



HSA State Implementation Report, 2007

Health Savings Accounts (HSAs) became available in January 2004, creating a virtual “HSA revolution.” According to America’s Health Insurance Plans (AHIP), the program has grown from 438,000 participants in 2004 to 3.2 million people covered in 2005 (AHIP will soon release updated 2006 survey numbers). According to “Inside Consumer-Directed Care” (ICDC) Managing Editor Steve Davis, the publication surveyed about 40 banks and other firms that administer HSAs and reports that the companies have collectively opened 1.65 million accounts holding nearly \$2 billion in assets. It is clear from such data that HSAs have proven to be popular with insurers, employers and insurance purchasers. So much so, that the U.S. Treasury projects that by 2010 (based on current law) there could be as many as 14 million HSAs covering 25 million to 30 million people. If changes were made to existing HSA law, such as those contained in the president’s recent health care proposals (<http://www.whitehouse.gov>), the U.S. Treasury projects that as many as 21 million policies covering 40 million to 45 million people could be in effect.

HSAs have been popular in the state legislatures as well. Unfortunately, this popularity doesn’t mean that all states have solved the implementation issues posed by the new HSA law. For example, as states continue to pass state mandated health insurance benefit laws, some of those laws could interfere with owning an HSA unless a special exemption is made. The Council for Affordable Health Insurance’s (CAHI) HSA Working Group and Research and Policy Department have followed these issues closely in the states, and the results have been identified below.*

Tax Treatment of HSAs. Some states define income differently than the Internal Revenue Service. As a result, some income that may be tax free at the federal level may not be at the state level. The federal government does not tax qualified HSA contributions, distributions and rollovers from an Archer Medical Savings Account (MSA) to an HSA, but some states do. While these state laws are not necessarily a barrier to offering HSAs, they could be a disincentive to having one. All but a few states now conform to the federal Internal Revenue Code for HSA purposes.

The states that do not accept or follow the federal tax treatment for HSAs are detailed below. We have provided the link to the state’s revenue department for more information.

- Alabama: <http://www.ador.state.al.us/>

- California: <http://www.ftb.ca.gov/>
- New Jersey: <http://www.state.nj.us/treasury/taxation/index.html>
- Wisconsin: <http://www.dor.state.wi.us/>

Note: Some people have inquired about Washington, DC. At press time we have no new information to report on the tax treatment of HSAs there. (For more information please visit <http://cfo.dc.gov/cfo/site/default.asp>.)

States that have legislation to address state tax relief for HSAs (note in each case Archer MSAs are exempt from income tax but not HSAs):

- California (AB 84, AB 142 and AB 245)
- New Jersey (AB 724 and SB1944)
- Wisconsin (AB 47 and SB 18)

States with no income tax: States without a state income tax have difficulty providing a tax break for HSA contributions. The states are:

- Alaska
- Florida
- Nevada
- South Dakota
- Texas
- Washington
- Wyoming

States that do not tax income, but do tax dividends and interest: Two states have no income tax – so they cannot provide a tax break for HSA deposits – but do tax dividends and interest. HSA holders may have to pay taxes on any interest or dividends earned in their HSA.

- New Hampshire
- Tennessee

HSA State Mandated Benefit Issues. HSA plans, combined with high deductible health insurance, require people to pay smaller and routine health care expenditures out of pocket – that is, out of their HSAs. Insurance is reserved for major health care expenses.

However, the IRS has provided a safe-harbor list of preventive-care services that do not have to be subject to the deductible. These benefits include periodic health evaluations (e.g., annual physicals); screening services (e.g., mammograms); routine pre-natal and well-child care; child and adult

immunizations; tobacco cessation programs; and weight loss programs.

The problem is that some states mandate coverage of services like these before any deductible is met, usually referred to as first-dollar coverage. First-dollar mandates violate IRS requirements for qualification as a high deductible plan. For example, a state might require all insurance plans to provide first-dollar coverage of any treatment of lead poisoning found during lead screening. Thus none could qualify as an HSA-qualified high deductible health plan.

We expect that states will continue to introduce (and perhaps enact) state mandated benefit laws that may interfere with the HSA requirements. Under such a scenario, states should adopt laws that exempt HSA high deductible health plans from state mandated benefit requirements so that residents may keep their HSA plan. For a comprehensive list of state mandated benefit laws, please see CAHI's "Health Insurance Mandates in the States, 2007" available at: <http://www.cahi.org>.

States with health benefits that conflict with HSA implementation:

- New York (all plans)

Interesting recent enactments:

- Ohio – Mandate-free high deductible health plan for HSAs (HB 5 and SB 5 signed into law December 22, 2006). Ohio will now permit small employers to offer health plans without mandated benefits and providing for the operation of HSAs consistent with the federal HSA law.

States that have legislation to fix first-dollar mandated benefits:

- New York – Has a \$50 home-health deductible and no deductible for maternity benefits (however, legislation to exempt HSA-qualified high deductible health plans from such mandate requirements has been introduced: AB 3880 and SB 2968). NY is a difficult state to report on. For example, it does not permit HSAs to be sold in the individual market. Further, NY has some disqualifying health insurance mandates on the books, but we have heard that the NY Department of Insurance is allowing companies to sell HSA plans in the group market if filed properly. Also, NY is offering HSAs through the Healthy New York program – see "HSAs for Medicaid Beneficiaries" section below.
- Rhode Island – Has introduced legislation (SB130) that imposes a moratorium on mandated benefit laws after January 1, 2007, so that certain high deductible health plans qualify for HSAs.

HSAs and High-Risk Pools. Health insurance risk pools are special safety net programs created by state legislatures for the one to two percent of the population that is medically uninsurable. Some state high-risk pool plans have added an HSA option.

States that have adopted HSAs for their high-risk pool plans:

- Alabama**
- Arkansas
- Colorado**
- Idaho
- Kentucky**
- Louisiana**
- Maryland**
- Minnesota**
- Missouri**
- Nebraska**
- South Dakota**
- Wyoming

Legislation that addresses HSAs for high risk pools:

- North Carolina (SB 177)

HSAs for State and Municipal Employees. State and local governments are employers, too; and several of them are looking at Health Savings Accounts as a state-employee option, although some are facing significant opposition, especially from unions.

States that have adopted HSAs for their state and/or municipal employees:

- Arkansas
- Colorado
- Florida
- Indiana
- Kansas
- Kentucky
- Ohio
- Oklahoma
- South Carolina
- Utah
- Washington

States that have legislation that would allow HSAs for state and/or municipal employees:

- California (AB 1377)
- Michigan (HB 4012)
- Minnesota (HB 464 and SB 276)
- Montana (SB 519)
- Virginia (HB 2948 and HB 2651)

HSAs for Medicaid Beneficiaries. Medicaid is the federal-

state program that provides health insurance, long-term care and other health care services to about 52 million poor, disabled and senior Americans. States are looking for new and innovative ways to control their Medicaid costs, and some think HSAs should be part of the solution.

- Florida's waiver was approved (HHCG1 – pre-filed March 22, 2005, and HB 1873 filed April 1, 2005)
- Iowa passed into law a Medicaid HSA (HB 841, on May 12, 2005)
- South Carolina submitted its proposal to the Centers for Medicare and Medicaid Services in late November 2005 and is waiting for its approval. In the meantime, the 2006 Deficit Reduction Act (DRA) contained a provision to allow 10 states to implement South Carolina's proposal to start an HSA pilot program for Medicaid recipients. SC is expected to seek approval to become one of those states. (For more information, please visit http://www.dhhs.state.sc.us/internet/pdf/SouthCarolinaHealthyConnectionsSeptember6_2006.pdf.)
- Beginning January 1, 2007, New York's Healthy NY program will offer a new plan option -- high-deductible health plans designed to be used with HSAs. (For more

information please visit <http://www.ins.state.ny.us/website2/hny/english/hnyhdhp.htm>.)

States that have legislation that would allow HSAs for Medicaid beneficiaries:

- Oregon (HB 2552)

Conclusion. Just because a federal bill becomes law (e.g., the HSA legislation) doesn't mean that implementation will go smoothly in the states. Since each state regulates the health insurance industry and products for its state residents, issues can arise. However, the issues highlighted in this document are easily rectified with the appropriate legislation and would greatly enhance people's access to HSAs and affordable coverage. *For more information visit www.cahi.org.*

Endnotes:

* Since the legislation and state environment can change quickly, the information included here is subject to change. The information is derived from CAHI's legislative tracking vendors, HSA Working Group members and CAHI's state department of insurance surveys. This information should not be used as a compliance document, but rather as a guide for state legislators who want to ensure that citizens of their state have access to the full range of HSA opportunities.

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