POWER *through Partnership*

Consumer-Driven Healthcare Options

Medical Savings Account

Health Savings Account

Flexible Savings Account

Health Reimbursement Arrangement

Choosing The Best Approach

*Employers are increasingly looking to consumer-driven health plans to help soften the blow of continually rising healthcare costs. Depending on the model, these plans typically include **Medical Savings Accounts (MSAs), Health Reimbursement Arrangements (HRAs), Health Care Flexible Spending Accounts (FSAs)**, and most recently, **Health Savings Accounts (HSAs)**. Some plans allow employees to use these accounts to pay for medical expenses that are not covered by insurance, while employers use others to provide employees with a fixed dollar amount with which they can purchase healthcare services or a health insurance policy on the open market.*

The explosion of these types of plans — or at least the explosion of discussion about these types of plans as a potential cure for rising healthcare costs — has left many consumers and employers confused about the right approach.

Medical Savings Accounts

Perhaps the original consumer-driven health plan, the Archer MSA is an account that allows year-to-year rollovers and is designed to be combined with a high-deductible health insurance policy. The high deductible policy protects the insured from catastrophic loss, such as a prolonged illness or hospitalization, or simply an unexpected period of poor health. The savings account is controlled by the individual, and is intended to pay for routine healthcare services.

MSAs were authorized under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Congress simultaneously imposed on Archer MSAs several restrictions that reduce their practicality and appeal to employers and employees. For example, tax-free MSAs are only available to the self-employed and the employees of small businesses (under 50 employees). Larger and medium-sized employers and employees of companies that do not provide health insurance are not eligible for an Archer MSA. These individuals may be eligible for a nonqualified MSA plan, but the nonqualified plans provide no federal tax break.

Another downside to the Archer MSA: the employer and employee may not both contribute to the employee's MSA in the same year.

The MSA pilot program expired on December 31, 2003. While MSA accounts established prior to this date may continue to be used and receive contributions, no new accounts may be established.

Health Savings Accounts

In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a new type of tax-favored health savings account (HSA). HSAs are much like MSAs, but the rules applicable to HSAs are less restrictive.

An individual that is (a) covered by a high deductible health plan, (b) does not have other health insurance coverage (with some exceptions), and (c) is not claimed as a dependent on another person's tax return may establish an HSA. An HSA may be established by an individual, including the self-employed, or may be employer sponsored. Unlike MSAs, the employer and employee can contribute to the HSA in the same year, subject to annual limits.

Like the MSA, the high deductible health plan is designed to protect the individual against catastrophic loss, but allows the individual to rollover unspent funds in the HSA from year to year. Since the MSA is a tax-exempt trust owned by the individual, the employee takes the account with them upon termination or retirement.

In December 2006, Congress approved legislation that included several provisions affecting health savings accounts (HSAs) and flexible spending accounts (FSAs). This legislation:

- Removes the annual deductible limitation on contributions to HSAs and subject anyone with an HDHP to the statutory contribution limit:
  - $2,850 in 2007 for self-only coverage; and
  - $5,650 in 2007 for family coverage. *
- Under prior law, the contribution limit for HSAs is the "lesser of" (1) the annual deductible under the HDHP or the (2) indexed statutory limit.
- Allow those who enroll in an HDHP midyear to make a full-year contribution to HSAs.
- Allow a one-time distribution from an existing flexible spending account (FSA–that previously adopted the 2.5 month grace period) or health reimbursement arrangement (HRA) to fund an HSA. The limit on the transfer from an FSA or HRA to an HSA would be the lesser of:
  - the balance in the HCFSA or HRA as of September 21, 2006; or
  - the balance in the HCFSA or HRA as of the date of the distribution.

  The rollover must be made directly to the HSA before January 1, 2012.
- Allow a one-time distribution from an IRA to an HSA.
- Require that the government publish cost-of-living adjustments (COLAs) affecting HSAs earlier in the year (by June 1st).
- Add an exception to the comparable contribution requirements. The provision would allow employers to make larger HSA contributions for nonhighly compensated employees (non-HCEs) than for highly compensated employees (HCEs).

continued

* *see the chart on the back page for a list of the current requirements / limitations*

By 2007, over 80% of HDHP-HSA plans provided first-dollar coverage for preventive care. This was true of virtually all HDHP-HSA plans offered by large employers and over 95% of the plans offered by small employers. Over half of the plans purchased by individuals (59%) also provided for first-dollar coverage for preventive care. So, despite analysts/industry opinions that only the Affordable Care Act brought these changes, HSA users enjoyed these benefits for years before the Affordable Care Act was passed.

Flexible Spending Accounts

In 1986, the Internal Revenue Code Section 125 introduced the Flexible Spending Account. FSAs provide a means for employees to considerably reduce their income tax liability through salary reduction. Employees can contribute a portion of their own salary to an account designated to pay for healthcare expenses. These pre-tax contributions are exempt from income and payroll taxes.

Several inherent design flaws have contributed to modest FSA participation. A few of these have been minimized by recent legislation. The tax code requires that only employers set up these accounts for their employees, leaving self-employed individuals and millions of other employees unable to set up their own accounts. In addition, the use-it-or-lose-it provision within the FSA is its biggest downside. Employees are required to elect a specific amount of salary deduction at the beginning of the year, and then must use every dollar in the account by the end of that year. Because annual medical expenses are often hard to predict, employees often overfund the accounts and then spend unnecessarily at the end of the year to avoid forfeiting the money in their accounts. A 2005 Treasury Department ruling may help some in this aspect as it permits employers the option of extending this time frame 2-1/2 months to March 15th of the following year.

Critics of FSAs also note that they are difficult and confusing to set up and administer, causing many small and midsize employers without adequate resources to forego their use. In addition, filing claims for reimbursement can sometimes be difficult and time consuming for the employee. Legislation in 2003 outlining the use of debit cards has built more consumerism into the use of FSAs by eliminating some of these reimbursement delays and allowing employees direct access to the funds.

In 2013, employers had the option to permit a rollover of $500 or less into the next year's HCFSA. (Note: You cannot have the 2.5 month grace period to spend monies and have the $500 rollover feature. You must pick one or the other). Also, if plan participants elect a HSA plan in a later year, they must waive their rights to any rollover HCFSA monies.

Treasury Department Modified "Use-it-or-Lose-it" HCFSA Rule

- Effective in plan year 2014, employers that offer HCFSA programs will have the option of allowing participants to roll over up to $500 of unused funds at the end of the plan year.
- Effective immediately, employers that offer HCFSA programs that do not include a grace period will have the option of allowing employees to roll over up to $500 of unused funds at the end of the current 2013 plan year. Grace periods are used by plans when they want to give you an additional 2.5 months to incur claims. Grace periods are not "run-out" or "submission deadline" periods.

For several years, AssuredPartners and its vendor partners have been deeply involved in industry efforts to educate and convince policymakers to adopt this major new feature for HCFSAs. We are thrilled that these efforts have borne fruit – and believe that this is fantastic news for all HCFSA stakeholders.

From our perspective, the major benefits of this new "rollover" provision include:

- Eliminating the most significant impediment to HCFSA adoption (use-it-or-lose-it) – creating significant upside for FSA adoption growth, which has been limited over the past several years.
- Enhancing healthcare options and offering greater funds protection for HCFSA participants, particularly lower & middle income workers who are highly concerned about cash flow.
- Minimizing risk for constituents with unpredictable healthcare expenses, such as those dealing with chronic conditions that may necessitate high-cost procedures/services with ambiguous timing or
- Curbing wasteful & potentially unnecessary end-of- year spending by HCFSA participants seeking to avoid losing unused funds.

Health Reimbursement Arrangements

In June 2002, the IRS confirmed that funds within a Health Reimbursement Arrangement (HRA) may be rolled over from year to year. HRAs allow employees to use employer contributions only for medical expenses or to pay health insurance premiums.

Unlike FSAs, unused HRA balances may accumulate from year to year, thus providing a personal stake for the consumer in the financial outcome of his or her healthcare spending decisions.

Because HRAs are group health plans, they are subject to laws such as HIPAA and COBRA. If an employee leaves an employer, he may continue to access unused funds within the HRA by electing COBRA. Under COBRA, the employer may also be required to continue its contributions during the COBRA coverage period. The requirement to continue contributions and comply with HIPAA is a deterrent for employers to implement an HRA.

Introducing consumerism into your health plan requires an evaluation of the benefits and the disadvantages of MSAs, HSAs, FSAs, and HRAs. No one solution is right for every employer. In light of the complexities of choosing the right consumer-driven health plan, many employers continue to take a wait-and-see approach.

If your organization is considering implementing a consumer-driven health plan, AssuredPartners can help you decide which plan is best for you.

Please refer to the comparison of tax-advantaged accounts on the next page.

	HSAs	MSAs	HRAs	FSAs
Account Owner	Individual/EE	Individual/EE	ER	ER
Account Contributions	EE or ER, can be both in same year EE contributes pre-tax through Section 125 Plan	ER or EE, not both in same year Must be small ER or self-employed individual	ER Self-employed individuals, including partners, and more than 2% shareholders in a subchapter S-corp cannot contribute	ER/EE EE contributes pre-tax through Section 125 plan
Associated Health Plans	HDHP Minimum Deductible **2012**: $1,200/ind; $2,400/fam[1] **2013**: $1,250/ind; $2,500/fam[2,3] **2014**: $1,250/ind; $2,500/fam[2,3] **2015/2016/2017**: $1,300/ind; $2,600/fam[4,5,6] **2018/2019:** $1,350/ind; $2,700/fam[7,10] **2012**: OOP Max $6,050/ind; $12,100/fam[1] **2013**: OOP Max $6,250/ind; $12,500/fam[2] **2014:** OOP Max $6,350/ind; $12,700/fam[3] **2015:** OOP Max $6,450/ind; $12,900/fam[4] **2016:** OOP Max $6,550/ind; $13,100/fam[5] **2017:** OOP Max $6,550/ind; $13,100/fam[6] **2018:** OOP Max $6,650/ind; $13,300/fam[7] **2019:** OOP Max $6,750/ind; $13,500/fam[7,10]	HDHP Minimum Deductible $2,200/ind; $4,550/fam Maximum Deductible $3,250/ind; $6,550/fam OOP Max $4,350/ind; $8,000/fam	Any or no health plan	Any or no health plan
Annual Contribution Limits	**2012:** Up to $3,100/ind; $6,250/fam[1] **2013:** Up to $3,250/ind; $6,450/fam[2] **2014:** Up to $3,300/ind; $6,550/fam[3] **2015:** Up to $3,350/ind; $6,650/fam[4] **2016:** Up to $3,350/ind; $6,750/fam[5] **2017:** Up to $3,400/ind; $6,750/fam[6] **2018:** Up to $3,450/ind; $6,900/fam[7,8,9] **2019:** Up to $3,500/ind; $7,000/fam[7,8,9,10] Catch-up contributions: age 55 **2009 and thereafter:** $1,000	65% of ind deductible; 75% of fam deductible	No IRS limit	No IRS limit **2013: $2,500 Limit on Healthcare began** **2013:** Employers have the option to permit a rollover of $500 or less into the next year's HCFSA (Note: You cannot have the 2.5 month grace period and the $500 rollover feature. Must pick one or the other). Also, if plan participants elect a HSA plan in a later year, they must waive their rights to any rollover HCFSA monies. **2015/2016:** $2,550 Limit **2017:** $2,600 Limit **2018:** $2,650 Limit
Uniform Coverage Rule Applies	No	No	No	Yes
Rollover of Funds	Yes, 1 time	Yes	Yes, subject to COBRA	No
Eligible Expenses	Section 213(d) medical expenses COBRA premiums, QLTC premiums, Health premiums while receiving unemployment benefits. If Medicare eligible due to age, health premiums except medical supplement policies	Section 213(d) medical expenses COBRA premiums, QLTC premiums, Health premiums while receiving unemployment benefits.	Section 213(d) medical expenses Health insurance premiums for retirees, and qualified beneficiaries, and QLTC premiums ER defines "eligible medical expenses"	Section 213(d) medical expenses Expenses for insurance premiums are not reimbursable ER defines "eligible medical expenses"
Reimbursement Substantiation	No	Yes	Yes	Yes, with exceptions
Reimburses Non-Medical Expenses	Yes, possible penalty	Yes, possible penalty	No	No
Account Interest	Yes, tax-free	Yes, tax-free	Yes, for ER	No

1 IRS Rev. Proc. 2011-32 at http://www.irs.gov/pub/irs-drop/rp-11-32.pdf
2 IRS Rev. Proc. 2012-26 at http://www.irs.gov/pub/irs-drop/rp-12-26.pdf
3 IRS Rev. Proc. 2013-25 at http://www.irs.gov/pub/irs-drop/rp-13-25.pdf
4 IRS Rev. Proc. 2014-30 at http://www.irs.gov/pub/irs-drop/rp-14-30.pdf
5 IRS Rev. Proc. 2015-30 at http://www.irs.gov/pub/irs-drop/rp-15-30.pdf
6 IRS Rev. Proc. 2016-28 at https://www.irs.gov/pub/irs-drop/rp-16-28.pdf
7 IRS Rev. Proc. 2017-37 at https://www.irs.gov/pub/irs-drop/rp-17-37.pdf
8 IRS Rev. Bulletin 2018-10 at https://www.irs.gov/pub/irs-irbs/irb18-10.pdf
9 IRS Rev. Procedure https://www.irs.gov/pub/irs-drop/rp-18-27.pdf
10 IRS Rev. Procedure 2018-30: https://www.irs.gov/pub/irs-drop/rp-18-30.pdf

Note: HDHPs with HSA cannot have an OOP Max greater than the individual OOP Max limit established by PPACA for non-HDHP plans.
An HDHP-HSA plan could have an imbedded OOP Max at the HSA-indivudal limit or the PPACA-established limit (as set be HHS) for the applicable year.

Revised 5/18

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