THE MODERNIZATION OF HEALTH SAVINGS ACCOUNTS

WRITTEN BY KRISTA J. MASCHINOT

Health Savings Accounts (HSAs) were originally introduced as part of the Medicare Prescription Drug, Improvement, and Modernization Act that was signed into law by President George W. Bush on December 8, 2003. While the contribution amounts have increased gradually since this time, no other significant changes have occurred. Congress is addressing this issue and attempting to help individuals and families afford the ever increasing medical expenses plaguing the United States.

HSAs are highly regulated, tax-exempt savings accounts that both individuals and employers may contribute to on behalf of individuals covered by certain high-deductible health plans (HDHPs). These accounts are designed to help individuals set aside funds to be used for the qualified medical expenses of the individuals, their spouses, and their tax dependents.

Unlike flexible spending accounts (FSAs), HSAs are not subject to mandatory "use it or lose it rules" and while FSAs are not portable, HSAs are portable as they are owned by the individual, not the employer, and can follow the individual as he or she changes jobs similar to a 401(k) or an individual retirement account (IRA).

HSAs can be invested similar to a retirement account and have the ability to grow over time making them a valuable retirement vehicle. They are funded on a pretax basis through a cafeteria plan and result in a triple tax savings for the individual as they are funded with pretax dollars, grow tax-free, and are not taxed upon withdrawal so long as they are used to pay for qualified medical expenses.

The House of Representatives passed the Restoring Access to Medication and Modernizing Health Savings Account Act of 2018 (HR 6199) and the Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018 (HR 6311) on July 25, 2018.

As the names imply, the bills focus on updating and modernizing the current laws surrounding the use of Health Savings Accounts (HSAs). These updates include increasing the contribution limits for both individuals and families, expanding coverage to include qualified medical expenses that were previously omitted, and allowing for direct primary care physician arrangements to be accessed by individuals covered under an HDHP.

CONTRIBUTION LIMITS INCREASED

For 2018, the contribution limit (for employer and employee combined) for an individual is $3,450, while the limit for a family is $6,900 (increased from the original $2,600 for individuals and $5,150 for families).

One modernization that HR 6311 will make is to increase to the contribution limits for individuals and families to $6,900 and $13,300 respectively. These amounts are the current annual limits on deductibles and out-of-pocket expenses for HSA-eligible HDHPs.

In addition, individuals with HSA-qualifying family coverage who were previously deemed ineligible due to their spouse being enrolled in a medical FSA will now be permitted to contribute to an HSA.

COVERAGE EXPANDED

Under the current law, the funds in an HSA may only be used to pay for qualified medical expenses pursuant to IRC Section 213(d), which include amounts paid:

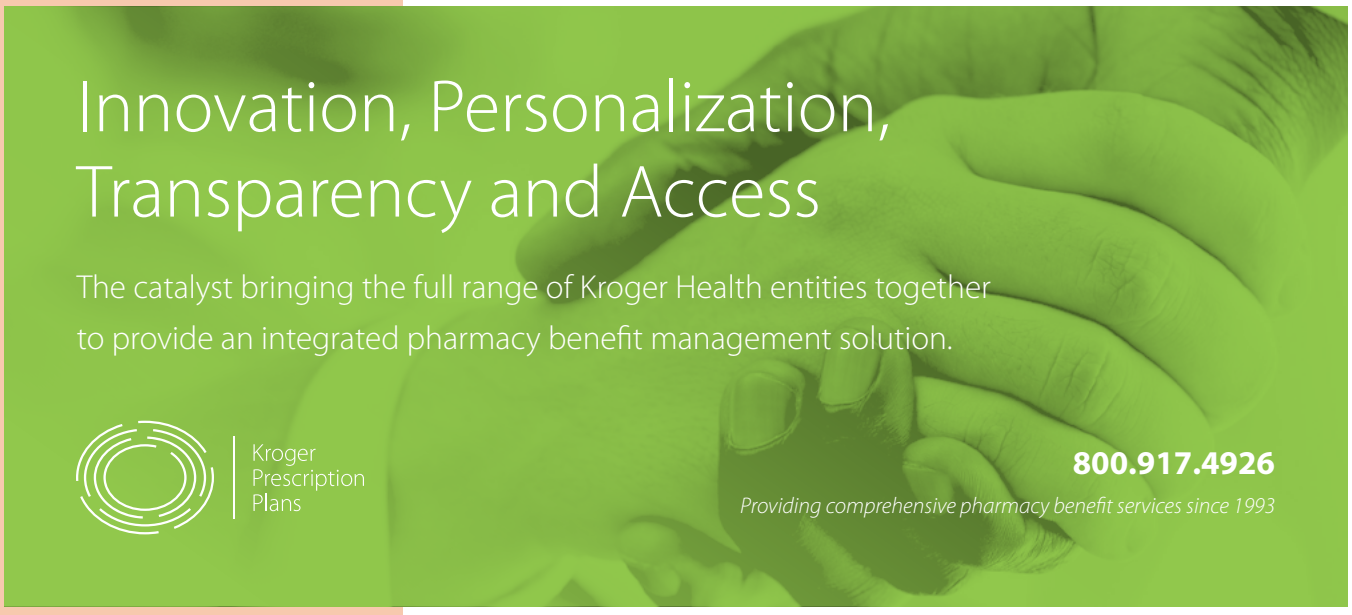
> "(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,
>
> (B) for transportation primarily for and essential to medical care referred to in subparagraph (A),
>
> (C) for qualified long-term care services (as defined in section 7702B(c)), or
>
> (D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and (B) or for any qualified long-term care insurance contract (as defined in section 7702B(b)).
>
> In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D)."

HR 6199 further expands the permissible eligible expenditures to also include gym memberships and certain physical exercise programs (up to $500 for individual and $1,000 for family) along with feminine care products and other over-the-counter medical products.

DIRECT PRIMARY CARE PERMITTED

A Direct Primary Care service arrangement (DPC) is an alternative to a tradition health care plan wherein individuals pay a flat fee each month, similar to a membership fee, to a primary care physician that covers all of the individual's primary care service needs.

For services that are outside the realm of primary care, additional fees will apply. At the current time, individuals cannot use their HSA funds to pay for the DPC monthly fee as they do not qualify as medical expenses under IRC Section 213(d).



Liberty Mutual entered the Employer Stop Loss Market through its acquisition of TRU Services, LLC in April 2017. Since then we have merged our brands and are issuing the Liberty Insurance Underwriters Inc. (LIU) Policy.

You will receive the same service you have grown to know of TRU, but with the strength of Liberty Mutual.

For more information please contact:

Rocko Robinson, Senior VP of Underwriting and Sales

Email: Robert.Robinson01@libertyIU.com

20 Plus years of industry knowledge, expertise, and unsurpassed service

Strength of Liberty Mutual which holds an A rating by both Best and S&P

Plan Mirroring availability

Disclosure statements no longer required on renewal business

Specific Advance Funding ability with enhanced features for qualified producers

152 Conant Street

2nd Floor

Beverly, MA 01915

Phone: 978-564-0200

Fax: 978-564-0201

Website: www.truservices.com

Liberty International Underwriters®

Other issues surrounding DPC arrangements include the fact that when a DPC is offered outside of the employer's health plan it is considered to be a second health plan and impermissible other coverage as Section 223(c) of the Internal Revenue Code (IRC) states:

> "[S]uch individual is not, while covered under a high deductible health plan, covered under any health plan-
>
> (I) which is not a high deductible health plan, and
>
> (II) which provides coverage for any benefit which is covered under the high deductible health plan."

As a result of this Code section, individuals are not permitted to be covered under an HDHP and to also be offered other coverage, include a DPC, outside of the employer's self-funded health plan as (1) a DPC is not an HDHP and (2) a DPC offers benefits that are already covered under the employer's HDHP.

Further, individuals are not permitted to use their HSA funds for services related to DPCs, as DPCs are considered to be health plans and use of such funds would be deemed impermissible other coverage.

If the DPC is a benefit under the employer's self-funded health plan, the following consideration applies. An HDHP is not permitted to provide any first dollar coverage for benefits until a minimum deductible has been satisfied with the exception of preventive care services.

Since the services provided by DPCs and other primary care physicians are not always considered preventive care, there will be times where the patient's care is still subject to the deductible. As a DPC does not typically include a fee for service, there is no fee to apply to the deductible which is problematic.

- Permit the use of employment-related health services and employer sponsored onsite medical clinics for limited use without violating HSA eligibility restrictions;
- Allow for rollovers of health FSA balances from year to you (up to three times the contribution limit);
- Allow for transfers of up to $2,650 for individuals and $5,300 for families from FSAs and HRAs to HSAs when enrolling in a qualifying high-deductible health plan with an HSA;
- Allow spouses to make annual catch-up contributions of up to $1,000 to an HSA; and
- Permit working seniors currently enrolled in Medicare Part A to contribute to an HAS when covered by a qualifying HDHP.

If enacted, HR 6311 will help solve the issues surrounding the ability of DPCs to be used along with HSA-eligible HDHPs. Specifically, it would permit DPC service arrangements to no longer be treated as health plans, thus no longer disqualifying an individual from contributing to an HSA.

Additionally, the monthly DPC fees would qualify as medical expenses, meaning individuals would be permitted to use their HSA funds to pay for such fees (with a cap of $150 per individual and $300 per family per month).

OTHER CHANGES

The bills, again, if enacted, would also:

- Allow up to $250 for individuals and $500 for families to be covered for non-preventive services under HDHPs;

While these bills passed the House in July of this year, there has been no action on either in the Senate and December is quickly approaching. As the tax advantages offered in each are beneficial to both employees and employers, employers should monitor the bills as the year comes to a close. ■

Krista is an attorney with The Phia Group where she focuses on health plan document design and the regulatory issues affecting the administration of employee benefit plans. She received her Juris Doctor from The Catholic University of America and is admitted to the Bar in the Commonwealth of Massachusetts.