Notice of Transition Relief Regarding the Application of Section 223 to Certain Health Plans Providing Benefits for Male Sterilization or Male Contraceptives

Notice 2018-12

PURPOSE

This notice clarifies that a health plan providing benefits for male sterilization or male contraceptives without a deductible, or with a deductible below the minimum deductible for a high deductible health plan (HDHP) under section 223(c)(2)(A) of the Internal Revenue Code (Code), is not an HDHP under current guidance interpreting the requirements of section 223(c)(2) of the Code. This notice further provides transition relief for periods before 2020 during which coverage has been provided for male sterilization or male contraceptives without a deductible, or with a deductible below the minimum deductible for an HDHP.

BACKGROUND

Section 223 of the Code permits eligible individuals to deduct contributions to Health Savings Accounts (HSAs).[1] Among the requirements for an individual to qualify as an eligible individual under section 223(c)(1) is that the individual be covered under an HDHP and have no disqualifying health coverage. As defined in section 223(c)(2), an HDHP is a health plan that satisfies certain requirements, including requirements with respect to minimum deductibles and maximum out-of-pocket expenses.

Generally, under section 223(c)(2)(A), an HDHP may not provide benefits for any year until the minimum deductible for that year is satisfied. However, section 223(c)(2)(C) provides that "[a] plan shall not fail to be treated as a high deductible health plan by reason of failing to

[1] Tax-favored contributions may also be made on behalf of eligible individuals by their employers. See Q&A 19 of Notice 2004-2 (2004-2 I.R.B. 269).

have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary)."[2] Therefore, an HDHP may provide preventive care benefits as defined for purposes of section 223 without a deductible, or with a deductible below the minimum annual deductible otherwise required by section 223(c)(2)(A) of the Code. To be a preventive care benefit as defined for purposes of section 223, the benefit must either be described as preventive care for purposes of the SSA or be determined to be preventive care in guidance issued by the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS).

Notice 2004-23 (2004-15 I.R.B. 725) and Q&As 26 and 27 of Notice 2004-50 (2004-33 I.R.B. 196) provide guidance issued by the Treasury Department and the IRS regarding preventive care benefits that an HDHP may provide without satisfying the minimum deductible requirement of section 223(c)(2)(A). Notice 2004-23 clarifies that preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition.

Notice 2004-23 also explains that state law requirements do not determine whether health care constitutes preventive care under section 223(c)(2)(C). State insurance laws often require health insurance policies and similar arrangements subject to state regulation to provide certain health care benefits without regard to a deductible or on terms no less favorable than other care provided by the health insurance policy or arrangement. However, the determination whether a health care benefit that is required by state law to be provided by an HDHP without regard to a deductible is "preventive" for purposes of the exception for preventive care under section 223(c)(2)(C) is based on the standards set forth in guidance issued by the Treasury Department and the IRS, rather than on how that care is characterized by state law.

Notice 2004-23 further indicates that the Treasury Department and the IRS are considering the appropriate standard for determining preventive care under section 223(c)(2)(C)

[2] Section 1871 of the Social Security Act (SSA) does not address preventive care. Rather, section 1861 of the SSA describes the scope of preventive services for purposes of Medicare.

and, in particular, whether any benefit or service should be added to the list of preventive care benefits and services set forth in Notice 2004-23 or other guidance.

Notice 2004-50, Q&A 27, provides that drugs or medications are preventive care when taken by a person who has developed risk factors for a disease that has not manifested itself or become clinically apparent, or to prevent the reoccurrence of a disease from which a person has recovered.

Section 1001 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (Affordable Care Act), added section 2713 to the Public Health Service Act (PHS Act) requiring non-grandfathered group health plans and health insurance issuers offering group and individual health insurance coverage to provide benefits for certain preventive health services without imposing cost-sharing requirements.[3] The Affordable Care Act also added section 715(a)(1) to the Employee Retirement Income Security Act of 1974 (ERISA) and section 9815(a)(1) to the Code to incorporate the provisions of part A of title XXVII of the PHS Act, including section 2713 of the PHS Act, into ERISA and the Code. Guidance under section 2713 of the PHS Act is published jointly by the Treasury Department and the Departments of Labor and Health and Human Services.

Under section 2713(a)(1) of the PHS Act, evidence-based items or services constitute preventive health services if they have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved. Also, preventive health services under section 2713(a)(4) of the PHS Act include, "with respect to women, such additional preventive care and screenings not described in paragraph (1) [concerning the USPSTF A or B rated recommendations] as provided for in comprehensive guidelines supported by the Health Resources and Services Administration" (HRSA). HRSA guidelines generally provide for coverage of all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education

[3] 42 U.S.C. 300gg-13.

and counseling for all women with reproductive capacity. The guidelines, however, do not provide for coverage of benefits or services relating to a man's reproductive capacity, such as vasectomies and condoms. (78 FR 8456 (Feb. 6, 2013) at 8458 n. 3.)

Notice 2013-57 (2013-40 I.R.B. 293) provides that any item that is a preventive service under section 2713 of the PHS Act will also be treated as preventive care under section 223(c)(2)(C) of the Code.

The Treasury Department and the IRS are aware that several states have recently adopted laws that require certain health insurance policies and arrangements to provide benefits for male sterilization or male contraceptives without cost sharing.[4] Some individuals in those states are participants or beneficiaries in insured health plans or other arrangements subject to the state's insurance laws. Certain stakeholders have asked the Treasury Department and the IRS whether benefits for male sterilization or male contraceptives constitute preventive care for purposes of section 223(c)(2)(C).

ANALYSIS

Under section 223(c)(2)(C), "preventive care" means (1) preventive care within the meaning of section 1871 of the SSA, and (2) preventive care as otherwise provided for by the Treasury Department and the IRS. Benefits for male sterilization or male contraceptives are not preventive care under the SSA, and no applicable guidance issued by the Treasury Department and the IRS provides for the treatment of these benefits as preventive care within the meaning of section 223(c)(2)(C). Accordingly, under current guidance, a health plan that provides benefits for male sterilization or male contraceptives before satisfying the minimum deductible for an HDHP under section 223(c)(2)(A) does not constitute an HDHP, regardless of whether the coverage of such benefits is required by state law. An individual who is not covered by an

[4] See, e.g., 215 Ill. Comp. Stat. Ann. 5/356z.4 (West 2017); Md. Code Ann., Insurance § 15-826.2 (West 2017); 2017 Or. Laws Ch. 721, § 2; Vt. Stat. Ann. tit. 8, § 4099c (West 2017).

HDHP with respect to a month is not an eligible individual under section 223(c)(1) and, consequently, may not deduct contributions to an HSA for that month. Similarly, HSA contributions made by an employer on behalf of the individual are not excludible from income and wages.

TRANSITION RELIEF

The Treasury Department and the IRS are aware that certain states require benefits for male sterilization or male contraceptives to be provided without a deductible, and that individuals have enrolled in health insurance policies and other arrangements that otherwise would qualify as HDHPs with the understanding that coverage for male sterilization or male contraceptives without a deductible did not disqualify the policies or arrangements from being HDHPs. The Treasury Department and IRS also understand that certain states may wish to change their laws that require benefits for male sterilization or male contraceptives to be provided without a deductible in response to this notice, but may be unable to do so in 2018 because of limitations on their legislative calendars or for other reasons. Until these states are able to change their laws, residents of these states may be unable to purchase health insurance coverage that qualifies as an HDHP and would be unable to deduct contributions to an HSA.

Accordingly, this notice provides transition relief for periods before 2020 (including periods before the issuance of this notice), to individuals who are, have been, or become participants in or beneficiaries of a health insurance policy or arrangement that provides benefits for male sterilization or male contraceptives without a deductible, or with a deductible below the minimum deductible for an HDHP. For these periods, an individual will not be treated as failing to qualify as an eligible individual under section 223(c)(1) merely because the individual is covered by a health insurance policy or arrangement that fails to qualify as an HDHP under section 223(c)(2) solely because it provides (or provided) coverage for male sterilization or male contraceptives without a deductible, or with a deductible below the minimum deductible for an HDHP.

REQUEST FOR COMMENTS

The Treasury Department and the IRS continue to consider ways to expand the use and flexibility of HSAs and HDHPs consistent with the provisions of section 223. Accordingly, the Treasury Department and the IRS request comments on the appropriate standards for preventive care under section 223(c)(2)(C) (in particular, the appropriate standards for differentiating between benefits and services that would be considered preventive care and those that would not be considered preventive care) and other issues related to the provision of preventive care under an HDHP.

Comments should include a reference to Notice 2018-12. Send submissions to CC:PA:LPD:PR (Notice 2018-12), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, 54 Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2018-12), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20224, or sent electronically, via the following e-mail address: Notice.comments@irscounsel.treas.gov. Please include "Notice 2018-12" in the subject line of any electronic communication. All material submitted will be available for public inspection and copying.

DRAFTING INFORMATION

The principal authors of this notice are Karen Levin and Janet Laufer of the Office of Associate Chief Counsel (Tax Exempt and Governmental Entities), though other Treasury Department and IRS officials participated in its development. For further information on the provisions of this notice, contact Karen Levin or Janet Laufer at (202) 317-5500 (not a toll-free number).