Prospects for Account-Based Health Plans Under the Patient Protection and Affordable Care Act

by Roland D. McDevitt and Jay Savan, CEBS

Account-based health plans (ABHPs), which combine high-deductible plans with either health reimbursement arrangements (HRAs) or health savings accounts (HSAs), have gained popularity in recent years. Because there is growing evidence these plans are indeed engaging consumers and moderating cost increases, employers will need ABHP design options as they strive to bring costs under control in coming years. Some observers, however, are now concerned that benefits standards introduced by federal health care reform will undermine these plans, and many in the business community anticipate new health benefits mandates will drive up employers’ total health care costs. The authors show that although the Patient Protection and Affordable Care Act (PPACA) of 2010 includes numerous provisions that will likely increase costs for employers, the law also accommodates, and may even foster, HSAs and HRAs.

INTRODUCTION

Many large employers have adopted account-based health plans (ABHPs) as a key element of their cost-containment and consumer engagement strategies over the past decade. In 2002, only 2% of large employers reported offering a plan coupled with a personal account; but by 2010, over half of these large employers were offering such plans, and these plans accounted for 15% of enrollment. All of the national carriers now offer ABHPs, that create financial incentives for consumers to inform themselves about and consider the value of treatment options. Although it is difficult to generalize about the outcomes of these plans, the American Academy of Actuaries reviewed studies by major carriers and a consulting firm and found:

The primary indications are that properly designed consumer-driven health plans [ABHPs] can produce significant (even substantial) savings without adversely affecting member health status. To the knowledge of the work group, no data-based study has emerged that presents a contrary view.

Some PPACA critics have expressed concern that the law will undercut their ability to offer ABHPs. Considering the growing cost of health benefits and the additional demand that will likely follow from health care reform, employers have a strong interest in retaining ABHP design options. The new law does little to control health care spending or premium expense, at least in the short term, and it includes numerous provisions that will increase employers’ costs. For example, large employ-
ers offering health benefits might anticipate additional costs for any of the following reasons:

- Benefit standards may restrict the levels at which deductibles and out-of-pocket maximums can be set.
- Annual and lifetime benefit limits will not be allowed.
- Minimum standards for actuarial value and employer premium contributions must be satisfied if employers are to avoid financial penalties.
- Financial penalties will be imposed on employers whose full-time employees find the employer’s plan unaffordable and obtain subsidies through a health insurance exchange.
- An excise tax will be imposed on employers if their premiums exceed specific levels.

**CONSEQUENCES FOR ABHPs**

Although many of the reform law provisions will drive up employers’ health benefit spending, the law does not undermine the feasibility of high-deductible ABHPs. The following discussion highlights the implications for HSA-compatible plans, in particular, considering the minimum essential coverage that is required, the application of financial penalties that may affect employers, and several other considerations that may favor the continued growth of ABHPs. Although the discussion focuses on HSA-compatible plans, the findings also apply to HRA-based plans unless otherwise noted.

**MINIMUM ESSENTIAL COVERAGE**

PPACA emphasizes individual responsibility, requiring individuals who fail to maintain “minimum essential coverage” to pay a penalty beginning in 2014. Whether provided through an employer plan or through the individual market, this essential coverage limits cost sharing within the plan and must meet minimum standards of actuarial value.

**Cost Sharing**

PPACA specifies that when the individual mandate is implemented in 2014, essential coverage offered in the small group market must not include deductibles that exceed $2,000 for single coverage and $4,000 for family coverage. Although not entirely clear in the legislation, it appears these limits will also apply to large employers. Moreover, plans offered by employers will be subject to the out-of-pocket maximums for HSA-compatible plans beginning in 2014. Contrary to ruling out HSA plan designs, these limits accommodate the existing HSA plan limits that were developed under the Medicare Modernization Act of 2003.

**Actuarial Value**

Actuarial value is the percentage of allowed charges that a plan would pay for a standard population. The reform law classifies plans into actuarial value tiers. A plan pays 60% at the bronze level, 70% at silver, 80% at gold and 90% at platinum. These categories are intended to help consumers select a plan in the context of a health insurance exchange, but the standard for minimum essential coverage is set at the bronze level of 60%.

Most ABHP designs offered by employers already provide benefits well in excess of this 60% minimum even when the employer account contribution is not considered toward the calculation of actuarial value. For example, a recent Consumers Union report illustrated a 70% plan with an individual deductible of $1,500, 20% coinsurance and $5,950 out-of-pocket maximum in 2010. This out-of-pocket maximum is at the limit allowed for HSA plans in 2010, and many employers offer HSA-compatible plans that are more generous.

PPACA provides that employers’ HSA contributions may be included when calculating the actuarial value of HSA-based plans, and similar employer contributions to HRAs would also be included in calculating the actuarial value. The authors estimate that an employer contributing $500 toward the account for single coverage in the Consumers Union example would raise the actuarial value from 70% to 78%. This is equivalent to the actuarial value associated with many traditional preferred provider organization (PPO) plans.

**Essential Benefits**

Plans offered through a health insurance exchange will be required to provide coverage for at least the following ten specified service categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care.
Employers outside the exchange will retain their plan design flexibility and will not be required to comply with the essential benefits package described above. Still, the plans offered by employers today—including ABHPs—generally include these essential benefits.

**AFFORDABLE COVERAGE**

Even when a large employer offers a plan that meets the above standards for minimum essential coverage, the employer might face a penalty if the coverage is not affordable to certain employees. If a full-time employee of a large employer seeks coverage through an exchange, and qualifies for either a premium tax credit or a cost-sharing reduction due to low income, the employer is subject to a nondeductible penalty. The monthly employer penalty is equal to the product of the number of full-time employees receiving one of these subsidies and one-twelfth of $3,000.8 Employees and their families are permitted to obtain these subsidies only when the employer plan that is offered is not affordable in relation to household income.

An ABHP is more likely than other plans to meet the affordability standard. ABHPs typically offer lower premiums than other plans, reducing the share of the employee’s household income that would be consumed in paying the employee portion of premium. For example, the average employee-only premium reported by large employers in the *Towers Watson 2010 Health Care Cost Survey* is $5,352 for all non-ABHP plans, $4,824 for HRAs and $4,320 for HSA plans.9 These premiums include the value of any employer account contributions associated with HRA- and HSA-based plans.

Even if a portion of these differences is attributable to favorable selection when employees are given a choice of plans, the American Academy of Actuaries study discussed above suggests that ABHPs produce significant savings that will in turn lower premiums. Depending on cost-sharing provisions of the plan and the level of any employer account contributions, ABHPs can also be affordable with respect to actuarial value. As discussed above, an HSA with an employer account contribution is often comparable to a PPO plan in terms of actuarial value.

**CADILLAC TAX**

Federal tax law has long excluded employer-sponsored health benefits from taxable income, encouraging workers to seek more of their compensation in the form of health benefits and less in the form of wages. The result has been enriched health care benefits and lower financial incentives for consumers to actively consider the cost and value of treatment options.

PPACA does not change this exclusion from income, but starting in 2018 it places a 40% excise tax on the portion of health benefit premiums that exceed $10,200 for single coverage and $27,500 for family coverage. There will be higher limits for early retirees, high-risk occupations and some employer groups that have higher risk due to their age and gender mix. For insured plans, this tax will be paid by the insurance company; for self-funded employer plans, the tax will be paid by the employer or by the plan administrator.

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**THE AUTHORS**

Roland D. McDevitt, Ph.D., is director of health care research at Towers Watson’s Research & Innovation Center in Arlington, Virginia. Over the past 25 years, he has developed medical claims databases and microsimulation models to estimate health plan payments and member out-of-pocket costs for pre-65 and post-65 populations. He has partnered with the RAND Corporation on a multiyear study of account-based health plans (ABHPs) and how they affect the plan spending, member out-of-pocket expense, and quality of care for enrollees generally and vulnerable groups in particular. McDevitt holds a Ph.D. in political science and public policy analysis from the University of California at Santa Barbara.

Jay Savan, CEBS, CLU, ChFC, CFP, is a senior consultant based in Towers Watson’s St. Louis office and a leader in the development of the firm’s health care consumerism initiatives. In addition to leading the firm’s Health & Group Benefits business development efforts in the central United States, he participates on Towers Watson’s Intellectual Capital Council and is responsible for helping create and deploy innovative program strategies. Savan has assisted numerous clients in designing, implementing and evaluating leading-edge programs. A frequent speaker and author, he has been recognized as one of the ten most influential people in the industry and identified as “most innovative consultant” by a national trade publication. Savan holds an M.B.A. degree from Loyola Mary Mount University in Los Angeles.
This will create a powerful incentive for employers to limit the growth in plan premiums, and ABHPs will likely play a prominent role. The 2018 excise tax thresholds could impact 60% of companies if the current health care spending trend continues. Additional plans and employers would be impacted in subsequent years if health care spending continues to rise in excess of inflation. The authors expect that employers will take advantage of the opportunity that ABHPs offer to help mitigate the growth in premiums.

ABHPs FAVORED OVER FSAs

Many employers with traditional plans offer flexible spending arrangements (FSAs) through their cafeteria plans, allowing employees to specify a salary reduction and receive that amount in the form of a tax-free employer contribution to their FSA. FSA money can be used to pay for qualified medical expenses, which include deductibles, coinsurance and copayments, as well as other expenses, such as dental and vision care, that may not be payable through insurance.

Unlike HRA and HSA balances, FSA balances are subject to a “use it or lose it” restriction—the FSA balance is not permitted to roll over from year to year. It is typically difficult for individuals and families to predict what their out-of-pocket health care expenses might be in the coming year. If they underestimate their expenses, they will not be able to take advantage of the tax protection for a portion of their medical expense. If they overestimate their health care expenses, they might forfeit the balance remaining in their FSA at the end of the year. Not surprisingly, there is a flurry of spending at the end of each year as participants spend any remaining balances. This is hardly the kind of incentive that might foster greater consumerism.

Employers have been permitted to specify the maximum annual FSA election for employees, but beginning in 2013, PPACA restricts this annual election to $2,500 per employee. An employee’s FSA election accrues toward the excise tax thresholds, such that employers might further reduce the maximum annual election, or even eliminate the FSA altogether, as they strive to keep their medical plan expense under the excise tax thresholds that will apply in 2018.

For calendar year 2010, the HSA contribution limits were set at $3,050 for single coverage and $6,150 for family coverage, with an additional $1,000 contribution per year allowed for individuals aged 55 and older. Both HSAs and HRAs create better incentives for members to act as prudent consumers.

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OTHER CONSIDERATIONS

Growing Value of Tax Deductions

Considering the growing federal deficit, the possible expiration of the Bush tax cuts, and the growing impact of the alternative minimum tax, the tax protection offered by HSAs will be increasingly valuable to employees. This is particularly true for those with higher incomes, although it’s notable that the expiration of the Bush tax cuts would result in a 50% increase in the lowest marginal tax bracket—from 10% to 15%—suggesting that even those at lower tax rates might find an HSA appealing. As deductibles continue to rise in conventional plans, it will be increasingly attractive for employers to raise deductibles up to at least the HSA minimum (currently $1,200 for single and $2,400 for family coverage) and offset the loss in plan value with an employer contribution to the HSA.

HSAs will continue to provide very attractive protection from taxes. The contributions are deductible from current income, and no tax is ever paid by the employee or spouse on the funds if they remain in the account or are used to reimburse qualified health care expenses. PPACA does increase the penalty for those who withdraw HSA funds for nonmedical use—from 10% to 20% of the distribution—beginning in 2011.
Retiree Medical Savings

The value of retiree medical plans available to employees continues to erode where those plans are still offered. Most employers that still offer a plan have capped their contributions to these plans, and there is an increasing need for employees to plan ahead and accumulate savings to offset their future retiree medical expense. HSA-compatible plans offer access to the most tax-efficient vehicle available under the Internal Revenue Code for this important accumulation of funds.

Continued Support for Consumerism

Consumerism now extends well beyond account-based plans, but HSAs offer an attractive vehicle to support the culture of personal responsibility. PPACA allows plan designs with significant financial incentives to encourage healthy behaviors. Under PPACA, financial incentives of up to 30% of the premium amount can be directed to plan members who participate in wellness programs. By placing these funds in a tax-free HSA, the value of this incentive is leveraged.

CONCLUSION

Congressional Democrats were generally not enthusiastic about the HSA plans that grew out of the Bush administration’s Medicare Modernization Act of 2003, but the new health care reform law creates incentives that are favorable to both HSA- and HRA-based plans. PPACA’s provisions for employer-sponsored minimum essential coverage are generally consistent with the benefits currently offered by large employers’ HSA- and HRA-based plans. The standards for member cost sharing, the standards for minimum actuarial value and the minimum employer premium contributions are all set at levels that accommodate most current plans. There is no mandate to include specific essential services in employer plans offered outside the health insurance exchange, but typical employer plans compare favorably to the standards set out for those in the exchange.

Cost control will be more important than ever as health care reform provisions are implemented. Employers that do not offer their employees an affordable plan will be penalized, and ABHPs offer an important path to keeping the plan affordable. When the excise tax is implemented in 2018, the focus on cost control will be intensified, as any portion of premium over the thresholds will be taxed at a 40% rate.

The focus on consumerism is no longer limited to ABHPs, but these are the plans that have driven much of the recent innovation, including better information to help consumers evaluate their treatment options, better wellness and self-management programs, and better targeting of high-risk members for education and interventions to avoid health risks.

Contrary to fears that HSA and HRA plans would be undermined by health care reform, it appears their prospects are bright. With cost challenges looming, employers will need every available tool to continue offering affordable coverage to employees and their families.

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Endnotes

1. Many people use the term “consumer-directed health plan,” or CDHP, to encompass both health reimbursement arrangements (HRAs) and plans tied to health savings accounts (HSAs). These plans were closely tied to the development of consumerism, but in recent years consumerism has come to pervade other plans as well. Consequently, the authors use “account-based health plans” (ABHPs) to refer to HRA and HSA plans. They do not include flexible spending accounts in the ABHP category of plans.
5. Although PPACA does little to control health care costs in the short term, there are several provisions that might help temper cost trends over the long term. These include the excise tax on premiums of high-cost plans, the funding of comparative effectiveness research, and pilot projects on delivery system reform.
6. Each of these cost-sharing limits apply only to non-grandfathered plans, and the limits would be adjusted annually.
8. The total monthly penalty is not to exceed the product of the total number of full-time employees in the company and one-twelfth of $2,000.