The Impact of Health Reform on HSAs

by Whitney R. Johnson

The health care reform law contains only two direct changes to health savings accounts (HSAs): eliminating the ability to use the HSA for over-the-counter drugs and increasing the early withdrawal penalty from 10% to 20%. The indirect changes, however, could drastically curtail the growth of HSAs or even result in the end of HSAs. The actual impact is uncertain at this time because much of the detail of the law is left to regulatory interpretation. This article identifies and analyzes seven areas in the new law that could indirectly impact HSAs.

The new health care law will profoundly change our health care system by insuring 30 million previously uninsured Americans, by requiring individuals and some businesses to buy health insurance, and by providing subsidies to lower income Americans and small businesses. The Patient Protection and Affordable Care Act (PPACA)[1] also significantly revises Medicaid and Medicare and puts the federal government, rather than the states, in charge of health insurance. With all this change, what happens to health savings accounts (HSAs)? This article discusses the future of HSAs in the context of PPACA.

BACKGROUND

Some background on the law and the political context will aid in understanding the potential issues that could impact the future of HSAs.

Law Not Focused on HSAs

PPACA includes the acronym HSA only six times in the entire law. The law is not about HSAs, and Congress did not significantly consider HSAs in drafting it. At first glance, supporters of HSAs are likely to view this positively. Congress was unlikely to expand HSAs, and at least the new law does not significantly restrict or directly eliminate their use. The details of the new law, however, pose challenges to HSAs.

Different Approach to Health Care

From a broad perspective, PPACA takes a different approach to health insurance than the consumer-directed health care movement that includes HSAs. PPACA mandates insurance coverage and provides very specific levels of detail on what health coverage must include with an emphasis on making sure essential care and preventive services are covered.

The philosophy behind the consumer-directed movement with high-deductible health plans (HDHPs) is that individuals should take charge of health care dollars and pay for most routine, low-cost care and day-to-day medical procedures. Insurance should be reserved for large or even catastrophic medical payments.

These two different approaches to health insurance and health care result in a number of potential conflicts for regulators in meshing the new law with the law for HDHPs and HSAs. This article reviews those potential conflicts.

Law Is Controversial

Congress passed PPACA amidst controversy. The

Senate passed the bill on December 24, 2009, with no votes to spare as 60 Democrats voted for the bill and 39 Republicans against. The Senate anticipated returning from holiday break to start conference committee work with the House. The conference committee work never happened. Massachusetts elected Scott Brown to the Senate partly on his campaign against the health care bill, and the administration feared it would lose a vote on a conference committee bill.

In an effort to try to gain bipartisan support for the bill, President Obama held a Health Care Summit in February 2010. At the summit, Senator Barrasso of Wyoming asked a key question for this article on how HSAs fit into the new legislation with an underlying concern that the legislation kills HSAs. The president responded in an official letter to Congress shortly after the summit:

> I know many Republicans believe that HSAs, when used in conjunction with high-deductible health plans, are a good vehicle to encourage more cost-consciousness in consumers' use of health care services. I believe that high-deductible health plans could be offered in the exchange under my proposal, and I'm open to including language to ensure that is clear. This could help to encourage more people to take advantage of HSAs.[2]

The president's response is instructive because it recognizes some doubt over the future of HSAs in the Senate bill and it also expresses the president's willingness to clarify that HSAs survive. The president's expression of support for HDHPs and HSAs is also important because Congress never revised the bill to include the language making it "clear" that HDHPs and HSAs survive. Instead, the administration decided to pursue the successful strategy of the House passing the Senate bill and then allowing limited fixes through a reconciliation process.

Language clarifying that HDHPs and HSAs survive would have been very welcome for HSA supporters because Congress left much of the detail of the new law to the regulatory agencies. With conscious effort, the regulators can draft rules that allow for HDHPs and HSAs to survive and possibly thrive under the new law. Alternatively, regulatory rulings could mark the end of HSAs. This could happen with a conscious and open decision that HDHPs and HSAs are not the right choice for health care in America and do not fit within the parameters of PPACA, or more likely with a detailed regulatory rulemaking process that on its surface has nothing to do with HSAs.

The political controversy is also relevant to the legislation because the law could change. The key provisions in PPACA do not apply until 2014, and that provides time for changes. Although some legislators are advocating outright repeal of the entire law, that is difficult and unlikely. More likely, Congress will make changes. Already, both parties are supporting a change to some of the business-reporting requirements contained in the law and both the House and the Senate have passed bills doing so. This endeavor is likely just the beginning of a series of changes to the law.

No Change for Existing HSA Balances

Other than the changes that directly impact HSAs, discussed below, PPACA provisions threaten the future of HSAs from the standpoint of individuals continuing to be eligible for them. Any money already contributed to HSAs will continue to follow the same rules and enjoy the same benefits of tax-free withdrawal for eligible medical expenses. There is no threat to the existing HSA owners and existing balances—the HSA laws remain virtually unchanged as this article discusses. Given any uncertainty over future eligibility, now may be a good time for existing HSA owners to maximize their HSA contributions to build as large a balance as possible.

Eligibility for an HSA requires coverage under an HDHP plan, and the areas for concern in PPACA revolve around the future of HDHPs. If HDHPs are not qualified health plans under PPACA, insurance companies will stop offering HDHPs. If HDHPs are otherwise less popular, Americans will change their HDHPs back to traditional insurance and lose HSA eligibility. Eligibility for an HSA, however, impacts only the ability to contribute new money into an HSA. HSA owners who change insurance and are no longer eligible for an HSA may continue to use their existing HSA balance tax-free for medical expenses or save it for retirement.

DIRECT IMPACT ON HSAs

The only two direct changes to HSAs are the elimination of over-the-counter drugs as an eligible medical expense and the increase in the penalty for nonmedical distributions from 10% to 20% (see Table I).

No Over-the-Counter Drugs

Over-the-counter drugs are no longer eligible medical expenses as of January 1, 2011. This is a large tax increase for active HSA owners who purchase over-the-counter drugs. The Congressional Budget Office projects that Americans will pay $400 million

TABLE I

DIRECT IMPACT TO HSAs

New Law (Year Effective)	Impact to HSAs
No over-the-counter (OTC) drugs (2011)	HSA owners will no longer be allowed to use their HSA tax- and penalty-free for OTC medicines. Nondrug OTC items will still be allowed. HSA owners could get a prescription for an OTC drug making it eligible as well.
Increased penalty for noneligible withdrawals to 20% (2011)	The 10% penalty tax for early withdrawals for noneligible medical expenses increased to 20% as of January 1, 2011.

more in taxes in 2011 based on this change (for both HSAs and flexible spending accounts (FSAs)) and $5 billion from 2011 to 2019.[3]

The new law applies only to over-the-counter medicines/drugs. Examples include allergy remedies, cold medicines, laxatives, motion sickness medicines, aspirin, stomachache medicines, rash ointments and diarrhea remedies. The law contains an exception for insulin; HSA owners can continue to use their HSA to purchase insulin without a prescription. The law does not apply to nondrug over-the-counter items such as bandages or blood pressure monitors. The Internal Revenue Service (IRS) will likely issue additional guidance on the definition of *over-the-counter drug*.

The law also allows doctors to prescribe over-the-counter medicines, making the over-the-counter drug eligible for tax-free purchase from the HSA. Some commentators are suggesting that this may increase health care costs as individuals seek medical prescriptions for items they previously would have purchased without visiting a doctor.

Increased Penalty

The 10% penalty tax for early withdrawals for noneligible medical expenses increased to 20% as of January 1, 2011. This is expected to raise less than $50 million in 2011 and $1.4 billion over the 2011-2019 period.[4] The existing exceptions to the penalty will continue: distributions for an eligible medical expense, distributions after the age of 65, distributions due to disability and distributions due to death. Uncharacteristic of PPACA, this change is straightforward without need for additional guidance or explanation from IRS or Health and Human Services (HHS).

POTENTIAL IMPACT TO HSAs

The key to the future of HSAs lies in the interpretations of seven items in PPACA. In Table II, each of these items is analyzed and rated in terms of its possible impact on the viability of HSAs.

Preventive Care Services— Moderate Risk to HSAs (2010-2011)

PPACA requires that a group or individual health plan offer preventive care services without cost sharing. The obvious goal of requiring insurance companies to offer preventive care without cost sharing is to encourage Americans to seek preventive care and potentially avoid more expensive care in the future. Preventive care is a common theme in PPACA, and a qualified health plan must offer preventive care as to:

- **Evidence-based preventive care.** The law creates a new U.S. Preventive Care Task Force that will rank all preventive care services. Those receiving a rating of an A or B must be included in coverage at zero cost sharing.
- **Immunizations.** Immunizations that have "in effect" a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention must be included at zero cost sharing.
- **Infant/youth care.** Evidence-informed care provided for in comprehensive guidelines from the Health Resources and Services Administration must be covered for infants and youth.
- **Women care.** Additional screenings and care as provided for by the Health Resources and Services Administration must be covered for women.

The four categories above require definitions from three different regulatory committees. A 47-

TABLE II

INDIRECT IMPACT TO HSAs

New Law (Year Effective)	Impact to HSAs
Preventive care services (plan years starting on or after Sept. 23, 2010)	Definition of *preventive care* for new law must match definition for high-deductible health plans (HDHPs). Definitions are likely to match but will increase cost of some HDHPs.
Medical loss ratio (MLR) (2011)	HDHPs likely have lower MLRs and are at risk of being canceled by insurance companies.
Essential benefits (2014)	HDHPs must offer "essential benefits." This will likely expand the medical services offered by some HDHPs and increase premiums.
Maximum deductibles for small groups (2014)	Small groups that want HSAs must select lower deductible HDHPs than currently allowed—no more than $4,000 for families and $2,000 for individuals. This change will decrease HDHP choice and increase premiums. The change may result in groups opting for flexible spending accounts (FSAs) instead of HSAs.
Insurance exchanges and actuarial value (2014)	HDHPs must meet actuarial value requirements for inclusion on exchanges. HDHPs should meet the actuarial requirements, but it is an area to watch.
Maximum out-of-pocket expenses (2014)	Law requires all insurance plans to meet HDHP maximum out-of-pocket expenses. This change should increase the number of people eligible for HSAs.
Cadillac tax (2018)	Impacts HSAs uniquely because HSA contributions (employer and payroll deferral) count toward the Cadillac tax cap. After the cap is reached, a 40% tax applies.

page joint release from IRS, HHS and the Department of Labor covers "interim final" rules regarding the definition of *preventive care* under PPACA.[5] What constitutes *preventive care* is a much more complicated question under PPACA than under HDHP law.

The definition of *preventive care* is crucial to both PPACA and the law that created HSAs, the Medicare Prescription Drug, Improvement, and Modernization Act. The key to the survival of HSAs is that the definitions match. If *preventive care* under PPACA expands to include items that are not allowed under HDHP rules, then HDHPs will no longer be considered health plans under PPACA. If that happens, presumably insurance companies will stop offering HDHPs in order to comply with PPACA.

The HDHP law provides that "[a] plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventative care . . . except as otherwise provided for by the Secretary."[6] This definition allows for periodic health evaluations, routine prenatal and well-child care, immunizations, tobacco-cessation programs, obesity programs and screening services, but does not include services to treat an illness. This definition is substantially simpler than the PPACA definition.

The references to the laws above illustrate the dif-

ferent approaches. Fortunately, both laws put preventive care in a special category, with PPACA requiring preventive care services at zero cost sharing and the HDHP law allowing for preventive care services without cost sharing. Also, both laws place the details of the definition within the regulatory scope of the secretary of HHS. These two points should give comfort to supporters of HSAs. Nevertheless, the two different approaches to preventive care and the potential for the definitions to diverge make this an area to watch.

For supporters of consumer-directed health care and HSAs, the forthcoming regulations—as well as market reaction—will be critical to the future of HSAs and whether the 30 million new Americans who are expected to buy insurance will buy HSA-eligible plans or not. ◄

Medical Loss Ratio Requirements—High Risk to HSAs (2011)

PPACA requires that health plans maintain a medical loss ratio (MLR) of 85% for large-group plans and 80% for small-group or individual plans. An MLR is calculated by determining the amount of insurance premiums that are used toward qualifying medical expenses. For example, if an insurance plan spends 80¢ out of $1 of insurance premium on medical expenses, the plan has an MLR of 80%. This rule will prevent insurance companies from making excessive profits from health insurance, but also creates administrative and policy questions.

Failure to maintain the MLR of 80% or 85% results in a mandatory refund to the premium payers of the amount exceeding the permitted MLR. An insurance company with an MLR of 80% in the *large-group market* (100 employees or more) must rebate 5% of the premiums back to enrolled participants because the plan failed to meet the required 85% MLR. An Oppenheimer & Company statistic calculated that the six largest for-profit insurers would have had to refund $1.9 billion to enrollees if the MLR law had been in effect in 2009.[7]

Although refunds may have been required in 2009, Congress must have used current MLR data to select its ratios. According to a Senate staff report, the average MLR ratio in 2009 was 81.2% in the small-group market and 85.1% in the large-group market.[8] However, those numbers represent an industry aggregate; individual companies' MLRs vary widely.

Using historic MLR data is also troublesome for making projections because PPACA's definition of *MLR* will differ from past calculations. WellPoint, a large health insurance company, reclassified $500 million of administrative expenses into medical expenses based on the MLR in PPACA for 2010.[9] WellPoint reclassified a nurse hotline, clinical health studies and wellness programs prior to any government regulations clarifying that such reclassification would be correct under the new definition. HHS subsequently confirmed WellPoint's reclassification when it released regulations on MLRs on November 22, 2010.[10] The HHS regulations were adopted from recommendations by the National Association of Insurance Commissioners (NAIC). The NAIC cover letter accompanying its recommendations demonstrated an ongoing concern with "unintended consequences arising from the medical loss ratio" and stated that "consumers will not benefit from higher medical loss ratios if the outcome is destabilized insurance markets where consumer choice is limited and the solvency of insurers is undermined."[11]

NAIC's concern regarding the solvency of insurers is especially relevant to HDHP providers and, accordingly, HSAs. Although good data are hard to find, HDHPs are likely to have lower MLRs than traditional health insurance. UnitedHealth Group's Golden Rule Insurance subsidiary provides an anecdotal example. Golden Rule focuses on HSAs and was an early pioneer in the area. Golden Rule's 2009 MLR is only 63%, according to the Oppenheimer report.[12] The first reporting requirement using the new regulatory definition of MLR will be in 2012 for 2011 so we will not know for some time how the MLR rules impact various types of insurance, but there is reason for concern for HDHPs. HDHPs require that individuals pay most of the cost up to a high-deductible amount, thus reducing cost sharing and the MLR. Serious medical issues drive much of health care spending, but at the margin individual cost sharing and high deductibles will impact the MLR nega-

tively for HDHPs. Traditional health insurance has an element of prepaid health services built in that increases the MLR.

HDHPs have also been successful in the individual and small-group markets because HDHPs and HSAs generally represent the most affordable health insurance option. The individual and small-group markets have higher marketing and other administrative costs as there is less ability to spread the cost over a larger pool. Maine's recent request for an exemption from the MLR rules supports this point. PPACA grants the secretary of HHS the power to reduce the MLRs if enforcing them would "destabilize the existing individual market in such State."

Maine's superintendent of insurance requested an exemption to reduce the MLR to 65% and cited that the 80% guideline will drive out of her state one of the only two remaining insurance companies offering individual policies.[13] The company Maine is worried about losing provides high-deductible catastrophic insurance policies, "which by their nature have lower claims costs, relative to expenses, than more comprehensive products."[14]

The risk to HSAs from the MLR rules is that insurance companies stop offering HDHPs. If HDHPs cannot meet the MLRs, insurance companies will not continue to offer HDHPs. An early example of this could be nHealth, a Virginia-based insurance company. nHealth sold HDHPs and HSAs and was devoted to consumer-directed health care. In July 2010, nHealth announced it would terminate all of its plans effective December 31, 2010 and is now in the process of winding down its business.[15] In a letter to brokers about its demise, it specifically cited higher MLRs as a reason to pull out of the insurance market (nHealth also cited general uncertainty caused by PPACA and higher capital requirements). nHealth lost money in 2008 through the first quarter of 2010, so health reform may not be the sole or even the primary reason for its termination, but it is the stated reason.

Another early example, American National Insurance Company, announced on June 20, 2010 that it would no longer sell individual coverage through two of its subsidiaries: American National Life Insurance Company of Texas and Standard Life and Accident Insurance Company.[16] Most of the products sold by the subsidiaries were HDHPs.

The importance of the MLR rules and the early implementation starting in 2011 will put MLR discussions in the forefront of health reform. Although the 71 pages of regulations provide much-needed detail on the MLR requirements, the ultimate test of whether HDHP plans survive the MLR requirements will be what happens in the marketplace. With insurance companies required to report data on MLR requirements for 2011, how HDHPs and HSAs perform under the MLR rules will soon be better understood.

Essential Benefits—Low Risk to HSAs (2014)

PPACA requires that a qualified health plan offer *essential benefits*. Although the law provides some examples of these benefits, including ambulatory services, emergency services and hospitalization, future regulations will provide the details.

The concern for HSAs with essential benefits is again definitional. *HDHPs* are also defined by statute and will need to meet PPACA's *qualified health plan* definition in order to survive. If the regulatory agencies include an essential benefit that is not compatible with the definition of an HDHP, then new contributions to HSAs will not continue. HDHPs are allowed to include most types of coverage, so this change is not likely to directly threaten HDHPs and HSAs.

The change will likely require individual HDHPs to expand coverage beyond current offerings. This expansion may cause premium increases and reduce the desirability of the HDHP and HSA option.

Maximum Deductibles—Low Risk to HSAs (2014)

PPACA imposes maximum deductibles for the small-group markets of $2,000 for individuals and $4,000 for families. These deductibles are within the

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current limits for HDHPs of $1,200 minimum deductible for single coverage and $2,400 for family. The change, however, will require groups that currently offer higher deductible plans to lower their deductibles. Lowering deductibles increases premiums and makes the HDHP and HSA combination less attractive. This change fits within the overall impact of PPACA in narrowing the options available as *health care* is defined more exactly by the government.

The law allows the deductible thresholds to increase by the amount available under an employer-funded FSA. An employer that puts $1,000 into an FSA of an employee could increase the deductible by $1,000. The same logic should allow for a credit for employer HSA contributions as well, but the law does not include that. This anomaly could encourage employers to offer HDHPs in combination with an FSA instead of an HSA.

Minimum Actuarial Value and Insurance Exchanges—Moderate Risk to HSAs (2014)

PPACA creates new American health benefit exchanges. The issue for HSAs is that HDHPs be included in the exchanges. This is the issue that President Obama stated he was open to making clear: that they could be included in the exchanges.

Whether HDHPs can be included hinges on many of the other issues already discussed as the plans in the exchanges must offer essential benefits, provide preventive care, meet the maximum out-of-pocket costs and abide by other requirements of PPACA.

A new requirement for the exchanges is that health insurance must meet one of five levels: bronze, silver, gold, platinum or catastrophic. The bronze level, the easiest to meet other than catastrophic, must provide an actuarial value of at least 60%. The actuarial value is another tool to ensure that the health plan meets certain minimum requirements established by PPACA. What the bronze level requires is that the plan must pay at least 60% of the expenses of an identical plan with zero cost sharing (i.e., no deductibles, no copays, basically no cost to the insured other than the premium). This rule will require more data and guidance to fully understand but it could be difficult for HDHPs to meet. HDHPs, because of the high deductible, do not pay as much for medical coverage. This issue follows a similar discussion to the MLR and should be placed into a category to watch to ensure that HDHPs can meet the requirements.

The law creates a special category for catastrophic care that provides the most lenient rules for allowance on the exchange. The catastrophic category applies only to individual plans and only for individuals under the age of 30 or meeting other limited exceptions for hardship. Whether these catastrophic plans will be HDHPs is uncertain but seems likely, and this could be a limited growth area for HSAs.

Maximum Out-of-Pocket Expense—Positive for HSAs (2014)

The new law requires qualified health insurance plans to have maximum out-of-pocket expenses that match the current inflation-adjusted HDHP maximum out-of-pocket expenses ($5,950 for single coverage in 2010 and $11,900 for families).

This change is mentioned not as a risk but as a potential benefit for HSAs. Congress's use of the HDHP limits consciously acknowledged HSA laws and will help expand eligibility for HSAs.

Prior to PPACA, insurance companies offered catastrophic plans that failed to meet the definition of an *HDHP* because the plans allowed for total out-of-pocket costs that exceeded the limit for HDHPs. Although individuals selecting these plans faced large deductibles, they were not eligible for an HSA. High out-of-pocket limits can be attractive to both lower income Americans trying to save money on premiums and higher income Americans who can afford a potentially large deductible. New plans will have to comply with the HDHP maximum out-of-pocket costs, potentially increasing the number of Americans eligible for HSAs.

Cadillac Tax—Low Risk to HSAs (2018)

The new law places a tax called the *Cadillac tax* on *high-cost health plans*, defined as those costing more than $10,200 for individuals and more than $27,500 for families. At first glance, this appears to cause no issues for HDHPs and HSAs, as HSA plans are generally less expensive plans. However, both employer and employee payroll-deferral HSA contributions count toward the Cadillac tax cap.

The Cadillac tax does not apply until 2018, but using 2011 HSA contribution limits illustrates how this tax could impact HSAs. An employee who makes a $3,050 HSA contribution through payroll deferral (single HSA limit for 2011 that will increase by 2018) would have only $7,150 left for insurance premiums without facing the Cadillac tax ($3,050 + $7,150 = $10,200 the Cadillac tax limit). Although $7,150 for a single HDHP policy is high, most Americans are not likely to think that a cost at this level could trigger the Cadillac tax. According to IRS, the average employee-only coverage cost is $4,903, so a $7,150 premium is 46% higher.[17]

The inflation adjustment for the Cadillac tax, how-

ever, makes this issue more important. The Cadillac tax limits are adjusted using the Consumer Price Index (CPI) plus 1% for 2019 and after that the straight CPI. Medical inflation has outpaced the CPI in every year since 1973 when oil prices disrupted the CPI.

The use of the CPI for the Cadillac tax will likely lead to the tax applying to more plans than expected. The Joint Economic Committee's Minority Staff Report Study predicts that in just eight years after the Cadillac provisions take effect, the average-priced insurance policy will be subject to the Cadillac tax.[18] If that projection is true, this provision will draw comparisons to the alternative minimum tax. The inflation issue combined with the fact that employer HSA contributions, including payroll deferral, count toward the total cap, make this an issue to watch for HSA supporters.

CONCLUSION

HDHPs and HSAs have fostered a consumer-driven health care alternative in America that is not reflected in PPACA. The act does make some relatively minor direct changes to HSAs, but the potentially significant changes will be indirect and uncertain. For supporters of consumer-directed health care and HSAs, the forthcoming regulations—as well as market reaction—will be critical to the future of HSAs and whether the 30 million new Americans who are expected to buy insurance will buy HSA-eligible plans or not. ◀

Endnotes

1. The Patient Protection and Affordable Care Act passed on March 23, 2010 (Pub. Law No 111-148), and the corresponding Health Care and Education Reconciliation Act passed on March 30, 2010 (Pub. Law No 111-152).
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3. Joint Committee on Taxation, JXC-16-10, March 18, 2010.
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17. IRS Rev. Rul. 2010-13.
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