

# CRS Report for Congress

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## Health Savings Accounts

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# Health Savings Accounts

## Summary

Health Savings Accounts (HSAs) are a new way that people can pay for medical expenses not covered by insurance or other reimbursements. Eligible individuals can establish and fund these accounts when they have a qualifying high deductible health plan (at least \$1,000 for single and \$2,000 for family coverage) and no other health insurance, with some exceptions. The accounts have tax advantages that can be significant: contributions are deductible, withdrawals used for medical expenses are not taxed, and account earnings are tax-exempt. Unused balances may accumulate without limit. HSAs were authorized in November 2003 by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

Three other tax-advantaged accounts to pay for unreimbursed health care have existed for some time: Archer Medical Savings Accounts (MSAs) and two employer-offered arrangements, Health Reimbursement Accounts (HRAs) and health care Flexible Spending Accounts (FSAs). When coupled with high-deductible health insurance, these accounts are part of what some call “consumer-driven health plans.” These plans have been spurred largely by employers anxious to moderate premium increases; they also have emerged in response to utilization controls of managed care and as a way to encourage effective care.

The effectiveness of consumer-driven health plans depends on the way high deductible insurance and the savings accounts are structured and interact. How high deductible insurance affects the cost and quality of care depends on the availability of information, competition among health care providers, and consumers’ sensitivity to prices. How savings accounts affect these outcomes depends on contributions and accumulations and whether accounts are considered to be savings or insurance.

A burgeoning market has developed to offer HSAs and qualifying high deductible health plans. The first providers were niche insurance companies that had offered MSA plans, but now prominent insurance companies are also offering HSA products, some which may be available nationwide. HSAs have elicited widespread interest among large employers already offering HRAs or other high deductible insurance and small employers whose owners would like a readily available product that pays unreimbursed medical bills with significant tax advantages. Employers can also save employment taxes on account contributions.

There is some evidence (though no rigorous studies) that HRAs reduce health care spending, and HSAs may have similar effects. Even so, the majority of health care expenditures are for catastrophic costs, and it is not obvious how either HRAs or HSAs will affect those. HSAs might result in adverse selection among insurance plans, which could increase insurance costs for people with the highest health care needs. However, employers have strategies for dealing with this problem.

This report will be updated as more information becomes available and for legislative activity. The President’s FY2006 budget included several proposals to increase the attractiveness and availability of HSAs.

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# Health Savings Accounts

Health Savings Accounts (HSAs) are a new way that people can pay for unreimbursed medical expenses such as deductibles, copayments, and services not covered by insurance. Eligible individuals can establish and fund these accounts when they have a qualifying high deductible health plan (insurance with a deductible of at least \$1,000 for self-only coverage and \$2,000 for family coverage plus other criteria) and no other health plan, with some exceptions. HSAs carry tax advantages that can be significant for some people: contributions are deductible (or excluded from income that is taxable if made by employers), withdrawals are not taxed if used for medical expenses, and account earnings are tax-exempt. Unused balances may accumulate without limit.

HSAs were first authorized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). However, tax-advantaged accounts for health care expenses have existed for some time. Flexible Spending Accounts (FSAs), which many employees can use, began spreading in the 1980s once the Internal Revenue Service (IRS) established clear guidelines. Archer Medical Savings Accounts (MSAs), a precursor of HSAs, became available for a limited number of people starting in 1997. Health Reimbursement Accounts (HRAs), made available by some employers, were approved for tax-exempt status in 2002. When coupled with high-deductible health insurance, these accounts are part of what some call “consumer-driven health plans.”

Like these other accounts, HSAs have several objectives. One is to encourage individuals and families to set money aside for their health care expenses. Another is to give them a financial incentive for spending health care dollars prudently. Still another goal is to give them the means to pay for health care services of their own choosing, without constraint by insurers or employers.

Since HSAs are new, the extent to which they will further these objectives is not yet known. Among other things, it remains to be seen how many people will establish accounts, how much they will contribute to them, and how much they will carry over to subsequent years. Their effect on health care use is largely speculative, as is their effect on insurance and health care costs. However, many individuals and employers are interested in HSAs, and information about them is likely to emerge quickly. The federal government began offering HSA products to its employees in 2005.

This report has five parts. It begins with a summary of the principal rules governing HSAs, covering such matters as eligibility, qualifying health insurance, contributions, and withdrawals. The report then compares HSAs to the other types of tax-advantaged accounts mentioned above. Third, it presents data on availability and use of HSA plans (products that combine both the HSA and the associated health

insurance) and discusses how rapidly and widely they might spread. Fourth, it discusses HSA plans in the context of what are called consumer-driven health plans. Finally, there is a discussion of several issues, including the effect of HSA plans on adverse selection, the number of uninsured, and health care spending, and an overview of legislation in the 108<sup>th</sup> and 109<sup>th</sup> Congresses.

This report will be updated and expanded to reflect substantial new developments and analyses.

## **Principal Rules Regarding HSAs**

Rules governing HSAs are laid out primarily in Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and guidance issued by the IRS. The latter includes guidance issued on December 22, 2003, March 30, 2004, May 11, 2004, June 18, 2004, August 9, 2004, and January 12, 2005.<sup>1</sup> Other guidance may be released in the future.

HSAs are affected by other rules as well. For example, Section 213(d) of the Internal Revenue Code governs whether an expenditure is a qualified medical expense; aside from exceptions pertaining to the purchase of health insurance, the HSA statute and guidance do not change these rules. Similarly, whether HSA arrangements are covered by privacy rules is governed by the Health Insurance Portability and Accountability Act and previously existing definitions regarding group health plans.

This part of the report summarizes the principal rules regarding HSAs. It does not provide all details or cite supporting documentation. Further information about HSA requirements might be obtained by referring to the original source material cited above, to IRS and other government publications, or to a growing body of secondary analyses.

### **What is an HSA?**

An HSA is a tax-exempt trust or custodial account established for paying qualified medical expenses of the account beneficiary. Accounts may be established with banks and insurance companies or with other entities approved by the IRS to hold Individual Retirement Accounts (IRAs) or MSAs. In addition, other entities may request approval to be an HSA trustee or custodian.

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<sup>1</sup> IRS Notice 2004-2 (Dec. 22, 2003); IRS Notice 2004-23, Notice 2004-25, Rev. Proc. 2004-22, Rev. Rul. 2004-38 (Mar. 30, 2004), IRS Rev. Rul. 2004-45 (May 11, 2004), IRS Notice 2004-43 (June 18, 2004), IRS Notice 2004-50 (revised and corrected August 9, 2004), and IRS Notice 2005-8 (January 12, 2005). These and other IRS documents cited in this report can be accessed through the IRS website, [<http://www.irs.gov>], using the search box in the upper left corner of the screen at that site.

Insurance companies that offer qualified high deductible health plans (HDHPs) often also establish HSAs for the policyholders. However, there is no federal requirement that HSAs be established by the entity that provides the health plan.

Individuals interested in establishing an HSA must locate an entity that accepts the accounts; they cannot simply deem an ordinary savings account to be an HSA.

## **Who May Have an HSA?**

Individuals are eligible to establish and contribute to an HSA if they have a qualifying HDHP and no disqualifying coverage, as discussed under the next two headings. Whether someone has a qualifying HDHP is determined as of the first of each month; thus, a person might be eligible to contribute to an HSA in some months but not others.<sup>2</sup> For example, if someone first enrolled in an HDHP on September 15, their HSA eligibility period would begin on October 1 of that year.

Individuals cannot be enrolled in Medicare (a form of disqualifying coverage), which generally occurs at age 65.<sup>3</sup> They cannot have received Veterans Administration medical benefits (another form of disqualifying coverage) within the past three months.

Individuals are not eligible if they may be claimed as a dependent on another person's tax return. Tax dependency is determined on a yearly basis; this might not be known until the end of the year.

Individuals may keep their HSAs once they become ineligible. Thus, individuals do not lose their HSA (or the right to access it) by turning age 65 or by obtaining insurance with a low deductible. However, they could not make contributions until they become eligible once again.

Individual members of a family may have their own HSAs, provided they each meet the eligibility rules just described. They can also be covered through the HSA of someone else in the family; for example, a husband may use his HSA to pay expenses of his spouse even though she has her own HSA.

Individuals may have more than one HSA account.

## **What Is a Qualifying Health Plan?**

A health plan must meet several tests to be qualified: it must have a deductible above a certain minimum level, and it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum level. These two tests are described immediately below.

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<sup>2</sup> Individuals should be able to find out from their insurer whether their HDHP is qualifying coverage. They need not apply to the IRS or other government agency for a determination.

<sup>3</sup> Individuals remain eligible to establish and contribute to HSAs after becoming *entitled* to Medicare, provided they do not enroll in either Part A or Part B.

In addition, a qualifying health plan must provide general coverage: substantially all of its coverage cannot be through what the statute calls “permitted insurance” (e.g., coverage for only a particular disease) or certain other coverage (e.g., vision care). This rule prevents individuals from making HSA contributions when the only insurance they have is high deductible coverage for a narrow class of benefits. (More details on permitted insurance and these other forms of coverage are provided under the heading “what is disqualifying coverage?”)

**Minimum Deductible.** For self-only coverage, the annual deductible in 2005 must be at least \$1,000; for family coverage, it must be at least \$2,000. These amounts will be adjusted for inflation (rounded to the nearest \$50) in future years.

Only usual, customary, and reasonable charges for covered benefits are taken into account in determining whether deductibles are met. Premiums are not included in meeting the deductible, though copayments may be at the option of the HDHP.

The minimum deductible requirement does not apply to preventive care. The exception is established in the statutory language, which does not define the term. However, IRS regulations provide that preventive care includes but is not limited to periodic health evaluations (including tests and diagnostic procedures ordered in connection with routine examinations), routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and various screening services. Drugs and medications can be included when taken by a person who has developed risk factors for a disease, or to prevent its recurrence. In general, preventive care does not include services or benefits intended to treat existing illnesses, injuries, or conditions; an exception is allowed when the treatment is incidental to the preventive care service and it would be unreasonable or impracticable to preform another service.

The IRS has ruled that prescription drugs are not exempt from the minimum deductible, whether they are included in the high deductible insurance plan or provided separately. However, in order to allow health plans time to adjust to this requirement, the IRS delayed its effective date until January 1, 2006.

Similarly, the IRS has ruled that until January 1, 2006, a plan may qualify as a HDHP even if state law requires that certain benefits be provided without a deductible or below the minimum annual deductible.

Prescription or other discount cards do not disqualify individuals from meeting the minimum deductible requirement. Similarly, individuals are not disqualified by coverage under an employee assistance program, disease management program, or wellness program, provided the program does not provide significant benefits in the nature of medical care or treatment.

**Out-of-Pocket Limit.** For self-only coverage, the annual limit on out-of-pocket expenditures for covered benefits must not exceed \$5,100. For family policies, the limit must not exceed \$10,200. These amounts will be adjusted for inflation (rounded to the nearest \$50) in future years.



These limits should not be interpreted as ceilings on all out-of-pocket expenditures for health care. Premiums for the HDHP and other insurance would be extra, as would payments for benefits not covered by insurance. Even for covered benefits, the limits would apply only to payments for usual, customary, and reasonable charges. On the other hand, both deductibles and copayments must be taken into account in determining whether the limits are exceeded.

The out-of-pocket limit rule does not preclude HDHPs from imposing reasonable lifetime limits (for example, \$1 million) on plan benefits.

## **What Is Disqualifying Coverage?**

While covered by a qualifying HDHP, individuals generally must not have other coverage that is not high deductible and that provides coverage for any benefit under their high deductible plan. For example, individuals with a qualifying HDHP are not eligible to establish or contribute to an HSA if they are also covered under a spouse's low deductible policy for the same benefits. (If the spouse's policy were high deductible, the individual could contribute to his or her own HSA.)

However, eligible individuals may have "permitted insurance," which is insurance under which substantially all coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property (such as automobile insurance); insurance for a specified disease or illness; or insurance that pays a fixed amount per day or other period of hospitalization. In addition, eligible individuals may have what the legislation calls "other coverage" (through insurance or otherwise) for accidents, disability, vision care, dental care, or long-term care. As mentioned above, the permitted insurance and other coverage described here do not provide the general form of coverage to be considered a qualifying health plan for purposes of HSA eligibility.

Eligible individuals may also have Flexible Spending Accounts and Health Reimbursement Accounts, provided these accounts are for limited purposes (for example, dental services or preventive care), provide reimbursement for services covered by the HDHP only after the qualifying deductible is met, or are used in retirement.

## **Who May Contribute to an HSA?**

Contributions to HSAs may be made by eligible individuals as well as by other individuals or entities on their behalf. Thus, individuals may contribute to accounts of eligible family members, and employers may contribute to accounts of eligible employees. Contributions could also be made by state governments.

Contributions by one individual or entity do not preclude contributions by others, provided they do not exceed annual contribution limits.

Contributors cannot restrict how HSA funds are to be used. For example, employers may not limit HSAs just to medical expenses, even for funds they contribute. (Account owners always can make withdrawals for other purposes,

though nonqualified withdrawals are subject to taxation, as discussed below.) In contrast, employers can restrict the types of medical expenses for which flexible spending account may be used.

## When and How May Contributions be Made to an HSA?

Contributions to HSAs may be made at any time during a calendar year and until the filing date (without extensions) for federal income tax returns, normally April 15 of the following year. Thus, contributions could occur over a 15½ month time span (e.g., from January 1, 2005, through April 15, 2006), provided they do not exceed the allowable annual limit described below.

As with IRAs, contributions to HSAs must be made in cash; contributions of property are not allowed.

HSA contributions may be made through cafeteria plan salary reduction agreements, that is, benefit arrangements established by employers under which employees accept lower take-home pay in exchange for the difference being deposited in their account.<sup>4</sup> The IRS has determined that salary reduction agreements must allow employees to stop or increase or decrease their HSA contributions throughout the year as long as the changes are effective prospectively; however, employers may place restrictions on these elections if they apply to all employees. The IRS has also determined that these agreements allow employers to contribute amounts to cover medical expenses that exceed employees' current HSA balances (subject to maximum amounts the employees had elected to contribute), provided the employees repay the accelerated contributions before the end of the year.

## How Much May Be Contributed to an HSA?

Two types of contributions may be made to HSAs, regular and catch-up. Both have annual limits that are calculated on a monthly basis: for each month during the year when individuals are eligible, they may contribute (or have others contribute on their behalf) up to one-twelfth of the applicable annual limit. For example, an individual who was eligible for seven months could contribute seven-twelfths of the annual limit for that year. Contributions need not actually occur monthly; one contribution can be made for the entire year, provided it does not exceed the sum of the allowable monthly limits.

**Regular Contributions.** The annual contribution limit for self-only coverage is \$2,650 (in 2005) or 100% of the insurance deductible, whichever is lower. The annual limit for family coverage is \$5,250 (in 2005), 100% of the overall deductible, or the embedded deductible (the deductible applying to one individual) multiplied by the number of covered family members, whichever of the three is lowest.<sup>5</sup> The

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<sup>4</sup> Health care flexible spending accounts generally are also funded through salary reduction agreements; however, they have a number of restrictions that do not apply to HSAs.

<sup>5</sup> Family coverage may have both an overall deductible (applying to expenses for all covered members) and an embedded deductible (applying to expenses for just one covered member);

\$2,650 and \$5,250 limits will be adjusted for inflation (rounded to the nearest \$50) in future years.

In the case of a married couple, if one spouse has family insurance coverage both will be treated as if they have only that coverage; the monthly contribution limit will be divided equally between them unless they agree on a different division. If both spouses have family coverage, the joint contribution limit will be the least of \$5,250, the lower of the two overall deductible limits, or the lower of the two embedded deductibles multiplied by the number of covered family members.

**Catch-up Contributions.** These contributions may be made by individuals who are at least 55 years of age but not yet eligible for Medicare. In 2005, they may contribute an additional \$600. The annual catch-up amount will increase by \$100 each year through 2009, when it will be \$1,000. These amounts are not indexed for inflation.

**Rollovers.** Account owners may rollover balances from one HSA to another without being restricted by the annual contribution limits or affecting new contributions. If the owner withdraws funds and deposits them in another account, only one rollover is allowed each year. Deposits must be made within 60 days in order for the transfer to be considered a rollover. If instead an HSA trustee transfers funds to another, there is no limit on the number of rollovers allowed each year. HSA trustees are not obligated to accept either owner or trustee rollovers.

**Interaction with MSAs.** The annual limitations just described are reduced by the amount of any contribution individuals make to their MSAs in the same year.

Individuals are permitted to rollover MSA balances to their Health Savings Accounts. Rollovers are not taken into account for purposes of the annual limits on HSA contributions. Rollovers are not permitted from Health Reimbursement Accounts or health care Flexible Spending Accounts.

**Excess Contributions.** Contributions exceeding annual limits might occur for a number of reasons, including failure of employees to take account of employer contributions, early deposits that incorrectly anticipated continuing eligibility, and mathematical errors.

If an excess contribution and any earnings on it are withdrawn by the filing date (without extensions) for the federal income tax return for the year, the individual will not be subject to a penalty. Otherwise, the excess contribution will be subject to a 6% excise tax each year until it is withdrawn.

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<sup>5</sup> (...continued)

the health plan would begin to pay benefits once either amount is exceeded. To be a qualified HDHP, the embedded deductible cannot be less than the minimum annual deductible (\$2,000 in 2005).

**Comparability Requirement.** Employers are not required to contribute to employees' HSAs, but if they do the contributions must be comparable.<sup>6</sup> Generally, contributions must be the same dollar amount or the same percentage of the HDHP annual deductible, adjusted to reflect the proportion of the year the employees have worked. Employer matching contributions (which might vary) satisfy the comparability requirement only if employee contributions are made through a cafeteria plan salary reduction agreement.

Employers may limit contributions just to employees who participate in the employers' HDHPs; however, if they make contributions to employees who participate in other HDHPs they must make comparable contributions to all employees with HDHPs.

Different treatment is allowed for full-time and part-time employees, and for self-only and family coverage.

## **What Is the Tax Treatment of HSA Contributions?**

Individuals who contribute to their HSAs may claim a deduction on their federal income tax. The deduction is "above-the-line," that is, it is made in determining adjusted gross income; it may be taken by all taxpayers, even those who claim the standard deduction instead of itemizing deductions.

Contributions made by employers are excluded from gross income of employees in determining their income tax liability. In addition, employer contributions are exempt from social security and Medicare taxes for both employers and employees.<sup>7</sup> (Social Security taxes are 6.2% of wages up to \$90,000 in 2005; Medicare taxes are 1.45% of total wages.) In addition, employer HSA contributions are exempt from federal unemployment insurance taxes. If employees contribute to their HSAs through salary reduction cafeteria plans, the contributions are considered to be made by the employer and are exempt from these three employment taxes.

State income taxes generally follow federal rules with respect to deductions and exclusions. However, some states may elect different treatment.

## **What Is the Tax Treatment of HSA Withdrawals?**

Withdrawals from HSAs are exempt from federal income taxes if used for qualified medical expenses, with one exception.<sup>8</sup> The exception is that while

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<sup>6</sup> The comparability requirement is in Section 4980G of the Internal Revenue Code, which references rules for MSAs in Section 4980E.

<sup>7</sup> If an individual is self-employed, contributions are not taken into account in determining net income from self-employment; as a consequence, they are not exempt from Social Security and Medicare taxes.

<sup>8</sup> Qualified medical expenses are described generally in Section 213(d) of the Internal Revenue Code; they include expenditures for a spouse and dependents, even if they are not  
(continued...)

payments for health insurance are qualified under Section 213(d), they generally are not qualified for purposes of HSAs. Thus, accounts cannot be used to pay some or all of the premiums of the associated HDHP. However, payments for four types of insurance are considered to be qualified expenses: (1) long-term care insurance,<sup>9</sup> (2) health insurance premiums during periods of continuation coverage required by federal law (e.g., COBRA), (3) health insurance premiums during periods the individual is receiving unemployment compensation, and (4) for individuals age 65 years and older, any health insurance premiums (including Medicare Part B premiums) other than a Medicare supplemental policy.

Withdrawals not used for qualified medical expenses are included in gross income in determining federal income taxes; they also are subject to a 10% penalty tax. The penalty is waived in cases of disability or death and for individuals age 65 and older.

There is no time limit on when HSA withdrawals are made to pay (or reimburse payments for) qualified expenses, provided adequate records are kept. However, HSAs may not be used to pay expenses incurred before the HSA was established.

HSA withdrawals are not subject to nondiscrimination provisions applying to self-insured medical reimbursement plans.

## **What Happens to HSAs at Death?**

If a surviving spouse is the designated beneficiary of an HSA, it becomes an HSA for that widow or widower.

If someone other than a surviving spouse is the designated beneficiary, the HSA is terminated as of the date of death and the fair market value becomes taxable income to that person. If there is no designated beneficiary, the remaining assets become part of the estate and the fair market value becomes taxable income to the deceased individual on the final return. In these instances, amounts included in gross income are reduced by qualified expenses incurred by the deceased before death and paid within one year.

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<sup>8</sup> (...continued)

eligible to have an HSA themselves. IRS publication 502, *Medical and Dental Expenses*, provides a good overview; it is available online at [<http://www.irs.gov/pub/irs-pdf/p502-pdf>]. The principal purpose of Section 213(d) is to describe which expenses may be taken into account in determining the itemized deduction for medical expenses.

<sup>9</sup> The IRS considers payments for long-term care insurance to be qualified expenses even if the HSA is funded through a salary reduction agreement under a cafeteria plan, notwithstanding the explicit provision in Section 125(f) of the Internal Revenue Code prohibiting cafeteria plans from including long-term care insurance; the rationale is that it is the HSA that is paying for the insurance, not the cafeteria plan.

## What Administrative Provisions Apply to HSAs?

The IRS has proposed model forms that banks, insurance companies, and other approved entities can use as trust or custodial agreements with eligible individuals. The proposed agreements, which are not mandatory, provide a safe harbor definition of these institutions' responsibilities. Among other things, the proposed forms clarify that trustees and custodians may rely on account owners' representations about their age, that they are covered by a HDHP, and that their contributions do not exceed the maximum allowed.<sup>10</sup> In addition, the proposed forms state that trustees and custodians are not responsible for determining whether distributions are used for medical expenses.

HSA funds may be invested in investments approved for IRAs, such as bank accounts, annuities, certificates of deposit, stocks, mutual funds, and bonds. However, trustees and custodians need not make available all of these options. HSA funds may not be invested in life insurance contracts or most collectibles (i.e., tangible property).

Administration and account maintenance fees may be withdrawn from the HSA (in which case they will not be considered taxable income) or paid separately (in which case they will not be taken into account with respect to contribution limits).

Trustees and custodians may place reasonable restrictions on the frequency and minimum amount of HSA distributions.

## Are HSAs Covered by ERISA?

The Employee Retirement Income Security Act (ERISA) establishes requirements for employee benefit plans. Among other things, it establishes reporting, disclosure, and fiduciary standards for employers, superceding state laws on these matters. Benefit plans with minimal employer involvement are exempted.

The U.S. Department of Labor (DOL) has determined that HSAs generally will not be considered ERISA plans, even if employers make contributions to the accounts, provided employer involvement is otherwise limited.<sup>11</sup> For the exemption to apply, employers must not limit employees' ability to move funds to another HSA, impose additional conditions on using HSA funds, make or influence investment decisions regarding HSAs, represent that HSAs are employee welfare benefit plans established by the employer, or receive any payment or compensation in connection with HSAs.

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<sup>10</sup> However, trustees and custodians may not accept contributions that exceed the annually-adjusted dollar amounts (e.g., \$2,650 and \$5,250) and allowable catch-up contributions.

<sup>11</sup> Department of Labor, *Field Assistance Bulletin* 2004-1, Apr. 7, 2004.

The DOL has also determined that certain cash contributions offered by HSA trustees or custodians as an incentive to establish an HSA are not a prohibited transaction under ERISA.<sup>12</sup>

## What State Requirements Apply to HSAs ?

States do not have to approve HSAs for them to become available within their jurisdictions. However, individuals cannot establish or make contributions to HSAs unless they have a qualifying HDHP. Currently, some states do not allow the sale of insurance that meets the requirements for these plans since they require all insurance to include certain benefits with no or low deductibles. (Some of these benefits may not fall within the IRS definition of preventive benefits, which would allow the insurance to be considered qualified.) The IRS has granted a waiver until January 1, 2006, that allows insurance in these states to be considered HDHPs, giving the states time to change their laws. However, some states might not act by that date or at all.<sup>13</sup>

This regulatory barrier does not apply to employers that self-insure since ERISA generally exempts their plans from state insurance mandates.<sup>14</sup> It does apply to employers that purchase insurance from insurance companies as well as to insurance that is sold in the individual market and small group market.

## HSAs and Other Health Care Accounts

HSAs are new, but the concept of a tax-advantaged account to pay for unreimbursed health care expenses is not. Three other types of tax-advantaged health care accounts have existed for sometime: Archer Medical Savings Accounts (MSAs), Health Reimbursement Accounts (HRAs), and health care Flexible Spending Accounts (FSAs). This section provides a brief overview of these other accounts.<sup>15</sup>

It is possible for individuals to have more than one of these accounts; the most likely combinations would be HRAs and FSAs, or HSAs and FSAs. However, employers must coordinate how multiple accounts are used so that eligibility requirements are not violated. For example, they might limit their FSAs to benefits that are not covered by their HRAs (vision care, perhaps) or require that HRAs be exhausted before the FSAs can be used.

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<sup>12</sup> Department of Labor Advisory Opinion 2004-09A, Dec. 22, 2004.

<sup>13</sup> For additional information, see *Health Savings Accounts: Issues and Implementation Decisions for States*, by Mila Kofman. AcademyHealth, Washington, D.C. 2004.

<sup>14</sup> For additional information, see CRS Report RS20315, *ERISA Regulation of Health Plans: A Fact Sheet*, by Hinda Ripps Chaikind.

<sup>15</sup> For additional general information, see IRS publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*.

## Medical Savings Accounts

MSAs are precursors to HSAs: both consist of a tax-advantaged account that must be accompanied by a high-deductible health plan at the time that contributions are made. MSAs were first authorized as a demonstration under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). They were renamed Archer MSAs by P.L. 106-554.

MSAs were not as widely available as HSAs. To enroll in an MSA, individuals had to either be self-employed or employees covered by a high deductible insurance plan established by their small employer (50 or fewer employees on average). In contrast, there is no work-related requirement for HSAs.

MSAs are less attractive than HSAs in other respects as well. The minimum deductible for the qualifying high-deductible insurance in MSA plans is higher than that required for HSAs plans. For 2005, the minimum self-only deductible for an MSA plan is \$1,750; for an HSA plan it is \$1,000. For 2005, the minimum family deductible for an MSA plan is \$3,500; for an HSA plan, it is \$2,000. In addition, contributions to MSAs are limited to no more than 65% of the insurance deductible for self-only coverage and 75% of the deductible for family coverage. In contrast, contributions to HSAs of up to 100% of the insurance deductible are permitted, subject to some maximum limitations, as previously discussed.<sup>16</sup> The penalties for non-medical withdrawals from MSAs (15% of the withdrawal amount) are greater than for HSAs (10%).

One obstacle to the popularity of MSAs was that the initial authorizing legislation established a cut-off date after which no new MSAs could be established. (It also established numerical limits on the number of accounts, but these were far above the number of accounts actually created.) As that date approached, Congress passed legislation to extend it, most recently through December 31, 2005.<sup>17</sup> The absence of permanent authorization created uncertainty about the future growth of MSAs and discouraged banks and insurance companies from marketing MSA plans. Although now no new MSAs may be created, with some exceptions, current holders of MSAs can maintain their accounts and, provided they have a qualifying high-deductible health plan, can continue to make contributions to the MSA. However, MSA owners can now have HSAs, and their MSA balances can be rolled over into the new accounts.

## Health Reimbursement Accounts

Unlike HSAs and MSAs, HRAs are not explicitly authorized by legislation. HRAs were first offered in the marketplace several years ago under the assumption that they too could be a tax-advantaged way to pay for unreimbursed medical

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<sup>16</sup> Even so, 100% of the HSA insurance deductible might be a lower dollar figure than 65% or 75% of the MSA insurance deductible. If deductibles do not exceed \$2,650, however, HSA contributions could cover the deductibles while MSAs contributions could not.

<sup>17</sup> The latest extension was in the Working Families Tax Relief Act of 2004, P.L. 108-311.



expenses; this was ultimately affirmed by the Treasury Department in 2002, with certain stipulations.<sup>18</sup>

HRAs can be funded only by employer contributions; unlike the other accounts discussed here, employees may not contribute on their own. However, HRAs need not actually be funded; employers may treat them simply as notional accounts and pay reimbursements from other sources as needed. HRAs also need not be associated with high deductible health plans, though in practice employers generally couple them with insurance having a deductible greater than the annual contribution to the HRA.

Because the HRA is owned by the employer rather than the enrollee, the employer is free to set limits on it. For example, employers generally limit the total amount that can be built up in the account. The employer also determines what happens to the account when an employee leaves the company; generally, the account balance is forfeited back to the employer, although as a form of employer-provided health coverage, HRAs are subject to COBRA provisions.<sup>19</sup>

Non-medical withdrawals from HRAs are not permitted.

## **Flexible Spending Accounts**

FSAs are employer-established benefit plans that reimburse employees for specified expenses as they are incurred. They can be used for health care or for dependent care, though there must be separate accounts for these purposes. FSAs are not explicitly authorized by the Internal Revenue Code; instead, rules governing them were spelled out in proposed regulations that the IRS issued for cafeteria plans in 1984 and 1989 and in final rules issued in 2000 and 2001 regarding mid-year plan changes.<sup>20</sup>

While FSAs can be used to pay for unreimbursed health care expenses, unlike the other accounts discussed here they usually are not coupled with a particular health insurance plan. They are standalone accounts the principal purpose of which is to enable employees to pay out-of-pocket health care costs with pre-tax dollars.

Most FSAs are funded through salary reduction arrangements under which employees receive less take-home pay (for example, \$100 a month) in exchange for equivalent contributions to their accounts (in this case, \$1,200 for the year).

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<sup>18</sup> IRS Rev. Rul. 2002-41 and Notice 2002-45 (June 26, 2002). The IRS ruling is based upon Sections 105 and 106 of the Internal Revenue Code, which deal with accident and health plans.

<sup>19</sup> COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), which among other things requires employers with 20 or more employees to allow separated employees and their surviving spouse and dependents to continue health insurance coverage for a certain length of time.

<sup>20</sup> For additional information on the legal basis of FSAs, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Chris L. Peterson and Bob Lyke.

An important distinction between FSAs and the other accounts is end-of-year balances cannot be used in the following year; any balance at the end of the year is forfeited to the employer. This is commonly called the “use it or lose it rule.” In recent years, legislation has been introduced to allow limited FSA sums to be carried over to the following year or rolled over into a qualified retirement account, but none of these bills has been enacted.

HRAs and FSAs are similar in that non-medical withdrawals are not permitted and there is no required health plan to accompany the account. In addition, the annual amount to be deposited in the account is available at the beginning of the year, even before all the deposits have been made. In contrast, with HSAs and MSAs, one may not withdraw an amount greater than the current account balance.

## **Availability and Use of HSAs**

### **Available Products**

The initial entrants in the market for HSA products were specialty companies such as Golden Rule Insurance Company, Definity Health, Lumenos, and Assurant Health that had earlier sold MSA and HRA plans. These companies were able to readily adapt systems used to administer MSA and HRA plans for administration of HSA plans.

In recent months several large insurers have made decisions to either introduce or expand upon the availability of HSA products. The BlueCross BlueShield Association announced in November 2004 that its member plans would offer a variety of products tied to HSAs in virtually every state by 2006. As of February 2005, Blue Cross and Blue Shield companies offered HSA-compatible products in 38 states.

The growth in the HSA market may also receive an impetus from the acquisition of Definity Health by United Health Care.<sup>21</sup> Definity Health is generally credited with the creation of the HRA concept, while United Health Care is one of the largest health insurers in the United States. The combined company should be able to offer an HSA product that benefits from the knowledge base of Definity Health and the deep provider network discounts of United Health Care. The HSA product is likely to be of particular interest to employers who wish to offer employees a choice of plans (HMOs, PPOs, fee for service, and HSA, for example) while using the same vendor to administer all plans.

Based on their core expertise, one would expect insurance companies to sell HDHPs, and banks and trusts to sell HSA administration services. However, many insurance companies have partnered with banks and trusts to offer integrated HSA and HDHP services with sophisticated capabilities. Such an integrated HSA product may feature a tax-advantaged interest-earning or investment account; a debit card and checkbook that allow members to pay medical expenses directly from their account;

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<sup>21</sup> As of the date of this report, the acquisition was yet to be approved by regulators.

automatic claim rollover that allows account holders to choose to have their account automatically debited instead of manually submitting forms; and an integrated approach that provides customer service and Web experience. In addition, enrollees would have access to the health insurer's provider network and medical management programs.

Integrated HSA products have been announced by Anthem Blue Cross and Blue Shield, CIGNA as well as Humana in alliance with JP Morgan Chase Bank, Kaiser Permanente with Wells Fargo Bank, Alliance Benefit Group with Charles Schwab Trust Company, Evolution Benefits with CareGain, Mellon Financial Corporation with North American Health Plans, and Wausau Benefits in conjunction with various banks. The federal government began offering HSA products to its employees in 2005.

*The HSA Insider* website [<http://www.hsainsider.com>] lists insurance companies that sell HDHPs and banks and trusts that provide HSA custodial and administrative services. As of January 7, 2005, the website listed 83 insurance companies and 45 banks/trustees.<sup>22</sup>

At this time, an individual who wishes to open an HSA account is unlikely to find this product being offered by a local bank. Theoretically, any bank or trustee may set up an HSA, as long as the HSA meets Internal Revenue Service (IRS) rules. However, many local banks are not knowledgeable about HSAs, and as of now, banks and financial institutions administering HSAs tend to be specialty organizations. As HSAs become better known and HSA account balances grow, one can expect that more local banks will offer HSA accounts.

IRS Forms 5305-B and 5305-C are model nonmandatory forms that HSA trustees and custodians, respectively, can use to allow individuals to establish HSAs. The forms may be obtained through the IRS website [<http://www.irs.gov>]. An HSA is established after a form is fully executed by the account owner and the trustee or custodian.

HSA fees and services vary. Most plans have both a setup fee and ongoing administrative fees. Investment options vary from simple interest-bearing accounts (sometimes with graded interest rates based on the account balance) to mutual funds and a full range of brokerage services. Some plans offer debit cards, free checking, online access, and Internet transactions. Individuals who anticipate accessing their HSA accounts frequently will value plans that offer free debit cards or free checking. Individuals who anticipate letting their HSA balances accumulate might be more interested in plans that offer sophisticated investment options.

## **Use of HSAs**

In the United States, people under age 65 have health insurance from a variety of sources. (Once they reach 65, nearly everyone becomes entitled to Medicare.) In

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<sup>22</sup> It should be noted that neither *The HSA Insider* nor CRS has verified the information presented on the website.

2003, approximately 65% of those under 65 (over 165 million people) had employment-based health plans as their primary source of coverage. The private nongroup or individual market covered about 7% (over 16 million). Approximately 18% (45 million) were uninsured.<sup>23</sup> This section discusses how the employer and individual markets are likely to respond to the availability of HSAs.

**Employer Market.** Results from several surveys indicate that HSAs have elicited widespread interest from employers. The 2004 Employer Health Benefits Survey conducted by The Kaiser Family Foundation and Health Research and Educational Trust reports on the percentage of firms that say they are “very likely” or “somewhat likely” to offer a high-deductible plan with a personal account or HSA option in the next two years. The percentage of firms indicating they are very or somewhat likely to offer such an option increases with the size of the firm. For example, while 26% of all small firms (3-199 workers) are very or somewhat likely, 50% of jumbo firms (5000 or more workers) are very or somewhat likely to offer a high-deductible plan with a personal account or HSA option.<sup>24</sup>

Hewitt, in January 2005, reported a similar interest in HSAs from large employers. Hewitt conducted a survey of more than 500 major employers covering more than 6 million employees and family members. Hewitt reported that 57% of its survey respondents were considering HSAs for future use.<sup>25</sup>

Large and small employers face different issues regarding health insurance coverage for their employees, and their consideration of HSA plans may differ. These categories are considered separately below.

**Large Employers.** Large employers are generally defined as those with over 500 employees. Two segments of these employers are likely to be particularly interested in HSA plans: those that currently offer HRAs and others that also offer some form of high deductible insurance.

Employers that currently offer HRA plans are likely to give serious consideration to adopting HSAs, which generally are more advantageous for employees. These employers have already bought into the concept of consumer-driven health plans as a strategy for improving cost awareness and accountability. They have programs in place for educating employees about provider costs and choices.

Other employers offer high deductible insurance without HRAs. According to the 2004 Kaiser survey, 20% of jumbo firms (5,000 or more workers) offered a health

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<sup>23</sup> CRS analysis of data from the Mar. 2003 Current Population Survey (CPS).

<sup>24</sup> Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2004 Annual Survey*. The survey is temporarily available through the Kaiser Family Foundation website, [<http://kff.org>].

<sup>25</sup> Hewitt summarizes the results of the survey on its website, [<http://was4.hewitt.com>].

plan with a deductible of \$1,000 or more for single coverage in 2004.<sup>26</sup> These plans may not meet the definition of a qualified HDHP under the HSA legislation, but many could be modified to do so.

Some large employers may find it difficult or inadvisable to offer HSA plans because prescription drugs will not be exempt from the deductible requirements of the HDHP. Currently, large employers often offer prescription drug plans through specialty vendors such as Medco or Express Scripts. The prevalent design provides prescriptions without a deductible, with separate copayments for generic versus brand name drugs and for mail order versus retail drugs. Revenue Ruling 2004-38 issued in March 2004 clarified that in order to meet statutory requirements, prescription drug benefits must be subjected to the deductible underlying the HDHP along with other health care claims. However, the Treasury Department was responsive to complaints from employers and health plans that it would take time to change plan design and administrative systems to comply with this ruling. Revenue Procedure 2004-22, released concurrently with Revenue Ruling 2004-38, provides transition relief until January 1, 2006, by allowing individuals to be eligible for HSAs even if covered by a prescription plan that provides benefits before the annual HDHP deductible is satisfied.

Despite this transition relief, some large employers may consider the eventual application of Revenue Ruling 2004-38 a barrier for HSAs. Large employers would be likely to offer an HSA plan as one option among many and might not wish to modify their prescription drug plan design and administration for only that option. Moreover, some employers believe that subjecting prescriptions to a high deductible may be a perverse incentive that induces some enrollees to skip required medications, ultimately leading to greater health care costs in the future.

**Small Employers.** Employers with fewer than 50 workers constitute the vast majority of the nation's employers.<sup>27</sup> Among small firms that offer health insurance, few have plans with tax-advantaged accounts. The uncertainty surrounding MSAs made them an unattractive option, as did their other limitations. FSAs and HRAs are also unpopular since often the owners of small firms cannot participate in them. Many small businesses are organized as partnerships, S corporations, Limited Liability Companies (LLCs), or sole proprietorships,<sup>28</sup> yet partners, more than 2% owners of S-corporations, members of an LLC, and sole proprietors are not considered to be employees for purposes of FSAs or HRAs.

HSAs do not have these drawbacks. Compared to MSAs, they have permanent authorization, no limit on the number of accounts, and allow for larger contributions. Compared to HRAs and FSAs, they offer owners access to a widely available product that pays unreimbursed medical expenses and also has significant tax advantages.

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<sup>26</sup> The survey reported that 10% of all firms offered a health plan with a deductible of more than \$1,000 for single coverage in 2004. Some of these plans were HRA plans, though presumably most were not.

<sup>27</sup> According to the Kaiser survey, 90% of the nation's employers had 3-49 workers.

<sup>28</sup> For information about these firms and their tax status, see CRS Report RL31538, *Passthrough Organizations Not Taxed as Corporations*, by Jack Taylor.

Early reports are that these firms may adopt HSAs in large numbers. It is also expected that their high income employees would be most likely to participate in these plans.

Small employers that do not offer health insurance generally attribute this to its cost. They might have been able to afford sparse insurance coverage with high deductibles and limited benefits, but may not have had much choice of plans. With the advent of HSAs, however, HDHPs will become more widely available, perhaps at more competitive rates. Small employers may also find HSA accounts attractive since they would obtain employment tax savings on employee contributions that are made through salary reduction plans.

**Individual Insurance Market.** Individual market health insurance is for self-employed individuals and individuals who do not have access to employer-provided insurance or choose not to participate in it. If individuals are self-employed, they generally can deduct 100% of the cost of the HDHP as well as any HSA contribution they make. If individuals are not self-employed, the tax advantages are not as marked; while they can also deduct HSA contributions, HDHP premiums are deductible only to the extent they exceed 7.5% of adjusted gross income when combined with other unreimbursed health expenses.

In his FY2005 budget, President Bush proposed allowing premiums for HDHPs purchased in the individual market to be claimed as an above-the-line tax deduction when individuals made HSA contributions. (An above-the-line deduction can be claimed by taxpayers whether or not they itemize their deductions.) If this proposal were adopted, it would spur the growth of HSAs, particularly among high income individuals for whom the tax savings would be more significant. (The effect of the President's proposal on the number of uninsured is discussed below on pages 22-24.)

One possible consequence of the introduction of HSAs in the individual market might be reduced availability of comprehensive health care plans. If healthier-than-average individuals enroll in HDHPs, less-healthy individuals could constitute an increasing proportion of those with more comprehensive policies, driving up their cost. This could cause such policies to become less affordable and less prevalent, although regulations in some states could limit this effect. (Selection issues are further discussed below on pages 21-22.)

**Uptake.** *Inside Consumer-Driven Care (ICDC)*, a biweekly newsletter, estimates that more than 3.2 million people were covered by an account-based consumer-directed health plan as of January 1, 2005. Of these, ICDC estimates that 580,000 people were covered by HSAs. Large employers need a lead time of several months to incorporate a benefit design in their health plan offerings. Most large employers were unable to incorporate HSAs in their 2005 benefit offerings since final Treasury guidance had not been released by the time they made their benefit decisions. ICDC estimates that enrollment in HSAs could quadruple in 2006.<sup>29</sup>

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<sup>29</sup> ICDC's estimates are based on data provided by 60 national and regional insurers, CDHP vendors, and third-party administrators. ICDC can be accessed online; the website is (continued...)

## Consumer-Driven Health Plans

HSAs are examples of what some call “consumer-driven health plans.” While definitions vary, in general consumer-driven health plans involve two central components: high-deductible health insurance and a tax-advantaged savings account from which unreimbursed health care costs, including the insurance deductible, can be paid.<sup>30</sup> By this definition, consumer-driven health plans (CDHPs) include HSAs, HRAs, and MSAs, each of which was discussed earlier. Some might also include FSAs, though currently most of these accounts are not coupled with high-deductible insurance. It is possible for individuals to have more than one of these accounts.

The development of CDHPs has been spurred by employers anxious to moderate annual premium increases, which have exceeded 10% the past few years.<sup>31</sup> Simply moving toward high deductibles enables employers to reduce the cost of insurance, since it covers less risk; even if growth rates continue, the additional cost is smaller. Insurance costs might also be constrained if employees have a greater financial stake in their health care, which the tax-advantaged accounts might encourage.

CDHPs also emerged in response to the backlash against managed care that had tight utilization controls. Managed care obtained a reputation in some circles of refusing to pay for care people thought was needed. In response, health plans now offer a greater choice of providers and are less active in trying to deter health care utilization. As part of this trend, CDHPs, which have fewer limitations on enrollees’ health care choices, attempt to put in place financial incentives that encourage the appropriate use of cost-effective care.

The effectiveness of CDHPs in slowing health care spending and encouraging enrollees to use cost-effective care depends on how the two CDHP components are structured and interact. The discussion below outlines some factors that appear to be important in these regards.

### High Deductible Health Insurance

Economic theory, academic research, and insurance companies’ experience all indicate that substantial increases in patient cost-sharing — insurance deductibles and copayments — generally result in significant reductions in health use. Probably the most frequently cited research is the Rand Health Insurance Experiment, a carefully designed study of 5,800 people at six sites between 1974 and 1982. Among other

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<sup>29</sup> (...continued)

available at [<http://www.aishealth.com/AISConsumerDirected.html>].

<sup>30</sup> Others define CDHPs more broadly, arguing that they permit enrollees to choose their own network of providers (i.e., doctors and hospitals) or to choose their plan’s specific benefits, varying the premiums according to each enrollee’s choices. Jon R. Gabel et al., *Consumer-Driven Health Plans: Are They More Than Talk Now?* *Health Affairs* web exclusive, Nov. 20, 2002, [<http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.395v1.pdf>].

<sup>31</sup> Kaiser Family Foundation and Health Research and Education Trust (KFF/HRET), “Employer Health Benefits: 2003 Annual Survey,” p. 2.

things, this study showed that per capita expenses for patients with a 95% coinsurance requirement for outpatient services were 31% lower than those for patients without cost-sharing.<sup>32</sup> Reductions in expenses were somewhat smaller for patients who had 25% or 50% coinsurance requirements, as they were for those with deductible policies. Reductions occurred for a broad range of conditions, especially for ambulatory care but also for hospitalizations. Reductions were primarily in the number of contacts rather than the intensity of services.<sup>33</sup>

The Rand Experiment occurred over three decades ago, and the magnitude of reductions might be different today. American households have changed, as have their economic prospects; likewise, the health care sector is different, particularly with the spread of managed care in one form or another. Nonetheless, compared to traditional health plans with low deductibles and nominal copayments, high deductible health plans are likely to have lower health care utilization. One reason for this is that enrollees in traditional health plans usually are unaware of the total cost of their care; they generally are not informed of the part covered by third-party payers such as insurance companies. Another reason is that enrollees in traditional plans have little incentive to hold down costs; once the low deductible is met, the insurer will pay most of the cost of additional covered goods and services. Financially, enrollees have little need to see if other providers might recommend different treatments or charge lower prices.

By themselves, higher deductibles may not be sufficient for enrollees to seek cost-effective, higher quality care. Additional features that increase the likelihood that improvements will result include the following:

- *Availability of information.* Enrollees need comparative information on the cost and quality of providers, procedures, pharmaceuticals, and medical devices. Many CDHPs provide enrollees with decision-support tools and information related to their individual health (for example, how to manage their chronic conditions and the availability of more cost-effective prescription drugs). However, consumers rarely have access to both the price and quality of services from individual physicians, hospitals, and other providers. Proponents of CDHPs believe that demand for such information will increase as CDHPs become more commonplace and will spur the accessibility of such information.<sup>34</sup>

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<sup>32</sup> The former group had to pay 95% of their expenses out-of-pocket, up to an annual limit of 15% of family income or \$1,000, whichever was lower. The latter group had no out-of-pocket expenses for services.

<sup>33</sup> Willard G. Manning, et al., Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment, *The American Economic Review*, vol. 77, no. 3, June 1987. p. 258.

<sup>34</sup> For research findings on CDHPs and the information that enrollees need but do not have in order to make good health care choices, see Arnold Milstein's testimony before the Joint Economic Committee, Feb. 25, 2004, [[http://jec.senate.gov/\\_files/Milstein02252004.pdf](http://jec.senate.gov/_files/Milstein02252004.pdf)]. Some employers have formed coalitions to provide more information about provider quality.



- *Competition.* If there is only one practical option for needed health care, exposure to the full cost up to the deductible will not affect choice of providers. Providers have little incentive to offer competitive prices when no competition exists. In the presence of competition, however, enrollees are able to choose among providers based on price and other factors.
- *Price sensitivity at the point of service.* Exposure to the full cost up to the deductible will have no impact on utilization when demand for a good or service is inelastic (that is, when a person is willing to pay practically any price for it, such as with a life-threatening emergency). However, utilization is affected when willingness to obtain health care depends heavily on prices that enrollees must pay. (One complication here is that consumers may not know in advance what they will be charged for a service, nor will they know what proportion of the charge will be covered by their insurance.)

One concern regarding HDHPs is that enrollees may forgo care they need as well as care that is optional or of little value. If they go to doctors less often, some serious medical conditions might not be diagnosed or treated, notwithstanding the availability of effective interventions. Examples include diabetes, high blood pressure, and breast cancer. The Rand Health Insurance Experiment found that cost-sharing deterred patients equally from seeking care that is highly effective and care that is rarely effective. Patients became more frugal, but not necessarily better, consumers of medical care.<sup>35</sup>

Supporters argue that CDHPs will not exhibit these effects. Many CDHPs exempt preventive care from high deductible restrictions; in fact, statutory language for both MSAs and HSAs permit high deductible insurance to have exceptions for preventive care.<sup>36</sup> (At the same time, the statutory language does not *require* an exemption for preventive care, and some insurance plans could allow it only in limited ways.) Many CDHPs also provide enrollees with information to help them make informed decisions about when to see doctors; arguably, at-risk enrollees will

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<sup>34</sup> (...continued)

Laura Landro, Doctor “Scorecards” Are Proposed in a Health-Care Quality Drive, *Wall Street Journal Online*, Mar. 25, 2004, available online at [<http://webreprints.djreprints.com/956040987875.html>]. The article also provides websites where one can obtain information about individual doctors.

<sup>35</sup> Kathleen N. Lohr, et al., Use of Medical Care in the Rand Health Insurance Experiment. *Medical Care*, vol. 24, no. 9, Sept. 1986. pp. S72-S87. Conditions for which adverse consequences were apparent included high blood pressure and vision corrections for adults and anemia for children. Nonetheless, for adults and children as a whole, reductions in service associated with coinsurance and deductibles appeared to have only negligible effects on general measures of health. It is not known whether effects on health would have been greater had the service reductions continued beyond the end of the Experiment.

<sup>36</sup> For MSAs, the high deductible insurance may exempt preventive care only if this is required by state law.

be more likely to seek health care than if they had traditional insurance which did not provide information. (Nonetheless, statutory language does not require that enrollees be given information, and some would argue that information by itself may not prompt appropriate action.)

Enrollees also might not obtain the care they need if they do not have the money to pay for it. The Rand Health Insurance Experiment found that cost-sharing led to greater reductions in care for poor than nonpoor people, with poor children among the most affected.<sup>37</sup> This indicates that wherewithal to pay has an independent effect on the likelihood of seeking medical advice and treatment, hardly a surprise. However, CDHP supporters argue that tax-advantaged health savings accounts, the second of the two CDHP components, will reduce the likelihood that enrollees will not have money to pay for medical care when needed.

## Health Savings Accounts

By itself, moving from low-deductible to high-deductible health insurance will likely reduce health care utilization and could impede enrollees from obtaining care they need. How tax-advantaged health savings accounts — HSAs, MSAs, and HRAs — affect these outcomes will depend on several factors:

- *Contributions to accounts.* Health savings accounts will play a significant role only if employers and enrollees make contributions to them, probably regularly. How much is contributed is also relevant; while there are limits on maximum contributions, there are no minimum contribution requirements.
- *Accumulation within accounts.* Health savings accounts will be significant only if account balances build up over time. If contributions are withdrawn the same year, the accounts will function like FSAs, simply allowing health care expenses to be paid with pretax dollars.<sup>38</sup>
- *Savings or insurance.* If enrollees think of their accounts as personal savings, they are likely to be frugal with them, just as if they were paying expenses out of their own pocket. Alternatively, if enrollees think of their accounts as personal insurance, they are likely to see them as resources to be used for current expenses; in effect, their accounts would provide no-deductible insurance, thus offsetting the utilization reductions of the high deductible insurance. Some enrollees might initially consider their accounts as savings but then, after balances grow, be more willing to spend part of the accumulation.

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<sup>37</sup> Kathleen N. Lohr, et al., Use of Medical Care.

<sup>38</sup> In theory, the “use it or lose it” rule for FSAs should encourage spending while the high deductible insurance requirement for HSAs should discourage spending. However, for individuals and families with a steady stream of health care expenditures, actual use may be the same.

**Using HSAs to Build Retirement Savings.** One incentive for enrollees to consider HSA accounts as savings rather than insurance is that they have tax advantages not shared by tax-advantaged retirement arrangements such as qualified pensions, 401(k) plans, and Individual Retirement Accounts (IRAs). In fact, it has been argued that the most significant impact of HSAs will not be on how consumers use health care but on how employers rearrange contributions to workers' tax-advantaged retirement savings.<sup>39</sup>

HSAs have several advantages over other forms of retirement savings. If employee contributions are made through salary reduction agreements, the contributions are not subject to employment taxes if made to HSAs; they are subject to them if made to 401(k) accounts. The employment tax exemption saves money for both the employer and the employee. (In both cases, employee contributions through salary reduction agreements are exempt from income taxes, and employer contributions are exempt from both employment and income taxes.) The income used for IRA contributions, either deductible or nondeductible, is also subject to employment taxes.

HSAs also have a clear advantage with respect to the income tax treatment of withdrawals. Provided they are used for qualified medical expenses, HSA withdrawals are always exempt from income taxation; in contrast, withdrawals from qualified retirement plans are generally taxable except to the extent they represent after-tax contributions. Considering how significant health care expenditures can be for retirees, this difference may lead some people to put more money into HSAs and less into their retirement accounts.<sup>40</sup>

In one respect, HSAs have some disadvantages compared with the retirement accounts. If HSA funds are withdrawn before age 65 and not used for qualified medical expenses, they are subject to a 10% penalty. For retirement accounts, the 10% penalty applies only to withdrawals made before age 59½ ; in addition, the penalty is waived if the withdrawal is used for certain expenses or is taken in a series of roughly equal payments.<sup>41</sup>

The tax advantages of HSAs become more marked for high income individuals. A Mercer survey in April 2004 asked employers which of their employees would be most likely to participate in an HSA plan. The majority of employers surveyed (61%) believed it would be their higher paid employees. Nearly half of large employers (48%) said a likely motivation would be to provide a savings vehicle for post-retirement health care needs. However, employers do not view HSAs as primarily a tax break for their highly paid employees. Only 5% of respondents in the

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<sup>39</sup> Henry J. Aaron, The 'Sleeper' in the Drug Bill, *Tax Notes*, vol. 102, no. 8, Feb. 23, 2004, pp. 1025-1030.

<sup>40</sup> Albert B. Crenshaw, Health Care Costs Darken Sunset Years, *Washington Post*, July 4, 2004, p. F4.

<sup>41</sup> For additional information, see CRS Report RL31770, *Retirement Savings Accounts: Early Withdrawals and Required Distributions*, by Patrick J. Purcell.

survey said they would offer an HSA plan specifically to provide a tax shelter for highly compensated employees.<sup>42</sup>

## Issues and Legislation

### Effect on Health Plan Selection

If HSA plans mostly attract people who are healthy, adverse selection may become a problem. Adverse selection occurs when employers or health plans do not anticipate the claims experience of less-healthy people and underprice a health plan.<sup>43</sup> Adverse selection can have serious consequences when some health plans mostly enroll healthy people who have lower than average medical costs while other plans enroll less-healthy people with higher than average costs. Initially, premiums for the former plans would go down compared to plans that enroll people with average claims experience, while premiums for the other plans would rise. Over time, the healthiest people in the higher cost plans would switch to lower cost plans (since they could pay lower premiums), resulting in premium increases for those plans but even greater increases for people remaining in higher cost plans (since their plans would increasingly have the most expensive people). If premiums reflect only the expenditures of plan enrollees, higher cost plans could face a “death spiral” in which annual premium increases cause additional healthier individuals to disenroll until the plans become unaffordable for some who need insurance the most.

Adverse selection is not caused by HSAs themselves; rather, it results from different responses to the requirement that HSA contributions can occur only when individuals have a HDHP. Young and healthy people are likely to find this insurance attractive since they generally do not anticipate large health care expenses; they would prefer to pay lower premiums and make contributions to (or have contributions made on their behalf) to an HSA. Older and less healthy people are likely to find high deductible insurance unattractive; they generally would anticipate large expenses not covered by the deductible and would worry that their HSA balances would not be sufficient to make up the difference.<sup>44</sup>

Other choices may partially offset this selection pattern. Some less healthy people may find HSA plans attractive because they enable them to circumvent the restrictions of managed care plans. Conversely, some healthy people may find them unattractive because they are very risk-averse; they would prefer to pay more for comprehensive insurance with low deductibles. Older people may find HSA plans attractive because of the tax advantages: being in higher tax brackets (since average earnings increase with age until people are in their 50s), their tax savings from

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<sup>42</sup> *Survey on Health Savings Accounts*, temporarily available through the Mercer website, [<http://www.mercerhr.com>].

<sup>43</sup> Underestimation by insurers stems from the information asymmetry in insurance markets: individuals purchasing insurance know more about their health status than the insurers do.

<sup>44</sup> Dwight McNeill, Do Consumer-Directed Health Benefits Favor the Young and Healthy? *Health Affairs*, vol. 23, no. 1, Jan./Feb. 2004, pp. 186-193.

contributions would be greater. People who are 55 but not yet 65 years of age would also be attracted by the additional catch-up contributions they may make. By the same token, younger people with low incomes may consider the HSA tax advantages inconsequential.

If employers offer only an HDHP (with or without an HSA), selection issues will not be a problem. However, if employers offer an HDHP as one of several health plan options, they would need to guard against adverse selection.<sup>45</sup> In 2002, 57% of larger private-sector establishments (50 or more employees) that offered health insurance provided a choice of health plans, while only 12% of smaller private-sector establishments did.<sup>46</sup> It would not be advisable for employers that offer HSA plans as an option to determine their employee premiums on the basis of the anticipated claims experience for the HSAs plans alone. This pricing strategy would likely lead to high prices for the comprehensive health plan options since the healthier employees would likely enroll in the HSA options, setting in motion the “death spiral” described above. Employers can avoid death spirals by combining the risk pool for all options. Specifically, they could provide subsidies for the comprehensive health plan options and price the employee contributions for these options at a lower level than justified by their claims experience alone.

Another strategy some employers use to limit adverse selection is to limit free movement across plan options. For example, an employer that offers four plan options with different employee premiums might allow an individual enrolled in a low cost health plan to move up only to the plan with the next higher cost in the following year. Thus, an employee enrolled in an HSA plan who has just found out that he needs coronary bypass surgery would not be able to switch in the upcoming enrollment period to the most comprehensive health plan option.

## **Effect on Number of Uninsured**

HSA plans might help some people without health insurance acquire coverage. High deductible health insurance costs less than traditional comprehensive insurance, other things being equal, and competition to establish market share for HDHPs may help moderate annual increases, at least temporarily. In addition, some small employers might offer coverage for the first time. While HSAs themselves may not make much difference — gains in coverage would come from lower cost insurance — they can be used to purchase COBRA continuation coverage and to pay for medical expenses; in effect, the accounts provide limited insurance themselves.

However, HSA plans are not likely to make a big difference in the number of uninsured. Generally, people do not have health insurance because their employer

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<sup>45</sup> Employers generally expect consumer-driven health plans to attract healthier-than-average workers. John Gabel, et al., *Employers’ Contradictory Views About Consumer-Driven Healthcare: Results From A National Survey*, *Health Affairs*, Web exclusive W4, Apr. 21, 2004, pp. 210-218.

<sup>46</sup> The estimates are from the Insurance Component of the 2002 Medical Expenditure Panel Survey (MEPS-IC): [[http://meps.ahrq.gov/MEPSDATA/ic/2002/Tables\\_I/TIA2d.htm](http://meps.ahrq.gov/MEPSDATA/ic/2002/Tables_I/TIA2d.htm)].

does not offer it or they cannot afford the premiums.<sup>47</sup> Some can afford average premiums but not surcharges for their age or pre-existing conditions. Still others do not value insurance enough to purchase it, even for modest premiums. For these people, the reduced cost of high deductible insurance generally will not make a difference.<sup>48</sup> Many uninsured are in the 10% or 15% tax brackets and would not find the tax advantages of HSA contributions a compelling reason to buy the insurance.

In his FY2005 budget, President Bush has proposed allowing premiums for HDHPs to be claimed as an above-the-line deduction; this would not be limited to taxpayers who itemize deductions. (One bill, H.R. 3901, has been introduced to authorize this deduction, though it would also apply to employment-based insurance that did not have employer subsidies.) If adopted, this proposal would further reduce the effective cost of the high deductible insurance. The Department of the Treasury estimated that the above-the-line deduction would reduce revenue by \$8.7 billion over fiscal years 2005 through 2009 and \$24.8 billion over fiscal years 2005 through 2014.<sup>49</sup>

There is conflicting analysis of the likely effects of this proposal. Using work by Jonathan Gruber of MIT, Edwin Park and Robert Greenstein of the Center on Budget and Policy Priorities (a liberal think tank) estimate that the above-the-line deduction would *increase*, not reduce, the aggregate number of uninsured by approximately 350,000; while some currently uninsured would be induced to buy insurance, their numbers would be more than offset by employees losing coverage on account of employers dropping health plans.<sup>50</sup> In contrast, using different

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<sup>47</sup> *The Uninsured and Their Access to Health Care*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, Jan., 2003. Also see Sara R. Collins, et al., *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey*, Commonwealth Fund, Mar. 2004, HSAs are most likely to make a difference for higher income uninsured; about one-third of the 43 million people without coverage for all of 2002 had household incomes over \$50,000. *Health Insurance Coverage in the United States: 2002*, U.S. Census Bureau, U.S. Department of Commerce, Sept. 2003, table 1.

<sup>48</sup> Raising the deductible reduces the cost of insurance, though most health care expenditures occur after the deductible has been reached. In addition, enrollees' total expenditures may not decline as much as one anticipates since their out-of-pocket expenses would likely increase, even assuming a reduction in health care use. For a discussion of these effects, see the American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, Washington, 1995, p. 8.

<sup>49</sup> U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals*, Feb. 2004, p. 26.

<sup>50</sup> Edwin Park and Robert Greenstein, *Proposal for New HSA Tax Deduction Found Likely to Increase the Ranks of the Uninsured*, Center for Budget and Policy Priorities, May 10, 2004, [<http://www.cbpp.org/5-10-04health.pdf>]. Jonathan Gruber's work is included in *Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals*, The Henry J. Kaiser Family Foundation, Mar. 2004, [<http://www.kff.org/insurance/7049.cfm>]. Whether employers would drop coverage is a critical point. While some employers might want to terminate a benefit plan they find burdensome, others might want to establish HSA plans that employees fund through salary

(continued...)

assumptions Richard Nadler and Dan Perrin of the HSA Coalition (an advocacy group for HSAs) find that the above-the-line deduction would result in a net decrease in the aggregate number of uninsured by approximately 1.2 million to 4.3 million.<sup>51</sup>

## Effect on Health Care Spending

It is too early to know the extent to which HSA plans will reduce health care spending, particularly by employers. The market for HSA plans is just developing, and it may be several years before representative data are available. In addition, there are complex issues involving the relationship between health care utilization, health care prices, and employer subsidies that merit careful study.

**Experience with HRAs.** Some indications about the effect of HSA plans on spending might be derived from the early experience of HRA plans:

- *Mercer Human Resource Consulting* released an employer study on November 22, 2004, that showed that CDHPs cost employers less per employee than more traditional health coverage options. According to the study, CDHP coverage cost employers an average of \$5,233 in 2004, almost \$600 less than an HMO. The cost to cover an employee with a traditional indemnity health plan was \$6,707. In the study CDHPs included both HRAs and HSAs, with HRAs being the predominant CDHP form in 2004.<sup>52</sup>
- *Humana* provided a CDHP option (along with traditional HMO and PPO options) to the 10,000 employees and dependents at its headquarters office in 2001 as well as an HRA option in 2002. Humana saw yearly cost increases for its health plan drop to 4.9% in 2002 and 2.7% in 2003. The 4.9% rate was low compared to an average trend of 15% in the Louisville market, where Humana is based. The 2.7% rate was low compared to nationwide trends between 10% and 20%. Humana's Chief Actuary gave the following

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<sup>50</sup> (...continued)

reduction agreements since employers save on the employment taxes on such contributions.

<sup>51</sup> Richard Nadler and Dan Perrin, *The Center for Budget and Policy Priorities' Study on HSA Premium Tax Deduction Misses the Point*, HSA Coalition, May 25, 2004. Among other things, the report cites data from Assurant that 42% of its HSA customers were previously uninsured, which it considers evidence that the assumption used in the Kaiser report is too low. However, it is not known how representative those who enrolled in the Assurant plan in the first months of 2004 are of the uninsured in general. For a response, see Edwin Park and Robert Greenstein, *Assessing the HSA Coalition's Coverage Estimates for the Administration's Proposed HSA Tax Deduction*, Center on Budget and Policy Priorities, September 13, 2004.

<sup>52</sup> Information in this paragraph was obtained from the following website: [<http://www.aishealth.com/ConsumerDirected/CDarticles/CDHCCostSavings.html>].

reasons for the lower health care cost trend observed for its employees.<sup>53</sup>

- Employees chose to migrate to lower cost options
  - Use of emergency room and outpatient hospital services decreased while use of physician office visits and prescriptions increased;
  - More employees waived coverage; and
  - Some coverage was cut back (Humana added hospital copays to all benefit options).
- *Aetna* studied 14,000 employees and dependents of 19 different employer clients who were enrolled in its HRA plans. Preliminary results showed that HRA plan enrollees had a 1.5% increase in medical claims, compared to double-digit increases for the matched cohort. There was a reduction in pharmacy costs for HRA plan enrollees driven by a decline in overall prescriptions and an increase in generic utilization.<sup>54</sup>
  - *Definity Health*, the first company to start marketing HRA plans, focused on the large self-funded employer market and had 30 employer clients as of January 1, 2002. Definity Health reported that most of its 2002 employer clients saw very low or negative cost increases when they renewed for 2003. This was true both where the HRA plan was the only option offered to employees or one among several options.<sup>55</sup>

While these studies are interesting, they cannot be taken as hard evidence that HRA plans reduce costs. In most studies to date, adjustments are not made for any benefit cutbacks or for shifts of employees between options from one year to another. In addition, the savings reported are determined by the health plans themselves rather than by independent researchers.

Even when early studies show that HRA plans are associated with reduced costs, it is difficult to predict whether the savings can be sustained over time. There is anecdotal evidence that cost trends in subsequent years are higher than the initial year, although not quite as high as for traditional health plans. In addition, it is not known whether part of the savings achieved by an HRA plan might be on account of

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<sup>53</sup> Testimony of John Bertko before the Joint Economic Committee, Feb. 25, 2004. Humana also was able to study the trend for 48,000 members covered by employer clients that offered a CDHP option to their employees; the average for this group was between 5% and 8%.

<sup>54</sup> *Aetna HealthFund Study*, Aetna Press Release, Feb. 16, 2004. The study compared claims data for the first nine months of 2003 with claims data for the same members in the first nine months of 2002 prior to their joining Aetna's CDHP. Claims activity for these individuals was also compared with that of a matched cohort enrolled in other plans.

<sup>55</sup> Developing a Successful Defined Contribution Health Plan, *Record of the Society of Actuaries*, vol. 29, no. 2



individuals skimping on required prescriptions or tests, which may lead to more severe conditions and higher costs in the long run.

**Whether HSA Plans Will Differ from HRA Plans.** Despite their similarities, the effect of HSA plans on spending may differ in several respects from the HRA plans discussed above:

- *HSAs are more likely to be viewed as savings.* As discussed above, the extent to which HSAs will be considered savings or insurance is unclear. Compared to HRAs, HSAs are more likely to be viewed as savings, which should further reduce spending:
  - There is no limit to how much may be rolled over to following years;
  - HSA balances are portable and not owned by employers;
  - HSA balances may be used for expenditures other than health care, albeit subject to income taxes and, if under the age of 65, an additional 10% penalty.
- *HSAs are likely to have higher participation rates.* While it is premature to estimate how popular HSAs will be, they are likely to have more participation than HRAs, which can only be established by employers and are not portable. Consultants seem to agree that an enrollment of 10% or more constitutes a successful CDHP enrollment, and HRAs might meet that standard. However, while 10% enrollment may meet employers' expectations, it is not large enough to make a significant impact on overall employer health care costs.
- *HSAs are likely to have larger network discounts.* One factor in CDHP cost savings is the extent to which the plan administrator can negotiate a managed care network discount. In the past, CDHPs had specialty administrators such as Definity Health or Lumenos whose discounts were not as great as those obtained by large insurers able to steer large numbers of enrollees into a managed care network. Since practically all large health insurers are entering the HSA market, this situation will change.

While HSA plans may reduce health care spending, it would be unreasonable to expect them to produce a significant reduction in the nation's health care costs. It is a well established paradigm that 5% of individuals account for approximately 50% of health care costs and 20% account for approximately 80% of costs. HSA plans with their relatively low out-of-pocket maximums will have little impact in reducing the health care spending for these groups.

## **Effect on the Federal Budget**

HSAs reduce federal budget receipts in several ways. Contributions made by employers are excluded from employees' gross income in determining income tax liability; if made by individuals, they are deductible. Account earnings are exempt

from taxation, as are distributions used to pay health care expenses. In addition, employer contributions are exempt from employment taxes.

When the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was enacted, the Joint Committee on Taxation (JCT) estimated that revenue losses due to HSAs would be \$2.4 billion for fiscal years 2004 through 2008 and \$6.4 billion for fiscal years 2004 through 2013. The JCT estimated that the losses would grow yearly across these periods, starting at \$160 million for FY2004 and increasing to \$897 million for FY2013.<sup>56</sup> If HSA participation is as widespread as the JCT predicts, costs beyond FY2013 will be even greater.

In January, 2005, the JCT estimated that HSAs would result in a tax expenditure of \$2.7 billion across FY2005 through FY2009.<sup>57</sup> The Department of the Treasury's tax expenditure estimates for the same period are considerably higher, \$13.0 billion, largely because it predicts that more accounts will be established.<sup>58</sup>

Considering current and projected federal budget deficits, it might be asked how these losses can be justified. Supporters of HSAs can make two general arguments. First, to the extent HSAs reduce health care spending, they might serve as a model for ways of generally reducing the nation's health care costs, along with the tax subsidies associated with them. Second, the losses might be justified on grounds of equity: to the extent account owners assume risk that otherwise would be borne by health plans, they would be giving up the larger tax subsidies for comprehensive insurance for smaller subsidies for their high deductible insurance.

On the other hand, the revenue loss attributable to HSAs might be criticized in several respects. Some might question whether it is fair that the largest tax savings per person will likely flow to healthy, higher income taxpayers. Some might also question whether the revenue loss is an appropriate use of federal health care resources, given the many people in the country who have no health insurance whatsoever.

## 108<sup>th</sup> Congress Legislation

In the 108<sup>th</sup> Congress, most attention regarding HSAs was focused on influencing the development of administrative regulations. Nonetheless, several bills that would have affected the availability or attractiveness of HSAs were introduced after they were authorized in November 2003:

- S. 1992 (Senator Kennedy) would have eliminated the authorization for HSAs. It would also have amended or eliminated other parts of

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<sup>56</sup> JCX-102-03, Nov. 21, 2003.

<sup>57</sup> JCS-1-05. Tax expenditure estimates reflect changes in aggregate tax liabilities; they are not the same as revenue loss estimates.

<sup>58</sup> Executive Office of the President, *Analytical Perspectives, Fiscal Year 20056 Budget*, p. 318. The estimate includes the tax expenditure for medical savings accounts, which would be a small if not negligible part of the total

the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

- H.R. 3901 (Representative Crane) would have authorized an above-the-line deduction (one not limited to itemizers) for premiums paid for HDHPs; the deduction would have been limited to individuals who do not receive employer-subsidized health insurance and who make HSA contributions;<sup>59</sup>
- H.R. 4007 (Representative Royce) would have allowed up to \$500 in unused FSA balances to be carried over to the following year or rolled over into an HSA or qualified retirement plan; and
- H.R. 4279 (Representative McCreary) would have allowed up to \$500 in unused FSA balances to be carried over to the following year or rolled over into an HSA.

H.R. 4279 passed the House on May 12, 2004, after which H.R. 4280 (dealing with medical liability law) and H.R. 4281 (dealing with association health plans for small businesses) were added to it pursuant to H.Res. 638. Prior to its passage, there was extended floor debate over H.R. 4279, during which an alternative proposed by Representative Stark allowing an FSA carryover but not the HSA rollover was defeated. The alternative also included revenue offsets.<sup>60</sup>

On September 15, 2004, the House defeated an amendment by Representative Moran to the FY2005 Transportation, Treasury, and Independent Agencies Appropriations bill (H.R. 5025) that would have blocked HSAs in the Federal Employees Health Benefit Program (FEHBP).<sup>61</sup>

On September 21, 2004, the House defeated an amendment by Delegate Norton to the FY2005 Transportation, Treasury, and Independent Agencies Appropriations bill (H.R. 5025) that would have required enrollees in HDHPs offered under FEHBP to remain enrolled for at least 3 consecutive years from the date of initial enrollment.<sup>62</sup>

## 109<sup>th</sup> Congress Legislation

The President's FY2006 budget included two proposals that would increase the attractiveness and availability of HSAs.

- Individuals who contribute to an HSA because they are covered by a qualifying health plan in the individual market (i.e., not through an employer) would be allowed to deduct the

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<sup>59</sup> President Bush included a similar proposal in his FY2005 budget, though his deduction would be limited to individuals who purchase insurance in the individual market and make HSA contributions.

<sup>60</sup> *Congressional Record*, May 12, 2004, pp. H2838-H2853.

<sup>61</sup> *Congressional Record*, September 15, 2004, pp. H7203-07 and H7210-11.

<sup>62</sup> *Congressional Record*, September 21, 2004, pp. H7277-79 and H7292-93.

premiums they pay for the plan, even if they do not itemized deductions

- Small employers (having fewer than 100 employees on a typical business day) would be allowed a tax credit for HSA contributions of up to \$200 for single coverage and \$500 for family coverage.

As of March 20, 2005, two bills had been introduced in the 109<sup>th</sup> Congress to allow the deduction for health plan premiums for individuals making HSA contributions: H.R. 37 (Representative King) and S. 160 (Senator Murkowski). S. 160 would also authorize the tax credit for small employers making HSA contributions that the President proposed in his budget.