

Highmark spokesman Aaron Billger on Monday said the insurer has no immediate plans to contact patients, but "that doesn't mean we won't need to in the future."

Highmark's immediate and primary focus, he said, remains negotiating a contract with UPMC. "Highmark wants to have a contract. The people in Harrisburg do as well," he said.

For months, UPMC, the region's largest health system, and Highmark, the largest insurer, have waged full-out marketing campaigns in anticipation of the UPMC-Highmark contract expiring Dec. 31, 2014.

UPMC has steadfastly said it will break ties with Highmark in 2015 because the insurer became a competitor once it purchased the West Penn Allegheny Health System and began constructing its own provider network.

"UPMC believes both Highmark and UPMC owe the community clarity and cooperation as we move through 2014 toward a major realignment of our contractual relationships," said UPMC

spokesman Paul Wood. "The business community and others in this region have clearly moved on."

Highmark's public pitch is that UPMC should continue contracting with Highmark, willingly or by legislative force, to give patients a choice and protect sometimes long-standing physician-patient relationships.

Employee benefits consultant James McTiernan of Triad USA, Downtown, said the Highmark letter sounds like an advisory for providers to plan in case there is no contract and that "it could be too late if you don't take appropriate measures to prepare."

But he said he and many others still think there will be a contract.

"It's in UPMC's favor to take as long as they can. If you're them, you can't show any sign of weakness in this negotiation," he said, adding that ultimately "I believe they need each other, no matter what they say."

UPMC, meanwhile, is ramping up outreach to its members with a new program -- unrelated to the nearing expiry of the contract, it says -- called "UPMC AnywhereCare," which features 24/7 online care for nonurgent ailments such as sinus infections, colds and the flu.

The letter, sent to MyUPMC members, promises "a quick response with a diagnosis and treatment plan, typically within 30 minutes, any time of the day or night."

While consumers may appreciate the convenience, Mr. McTiernan said such initiatives, by either side, may not win over consumers after their extensive public relations battle.

"At the end of the day, they both come out of this not looking very good after holding the community hostage over this," he said.

Steve Twedt: stwedt@post-gazette.com or 412-263-1963.

Read more: http://www.post-gazette.com/local/region/2013/12/31/Highmark-UPMC-prepare-for-end-of-contract/stories/201312310058000000#ixzz2qTU9IEugntact him at kmamula@bizjournals.com or 412-208-3825

UPMC, Highmark drop antitrust lawsuits

By Brian Bowling

Published: Monday, Dec. 30, 2013, 2:51 p.m.

UPMC and Highmark Inc. ended four years of antitrust litigation on Monday by dismissing their lawsuits to meet a federal judge's order.

U.S. District Judge Joy Flowers Conti on Dec. 19 ordered Highmark to compel its West Penn Allegheny Health System board to drop the original antitrust lawsuit filed in 2009 and ordered UPMC to drop its competing 2012 antitrust lawsuit.

The companies dismissed their lawsuits with prejudice, which means they can't refile them.

A third antitrust lawsuit names both companies as defendants.

Royal Mile Co., a Whitehall property management company, Cole's Wexford Hotel Inc. of Pine and a customer claim that a conspiracy between Highmark and UPMC allowed Highmark to charge them excessive premiums. Conti on Sept. 27 threw out the second version of their complaint, giving them 30 days to file another or appeal the decision.

Their lawyers filed an amended complaint, but Conti has not decided whether to let that complaint move forward.

Brian Bowling is a Trib Total Media staff writer. Reach him at 412-325- 4301 or bbowling@tribweb.com.

Read more: http://triblive.com/news/adminpage/5335315-74/antitrust-highmark-upmc#ixzz2qNRUynDQ
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Top health care stories of 2013: Highmark –UPMC rift topped news December 18, 2013

By Kris Mamula, reporter Pittsburgh Business Times

Creation of the Allegheny Health Network was the biggest health care news of 2013, overshadowed only by the tussle between health insurer Highmark Inc. and rival hospital giant UPMC, which raged deep into December.

UPMC-Highmark rift

The Highmark-UPMC war did have a silver lining for employers: continued downward pressure on health insurance rates as national carriers got their first crack at UPMC's hospitals in years and Highmark and UPMC Health Plan squeezed rates to attract and retain members. The bad newsis the rate party may end in 2014 when most small group rates are expected to rise, with some rates going up over 200 percent in what brokers called health care reform's new normal.

The state Insurance Department on April 29 approved a corporate restructuring at Highmark Inc. to allow acquisition of the oldWest Penn Allegheny Health System. The deal got Highmark into the medical services provider arena, a strategy designed to offer choice in the Pittsburgh market with lower costs and improved quality. At the same time, relations between Highmark and UPMC were going from bad to worse.

Just weeks before getting state approval, Highmark President and CEO William Winkenwerder said he'd had a telephone conversation with UPMC President and CEO Jeffrey Romoff. Both said they were looking forward to "getting together and talking."

But UPMC spokesman Paul Wood said the conversation never happened. Furthermore, UPMC had no interest in talking about a new contract between the health care titans, a message that was popped up in newspaper ads and other forums throughout the year.

In October, U.S. District Court Judge Joy Flowers Conti ordered Highmark and UPMC lawyers to come to terms on a four-year-old antitrust lawsuit – which they did, at least verbally. But the agreement fell apart when Highmark added a sentence to the written version of the agreement, which UPMC protested.

In the lawsuit, West Penn Allegheny Health System claimed that UPMC and Highmark had colluded over several years to keep national insurers out of the market while trying to squeeze WPAHS with low reimbursement. Highmark was dropped as a defendant with its acquisition of WPAHS.

And even the re-introduction of a health insurance plan by Highmark turned into shrapnel in the insurer's dispute with UPMC. Highmark took the wraps off its Community Blue insurance product in January 2013 with discounts up to 25 percent in exchange for a limited network of providers. Highmark said Community Blue's providers were low-cost, high quality.

The tiered coverage strategy is one that has been rolling out nationwide by other insurers, but had not be an option in Pittsburgh since 2002. Soon after it was introduced, UPMC said the coverage would not be honored by any UPMC doctor or hospital, even it the patient paidcash for the visit.

UPMC also saw Highmark's hand in two bills introduced by state Representatives Dan Frankel of Squirrel Hill and Jim Christiana of Beaver, which would require big hospital networks to contract with any insurer while prohibiting excessive charges for care. Wood said the bills were introduced at the behest of Highmark.

Here are some other highlights of the simmering Highmark-UPMC differences of 2013:
Hearing set in Highmark-UPMC dispute
Highmark: UPMC trying to kill WPAHS deal
Allegheny County Medical Society leader dives into Highmark-UPMC dispute
UPMC ordered to stop using documents
Highmark: UPMC hurting hospitals
UPMC board nixes new Highmark pact

Allegheny Health Network creation

Highmark and West Penn Allegheny Health System originally announced affiliation plans in June 2011, but a series of setbacks prevented the acquisition from occurring until this year. With its completion, WPAHS became the Allegheny Health Network. The reborn health system has since been working to make improvements at Forbes, West Penn and Allegheny General hospitals.

AHN takes ambitious step with e-records system
WPAHS furloughs 262 employees
Allegheny Health hospitals form alliance
Allegheny Health Network kicks off branding campaign
Done deal: Highmark-WPAHS deal OKd

Health care reform continues roll out

The unveiling of ObamaCare continued with the roll out of health insurance exchanges and the implementation of new fees and taxes.
Some small group health insurance rates skyrocket
Affordable Care Act 'unwarranted nightmare' to some businesses

Insurers roll out competing plans on online marketplace
Younger, healthier workers may be hit hard by changes
Kris Mamula covers health care, insurance and employee benefits for the Pittsburgh Business Times. Contact him at kmamula@bizjournals.com or 412-208-3825.
Industries:

Legal Services, Media & Marketing, Insurance, Health Care

Kris Mamula covers health care, insurance and employee benefits for the Pittsburgh Business Times. Contact him at kmamula@bizjournals.com or 412-208-3825

PA House panel weighs Highmark-UPMC proposal

By Karen Langley / Post-Gazette Harrisburg Bureau
December 18, 2013

HARRISBURG -- Depending on who was speaking, a House panel Wednesday heard that bills targeting the ongoing dispute between the UPMC health system and insurer Highmark would be either a very good or very bad deal.

The legislation from Rep. Jim Christiana, R-Beaver, and Rep. Dan Frankel, D-Squirrel Hill, would require hospitals operating as part of an integrated delivery network -- such as UPMC, which operates both a hospital network and a health insurance company -- to contract with any willing insurer.

The bill would mean hospitals couldn't favor some insurers while locking out others. It's a hot topic in southwestern Pennsylvania, where the contract between UPMC and Highmark is set to expire at the end of 2014, threatening to leave customers of the Pittsburgh region's dominant insurer without in-network access to the practitioners of its dominant health care provider.

The House Health Committee heard hours of testimony Wednesday from Highmark, UPMC and others in the industry.

Highmark CEO William Winkenwerder Jr. told the committee that the bills in question would stimulate competition and allow people to choose both their preferred health plans and their preferred doctors. He said the state must guard against a situation in which a dominant health care system controls the price of medical care.

Committee members heard the opposite from a senior vice president and chief legal officer of UPMC, Tom McGough, who said Highmark's acquisition of the West Penn Allegheny Health System meant the insurer would have to make UPMC unaffordable for its subscribers, in effect steering customers to seek medical services at Highmark's own new system.

Others in the industry voiced concerns -- in spoken and written testimony -- about the bills. Henry Miller, director of health analytics of Berkeley Research Group, who has worked as a consultant to UPMC Health Plan and Highmark Blue Cross Blue Shield, said the proposal would allow insurers to pay hospitals at rates below costs.

And Paula Bussard, senior vice president of the Hospital & Healthsystem Association of Pennsylvania, said the proposal would harm competition by lessening the incentive for providers and insurers in crafting benefit packages.

Nurses who testified alongside the president of SEIU Healthcare Pennsylvania, a union which is trying to organize UPMC service and maintenance workers, applauded the bills.

Committee Chairman Matt Baker, R-Tioga, said members need time to review the testimony. Mr. Frankel said the legislation might need adjustments before it would be ready for passage.

Karen Langley: klangley@post-gazette.com or 717-787-2141.

Read more: http://www.post-gazette.com/news/state/2013/12/19/House-panel-weighs-Highmark-UPMC-proposal/stories/201312190155000000#ixzz2qTX9eZvH

Pa. House legislators tackle UPMC-Highmark dispute

October 3, 2013 12:00 AM

By Kate Giammarise Post-Gazette Harrisburg Bureau

HARRISBURG -- Two Western Pennsylvania legislators from opposite sides of the aisle are putting forth two bills they say would protect health care consumers and preserve patient choice in the ongoing UPMC-Highmark dispute.

The measures would require hospitals and physician-owned practices that "are part of an integrated delivery network" -- such as UPMC -- "to contract with any willing insurer."

Co-sponsors Rep. Dan Frankel, D-Squirrel Hill, and Rep. Jim Christiana, R-Beaver, discussed the bills at a press conference in Harrisburg on Wednesday morning, accompanied by two nurses.

"I am the first to criticize government for putting its nose where it doesn't belong," Mr. Christiana said, noting that he and Mr. Frankel don't agree on much policy-wise.

"However, I am convinced that the consolidation of hospitals and doctors' offices and the power of large health care providers demands that the government put safety nets in place to protect the interests of all Pennsylvanians. ... We must protect the access for our constituents."

The contract between Highmark and UPMC expires at the end of 2014; if the two don't arrive at a new contract before then, many Highmark customers won't have in-network access to UPMC doctors and hospitals.

It's not clear if the legislation will gain broader support, or if the effort will be seen as merely a regional issue that's of little concern to other parts of the state. Currently, there is no companion legislation in the Senate.

"It's not just about Western Pennsylvania, it's not just about Highmark, and UPMC, and the Allegheny Health Network, and the UPMC Health Plan," Mr. Frankel said Wednesday.

"This is about a trend that is taking place and will continue to take place. We have two integrated delivery networks in Western Pennsylvania, and another one in Geisinger [Health System] in the middle of the state. ... This is a trend that is taking place along with the consolidation of hospitals and physician practices. If it's not in your neighborhood now, it's coming soon," he said.

House Majority Leader Mike Turzai, R-Bradford Woods, did not show much enthusiasm for the proposal when questioned by reporters Wednesday.

"Now, we think there is appropriate competition on the provider side and appropriate competition on the insurance side and really ... many folks believe now just to let that play out," he said.

UPMC officials have said the legislation would make Pennsylvania alone among states to pass such a requirement, which would harm competition among insurers.

The Insurance Federation of Pennsylvania, which represents leading national insurers (and UPMC Health Plan), said the proposal shows "Highmark is again looking for the government to help it perpetuate its monopoly. That's what this bill is all about -- not protecting consumers or giving them good choices and competition for health insurance."

A spokesman for the Hospital & Healthsystem Association of Pennsylvania said the organization also opposes the bills because they "will result in unfair competition. ... In addition, we do not believe the mandatory arbitration process called for by either bill is feasible."

Kate Giammarise: kgiammarise@post-gazette.com, 1-717-787-4254 or on Twitter @KateGiammarise. Karen Langley contributed.

Read more: http://www.post-gazette.com/news/state/2013/10/03/Pa-House-legislators-tackle-UPMC-Highmark-dispute/stories/201310030124000000#ixzz2qNPHVIvM

COMMERCIAL SONG LYRICS

Original Lyrics written and performed by Robert Sebastian

Single Payer's Painless
To the tune of "MASH"

In Canada they have a plan
That covers all that live in that land
When you get sick
You never have to pay

But down here in the USA
We still live in yesterday
When you get sick
You have to pay and pay

Chorus:
But Single Payer's painless
But we won't make the changes
And no one seems to know which way to go

You know Mitt Romney had a plan
He'd made it work in New England and
Republicans thought that it
was really keen

But then Obama had the gall
To try to apply that plan to all
And then the names that he got called
Could only be described as obscene

Chorus:

It's The Law Jack
(Hit The Road Jack)

Chorus:
It's the law, Jack
You can't roll it back
No more no more
No more no more
It's the law, Jack
You can't roll it back no more

What you say?

Chorus

Well Boehner and Cantor and McConnell all say
That they'll get rid of that law some day
But then John Roberts and his Supremes said
It's the law of the land get it through your head

Chorus

Well Congress oh Congress why you treat it so mean?
You're the meanest damn Congress that I ever seen
They don't care what you think it's understood
Even though it's their idea it ain't no good

Chorus

Repeat: Can't roll it back no more (4 times)

I Can't Get No (Health Insurance)

To the tune of "Satisfaction

I can't get no health insurance
I can't get no health insurance
But I try
And I try
And I try and I try

I can't get no
I can't get no

When I go to the website
And I try to get online
And a sign pops up and tells me
That I
Maybe ought to come back
Later next week
After they have time
To give it a tweak
I can't get no
No no no

Hey hey hey
%$^#*^ ACA

Your Mama is Broke (And Your Daddy Ain't Got No Dough)

To the tune of "Your Mama Can't Dance"

Your mama is broke
And your daddy ain't got no dough
Your mama is broke
And your daddy ain't got no dough
So hop into the car
Cause it's off to the ER
That's where you go
When you got no dough

PROPOSED RULES

AMENDMENTS TO THE RULES OF CIVIL PROCEDURE RELATING TO DOMESTIC RELATIONS MATTERS

SUPREME COURT OF PENNSYLVANIA
DOMESTIC RELATIONS PROCEDURAL RULES COMMITTEE

RECOMMENDATION 127

The Domestic Relations Procedural Rules Committee is planning to recommend that the Supreme Court of Pennsylvania amend the Rules of Civil Procedure relating to domestic relations matters as set forth herein. This proposal has not been submitted for review by the Supreme Court of Pennsylvania.

Notes and explanatory comments which appear with proposed amendments have been inserted by the committee for the convenience of those using the rules. Reports, notes and comments will not constitute part of the rules and will not be officially adopted or promulgated by the Supreme Court.

The committee solicits and welcomes comments and suggestions from all interested persons prior to submission of this proposal to the Supreme Court of Pennsylvania. Please submit written comments no later than **Friday, February 14, 2014** directed to:

Patricia A. Miles, Esquire
Counsel, Domestic Relations Procedural Rules Committee
Pennsylvania Judicial Center
601 Commonwealth Avenue, Suite 6200
P.O. Box 62635
Harrisburg, PA 17106-2635
Fax: 717 231-9531
E-mail: domesticrules@pacourts.us

Deleted material is **bold** and **[bracketed].** New material is **bold** and **underlined.**

By the Domestic Relations Procedural Rules Committee

Carol S. Mills McCarthy, *Chair*

SUPREME COURT OF PENNSYLVANIA

DOMESTIC RELATIONS PROCEDURAL RULES COMMITTEE

RECOMMENDATION 127

Rule 1910.16-6. Support Guidelines. Adjustments to the Basic Support Obligation. Allocation of Additional Expenses.

Additional expenses permitted pursuant to this Rule 1910.16-6 may be allocated between the parties even if the parties' incomes do not justify an order of basic support.

* * *

(c) *Unreimbursed Medical Expenses.* Unreimbursed medical expenses of the obligee or the children shall be allocated between the parties in proportion to their respective net incomes. Notwithstanding the prior sentence, there shall be no apportionment of unreimbursed medical expenses incurred by a party who is not owed a statutory duty of support by the other party. The court may direct that the obligor's share be added to his or her basic support obligation, or paid directly to the obligee or to the health care provider.

(1) For purposes of this subdivision, medical expenses are annual unreimbursed medical expenses in excess of $250 per person. Medical expenses include insurance co-payments and deductibles and all expenses incurred for reasonably necessary medical services and supplies, including but not limited to surgical, dental and optical services, and orthodontia. Medical expenses do not include cosmetic, chiropractic, psychiatric, psychological or other services unless specifically directed in the order of court.

Note: While cosmetic, chiropractic, psychiatric, psychological or other expenses are not required to be apportioned between the parties, the court may apportion such expenses that it determines to be reasonable and appropriate under the circumstances.

(2) An annual limitation may be imposed when the burden on the obligor would otherwise be excessive.

(3) Annual expenses pursuant to this subdivision (c), shall be calculated on a calendar year basis. In the year in which the initial support order is entered, **<u>or in any period in which support is being paid that is less than a full year,</u>** the $250 threshold shall be pro-rated. Documentation of unreimbursed medical expenses that either party seeks to have allocated between the parties shall be provided to the other party not later than March 31 of the year following the calendar year in which the final bill was received by the party seeking allocation. For purposes of subsequent enforcement, unreimbursed medical bills need not be submitted to the domestic relations section prior to March 31. Allocation of unreimbursed medical

expenses for which documentation is not timely provided to the other party shall be within the discretion of the court.

<u>(4) In cases involving only spousal support or alimony pendente lite, the parties' respective net incomes for purposes of allocating unreimbursed medical expenses shall be calculated after the amount of spousal support or alimony pendente lite is deducted from the obligor's income and added to the obligee's income.</u>

Note: If the trier of fact determines that the obligee acted reasonably in obtaining services which were not specifically set forth in the order of support, payment for such services may be ordered retroactively.

* * *

§ 4326. Mandatory inclusion of child medical support.

(a) **General rule.**--In every proceeding to establish or modify an order which requires the payment of child support, the court shall ascertain the ability of each parent to provide medical support for the children of the parties, and the order shall include a requirement for medical support to be provided by either or both parents, provided that such medical support is accessible to the children.

(b) **Noncustodial parent requirement.**--If medical support is available at a reasonable cost to a noncustodial parent, the court shall require that the noncustodial parent provide such medical support to the children of the parties. In cases where there are two noncustodial parents having such medical support available, the court shall require one or both parents to provide medical support.

(c) **Custodial parent requirement.**--If medical support is available at a reasonable cost to a custodial parent, the court shall require that the custodial parent provide such medical support to the children of the parties, unless adequate medical support has already been provided through the noncustodial parent. In cases where the parents have shared custody of the child and medical support is available to both, the court shall require one or both parents to provide medical support, taking into account the financial ability of the parties and the extent of medical support available to each parent.

(d) **Additional requirement.**--If the court finds that medical support is not available to either parent at a reasonable cost, the court shall order either parent or both parents to obtain medical support for the parties' children which is available at reasonable cost.

(d.1) **Medical support notice.**--The department shall develop a medical support notice for use by the department or domestic relations section in accordance with procedures established by the department. The medical support notice shall comply with national standards established by the Federal Government for medical support notices. The department or domestic relations section shall send the medical support notice to the employer within two business days after the date of entry of an employee who is a new hire into the Commonwealth directory of new hires under section 4392 (relating to employer reporting).

(e) **Uninsured expenses.**--The court shall determine the amount of any deductible and copayments which each parent shall pay. In addition, the court may require that either parent or both parents pay a designated percentage of the reasonable and necessary uncovered health care expenses of the parties' children, including birth-related expenses incurred prior to the filing of the complaint. Upon request of the domestic relations section, the department shall provide to the domestic relations section all birth-related expenses which the department has incurred in cases it has referred to the domestic relations section for child support services.

(f) **Proof of insurance.**--Within 30 days after the entry of an order requiring a parent to provide health care coverage for a child or after any change in health care coverage due to a change in the parent's employment, the obligated parent shall submit to the other parent, or person having custody of the child, written proof that health care coverage has been obtained or that application for coverage has been made. Proof of coverage shall consist of at a minimum:

(1) The name of the health care coverage provider.
(2) Any applicable identification numbers.
(3) Any cards evidencing coverage.
(4) The address to which claims should be made.

(5) A description of any restrictions on usage, such as prior approval for hospital admissions, and the manner of obtaining approval.

(6) A copy of the benefit booklet or coverage contract.

(7) A description of all deductibles and copayments.

(8) Five copies of any claim forms.

(g) Obligations of insurance companies.--Every insurer doing business within this Commonwealth shall be obligated as follows:

(1) to permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent and to make payment on such claims directly to such custodial parent, the provider or, in the case of Medical Assistance patients, to the department;

(2) to provide such information to the custodial parent as may be necessary to obtain benefits, including copies of benefit booklets, insurance contracts and claims information;

(3) if coverage is made available for dependents of the insured, to make such coverage available to the insured's children without regard to enrollment season restrictions, whether the child was born out of wedlock, whether the child is claimed as a dependent on the parent's Federal income tax return, whether the child resides in the insurer's service area, the amount of support contributed by a parent, the amount of time the child spends in the home or the custodial arrangements for the child;

(4) to permit the enrollment of children under court order upon application of the custodial parent, domestic relations section or the department within 30 days of receipt by the insurer of the order;

(4.1) not to disenroll or eliminate coverage of any child unless the insurer is provided satisfactory written evidence that a court order requiring coverage is no longer in effect or that the child is or will be enrolled in comparable health coverage through another insurer which will take effect no later than the effective date of such disenrollment;

(4.2) to receive, process and pay claims (whether or not on behalf of a child), including electronically submitted claims, submitted by the department within the time permitted by law without imposing any patient signature requirement or other requirement different from those imposed upon providers, agents or assignees of any insured individual;

(5) to provide the custodial parent who has complied with subsection (j) with the same notification of termination or modification of any health care coverage due to nonpayment of premiums or other reason as is provided to other insureds under the policy; and

(6) except as provided in paragraph (4.2), to not take into account the fact that any individual, whether or not a child, is eligible for or is being provided medical assistance when enrolling that individual or when making any payments for benefits to the individual or on the individual's behalf.

(h) Obligations of noninsurers.--To the maximum extent permitted by Federal law, the obligations of subsection (g) shall apply to noninsurers providing health care coverage within this Commonwealth, including health maintenance organizations, self-insured employee health benefit plans and any other entity offering a service benefit plan.

(h.1) Obligations of employers.--Every employer doing business within this Commonwealth shall be obligated as follows:

(1) in any case in which a parent is required by a court order to provide health coverage for a child and the parent is eligible for family health coverage, the employer shall permit the insured parent to enroll any child who is otherwise eligible without regard to any enrollment season restrictions;

(2) if the insured parent is enrolled but fails to make application to obtain coverage for such child, to enroll the child under the family coverage upon application by the child's other parent, the domestic relations section or the department;

(3) not to disenroll or eliminate coverage of any such child unless the employer is provided satisfactory written evidence that the court or administrative order is no longer in effect, the child is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment or the employer has eliminated family health coverage for all of its employees;

(4) to transfer health coverage for any child to the health coverage of the employer upon receipt of a medical support notice under subsection (d.1) issued by the department or a domestic relations section within 20 business days after the date of the notice; and

(5) to notify the domestic relations section whenever the insured parent's employment is terminated.

(i) Obligations of custodial parent.--The custodial parent shall comply with the insurer's existing claim procedures and present to the insurer one of the following documents:

(1) a copy of a court order as defined in subsection (l); or

(2) a release signed by the insured permitting the insurer to communicate directly with the custodial parent.

(j) Enforcement of order.--The employee's share, if any, of premiums for health coverage shall be deducted by the employer and paid to the insurer or other entity providing health care coverage. If an obligated parent fails to comply with the order to provide health care coverage for a child, fails to pay medical expenses for a child or receives payment from a third party for the cost of medical services provided to such child and fails to reimburse the custodial parent or provider of services, the court shall:

(1) If, after a hearing, the failure or refusal is determined to have been willful, impose the penalties of section 4345(a) (relating to contempt for noncompliance with support order).

(2) Enter an order for a sum certain against the obligated parent for the cost of medical care for the child and for any premiums paid or provided for the child during any period in which the obligated parent failed or refused to provide coverage. Failure to comply with an order under this paragraph shall be subject to section 4348 (relating to attachment of income).

(3) Upon failure of the obligated parent to make this payment or reimburse the custodial parent and after compliance with due process requirements, treat the amount as arrearages.

(k) Enforcement against insurers.--Any insurer or other entity which violates the obligations imposed upon it under subsection (g) or (h) shall be civilly liable for damages and may be adjudicated in contempt and fined by the court.

(l) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Birth-related expenses." Costs of reasonable and necessary health care for the mother or child or both incurred before, during or after the birth of a child born in or out of wedlock which are the result of the pregnancy or birth and which benefit either the mother or child. Charges not related to the pregnancy or birth shall be excluded.

"Child." A child to whom a duty of child support is owed.

"Health care coverage." Coverage for medical, dental, orthodontic, optical, psychological, psychiatric or other health care services for a child. For the purposes of this section, medical assistance under Subarticle (f) of Article IV of the act

of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, shall not be considered health care coverage.

"Insurer." A foreign or domestic insurance company, association or exchange holding a certificate of authority under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921; a risk-assuming preferred provider organization operating under section 630 of The Insurance Company Law of 1921; a health maintenance organization holding a certificate of authority under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act; a fraternal benefit society holding a certificate of authority under the former act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code; a hospital plan corporation holding a certificate of authority under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations); a professional health service plan corporation holding a certificate of authority under 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations); or a similar entity authorized to do insurance business in this Commonwealth.

"Medical child support order." An order which relates to the child's right to receive certain health care coverage and which:

(1) includes the name and last known mailing address of the parent providing health care coverage and the name and last known mailing address of the child;

(2) includes a reasonable description of the type of coverage to be provided or includes the manner in which coverage is to be determined;

(3) designates the time period to which the order applies;

(4) if coverage is provided through a group health plan, designates each plan to which the order applies as of the date the order is written;

(4.1) requires that, if health care coverage is provided through the noncustodial parent's employer and that parent changes employment, the provisions of the order will remain in effect for the duration of the order and will automatically apply to the new employer. The new employer shall enroll the child in health care coverage without need for an amended order unless the noncustodial parent contests the enrollment; and

(5) includes the name and address of the custodial parent.

"Medical support." Health care coverage, which includes coverage under a health insurance plan or government-subsidized health care coverage, including payment of costs of premiums, copayments, deductibles and capitation fees, and payment for medical expenses incurred on behalf of a child.

"Reasonable cost." Cost of health care coverage that does not exceed 5% of the party's net monthly income and, if the obligor is to provide health care coverage, the cost of the premium when coupled with a cash child support obligation and other child support-related obligations does not exceed the amounts allowed by the Federal threshold set forth in the Consumer Credit Protection Act (Public Law 90-321, 15 U.S.C. § 1601 et seq.).

(Dec. 4, 1992, P.L.757, No.114, eff. 90 days; Dec. 16, 1994, P.L.1286, No.150, eff. imd.; Dec. 16, 1997, P.L.549, No.58, eff. Jan. 1, 1998; Dec. 17, 2001, P.L.942, No.112, eff. imd.; May 13, 2008, P.L.144, No.16, eff. imd.)

2008 Amendment. Act 16 amended subsecs. (a), (b), (c), (d) and (l), retroactive to March 31, 2008.

2001 Amendment. Act 112 amended subsec. (h.1) and added subsec. (d.1).

1997 Amendment. Act 58 amended subsecs. (a), (e), (f) intro. par., (g)(1), (4) and (4.2), (h.1)(2) and (l). Act 58 of 1997 was suspended by Pennsylvania Rule of Civil Procedure No. 1910.50(3), as amended May 31, 2000, insofar as it is inconsistent with Rule No.1910.20 relating to the availability of remedies for collection of past due and overdue support.

1994 Amendment. Act 150 amended subsecs. (g), (h), (i), (j), (k) and (l) and added subsec. (h.1). Section 5 of Act 150 provided that the amendment of section 4326 shall apply to all actions pending on the effective date of Act 150.

1992 Amendment. Act 114 added section 4326. Section 4(1) of Act 114 provided that section 4326 shall apply to all support orders entered, reviewed or modified on or after the effective date of Act 114, and section 4(2) provided that section 4326(j) shall apply to support orders entered prior to the effective date of Act 114.

References in Text. The act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code, referred to in the def. of "insurer" in subsec. (l), was repealed by the act of July 10, 2002 (P.L.749, No.110). The subject matter is now contained in Article XXIV of The Insurance Company Law of 1921.

Cross References. Section 4326 is referred to in sections 4348, 6108 of this title.