High Deductible Health Plans (HDHP) used with Health Savings Accounts (HSA)

The use of a health savings account (HSA) may encourage your employees to be more involved in the decisions associated with their own health care. The Internal Revenue Service applies detailed rules on the set up and administration of HSA's. In order for the account holder to benefit from tax advantages associated with such an account, the individual must also be covered under a qualifying high deductible health plan (HDHP).

The following are some considerations a plan sponsor should use in designing such a HDHP.

- **The primary HSA account holder (your employee) cannot be enrolled in certain other health coverage and still contribute to the HSA.** Your employee will not be able to make contributions to the HSA without incurring additional taxes and penalties if the employee has coverage under any of the following:
    - non-HDHP coverage through another employer, or under COBRA;
    - Medicare (enrollment in Medicare A only would still be impermissible coverage);
    - Veteran's Affairs coverage. If an individual is eligible for VA coverage, but has not used such coverage for three months, he or she can still contribute to, and use, an HSA;
    - TriCare;
    - a flexible spending account (FSA) or health reimbursement arrangement (HRA) reimbursing medical expenses, other than a "limited purpose" FSA or HRA (see below);
    - coverage as a dependent under a spouse's or parent's health plan that is not a HDHP;
    - a separate plan covering only prescription drugs or mental health care;
    - a deductible reimbursement arrangement;
    - an on-site clinic offering significant medical care for free or at discounted rates for employees that are lower than would be offered under a PPO contract. For example, if a physician practice or hospital provided treatment to its own employees without charge, or a pharmacy provided drugs to its own employees for less than would be charged to another participating health plan, this would be considered as impermissible coverage; or
    - telemedicine programs that provide free or reduced-cost benefits before an individual meets his HDHP deductible.

    A dependent of the primary account holder in an HSA can still use HSA funds for reimbursement of his or her health care expenses paid by the primary account holder, even if enrolled in any of the above coverages, as long as the dependent meets the IRS rules to be considered a qualifying dependent for this purpose, and all other sources of reimbursement have been exhausted prior to utilizing the HSA funds. A dependent is considered a qualifying dependent by the IRS if they are the spouse of a primary account holder or any individual that the primary account holder claims as a dependent on his or her federal tax return. In addition, individuals who are not claimed on the primary account holder's tax return are able to use HSA funds for health care expense reimbursement, unless 1) the individual filed a joint return; 2) the individual

had gross income in excess of the amount allowed to be claimed as a dependent; 3) the primary account holder or his or her spouse if filing jointly, could be claimed as a dependent on someone else's return; or 4) the dependent is claimed as a dependent by his or her other parent, including an ex-spouse.

Any employee who is covered under any of the above can still be enrolled in the HDHP. He or she would just not be able to contribute to an HSA during the time he or she had such other coverage without incurring tax penalties.

If you have a significant number of employees who have these types of coverage in addition to the employer health plan, it might be best to offer another plan option, such as a non-HDHP with a lower deductible, to those employees who are 65 or older and have elected Medicare coverage to make up for the loss of the HSA. To avoid age discrimination issues, the coverage offered to the older employees should be equal in cost to the employer, or better than, that offered to the younger employees.

- **Coverage under any of the following would not disqualify an employee from making contributions to the HSA:**
  - another qualifying HDHP;
  - a plan providing only "permitted expenses." This includes benefits such as dental or vision, preventive care or wellness services only, coverage for a specific disease such as cancer, worker's comp, auto insurance providing medical benefits, or policies paying a specific amount per day (such as AFLAC plans);
  - a limited purpose HRA or FSA. This would be an account that reimburses only expenses that are permitted expenses, or that only reimburses medical expenses after the deductible in the HDHP has been satisfied;
  - a "discount card" offering services or supplies at managed care market or PPO rates, rather than those rates offered to the general public, provided that the discounted cost of the item is still subject to the deductible in the HDHP; or
  - an on-site clinic maintained by any employer offering only care for work related injuries or other permitted expenses, preventive care or minor treatment, such as administering allergy injections or providing non-prescription pain relievers.
- **The in-network deductible and out-of-pocket limits cannot exceed the amounts established by the IRS for such a plan, which are subject to change each year.**

  The IRS issues a notice every year, generally in the spring or early summer, outlining the minimum annual in-network deductible and maximum out-of-pocket limits that will be in effect for the following calendar year. This minimum deductible and maximum out-of-pocket listed in this notice are for individuals with self or employee-only coverage, and individuals with family coverage. Under the HDHP model envisioned by the IRS, all expenses applied to the deductible in a plan covering a family, that are incurred by any family member, must be applied to the deductible before any expenses that are subject to the deductible can be paid for any family members for that year. However, most health plans providing family coverage allow for an individual deductible for each family member (after which expenses could be paid for that individual), with a family deductible limit applied for all family members. To accommodate this type of deductible structure, some HDHPs employ what is known as an "embedded deductible," which means that the individual deductible level (including that applied to employees with self-only coverage) is set at or above the IRS

minimum family deductible limit, with a higher accumulative limit applied to the family as a whole.

The maximum out-of-pocket limit is a different issue. A plan could still apply separate in-network out-of-pocket limits for self-only and family coverage within the limits established by the IRS for that year. These limits are usually different from (and likely less than) the out-of-pocket limits established by the ACA for non-grandfathered health plans. To accommodate the ACA limits, therefore, a plan is still required to set the individual out-of-pocket limit for someone in a non-grandfathered family plan within the level permitted under the ACA rules. For example, in 2024, the HDHP out-of-pocket limits are $8,050.00 for self-only coverage, and $16,100.00 for family coverage. However, the individual out-of-pocket limit under the ACA is $9,450.00 per individual. Therefore, the self-only coverage could only have up to a $8,050.00 limit, and family coverage would have a $9,450.00 per individual limit with a $16,100.00 accumulative family limit.

If the plan chooses to apply the same out-of-pocket limits to all covered persons, that out-of-pocket limit cannot exceed the self-only out-of-pocket limit established by the IRS for that year. In the 2024 example, that would mean that the maximum out-of-pocket limits would be $8,050.00 per individual and $16,100.00 per family.

Also, while it is still possible under a non-grandfathered plan to exclude non-essential health care benefits from the out-of-pocket limits, or to set up a separate prescription plan to avoid applying prescription benefits to the out-of-pocket limits in the medical plan, all medical expenses, including prescription benefits and non-essential health benefits, have to apply to the out-of-pocket limits if they are received from an in-network provider in a qualifying HDHP.

The minimum deductibles described above still apply to out-of-network coverage, but the family out-of-pocket limits, if any, for out-of-network coverage can exceed the amounts set by the IRS. If the plan does not utilize a network, all expenses covered by the plan would be subject to these minimum and maximum limits.

- **The accumulation period for a HDHP should be 12 months.**

  This may come up if the plan applies a deductible carryover provision (i.e. expenses applied to the deductible during the final three months of a plan year will apply to the next plan year's deductible). As this essentially makes the deductible accumulation period 15 months, under the IRS rules, the minimum annual deductible allowed would have to be proportionally increased to cover the additional three-month accumulation period. For 2024, therefore, using the $3,200.00 minimum family deductible set by the IRS, if deductible carryover were applied, the family deductible would need to be increased up to $4,000.00 for the year. We therefore recommend <u>not</u> using a carryover feature in a HDHP.

- **No expenses, other than preventive care and certain expenses required to be paid by an IDR arbitrator, can be paid under a HDHP prior to the satisfaction of the deductible.**

  Preventive care under a HDHP is defined differently than it is under the ACA. Under the ACA, the definition is based on recommendations made by specific established medical authorities and regulatory guidance. Under a HDHP, this term is much more loosely defined, and may include services and supplies that would not necessarily be covered without cost sharing under a non-grandfathered plan. In 2004, the IRS stated that any service or supply that is intended to treat an illness or injury would not be considered a "preventive" service for the purposes of the HDHP rules, and provided a

few examples of what that could be considered preventive. Any recommended preventive service that is covered under the ACA will need to be paid at 100% if the plan is non-grandfathered.

More recently, in response to President Trump's Executive Order 13877 – "Improving Price and Quality Transparency in American Healthcare to Put Patients First" the Treasury Department and the IRS were directed to consider ways to expand the use and flexibility of Health Savings Accounts and High Deductible Health Plans (HDHP) consistent with the current Health Savings Account rules. Treasury Department Notice 2019-45, effective July 17, 2019, expands the list of preventive care benefits permitted to be provided by a HDHP without a deductible (or with a deductible below the applicable minimum HDHP deductible).

To expand the availability of services and treatments, the Notice explains that certain medical care services, including treatment and prescription drugs for certain chronic conditions can be classified as preventive care for someone with that chronic condition. This allows HDHPs to cover these additional services and prescriptions at 100% under a HDHP - since they are now re-classified under the Notice as "preventive care." The Notice specifically lists those chronic conditions which will now be classifiable as preventive care with respect to an individual with the relevant chronic condition.

Criteria. Each medical service or item, when prescribed or performed for an individual with the related chronic condition, must meet all the following criteria:

- The service or item must be low-cost. This means that no high cost brand or generic drugs or treatment are eligible to qualify a treatment or prescription drug as preventive.
- There must be medical evidence supporting high cost efficiency (a large expected impact) of preventing exacerbation of the chronic condition or the development of a secondary condition when using the low-cost treatment or prescription.
- There must be a strong likelihood, documented by clinical evidence, that with respect to the class of individuals prescribed the item or service, the specific service or use of the item will prevent the exacerbation of the chronic condition or the development of a secondary condition that requires significantly higher cost treatments.

The List. Only those conditions listed below qualify as preventive care under a HDHP:

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Important Note: The Notice is very clear that the Criteria does not expand the scope of preventive care beyond the above List. That means that medical care services or prescriptions that meet (or may meet) the Criteria but are not on the List are not treated as preventive care as a result of this Notice or on any other basis.

The most recent IRS guidance also clarifies that the deductible should apply to elective sterilizations for men (elective sterilizations for females are included in the ACA recommendations). While this service may not always be seen as actually treating an illness (for men) it is also not preventing an illness for these individuals.

- **Copayments can still be applied under a HDHP, but only after the deductible is satisfied.**

  Any copayment applied for in-network services, including under the drug card or mail order coverage, would still need to be applied to the annual out-of-pocket limits discussed above.

- **Payments made by a plan sponsor of a high deductible health plan in compliance with an Independent Dispute Resolution judgment will not invalidate a HDHP.**

  Effective January 1, 2022, any payments for services and/or treatment made by a plan in compliance with an Independent Dispute Resolution arbitrator's judgment shall not invalidate the high deductible health plan even if such payments are made prior to the satisfaction of the applicable individual's deductible.

The MedBen Compliance Department is here to help you with the design of your HDHP. The IRS also has information regarding HSAs available on its website at www.irs.gov. If you have any questions, please contact Erin Kelly in MedBen's Compliance Department at (740) 522-7368 or (800) 423-3151, ex 368.