

The Fundamentals of Health Savings Accounts and High-Deductible Health Plans

Beth Fuchs, PhD, and Lisa Potetz, *Consultants*

OVERVIEW — *This background paper updates and expands on a previous NHPF document that looked at the fundamentals of health savings accounts (HSAs) and high-deductible health plans (HDHPs), their intellectual and legislative origins, and the ways they work.¹ In addition to updating information on the HDHP/HSA marketplace, this paper presents a description of how the HDHP combined with the HSA works for enrollees. Using a question-and-answer format, it then addresses some of the more complicated details of these arrangements, looking first at the HDHPs and then the HSAs. This closer examination suggests some potential policy challenges for lawmakers, the focus of the paper's final section.*

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National Health Policy Forum
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2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web]

Judith Miller Jones
Director

Sally Coberly
Deputy Director

Monique Martineau
Publications Director

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The Fundamentals of Health Savings Accounts and High-Deductible Health Plans

Whether insured through an employer health plan or seeking health insurance in the individual (nongroup) market, consumers are increasingly being asked to consider enrolling in a high-deductible health plan (HDHP). In many instances, the high-deductible policy is being offered with a health savings account (HSA), a tax-advantaged personal savings account designed to give the owner of the account a way to pay for health care expenses that are not covered by his or her insurance. Along with high-deductible health plans, HSAs are part of a family of health insurance products that many refer to as “consumer-directed” or “consumer-driven” health care.

HSAs are at the center of a major health policy debate in Washington. Their proponents, including President Bush, assert that the shift to this type of health insurance from more traditional insurance products will be transformative, producing a more cost-effective health care system. They argue that when consumers have to spend more of their own money up front, they will shop for the best value and use fewer and less costly services. As this occurs, providers of health care will then be driven to compete on the price and quality of their services, helping to hold down health insurance premiums. More affordable premiums will in turn lead to fewer uninsured as more Americans are able to buy and retain coverage. Moreover, proponents argue, HSAs will lead more Americans to save for their health expenses in retirement.

Others, including many congressional Democrats, regard HSAs more skeptically. They point to studies that show that most health care costs are incurred by only a small percentage of very sick or injured individuals and conclude that HDHP/HSA arrangements can do little to contain those high-end expenditures. Another concern is that these arrangements will disproportionately attract healthier and wealthier individuals, concentrating sick and poorer individuals in traditional, comprehensive insurance plans, thereby driving those plan premiums ever higher. As a result, in their view, HDHP/HSAs will lead to increases in the number of underinsured Americans without doing much to reduce the overall number of those who are uninsured. Critics also question whether the tax benefits provided to HSAs are an efficient and equitable use of federal revenues.²

Against this backdrop of intense debate, policymakers have opened the door ever wider to HDHP/HSAs through a series of legislative and regulatory measures. Building on the earlier “Archer” medical savings accounts

(MSAs) and health reimbursement arrangements (HRAs),³ Congress authorized HSAs as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).⁴ The Bush administration has since encouraged these arrangements through a series of regulatory decisions and an informational campaign.⁵ The marketplace has responded. As of January 2006, about 3.2 million people were enrolled in HSA-qualified HDHPs, and HSAs held an estimated \$1.5 billion in assets as of mid-2006.

No one knows whether HDHP/HSAs will be yet another flash in the health care pan or a more enduring and important part of the insurance landscape. What is clear from most accounts, however, is that purchasers (employers, employees, and consumers at large) as well as health care providers are taking them seriously, thus indicating that a closer examination of these insurance arrangements may provide some lessons useful to the policy debate.

RECENT DEVELOPMENTS

In the 109th Congress, HSA proponents argued that HDHP/HSAs would experience much faster growth if Congress would remove certain constraints imposed on these arrangements by the MMA. Accordingly, the Bush administration pressed for a number of changes to the law relating to HSAs. The President's fiscal year (FY) 2007 budget proposed refundable tax credits to help low-income, uninsured Americans pay for HSA-qualified HDHPs and other changes to encourage and facilitate the formation of HSAs.⁶ Although the tax credit proposal did not get traction in Congress, some administration-supported changes to the HSA provisions were enacted as part of a tax and health care package passed in the last hours of the 109th Congress.⁷

In his FY 2008 budget proposal for health care, President Bush is seeking additional changes to the law to increase "the incentive for individuals to change to HSA-eligible coverage."⁸ For example, an HSA-qualified HDHP would be permitted to require 50 percent or higher coinsurance instead of the current minimum deductible amounts. In addition, employers would be permitted to contribute more to the HSAs of employees who have a chronic illness or who have a spouse or dependent with a chronic illness.⁹

The Bush administration has also promoted HSAs in other venues. As of January 2007, Medicare beneficiaries in most states are able to elect a Medicare MSA plan or an MSA demonstration plan from the array of private plan options offered under the Medicare Advantage program. The MSA demonstration plan works much like the HDHP/HSA arrangements in the under-65 market.¹⁰ Also, under an August 2006 *Executive Order*, federal agencies that administer or sponsor a federal health insurance program are required to promote quality and efficiency, objectives that may, in part, be met if the agencies make available to their beneficiaries or enrollees "consumer-directed health care insurance products,"¹¹ including HDHPs and HSAs.

109th Congress Changes to HSAs

- Allows increased HSA contributions to an annual maximum (\$2,850 in the case of self-only coverage and \$5,650 in the case of family coverage in 2007).

The law previously limited contributions to the lesser of these amounts or the deductible of the qualified plan.

- Allows certain amounts in a health flexible spending account (FSA) or HRA to be rolled over into an HSA. Allows a one-time rollover of funds in an IRA into an HSA.

- Allows employers to make higher contributions to the HSAs of employees who are not highly compensated.

- Allows individuals who become covered under a high-deductible plan in a month other than January to make the full deductible HSA contribution for the year.

Source: H.R. 6111 (P.L. 109-432)

THE MECHANICS OF HDHPs AND HSAs: AN OVERVIEW

To be eligible to make tax-free contributions to an HSA, an individual must be enrolled in an HDHP that meets specific requirements. The combination of the HSA and the high-deductible insurance is intended to provide financial protection against high medical expenses while retaining incentives for individuals to be prudent purchasers of health care services.

HSA accounts are similar in concept to individual retirement accounts (IRAs). Individuals who meet specific qualifications may establish HSA accounts with banks and other financial institutions approved by the IRS. Money may be deposited into the accounts by the individual, an employer, or anyone else on behalf of the individual, although the combined contributions may not exceed certain annual limits.

Funds deposited in HSAs by individuals or employees may be claimed by the account holder as deductions from adjusted gross income, regardless of whether or not the taxpayer files an itemized return (referred to as an “above-the-line” deduction). Deposits by employers on behalf of employees, including employee contributions made through salary reduction, are excluded from income and wages for federal employee income and payroll taxes and, depending on state law, may also be exempt from state taxes. Account earnings accumulate on a tax-free basis. As discussed below, HSA funds may be invested in a number of ways.

HSA fund balances may build from year to year; there are no “use or lose” requirements. Even if an individual is no longer eligible to make HSA contributions, any funds deposited in the account while he or she was eligible remain available to be used on a tax-free basis for qualified medical expenses. Thus, HSAs provide a form of portable health benefit that follows an individual, regardless of changes in employment or insurance status.

Eligibility

Individuals are eligible to deposit money on a tax-free basis in an HSA if they are covered under a qualified HDHP and are not covered under other first-dollar health insurance¹² (including enrollment in Medicare). Individuals claimed by taxpayers as dependents (for example, children) may not set up their own HSAs, although their health expenses may be reimbursed from the HSA of the person claiming them as a dependent (for example, a parent). An individual does not have to be earning income to qualify for an HSA, nor are there any income limits on who can set one up.

HSA Contributions

Prior to 2007, annual contributions were limited by law to the lesser of the amount of the deductible in the HDHP in which the individual was enrolled,¹³ or a maximum of \$2,700 for an individual or \$5,450 for a family. As

of 2007, the amount of the plan deductible no longer affects the contribution. Instead, the annual contribution is limited to a statutory maximum, which is \$2,850 for an individual or \$5,650 for a family. As before, these amounts are adjusted annually for general inflation (consumer price index) and rounded to the nearest \$50.

To encourage saving for health expenses after retirement, individuals eligible to make HSA deposits who are age 55 and older are allowed to make additional catch-up contributions. Catch-up contributions are limited to \$800 for 2007. The catch-up contribution limit will increase by \$100 each year through 2009 and then remain at \$1,000 for years after 2009 (Table 1).

TABLE 1
Maximum HSA Contributions,
Out-of-Pocket Limits, and Deductibles, 2007

	Individual	Family
Annual Contribution Limit	\$ 2,850	\$ 5,650
“Catch-Up” Contribution Limit (age 55+)	— \$ 800 per person —	
HDHP Maximum Out-of-Pocket Spending Limit	\$ 5,500	\$11,000
HDHP Minimum Annual Deductible	\$ 1,100	\$ 2,200

Source: U.S. Department of the Treasury, “2007 HSA Indexed Amounts”; available at <http://www.treasury.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml>.

Individuals may have more than one HSA, but the annual contribution limits apply to the aggregate deposits in all HSA accounts. If more money is deposited into an HSA than is allowed under law (referred to as “excess contributions”), the amount that exceeds the limit is subject to a 6 percent excise tax penalty each year until the money is withdrawn. The penalty may be avoided, however, if the excess amount and any earnings on it are withdrawn before the federal income tax filing date (generally April 15).¹⁴

Use of HSA Funds

Funds withdrawn from an HSA are not taxed if they are used to pay qualifying medical expenses for any beneficiary of the account to the extent the expenses have not been reimbursed by insurance or otherwise compensated. The definition of qualifying medical expenses generally includes those items and services allowed under section 213(d) of the Internal Revenue Code (IRC).¹⁵ HSA funds that are withdrawn and used for other than qualified health expenses must be included in gross income for tax purposes and are subject to a 10 percent penalty tax. The penalty is waived, however, in cases of disability or death or for individuals age 65 and over.

HDHPs

To qualify as an HDHP for purposes of an HSA, a health plan must meet certain requirements. The HDHP must provide general medical benefits. Coverage for only a narrow range of services, such as that provided by a dental or vision plan, would not qualify. The plan must impose a minimum annual deductible and also provide catastrophic coverage after out-of-pocket expenditures reach a specified level. The minimum annual deductible amounts for 2007 are \$1,100 for an individual or \$2,200 for family coverage (Table 1). These amounts are indexed to change by the rate of general inflation each year, rounded to the nearest \$50. The deductible must apply to all covered benefits (except preventive care), including prescription drugs.

Some family plans have embedded deductibles which apply to individuals within the family and which are each less than the aggregate family deductible. For example, a plan may have a family deductible of \$4,000 but an embedded individual deductible of \$2,200 per family member. In such a case, the plan would begin paying benefits for each individual family member who incurs \$2,200 in spending and would pay benefits for all family members once the \$4,000 deductible had been met. To qualify as an HDHP for HSA purposes, the plan cannot have an embedded individual deductible that is less than the minimum required family deductible (that is, \$2,200 in 2007).¹⁶

To avoid discouraging the use of preventive services, the law permits, but does not require, certain preventive services to be exempt from application of the deductible. HDHP policies must also have catastrophic coverage that pays all costs for covered services once an annual spending threshold for copayments, coinsurance, and deductibles has been met. For 2007, the out-of-pocket threshold can be no more than \$5,500 for an individual or \$11,000 for a family. These amounts are also indexed to rise each year for general inflation.

Closed panel health maintenance organizations (HMOs), preferred provider organization (PPO) plans (which charge higher cost-sharing for using out-of-network providers), fee-for-service indemnity plans, and hybrid plans (for example, point-of-service plans) can all qualify as HDHPs if they meet the minimum requirements. Deductibles, coinsurance, and out-of-pocket limits can vary when in-network and out-of-network providers are used, depending on the type of plan chosen.

FACTS AND FIGURES ON HDHP/HSAs: THE DETAILS

Limited information is available on enrollment in HDHPs and contributions to HSAs, and what data are available can be difficult to compare. Some data report only on employer-sponsored health plans, while others combine group and individual health insurance information. Information on HSAs is sometimes reported separately and other times in combination with data on the predecessor HRAs.

Enrollment

As of January 2006, nearly 3.2 million people were enrolled in HSA-qualified HDHPs, according to a survey of its member companies conducted by America's Health Insurance Plans (AHIP).¹⁷ Of the total, 1.4 million people were covered through an employer-based plan and another 855,000 through individual plans, while the classification of the remaining 878,000 enrollees is unknown. Among individual plan enrollees, 31 percent are reported by AHIP as having been previously uninsured, and one-third of small-group policies were purchased by employers that did not previously offer health insurance coverage. The actual net effect on the number of uninsured is unclear, however, in part because some individuals and small employers newly covered by these plans might have chosen other coverage if HDHPs were not available.¹⁸

The 3.2 million figure represents a tripling from the previous year's industry survey but remains a small fraction of private health insurance coverage. A recent population-based survey found only 1 percent of privately insured individuals ages 21 to 64 are enrolled in a consumer-directed health plan, defined as a combination of a HDHP and an HSA or HRA. Another 7 percent were found to be enrolled in a qualifying HDHP but not to have an accompanying HSA or HRA.¹⁹

AHIP found the fastest HDHP enrollment growth occurred in the group market, which increased by about 1 million enrollees between March 2005 and January 2006, at which point 60 percent of all HDHP enrollees were in group plans. Plans sold to individuals increased by about 300,000, representing 23 percent of new purchases of coverage in the individual market.

A separate 2006 survey of employer health plans found that HDHPs combined with a health savings option account for only 4 percent of employee health plan enrollment. Among firms offering health benefits, 7 percent offered an HDHP/HRA or HSA option in 2006, with large employers (those with more than 1,000 employees) twice as likely as others to offer this option.²⁰ A different survey of 573 large companies found a much higher percentage offering an HDHP/HRA or HSA option but a similarly low employee participation rate. In this survey, 38 percent of companies offered this option, but only 8 percent of employees enrolled.²¹

Funding and Management of HSAs

Just over half of HSA-eligible HDHP enrollees contributed funds to an HSA, according to a Government Accountability Office (GAO) review of federal tax filings.²² Specifically, in 2004, about 55 percent of HSA-eligible plan enrollees claimed an HSA deduction or reported an HSA contribution. On average, tax filers claimed a \$2,100 deduction for these HSA contributions, an amount that increased with income. Those with incomes below \$50,000 averaged a \$1,370 HSA deduction compared with a \$3,010 average for those with incomes of \$200,000 or more. Importantly, however,

these data on tax-deductible contributions exclude contributions made by individuals through their employer as salary reductions, which are excluded from taxable income. Data on the extent of these contributions are not available.²³

Two-thirds of employers offering HSA-eligible health plan coverage in 2005 contributed to their employees' HSAs.²⁴ Employees are more likely to contribute to an HSA if their employer made a contribution, the GAO review found. Employer HSA contributions reported to the IRS averaged \$1,064 in 2004.

In general, individuals reporting HSA contributions have higher incomes. Those reporting contributions in 2004 had average adjusted gross incomes of \$133,000, more than 2.5 times the average of \$51,000 for all tax filers under age 65. More than half of HSA contributors had incomes above \$75,000, compared with only 18 percent of all nonelderly tax filers.²⁵

A mid-2006 estimate by one industry newsletter based on data provided by a survey of 60 financial firms that administer HSAs identified \$1.5 billion in assets held in 1.2 million HSA accounts.²⁶ According to these industry survey data, most HSA assets were concentrated in a few firms: HSA Bank, a division of Webster Bank (\$289 million); Exante Bank (\$250 million); JPMorgan Chase (\$130 million); and Wells Fargo (\$110 million).

Use of HSA Funds

HSA account holders use funds both to pay medical expenses and to accumulate savings. Federal tax data reviewed by the GAO show that 45 percent of those who made contributions to an HSA in 2004 also made withdrawals. About 40 percent of all funds contributed to HSAs were withdrawn from the accounts by the end of that year. Balances can accumulate when account holders do not need to use all the funds for medical expenses or when they choose to pay for medical expenses with other available funds, preserving the tax-advantaged HSA account as a savings vehicle. The GAO reported that many focus group participants in their study indicated that they use their HSAs as tax-advantaged savings vehicles.²⁷

HDHP Premiums and Benefits

HSA-eligible HDHPs generally have lower premiums, higher deductibles, and higher out-of-pocket spending limits but in other ways resemble traditional health insurance plans.²⁸ AHIP reports that annual premiums for best-selling HDHPs in the individual market averaged about \$1,900 for individual coverage and \$3,950 for families (Table 2, next page). A separate GAO analysis of plans sold through ehealthinsurance.com found somewhat lower premiums, with average individual annualized premiums of \$1,332, about 20 percent less than the \$1,656 average for traditional health plan offerings.²⁹

Premiums for employer-based HDHPs in 2006 averaged about \$3,200 for single coverage and \$8,500 for family coverage (Table 3). By contrast, premiums for all employer-based plans overall averaged \$4,200 and \$11,500, respectively. Premium differences across plans may reflect differences in the health status of enrollees as well as other factors, such as variations in provider reimbursement and administrative overhead.

Premiums for employer-based HDHPs increased 4.8 percent on average between 2005 and 2006. This is significantly lower than the average 8.6 percent increase in HMO premiums but not statistically different from the increase in PPO plan premiums, the most common plan type.³⁰

Deductibles for HDHPs are, as expected, higher than those for traditional health plans, and they vary considerably. Among employer plans, HDHP deductibles average about \$2,000 for self-only coverage, but 63 percent of workers in these plans have deductibles above that amount. By comparison, in traditional PPO plans, 31 percent of workers are enrolled in plans with no deductible and, where they are applied, deductibles average \$473 for self-only coverage. Among workers in PPO plans with deductibles, 51 percent are in plans that do not apply the deductible to prescription drug coverage and 47 percent are in plans with no deductible for preventive services.³¹

TABLE 2
Features of Individual Market
Best-Selling HDHPs (AHIP Survey)

	AVERAGES	
	Single	Family
Premium (Age 30-54)	\$ 1,914	\$ 3,951
Deductible	2,378	4,760
Out-of-Pocket Maximum	3,371	6,837
Lifetime Maximum	\$3.8 million	\$4.1 million

Source: Hannah Yoo and Teresa Chovan, "January 2006 Census Shows 3.2 Million People Covered by HSA Plans," *America's Health Insurance Plans (AHIP) Center for Policy and Research*, Washington, DC, 2006; available at www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf.

TABLE 3
Comparison of Features: HDHP and All Employer Plans
(Kaiser-HRET Survey)

	Averages for...			
	HSA-QUALIFIED HDHP		ALL EMPLOYER PLANS	
	Single	Family	Single	Family
Premium	\$ 3,176	\$ 8,515	\$ 4,242	\$ 11,480
Deductible*	2,011	4,008	473	1,034
Out-of-Pocket Maximum	3,172	6,017	**	**

* Figures for all employer plans include only PPO plans with a deductible. Family coverage amount is for plans with an aggregate deductible for all family members, which is the type faced by 71 percent of workers.

** About 21 percent of workers are in plans with no out of pocket maximum, usually because cost sharing is minimal. Among PPO plans, 54 percent of single workers have out of pocket maximums of less than \$2,000, and 55 percent of those in family coverage with an aggregate out-of-pocket maximum have limits below \$4,000.

Source: Kaiser Family Foundation and Health Research and Educational Trust (Kaiser-HRET), *Employer Health Benefits: 2006 Annual Survey* (Menlo Park, CA: Kaiser Family Foundation, 2006); available at www.kff.org/insurance/7527/index.cfm. Figures on HSA-qualified HDHPs from "Section 8: High Deductible Health Plans with Savings Options," p. 8, and figures for all health plans from "Section 6: Worker and Employer Contributions for Premiums," p. 5, and "Section 7: Employee Cost Sharing," pp. 3, 6, and 11.

Average deductibles for the best-selling HDHP plans sold to individuals rather than employers are higher than those for plans sold to employers. The AHIP survey reported deductibles averaging \$2,400 for single coverage and \$4,800 for family coverage, while the GAO analysis of ehealthinsurance.com offerings found in-network average deductibles of \$3,190 for singles and \$5,213 for family coverage.³² Where applicable, out-of-network deductibles are typically much higher.

Impact on Costs

Given the early and limited experience with HSA enrollment to date, data needed to answer key questions about the extent to which the HDHP/HSA approach achieves its goals of slowing growth in health expenditures are also limited. HSA proponents cite initial evidence supporting their view that consumers are changing behavior and reducing health costs.³³ Critics cite other evidence suggesting that enrollees are more likely to skip needed medical care.³⁴

The Congressional Budget Office (CBO) has reviewed available information in order to examine the impact of consumer-directed health plans on the use of health care and the price and quality of health care services. While earlier research, particularly the 1970s RAND Health Insurance Experiment, suggested potential cost savings from HDHPs, the CBO found that these effects could be mitigated by the subsidy provided by favorable tax treatment of HSAs. Moreover, the CBO observed that the savings from the consumer-directed approach might not be as great as those achieved by tightly managed health care plans.

In general, CBO found that the available evidence is of limited use in determining the effects of HDHP/HSAs on health spending and should be treated cautiously. In particular, the CBO indicated that some studies that have reported cost savings from consumer-directed plans do not describe the extent to which total health expenditures are reduced, but instead measure changes in costs borne by insurers. In addition, studies comparing expenditures between consumer-directed plans and others do not always properly account for differences in the plans' enrollees. Studies regarding the extent to which consumer-directed plans attract healthier enrollees showed mixed results. The CBO also found no evidence that these plans will have a negative effect on the health of enrollees, as is suggested by some critics. More data and analysis will be needed to answer these fundamental questions.

ENROLLING IN HDHPs AND HSAs: CONSIDERATIONS AND QUESTIONS

Of greatest importance to understanding HSAs is the basic rule that an individual needs to be enrolled in an HDHP in order to make contributions to an HSA (or to have contributions made on his or her behalf by an employer). However, an individual may be enrolled in an HDHP without having an HSA.

As described earlier, an HDHP/HSA arrangement includes traditional medical coverage that is subject to a deductible, catastrophic protection for out-of-pocket expenses, and the HSA. Whether this type of arrangement makes sense for an individual depends on his or her particular situation.

Table 4 illustrates how these components work together to finance health care costs for individuals with different levels of medical expenses and savings goals. In each case, an HSA contribution of \$2,100 is assumed (the average reported by the GAO analysis of 2004 tax filings), along with an HDHP deductible of \$2,378, the average reported in the 2006 AHIP plan survey. Individual A would cover her \$500 in total annual medical expenses from her HSA account, leaving a balance of \$1,600 to roll forward for future use. The HDHP deductible would not be met, and no plan coverage would be used.

For Individual B, with \$2,500 in medical expenses, the first \$2,100 would be drawn from his HSA and used to meet the HDHP deductible. The HSA would be depleted, and he would have to cover \$278 out-of-pocket to meet the deductible. The additional \$122 in medical expenses would be covered by the HDHP, unless they were for uncovered services, services for which the HDHP requires cost sharing, or out-of-network services to which an additional deductible applies. Individual C also has \$2,500 in medical expenses but chooses not to withdraw HSA funds to cover these expenses. Instead, this person chooses to meet the HDHP deductible using other funds, leaving the HSA funds untouched to accumulate tax-free interest. Again, once the deductible is met, the HDHP coverage begins but coinsurance may apply, or some services may be uncovered by the plan.

TABLE 4
How HSAs and HDHPs Finance Medical Expenses: Four Scenarios

	Individual A	Individual B	Individual C	Individual D
	Uses HSA to pay medical expenses	Uses HSA maximum withdrawal + HDHP to pay medical expenses	Uses HDHP + out-of-pocket to pay medical expenses; uses HSA to build up tax-free savings	Uses HSA maximum withdrawal + HDHP to pay medical expenses
Annual Medical Expenses	\$ 500	\$ 2,500	\$ 2,500	\$ 20,000
Amount Drawn from HSA	500	2,100	0	2,100
Amount Paid by HDHP* <i>(deductible = \$2,378)</i>	0	122	122	17,622
HSA Contribution	2,100	2,100	2,100	2,100
HSA Balance Available for Rollover	1,600	0	2,100	0

* Assumes the HDHP covers the services in question without imposing any coinsurance or a separate out-of-network deductible. Depending on the services and the plan coverage, however, the enrollee may be required to pay some or all of this amount.

Individual D has medical expenses totaling \$20,000 and chooses to pay for \$2,100 of that total using available HSA funds. In order to meet the deductible, this individual would have to pay \$278 out of pocket. In this case, the HDHP would cover \$17,622 in expenses, assuming, as in the other examples, that all services are covered and no additional cost-sharing applies.

As with any insurance, the appropriateness of HDHP coverage for an individual is subject to the scope of coverage under the plan. Of particular concern with respect to HDHPs, no one should assume that, once the plan's deductible or out-of-pocket limit is met, all remaining medical expenses will be paid by the plan. As is the case with any type of health insurance, HDHP benefits are subject to the insurer's definitions, limitations, and exclusions and are payable only if the insurer determines they are medically necessary. (Depending on the type of plan and how it is regulated, such decisions may be subject to plan reconsideration and external appeal.)

Also, like traditional health insurance, HDHPs are subject to different underwriting, rating, and market conduct rules, depending on the nature of the issuer. The regulation of health insurance varies, and insurance sold in the small group and individual markets (generally regulated by the state in which it is sold but also subject to certain federal standards) must comply with different rules than a health plan which is sponsored by a self-insured, private-sector employer. A consumer seeking coverage without the benefit of an employer sponsor may find it more difficult to find an available HDHP at an affordable premium, especially if the person is older or has a preexisting medical condition. This is because, in most states, insurers selling in the individual market are not required to accept all applicants. Moreover, most states permit insurers selling in the individual market to compute policy premiums based on the applicant's risk factors, including age and health status.³⁵ Small group coverage must be sold on a guaranteed issue basis, but states differ in the extent to which they permit insurers to vary premiums for risk factors such as age and health status.

Table 5 (next two pages) illustrates cost-sharing requirements, benefit limits, and other features of HSA-qualified HDHPs offered by two major insurers in a northern Virginia county in 2006 in the individual market. Plan premiums vary for age, zip code, and whether the individual has used tobacco in the past 12 months. Premiums displayed in the table for the individual policies are standard rates (not adjusted for health status) for a couple, both persons age 55, and for a family of four (where the parents are in their 20s and the children are under age 5). While the table includes HSA-qualified high-deductible PPOs, some companies that offer

Like traditional health insurance, HDHPs are subject to different underwriting, rating, and market conduct rules, depending on the nature of the issuer.

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TABLE 5
Illustrative HSA-Qualified High-Deductible Health Plans Sold in the Individual Market in 2006
 (Standard Rates, Nonsmokers, Northern Virginia)



	Option A-1	Option A-2	Option B-1	Option B-2
Monthly Premium <i>(young family of 4)*</i>	\$311	\$232	\$204	\$118
Monthly Premium <i>(early retiree couple)†</i>	\$513	\$424	\$357	\$279
Preexisting Conditions Limit	12 months for conditions in prior 6 months	12 months for conditions in prior 6 months	12 months for conditions (advice or treatment) in prior 6 months	12 months for conditions (advice or treatment) in prior 6 months
Lifetime Maximum	\$5 million per person	\$5 million per person	\$3 million per person	\$3 million per person
I N - N E T W O R K C O V E R A G E				
Deductible	\$2,750 individual \$5,500 family	\$5,000 individual \$10,000 family	\$5,450 family	\$10,000 family
Out-of-Pocket Limit	\$5,500 (\$2,750 per person)	\$10,000 (\$5,000 per person)	\$5,450 (includes deductible)	\$10,000 (includes deductible)
Preventive Services	Well baby: covered as per state mandates, deductible waived; Adult periodic health exam: \$20 copay; Annual pap and mammogram: deductible waived	Well baby: covered as per state mandates, deductible waived; Adult periodic health exam: \$25 copay; Annual pap and mammogram: deductible waived	Periodic health exam: no charge after deductible (up to \$500 annually for each adult), after 3-month waiting period. Periodic OB-GYN exam: no charge after deductible. Well baby: up to \$500 annually for immunizations, after 3-month waiting period.	Periodic health exam: not covered. Periodic OB-GYN visit: no charge. Well baby: not covered, except where state-mandated
Office Visit	\$20 copay after deductible	No charge after deductible	No charge after deductible	Not covered
Specialist Visit	\$30 copay after deductible	No charge after deductible	No charge after	Not covered
Hospitalization	20% coinsurance after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Prescription Drugs	After deductible, \$15 copay for generic; \$25 for brand; \$40 for non-preferred brand. \$5,000 maximum benefit per year per individual applicable to combined in- and out-of-network	After deductible, no charge for formulary drugs. \$5,000 maximum benefit per year per individual applicable to combined in- and out-of-network	After deductible, no charge for generics or brand-name drugs (on or off formulary)	Not covered

* Family of 4, parents ages 28 & 27, children ages 2 and 3. †Both people age 55.

TABLE 5 — ILLUSTRATIVE HSA-QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS SOLD IN THE INDIVIDUAL MARKET IN 2006 (STANDARD RATES, NONSMOKERS, NORTHERN VIRGINIA)

INSURER A INSURER B

continued > In-Network Coverage	Option A-1	Option A-2	Option B-1	Option B-2
Mental Health	Limited to severe, biologically based mental or nervous disorders and associated treatment of drug and alcohol dependencies. 20% coinsurance after deductible for in-network. (<i>Out-of-network not stated</i>)	Limited to severe, biologically based mental or nervous disorders and associated treatment of drug and alcohol dependencies. No charge after deductible for in-network. (<i>Out-of-network not stated</i>)	No charge after deductible \$50 maximum benefit per visit; \$3,000 maximum lifetime benefit	Not covered
Maternity	\$30 copay for initial visit; no charge thereafter in-network; 50% coinsurance out-of-network for initial visit. Maternity hospital = 20% coinsurance after deductible for in-network; 50% coinsurance out-of-network	No charge after deductible for in-network or out-of-network	Not covered	Not covered
OUT-OF-NETWORK COVERAGE				
Deductible	\$5,500 individual \$11,000 family	\$10,000 individual \$20,000 family	Separate deductible of \$5,450 family	Separate deductible of \$10,000 family
Out-of-Pocket Limit	\$10,000 individual \$20,000 family	\$10,000 individual \$20,000 family	Not specified	Not specified
Office, Specialist Visits, and Hospitalization	Pays 50% of allowable fee after deductible	Pays 100% of allowable fee after deductible	Coverage is reduced by 25% for non-emergency services and subject to separate deductible equal to calendar year deductible	Not specified but appears to be uncovered
Prescription Drugs	After deductible: <i>generics</i> — \$15 copay + 50% coinsurance; <i>preferred brand</i> — \$25 copay + 50% coinsurance; <i>nonpreferred brand</i> — \$40 copay + 50% coinsurance. \$5,000 maximum benefit per individual per year applicable to combined in- and out-of-network	Pays 100% after deductible for generic and brand. \$5,000 maximum benefit per individual per year applicable to combined in- and out-of-network	Not covered	Not covered

Note: All policies are subject to medical underwriting. Certain conditions may be subject to preexisting condition exclusions or waiting periods. Source: EHealthinsurance.com. Rates are quoted as of November 1, 2006, for Fairfax County (Zip Code 22101).

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HMO products also sell HSA-qualified HDHPs. In addition to the significant variation in plan features, such as the amount of the deductible and the out-of-pocket limit (maximum), there is also a difference in the extent to which coverage is provided for prescription drugs, mental health, and maternity care. Although some plans impose no cost sharing once the deductible has been met (as long as the individual obtains services from a network provider), an individual electing to obtain services out-of-network under the plans shown in Table 5 would have to satisfy significant additional deductibles before any services would be paid for.

QUESTIONS TO ASK ON CHOOSING AN HDHP

What is the plan deductible?

When considering an HDHP, consumers should consider how they will pay if the need arises and they must finance medical bills up to the full amount of the plan's deductible. Those with an HSA should also consider the amount of the deductible in comparison to the funds in the HSA. If the amount available in the HSA is less than the plan's deductible, additional funds will be needed to pay for medical expenses until the health plan coverage begins.

What rules apply for in-network and for out-of-network services?

Plans may vary cost-sharing requirements based on whether services are received from a provider that is included in the plan's provider network. If an HDHP is structured as a plan that has a network of contracted providers (for example, a PPO), some special rules apply. Such a plan is permitted to have an out-of-pocket limit for services obtained out-of-network that is higher than the maximum allowed under the HDHP rules, so long as the out-of-pocket limit applicable to in-network services meets HDHP requirements.

Often plans have a different deductible for out-of-network services. In addition to a higher deductible, greater copayments or coinsurance may be required for services received. In addition, any extra amounts paid for services provided outside the plan's network may not count toward the out-of-pocket maximum.

For example, plan Option A-1 shown in Table 5 has an individual deductible of \$2,750 for in-network services and \$5,500 for out-of-network care. Similarly, the per-person out-of-pocket cap for this plan is \$2,750 for in-network care but \$10,000 for out-of-network services.

Does the deductible for family coverage apply to all expenses for the family, or are expenses for individual family members treated separately?

In some cases, the HDHP treats all medical expenses for the family as a group, and plan coverage for medical expenses for everyone in the family begins once the aggregate deductible is met. In other cases, the plan has a separate deductible for each family member, and will only begin coverage of medical expenses once some or all family members have met the individual deductibles.

Does the HDHP have a preexisting condition waiting period before full coverage begins?

A waiting period or other limits or exclusions on coverage for preexisting conditions may be imposed under HDHP coverage. Table 5 gives examples of these limits. In general, a preexisting condition is a health problem that existed before the effective date of the health plan coverage, but health plans vary in the specifics of how they define and apply preexisting condition coverage limits. Group plans are required under the federal Health Insurance Portability and Accountability Act (HIPAA) to count against a preexisting condition waiting period most types of health insurance coverage that a person might have had in the recent past. Such coverage may only be credited, however, if there is no significant break in coverage (generally 63 days or more). The protections of HIPAA against preexisting condition exclusions also extend to individuals moving from a source of group health coverage to nongroup (individual) coverage. However, for individuals without creditable coverage or for those who are newly purchasing nongroup coverage, and depending on state law, an insurer may impose waiting periods as well as exclusions more generally for preexisting conditions.

Which medical expenses will be covered by the HDHP, and which are not covered? Are there any exclusions or coverage limits for particular health care services?

Like traditional health insurance plans, HDHPs may have rules that limit coverage. These may include lifetime limits on benefits, limits on coverage of specific services, such as the number of hospital days, physician visits, or physical therapy visits. Plans may also require precertification for coverage of a hospital stay or other medical service. Table 5 illustrates some examples of coverage limitations, particularly with respect to mental health and maternity care.

The rules regarding the deductible and out-of-pocket limits apply only to expenditures for benefits covered by a plan and not to all medical expenses an HSA owner may incur during a year. For example, many health plans sold directly to individuals and families exclude coverage for normal

pregnancy or maternity care.³⁶ In that case, the enrollee would be responsible for not only the HDHP deductible and cost sharing but also the costs of prenatal care and delivery. These services could, however, be paid for by withdrawing any available HSA funds, even though they are not covered by the HDHP. Similarly, if an HDHP does not cover eyeglasses, the cost of eyeglasses would not count towards the plan's deductible or out-of-pocket limit (although the eyeglasses could be purchased with funds from the HSA).

Will the plan cover preventive services before the deductible is met?

HDHPs are allowed to cover preventive health care services such as cancer screenings and well-child visits before the deductible is met. Not all plans do so, however. Even when preventive services are covered outside the deductible, a plan may require cost sharing for these services. Table 5 illustrates some examples of how HDHPs treat preventive services.

Preventive services may include, but are not limited to the following: (i) periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals; (ii) routine prenatal and well-child care; (iii) child and adult immunizations; (iv) tobacco cessation programs; (v) obesity weight-loss programs; and (vi) specific screening services, including those for cancer, heart disease, infectious disease, mental health and substance abuse, vision and hearing, osteoporosis, and pediatric conditions.³⁷

In addition to these services, the plan may choose to cover some prescription drug expenses as preventive services, if they are taken to prevent occurrence or recurrence of a disease.³⁸ While it is not always clear which drugs for chronic conditions can be called preventive, one example of permitted coverage is the use of statins for the treatment of high cholesterol to prevent heart disease. Drugs used as part of procedures providing preventive care services, such as tobacco cessation and obesity weight-loss programs, are also considered preventive care.

If an enrollee regularly takes one or more prescription drugs that are not covered as preventive, no coverage for the drugs will be available until the plan's deductible is met. Consumers who are used to traditional health plan cost-sharing amounts may find themselves covering a much higher share of the annual cost of their drugs out-of-pocket.

What are the plan's cost-sharing requirements beyond the deductible?

Once the deductible has been met and HDHP coverage begins, a plan may require cost sharing for services received, up to an out-of-pocket maximum. Each HDHP must have a cap on the amount that an enrollee can be required to pay for the deductible, copayments, and coinsurance. For 2007, this amount may not exceed \$5,500 for an individual and \$11,000 for a family. Not all medical expenses count toward this amount, however. For example, some plans limit coverage to a "usual, customary, and

reasonable” amount it calculates for each service in a geographic area. If a health care provider charges more than that amount, the patient must pay the difference, even if the plan does not generally require any cost sharing for the service. In addition, amounts in excess of the usual, customary, and reasonable limit may not count toward the out-of-pocket maximum under the plan. That is, these amounts must be paid in addition to the health plan’s out-of-pocket maximum.

Does the HDHP make available discounted provider rates for services purchased below the deductible?

Even though an HDHP will not pay for services (with the possible exception of preventive care) until the required deductible is met, a plan may make provider discounts available to enrollees choosing the plan’s network providers. Such discounts may provide substantial savings from what a patient would otherwise pay the same provider for the same care.

What discounted services (for example, vision exams and over-the-counter medications) are offered by the HDHP?

Many insurers that offer HDHPs make available one or more discounted services as a free additional benefit of enrollment. (Such discounted services are also sometimes offered by insurers in conjunction with traditional health insurance policies.) These benefits may be arranged by the insurer through a marketing relationship with a health discount company, typically a non-risk-bearing entity that offers a small discount off of the price that an uninsured consumer would pay for the item or service. For example, one insurer markets an HDHP/HSA that includes as a free benefit a health discount program that “helps you save 10% to 50% on health and well-being services not covered by your medical plan. Services include but are not limited to: dental, vision and hearing; infertility; long term care; acupuncture; smoking cessation; and nutrition and fitness.”³⁹ The insurer’s plan brochure also lists discounts on such services as LASIK vision correction procedures, fitness clubs, cosmetic dental services, and adult day care. Discount programs are not insurance coverage, a distinction that can be hard for some consumers to understand.⁴⁰

QUESTIONS TO ASK ON CHOOSING AN HSA

How will the HSA be used?

HSAs are being promoted to achieve a variety of objectives. Although primarily they are viewed as accounts from which their owners can pay medical expenses that are not covered under their HDHP, they are also viewed as an instrument for accumulation of savings that can be used at some future point to pay expenses, medical or otherwise. Payment for health expenses (including long-term care insurance and Medicare premiums as well

as deductibles, copayments, and for uninsured services) after retirement is viewed by many as an especially important use for HSAs. Unlike distributions from many forms of retirement income accounts, those from HSAs for qualified expenses are not taxable.

Paul Fronstin of the Employee Benefits Research Institute examined the pros and cons of using an HSA as a retirement vehicle and concluded that, while HSAs have the distinction of being tax-advantaged, they have certain drawbacks. First, their availability and contributions are limited.⁴¹ Taxpayers may make contributions only when they are enrolled in qualified HDHPs, and annual contributions are limited by law. In addition, because HSA owners can use the monies in their accounts to pay for medical expenses during their working years, not much, if any, balance may be left upon retirement. Even if no HSA distributions are made prior to retirement for health expenses, the maximum amount that can be accumulated is less than is likely to be needed to cover estimated retiree health expenses.⁴² Although Fronstin's analysis predated the Tax Relief and Health Care Act of 2006, which increased the annual amounts that may be contributed to an HSA, it suggests caution in using an HSA as the sole vehicle for financing retiree health care expenses.

Who is qualified to establish and contribute to the HSA?

Money may be deposited into the accounts by the individual, an employer, or anyone else on behalf of the individual, although the combined contributions may not exceed certain annual limits. Qualified individuals must establish their own HSAs; there cannot be joint HSA accounts, even for individuals enrolled in a single-family HDHP (although the HSA contribution limits are higher for individuals with HDHP family coverage). A couple can divide their contribution however they wish and make deposits into the separate accounts or all into one account. If either spouse is 55 or older, that spouse can also make an additional "catch-up" contribution to his or her account. Dependent children may not have their own HSAs, but their medical expenses may be reimbursed from a parent's HSA. An individual does not have to be earning income to qualify for an HSA, nor are there any income limits on who can set one up.

Which health care expenditures are qualified to be paid for out of the HSA?

Qualifying health care expenditures are generally medical expenses allowed under the individual medical expense deduction provided under section 213(d) of the IRC. These items and services are more extensive than those generally covered under health insurance policies and include, in addition to medical, dental, and vision services, such things as attending medical conferences on a family member's chronic illness, transportation for medical services, smoking cessation and weight loss programs, and special education for learning disabilities. As is the case

for the individual medical expense deduction, gray areas may exist and consumers are advised to retain receipts in the event of an audit (see “Should the HSA account holder keep receipts?”). Although most over-the-counter medicines cannot be deducted under section 213(d) of the IRC, HSA funds may be withdrawn and used tax-free to pay for these products.⁴³

While health insurance premiums are allowed to be deducted under section 213(d), HSA funds may not be withdrawn and used tax-free to pay health plan premiums. Payment for premiums for certain types of insurance is allowed, however, including continuation coverage (for example, COBRA premiums),⁴⁴ qualified long-term care policies (as defined in section 7702B [b] of the IRC), health insurance purchased while receiving federal or state unemployment compensation, and, for Medicare beneficiaries, any insurance other than Medicare supplemental policies. (Thus, for example, a Medicare beneficiary could use funds in an HSA he or she established before becoming Medicare-covered to pay premiums for Medicare Parts B and D.)

Which entities are eligible to offer HSAs?

Banks and credit unions are automatically approved to offer HSAs, as either a trust or a custodial account. Insurance companies and other entities that are approved trustees or custodians of IRAs or Archer MSAs are also approved to offer HSAs. Other entities that wish to become approved trustees or custodians of HSAs have to apply to the IRS to do so in accordance with procedures that are specified in regulations governing trusteeships for 401(k) accounts.⁴⁵ These rules require, for example, that the entity demonstrate to the commissioner of IRS the capability to serve on an ongoing basis as a fiduciary, the ability to exhibit a “high degree of solvency,” experience and competence with respect to accounting for the interests of a large number of individuals, experience and competence in handling of retirement funds, and adequate net worth.⁴⁶ A consumer looking to set up an HSA with an entity that is not an established bank or credit union should therefore check to make sure that it has been approved by the IRS to be trustee for IRAs or Archer MSAs. Again, this means that the entity has met the IRS standards to serve as a trustee for HSAs.⁴⁷ (A listing of such entities as of 2005 is available from the IRS.)⁴⁸

If an employer contributes to an employee’s HSA, does the money in the HSA belong to the employee?

An HSA is owned by the individual and not by the employer.⁴⁹ Accordingly, the individual decides whether to contribute, how much of the account to draw from for medical expenses and which expenses to pay for, and how much, if any, of the account is saved for future use. The account holder also decides which entity—a bank, credit union, insurer, or company that has been established for the sole purpose of administering HSAs—will hold the account as the HSA custodian or trustee.⁵⁰

What is the difference between an HSA custodian and an HSA trustee?

The differences between a custodian and a trustee are minor and reflect distinct fiduciary requirements on the one (the trustee) and not the other. The determination of the nature of the arrangement is up to state law.⁵¹

What are the rules relating to annual contributions to HSAs? Is the total annual contribution made at the beginning of the year?

Contribution limits for both the regular HSA and catch-up contributions are calculated on a monthly basis. Individuals (and or their employers) may contribute up to 1/12 of the annual contribution maximum for each month that they are eligible during a year. Thus, an individual who is eligible for six months could make contributions of up to one-half of the annual limit. In the first year that an individual has HSA-qualified coverage, he or she may make the full-year regular contribution, even if his or her coverage begins partway through the year. To do this, however, the individual must maintain coverage for at least 12 full months. Contributions need not be made each month; they may be made at any time up to the filing date for the tax year. Contributions to HSAs must be made in cash (contributions through property are not allowed).

An HSA trustee or custodian is not permitted to accept contributions that exceed the annual limits (which would include the catch-up contribution if the person is age 55 or older). An exception is provided for rollover deposits from other HSA accounts of the individual. Account owners must be given unrestricted access to the accounts. Oversight of the use of funds is the responsibility of the IRS.

HSA contributions may be made through cafeteria plan salary reduction agreements. These are arrangements established by employers under which employees accept lower take-home pay in exchange for the difference being deposited in their account. Salary reduction agreements must allow employees to stop, increase, or decrease their HSA contributions throughout the year as long as the changes are effective prospectively. Employers may place restrictions on these elections if such restrictions apply to all employees.⁵² In addition, these agreements allow employers to contribute amounts to cover expenses that exceed employees' current HSA balances (subject to maximum amounts the employees had elected to contribute), if the employees repay the accelerated contributions before the end of the year.⁵³

Does an employer have to contribute the same amount for all of its employees?

Employers are not required to contribute to employees' HSAs but, if they do, the contributions must be comparable, with an exception. The general rule is that 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. 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. Under the Tax Relief and Health Care Act of 2006 (P.L. 109-432), an exception to the comparability rule is permitted enabling employers to make higher HSA contributions to employees who are not highly compensated. (A highly compensated employee includes one who owns 5 percent of the firm or receives a salary in excess of a statutory-based threshold or meets other criteria specified in section 4141(q) of the IRC.)⁵⁴ For example, an employer may contribute more to the HSAs of its rank and file than to its top-level executives, assuming the latter make in excess of the statutory-based threshold for highly compensated employees.

Does the individual wishing to establish an HSA need to use the bank, insurer, or other entity that is suggested by the HDHP insurer as the trustee or custodian for the HSA?

The Department of Treasury has indicated that the taxpayer can control which custodian or trustee holds the HSA. Additional paperwork may be associated with designating a custodian that differs from the one offered through the HDHP insurer. Certain advantages may be associated with selecting the custodian designated by the insurer (sometimes referred to as the "preferred HSA administrator"). For example, to pay for qualified medical expenses out of the HSA, the insurer may offer a debit card that can be used only in conjunction with the insurer's designated custodian.

What fees are charged by the HSA custodian or trustee?

Administrative fees are a factor in the competition between banks, insurers, and other entities to attract customers and may represent a significant cost to HSA enrollees.⁵⁵ Administrative fees may be charged for the initial establishment of the HSA, monthly maintenance of the account, and check fees. In addition, fees may be charged for activities such as allowing account balances to drop below some minimal balance, changing investment options, and obtaining certain records of HSA transactions. Such fees vary significantly, as illustrated in Table 6 (next page). Information about the various administrative fees may be obtained from Internet sources such as HSAfinder.com (www.hsafinder.com) and Vimo (www.vimo.com).

Vimo, which describes itself as an independent, objective source of HSA information, in October 2006 published a ranking of major HSA custodians, using as criteria their various fees and rates of interest, as determined

HSA Administrative Fees & Policies:
**Questions Consumers
Should Ask**

- Is there a fee to open an HSA?
- Is there a minimum start-up deposit?
- What are the associated monthly, annual, transaction, and closing fees?
- Is there a monthly, annual, or other contribution required to maintain the account?
- Will the account holder receive checks, a debit card, or a credit card with this account to pay for qualified medical expenses?
- What fees and interest rates are associated with these payment options?
- Will interest be paid on deposits to the HSA? Is the interest rate fixed or variable?

Source: Connecticut Health Policy Project, "Health Savings Accounts: Avoiding the Consumer Traps," February 2006; available at www.cthealthpolicy.org/pubs/hsa_consumer_traps.pdf.

through a survey of HSA custodian materials and through phone verification. The Vimo survey found an “enormous amount of variance in the fee structures of HSA custodians” and cautioned that “there are no standard ‘fee disclosure notices’ like there are with credit cards.” Furthermore, it noted, “many custodians don’t disclose the full range of fees associated with a given HSA product in their marketing materials or

TABLE 6
Health Savings Accounts: Illustrative Administrative Fees, Investment Options, Interest Rates

	H S A I N S T I T U T I O N			
	HSA Bank	Exante Bank (financial services)	Sterling HSA (independent HSA administrator)	Wells Fargo Health Benefit Services
Set-up Fee	\$ 18	\$ 12	\$ 15	\$ 0
Minimum Deposit	25	0	100	100
Minimum Balance	No minimum	0	50	100
Recurring Fees	\$2.25 per month; waived on balances above \$3,000	\$3.50 per month; waived on balances of \$1,500 or more	\$ 2.50 per month	\$4.25 per month
Investment Options	Self-directed; stocks, bonds, and more than 8,000 mutual funds	HSA account holders with balances over \$2,000 have the option to invest HSA dollars into a preselected set of highly rated [investment options]	Self-directed, using any investment option of account holder’s choice approved by the IRS	Six (6) Wells Fargo mutual funds
Interest Rates	APYs* as of 7/13/06: Below \$500 1% \$500–\$2,499 2% \$2,500–\$4,999 ... 2.3% \$5,000–\$14,999...3.3% \$15,000 & up ... 4.75%	Up to 4.5%	Under \$1,000 1% Under \$5,000 2% Over \$5,000 3%	Varies by fund
Other Fees/Services	Fees for specialty services, such as checks renewal for debit cards; \$25 to close account	Standard banking / usage fees (for example, for insufficient funds)	Online banking with echecking, free of charge	\$10 fee to replace a lost / stolen or receive a third debit card

*Annual percentage yield.

Note: More than 100 entities are listed. The entities were selected by the report’s authors to illustrate a large range of options for some of the largest HSAs in terms of enrollment and total deposits. Interest rates are applicable to savings and money market investments offered by an HSA administrator. Descriptions are those of EHealthInsurance and not of the report’s authors.

Sources: HSA Bank, “Health Savings Account Rates and Fees,” October 20, 2006, available at http://www.hsabank.com/products/hsa_rates.aspx, and HSAFinder.COM, “Where to Open an HSA Savings Account,” September 30, 2006, available at www.hsafinder.com/finder/accountcustodians.aspx#hsatable.

website, and those that do often provide less-than adequate explanations of those fees, making side-by-side product comparisons fiendishly difficult.” Vimo also found that for many of the HSA accounts in its survey, consumers would actually lose money because the annual costs of their HSA accounts would exceed the total of their account balances plus the annual rate of return and administrative fees.⁵⁶ Comparing the differing fees and interest rates offered by competing HSA custodians may, therefore, prove worthwhile.

On a more technical note, administrative 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.⁵⁷ However, they also do not increase the maximum HSA contribution amount. If the HSA holder or his or her employer pays the administrative fees directly to the HSA custodian or trustee, the amounts of money involved do not count toward the annual maximum contribution limit.⁵⁸

How is the money that is contributed to an HSA invested? Is the money insured?

Depending on which company serves as the HSA custodian or trustee, the money contributed by the individual, employer, or both to the HSA may be invested in an interest-bearing account, certificates of deposit, annuities, money market funds, or mutual funds (which may in turn invest in stocks, bonds, or both). Some HSA companies determine how the money is invested; in the case of others, investment decisions are “self-directed,” that is, left to the account holder, whether from a fixed set of options or from any type of investment option approved by the IRS. This means that consumers need to decide what level of risk to take with the money in their HSAs. To minimize risk, an individual may want to select an HSA that deposits contributions to an interest-bearing account that is insured by the federal government. At the other end of the spectrum, mutual funds may provide a greater return but are not FDIC-insured and carry the most risk of losing value.⁵⁹ Some HSA custodians and trustees require a minimum balance before specific investment options can be used. For example, Exante Finance Services requires account balances to be over \$1,000 before funds can be invested in their portfolio offerings of mutual funds.⁶⁰ (See Table 6 for an illustration of different investment options offered by some major HSA companies.)

Funds in HSAs may not be invested in “life insurance contracts, or in collectibles (e.g., any work of art, antique, metal, gem, stamp, coin, alcoholic beverage, or other tangible personal property.”⁶¹ In addition, certain transactions between the HSA beneficiary and the custodian or trustee are prohibited and the amounts involved would then no longer be regarded as qualified medical expenses but instead would be treated as taxable income and subject to a 10 percent tax penalty on the amounts involved.⁶²

Is the HSA custodian- or trustee-regulated?

Because HSAs are not insurance but are instead investment accounts sold in conjunction with qualified HDHPs, their regulation depends on the type of institution that administers the accounts. If the institution is a bank or credit union, it operates under established federal and state laws.⁶³ Since the law also permits insurers and “other persons” to serve as custodians or trustees of HSAs, the source and nature of regulation are less evident. Some entities offering HSAs may be approved as “nonbank” trustees or custodians to offer HSAs as a result of their approval by the IRS to offer IRAs (see “Which entities are eligible to offer HSAs?” above). Mutual fund and stock investment management companies may derive their IRS approval to offer HSAs in this way.

If insurers want to administer their own HSAs, this may raise concerns for regulatory oversight of insurer solvency and financial accounting.⁶⁴ In a 2005 review of HSA law and regulation, legal analysts Timothy Jost and Mark Hall found that most states did not appear to have a regulatory mechanism for overseeing insurers that offered financial services.⁶⁵ Thus, as with any financial investment, consumers should check to ensure that the HSA trustee or custodian is legitimate and appropriately credentialed.⁶⁶

What happens if the money from the HSA is used for nonqualified expenses, such as food, rent, child care, or vacations?

Money that is used from an HSA to pay for nonqualified medical expenses is taxed as income on top of a 10 percent additional penalty. An account holder who is disabled or 65 or older may take money out of his or her HSA for nonqualified purposes without penalty. The money is still taxed as income, however. This latter rule may encourage some individuals to use their HSAs as a vehicle to build their savings for retirement, and some HDHP insurers promote this feature as an option for customers’ retirement planning.

What tax forms need to be filed if an individual has an HSA?

Each year, the entity issuing the HSA is required to send the account holder two forms: Form 5498-SA and Form 1099-SA. The first form shows what contributions the individual and/or employer have made to the account. The second shows what money has been withdrawn from the account. The taxpayer must use this information to fill out IRS Form 8889, which calculates the income tax deduction for the HSA as well as any penalties for nonqualified distributions. This form is attached to the taxpayer’s IRS Form 1040.⁶⁷

Should the HSA account holder keep receipts?

The government says yes. An individual may need to prove to the IRS that the funds withdrawn from the account (“the distribution”) were indeed for medical expenses. In addition, the receipts may be needed to

prove to the insurer of the HDHP that the deductible was met. Another reason to retain receipts is that an HSA account holder is permitted to use the funds to pay any qualified medical expenses that are incurred, so long as they were incurred after the account was established. For example, if the HSA is established in 2006 and expenses are incurred in 2007, the individual is permitted to use the account to pay expenses incurred in 2007 (even if the person is no longer enrolled in an associated HDHP). The IRS advises individuals to “keep records sufficient to prove that the expenses were incurred and that they were not paid or reimbursed by another source or taken as an itemized deduction.”⁶⁸

Does an HSA ever expire?

Yes, upon the death of an HSA owner, the account balance transfers to the designated beneficiary. The only exception is that a spouse may continue to use the funds as his or her HSA. For other beneficiaries, the account balance is taxable as individual income. If no beneficiary is designated, the HSA balance becomes part of the estate and is taxable as income to the deceased on the final tax return. The amount is reduced by any qualified medical expenses incurred by the deceased individual prior to death and paid within one year.

What happens in the case of an individual who has both an HSA and a flexible spending account (FSA)?

The answer depends on the type of FSA and the purpose for which it is being used. In general, having an FSA may make the individual ineligible to contribute to the HSA unless the FSA is for a “limited purpose” (dental, vision, or preventive care), pays for medical expenses after the deductible is met, or is used in retirement.⁶⁹ Under the Tax Relief and Health Care Act of 2006, certain amounts in a health FSA may be rolled over into an HSA. Such a rollover may only be made once and must be made directly to the HSA before January 1, 2012.⁷⁰

DECISION SUPPORT TOOLS AND PLAN INFORMATION

The major insurers offering HDHPs are competing not only on the basis of their premiums. They are also seeking to attract market share on the basis of their decision support tools. In the employer and nongroup markets, many insurers offering HDHPs are either partnering with health information technology companies or developing inhouse capabilities to provide an array of Internet-based services to their customers, consistent with the idea of consumer-directed health care. The most sophisticated vendors offer one-stop shopping for decision support tools for both the HDHP and the HSA (see text box, following page). Some HDHPs, especially those

offered by major carriers and managed care organizations, provide information about diseases, treatment options, and some quality indicators.

It appears that detailed information on the plan itself, the contract language or certificate of coverage, tends to be less available for prospective enrollees, especially in the small-group and individual markets.⁷¹ Insurance purchased by employers and individuals from state-licensed health plans are subject to state requirements, if any, related to plan disclosure. Few if any states appear to require health insurers to disclose contract details of their policies to prospective enrollees. Under the Employee Retirement Income Security Act, or ERISA, private-sector employers are required to provide such information in the form of “summary plan descriptions.” However, researchers have found that such descriptions are not always adequate, timely, or written at a level that is clearly understandable by the average employee.⁷²

FUTURE POLICY CHALLENGES

For some people, the HDHP/HSA can be an attractive health plan option. The HDHP premium may be less than lower-deductible policies and, with its preferential tax treatment, the HSA can be a good long-term savings vehicle. Depending on how well the HSA funds are managed and invested, the accounts may build up significant amounts of money that are not taxed at any point, so long as they are used for qualified medical expenses. Should funds be withdrawn for nonqualified purposes, the tax benefits may still outweigh the penalties, which are waived for individuals age 65 or older.

HDHPs and HSAs may not be the best choice for all consumers, however. As discussed above, given the greater financial exposure of HDHPs, it is important to understand the limits of the coverage and the financial and other responsibilities placed on the enrollee. In this regard, lawmakers at the federal and state levels may decide to consider whether strengthening consumer protections might be warranted. Possibilities, discussed briefly below, include improving the transparency of HDHP policies, facilitating comparison of HDHP options, requiring coverage of preventive services outside the HDHP deductible, instituting federal standards for the underwriting and pricing of HDHP policies, and establishing standards for management of HSA trusts.

Adding any or all of these requirements to HDHP/HSAs would constrain market forces in shaping these products, however, resulting in a limiting of consumer choice and, in some cases, increasing the cost of health insurance.

Possible Online Services Offered by HDHPs

- Health education information (for example, prescription drug information, health promotion and prevention advice).
- Physician directories (for example, name, address, age, specialty, hospital affiliation, some background information such as medical school, degrees, physician medical board certification, languages spoken, years in practice).
- Hospital and pharmacy directories.
- Network provider quality information (for example, volume of procedures provided by network hospitals and outcomes of those procedures or links to Web sites containing such information, quality information on physicians).
- Provider cost information (for example, average hospital cost estimates, average physician cost estimates for selected services (but unlikely to include the actual negotiated payment rates enrollees would be charged by a specific provider), drug price information for retail and mail order (but unlikely to include actual negotiated rates payable at a particular pharmacy)).
- Available discount services, such as discount drug cards, discount vision care, and discounts on over-the-counter medications and dietary supplements.

Policymakers would need to weigh these costs against the potential benefits to consumers of imposing new requirements on HDHPs and HSAs. Defining a role for federal versus state regulators would also have to be determined.

HDHP Transparency

As is the case for health plan information generally, consumers have to dig hard to obtain the details of HDHP policies, especially prior to purchase. One way to help consumers better understand their choices would be to require plans to provide, before enrollment, a standardized summary of plan information to include items such as a plain English description of what services are and are not covered and what expenses do and do not count toward the deductible and out-of-pocket maximum as well as an explanation of “usual, customary, and reasonable charges” (or other plan terminology used to limit reimbursement), appeal rights, and rules regarding coverage in and out of the plan’s provider network.

In addition, wide variation in plan deductibles and out-of-pocket maximums can make it difficult for consumers to compare plans. One approach to facilitating plan comparisons would be to limit HDHP offerings to a limited number of standardized plan deductibles and out-of-pocket thresholds, so that consumers could more easily discern differences in premiums and other plan features. Another approach would be to continue reliance on health plans and others to provide plan comparisons such as those made available by eHealthInsurance (www.ehealthinsurance.com) and other Web-based sources of health plan information.

Coverage of Preventive Services

Federal standards (which already permit coverage of preventive benefits before applying the deductible) might require the coverage of certain preventive services on the basis of health promotion and increased cost-effectiveness. Such services might include prenatal care, well-child care, vaccinations, and annual check-ups, and certain prescription drugs.

Rating and Underwriting of HSA-Qualified HDHPs

In order to ensure that qualified HDHPs are affordable for those individuals who are older or who have preexisting medical conditions, minimum standards could be established for HDHP rating practices in the individual market. These might include community rating or limits on the range of permitted premium variation and a guaranteed issue requirement that a health insurance issuer accept all applicants, regardless of health status, claims experience, medical history or other health-status related factors (this requirement already applies to small-group coverage). However, while such changes would make HDHPs more accessible

for older, high-cost individuals, premiums would be increased for younger, healthier individuals and might make coverage unaffordable for some.

Tax-Free Withdrawals from HSAs

In order to ensure that HSAs are used to finance medical expenses rather than to shelter ordinary savings from taxes, the penalty for withdrawals for nonqualified purposes could be increased from the current levels of 10 percent for those under age 65 and zero for those individuals age 65 and older. Low penalties make HSAs attractive as tax shelters for higher-income individuals, who can afford to allow the tax-free contributions and tax-free interest buildup on those amounts to accumulate in their HSAs while they pay their medical expenses using other sources of less tax-advantaged money.

HSA Trusts

Federal requirements for banks, insurance companies, and others that manage HSA contributions could be expanded. HSA custodians and trustees vary widely in the fees they charge, the amount of risk associated with their investment instruments, and their rates of return. It could be argued that basic consumer protections and transparency requirements are the least that should be expected for a type of insurance that is strongly encouraged by federal tax laws. On the other hand, an unfettered market may be the best way to meet diverse consumer preferences.

ENDNOTES

1. Beth Fuchs and Julia A. James, "Health Savings Accounts: The Fundamentals," National Health Policy Forum, Background Paper, April 11, 2005; available at www.nhpf.org/pdfs_bp/BP_HSAs_04-11-05.pdf.
2. Fuchs and James, "Health Savings Accounts: The Fundamentals."
3. HRAs are a way that employers may provide tax-free funds to employees to use for health care expenses, in addition to or in lieu of health insurance benefits. An HRA can be funded only by employer contributions (that is, employees cannot contribute on their own), are not portable from employer to employer, and cannot be used for nonmedical expenses. HRAs do not have to be but often are associated with HDHPs. More information on the differences between HRAs and HSAs can be found in Fuchs and James, "Health Savings Accounts: The Fundamentals."
4. The legislative history leading to the MMA (P.L. 108-173) is summarized in Fuchs and James, "Health Savings Accounts: The Fundamentals."
5. See U.S. Department of Treasury, "Health Savings Accounts"; available at www.treasury.gov/offices/public-affairs/hsa/. This Web page includes basic information, technical guidance, frequently asked questions, and links to other sources, including commercial Web sites promoting HSA-qualified HDHPs and HSAs.

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6. U.S. Department of the Treasury, "General Explanations of the Administration's Fiscal Year 2007 Revenue Proposals," February 2006, pp. 21–27; available at www.treasury.gov/offices/tax-policy/library/bluebk06.pdf.
7. These and other more technical changes to the law relating to HSAs are projected to cost \$1.035 billion over FY 2007–2016. U.S. Congress, Joint Committee on Taxation, *Estimated Revenue Effects of the Revenue Provisions Contained in the Tax Relief and Health Care Act of 2006*, December 7, 2006; available at www.house.gov/jct/x-51-06.pdf.
8. U.S. Treasury, "General Explanations of the Administration's Fiscal Year 2008 Revenue Proposals," February 2007, p. 23; available at www.treasury.gov/offices/tax-policy/library/bluebk07.pdf.
9. U.S. Treasury, "General Explanations of the Administration's Fiscal Year 2008 Revenue Proposals."
10. Beth Fuchs and Lisa Potetz, "Medicare Consumer Directed Health Plans: Medicare MSAs and MSA-like Plans in 2007," Henry J. Kaiser Family Foundation, Medicare Issue Brief, March 2007; available at www.kff.org/medicare/7623.cfm.
11. George W. Bush, "Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs," The White House, Washington, DC, August 22, 2006; available at www.whitehouse.gov/news/releases/2006/08/print/20060822-2.html.
12. Individuals may have certain types of insurance and still qualify for an HSA. Types of insurance that are allowed include coverage for specific diseases; vision, dental, and long-term care coverage; and drug discount cards or employee assistance benefits that do not provide significant medical coverage. Veterans may qualify for an HSA if they have not received veterans' health benefits during the previous three months.
13. If the HDHP has an embedded deductible for one family member, the limit is the lower of the embedded deductible and the overall deductible for the policy.
14. The rules require that any income attributable to an excess contribution also be withdrawn from the account before the tax filing date for the year, or it will be subject to the penalty. The same rules for computing net income for excess contributions to IRAs apply to HSAs. The net income must be included in an individual's gross income. See U.S. Treasury, "Net income calculation for returned or recharacterized IRA contributions," Title 26 *Code of Federal Regulations* (CFR) Part 1, 408-11, 2005; available at http://a257.gakamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/aprqr/26cfr1.408-11.htm.
15. Generally, section 213(d) of the IRC allows individuals who file itemized tax returns to claim a deduction for medical and dental expenses paid for care for themselves, their spouse, or dependents to the extent that the expenses exceed 7.5 percent of adjusted gross income.
16. The Bush administration is proposing to change this provision to allow family coverage to include coverage under which each individual in the family can receive benefits once he or she has reached the minimum deductible for an individual HDHP. See U.S. Treasury, "General Explanations of the Administration's Fiscal Year 2008 Revenue Proposals," p. 23.
17. Hannah Yoo and Teresa Chovan, "January 2006 Census Shows 3.2 Million People Covered by HSA Plans," America's Health Insurance Plans (AHIP) Center for Policy and Research, Washington, DC, 2006; available at www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf.
18. Congressional Budget Office (CBO), "Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes," December 2006, pp. 75–76; available at www.cbo.gov/ftpdocs/77xx/doc7700/12-21-healthplans.pdf.

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19. Paul Fronstin and Sara Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans," Employee Benefit Research Institute, Issue Brief 300, December 2006; available at www.ebri.org/pdf/briefspdf/EBRI_IB_12-20061.pdf.
20. Gary Claxton *et al.*, "Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest," *Health Affairs* Web Exclusive, September 26, 2006.
21. Watson Wyatt Worldwide, "More Companies Offering Consumer-Directed Health Plans, Watson Wyatt/National Business Group Health Survey Finds," press release, March 15, 2007; available at www.watsonwyatt.com/news/press.asp?ID=17172.
22. Government Accountability Office (GAO), "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans," GAO-06-798, August 2006, p. 22; available at www.gao.gov/new.items/d06798.pdf.
23. CBO, "Consumer-Directed Health Plans," p. 11.
24. GAO, "Consumer-Directed Health Plans," p. 25, and Kaiser Family Foundation and Health Research and Educational Trust (Kaiser-HRET), "Section 8: High Deductible Health Plans with Savings Options," in *Employer Health Benefits: 2006 Annual Survey* (Menlo Park, CA: Kaiser Family Foundation, 2006); available at www.kff.org/insurance/7527/sections/upload/7527-Section_8.pdf. The Kaiser-HRET employer survey found 63 percent of employer plans contributing.
25. GAO, "Consumer-Directed Health Plans," p. 18.
26. Atlantic Information Services, "Data on Consumer-Directed Care," *Inside Consumer-Directed Care*, August 25, 2006, reprint; available at www.aishealth.com/ConsumerDirected/CDdata/HSAmidyear.html.
27. GAO, *Consumer-Directed Health Plans*, 26.
28. Kaiser-HRET, "Section 8."
29. GAO, "Consumer-Directed Health Plans," p. 16.
30. Claxton *et al.*, "Health Benefits in 2006," pp. w477–w478.
31. Kaiser-HRET, "Section 7: Employee Cost Sharing," in *Employer Health Benefits 2006 Annual Survey*, p. 2; available at www.kff.org/insurance/7527/sections/upload/7527-Section_7.pdf.
32. GAO, "Consumer-Directed Health Plans," p. 16.
33. See, for example, Vishal Agrawal *et al.*, "Consumer Directed Health Plan Report—Early Evidence Is Promising," McKinsey & Company, June 2005, available at www.mckinsey.com/clientservice/payorprovider/Health_Plan_Report.pdf, and Humana Inc., "Health Care Consumers: Passive or Active?" June 2005, available at <http://apps.humana.com/marketing/documents.asp?file=519272>.
34. See, for example, Kaiser Family Foundation, "National Survey of Enrollees in Consumer Directed Health Plans," November 2006, p. 6; summary, chartpak, and topline available at www.kff.org/kaiserpolls/pomr112906pkg.cfm.
35. Mark Merlis, "Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform," National Health Policy Forum, Background Paper, April 13, 2005; available at www.nhpf.org/pdfs_bp/BP_Underwriting_04-13-05.pdf; Mila Kofman and Karen Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," Georgetown Health Policy Institute, April 2006; available at www-tc.pbs.org/now/politics/Healthinsurancereportfinalkofmanpollitz.pdf?mii=1. Note that, in the small-group market, most states require rate bands which limit the allowable range of variation for risk factors.

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36. Ed Neuschler, "Policy Brief on Tax Credits for the Uninsured and Maternity Care," Institute for Health Policy Solutions, January 2004; available at www.marchofdimers.com/TaxCreditsJan2004.pdf.

37. U.S. Treasury, Notice 2004-23; available at www.treasury.gov/offices/public-affairs/hsa/pdf/notice2004-23.pdf.

38. U.S. Treasury, Notice 2004-50; available at www.treasury.gov/press/releases/reports/hsanotice200450072304.pdf.

39. UnitedHealth Allies, "Health Discount Program"; available at www.unitedhealthallies.com. The product is offered through UnitedHealthcare's Definity Health HDHP/HSA. The policy "does not make payments directly to the providers of medical services. The program member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization."

40. Although some states now prohibit medical discount programs from saying that their products are insurance, the programs have mostly operated free of regulation. In September 2006, the NAIC adopted a new model act aimed at addressing "the growing number of consumer complaints regarding discount medical plans." See National Association of Insurance Commissioners, "Discount Model Act Helps Regulators Track Medical Plan Organizations," news release, October 5, 2006; available at www.naic.org/Releases/2006_docs/discount_model.htm.

41. Paul Fronstin, "Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement," Employee Benefit Research Institute, Issue Brief 295, July 2006; available at www.ebri.org/pdf/briefspdf/EBRI_IB_07-20061.pdf. Note that this analysis preceded the changes made by the Tax Relief and Health Care Act of 2006 to permit higher annual HSA contributions.

42. Fronstin, "Savings Needed." Fronstin calculated that the totals would be about \$46,400 over 10 years, \$91,300 after 20 years, and \$183,600 after 30 years. This assumed no catch-up contributions are made once the individual reaches age 55, but even if they were, Fronstin concludes that the totals would likely fall short of needed amounts. "For retirees with access to employer-based retiree health benefits, to pay the full cost of premiums and out-of-pocket expenses for the rest of their lives, a couple age 65 today will need \$295,000. For retirees who do not have access to employment-based retiree health coverage, an average couple age 65 today will need \$154,000 to cover premiums for Medicare parts B and D, Medigap, and out-of-pocket prescription drug expenses if they have average drug use. A couple with drug use significantly above average will need \$299,000." Fronstin says that these estimates are likely to significantly underestimate the amounts needed after retirement (for example, long-term care is not included) and does not address those who retire before age 65.

43. U.S. Treasury, "HSA Frequently Asked Questions: Using Your HSA"; available at www.treasury.gov/offices/public-affairs/hsa/faq_using.shtml#hsa1.

44. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), employers with 20 or more employees are required to provide certain employees and their family members the option of purchasing continued health insurance coverage at group rates in the case of certain designated events. The major events include termination or reduction in hours of employment, death, divorce, eligibility for Medicare, or the end of a child's dependency under a parent's health insurance policy.

45. U.S. Treasury, "HSA Frequently Asked Questions: Trustees/Custodians"; available at www.treasury.gov/offices/public-affairs/hsa/faq_trustees-custodians.shtml.

46. U.S. Treasury, "Individual retirement accounts," Title 26 CFR, Part 1, 408-2, 2005; available at www.access.gpo.gov/nara/cfr/waisidx_05/26cfr1e_05.html. Upon approval, the IRS will state the day on which its approval becomes effective, and the approval remains effective until it is revoked by the IRS or withdrawn by the applicant.

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47. U.S. Treasury, "HSA Frequently Asked Questions: Setting Up Your HSA"; available at www.treasury.gov/offices/public-affairs/hsa/faq_setup.shtml#hsa4.
48. U.S. Treasury, "Announcement 2005-59: List of Nonbank Trustees and Custodians," Internal Revenue Bulletin 2005-37; available at www.irs.gov/irb/2005-37_IRB/ar15.html.
49. In contrast, an HRA is established by the employer on behalf of the employee and any funds in the account revert back to the employer, should the employee leave the firm.
50. U.S. Treasury, "All About HSAs," April 5, 2007; available at www.treasury.gov/offices/public-affairs/hsa/pdf/all-about-HSAs_040507.pdf.
51. According to the IRS, the "differences between a 'custodian' and a 'trustee' are minor. A trust is a legal entity under which assets are actually owned and held on behalf of a beneficiary. The trustee has some level of discretionary fiduciary authority over the assets of the fund. The trustee must exercise that authority in the best interests of the beneficiary. A custodial arrangement, on the other hand, is like a trust, but the custodian simply holds the assets on behalf of the owner of the assets. Other than holding the assets and doing as the owner orders, the custodian has no fiduciary obligations to the owner. The determination of what constitutes a trust or custodial arrangement is a determination made under state law." See U.S. Treasury, "HSA Frequently Asked Questions: Setting Up Your HSA."
52. Robert Lyke, "Health Savings Accounts: Overview of Rules for 2007," Congressional Research Service Report to Congress, RL 23357, March 12, 2007.
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54. Note that the comparability requirement also does not apply to HSA contributions made through a cafeteria plan or to independent contractors, partners in a partnership, and sole proprietors. In addition, it does not apply to employees who are included in a unit of employees covered by a bona fide collective bargaining agreement and one or more employers. U.S. Department of Treasury, "Final Regulations, Employer Comparable Contributions to Health Savings Accounts under Section 4980G," *Federal Register*, 71, no. 46 (July 31, 2006), pp. 43056–43067.
55. One research company predicts that by 2012, HSA-related fees will exceed \$1 billion. This is in addition to the billions of HSA dollars held by the HSA administrators or their partnering financial organizations. Cinda Becker, "One Question: Credit or Debit? As Health Savings Accounts Gain in Popularity, Insurers and the Financial Services Industry Want to Bank the Cash," *Modern Healthcare*, 36, no. 3 (January 16, 2006) pp. 6–7, 16.
56. Vimo, "HSA Custodians, A Vimo Ratings Report," October 2006; available at www.vimo.com/reports/hsarankings.pdf.
57. Lyke, "Health Savings Accounts: Overview."
58. U.S. Treasury, Notice 2004-50, pp. 70–71.
59. eHealthInsurance, "FAQs on HSAs. Is my money safe?"; available at www.ehealthinsurance.com.
60. UnitedHealth Group, "Exante Financial Services Introduces Consumer Health Investment Options," news release, November 7, 2005; available at www.exantebankhsa.com.
61. See U.S. Treasury, Notice 2004-50, A-65.
62. Specifically, "an account beneficiary may not sell, exchange, or lease property, borrow or lend money, furnish goods, services, or facilities services or facilities, transfer to or use by or for the benefit of himself/herself any assets, pledge the HSA, etc)." See U.S. Treasury, Notice 2004-50, A-67.
63. Federal regulators include the Federal Deposit Insurance Corporation and the Comptroller of the Currency. Depending on the type of bank, it may also be regulated under state law.

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64. Timothy S. Jost and Mark A. Hall, "The Role of State Regulation in Consumer-Driven Health Care," *American Journal of Law and Medicine*, 31 (2005), pp. 395–418.
65. Jost and Hall, "The Role of State Regulation," p. 408. The only rules that state regulators could identify were that the HSA funds and those of the insurer must be maintained in a separate account and could not be commingled with insurer funds that are at risk. If the funds were maintained separately from the insurer's other funds, then they were not subject to, and did not affect, the insurer's solvency and reserve requirements. As these authors suggest, when the first consumers encounter problems with their HSAs, regulators may eventually be criticized for not anticipating and planning for HSA failures to deliver on their services or, in the worst case, insolvencies.
66. Because the U.S. Department of Labor does not consider HSAs to be plans regulated under ERISA, states may see an opportunity to impose their own rules on them. See Jost and Hall, "The Role of State Regulation."
67. U.S. Treasury, "HSA Frequently Asked Questions: Trustee/Custodians."
68. U.S. Treasury, "All About HSAs."
69. U.S. Treasury, "Health Savings Accounts-Interaction with Other Health Arrangements," Rev. Rul. 2004-45; available at www.treasury.gov/offices/public-affairs/hsa/pdf/revrul2004-45.pdf.
70. Section 302(a) of P.L. 109-432; U.S. Treasury, Notice 2007-22, IRS Bulletin 2007-10, March 5, 2007; available at www.irs.gov/irb/2007-10_irb/ar10.html#d0e2603.
71. Based on an informal Internet survey, undertaken by the authors, of major insurers offering HSA-qualified HDHPs to individuals and small firms.
72. Certain employer group health plans are exempt from ERISA, including church-related plans, and therefore may not provide for summary plan descriptions. State and local governmental health plans as well as plans sold in the nongroup market are subject to state law. The Office of Personnel Management, which administers the Federal Employees Health Benefits Program, requires participating health plans to provide annually an up-to-date detailed description of plan provisions. Each insurer follows a similar format to describe the elements of the plan, such as requirements and coverage rules.



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