

The Sandbox Bully: Health Savings Accounts, Onsite Clinics, and Telemedicine

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Employers, particularly those employers that feel they are running out of room to further pare down medical plan design(s) or shift cost-sharing to employees, are increasingly looking toward alternatives like telemedicine and onsite clinics to help lower the cost of their group health plans.

Telemedicine is relatively easier to implement than an onsite clinic. Onsite clinics require a sufficient concentration of participants (which can include employees and their dependents) in a given location to be effective. Having a sufficient concentration of participants is less of an issue for healthcare systems, which also have the advantage of being able to operate an onsite clinic as an own-use facility. *Note: It is possible for multiple employers to share an onsite clinic with clever separate accounting and administration, but that is beyond the scope of this article.*

For all of their advantages, health savings accounts (HSAs) do not easily co-exist with many other benefits. This article focuses on the HSA-compatibility issues employers face when implementing telemedicine and/or an onsite clinic in conjunction with a high deductible health plan (HDHP) with an HSA and potential solutions.

HSA “Eligibility”

In order for an individual to be eligible to make or receive HSA contributions, he or she must be covered under an HDHP and not have any other disqualifying coverage. Other disqualifying coverage includes many arrangements that do not qualify as an HDHP and that pay for medical expenses, including most forms of traditional health insurance, Medicare, and general purpose healthcare flexible spending accounts and health reimbursement arrangements that can reimburse an individual’s medical expenses (including the expenses of a covered spouse or dependent).

Through what is best described as scattered guidance, there are a number of exceptions to this *other disqualifying coverage* rule:

- Coverage for preventive services (including within the HDHP itself);
- “Permitted insurance,” including property and casualty insurance that pays benefits for accident or injury, workers’ compensation, insurance for a specified illness or disease (e.g. cancer, diabetes, asthma), and indemnity coverage;
- “Permitted coverage,” including dental, vision, accident, disability, and long term care coverage;
- Employee assistance program, disease management, and wellness coverage that do not provide significant medical care benefits;
- Arrangements that provide medical benefits only after the statutory minimum deductible for an HDHP has been met (which also means coverage under more than one HDHP does not create an HSA eligibility conflict), known as “post-deductible benefits;” and
- Services for which the individual has paid fair market value (effectively meaning that there was no other disqualifying coverage with respect to the service(s)).

An arrangement may fit under more than one exception.

Pain Points

It is a fairly common misconception that maintaining other disqualifying coverage affects eligibility under the HDHP itself. It does not, although dual coverage may create a coordination of benefits issue between the HDHP and the other disqualifying coverage. Instead, other disqualifying coverage causes the individual to be ineligible to make or receive HSA contributions. Eligibility is determined on the first of each month.

An employer generally has no obligation to police the eligibility status of its employees outside its own knowledge and only a limited ability to force a recovery of HSA contributions when: (i) the individual was never eligible for an HSA contribution, (ii) an amount contributed was in excess of the statutory annual limit, or (iii) there is clear case of administrative error.

An individual who has made or received an ineligible contribution must take a corrective taxable distribution for the ineligible contribution plus any related earnings before their personal income tax return due date for that year (generally April 15th of the following year) or pay a 6 percent excise tax on the ineligible amount. The excise tax is not a one-shot penalty that absolves the ineligible amount and continues each year until the corrective distribution is taken. Admittedly, unless the individual self-reports, the IRS needs to be aware of the ineligible contribution in order to penalize the individual.

Note: Other disqualifying coverage does not generally affect HSA contributions the individual was eligible for or his/her ability to use those funds to reimburse for qualifying medical expenses.

Telemedicine, Onsite Health Clinics, and HSA Eligibility Solutions

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

1. 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 health plan.

2. 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.

3. Charge fair market value for the services

If the HDHP participants pay the fair market value (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:

- (a) Use the Medicare reimbursement rate for the given service;
- (b) Use the in-network usual, customary, and reasonable charge for the given service;
and
- (c) Develop standard rates for services/bundles of services based on the expected cost of providing them through the telemedicine or onsite health 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 an onsite 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 onsite health 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 onsite health clinic benefits, and employers can provide HSA seeding 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 a problem.

We recommend that the costs for telemedicine and onsite health clinic benefits that are fully integrated with medical coverage (e.g., you must be a participant in the medical coverage to use the telemedicine and/or clinic benefit) accumulate toward the individual’s out-of-pocket maximum limit in that medical coverage. An employer could choose to exclude these costs from the corresponding deductible.