



Health Reform Provisions that Could Impact Consumer-Driven Health Plans

The health care reform legislation approved by the 111th Congress (H.R.3590, now Public Law 111-148, as amended by the budget reconciliation bill, H.R.4872) will likely have a modest impact on consumer-driven health plans and their associated health care accounts (i.e., FSAs, HRAs, and HSAs). Earlier proposals that would have eliminated some of these options (particularly FSAs and HRAs) did not survive the legislative process. Below is a description of the provisions that were included in the final legislation.

Changes Impacting All Health Care Accounts (FSAs, HRAs, HSAs, and Archer MSAs)

P.L. 111-148 includes a change in the definition of a “qualified medical expense” that impacts reimbursements and withdrawals under all types of health care accounts (i.e., FSAs, HRAs, HSAs, and Archer MSAs). Beginning with 2011, expenses incurred for over-the-counter (OTC) medications will no longer be eligible for payment or reimbursement from any of the health care accounts. However, the law would still allow OTC medicines obtained with a prescription and insulin to be reimbursed or paid tax-free from these accounts.

The new law imposes an excise tax of 40 percent on employer-sponsored coverage that has a benefit value in excess of \$10,200 for single coverage and \$27,500 for family coverage (indexed annually). The benefit value of employer-sponsored coverage would include the value of the group health plan and contributions to employees’ FSAs, HRAs, and HSAs. This tax would be imposed on insurance companies, including self-insured plans and plans sold in the group market, and plan administrators. However, this provision does not go into effect until 2018.

Changes Impacting Only Flexible Spending Arrangements (FSAs)

H.R.3590 imposes a new annual limit on contributions made by employees to flexible spending arrangements (FSAs) for health care. The legislation limits contributions to no more than \$2,500 annually. The limit is indexed to inflation for future years. H.R.4872 delayed the effective date of this provision to 2013.

Changes Impacting Only Health Savings Accounts (HSAs)

The only provision directly impacting HSAs (in addition to the change in the definition of a qualified medical expense described above) is that the tax penalty on HSA withdrawals that are not used for qualified medical expenses will be increased from the current 10 percent to 20 percent. The legislation also increases the penalty for non-qualified withdrawals from Archer MSAs. These provisions will go into effect in 2011.



However, the changes proposed to all health insurance policies could have potentially adverse affects on high deductible health plans (HDHPs) that currently make people eligible to contribute to HSAs. Some of the impact may not be known until regulations implementing the final provisions are written.

H.R.3590 sets new requirements for all insurance policies, including HDHPs. For example, all insurance policies will be required to provide first dollar coverage for preventive care services. In addition, the preventive services must be covered without any cost-sharing (e.g., copayments) or application of any deductibles. While HDHPs are currently allowed to provide first dollar coverage of preventive care services, and most do, in the future all HDHPs will be required to do so. These provisions will go into effect in 2014.

The U.S. Preventive Services Task Force (and the Secretary of HHS) will define the scope of preventive care services in the future. This could create a potential challenge for HDHPs to the extent that the preventive services prescribed by the USPSTF conflict with current IRS guidance on what constitutes “preventive care” for HSA purposes.

Another new requirement for all insurance policies is that they provide a minimum actuarial value for the benefits covered. The minimum actuarial value must be at least 60 percent. However, it is important to look more closely at how “actuarial value” is defined. The new law uses a different definition than the American Academy of Actuaries in that a plan’s actuarial value would be measured only by comparing the percentage of covered benefits paid by the insurance plan relative to an identical plan with zero cost-sharing (i.e., no deductibles, copays, or coinsurance). Conversations with congressional staff also suggest that a plan’s actuarial value would be determined assuming that an average or “standard” population would enroll in the plan, not taking into account any self-selection that may occur to do plan design features like deductibles, etc.

It is also not clear whether a plan’s actuarial value would include employer or individual contributions made to the individual’s HSA. The final legislation requires the Secretary of HHS to issue regulations on this matter.¹ Based on an analysis by the Congressional Budget Office,² it would appear that the Secretary should conclude that HSA contributions must be included. Including the contributions in the calculation of a plans actuarial value would make it easier for more HDHPs to meet the minimum actuarial value requirement. If contributions are not

¹Sec. 3102(d)(2)(B) of P.L. 111-148 states: “EMPLOYER CONTRIBUTIONS.—The Secretary must issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.”

²“An additional consideration arises when evaluating the actuarial value of consumer-directed health plans. Such plans generally combine a high-deductible health insurance policy with an account that enrollees may use to help finance their out-of-pocket costs (and which may accumulate balances over time). By design, the high-deductible insurance policy will generally have a lower actuarial value than conventional insurance policies. But the actuarial value of consumer-directed plans would include the expected value of any contributions that an insurer or employer sponsoring the plan would make to an enrollee’s account—so that contribution could be set to make the overall actuarial value of the consumer-directed plan equal to the value of a conventional health plan.” Source: Congressional Budget Office, <http://www.cbo.gov/ftpdocs/99xx/doc9924/Chapter3.7.1.shtml>



included, HDHPs, many of which have actuarial values below 60 percent (or whatever the final standard becomes) based on the insurance coverage alone, could no longer be sold. Including contributions in the actuarial value calculation can increase a plan's value by 10-20 percentage points (or more), depending on the size of contributions.

The new law requires all insurance plans to include limits on out-of-pocket expenses using the current law limits for HSAs (i.e., \$5,950 for individuals with self-only coverage and \$11,900 for individuals with family coverage in 2010) and adjusted annually for inflation. The out-of-pocket limits will go into effect in 2014.

The legislation includes a provision that would prevent small employers from offering plans with deductibles greater than \$2,000 for singles and \$4,000 for families. The limits on deductibles are indexed to the percentage increase in average per capita premiums. Employers may offer plans with deductibles higher than \$2,000 / \$4,000 if the employer offers a flexible spending arrangement (FSA) that reimburses the difference between the higher deductible and \$2,000 / \$4,000. This provision will go into effect in 2014.

The new law imposes a "medical loss ratio" requirement that may create challenges for HDHPs. For example, the new law will impose a lower standard of 80 percent on small employer and individual insurance policies, and a higher standard of 85 percent on large employer policies. Although some of the details on how this provision will work will not be known until the Secretary of HHS issues regulations, it is clear that the high medical loss ratio requirements are not appropriate for plans with high deductibles. It is hard to imagine most high deductible plans paying such a high percentage of premium revenues on medical claims.

The law creates a new "young invincible policy" that provides first dollar coverage for three primary care visits but no other coverage until the individual reaches current law HSA cost-sharing limits. These policies would be limited to those 30 years or younger and individuals exempt from the individual mandate due to affordability or hardship. These policies would provide an additional coverage option for younger individuals desiring to comply with the individual mandate under the law. However, it does not appear that these individuals would be eligible to contribute to HSAs.

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