



## Health Reform Provisions that Could Impact Consumer-Driven Health Plans

The health care reform legislation making its way through the 111<sup>th</sup> Congress will likely have a modest impact on consumer-driven health plans and their associated health care accounts (i.e., FSAs, HRAs, and HSAs). Earlier proposals that would have eliminated some of these options (particularly FSAs and HRAs) did not survive the legislative process. Below is a description of the remaining provisions that may be included in the final health reform legislation.

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

Both the House and Senate bills include a change in the definition of a “qualified medical expense” that impacts reimbursements and withdrawals under all types of health care accounts (i.e., FSAs, HRAs, HSAs, and Archer MSAs). As of 2011, expenses incurred for over-the-counter (OTC) medications will no longer be eligible for payment or reimbursement from any of the health care accounts. The House bill definition appears to apply to all OTC medications. However, the Senate bill would still allow OTC medicines obtained with a prescription and insulin to be reimbursed or paid tax-free from the health care accounts.

The Senate bill would impose an excise tax of 40 percent on employer-sponsored coverage that has a benefit value in excess of \$8,500 for single coverage and \$23,000 for family coverage (indexed annually). The benefit value of employer-sponsored coverage would include the value of the group health plan and contributions to employees’ FSAs, HRAs, and HSAs. This tax would be imposed on insurance companies, including self-insured plans and plans sold in the group market, and plan administrators. The House bill does not include a similar provision.

The House bill would also extend the same tax treatment that applies to qualified spouses and dependents under current law to any person who is an eligible beneficiary under the terms of the plan. As a result, if a plan includes coverage for domestic partners (or other individuals who do not meet the current law definition of a spouse or dependent under the tax code), the partners would also be considered a qualified beneficiary for tax purposes. These provisions would also make these individuals eligible for tax-free reimbursement of qualified medical expenses under FSAs and HRAs, but HSAs were specifically excluded. The provisions would be effective beginning in 2010. The Senate bill does not include a similar provision.

### Changes Impacting Only Flexible Spending Arrangements (FSAs)

The most significant change likely to be enacted is an annual limit on contributions made by employees to flexible spending arrangements (FSAs) for health care. Both the House and Senate



versions of health reform legislation would limit contributions to no more than \$2,500 annually. The limit would be indexed to inflation for future years. Under the House bill, these changes would not take effect until 2013. In the Senate bill, these changes would take effect in 2011.

### Changes Impacting Only Health Savings Accounts (HSAs)

The changes to health savings accounts (HSAs) proposed by the House and Senate bills are relatively minor. The only provision directly impacting HSAs (in addition to the change in the definition of a qualified medical expense described above) is that both the House and Senate bills would increase the tax penalty on HSA withdrawals that are not used for qualified medical expenses from the current 10 percent to 20 percent. The Senate bill also increases the penalty for non-qualified withdrawals from Archer MSAs. These provisions would go into effect in 2011.

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

Both the House and Senate bills set new requirements for all insurance policies, including HDHPs. For example, all insurance policies will be required to provide first dollar coverage for preventive care services. In addition, the preventive services must be covered without any cost-sharing (e.g., copayments) or application of any deductibles. While HDHPs are currently allowed to provide first dollar coverage of preventive care services, and most do, in the future all HDHPs will be required to do so. These provisions would go into effect in 2013 in the House bill and 2014 in the Senate bill.

The U.S. Preventive Services Task Force (and the Secretary of HHS) will define the scope of preventive care services in the future. This could create a potential challenge for HDHPs to the extent that the preventive services prescribed conflict with current IRS guidance on what constitutes “preventive care” for HSA purposes. If the final bill does not include a conforming change to the HSA law, or the IRS does not modify its current definition of “preventive care,” insurance plans may no longer qualify as HDHPs or may not meet the new requirements for all insurance policies in the future.

Another new requirement for all insurance policies is that they provide a minimum actuarial value for the benefits covered. Under the House bill, the minimum actuarial value must be at least 70 percent. Under the Senate bill, the minimum actuarial value must be at least 60 percent. Given the higher deductibles that most HDHPs have (compared to traditional HMO and PPO plans), the lower minimum actuarial value requirement in the Senate bill would make it easier for more HDHPs to meet the standard.

It is important to look more closely at how “actuarial value” is defined in these bills. Both bills use a different definition than the American Academy of Actuaries in that the bills would



measure a plan's actuarial value by comparing the percentage of covered benefits paid by the insurance plan relative to an identical plan with zero cost-sharing (i.e., no deductibles, copays, or coinsurance). Conversations with House and Senate staff also suggest that a plan's actuarial value would be determined assuming that an average or "standard" population would enroll in the plan, not taking into account any self-selection that may occur to do plan design features like deductibles, etc.

It is also not clear whether a plan's actuarial value would include employer or individual contributions made to the individual's HSA. The House bill is completely silent on this matter which would leave it up to the Secretary of HHS to define in regulations. The Senate bill requires the Secretary of HHS to issue regulations on this matter.<sup>1</sup> Based on an analysis by the Congressional Budget Office,<sup>2</sup> it would appear that the Secretary would conclude that HSA contributions should be included.

Including the contributions in the calculation of a plan's actuarial value would make it easier for more HDHPs to meet the minimum actuarial value requirement. If contributions are not included, HDHPs, many of which have actuarial values below 60 percent (or whatever the final standard becomes) based on the insurance coverage alone, could no longer be sold. Including contributions in the actuarial value calculation can increase a plan's value by 10-20 percentage points (or more), depending on the size of contributions.

Another potential conflict could arise for HDHPs if the current House bill's limits on out-of-pocket expenses for all health insurance plans are included in the final health reform legislation. The House bill sets limits on annual out-of-pocket expenses at levels lower than current limits for HSAs -- \$5,000 for individuals and \$10,000 for families -- and adjusted annually for inflation. The lower limits would also likely impact the actuarial value of insurance plans, although it would do so in a positive way (i.e., lower out-of-pocket limits should increase the actuarial value of insurance plans relative to the higher limits in the Senate bill, but the impact could be small).

The Senate bill also requires all insurance plans to include out-of-pocket limits but uses the current limits for HSAs (currently \$5,950 for individuals with self-only coverage and \$11,900 for individuals with family coverage in 2010) and adjusted annually for inflation. The out-of-pocket limits would go into effect in 2013 under the House bill and 2014 under the Senate bill.

---

<sup>1</sup>Sec. 3102(d)(2)(B) of the Senate bill states: "EMPLOYER CONTRIBUTIONS.—The Secretary must issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer."

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



The Senate bill includes a provision that would prevent small employers from offering plans with deductibles greater than \$2,000 for singles and \$4,000 for families. The limits on deductibles are indexed to the percentage increase in average per capita premiums. Employers may offer plans with deductibles higher than \$2,000 / \$4,000 if the employer offers a flexible spending arrangement (FSA) that reimburses the difference between the higher deductible and \$2,000 / \$4,000. The House bill does not include a similar provision.

The House and Senate bills both impose “medical loss ratio” requirements that may create challenges for HDHPs. For example, the House bill requires health insurance carriers to provide rebates to enrollees if the carrier does not spend at least 85 percent of premium revenues on medical claims. The Senate bill would impose a lower standard of 80 percent on small employer and individual insurance policies. Although some of the details on how this provision will work will not be clear until the Secretary of HHS issues regulations, it is clear that the high medical loss ratio requirements are not appropriate for plans with high deductibles. It is hard to imagine most plans with high deductibles paying such a high percentage of premium revenues on medical claims.

#### Other Provisions

The Senate bill would create a new “young invincible policy” that provides first dollar coverage for three primary care visits but no other coverage until the individual reaches current law HSA cost-sharing limits. These policies would be limited to those 30 years or younger and individuals exempt from the individual mandate due to affordability or hardship. These policies would provide an additional coverage option for younger individuals desiring to comply with the individual mandate under the Senate bill.

For more information contact:

**Roy Ramthun**  
Resident Fellow  
Council for Affordable Health Insurance  
ramthun@cahi.org

January 7, 2010