

## Health Savings Accounts and Other Account-Based Health Plans

by Paul Fronstin, EBRI

- This *Issue Brief* examines accounts that can be used to pay for health care services on a tax-favored basis. Starting with health savings accounts (HSAs), the function of these accounts is described, followed by a discussion of issues related to the accounts, whether expectations for the accounts will be met, and recent evidence on their impact.
- HSAs are now one of a handful of accounts that individuals can use to pay for health care services on a tax-favored basis. Flexible spending accounts (FSAs) have been available since the 1970s, while Archer Medical Savings Accounts (MSAs) have been available since 1996. Some employers also offer health reimbursement arrangements (HRAs).
- An HSA is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. Contributions to the account are deductible from taxable income and distributions for qualified medical expenses are not counted in taxable income. Tax-free distributions are also allowed for certain premiums. There is no use-it-or-lose-it rule associated with HSAs, as there is with FSAs. In order to make tax-free contributions to an HSA, an individual must be covered by a health plan that has an annual deductible of not less than \$1,000 for self-only coverage and \$2,000 for family coverage.
- There is strong interest in HSAs among employers. One study found that 73 percent of small business owners were interested in the HSA concept. Another study found that 61 percent of employers they surveyed were likely to offer HSAs in near future. A third study found that 19 percent of surveyed employers were very likely to offer HSAs by 2006, and another 54 percent were somewhat likely to offer them.
- HSAs are controversial. Proponents of HSAs think that they will encourage individuals to become more astute health care consumers. Opponents think they are a new way to shift costs from employers to employees. They also think that HSAs will attract only the healthiest and wealthiest employees—ultimately making health insurance more expensive for others and creating “adverse selection” problems for conventional health plans.
- The introduction and use of HSAs is one piece of a larger movement toward more consumer involvement in the financing and delivery of health care. Some employers have used high-deductible account-based health plans as a way of encouraging more consumer involvement in the health benefits. Other employers have increased deductibles and co-payments. Many have added incentives for employees to use less-costly physicians, hospitals, and prescription drugs. Taken together, these changes may mean that the way in which health care is delivered and paid for in the future could look a lot different than it does today.

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## **Introduction**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–173) included a provision to create a new type of tax-favored savings account that can be used for health care expenses. Under the MMA, individuals with certain high-deductible health plans during their working years are eligible to contribute to a health savings account (HSA). The theory behind these accounts is that by giving individuals more control over funds allocated for health care services, they will spend the money more responsibly, especially once they become more educated about the actual price of health services. Furthermore, these accounts can be used as a tax-advantaged vehicle to save for health care expenses in retirement.

HSAs are now one of a handful of accounts that individuals can use to pay for health care services on a tax-favored basis. Flexible spending accounts (FSAs) have been available since the 1970s, while Archer Medical Savings Accounts (MSAs) have been available since 1996. Some employers also offer health reimbursement arrangements (HRAs). (See Figure 1 for a comparison of various health care account features.)

This *Issue Brief* examines accounts that can be used to pay for health care services on a tax-favored basis. Starting with HSAs, the function of these accounts is described, followed by a discussion of issues related to the accounts, whether expectations for the accounts will be met, and recent evidence on their impact.

## **Health Savings Accounts**

A health savings account (HSA) is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. Contributions to the account are deductible from taxable income, even for individuals who do not itemize, and distributions for qualified medical expenses are not counted in taxable income. Tax-free distributions are also allowed for certain premiums (this is discussed in more detail below).

HSAs are owned by the individual with a high-deductible health plan and are completely portable. There is no use-it-or-lose-it rule associated with HSAs, as any money left in the account at the end of the year automatically rolls over and is subsequently available. A bank, insurance company, or other non-bank trustee approved by the Internal Revenue Service (IRS) must administer the HSA.

Very few employers offer, and very few individuals currently have, an HSA. HSAs were first introduced by a select number of insurers in January 2004. Employers waited for Treasury Department and IRS guidance (discussed in more detail below) before offering a plan. 2006 is viewed as the year many employers will begin to offer HSAs, as it is too late for most employers to design and implement a new plan in time for the 2005 open enrollment season during the Fall of 2004.

### **High-Deductible Health Plan**

In order for an individual to qualify for tax-free contributions to an HSA, the individual must be covered by a health plan that has an annual deductible of not less than \$1,000 for self-only coverage and \$2,000 for family coverage. Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed \$5,000 for self-only coverage and \$10,000 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit will be indexed to inflation in the future. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services.

## **Contributions to an HSA**

Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from workers' taxable income if made by the employer, and deductible from adjusted gross income if made by the individual. The maximum annual contribution is \$2,600 for self-only coverage and \$5,150 for family coverage in 2004. But the maximum permissible contribution cannot exceed the plan deductible. This means that an individual with a \$1,000 deductible is not allowed to contribute more than \$1,000 to an HSA. Future contribution limits will be indexed to inflation.<sup>1</sup>

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high-deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.<sup>2</sup> Beneficiaries enrolled in Medicare are not eligible to make HSA contributions, although they are able to withdraw money from the HSA for qualified medical expenses and certain premiums.<sup>3</sup> Individuals also may not make an HSA contribution if claimed as dependents on another person's tax return.

Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2004, a \$500 catch-up contribution is allowed. A \$1,000 catch-up contribution will be phased in by 2009.<sup>4</sup>

## **Distributions From an HSA**

Distributions from an HSA can be made at any time. An individual need not be covered by a high-deductible health plan to withdraw money from his HSA (although he must have been covered by a high-deductible health plan at the time the funds were placed in the HSA). Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under Internal Revenue Code (IRC) Sec. 213(d). Distributions for premiums for COBRA, long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare other than for Medigap, are also tax-free. This means that distributions used to pay Medicare Part A or B, Medicare Advantage plan premiums, and the employee share of the premium for employment-based retiree health benefits are allowed on a tax-free basis.

Distributions for nonqualified expenses are subject to regular income tax as well as a 10 percent penalty, which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

Individuals are able to roll over funds from one HSA into another HSA without subjecting the distribution to income and penalty taxes as long as the rollover does not exceed 60 days. Rollover contributions from Archer MSAs are also permitted. Earnings on contributions are also not subject to income taxes.

## ***Flexible Spending Accounts***

Flexible spending accounts (FSAs) are a type of benefits cafeteria plan, authorized under Sec. 125 of the IRC as part of the Revenue Act of 1978. FSAs can be offered on a stand-alone basis or as part of a larger cafeteria plan, under which participants can choose among two or more benefits and cash. FSAs are perhaps the most well-known type of health spending account. Eighty percent of employers with 500 or more employees offered FSAs in 2003 (Mercer Human Resources Consulting, 2004). FSAs are a simple and inexpensive way of allowing employees to use pre-tax dollars to pay for health care services not covered by health insurance. Employers have often introduced or expanded these plans to soften the impact of a benefit reduction, such as an increase in the deductible or co-payments. FSAs do not need to be paired with a high-deductible health plan. Individuals are eligible for an FSA only if an employer offers it as an option.

## **Contributions to an FSA**

FSAs are funded through employee pre-tax contributions. Employees must designate their contribution in the year prior to the plan year. Once made, changes are allowed only for certain circumstances, such as a change in family status, plan cost changes, and plan coverage changes. Contributions to FSAs are withheld in equal amounts from each paycheck throughout the plan year, but employers must make the full amount available to the employee at the beginning of the plan year. For example, an employee who chooses to contribute \$1,200 to an account will have \$100 deducted from his or her paycheck each month, but will have access to the full \$1,200 at the beginning of the plan year. If an employee is reimbursed more than he or she has contributed to the account, and then leaves the job, the employer may lose money on the arrangement. This rule is a disincentive for a small employer to offer such an account. While there is no statutory limit on annual contributions to a medical FSA, employers are allowed to set an upper limit, and usually do so to mitigate losses related to turnover.

Contributing to an FSA not only reduces salary for federal income tax purposes, but also reduces the wages on which Social Security and Medicare taxes are paid. As a result, employees with earnings below the Social Security wage base (\$87,900 in 2004) will also pay less in Social Security taxes after the deduction is made for FSA contributions. Employees at all income levels will also pay less in Medicare taxes. The employer's share of Social Security and Medicare taxes will also be reduced, and this reduction may be large enough to offset the cost of administering the benefit.

## **Distributions From an FSA**

Distributions from an FSA can be made at any time. Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d).

Employees forfeit any money left over in the FSA at the end of the plan year; this is known as the "use-it-or-lose-it" rule. Employers can keep the forfeited funds and use them for any purpose, except that the funds cannot be returned to employees who have forfeited them. Employers typically use the forfeited funds to offset losses or to offset the cost of administering the benefit. The forfeiture of unused funds may partially explain why only 19 percent of eligible employees participate in these plans (Mercer Human Resources Consulting, 2004).

Employees also tend to make conservative contributions when participating. In 2004, the average contribution was \$1,134. While some would argue that the use-it-or-lose-it rule provides an incentive for employees to spend the balance of their account on health care services to avoid losing the funds at the end of the year, this may not be the case, as it appears that employees are conservative in both their participation and contribution levels.

There is some evidence to suggest that much of an employee's FSA election amount is based on foreknowledge of expenditures. Cardon and Showalter (2001) examined 1996 data from an insurer and found that very few accounts had a substantial amount forfeited and also found that participants tend to use their accounts strategically, spending their election amount relatively early in the plan year.

## ***Medical Savings Accounts***

A medical savings account (MSA) is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. MSAs were first authorized as a demonstration project under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Employees are eligible to set up an MSA if employed at a firm with 50 or fewer employees. The self-employed are also eligible. Both must be covered by a high-deductible health plan.

## **High-Deductible Health Plan**

In order for an individual to qualify for tax-free contributions to an MSA, the individual must be covered by a health plan that has an annual deductible of between \$1,700 and \$2,600 for self-only coverage and between \$3,450 and \$5,150 for family coverage. Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed \$3,450 for self-only coverage and \$6,300 for family coverage. The allowable deductible range and maximum out-of-pocket limit are indexed to inflation.

## **Contributions to an MSA**

Both employees and employers are allowed to contribute to a worker's MSA, but both may not make contributions in the same year. Contributions are excluded from taxable income if made by the employer, and deductible from adjusted gross income if made by the individual. The maximum contribution for self-only coverage is 65 percent of the deductible in 2004. The maximum contribution for family coverage is 75 percent of the family deductible. Contributions cannot exceed annual earned income or net self-employment income.

## **Distributions From an MSA**

Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d). Distributions for premiums for COBRA, long-term care insurance, and health insurance while receiving unemployment compensation are also tax-free.

Distributions for nonqualified medical expenses are subject to regular income tax as well as a 15 percent penalty, which is waived if the owner of the MSA is age 65 or older, becomes disabled, or dies.

## ***Health Reimbursement Arrangements***

A health reimbursement arrangement (HRA) is an employer-funded health plan that reimburses employees for qualified medical expenses. IRS Revenue Ruling 2002-41 and Notice 2002-45 (published in *Internal Revenue Bulletin* 2002-28, dated July 15, 2002) provide guidance clarifying the general tax treatment of HRAs; the benefits offered under an HRA; the interaction between HRAs and cafeteria plans, FSAs, and coverage under COBRA; and other matters under current law.<sup>5</sup> HRAs are typically combined with a high-deductible health plan, though this is not required. HRAs can also be offered on a stand-alone basis or with comprehensive insurance that does not use a high deductible. Employees are eligible for an HRA only when their employer offers such a health plan.

HRAs are typically part of a health benefits package that includes comprehensive health insurance after a deductible has been met. As an example, an employer may provide a comprehensive health insurance plan with a high deductible, for instance, \$2,000. In order to help employees pay for expenses incurred before the deductible is reached, the employer would also provide a HRA with \$1,000 that they would use to pay for the first \$1,000 of health care services. While the actual deductible is \$2,000, in this example, because the employer provides \$1,000 to an account, employees are subject only to the \$1,000 deductible gap—that is, the difference between the initial value of the HRA and the deductible level. After the employees' expenses reach the deductible, comprehensive health insurance would take effect. Employers can also set up an HRA to allow employees to purchase health insurance directly from an insurer. Generally, distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d), although employers can place restrictions on the use of an HRA.

Employers have a tremendous amount of flexibility in designing health plans that incorporate an HRA. For example, the amount of money that is placed in the account, the level of the deductible, and the comprehensiveness of the health insurance are all subject to variation. Employers often

cover certain preventive services in full, not subjecting them to the deductible. Employers can offer comprehensive health insurance that covers 100 percent of health care costs after the deductible has been met or they may offer coverage with cost sharing after the deductible is met. If employers choose to pay less than 100 percent of health care expenses after the deductible has been met, they then have the option of designing the plan with or without a maximum out-of-pocket limit.

Employers can also vary employee cost sharing based on in-network visits and out-of-network visits. Employers may choose to pay 100 percent of health care consumed after the deductible has been met for employees who use network providers, but pay only 70 percent or 80 percent if employees use an out-of-network provider.

### **High-Deductible Health Plan**

There is no statutory requirement that an employee have a high-deductible health plan in order to also have an HRA. However, it is standard practice among employers that an employee must also choose a high-deductible health plan in order to have an HRA. Overall, just 1 percent of employers offered a plan with an HRA in 2003 (Mercer Human Resources Consulting, 2004), but offer rates were much higher among large employers, with 9 percent of those with 20,000 or more employees offering a plan in 2003, up from 7 percent in 2002. Since so few employers offer an HRA, there is not a wealth of data on deductibles and employer contributions. One study examined 23 plans to get a sense of the magnitude of deductibles and contributions and found that the median deductible for employee-only coverage was \$1,500 with an \$800 employer contribution to the HRA (Mercer Human Resources Consulting, 2004). This study found a median deductible of \$4,000 for family coverage with a \$1,900 employer contribution to the HRA. The study also found at least 90 percent enrollment at three employers, and an average of 11 percent enrollment among the rest.

### **Contributions to an HRA**

HRAs are typically set up as notional arrangements and exist only on paper. Employers do not incur expenses associated with the arrangement until an employee incurs a claim. Were employers to set up the HRA on a funded basis, they would incur the full expense at the time of the contribution, even if an employee had not incurred any expenses.

### **Rollovers**

HRAs can be thought of as providing “first-dollar” coverage until funds in the account are exhausted. Leftover funds at the end of each year can be carried over to the following year (at the employer’s discretion), allowing employees to accumulate funds over time, and, in principle, creating the key incentive for individuals to make health care purchases responsibly. Employers can place restrictions on the amount that can be carried over. One feature of HRAs is that when unused funds are carried over each year, employees may be able to accumulate enough funds in their accounts to satisfy their deductible in future years. In addition, as employees build account balances, they may be more likely to switch to higher deductible health plans in the future. However, employees may also choose to forego necessary health care in order to accumulate funds in the account. Ultimately, the amount of money in the account will be a function of how long persons have had an account, use of health care, the size of the annual contribution, and employer policy. Funds in the HRA can accumulate tax-free as long they remain employer-provided funds paid out only for qualified medical expenses.

### **Distributions From an HRA**

Distributions from an HRA for qualified medical expenses are made on a tax-favored basis. Employers can also let employees use an HRA to purchase health insurance directly from an insurer. Since unused funds are allowed to roll over, employees are able to accumulate funds over time.

Employers can allow former employees to use any leftover money in the HRA to continue to cover qualified medical expenses. Funds can be used for out-of-pocket expenses and premiums for insurance, long-term care, COBRA, and retiree health benefits. Employers are not required to make unused balances available to workers when they leave.

### ***Treasury and IRS Guidance***

The Treasury Department and IRS have already released guidance on a number of issues that were raised immediately after MMA was passed. On Dec. 22, 2003, Notice 2004-2 was released to provide basic guidance on definitions, contributions, distributions, and other aspects of HSAs.<sup>6</sup> A second set of guidance was released on March 30, 2004, in which the Treasury Department and the IRS provided a safe-harbor list of preventive care benefits not subject to a deductible under a high-deductible health plan.<sup>7</sup> This guidance also allows an individual to contribute to an HSA until 2006, even if his or her health plan provides prescription drug benefits with modest copayments and no deductible. (After Jan. 1, 2006, having such a relatively comprehensive drug benefit will disqualify a person from contributing to an HSA).

On May 11, 2004, the Treasury Department and the IRS issued guidance related to how HSAs interact with health reimbursement arrangements (HRAs) and flexible spending accounts (FSAs).<sup>8</sup> This guidance generally states that an individual cannot contribute to an HSA if he or she also has a general-purpose FSA or HRA. However, the guidance allows a number of exceptions where an individual can contribute to an HSA and make use of an FSA or HRA during the same plan year.

- Employers can suspend contributions to an HRA while an employee is contributing to an HSA.
- Limited-purpose FSAs and HRAs are allowed for such services as vision care and dental care.
- FSAs and HRAs are allowed to reimburse expenses after the deductible has been reached.
- Individuals with a retirement HRA are allowed to contribute to an HSA. A retirement HRA is funded solely by an employer and provides reimbursement for health care services only after retirement.

HSA owners are not allowed to contribute to the account if they are also covered by an unrestricted FSA or HRA because these accounts are also considered health plans, providing first-dollar coverage prior to meeting the high-deductible associated with the HSA.

What is expected to be the final set of regulatory guidance was released July 23, 2004.<sup>9</sup> This guidance addressed questions related to the interaction among high-deductible health plans, health savings accounts, and preventive care provided under employee assistance plans, disease management plans, and wellness programs. The guidance also addressed issues related to preventive drugs and treatments, out-of-pocket limits, and comparability of employer HSA contributions and employer matching contributions through a cafeteria plan.

### **Comparability of Employer HSA Contributions**

The law generally states that employers that contribute to an HSA must make comparable contributions for all employees within a given class. The IRS and the Treasury Department discussed a number of situations when comparability of contributions would be acceptable and when it would not be. The guidance generally states that employers must make the same contribution to the HSA for all comparable employees. Employers cannot simply give employees the option of getting the contribution. For example, if an employer conditions HSA contributions on an employee's participation in some type of health assessment or prevention program, and some eligible employees elect not to participate in the program, the employer contribution will fail to satisfy the

comparability rules. Similarly, the comparability rules will not be satisfied if the employer uses matching contributions as an incentive to get employees to participate if some employees choose not to participate, resulting in the employer providing different contribution amounts for different employees in the same class.

Cafeteria plans are essentially exempt from the comparability of contributions requirement. The MMA conference report states that the comparability rules do not apply to employer contributions made through a cafeteria plan. Matching contributions made through a cafeteria plan are still subject to Sec. 125 nondiscrimination rules for eligibility, contributions and benefits, and key employee concentration tests.

### **Preventive Care**

The July 2004 Treasury and IRS guidance clarifies previous guidance on issues related to coverage of preventive care. The original guidance on preventive care provided a safe-harbor list of preventive benefits that need not be subject to a deductible. The new guidance adds that any treatment of a related condition that is “incidental or ancillary” to a preventive care service or screening also falls within the safe-harbor for preventive care. The guidance provides one such example related to the removal of polyps during a diagnostic colonoscopy. If the colonoscopy was a preventive screening and polyps found during that screening were removed, the removal of the polyps could be considered preventive care provided before the deductible is met. Certain drugs and medications are also considered preventive care and can be provided before the deductible is met when taken by an individual who has developed risk factors for a disease that has either not manifested itself, has not become clinically apparent, or to prevent the recurrence of a disease from which a person has recovered.

### **Employer Forfeiture of Contributions**

Employers are not allowed to recoup unused HSA contributions. Once an employer makes a contribution to an HSA, the money becomes the property of the employee. If, for example, an employer makes the maximum annual contribution to the employees’ HSA in the expectation that the employee would work for the employer for the entire calendar year and the employee terminates employment early in the year, the employer may not recoup any portion of its contributions from the employee’s HSA.

### ***Issues to Consider***

Currently, there is strong interest in HSAs among employers. In December 2003, the National Small Business Association (NSBA) found that 73 percent of 256 small business owners were interested in the HSA concept.<sup>10</sup> In 2004, Hewitt Associates found that 61 percent of 270 employers they surveyed were likely to offer HSAs in the near future.<sup>11</sup> Mercer Human Resources Consulting found that 19 percent of 991 surveyed employers were very likely to offer HSAs by 2006, and another 54 percent were somewhat likely to offer them.<sup>12</sup>

Nevertheless, HSAs are controversial. Proponents of HSAs think that they will encourage individuals to become more astute health care consumers. Opponents think they are a new way to shift costs from employers to employees. They also think that HSAs will attract only the healthiest and wealthiest employees—ultimately making health insurance more expensive for others and creating “adverse selection” problems for conventional health plans.

It is too soon to know how HSAs will impact utilization and cost of health care services, as the economic incentives created by HSAs and other account types can be complicated. However, employers have been using HRAs for a few years and evidence is starting to emerge on their impact. Issues related to HSAs and account-based health plans are discussed below. When available, evidence from the research literature is also discussed.

## Impact of Accounts on Spending Growth

Advocates say the use of high-deductible health plans combined with HSAs could reduce overall health spending or growth in overall spending. It is well known that a small fraction of the population accounts for a large share of health spending. Among the adult population with employment-based health benefits, average individual total spending on health care was \$2,454 in 2001 (Figure 2). Approximately 25 percent of the population incurred expenses above the average, but this relatively small fraction accounted for 80 percent of total health care spending. It is unlikely that overall increases in health care costs would moderate if the 25 percent of the population that accounts for 80 percent of the spending all had high-deductible health plans and HSAs. Very high users of health care services are unable to influence their own consumption effectively (Scandlen, 2004). Even if many high users of health care services were able to change the way they used health care services because they have more “skin in the game,” the change might only delay the time at which they reach the annual deductible, and not mean that the individual spends less over the course of a plan year. Unless high-deductible health plans include incentives to affect the spending patterns of chronically high users of health care services, the total cost of providing health benefits is unlikely to be significantly reduced.

HRAs and high-deductible health plans are also unlikely to reduce low users’ consumption of health care services. In fact, HRAs may induce low users of health care services to increase their consumption of health care. As long as employees do not view the HRA as their own money, and instead view it as employer money, they may use health care services unnecessarily. Unless the HRA is portable—and it usually is not—employees only get value from the HRA when they use health care services. An employee whose employer credits a health reimbursement arrangement with \$1,000 each year may not think twice about going to the doctor unnecessarily or using other health care unnecessarily if he or she is generally healthy and will roll over *most* of the money in the HRA each year. In contrast, health savings accounts probably will not induce low users of health care services to increase their consumption of health care because the funds in the account belong to them, not the employer, and are completely portable from job to job.

In effect, regardless of whether HRAs are funded with notional or real dollars, accumulation of accounts over time will effectively reduce some employees’ cost-sharing responsibilities to zero. As individuals, especially healthy individuals, accumulate funds over time in an HRA, at some point there should be enough funds in the HRA to cover the entire deductible. At that point, additional contributions to the HRA could be spent without “tapping” the funds in the HRA that would cover the deductible. The additional contributions could be spent on health care services that count toward the deductible. They can also be spent on services that do not count toward the deductible, such as Lasik eye surgery. Employers that cap the value of the HRA at an arbitrary level to avoid inducing demand may see their employees up against the cap increasing their use of health care services in order to “make room” for additional HRA contributions.

If employers use notional accounts, they could retain ownership of the account. This means that although an employee could use the funds in the account to pay for health care services and could carry over unused funds in the account each year, he or she would not have access to the accumulated funds upon job separation. This raises an issue of induced demand for health care services as employees accumulate funds in an account. An employee anticipating a job separation (retirement, for instance) might have an incentive to spend the funds in the account before the job separation, even if the additional utilization of health care services is unnecessary. Whether the anticipation of losing the funds in an HRA will induce demand is an empirical question that may not be answered for a number of years.

Employers could allow employees access to the funds accumulated in the accounts upon job separation, which would reduce the impact of induced demand but increase overall employer spending on health benefits. Funds left over in the account at job separation could be used to pay for COBRA coverage, retiree health benefits, long-term care insurance, or long-term care expenses,

depending on how the employer structures the plan, although distributions from the account for nonmedical expenses would be subject to income taxes, including distributions from the HRA for qualified medical expenses in that tax year. Employers might prefer not to make funds available for COBRA because they might not want to give employees an incentive to take COBRA coverage. Past research has shown that the claims experience of COBRA beneficiaries is 50 percent higher than it is for active workers (Huth, 1997 and 2000). Employers might also prefer not to make funds available for retiree health benefits. Employers have already made changes to retiree health benefits as a result of Financial Accounting Statement No. 106 (FAS 106), and are unlikely to increase FAS 106 liabilities (Fronstin, 2001).

### **Adverse Selection**

Opponents of health accounts, such as HRAs and HSAs, believe that these plans will only be attractive to the healthiest employees. If only healthy individuals choose account-based plans, overall costs for these plans will decline, while the overall cost of traditional plans with a relatively unhealthy population will increase. This phenomenon is known as adverse selection. Adverse selection may be offset if account-based health plans are also attractive to wealthy individuals, because the wealthy population tends to be older, and therefore, less healthy on average. To the degree that wealthy, older, less-healthy individuals (especially those with chronic illness) enroll in account-based health plans, adverse selection will be mitigated. This would be true even if the wealthy simply use HSAs as a way to save more money for retirement on a tax-favored basis.

Early evidence suggests that adverse selection may be an issue. In general, research has shown that higher-income employees are more attracted to plans with an HRA than are low-income employees (Lo Sasso et al., 2004; Parente et al., 2004). In addition, while there is no evidence of adverse selection when examining employee characteristics or demographics, there is evidence of adverse selection when examining prior year claims history (Tollen et al., 2004).

### **Employer Adoption of HSAs**

Small and large employers may adopt HSAs and HRAs for different reasons. Over time, large employers may be found to prefer offering high-deductible health plans with an HRA rather than an HSA. Since HRAs are typically notional accounts that exist only on paper and are not actual funded accounts, employers do not incur an expense until an employee uses health care services. In contrast, if an employer contributes to an HSA, an expense is incurred immediately even if the employee has not used any health care services. Employers may be hesitant to make the same contribution across the board for all employees, when many workers use very few health care services in any given year. According to Figure 3, 50 percent of the adult population used very few health care services, accounting for only 6 percent of overall spending. Employers may hesitate to fund an account for a worker who would otherwise use very few health care services, and instead may want to direct resources toward the high-users of health care.

Employer premium savings will be offset by contributions made to employees' HSAs. However, these premium savings alone will not be adequate to make the maximum contribution allowable to an HSA. Employees will need to supplement employer funds to maximize the contribution. Savings to the employer may also be offset by any costs associated with employee education necessary to assist employees in becoming better consumers of health care.

Mercer Human Resources Consulting found that 39 percent of employers responding to its survey reported that they would not contribute to the employees' HSA.<sup>13</sup> This may indicate that employers interested in offering a high-deductible health plan with an HSA have already figured out that the only way they may realize savings is by simply moving to a high-deductible health plan, thereby keeping the savings from the lower premium.

Small employers may not move to account-based health plans at all because they are slower to change health benefits generally. In 2002, after three years of double-digit increases in insurance

premiums (Claxton, 2003), only 19 percent of small employers made a change to their health plan (Fronstin and Helman, 2003). Many employers maintained the current health benefits because offering those benefits had a positive impact on recruitment, retention, productivity, the health status of employees, and the overall success of the business. Instead of cutting back on health benefits, 43 percent of employers reported that they had reduced pay, reduced or eliminated raises or bonuses, reduced other employee benefits, or put off equipment and other purchases. Some employers also reported that they either were not able to hire needed workers or they let go of some workers. These findings reflect the fact that even when the cost of providing health benefits is increasing, employers will make trade-offs to maintain those benefits. This may indicate that a significant number of employers will not move toward account-based health plans if they think it will be harmful to the overall success of the business.

### **Stacking Deductibles**

HSAs are likely to be more attractive to individuals than to families, particularly if some members of the family are significantly healthier than others. Under a high-deductible family plan, no one in the family can have a separate deductible lower than the minimum family deductible. Consider the case of a married couple with no children. In order to contribute to an HSA this couple must have a family plan with at least a \$2,000 deductible. This means that the combined spending on health care services of the couple would need to reach \$2,000 before insurance begins to pay for health care services. This couple could not have separate (“stacked”) deductibles of \$1,000 each under the family plan. As a result, if the healthier half of the couple generally uses no or very few health care services in the year, the other half of the couple has, in effect, a \$2,000 deductible. This couple may not want to enroll in such a high-deductible health plan as a family but might prefer to enroll only the sicker person in single coverage with a \$1,000 deductible (if possible).

### **FSAs**

Guidance from the Treasury Department indicates that an individual cannot contribute to an HSA if also covered by a general purpose FSA. However, limited-purpose FSAs—those that restrict use to certain benefits such as vision and dental care—are allowed, and individuals can also contribute to an HSA when the FSA provides benefits only after the minimum annual deductible has been reached. Employees are already known to participate and contribute to FSAs very conservatively. The combination of the FSA use-it-or-lose-it rule and the Treasury Department guidance essentially prohibiting the withdrawal of funds from an FSA until the deductible has been reached may result in even fewer employees participating in such arrangements.

### **Savings for Retirement**

The amount of money that an individual can accumulate in an HSA is limited. An individual who contributes \$1,000 each year (and makes the maximum allowed catch-up contribution) can accumulate about \$23,000 after 10 years, \$47,000 after 20 years, \$81,000 after 30 years, and about \$137,000 after 40 years (Figure 4). These estimates are based on three assumptions: 1) that the individual earns an average annual rate of return of 5 percent on the funds held in the HSA, 2) that the maximum allowable contribution is indexed for inflation, and 3) maximum catch-up contributions are made once an individual reaches age 55. An individual making the maximum annual contributing of \$2,600 each year can accumulate \$44,000 after 10 years, \$101,000 after 20 years, \$190,000 after 30 years, and \$334,000 after 40 years.

An individual age 55 in 2004 can save a maximum of \$44,000 in an HSA by the time he or she reaches age 65. This is far from enough money to completely pay for health insurance premiums and out-of-pocket health expenses in retirement. Fronstin and Salisbury (2004) provide estimates on how much money an individual age 55 in 2004 will need by 2014 (when the individual is 65) to completely pay for insurance premiums and out-of-pocket expenses if he or she has access to employment-based retiree health benefits. An individual will need \$137,000 if he or she only lives

to age 80 and insurance premiums and maximum out-of-pocket expenses increase 7 percent annually (Figure 5). If an individual lives beyond age 80 or insurance premiums and maximum out-of-pocket expenses increase faster than 7 percent, he or she will need a lot more than \$137,000 (similar estimates are shown in Figure 6 for a person with Medigap and Medicare Part D drug benefits).

One of the difficulties in using an HSA to save money for premiums and out-of-pocket expenses during retirement is that individuals also can (and may need to) use the money in the account to pay for health care services during their working years or to pay COBRA premiums and insurance premiums while they are unemployed. Distributions from the account prior to becoming eligible for Medicare will erode the value of the account. In fact, if an individual takes distributions averaging only 10 percent of the end-of-year account balance each year, an individual contributing \$1,000 each year will have \$15,000 after 10 years, and \$28,000 if he or she contributes \$2,600 each year (Figure 4). Some individuals may choose to forego withdrawals from the HSA to pay for out-of-pocket expenses if able to pay those expenses on an after-tax basis.

Even if an individual is able to roll over 90 percent of the end-of-year account balance each year for 40 years, an individual contributing \$1,000 per year will have accumulated only \$25,000, while an individual contributing \$2,600 per year will have accumulated only \$51,000. These estimates are much lower than the potential savings that can be accumulated by an individual who rolls over the entire end-of-year account balance each year. In fact, an individual contributing \$1,000 per year over 40 years would have about \$137,000 in his or her account, while an individual contributing \$2,600 would have \$334,000. Hence, even a 10 percent distribution rate for out-of-pocket expenses will have a relatively large impact on the potential accumulation of assets in an HSA over a long period of time.

## **Conclusion**

The introduction and use of HSAs is one piece of a larger movement toward more consumer involvement in the financing and delivery of health care that started just a few years ago. Some employers have used high-deductible health plans, in many cases with some form of spending or savings account, as a way of encouraging more consumer involvement in their health benefits. Other employers have increased deductibles and co-payments. Many have added incentives for employees to use less-costly physicians, hospitals, and prescription drugs. Taken together, these changes may mean that the way in which health care is delivered and paid for in the future could look a lot different than it does today.

The introduction of HSAs has further spurred interest in account-based health plans. There are many theories and positions on the impact that account-based health plans will have on the health care system, but real evidence is lacking. In large part, the only academic research on account-based health plans published independently of a supplier of account-based products was published in August 2004, and even this only examined the experiences of early adopters of such arrangements.<sup>14</sup> It is necessary to understand the effects of early adoption of account-based plans, but far from sufficient to rely on them exclusively at a time when the market is changing rapidly and often in response to the initial results of early adoption.

Currently, health care accounts for about 14 percent of the nation's gross domestic product (GDP). Any time that 14 percent of GDP is changed there will be winners and losers, and many issues to grapple with. The movement toward account-based health plans, as part of the evolution of the financing and delivery of health care, not only has implications for the cost of providing health benefits and utilization of health care services, but also for quality of health care, the use of appropriate and inappropriate health care services, the health status of the population, risk selection, and efforts to expand health insurance coverage. Much more research needs to be done before moving from the theoretical implications of account-based health plans to a better understanding of the real-world benefits and costs.

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## Endnotes

- <sup>1</sup> The maximum annual contribution is actually the sum of the limits that are determined separately for each month. The monthly contribution limit is 1/12 of the lesser of the annual deductible or the maximum annual contribution. If an individual first becomes covered by a high-deductible health plan mid-year, the annual contribution limit is pro-rated, and the monthly contribution limit is based on the number of full months of eligibility. As an example, an individual who enrolled in a plan on July 1 with a \$1,000 deductible would be eligible to contribute one-half (6/12) of the annual maximum contribution or \$500 to the HSA.
- <sup>2</sup> Permitted insurance also includes worker's compensation, tort liabilities, and liabilities related to ownership or the use of property (such as automobile insurance).
- <sup>3</sup> Only Medicare enrollee's ages 65 and older are allowed to pay insurance premiums from an HSA. A Medicare enrollee under age 65 cannot use an HSA to pay insurance premiums.
- <sup>4</sup> The catch-up contribution is not indexed to inflation after 2009.
- <sup>5</sup> See [www.irs.gov/pub/irs-utl/revrul2002-41.pdf](http://www.irs.gov/pub/irs-utl/revrul2002-41.pdf) and [www.irs.gov/pub/irs-drop/n-02-45.pdf](http://www.irs.gov/pub/irs-drop/n-02-45.pdf) (last reviewed July 2004).
- <sup>6</sup> See [www.treas.gov/press/releases/js1061.htm](http://www.treas.gov/press/releases/js1061.htm) and [www.treas.gov/press/releases/reports/1061notice20042.pdf](http://www.treas.gov/press/releases/reports/1061notice20042.pdf) (last reviewed July 2004).
- <sup>7</sup> See [www.treas.gov/press/releases/js1278.htm](http://www.treas.gov/press/releases/js1278.htm), [www.treas.gov/press/releases/reports/notice200423.pdf](http://www.treas.gov/press/releases/reports/notice200423.pdf), [www.treas.gov/press/releases/reports/notice200423.pdf](http://www.treas.gov/press/releases/reports/notice200423.pdf), [www.treas.gov/press/releases/reports/rev.rul200438.pdf](http://www.treas.gov/press/releases/reports/rev.rul200438.pdf), and [www.treas.gov/press/releases/reports/rev.proc200422.pdf](http://www.treas.gov/press/releases/reports/rev.proc200422.pdf) (last reviewed July 2004).
- <sup>8</sup> See <http://www.treas.gov/press/releases/js1535.htm> and [www.treas.gov/press/releases/reports/js1535\\_revul200445.pdf](http://www.treas.gov/press/releases/reports/js1535_revul200445.pdf) (last reviewed July 2004).
- <sup>9</sup> See [www.treas.gov/press/releases/js1812.htm](http://www.treas.gov/press/releases/js1812.htm) and [www.treas.gov/press/releases/reports/hsanotice200450072304.pdf](http://www.treas.gov/press/releases/reports/hsanotice200450072304.pdf) (last reviewed July 2004).
- <sup>10</sup> See [www.nsbaadvocate.com/docs/2003\\_benefits\\_survey.pdf](http://www.nsbaadvocate.com/docs/2003_benefits_survey.pdf) (last reviewed July 2004).
- <sup>11</sup> See [was4.hewitt.com/hewitt/resource/newsroom/pressrel/2004/03-31-04.htm](http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2004/03-31-04.htm) (last reviewed July 2004).
- <sup>12</sup> See [www.mercerHR.com/USpress](http://www.mercerHR.com/USpress) (last reviewed July 2004).
- <sup>13</sup> See [www.mercerHR.com/USpress](http://www.mercerHR.com/USpress) (last reviewed July 2004).
- <sup>14</sup> See various papers in the August 2004 Part II issue of *Health Services Research*.

**Figure 1  
Comparison of Various Features in Health Care Accounts**

	<b>HSA<sup>a</sup></b>	<b>HRA<sup>b</sup></b>	<b>FSA<sup>c</sup></b>	<b>MSA<sup>d</sup></b>
<i>Overview</i>	Tax-exempt trust or custodial account to pay for qualified medical expenses of account holder and dependents	Employer-funded account that reimburses employees for qualified medical expenses	Employee-funded account to pay health expenses on a pre-tax basis	Tax-exempt trust or custodial account to pay for qualified medical expenses of account holder and dependents
<i>Eligibility</i>	Individuals covered by a qualified high-deductible health plan.	Employee whose employer offers an HRA.	Employee whose employer offers an FSA.	Self-employed and employees at firms with 50 or fewer employees covered by a high deductible health plan
<i>Ownership of funds</i>	Employee	Employer	Employee	Employee
<i>Use-it-or-lose-it by end of benefit year</i>	No, funds roll over	No, funds roll over	Yes	No, funds roll over
<i>Access to account upon end of job</i>	Yes	Depends on employer	Limited	Yes
<i>Who contributes</i>	Both	Employer	Employee	Both, but not in same year
<i>Must be paired with high deductible</i>	Yes	No, but often is	No	Yes
<i>May be used with other accounts</i>	Yes, but limited	Yes	Yes	Yes
<i>Money can be used for non-health expenses</i>	Yes, subject to tax and penalties	Yes, subject to tax and penalties	No	Yes, subject to tax and penalties
<i>Tax treatment</i>	Reduces taxable income	Tax free	Reduces taxable income	Reduces taxable income

Source: Employee Benefit Research Institute.

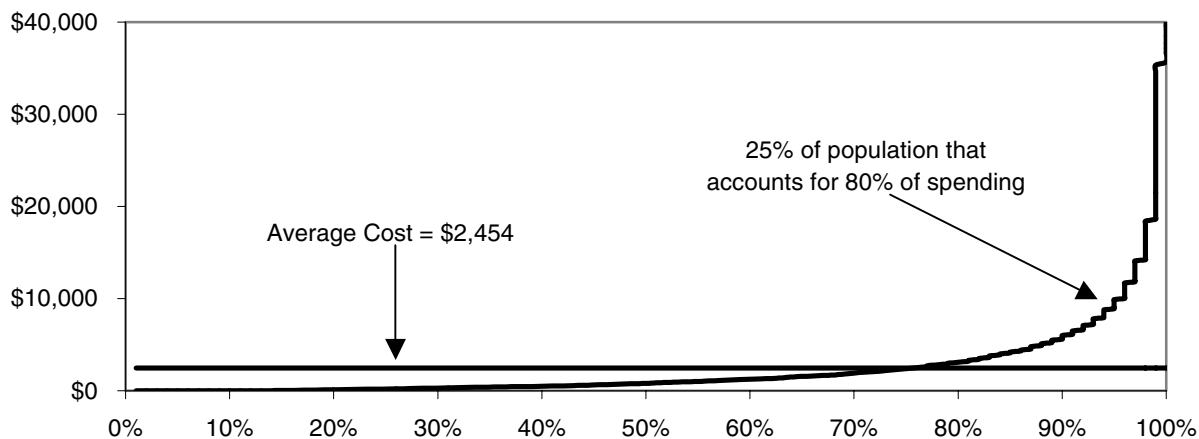
<sup>a</sup> Health savings accounts.

<sup>b</sup> Health reimbursement arrangements.

<sup>c</sup> Flexible spending accounts.

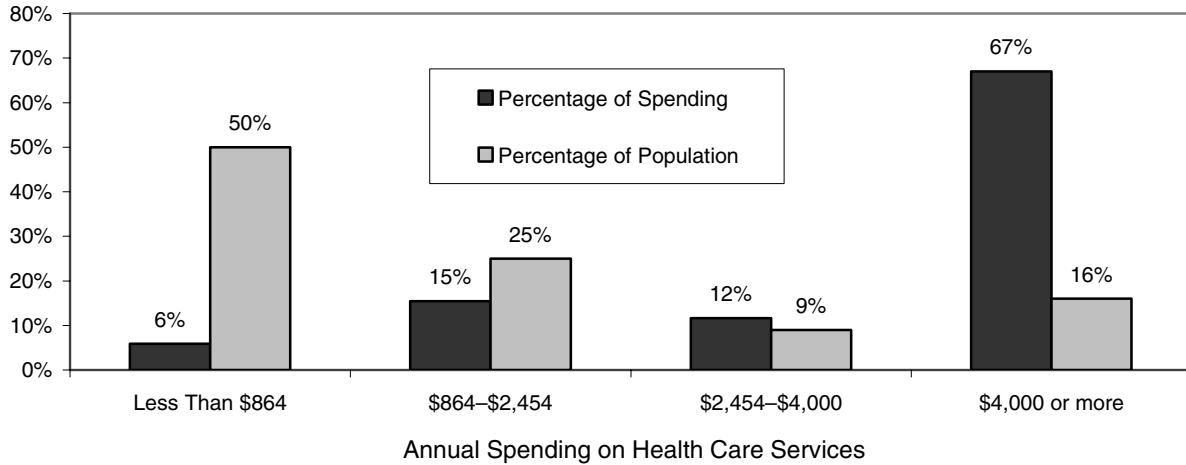
<sup>d</sup> Medical savings accounts.

**Figure 2  
Distribution of Health Spending, Adults Ages 18–64, 2001**



Source: Employee Benefit Research Institute estimates from the 2001 Medical Expenditure Panel Survey.

**Figure 3  
Distribution of Health Spending and Population,  
Adults Ages 18–64, 2001**



Source: Employee Benefit Research Institute estimates from the 2001 Medical Expenditure Panel Survey.

**Figure 4**

**Potential Savings in an HAS,<sup>a</sup> Assuming 5 Percent Rate of Return, Individual Rolls Over Various Amounts of End-of-Year Account Balance and Makes Maximum Catch-Up Contributions<sup>b</sup>**

Years contributing to HSA	Percentage of End-of-Year Account Balance Rolled Over					
	10%	25%	50%	75%	90%	100%
	<b>\$1,000 Annual Contribution</b>					
10	\$2,291	\$2,779	\$4,293	\$8,500	\$15,082	\$23,487
20	2,291	2,780	4,312	9,164	20,668	46,722
30	2,291	2,780	4,312	9,201	23,269	80,889
40	2,291	2,780	4,312	9,204	24,746	136,544
	<b>\$2,600 Annual Contribution</b>					
10	\$4,123	\$5,003	\$7,740	\$15,505	\$27,940	\$44,053
20	4,123	5,003	7,765	16,816	40,854	100,849
30	4,123	5,003	7,765	16,913	47,616	189,684
40	4,123	5,003	7,765	16,921	51,457	334,388

Source: Employee Benefit Research Institute.

<sup>a</sup> Health savings account.

<sup>b</sup> Maximum allowable HSA contributions are indexed for inflation.

Figure 5

**Savings Needed For Employment-Based Health Insurance Premiums,<sup>a</sup> Medicare Part B Premiums, and Maximum Out-of-Pocket Costs for Retirement at Age 65 in 2014, Assuming 4 Percent After-Tax Rate of Return on Investments**

	7% Increase in Employment-Based Retiree Health Premiums and Out-of-Pocket Costs		10% Increase in Employment-Based Retiree Health Premiums and Out-of-Pocket Costs	
Age at Death	Retiree Health Premium + Part B Premium	Retiree Health Premium + \$1,500 Maximum Out-of-Pocket + Part B Premium	Retiree Health Premium + Part B Premium	Retiree Health Premium + \$1,500 Maximum Out-of-Pocket + Part B Premium
80	\$137,000	\$202,000	\$223,000	\$337,000
85	193,000	285,000	341,000	518,000
90	257,000	381,000	495,000	754,000
95	330,000	490,000	696,000	1,064,000
100	409,000	610,000	956,000	1,469,000

Source: Employee Benefit Research Institute estimates based on various assumptions.

<sup>a</sup> Benefits package for the \$2,631 premium was developed by PricewaterhouseCoopers, LLP on behalf of the Mellon College Retirement Project. It contains the following benefits:

Major Medical Benefit: \$150 annual preventive care benefit, \$250 deductible, 80% coinsurance.

Outpatient Prescription Drug Benefit: \$50 deductible, 70% coinsurance.

Maximum out-of-pocket: \$1,500 (medical and prescription drug combined).

Figure 6

**Savings Needed For Medigap Premiums,<sup>a</sup> Medicare Part B Premiums, and Medicare Part D Expenses for Retirement at Age 65 in 2014, Assuming 4 Percent After-Tax Rate of Return on Investments, and Graduated Spending on Prescription Drugs<sup>b</sup>**

Age at Death	7% Increase in Medigap Premium, and Increases in Other Costs as Defined in Assumptions Section in Fronstin and Salisbury (2004)	10% Increase in Medigap Premium, and Increases in Other Costs as Defined in Assumptions Section in Fronstin and Salisbury (2004)
80	\$151,000	\$185,000
85	231,000	291,000
90	330,000	428,000
95	407,000	559,000
100	550,000	778,000

Source: Employee Benefit Research Institute estimates based on various assumptions.

<sup>a</sup> Benefits package for a \$1,380 premium for Medigap Plan F averaged across all plans in 2004. The plan contains the following benefits:

Inpatient Hospital Care: Covers the cost of Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.

Medical Costs: Covers the Part B coinsurance (generally 20% of Medicare-approved payment amount) or copayment amount, which may vary according to the service.

Blood: Covers the first three pints of blood each year.

Also covers the Part A Inpatient Hospital Deductible, the Part B Deductible, 100% of the Part B Excess Charges, the Skilled Nursing Facility Coinsurance, and Emergency Foreign Travel.

<sup>b</sup> Assumes that Medicare beneficiaries spend 25 percent of their retirement years in each of the following cost-sharing tiers:

Medicare Part D premium only.

Medicare Part D premium + Part D deductible.

Medicare Part D premium + Part D deductible + \$500 out-of-pocket drug spending (25% of \$2,250–\$250).

Medicare Part D premium + Part D deductible + \$3,300 out-of-pocket drug spending (25% of \$2,250–\$250 + 100% of \$5,100–\$2,250).

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