

Health Savings Accounts— American Idol?

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Consumer-driven health care (CDHC) is a 21st century change-driver that has the potential to revolutionize health care financing and the roles of both employers and employees. Out-of-control health costs and growing numbers of uninsured have fueled speculation that health savings accounts (HSAs) and CDHC will emerge as the future “stars” of U.S. health care policy. Whether CDHC wins broad workplace acceptance in the next five years, as “consumer-driven retirement” through 401(k)s caught on in the 1980s, will depend on the comfort level employers and employees ultimately have with HSAs, in the author’s opinion. This article examines current trends.

Millions of television viewers held their breaths last May as finalists Jordin Sparks and Blake Lewis went head to head in the 2007 “American Idol” competition. Sanjaya Malakar, Melinda Doolittle and LaKisha Jones had already been voted off when Sparks, a Glendale, Arizona teenager, broke through to be crowned as American Idol.

Now, as a presidential campaign heats up that will end with the inauguration of the 44th president of the United States about one year from now, an American Idol contest of a different kind is underway. Out-of-control health costs and growing numbers of uninsured have fueled speculation that HSAs and CDHC will emerge as the future “star” of U.S. health care policy. Are HSAs destined to become the “Jordin” of our country’s health care system?

Health Care “Megatrends”

Payroll, human resource (HR) and employee benefits professionals are evaluating HSAs in the context of five “megatrends” expected to redefine U.S. health care policy from 2008 to 2012:

1. Containing the explosive growth in

health care costs, now approaching a 100% increase since 2000, four times the rate of inflation

2. Extending insurance coverage to the 46 million uninsured, especially some 8 million uninsured children
3. Questioning U.S. tax policy supporting employer-provided coverage with pretax employee-paid premiums and tax-free employer-paid premiums
4. Addressing seismic shifts in the workplace landscape, with fewer employers offering health insurance to their employees and consumers taking on more decision-making responsibility
5. Providing greater transparency in quality and cost information to aid decision making and wellness.

Connecting these trends is CDHC, a 21st century change-driver that has the potential to revolutionize health care financing and the roles of both employers and employees.

Three Pillars

CDHC is generally thought to consist of three pillars:

1. A high-deductible health plan (HDHP)

with which insurance coverage is triggered only after a high deductible has been satisfied, for example, \$1,100 for individual coverage and \$2,200 for family coverage

2. A 401(k)-like tax-advantaged savings account to help finance the higher out-of-pocket costs associated with HDHPs. These can be HSAs, health reimbursement arrangements (HRAs) or in some cases flexible spending accounts (FSAs).
3. A decision support tool, preferably Web based, to help families evaluate care options, providers and costs.

HSAs: 401(k) of Health Care?

Whether CDHC wins broad workplace acceptance in the next five years, as “consumer-driven retirement” through 401(k)s caught on in the 1980s, will depend on the comfort level employers and employees ultimately have with HSAs.

Enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, HSAs were inaugurated in January 2004. America’s Health Insurance Plans, a national association representing nearly 1,300 member companies providing health insurance cover-

age to more than 200 million Americans, reported recently that in just three years, 4.5 million Americans became covered by HDHPs offered with HSAs, a 46% increase since 2005.

A 2006 Deloitte Consulting LLP cost survey, *Reducing Corporate Health Care Costs*, found that 40% of HR executives rate HDHPs the “most effective approach for managing costs and maintaining quality care.” The survey concluded that not only do 24% of large employer respondents now offer a consumer-driven health plan, some 70% plan to offer a consumer-driven health plan as an option or replacement over the next five years.

In large measure, therefore, whether the destiny of CDHC and HSAs is to take their place alongside 401(k)s as another consumer-based employee benefit rests in the hands of payroll, HR and benefits professionals—who have primary responsibility for educating workers and implementing new policy ideas in the real world of today’s workplace.

The professionals should focus on five defining principles of HSAs.

HSA Mechanics— Five Principles

At its core, the HSA is a 401(k) for medical expenses. HSAs are designed to encourage consumers to shoulder greater responsibility for health care decisions by subsidizing consumers’ savings for health costs that insurance does not cover. Accordingly, HSA funds may be used for out-of-pocket costs associated with HDHPs, but not for insurance premiums, except for certain “permitted insurance” such as Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums, long-term care insurance premiums, health coverage while on unemployment insurance and coverage for specific illnesses (IRS Notice 2004-50).

Principle 1: The Marriage of HSA and HDHP

Individuals are eligible to make pretax contributions to their HSAs only if they have high-deductible insurance coverage—In 2008, this means a minimum deductible of \$1,100 for individual coverage and \$2,200 for family coverage.

The idea is to expose individuals to the insurance deductible and make them

true health care consumers, as opposed to passive users of insurance.

Furthermore, with few exceptions (such as dental coverage or long-term care insurance), if an individual has any other insurance coverage, such as under a spouse’s preferred provider option (PPO) plan, the individual is not eligible for an HSA. Even a prescription drug plan, if it provides any benefits before the deductible has been met, disqualifies an individual from HSA eligibility.

One significant exception to this HDHP principle is preventive care, the costs of which may be covered before the insurance deductible is met without rendering the individual ineligible for an HSA. IRS Notice 2004-23 specified a range of health services that qualify for a “safe harbor for preventive care benefits” allowed to be provided by a HDHP without satisfying the minimum deductible. These preventive services include annual physicals, prenatal care, screening services (for example, mammograms and prostate tests) and even certain medications intended to be preventive, such as cholesterol-lowering drugs.

The Internal Revenue Service (IRS) has taken the HDHP exclusivity rule very seriously, going so far as to define even FSAs as “other coverage” that disqualifies individuals from having an HSA. Accordingly, only “limited-purpose FSAs,” such as those used to pay for vision care, dental care or out-of-pocket costs associated with preventive care, may be used without voiding HSA eligibility. Postdeductible FSA coverage is also permissible. Unless these regulations are changed (as President George W. Bush proposed in his 2008 budget), it is difficult for employers to coordinate interaction between HSAs and FSAs.

On a positive note for employers, a representative of the IRS Office of Employment Tax advised American Payroll Association members that employers may deny employee contributions to an employer’s cafeteria plan HSA if the employee does not participate in the employer’s HDHP. Consistent with IRS Guidance 2004-50, employers are responsible only for verifying employee participation “under an HDHP (and the deductible) sponsored by that employer.”

Principle 2: Zero Taxes

Put simply, an HSA mimics a tradi-

tional 401(k) for contributions and a Roth 401(k) for distributions. In other words, an HSA permits pretax contributions and tax-free distributions. When used for qualified medical expenses (as defined in Section 213(d) of the Internal Revenue Code), HSA funds are 100% free of federal income taxes.

HSA contributions made by employees through salary-reduction Section 125 cafeteria plans are also exempt from Social Security and Medicare taxes, as well as federal unemployment insurance taxes. In addition, any employer contribution to an employee HSA is also exempt from these taxes. Moreover, employee HSA contributions are often exempt from state income taxes too, though not all states take this approach.

It should be noted that employer contributions to Section 125 cafeteria plan HSAs, including matching contributions, while not subject to comparability rules, are indeed subject to cafeteria plan nondiscrimination rules.

Even if employee contributions to HSAs are made on an after-tax basis, i.e., not through a Section 125 cafeteria plan, IRS has made clear that such contributions should be counted as an “above-the-line” deduction on the employee’s tax return, making the contributions virtually free of taxes.

Finally, individuals who attain the age of 55 during the taxable year but are not yet enrolled in Medicare may make additional “catch-up” HSA contributions of up to \$900 in 2008. This allowed amount will rise to \$1,000 in 2009.

In any event, all HSA contributions must be reported on Form 8889 for health savings accounts and filed with Form 1040. Distributions from HSAs must also be reported on Form 8889.

It is important to note that distributions from HSAs that are not used for qualified medical expenses are included in gross income for federal income taxes and are subject to a special tax penalty of 10%.

Principle 3: W-2 Reporting

In the esoteric world of W-2 reporting, few areas are more complex than Section 125 cafeteria plans. For example, pretax contributions to dependent care assistance plans must be reported in box 10 of the employee’s Form W-2. Salary-reduction FSA contributions, on the other hand, are not reported on Form W-2.

HSA regulations further muddle this already complicated picture by specifying that employer contributions to HSAs must be reported in box 12 of Form W-2 under code W. After much consternation among payroll professionals, IRS clarified that box 12, code W must “show any employer contribution (including amounts the employee elected to contribute using a Section 125 plan) to an HSA.” In short, all HSA contributions, whether from employer or employee, must be reported on the employee’s Form W-2.

While employers have no responsibility to adjudicate eligibility of employees’ HSA distributions for medical expenses, custodians do report such distributions to IRS—And these are subject to IRS audit.

Principle 4: HSAs Are Not to Be Confused With FSAs

Employers and employees alike struggle with two distinguishing features of FSAs: “use it or lose it” and “uniform coverage.” The former requires participants to forfeit unused year-end FSA balances to their employers.

The latter feature entitles an employee to the full FSA election amount on day one of the plan year, even though payroll deductions must be made over the course of the year to reach the total pledged during open enrollment.

HSAs reflect neither of these FSA characteristics. Participants enjoy an unlimited rollover or carry-forward of unspent HSA funds. Indeed, lawmakers envisioned that some participants could accumulate a nest egg for retiree health costs that Medicare does not cover. (Ironically, employees appear not to understand the rollover benefit, incorrectly assuming that HSAs are subject to a “use-it-or-lose-it” rule, according to Towers Perrin 2007 research.)

On the other side of the equation, absent a uniform coverage rule, employees are entitled only to the funds they have already contributed to their HSAs, plus any earnings—They are fully exposed to the insurance deductible until they have saved enough to meet it.

This explains why many employers choose to “seed” employee HSAs with employer contributions. Such employers must be mindful of the *comparability rules* designed to ensure that employer HSA contributions benefit employees fairly. It’s also permissible for individuals

to “reimburse” for qualified medical expenses from non-HSA sources, taking advantage of the tax preferences for the associated contributions and distributions at a later date—so long as the HSA is established before expenses are incurred.

Principle 5: Portability

Unlike FSAs and most HRAs, HSAs are designed to be portable from one employer to another. With today’s employees changing jobs frequently, the health insurance ties that previously bound employees to their jobs, sometimes called *job lock*, are becoming less important. HSA holders “own” the funds in the accounts, including any employer contributions (which must be in cash) and can transfer their HSAs from job to job.

If a subsequent employer does not offer an HSA-eligible HDHP option, the employee can make no additional HSA contributions but can continue to draw down HSA funds for qualified medical expenses on a tax-free basis.

With cost shifting driving employee out-of-pocket costs ever higher, the HSA portability feature offers a potential additional layer of cushioning to help workers and their families absorb rising insurance costs.

HSAs are even portable after death—IRS rules allow a surviving spouse who is the designated beneficiary to take over the HSA and receive distributions on a tax-free basis for qualified medical expenses.

What’s New? Higher HSA Contributions

Recent legislative action is designed to make HSAs even more attractive. On December 20, 2006, President Bush signed the Tax Relief and Health Care Act of 2006 (TRHCA). Included in this new law were a number of provisions, effective in 2007, that increase the maximum amounts employees may contribute to HSAs in any one year. The president said the new law was designed to “encourage even more people to sign up for HSAs.” The bill raises contribution limits, makes accounts more flexible and allows contributions up to the annual limit, regardless of the insurance plan deductible. It also allows employees to fully fund HSAs no matter what time of year they sign up for the plan.

Two provisions of the new law are significant. First, TRHCA repeals an earlier provision that limited one’s maximum annual HSA contribution to the “lesser of” the insurance deductible or \$5,650 in the case of family coverage/\$2,850 in the case of individual coverage. Therefore, beginning in 2007, the maximum annual HSA contribution is no longer anchored to the insurance deductible. Accordingly, the maximum annual HSA contribution became simply \$5,650 or \$2,850, without regard to the deductible. For 2008, the contribution limits are \$5,800 for family coverage and \$2,900 for individual coverage.

It’s worth noting that IRS guidance (Notice 2004-2) makes clear that the maximum annual contribution can be made monthly or in a lump sum, as long as all HSA contributions are made before April 15 of the following tax year. Specifically, “[C]ontributions can be made in one or more payments, at the convenience of the individual or the employer. . . .”

The second big change is to repeal the previous “1/12 rule,” which tied a specific employee’s actual annual maximum contribution to the number of months the employee was enrolled in an HSA-eligible HDHP. This 1/12 rule provided that for each month that an individual was HSA-eligible by virtue of being enrolled in a qualifying HDHP, he or she could contribute 1/12 of the annual limit. Accordingly, notwithstanding the statutory maximum, for an October 1 enrollee the actual annual maximum HSA contribution was 1/12 times 3 months, or 3/12 the insurance deductible—e.g., \$2,400 times 3/12 or \$600.

The flaw in the 1/12 rule was that total health insurance deductibles are unaffected by the number of months of coverage. The October 1 enrollee has the same \$2,400 insurance deductible as the January 1 enrollee but far less time to build up a sufficient HSA balance to pay it. To alleviate this problem, Congress repealed the 1/12 rule, allowing employees to contribute the entire statutory annual maximum, regardless of the number of months of HSA eligibility.

Effective for 2007 and beyond, those who enroll October 1 in qualifying HDHP family coverage may contribute the statutory maximum, \$5,800 in 2008 for family coverage, in monthly installments or in a lump sum. This change allows employees to make HSA contributions even

for those months when the employee was not enrolled in an HDHP. Congress also mandated that employees remain enrolled in an HSA-qualifying HDHP during the subsequent 12-month “testing period” to make sure the annual HSA contribution corresponds to a 12-month period of HSA eligibility.

Taken together, the TRHCA changes may encourage much higher tax-free HSA contributions—and ultimately tax-free distributions—making the HSA potentially a more powerful engine of systemic change.

Compliance Implications for Employers—2008 and Beyond

The health care “megatrends” previously described, including the earthshaking shifts taking place in the workplace and the relentless escalation of costs, mean that employers and employees may continue to gravitate in the direction of HDHPs. If this happens, it will behoove employees to become more proactive and assume greater decision-making responsibility. Federal and state governments will no doubt play an important role in the changing landscape, especially as they act to extend health coverage to

more of the uninsured via HDHPs. Indeed, most states have aligned their tax policies with federal tax treatment of HSA contributions and distributions.

As more employers offer HSAs as an option or substitute for more traditional coverage, attention will focus on consumer-driven health care and especially on Web-based decision support tools to help families evaluate care options, providers and costs.

Effective communications—between employers and workers, between management and payroll compliance, between IRS and payroll and benefits pro-

fessionals—as well as trust building, will be key factors in determining the success of HSAs and consumer-driven health care over the next five years.

Additional Resources

“HSA Road Rules,” *HSA Insider* (A Division of Canopy Financial), January 2007.

IRS Publication 969—*Health Savings Accounts and Other Tax-Favored Health Plans*.

IRS Web site: www.ustreas.gov/offices/public-affairs/hsa.

Keller, Christine L. and Christopher E. Condeluci, “Tax Relief and Health Care Act Should Prompt Re-examination of HSAs,” *Legal Report*, Society for Human Resource Management, July-August 2007.



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