Health Savings Accounts

Frequently Asked Questions

Disclaimer

We share this information with our clients and friends for general informational purposes only. It does not necessarily address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues and application of these rules to your plans should be addressed by your legal counsel.

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Contents

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Basics

1. What is an HSA?

A Health Savings Account (HSA) is a tax-favored IRA-type of trust or custodial account to which “eligible individuals” or someone, such as an employer, on their behalf makes contributions. The deposited money earns tax-free interest, and funds are not taxed when used to pay for qualified medical expenses.

2. Who is an “eligible individual?”

An “eligible individual” is someone who: (1) has coverage under a qualified High Deductible Health Plan (HDHP); (2) cannot be claimed as a tax dependent by anyone else; (3) is not enrolled in any part of Medicare; and (4) does not have disqualifying coverage (see Q&A 7). Eligibility is determined on a monthly basis on the first day of each month.

3. When is an individual’s eligibility determined?

An individual’s eligibility is determined monthly, on the first day of the month. In addition, the HSA contribution limit is calculated on a monthly basis, and contributions may only be made for months in which an individual meets the eligibility requirements. If an individual becomes covered under an HDHP in the middle of a month, that individual becomes eligible to establish and contribute to an HSA on the first day of the following month (assuming all other eligibility requirements are met).

4. What is a Qualified High Deductible Health Plan?

A HDHP is a type of health insurance plan that meets Internal Revenue Code Section 223(c)(2) requirements for minimum annual deductibles and maximum out-of-pocket expense limits. Other than meeting the specific statutory requirements, HDHPs may take many different forms so long as the plan provides “significant benefits.” For example, a plan that covers only hospitalization or in-patient care does not provide “significant benefits” and thus cannot be an HDHP. Likewise a “fixed indemnity” plan (i.e., a plan that pays a flat dollar amount per day such as $100 per day while hospital confined) does not provide “significant benefits” and cannot be an HDHP. An employer-sponsored HDHP may be either self-insured or fully insured.

5. How do I know if someone can be claimed as a tax dependent?

Individuals who fall within the definition of "tax dependent" for purposes of Section 152 of the Internal Revenue Code are tax dependents for purposes of HSA eligibility. Code Section 152 defines tax dependents as either a "qualifying child" or a "qualifying relative." Spouses are not considered to be tax dependents for these purposes, but generally, children may be tax dependents. In any case, it is not the employer's responsibility to ask or verify whether an employee can be claimed as a tax dependent on another person's tax return; rather it is the individual's responsibility to know this information.

6. Is HSA eligibility limited to employees?

No, self-employed individuals such as partners may establish and contribute to an HSA as long as they satisfy all of the other requirements.

Disqualifying Coverage

7. What coverage is "disqualifying coverage?"

Generally, "disqualifying coverage" is any non-HDHP coverage. However, disqualifying coverage does not include: (1) coverage for certain preventive care benefits (e.g., annual physicals or routine immunizations); or (2) hospital care or medical services provided to a veteran received under any law administered by the Secretary of Veterans Affairs for a service-connected disability. See the Gallagher HSA Design Guide for additional information on specified preventive care services.

8. If our employees are covered by a traditional health flexible spending account (health FSA) or a health reimbursement arrangement (HRA), can they make contributions to an HSA?

No. Individuals covered by a traditional health FSA or HRA cannot contribute to an HSA (but see Q&As 9 –13).

9. What if our organization establishes a limited purpose health FSA or a HRA, can our employees make contributions to an HSA?

Yes. If an eligible individual is covered by an HDHP and by a health FSA (or an HRA) that pays or reimburses only permitted coverage such as limited scope dental or vision benefits, permitted insurance (e.g., cancer insurance coverage with premiums entirely paid by an employee a post-tax basis), or preventive care without regard to the HDHP deductible, that person can establish and make contributions to an HSA. Permitted

insurance is limited to certain limited scope benefits such as cancer only policies or fixed indemnity policies such as a policy that pays a fixed dollar amount per day of hospitalization.

Individuals who are covered by an Individual Coverage HRA may be eligible to contribute to an HRA if their individual policies qualifies as an HDHP. Individuals enrolled in an Excepted Benefit HRA (EBHRA) would be eligible to contribute to a HSA because the EBHRA as an Excepted Benefit would qualify as permitted coverage.

10. If our organization establishes a post-deductible health FSA (i.e., a health FSA that does not reimburse expenses other than for preventive care before the minimum statutory deductible under an HDHP has been met), can our employees contribute to an HSA?

Yes, so long as the FSA does not reimburse any expenses (other than for preventive care) until the statutory minimum deductible requirements have been met, employees remain eligible to establish and contribute to an HSA even if enrolled in the FSA.

11. If our organization establishes a post-deductible HRA (i.e., an HRA that does not reimburse expenses other than for preventive care before the corresponding deductible under an HDHP has been met), can our employees contribute to an HSA?

Yes. An employer can establish an HRA that only pays or reimburses medical expenses for preventive care or medical expenses incurred after the minimum annual statutory deductible has been met without making an employee ineligible for an HSA.

12. If our organization has a general purpose health FSA with a grace period, is the employee still eligible to establish an HSA?

Individuals enrolled in general purpose health FSAs with grace periods will not be eligible for an HSA during the grace period unless the individual had a $0 balance on a cash basis (i.e., claims incurred and paid, not merely claims incurred or submitted) on the last day of the plan year or the health FSA automatically converts to a limited purpose or post-deductible FSA (HSA-compatible FSA) during the grace period for all participants.

13. If our organization has a general purpose health FSA with a $500 carryover, is the employee still eligible to establish an HSA?

Enrollment in a general purpose health FSA with a carryover provision makes an individual ineligible to contribute to an HSA for the entire plan year. This includes an individual who has coverage under the general purpose health FSA only as the result of

a carryover of an unused amount from the prior year. However, there are three ways that a plan can be modified so that individuals do not lose HSA-eligibility as the result of a health FSA carryover provision: (1) permit employees who enroll in a general purpose health FSA to enroll in an HSA-compatible FSA for the following year and carry over unused balances to the HSA-compatible FSA. This election must be made before the HSA/HDHP plan year begins; (2) if a cafeteria plan offers both a general purpose and an HSA-compatible FSA, when an employee enrolls in an HDHP for the following year a cafeteria plan may automatically treat the employee as enrolled in the HSA-compatible FSA for the following year and transfer unused balances to the HSA-compatible FSA; or (3) permit employees enrolled in a general purpose health FSA to decline or waive the carryover of amounts of coverage to the next plan year. The waiver must be signed before the end of the plan year of the general purpose health FSA.

14. If our organization has an on-site health clinic or nurse practitioner, would that disqualify an employee from contributing to an HSA?

Possibly. If the on-site clinic or nurse practitioner provides medical care (beyond preventive care) for free or at below-market cost before an individual has met the applicable deductible for his or her HDHP, then the individual will not be eligible to establish and contribute to an HSA. For example, providing physicals or immunizations will not destroy HSA eligibility, but providing free or reduced cost antibiotics or other treatment for strep throat or pneumonia would.

15. If our organization offers telemedicine services, would that disqualify an employee from contributing to an HSA?

Maybe. Telemedicine services can constitute disqualifying coverage if they reimburse for telemedicine services before the employee's annual statutory minimum deductible has been met. If an employee has disqualifying coverage, then the employee is not eligible to make contributions to an HSA (and the employer is not eligible to make contributions to an HSA on his or her behalf).

It is possible that particular telemedicine programs may not be disqualifying coverage. For example, if the telemedicine services are limited to preventive services, or if they qualify as "permitted insurance" or "permitted coverage," then the services would not be disqualifying coverage. Note that these exceptions are somewhat narrow, and in general many telemedicine programs provide a more robust array of group health plan services and would not meet these exceptions.

16. If our organization offers telemental services, would that disqualify an employee from contributing to an HSA?

Maybe. When a program provides users with direct access, such as through phone, email chat, or video conferencing, to health coaches and other mental health care professionals, those benefits are often called “telemental” health benefits. Telemental health benefits are frequently tied to EAPs, and thus may fit into an exception to being disqualifying coverage for benefits that do not provide significant benefits in the nature of medical care. However, programs that offer more robust counseling and mental health treatment services may not meet the exception and thus may constitute disqualifying coverage.

Deductibles and Out-of-Pocket Maximums

17. What is the minimum annual deductible for qualifying self-only HDHP coverage?

Qualifying HDHP self-only coverage must have an annual deductible of at least $1,400 in 2020 before any reimbursement may be made for eligible medical expenses (other than for preventive care). This amount is indexed and will likely be higher in future years.

18. What is the maximum out-of-pocket expense limit for qualifying self-only HDHP coverage?

The maximum out-of-pocket expense limit for self-only HDHP coverage for 2020 is $6,900. This amount is indexed and will likely be higher in future years.

19. What is the minimum annual deductible for qualifying family HDHP coverage?

The minimum annual deductible for qualifying family HDHP coverage for 2020 is $2,800. See also Q&A 22. This amount is indexed and will likely be higher in future years.

20. What is the maximum out-of-pocket expense limit for family HDHP coverage?

The maximum out-of-pocket expense limit for family HDHP coverage for 2020 is $13,800. See also Q&A 22. This amount is indexed and will likely be higher in future years.

21. What if the HDHP has both an individual and a family deductible?

For qualifying HDHP coverage, individuals with family coverage cannot be reimbursed for medical expenses (other than preventive care) until the required statutory minimum annual deductible for family HDHP coverage has been met. Thus, if a plan has an individual deductible that is lower than the required minimum statutory deductible for family coverage, the HDHP coverage is not qualifying coverage. For example, if a plan has a $3,000 deductible for family coverage and provides reimbursement for any family member who has incurred $1,500 in expenses (i.e., met an embedded deductible), the plan would not be a qualified HDHP because medical expenses could be reimbursed before the family deductible statutory minimum of $2,800 in 2020 has been met.

However, if the individual deductible was as high as the applicable statutorily required deductible for qualifying HDHP coverage, the use of the embedded deductible would be permissible. For example, if a plan had a $5,000 family deductible and a $2,800 in 2020 individual deductible, then the plan would meet the statutory requirements.

Additionally, under Patient Protection and Affordable Care Act (ACA) HSA deductible could also be impacted by the out-of-pocket maximum guidance issued by the HHS, DOL, and IRS. See Q&A 22.

22. What is the ACA out-of-pocket maximum and how could it affect the HSA deductible?

The ACA limits the out-of-pocket maximum that may be used by employers sponsoring non-grandfathered medical plans. For 2014, the limit for non-grandfathered medical plans was equal to the out-of-pocket maximum for HSAs. However, beginning in 2015, the maximum out-of-pocket limits for non-grandfathered medical plans and high deductible health plans began to diverge.

Additionally, an “embedded” out-of-pocket maximum applies to non-grandfathered medical plans. Under this rule, other-than-self-only coverage under a non-grandfathered medical plan may not have an out-of-pocket limit greater than $8,150 in 2020 for any individual. Under IRS rules for an HSA, the HDHP coverage could be structured so that cost-sharing continues until the family as a unit has reached the $13,800 in 2020 – even if the entire $13,800 is attributable to only one family member. Under the FAQ rule for non-grandfathered medical plans, the HDHP coverage must limit cost-sharing for each individual in the family to $8,150 in addition to the $13,800 in 2020 limit on the family as a unit. As a result, a large family deductible under a non-grandfathered HDHP could fail to satisfy the ACA’s limit on maximum cost-sharing for any individual. For example, HDHP coverage with a per person deductible of $4,500 and $9,000 per family

deductible would not comply with the ACA's embedded out-of-pocket maximum because no individual can be required to pay more than the $8,150 in 2020.

23. What expenses count against the out-of-pocket maximum under a qualifying HDHP?

Co-payments, coinsurance, and amounts paid toward meeting a deductible count toward satisfying the out-of-pocket maximum under a qualifying HDHP. Required contributions toward the cost of coverage are not included. The out-of-pocket maximum may be based on in-network amounts for managed care plans. Higher amounts may be used for out-of-network services.

Contributions

24. Who can contribute to an HSA?

An employer, an employee, or someone on behalf of an employee may contribute to an HSA. Employer contributions to an employee's HSA are not included in the employee's gross income, and employers may deduct those HSA contributions as business expenses.

25. Does our organization have to verify an employee's eligibility for an HSA?

An employer is only required to verify whether: (1) the individual is enrolled in your organization's HDHP; (2) whether the individual is enrolled in disqualifying coverage through your organization such as a health FSA or an HRA that is not HSA-compatible; and (3) the individual's age (to determine if the individual is eligible for catch-up contributions). The employer may rely on information the employee provides about his/her age. The employer is not responsible for verifying that an individual may not be claimed as another taxpayer's dependent, that an individual is not enrolled in Medicare, or that the employee does not have disqualifying coverage from another source such as the spouse's employer.

26. If an employer makes contributions to employees' HSAs outside of a cafeteria plan, are there any requirements that the employer also provide contributions to other similar employees?

Yes. If the employer contributes to employees' HSAs outside of a cafeteria plan, the employer will be subject to an excise tax equal to 35% of all of its contributions during a calendar year unless it makes "comparable" contributions for all comparable, participating, HSA-eligible employees for each level of coverage. Comparable contributions are either the same dollar amount or the same percentage of the

applicable HDHP deductible. The comparability rules permit employers to base contributions on four different tiers of coverage: (1) self-only; (2) self-plus-one; (3) self-plus-two; and (4) self-plus-three-or-more. An exception is available for certain union groups. This rule applies on a controlled group basis – as defined in IRC Section 414(b), (c) and (m). These rules called "comparability" rules have limited flexibility. An employer could not, for example, make contributions to the HSAs of salaried employees, but not hourly employees, where both groups are eligible under the same medical plan. Similarly, wellness program incentives in the form of employer contributions to an HSA will not satisfy the comparability requirement. See the GBS HSA Design Guide for additional information.

If an employer makes HSA contributions to employees' HSAs through a cafeteria plan, different rules apply. See Q&A 27 for information.

27. If an employer makes contributions to employees' HSAs "through a cafeteria plan," what rules govern that employer's contributions?

If an employer makes contributions to employees' HSAs "through a cafeteria plan," then the HSA contributions will be subject to nondiscrimination rules under Section 125, which prohibits discrimination in favor of highly compensated or key employees. If employees are permitted to make their own contributions to their HSAs on a pre-tax basis (i.e., through pre-tax salary reductions), then the employer's contributions to employees' HSAs are considered to be made "through a cafeteria plan."

Distributions

28. Does an individual have to spend all of the contributions made during a given year in that same year?

No. HSA distributions that are made for "qualified medical expenses" are not subject to federal income tax. Unspent funds in an HSA may be rolled over to the next year and earnings will accrue tax-free. Distributions for expenses other than qualified medical expenses are subject to federal income tax and are generally subject to a 20% penalty.

29. Who owns an HSA?

HSAs are owned by the individual and not the employer. In addition, there are no joint accounts (e.g., a husband and wife do not jointly own an account).

30. How is an HSA established?

After enrollment in an HDHP, an individual must establish an account with a bona fide HSA custodian (or trustee). A “bona fide HSA custodian (or trustee)” is simply a financial institution such as a bank or a life insurance company. Other entities that have been specifically approved by the IRS may also be HSA trustees – a list is available on the IRS website.

31. Can an employer select a certain HSA trustee for employer and/or salary reduction contributions?

Yes, an employer may select an HSA trustee as long as there are no restrictions on the employee’s taking the money out of the account (for example, the employee may choose to transfer the funds to another HSA trustee as soon as they are deposited).

32. Is our organization required to monitor how employees use HSA funds?

No. The individuals who own the HSAs are responsible for determining if distributions are for qualified or non-qualified expenses. Neither the HSA trustee, nor the employer is responsible for making this determination. Unlike FSAs or HRAs, claims adjudication by an independent third party is not required.

33. Can our organization limit how employees use HSA funds – for example, by not allowing an employee to use the funds for anything other than qualified medical expenses?

No. The employee who owns the HSA account may use those funds for any purpose, although the money will be taxable and generally also subject to a 20% penalty if not used for qualified medical expenses, so an employer cannot limit how an employee uses HSA funds.

34. What expenses are qualified for distributions from an HSA?

Generally healthcare expenses that would be deductible on the individual’s federal income tax form are qualified distributions from an HSA. However, health insurance premiums are not a qualified expense except under certain limited circumstances. Internal Revenue Publications #969 and #502 provide more detailed information.

35. Can distributions from an HSA be made for the medical expenses of an individual’s child? Is the age limit for a child “under 26”?

Distributions from an HSA can be made for medical expenses of children whom the individual claims as dependents on his or her income tax return (or whom the individual

could claim, if the children's own incomes were disregarded). This means that for a child's expenses to be qualified medical expenses, the child must: (1) be under age 19 at the end of the year (or under age 24 if a student), (2) provide no more than half of his or her own support for the year, and (3) have the same principal place of abode as the individual for more than one-half of such taxable year. The child (adopted or natural) may be the individual's daughter, son, stepdaughter, stepson, or foster child, or a descendant of such a child (e.g., employee's grandchild); or the individual's brother, sister, stepbrother, stepsister, or a descendant of any such relative. In other words, HSA distribution rules do not use the "child under age 26" approach. The changes the ACA made to the tax treatment of adult children for health coverage such as major medical, dental, vision, and even FSAs do not apply to HSA distributions.

36. Can medical expenses for an individual's adult child – such as an employee's 25-year old daughter – ever be considered qualified medical expenses?

An adult child's medical expenses can be considered qualified medical expenses if the adult child meets the definition of "qualifying relative" under Section 152 of the Internal Revenue Code. Generally, a "qualifying relative" is someone whom the employee (i.e., the HSA account owner) provides with over one-half of support for the calendar year, and is the employee's child (or grandchild), sibling or step-sibling, parent, grandparent, step-parent, niece or nephew; aunt or uncle; son-in-law, daughter-in-law, father-law, mother-in-law, brother-in-law, or sister-in-law. Thus a 25-year-old daughter for whom the employee provides more than one half of her support for the calendar year satisfies the definition of qualifying relative whose medical expenses may be paid out of the HSA, even though she exceeds the age limit for "qualifying child" (see Q&A 33). An individual (other than the spouse) who for the year has the same principal place of abode as the taxpayer and is a member of the taxpayer's household may also be considered a "qualifying relative," if such individual receives more than one-half of his or her support from the HSA account holder for the calendar year.

37. Are medical expenses for domestic/civil union partners and their children considered qualified medical expenses?

Whether the medical expenses for domestic/civil union partners and their children are qualified medical expenses depends on whether they are the employee's tax dependents. The tax code definition of a tax dependent includes a qualifying child and a qualifying relative. Therefore, some domestic/civil union partners will qualify as tax dependents as a qualifying relative and others may not. However, the children of a domestic/civil union partner are almost never the employee's tax dependent. A domestic/civil union partner's child would be the domestic partner's qualifying child, not

the employee's qualifying child. One of the requirements for being a qualifying relative is that the individual not be another person's qualifying child. As a result, unless the employee has legally adopted the domestic/civil union partner's child, the child will not be the employee's tax dependent.

If domestic/civil union partners and their children are tax dependents, then HSA distributions for their qualified medical expenses are tax-free. However if domestic/civil union partners and their children are not tax dependents, then HSA distributions for their medical expenses are not qualified distributions and are includable as income and will generally be subject to the 20% penalty.

38. Does the individual have to be HSA eligible when a distribution is made from his/her HSA account?

No. The individual is required to be HSA eligible only when the HSA account is established and when he or she contributes money into the HSA account.

39. If our organization provides employees with an HDHP and contributes to the employees' HSA accounts, will the amount our organization contributes to those HSA accounts be included when determining "minimum value" under the employer shared responsibility requirement of the ACA?

A portion of an employer's contribution – but not all – may be included when determining "minimum value." The minimum value calculator provided by the Department of Health and Human Services includes an adjustment factor for HSA contributions.

40. If benefits for male sterilization or male contraceptives are reimbursed before the statutory minimum deductible is satisfied, is the plan a qualified HDHP?

Plans that pay benefits for female contraceptives in accordance with IRS guidelines (generally the ACA list of contraceptives that non-grandfathered plans are required to reimburse with no cost-sharing may be used) may be qualified HDHPs. Recently, the IRS clarified that coverage of benefits or services related to a man's reproductive capacity (e.g., vasectomies and condoms) do not fall within the guidelines for preventive care, and that plans that cover these services before satisfaction of the minimum statutory deductible are not qualified HDHPs. However, because several states have enacted insurance laws requiring coverage of male sterilization or male contraceptives without a deductible and it may take time for state legislatures to make changes in those laws, the IRS has provided transition relief until 2020. This transition relief is no longer available.