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COMPLIANCE NEWSLETTER

IN THIS EDITION:

Frequently Misunderstood Health Savings Account Issues

The health savings account (HSA) eligibility and contribution rules are often misunderstood, which can result in potential adverse consequences for participating employees.[1] This article focuses on certain employer-provided benefits that may unexpectedly affect an employee's ability to make or receive HSA contributions as well as certain rules that affect the contribution amounts a participant can make and/or receive during the year.

Unexpected Disqualifying Other Coverage and Potential Solutions

In order to be eligible to make or receive HSA contributions, an individual must participate in a qualified high deductible health plan (HDHP) and have no other disqualifying coverage. Some common employer-provided benefits may unexpectedly be disqualifying other coverage, and we'll address three of the most common "gotcha's" below.

1. Account-Based Plans (FSAs and HRAs)

General purpose health FSAs and HRAs that may be used to reimburse for a broad range of qualifying medical expenses are generally disqualifying other coverage and disqualify an individual from making or receiving HSA contributions for the entire plan year. This is also true if the FSA or HRA is your spouse's and can be used to reimburse for your medical expenses (whether or not this actually happens).

HSA Eligibility Solutions for Account-Based Plans

Employers should consider the following HSA compatible FSA plan design options when offering an account-based plan and an HDHP (these are often referred to as "HSA compatible FSAs"):

a. Offer a limited-purpose FSA or HRA that may only be used to reimburse for dental and vision expenses;

b. Offer a post-deductible FSA or HRA that may only be used to reimburse for general medical expenses after the individual has met their annual HDHP deductible; or

c. An employer can actually offer an FSA or HRA that combines both features by being limited to dental and vision expenses until the annual HDHP deductible is met and can then be used to reimburse for general medical expenses afterwards.

1. We address the consequences of ineligible contributions in the "Mistaken HSA Contributions" article appearing later in this newsletter.

Run-Out Periods, Grace Periods, and Carryover Provisions

FSAs usually operate with a run-out period allowing participants to submit claims after a plan year ends and may also include either a grace period or carryover provision (but not both). We'll describe how these can affect HSA eligibility when used in a general purpose FSA:

- **Run-Out Period –** When we say run-out period, we mean a participant has some period of time after the end of the plan year to submit claims that were incurred during the plan year. For example, a calendar year FSA may allow participants until March 31st to submit claims incurred by or before December 31, 2018. If I enroll in an HDHP during annual enrollment, an FSA with a run-out period does not interfere with my ability to make or receive HSA contributions at the start of the next plan year. In this example, I am eligible to make or receive HSA contributions on January 1, 2019.
- **Grace Period –** When we say grace period, we mean a participant has some period of time after the end of the plan year to submit claims that were incurred during the plan year **OR** during the grace period. For example, a calendar year FSA may allow participants until March 31st to submit claims incurred by or before March 15, 2019. If I enroll in an HDHP during annual enrollment, an FSA with a grace period can interfere with my ability to make or receive HSA contributions until the first of the month after the grace period is over. In this example, if I have an FSA balance as of December 31, 2018, I would not be eligible to make or receive HSA contributions until April 1, 2019.

  The issue is whether I have an FSA balance at plan year end. If I have a zero FSA balance at plan year end (December 31, 2018 in our example), I am HSA eligible at the start of the next plan year without regard to the FSA's grace period.
- **Carryover Provision –** An FSA might include a carryover provision permitting participants to carry over the lesser of: (i) their unspent FSA account balance as of the end of the plan year; or (ii) $500 as a contribution toward their FSA balance for the next plan year. Amounts carried over do not count toward an individual's annual FSA contribution limit ($2,700 for 2019). If funds are carried over into the following year and can be used to reimburse for general medical expenses, an individual will be ineligible to make or receive HSA contributions for the entire year.

  An employer can provide employees with options to avoid losing HSA eligibility for the following year:

  – The rules allow FSA funds to carry over from a general purpose FSA into an HSA compatible FSA plan. An employer could design the carryover feature to automatically carry over a balance from a general purpose FSA into an HSA compatible FSA when an individual elects HDHP coverage. This option obviously requires the employer also maintain an HSA compatible FSA.

  – An employer could allow affected employees to decline or waive a carryover at the end of the FSA plan year. An employer that doesn't provide an HSA compatible FSA might choose this option.

2. Clinics (both onsite and offsite clinics)

In terms of HSA compatibility, clinics can be divided into two categories:

HSA Conflict	No HSA Conflict
A clinic will cause an HSA conflict if <u>all</u> of the following is true: • The clinic provides medical services other than first aid, dental or vision care, preventive services, or certain disease management or wellness services; • The clinic provides the general medical services before an individual has met their annual HDHP deductible; and • The individual does not pay for the fair market value (FMV) of the general medical services before meeting their annual HDHP deductible.	A clinic does not cause an HSA conflict if <u>any</u> of the following is true: • The clinic's services are limited to first aid, dental or vision care, preventive services, or certain disease management or wellness services; • The clinic does not provide other medical services before an individual has met their annual HDHP deductible; or • The individual pays for the FMV of other medical services before meeting their annual HDHP deductible.

3. Telemedicine

There is much debate over whether telemedicine is a group health plan that is disqualifying other coverage for the purposes of HSA eligibility. We believe most telemedicine programs are disqualifying other coverage despite claims by some that telemedicine benefits should qualify for an exception available to employee assistance programs (EAPs).

The Myth of the EAP Exception for Telemedicine – IRS Notice 2004-50, Q/A #10 indicates that coverage under an EAP, disease management program, or wellness program isn't other disqualifying coverage if the benefits do not provide significant medical care and provides an example of short-term counseling available through an EAP as meeting this standard. We'll ignore for now whether a telemedicine benefit can be considered an EAP and agree there may be some wiggle room to do so.

The EAP exception is not a blanket exception for all EAPs without regard to their plan designs, and the real issue is whether the telemedicine benefit offers significant medical care. Some believe the medical care or treatment provided by a telemedicine benefit should not be considered significant because of the narrow range of available services that might be performed within a single telemedicine visit. We disagree. We can infer that a determination of significant medical care or treatment shouldn't be limited to a single episode of care or the example of the permissible EAP in IRS Notice 2004-50, Q/A #10 wouldn't bother describing the available counseling as "short-term." Instead, the language used by the IRS strongly suggests that an EAP providing many or an unlimited number of visits would be considered other disqualifying coverage.

EAPs generally provide for a limited number of visits per year. By contrast, telemedicine programs tend to provide for an unlimited number of participant visits. In addition, telemedicine programs can usually write prescriptions which are not available through most traditional EAPs.

This view is also consistent with statements made by the Departments of Labor, Treasury, and Health & Human Services during the rulemaking process creating the EAP exception under the Affordable Care Act in which the agencies suggested an EAP providing for many or an unlimited number of visits would not qualify.

Potential HSA Eligibility Solutions for Clinics and Telemedicine

It is reasonable to assume that many telemedicine and clinic benefits will be considered other disqualifying coverage and cause an HSA eligibility issue without some sort of solution to resolve the conflict:

- **Limit the scope** – The benefits could be limited in scope to services that do not interfere with HSA eligibility, such as preventive services, dental or vision care, first aid (in the case of the clinic), or other services deemed insignificant care by the IRS such as immunizations and providing non-prescription pain relievers.

This solution falls into the category of legally correct but not particularly useful, as limiting the scope of telemedicine and/or onsite health clinic benefits in this manner can defeat the purpose of meaningfully lowering the cost of the employer's medical plan.

- **Provide only post-deductible benefits** – If the benefits are restricted to an HDHP participant until after he or she has met their HDHP deductible, there is no HSA conflict. This solution also falls into the category of legally correct but not particularly useful and can be both difficult and impractical to administer.
- **Charge fair market value for the services** – If the HDHP participants pay the FMV for the services received, there is no HSA conflict. While unpleasant, this is often the most practical solution to implement. There is no guidance explicitly directing how to calculate FMV for these benefits, which should make several approaches reasonable:
  1. Use the Medicare reimbursement rate for the given service;
  2. Use the in-network usual, customary, and reasonable charge for the given service; and
  3. Develop standard rates for services/bundles of services based on the expected cost of providing them through the telemedicine or clinic benefit.

Flat rates are very common for telemedicine and clinic visits with additional charges for labs, tests, or prescriptions. An employer (particularly a healthcare system) may determine a discount is appropriate when determining the appropriate rates to take into account the lower cost of providing the services through a clinic or via telemedicine compared to general medical facilities. It is also not unusual for third-party administrators to have developed standard rates for services using the methods described above that employers can implement. If there is a monthly cost for access to the telemedicine or clinic benefit, that could be factored into the FMV fee calculation.

HSA contributions can be used to offset the cost of services for the telemedicine and clinic benefits, and employers can provide HSA contributions to assist. No fee needs to be charged for limited scope services (*e.g.,* preventive, dental, vision, etc.). Although it adds a layer of administrative complexity, it is also true that the clinic does not need to charge anything once the individual has met the HDHP deductible for the year.

If point-of-service charges are limited to HDHP participants, it does raise a potential nondiscrimination issue under the Tax Code. However, if there is a reasonable mix of both highly and non-highly compensated participants in the HDHP and other medical plan options, this should not present an issue.

Certain Rules Affecting Annual HSA Contribution Limits

In general, an individual's annual HSA contribution limit is pro-rated based on the number of months an individual is eligible to make or receive HSA contributions with HSA eligibility determined as of the first of each given month. This general rule has a lot of moving parts and is subject to several modifications.

Aggregation

Under the health FSA rules, the annual contribution limit ($2,700 for 2019) is based solely on the employee's own contributions, excluding carryovers. By contrast, all contributions made or received to an individual's HSA count toward the individual's annual HSA contribution limit ($3,500 self-only; $7,000 family for 2019), with the exception of rollovers.

The Last Month Rule

While eligibility and contribution limits are generally pro-rated monthly, an individual who is HSA eligible on December 1st can make or receive HSA contributions up to their full annual limit provided he or she remains HSA eligible through the end of the following calendar year. If the individual does not remain eligible throughout this period, the individual's annual HSA contribution limit for the year is retroactively determined using the pro-rata method and will usually lead to adverse tax consequences. An employer is not required to administer the last month rule for payroll deduction purposes. If an employer does not administer this, the employee is still free to take advantage by contributing the additional amounts to the HSA bank on an after-tax basis (usually by writing a check) and taking a deduction on their personal income tax return using IRS Form 8889.

A Special Rule for Spouses

A husband and wife cannot establish a joint HSA, but each spouse can set up their own HSA if eligible. If either spouse has family coverage in an HDHP, both spouses are treated as having family coverage and are limited to the annual HSA family contribution limit split between them. This limit is divided equally unless they agree on a different division. Spouses can demonstrate they've agreed to a different division by electing unequal contributions toward their HSAs.

A break for domestic partners – This special rule for spouses does not apply to domestic partners. Each domestic partner could contribute up to the annual HSA family contribution limit in this instance, because the contribution limit is not tied to tax dependent status. That said, an individual cannot use their HSA to pay for the medical expenses of a domestic partner on a tax free basis (or without penalty) unless the domestic partner is also the individual's tax dependent. The individual could avoid the penalty if the individual was already age 65 or older.

Catch-up Contributions

HSA eligible individuals who are age 55 or older by the end of the calendar year may contribute an additional $1,000 for that year and every year thereafter so long as they remain HSA eligible.[2] If both spouses are over age 55 or older and HSA eligible, both are able to make catch-up contributions to their separate HSAs.

2. Remember that an individual enrolled in Medicare is not HSA eligible.

Putting it all together

Chris (56 years old) is married to Jennifer (50 years old). Jennifer has enrolled in employee + children HDHP coverage through her employer and Chris has enrolled in employee-only HDHP coverage through his employer. Jennifer's employer makes an HSA contribution of $1,000 to her HSA on January 1, 2019. Chris' employer does not make a contribution to his HSA.

- For 2019, Jennifer could normally contribute up to $7,000 to her HSA and Chris could normally contribute up to $3,500 to his HSA. Due to the special rule for spouses, Jennifer and Chris begin with a combined annual HSA contribution limit of $7,000.
- Chris can contribute up to $3,500 plus an additional $1,000 catch-up contribution.
- Assuming Chris does contribute $4,500, Jennifer's annual contribution limit is $3,500. Her employer has already contributed $1,000, meaning Jennifer can only contribute an additional $2,500 herself.
- Alternatively, Chris could limit his HSA contribution to his $1,000 catch-up contribution and Jennifer would be free to contribute $6,000 to her HSA in addition to the $1,000 received from her employer.

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Mistaken HSA Contributions

When and How to Fix Incorrect Contributions

Health Savings Accounts (HSAs) have become increasingly popular over the past decade. When combined with a qualified high deductible health plan (HDHP), an HSA allows an individual to save money to be used on qualifying medical expenses at a later date. Employees may elect to contribute money to their HSA account on a pre-tax basis through their employer's cafeteria plan. Employers aren't required to contribute to employees' HSA accounts, but many choose to do so as part of their health insurance program.

Unfortunately, mistakes can and do occur when administering HSA contributions. Employers may think mistakes are easy to fix, but the HSA regulations are very particular about when (or even if) a mistaken HSA contribution can be recovered. Employers frequently can't recover the funds even if the HSA holder/employee agrees to the recoupment. However, the IRS does allow an employer is allowed to recover the mistaken contributions in certain situations.

Employee Was Never HSA Eligible

If HSA contributions are made to an employee who was never an HSA-eligible individual, the employer can recover the amounts. The employer may request the bank administering the HSA to return the funds. This option is not available if the employee was eligible for even one month during the year.

Administrative or Process Error

The IRS recently released General Information Letter 2018-0033 clarifying when and how to fix certain HSA contribution mistakes. If there is clear documentary evidence of an administrative or procedural error, the employer may request the HSA bank return the money to the employer so all parties are in the same position before the mistake was made. Examples of the types of mistakes that may be corrected include:

- Withholding and contribution of amount in excess of the employee's HSA salary reduction election;
- Incorrect entries by payroll administrators;
- Excess amount due to duplicate payroll files being accessed;
- Employee payroll election change is not timely processed resulting in wrong amount being withheld;
- Incorrect HSA contribution amount calculation;
- Wrong decimal entry;
- Incorrect spreadsheet being accessed; and
- Employee name confusion.

The above list is not exhaustive and only contains examples of administrative and procedural errors that can be fixed. Employers should maintain documentation to support their decision to correct a mistaken contribution. Documentation should include details on the type of mistake, how it occurred, the impact and the steps the employer took to correct the mistake.

Employee Is No Longer HSA Eligible

Another common mistake is for an HSA holder to continue contributing to their HSA when they are no longer eligible. Individuals must be enrolled in a HDHP and have no disqualifying coverage (such as enrollment in Medicare/Medicaid or coverage under a general purpose FSA or HRA) to be able to contribute to an HSA account.

The 2019 annual HSA contribution limit for those with self-only HDHP coverage is $3,500 and $7,000 for those with family HDHP coverage. HSA holders who lose HSA eligibility during the year will have their annual contribution maximum pro-rated for the months in which they were HSA eligible. HSA holders who are eligible as of December 1st may contribute up to the annual maximum, regardless of only being HSA eligible for part of the year, as long as they retain HSA eligibility through the end of the following calendar year.[3]

Corrective Distributions

If an individual makes or receives contributions in excess of their annual HSA contribution limit, including contributions received from an employer that the employer is unable to recoup as described earlier, they may be subject to a cumulative 6% excise tax for each year the impermissible contributions remain in the HSA.

To avoid this penalty, the excess contributions must be distributed to the account holder before the account holder's federal income tax return filing deadline for that taxable year (typically April 15th). HSA holders must also be careful also include the net income attributable to such excess contributions in their gross income for the taxable year in which the distribution was received. This is done by notifying the HSA bank of a need for a corrective distribution. The HSA bank will provide the account holder with the necessary forms and information to make the corrective distribution. We recommend HSA holders work with a tax advisor to correct any HSA errors.

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3. This is described in more detail in "Frequently Misunderstood Health Savings Account Issues" appearing earlier in this newsletter.