Insight

Health Savings Accounts and the Affordable Care Act

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INTRO

Health Savings Accounts (HSAs) are a form of consumer-directed health approach aimed at encouraging patients to make better informed choices about their health care needs by pairing high deductible health plans (HDHP) with tax-exempt savings accounts.[1] It has been estimated that families enrolled in these types of plans decrease their health care spending by 21 percent in the first year after a switch from traditional health insurance plans.[2] A shift towards consumer-directed health care, particularly in the employer-sponsored insurance market, could contribute to a $100 billion annual reduction in health care spending.[3]

WHAT IS AN HSA?

HSAs are a form of bank account, first recognized in 2003, into which an individual (or the individual's employer or another third-party) may contribute tax-exempt money for the specific purpose of paying for routine medical costs not covered by their health insurance, including deductibles and copayments. Individuals qualify for this tax-exempt savings vehicle if they are enrolled in a high-deductible health insurance plan (HDHP).[4] If the insured account holder switches from a HDHP to a plan that is not HSA compatible or ages into Medicare, the savings are still available to be used for qualified medical expenses. The account is owned by the individual and is portable, regardless of employment or insurance plan sponsor. The money rolls over from year to year, and grows tax-free until it is either used for medical expense, or transferred, or withdrawn for non-medical purposes.[5]

Contributions to an HSA

Individuals and their employers may contribute any amount up to $3,300 ($6,550 for families) per fiscal year into an HSA.[6] Individuals over 50 years old may also contribute an additional $1,000 annually. Contributions to an HSA are typically withdrawn directly from a paycheck and deposited into the HSA account; however, the owner of the HSA may also make tax-deductible contributions to the account at any time using personal funds. Money in the HSA may be invested, and growth in HSA funds is added to the funds of the account, tax free.[7]

The funds contributed to an HSA are tax-exempt so long as they remain in the account or are used for qualified medical expenses.[8] Money contributed to the account, and its growth, roll-over from year to year – there is no maximum balance for the account. The money may be removed in several ways. Payment for medical expenses and the death of the account-holder where the heir is the account-holder's spouse are both tax-free transfers.[9] HSA funds can be used for non-medical purposes, but this will trigger tax liability on that money and a 10-20 percent penalty. However, individuals who are disabled or have attained 65 years of age are exempted from the additional penalty. The death of an account-holder and transfer of the funds to a non-spouse trigger tax liability, but no penalty.[10]

HSA and High-Deductible Plans

HSAs may only be opened on behalf of individuals or families enrolled in a high-deductible health plan.[11] In 2014, high deductible plans were defined as plans with deductibles above $1,250 for an individual, and $2,500 for a family; however, the out of pocket max may not exceed $6,350 for individuals or $12,700 for families in these plans.[12]

High-deductible plans, though not paying first-dollar, or even co-pays in some circumstances, will still negotiate group rates with providers on behalf of their purchasers. It is worth noting, though, that individuals may still be able to negotiate lower rates with providers themselves.

Using HSA Funds

Funds from an HSA may only be used for qualified medical expenses without incurring tax liability.[13] The IRS provides examples of qualified expenses as: doctors' visits, dental care or braces, eye exams, eye glasses, LASIK surgery, prescription medications, acupuncture, chiropractic, hearing aids and batteries, long-term care expenses and insurance premiums, smoking cessation, physical therapy, psychological counseling, psychiatric care, and nursing

home care.[14]

UNDER THE ACA

The Affordable Care Act (ACA) has brought with it some interpretation challenges for HSAs. It was not immediately clear that all HSA compatible plans would satisfy the actuarial requirements for plans offered through the ACA exchanges, yet it appears that most high-deductible plans do satisfy the Essential Health Benefit (EHB) requirements. Plans offered on the exchange must have an actuarial value of at least 60 percent, meaning that the individual is expected to be responsible for 40 percent of health care costs, and the plan for 60 percent. An actuarial value of 60 percent qualifies as a Bronze plan. Furthermore, it seems that in year two of open enrollment, more high-deductible plans paired with HSAs were being sold on the exchanges as Silver plans than in the first year. This means that more insurers are offering these plans, and more importantly, the Secretary of Health and Human Services has approved these plans as having provided minimum essential coverage. This is not, however, the only complication that has arisen as a result of the ACA.

Because HSAs are considered "above-the-line", or pre-tax deductions, they do not factor into household income when determining subsidy eligibility.[15] This means that when reporting household income in order to determine whether an individual or family qualifies for an exchange subsidy, the $3,300 to $6,550 contributed towards the HSA are not included in that income figure, thereby reducing reported household income and increasing subsidy eligibility. For this reason alone they can contribute greatly to the overall value of a high-deductible plan, though this value is not immediately apparent to consumers searching for value on the exchanges.

An apparent glitch of the ACA excludes 24 to 26 year old children of parents with family HSAs from utilizing those funds, despite being in high-deductible plans.[16] The original law creating tax-preferred HSAs contained language reflecting the norm in 2003 to only allow children to remain on their parents' health insurance plans until they were 24 years old, and the extension to 26 mandated by the ACA did not account for this discrepancy, therefore leaving a small population of insured individuals unable to access HSA funds.[17]

The ACA also removed non-prescription over-the-counter (OTC) medications from the list of qualified medical expenses.[18] This move may encourage unnecessary physician visits (which are also covered by the HSA or ACA-mandated EHB coverage), for a prescription, when an OTC medication may be available to treat the same condition.

Despite steps taken through the ACA that diminish the value of HSAs, 80 percent of American rating areas (the assigned regions for offering a health insurance plan) will have

access to a median of three different ACA-compliant Bronze plans with HSAs in 2015.[*] In fact, about one-quarter of all Bronze plans in those areas are HSA eligible. Even 1 out of 7 Gold plans are HSA qualified in rating areas where Gold HSA plans are offered. Despite regular commentary to the contrary, HSAs are still widely available and advantageous to many American health insurance consumers.

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[*] This data is based on a survey of the 411 rating areas for which data was available; there are 501 total rating areas in the US.