

GROOM LAW GROUP

MEMORANDUM

February 4, 2020

TO: Susan Halpin, Connecticut Association of Health Plans

FROM: Groom Law Group

RE: Potential Recommendation Requiring Carriers to Collect Member Cost-Share

On June 26, 2019, Governor Lamont signed Public Act 19-117. Section 247 of the Act created a High Deductible Health Plan Task Force (“Task Force”) “to study the structure of high deductible health plans and the impact of such plans on enrollees in this state.” This memorandum addresses the issues regarding a suggested Task Force recommendation that would support legislation requiring carriers, rather than providers, to collect members’ deductible amounts. As discussed below, any such potential legislation would raise significant issues with the HSA-compatible status of a high deductible health plan (“HDHP”). For example: (1) a carrier’s payment of the deductible could be viewed as the HDHP paying an amount prior to the satisfaction of the deductible; and relatedly, (2) when the carrier credits the deductible with amounts it knows the member did not actually pay, the HDHP may no longer be HSA-compatible.¹

Although this memorandum is limited to these two issues, there are a host of other issues that should be considered prior to further consideration of the proposal. For example whether: (1) this approach could render certain HSA expenses as no longer qualifying medical expenses under the Code (e.g., to the extent the expenses constitute consumer debt); (2) the additional administrative costs associated with the carrier trying to collect from the patient the deductible amount paid by the carrier would pose compliance issues under state and federal medical loss rebate rules; and (3) the decision by the carrier to forgive the deductible amount owed raises issues under state anti-rebating laws. Please note that these are just a few of the many issues that should be considered. We also note that we do not believe there is a movement afoot by the states to adopt similar legislation.

Legal Framework

To be eligible to contribute to an HSA for a month, an individual generally must have HDHP coverage as of the first day of the month and must not be covered by any other “health plan” that (1) is not an HDHP and (2) provides coverage for any benefit that is covered under the HDHP. Code § 223(c)(1)(A). Certain types of coverage, called permitted insurance (e.g., insurance for a

¹ This is beyond the scope of this memorandum, but we note that this state legislation may also raise federal preemption concerns.

specified disease or illness) and permitted coverage (e.g., dental/vision coverage), are disregarded. Code §§ 223(c)(1)(B) and (c)(3).

An HDHP generally means a health plan that (1) has an annual deductible of at least \$1,400 for self-only and \$2,800 for family coverage (for 2020) before any reimbursement is made for eligible medical expenses (other than preventive care) and (2) has a maximum out-of-pocket amount of \$6,900 for self-only and \$13,800 for family coverage (for 2020). Code § 223(c)(2)(A).

In Notice 2008-59, Q&A-3 (June 25, 2008), the IRS stated that an employee is not eligible to contribute to an HSA if at any time his/her employer pays or reimburses, directly or indirectly, all or part of employees' medical expenses below the minimum HDHP deductible (other than permitted coverage or preventive care). The IRS also has held that in order for an individual to be an HSA-eligible individual, a prescription drug plan that is part of an HDHP must subject all covered expenses, including for prescription drugs, to the minimum annual deductible. Rev. Rul. 2004-38 (April 12, 2004).

The IRS has, however, also concluded that an employer's purchase of a pharmacy discount card will not cause an individual to become ineligible to contribute to an HSA, as long as the individual is responsible for paying the costs of the drugs (after the discount) until the deductible is met. Notice 2004-50, Q&A-9 (July 23, 2004). Although the discount itself would not cause the individual to be ineligible to contribute to an HSA, the IRS said that the HDHP must disregard drug discounts and other manufacturers' and providers' discounts in determining if the minimum deductible for an HDHP has been satisfied, and only the amounts actually paid by the individual can be taken into account. *Frequently Asked Questions (FAQs) about Affordable Care Act (ACA) Implementation Part 40* (August 26, 2019).

Potential Issues

We understand that certain stakeholders have voiced concerns that the potential recommendation could cause adverse, unintended consequences for consumers. Below, we address two specific issues related to HSAs and related HDHPs. The first issue arises to the extent an HDHP enrollee has not yet satisfied the minimum statutory deductible under Code § 213, and the carrier's payment of the deductible is viewed for purposes of federal tax law as the plan paying an amount *prior to* the HDHP enrollee's satisfaction of such deductible. The second issue arises where the enrollee fails to pay the carrier the full amount of the deductible otherwise paid by the carrier to the provider. We address each of these, in turn, below.

1. Carrier's Payment of the Deductible

There is a risk that the IRS would view the carrier's payment to the provider of the deductible amount as the HDHP paying the individual's medical expenses before the individual satisfied the deductible, similar to examples in IRS guidance where the employer paid an employee's medical expenses before the minimum HDHP deductible and/or where the prescription drug plan paid benefits pre-deductible. This risk may be lessened if the member repays the carrier in full

because then arguably the plan did not pay any medical expense pre-deductible and the member satisfied the deductible.

Where, however, the member does not repay the carrier in full the plan appears to have paid a medical expense pre-deductible. While counterarguments may be made², as explained in the *Potential Consequences* section below, this may create real jeopardy for the HSA owner.

2. Deductible Credit

An even bigger risk exists when the member does not repay the carrier in full and then the carrier credits the member's deductible for the provider's full charge. In that case, the carrier would be crediting the deductible with an amount it knows the member did not actually pay. This seems directly akin to the situation in the FAQ where the member receives a pharmacy discount or rebate and the carrier credits the deductible with the discounted/rebated amount, which the IRS has specifically said would render the HDHP no longer HSA compatible.³

We think it is important to distinguish this situation from the typical situation where the member sees a provider before he/she has satisfied the deductible, the provider submits a claim to the carrier, and the carrier credits the member's deductible with the member's cost-share amount. The typical situation does not raise HSA issues because, to the best of the carrier's knowledge, the member pays the provider the full amount owed. Although in some situations, the member may not end up paying the provider the full amount owed, either because the member does not pay the provider at all or because the provider sends the unpaid bill to a collection agency that accepts a reduced payment from the member, the carrier has no actual knowledge that the member did not pay the provider. Under the possible recommendation, however, the carrier has actual knowledge that the member did not actually pay the full amount.

Potential Consequences

The potential consequences of the HDHP failing to be HSA-compatible have the most impact on the consumer. This is because the individual would not be considered an "eligible individual" who was able to contribute to an HSA. Thus, the individual's HSA contributions for the time period that he/she is covered under the HDHP would be subject to a 6% excise tax until they are withdrawn. Code § 4973(g). If the plan is a group health plan, there could also be adverse tax consequences to the employer if the employer or employees made pre-tax contributions to the HSAs.

² In that case, it may be possible to argue that the arrangement is similar to the pharmacy discount card scenario and that the carrier's payment represents a discount on the provider's services. Unlike the pharmacy discount card, however, where the discount is provided by an unrelated third party, here, the plan itself is paying the "discount."

³ We considered whether this risk could be reduced if in practice the carrier instead does not credit the deductible with any amounts until the member repays the carrier, and then only credits the actual repayment amount. However, this could result in administrative difficulties for accumulating amounts towards the deductible accumulators that the member incurs before he/she repays the plan and/or this could cause the member to exceed the maximum out-of-pocket limit (which could raise both HSA and Affordable Care Act concerns).

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We hope that this is helpful. Please let us know if you have any questions or would like to discuss.