



# issue brief

## Health Savings Accounts: Issues and Implementation Decisions for States

by Mila Kofman, J.D.

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In 2003, the U.S. Congress enacted legislation to allow people to establish health savings accounts (HSAs) to work with qualifying high-deductible health coverage to help people finance medical expenses.<sup>1</sup> Beginning January 1, 2004, individuals or employers can make contributions to these accounts.

Federal policymakers have expressed a strong interest in making HSAs successful. However, because the accounts are new, it is too early to assess with certainty what impact they will have on people's ability to finance and access medical care, or on the health care system generally.

Although HSAs were legislated through a federal initiative, the availability of qualifying high-deductible health coverage depends partly on states. As the primary regulators of health insurance, states can choose whether to allow insurance companies to sell high-deductible policies.<sup>2</sup> This issue brief covers the key issues that state officials need to know about HSAs—including what they are, how they compare to other types of tax-preferred accounts, and what public policy implications and implementation issues need to be considered.

### Tax Benefits, Eligibility, and Use of Funds

HSAs are tax-free accounts that can be set up by individuals or employers; they are personal accounts that are owned by individuals, even when employers establish and contribute to them. Interest earned is not taxed, and funds that are not used may carry over to the following year. (See Table 1 on p. 2 for a summary of HSA terms and provisions.)

When individuals make contributions, they may deduct up to a statutory maximum of \$2,600 from federal taxes (up to \$5,150 for families), regardless of whether they itemize; this is called an "above-the-line" deduction. The amount allowed for the deduction is the lesser of the statutory maximum or the amount of the deductible of the qualifying high-deductible health plan (HDHP) indexed for inflation. People aged 55 and older may contribute more.

HSAs are required to be established in conjunction with HDHPs. A health plan qualifies as an HDHP if it has an annual deductible of at least \$1,000 (\$2,000 for families) and annual out-of-pocket expenses—including deductibles, co-payments, and coinsurance—that do not exceed \$5,000 (\$10,000 for family coverage).<sup>3</sup> Recent Internal Revenue Service (IRS) guid-



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ance allows for certain out-of-pocket expenses not to count toward the \$5,000 maximum limit for individual coverage (\$10,000 limit for family). For example, a plan may choose not to count any payments to a provider for which a person is responsible but that exceed “usual, customary, and reasonable” amounts.<sup>4</sup> Network plans can have higher out-of-pocket limits for out-of-network services.<sup>5</sup>

There is an exception to the requirement for an annual deductible: for preventive care. HDHPs can cover services such as physicals, immunizations, screenings, prenatal care, and tobacco-cessation programs without imposing any deductible.<sup>6</sup> In recent guidance, the IRS clarified that paying for a treatment that is incidental or ancillary to a preventive care service, such as removing polyps during a diagnostic colonoscopy, is also allowed. Furthermore, preventive care includes medication taken to prevent a disease or a reoccurrence of a disease—for example, taking cholesterol-lowering medications to prevent heart disease.<sup>7</sup>

For HDHPs that provide prescription drug benefits that are not subject to an annual deductible, the IRS has issued a transitional rule: If such coverage is either a rider or a separate plan (not the HDHP), it will still be considered a qualifying HDHP until 2006.<sup>8</sup> Otherwise, the IRS will not consider an HDHP covering prescription drugs at a low deductible or no deductible to qualify for an HSA.

People who have other health insurance would not qualify for an HSA, although policies for injury/accident, disability, vision, dental, and long-term care are allowed. Those enrolled in Medicare also do not qualify; nor do individuals who can be claimed as a dependent on another’s tax return.<sup>9</sup>

Funds in an HSA can be used to pay for an annual deductible, as long as it applies to IRS-determined qualified medical expenses, including prescription drugs, medical care and services (including mental health), and diagnostic devices.<sup>10</sup> In addition, Medicare beneficiaries who open an HSA prior to

enrollment in the program can finance medical expenses not covered by other insurance with their HSA funds. The accounts can also be used to pay for premiums for qualified long-term care insurance or for COBRA or other health insurance used during periods of unemployment. However, the funds cannot be used to pay Medigap premiums.<sup>11</sup>

If HSA funds are used for other purposes, then the distributed amount would be included in a person’s income and would be subject to a 10 percent penalty. The penalty does not apply to the heirs of a person with an HSA if he or she dies, becomes disabled, or becomes Medicare-eligible; if such individuals use the HSA for non-medical expenses, the funds used would be taxed as income but the 10 percent penalty would not apply.<sup>12</sup>

Some researchers estimate that individuals and families who now contribute to an individual retirement account (IRA)—a group that tends to be at the higher end of the income scale—are also likely to establish an

**Table 1: HSA Summary**

<b>Tax Benefit and Limits on Deductions</b>	<p>Amount contributed is not taxed and interest earned is not taxed.</p> <p>Contributions to an HSA can be deducted from one’s income even when a person does not itemize (“above-the-line” deduction).</p> <p>Individual deductions are up to \$2,600; family deduction is up to \$5,150.</p>
<b>Eligibility</b>	<p>HSAs are available to any individual covered under a high-deductible health plan (HDHP) who is not simultaneously covered by other health insurance or is on Medicare.</p>
<b>Who Can Contribute</b>	<p>Employers, employees, self-employed, and people with non-job-based health insurance can contribute.</p>
<b>High-Deductible Health Plan</b>	<p>Individual health insurance and job-based health coverage (both self-insured and fully insured) can qualify.</p> <p>The criteria for a qualifying HDHP are: an annual deductible of at least \$1,000 for individual coverage and at least \$2,000 for family coverage (except for preventive care allowed without deductible); annual out-of-pocket costs not to exceed \$5,000 for individuals and \$10,000 for families.</p>
<b>Qualified Medical Expenses &amp; Other Expenses</b>	<p>HSA pays for qualified medical expenses.</p> <p>This account can also be used to pay COBRA premium and health coverage premium while unemployed, qualified long-term care insurance premium, and Medicare-related expenses (except for Medigap premium).</p>

HSA. Those who earn more than \$160,000 annually have the highest IRA participation rate (17 percent); 2.4 percent of wage earners below \$20,000 have an IRA.<sup>13</sup>

### HSAs vs. Other Tax-Preferred Accounts

There are key differences among health savings accounts (HSAs), medical savings accounts (MSAs, also known as Archer Medical Savings Accounts), flexible spending accounts (FSAs), and health reimbursement arrangements (HRAs) with regard to eligibility rules, the tax benefit, and the type of health coverage that can be used to coordinate with the account. (See Table 2 on p. 5.)

Although similar to MSAs, HSAs are not as restrictive, have broader eligibility rules, provide a bigger tax break, and allow for an annual deductible that is lower than that for MSA-qualified policies. Some believe that these enhanced features will make HSAs more attractive to people and that they are a response to the relatively low impact that MSAs have had on the market, with few employers and self-employed people choosing MSAs and MSA-qualified high-deductible coverage.<sup>14</sup>

### Implications for State Policymakers

States' decisions about whether to promote high-deductible health insurance may affect the type and price of coverage that is available in their markets. For example, encouraging people to buy high-deductible coverage further shifts the cost of health care from employers and health plans to individuals. With more of their own dollars at stake, consumers may make more cost-efficient choices regarding their health care services. On the other hand, cost shifting might also result in people not getting or delaying necessary care—which could ultimately increase health care costs for employers and health insurers if people develop more serious conditions as a result of postponing services, and could perhaps increase costs for states if people turn to state safety net programs.<sup>15</sup>

Policymakers should also consider the possibility that HSAs could contribute to risk segmentation in the private market. According to employer benefits consultants and researchers, when individuals are given a choice between low-cost, high-deductible coverage and more costly comprehensive health insurance, healthy people tend to choose high-deductible coverage. Thus, if HSAs become more widely

available, fewer healthy people may remain covered under traditional insurance, and premiums could rise as a result of adverse selection. State policymakers may want to look for ways to ensure that comprehensive coverage stays affordable, whether through employer subsidies or other interventions.<sup>16</sup>

The impact of HSAs on state budgets is another factor that policymakers should take into account. Due to the tax break, HSAs are projected to cost the federal government approximately \$7 billion in lost revenue over 10 years. If states link their taxes to income determinations based on federal tax calculations, they will lose revenue as well. One way for states to address this is to require people who take the HSA deduction on their federal return to add it back when calculating their income on the state return. On the other hand, should states seek to encourage HSAs, for states that do not rely on federal calculations for their income determinations, legislators may wish to enact state HSAs to give people the maximum federal and state tax advantage.

### Implementation Decisions for States

If state officials decide to make HSAs available to their residents, they must first explore whether legislative or regulatory action is needed to authorize the sale of HSA-qualified HDHPs. Although high-deductible policies are already sold by some insurers (especially in conjunction with MSAs), federal standards for MSA-qualified policies differ from HSA-qualified ones, which may have lower annual deductibles. In addition, HSA-qualified HDHPs must limit out-of-pocket expenses to \$5,000 for individual coverage and \$10,000 for families—something that policies already on the market may not do.

Although policies with high deductibles are currently sold in the individual market, these are not as prevalent in the group market. Insurers may need to seek approval from state insurance regulators to sell group high-deductible plans. Depending on the state, legislators might have to amend their laws to allow the sale of HSA-qualified HDHPs, or insurance regulators may need to approve them for sale.

Another practical issue for policymakers to consider is whether state law allows HMOs to offer coverage with high deductibles. Some states require HMOs to offer “reason-

able” deductibles, and it is uncertain whether HSA-qualified HDHPs will be considered to have “reasonable” deductibles. State legislatures will have to examine such provisions if they wish to encourage HMOs to offer high-deductible coverage.

In addition, states require insurers to cover certain services regardless of whether an annual deductible has been met. An HSA-qualified HDHP must apply a deductible for all services except those deemed “preventive.” In general, preventive care does not include any treatment for existing conditions. Moreover, the IRS has stated that it will not defer to states to determine which services can be considered preventive. In some states, such as those that require plans to provide coverage without an annual deductible for mental health, hospice care, or problems identified through screening tests, the state-mandated coverage requirements may not meet the federal requirement regarding preventive care.

Seeking to address this, the IRS recently issued transitional relief, which applies until the end of 2005. If a state law was in effect on January 1, 2004, and requires certain non-preventive benefits to be covered without a deductible, then plans that would otherwise qualify as HDHPs are not excluded from qualifying because of the state requirement.<sup>17</sup> Because the transitional relief is temporary, state decision makers who seek to encourage HDHPs need to be sure that their health insurance standards comport with those included in federal law.

### HSAs and State Programs

In their role as employers, states face the same issues that private companies do. Because HSAs are new, there are many unanswered questions about employers' responsibility in establishing them and the interaction between HSAs and other employer-offered accounts (e.g., FSAs and HRAs). States and private employers will need to weigh these issues.

States must make the additional decision of whether to add HSA-qualified coverage to state programs such as high-risk pools and public-private initiatives designed to offer health insurance to small businesses.<sup>18</sup> There is no exclusion in the tax code for high-risk pool coverage and recently the IRS expressly stated that such coverage can qualify as an

**Table 2: Comparison of Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs)**

	HSAs	MSAs*	FSAs	HRAs
<b>Health plan type</b>	High-deductible only	High-deductible only	High-deductible and comprehensive	High-deductible and comprehensive
<b>Carry over from year to year?</b>	Yes	Yes	No	Yes
<b>Individual owns account (keep even after leaving job)?</b>	Yes	Yes	No	No (up to employer if individual allowed access to HRA after employee leaves)
<b>Type of coverage?</b>	Individual and job-based health coverage	Small business or self-employed health coverage only	Job-based only	Job-based only
<b>Who contributes?</b>	Individuals, employees, and employers	Employee, self-employed person, or small business employer (50 or less employees) – both employee and employer cannot contribute in a tax year	Employee	Employer
<b>How is it taxed?</b>	“Above-the-line” deduction (employer contribution not taxed as income)	“Above-the-line” deduction (employer contribution not taxed as income)	Not taxed as income	Not taxed as income

\*No new MSAs (Archer MSAs) allowed after December 31, 2003.

HDHP.<sup>19</sup> The IRS further clarified that states may even contribute to an HSA in conjunction with coverage through a high-risk pool.<sup>20</sup> Thus, high-risk pool coverage could likely be used in conjunction with an HSA if it meets the IRS’s criteria for an HDHP.

High-risk pools vary from state to state. Many states offer high-deductible coverage through their pools that may not qualify for HSAs, in part because they include prescription drug benefits that have no deductible or a low deductible or have maximum out-of-pocket expense limits that are higher than what is allowed under federal law. Thus, in order for HSAs to work with high-risk pools, state legislatures or the boards of directors of the pools may need to implement changes. Some states, including Maryland, have already begun this process.<sup>21</sup>

### Can HSAs Expand Coverage or Lower Costs?

Whether HSAs can expand coverage or lower health care costs is a matter of debate. HSA supporters and detractors generally agree that HSAs will shift the cost burden for health care decisions onto consumers. However, they see the implications of this differently. As discussed earlier, champions of HSAs believe that the accounts would help contain costs by creating a financial incentive for people to avoid over-utilizing services. In addition, the accounts allow individuals to carry over unused funds to the following year—which will enable people to save their money for when they most need it.<sup>22</sup>

Conversely, opponents fear that cost-shifting may result in less care or delays in care that would ultimately increase medical expendi-

tures. In addition, they say that HSAs fail to address many important reasons for escalating health care premiums, including provider costs.<sup>23</sup> The accounts also do not remedy the fact that a minority of people—typically the elderly and individuals with chronic conditions—account for the vast majority of health care costs. Without any mechanism for meeting the specific needs of the chronically ill, critics say, elevated medical expenditures will remain a substantial issue.

Proponents of the accounts contend that HSAs will reduce the inequity that exists because the federal government subsidizes job-based health insurance more than coverage in the individual market. The federal government currently provides more than \$100 billion annually in tax subsidies for job-based health insurance, compared with \$7 billion annually for individual



health insurance purchased by self-employed people.<sup>24</sup> Moreover, the subsidies for individual coverage are not available to certain groups, such as workers whose employers do not offer health insurance benefits. HSAs will allow some individuals who lack job-based insurance to receive a tax break.

On the other hand, opponents of the legislation point out that HSAs will not be available to all people without employer-sponsored coverage, particularly those who have medical conditions; in most states, insurers are not required to sell non-job-based coverage to people with past or current medical conditions, even when they can afford the premium.<sup>25</sup>

Furthermore, opponents also fear that HSAs will lead to an erosion of comprehensive job-based coverage. They argue that HSA tax incentives would encourage employers to shift benefits from comprehensive coverage to high-deductible plans. They also point to risk segmentation concerns that if young and healthy employees leave job-based coverage for HDHPs sold individually (due to cheaper rates and the tax benefit), then comprehensive job-based coverage for older workers and those with medical needs may become more expensive.

## Conclusion

Only experience will reveal the ultimate impact of HSAs on the health care system. In the meantime, if states are interested in making HSAs available to their residents, they will need to fully explore the implications of the legislation on their laws, budgets, and insurance markets. This may include examining ways to ensure that comprehensive coverage stays affordable, considering whether to adjust tax returns or enact state HSAs to maximize the tax advantage, and adjusting insurance standards to comply with federal law. In addition, officials will need to decide whether, and how, to add HSA-qualified coverage to state programs such as high-risk pools and public-private initiatives.

Finally, decision makers should be aware that federal policy with regard to HSAs is subject to change. Since the law's enactment, there has been a flurry of activity resulting in multi-stage guidance from the IRS on many aspects of HSAs and HDHPs. Due to the complexity of the new federal tax law and many unan-

swered questions, states will likely need additional federal guidance in the future.

## About the Author

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## Endnotes

- 1 Health insurance with high annual deductibles has been available in the market (although may not meet the criteria for HSA-qualified policies). Some observers call this "catastrophic" coverage, especially when the annual deductible is thousands of dollars and when the insurance does not pay claims until the deductible is met.
- 2 When employers choose to self-insure their health benefits, they do not need approval from state regulators and state insurance standards do not apply.
- 3 When enrollees use HSA funds to pay for out-of-pocket expenses, the fees they pay may be negotiated, depending on the type of high-deductible plan and whether the plan has negotiated a reduced fee for the type of service a patient needs. Some services are not covered; therefore, unless a consumer negotiates a discount directly with the provider, he or she will pay the full fee.
- 4 See IRS Notice 2004-50, question 16.
- 5 Notice 2004-2, IRS.
- 6 For additional information, see Rev. Proc. 2004-23, IRS Revenue Procedure.
- 7 See Notice 2004-50, questions 26 and 27.
- 8 Rev. Proc. 2004-22, IRS Revenue Procedure providing a transitional rule for prescription drug coverage under certain circumstances.
- 9 Recent IRS guidance indicates that people eligible for Medicare but not yet enrolled would qualify for an HSA. Notice 2004-50, question 2.
- 10 IRS Publication 502 available at [www.irs.gov/publications/p502](http://www.irs.gov/publications/p502).
- 11 Notice 2004-2, IRS.
- 12 *ibid.*
- 13 Glied, S. "Health Savings Accounts: What Differences Will They Make?" presentation to The Commonwealth Fund Health Insurance Task Force, March 30, 2004.
- 14 See Maynes, T. and T. Evans. "A Guide to Health Savings Accounts, and a Plea for Practicality," *Tax Analysts*, January 15, 2004, available at <http://services.taxanalysts.com/taxbase/tnt#nsf>.
- 15 See comments on Notice 2004-2 submitted to the IRS by the American Benefits Council, February 24, 2004 (on file with author; comments express some concerns of employers). An additional concern is with cost shifting to patients (higher deductibles, co-insurance, and co-pays), resulting in uncompensated care. Some providers note that it is more difficult to collect payment for services directly from patients.

16 For more information about risk selection concerns, see Sturm, M. *Can the Rise of Consumerism Control Increasing Healthcare Costs?*, Winter 2003–2004 Milliman Consultants and Actuaries, Benefits Perspectives Current Issues in Employee Benefits at 4. (Article discusses risk selection when employees have a choice of plans); Davis, K. "Concluding Commentary, Consumer-Directed Health Care: Will It Improve Health System Performance?" *Health Services Research*, August 2004, Vol. 39, No. 4, Part II. (Dr. Davis examines key findings from papers on early experience with consumer-directed health care plans.); AAA. *The Impact of Consumer-Driven Health Plans on Health Care Costs: A Closer Look at Plans with Health Reimbursement Accounts*, January 2004, p. 14. (This piece offers insights into potential impact of HSAs based on experience with HRAs and similar plan designs that have high-deductible features.)

17 Notice 2004-43.

18 See discussion of state purchasing coalitions for small businesses in Kofman, M. "Group Purchasing Arrangements: Issues for States," issue brief, State Coverage Initiatives, April 2003.

19 Notice 2004-50, question 13.

20 Notice 2004-50, question 29.

21 Interview with Bruce Abbe, May 17, 2004.

22 See Goodman, J. "Two Cheers for the Bush Health Plan," Brief Analysis no. 465, National Center for Policy Analysis, January 30, 2004; The Council for Affordable Health Insurance, *Issues & Answers: HSAs, HRAs or FSAs: Which Consumer-Driven Health Care Option Should You Choose?*, March 2004; press release, Independent Women's Forum. "Health Savings Accounts Critical to Improving Healthcare for Women," March 18, 2004; G. Scandlen. "Open Letter: Opponents Misrepresent Health Savings Accounts," *Health Care News*, The Heartland Institute, April 1, 2004.

23 See Blumberg, L. The Urban Institute, Testimony before the U.S. House of Representatives, Small Business Committee Subcommittee on Workforce, Empowerment and Government Programs, March 18, 2004; Greenstein, R. and E. Park. "Health Savings Accounts in Final Medicare Conference Agreement Pose Threats Both to Long-term Fiscal Policy and to the Employer-based Health Insurance System," Center on Budget and Policy Priorities, December 1, 2003; Park, E. "Health Savings Accounts: Undermining the Employer-Based Health System and Establishing Unprecedented Tax Shelters," presentation at Families USA Conference, January 22, 2004 (slides on file with author); Paul Ginsburg commentary, "Tax Free but of Little Account: Without Changes Health Savings Plans Unlikely to Achieve lofty Goals," *Modern HealthCare*, February 16, 2004; Cropper, C.M. "Why Health Savings Accounts May Flop," commentary, *BusinessWeek*, March 15, 2004.

24 Williams, C. "Tax Subsidies for Private Health Insurance: Who Currently Benefits and What are the Implications for New Policies?" *The RWJ Synthesis Project: New Insights from Research Results*, Policy Primer No. 1, May 2003, p. 1.

25 Pollitz, K., et al. "How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" Kaiser Family Foundation, June 2001.



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