March 16, 2010

PROPOSED HSA CLARIFICATIONS IN HEALTH CARE REFORM LEGISLATION

Issue:

Encouraging the use of Health Savings Accounts (HSAs) under the President's health care reform proposal.

Current law:

Under current law, individuals with HDHPs may establish and make tax-deductible contributions to HSAs. HSAs are similar to IRAs, in that the amounts in an HSA accumulate tax-free. Distributions for qualified medical expenses are excluded from gross income. Distributions that are not for qualified medical expenses are included in gross income and are subject to an addition 10% tax, with limited exceptions.

For 2010, the maximum annual contribution to an HSA is $3,050 (self) and $6,150 (family); individuals over 55 may contribute more, but may not make any additional contributions once they are enrolled in Medicare. These limits are indexed annually. Employers may contribute to an individual's HSA and that contribution is also excluded from income and payroll taxes.

Individuals may not establish HSAs if they are not covered under a HDHP. HDHPs, for 2010, must have an annual deductible that is at least $1,200 (self) or $2,400 (family) and cost-sharing (such as deductibles and out of pocket expenses) must be no more than $5,950 (self) or $11,900 (family). These limits are indexed annually.

HDHPs may not provide benefits until the annual deductible is satisfied. However, HDHPs may pay for preventive services before the annual deductible is met. IRS Notice 2004-23 creates a safe harbor that allows HDHPs to cover preventive services without satisfying the minimum deductible and outlines the specific services that may be provided.

The Senate bill:

The Senate bill does not directly change the operation of HSAs, with the exception of increasing the penalty from 10% to 20% for nonqualified distributions. However, many of the Senate bill's provisions could indirectly discourage the use of HSAs by limiting the use of HDHPs within an insurance exchange or by employers outside of an exchange.

Clarifications are needed in four provisions so that the bill does not inadvertently discourage the use of HSAs with HDHP plans:

- the requirement that preventive care be covered without cost-sharing,
- the discretion granted the Secretary to define essential benefits,
- the minimum actuarial value requirement, and
- the minimum essential benefit coverage calculation.

A. Preventive Care without Cost-Sharing

The Senate bill would require plans offered through insurance exchange to provide first dollar coverage (coverage without cost-sharing or deductible requirements) for preventive care. In addition, employers that offer coverage (inside or outside of an exchange) must include preventive care in order to satisfy the minimum essential coverage requirements. If an employer fails to provide minimum essential coverage, the employer may face penalties if their employees receive federal assistance to purchase coverage through an exchange. Finally, under the President's Proposal, grandfathered plans—plans that are in existence on the date of enactment and are exempt from several of the bill's provisions—would be required to cover preventive services by 2018.

Under the Senate bill, the recommendations of the U.S. Preventative Services Task Force as well as guidelines from Health and Human Services, determine what is considered 'preventive health services.' It is possible that the Task Force coverage recommendations would conflict with the current IRS safe harbor provisions that allow HDHPs to cover certain preventive care services without meeting the plan deductible. This uncertainty could discourage insurers from offering HDHP plans through an insurance exchange. If the plan provides preventive coverage in accordance with the Task Force definition, the plan may no longer meet the requirements to be considered a qualified HDHP based on the IRS guidance. Alternatively, if the plan provides preventive coverage in accordance with the IRS guidance -- but not in accordance with the recommendations of the U.S. Preventative Services Task Force -- the plan may not be certified as a Qualified Health Plan (and therefore would not be eligible to be offered through an exchange).

Proposed Solution

Clarify that Task Force recommendations regarding preventive care apply to HDHPs offered through an insurance exchange.

Proposed Language (added to 1302(b)(4))

(I) in coordination with the Secretary of the Treasury, provide that if a plan described in section 223(c)(2)(C) of the Internal Revenue Code of 1986 is offered through an exchange, that plan shall not fail to be treated as a high deductible health plan described in 223 by reason of failing to have a deductible for preventive care because the plan meets the requirements of section 2713 of the Public Health Service Act.

Proposed Solution

Clarify that HDHPs <u>outside</u> of an exchange may comply with preventative services task force recommendations regarding preventive care and remain qualified HDHPs.

Proposed Language (amending 1401(a), new IRC 36B(c)(2)(C)(ii))

<u>(v) A high deductible health plan (as defined in section 223(c)(2)(C)) that provides minimum essential coverage shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care because the plan meets the requirements of section 2713 of the Public Health Service Act.</u>

B. Essential Benefit Definition

To be offered in an exchange, and in the individual and small group markets outside of an exchange, plans must offer the essential benefits package. The Senate bill delegates the authority to define what benefits are considered essential to the Secretary of Health and Human Services (HHS). In defining essential benefits, the Secretary is instructed to ensure that the scope of the essential benefits package is equal to the scope of benefits provided under a typical employer plan. Because a high deductible health plan may not be what the Secretary considers as a "typical" plan, there is a risk that the essential benefits package may be defined in such as way as to discourage or prohibit the use of high deductible health plans inside and outside of an exchange.

Proposed Solution

Clarify that when the Secretary defines the essential benefits package, she may not prevent high deductible health plans from offering essential benefits.

Proposed Language (added to 1302(b)(2))

(C) RULE OF CONSTRUCTION- A plan shall not be deemed to fail to offer essential benefits solely because it is a high deductible health plan as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

Alternative Proposed Language (added to 1302(b)(2))

(A) IN GENERAL- The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of the benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multi-employer plans, and provide a report on such survey to the Secretary. However, in no case may the Secretary define the essential health benefits under paragraph (1) to exclude high deductible health plans (as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986) solely on the basis of such plans' annual deductible and/or out-of-pocket expenses.

C. Minimum Actuarial Value

The Senate bill requires plans to provide a minimum actuarial value of 60 percent to be offered through an exchange. In addition, employers that fail to offer coverage with a minimum actuarial value of 60 percent may face penalties if their employees receive federal assistance to purchase coverage through an exchange.

The current Senate bill already provides that the Secretary shall issue regulations that may allow employer HSA contributions to be counted toward the actuarial value of a plan.

In order to encourage the availability of HDHPs through an exchange, the Senate bill should be amended to require that any employer contributions to an HSA be counted toward the actuarial value of a plan.

Proposed Solution

Clarify that employer contributions to an HSA must be included in calculating an HDHP's actuarial value by changing the word "may" to "shall."

Proposed Language (amending 1302(d)(2)(B))

(B) EMPLOYER CONTRIBUTIONS - The Secretary shall issue regulations under which the employer contributions to a health savings account (within the meaning of section

223 of the Internal Revenue Code of 1986) shall be taken into account in determining the level of coverage for a plan of the employer.

D. Offering Minimum Essential Coverage

The Senate bill currently provides that employers that fail to offer their employees "minimum essential coverage" may face penalties if their employees receive federal assistance to purchase coverage through an exchange. One of the criteria of minimum essential coverage is that the plan provides minimum value: specifically, that the plan's share of the total allowed costs of benefits provided under the plan must be at least 60 percent of such costs.

In order to preserve the availability of HDHPs outside of an exchange, the Senate bill should be amended to require that any employer contributions to a health savings account (HSA) to be counted toward the calculation of minimum value.

Proposed Solution

Clarify that employer contributions to an HSA must be included in calculating an HDHP's minimum value by requiring that the value be calculated in the same way that the actuarial value of Exchange HDHPs is calculated. The proposed language added here parallels the actuarial value calculation language in 1302(d)(2)(B). It is added here, rather than a cross reference, because this section refers to "total allowed costs of benefits" rather than the actuarial value of the plan.

Proposed Language (amending 1401(a), new IRC 36B(c)(2)(C)(ii))

(ii) COVERAGE MUST PROVIDE MINIMUM VALUE-Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs. In calculating the total allowed costs of benefits provided under the plan, the employer contributions to a health savings account (within the meaning of section 223) shall be taken into account in determining the plan's share of costs.