HEALTH SAVINGS ACCOUNTS
BY GREG SCANDLEN
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The new Health Savings Accounts (HSA) provision in the Medicare bill was signed into law by President Bush on December 8, 2003 and goes into effect January 1, 2004. All 250 million non-elderly Americans will now have access to a Medical Savings Account (MSA), and one that is far more attractive than the Archer MSAs that were enacted in 1996. Account holders must have a qualified insurance plan, but the insurance requirements have been opened up considerably. Allowable deductibles have been lowered to $1,000 for an individual and $2,000 for a family. The maximum deductible requirement has been replaced by maximum out-of-pocket limits of $5,000 and $10,000 for individuals and families. These limits include deductibles and coinsurance for "in-network" providers. There is no restriction on the stop-loss limits for outof-network services. These amounts will be adjusted annually for cost of living increases. Preventive care services may be covered on a first-dollar basis. That is, deductibles will not have to apply to services as defined by section 1871 of the Social Security Act.
Annual contributions to the HSA are limited to 100% of the deductible up to a maximum of $2,600 for an individual or $5,150 for a family. Account holders aged 55 and up may make additional contributions of $500 in 2004, increasing by $100 each year until it reaches $1,000 in 2009.

Such contributions may be made by any combination of employer and individual. Employer contributions are excludable from income and individual contributions are deductible "above the line." That is, a taxpayer does not have to itemize deductions in order to take the contribution as a deduction. Employers may offer HSAs as part of a section 125(d) cafeteria plan.
Funds in an HSA may be invested as the account holder sees fit (certificates of deposit, money market funds, mutual funds, etc.) except they may not be invested in life insurance contracts. Earnings on the accounts build-up free of taxes. The funds will be held in a trust administered by a bank, insurance company, or other approved administrator.
Funds may be withdrawn tax-free to pay for

qualified medical expenses, which include all section 213(d) expenses, except health insurance premium payments. HSA funds may be used to pay premiums only for long-term care insurance, COBRA continuation premiums, other health insurance premiums for people receiving unemployment benefits, or retiree premiums other than MediGap.

Funds withdrawn for non-medical purposes will be included in the account holder's gross income and taxed accordingly. A penalty of 10% will also be applied except in cases of death, disability, or Medicare eligibility. In the case of death or divorce, the account may be transferred to a spouse without incurring taxes. If someone other than a spouse is the beneficiary, the funds will be treated as taxable income.

MARKET ANALYSIS

While it is always hard to predict how markets will react to any change in conditions, we can reasonably expect the following developments:

• There will be a rush of banks, insurance companies and third-party administrators (TPAs) to develop products. The previous restrictions on Archer MSAs have been removed. There is no longer a sunset provision, there is no limit on employer size or total enrollment. Companies were reluctant to invest much development effort in a product that was so tentative. But now there is a far greater assurance that such efforts have a chance to succeed.

• All these development efforts will lead to far greater public awareness of the product. In the past there were so few vendors that MSAs remained almost a secret, of no consequence at all to anyone who wasn't self-employed or the owner of a small business. Now there will be a critical mass of publicity and promotion that will break through the fog.

• The individual market will convert to HSAs in droves. It is hard to imagine very many individual purchasers who would not prefer an HSA over anything else on the market. Individual buyers who are not self-employed still will not get a tax break on their premium payments, but their HSA contributions will be 100% deductible. They will have a strong incentive to minimize their premium payment and maximize their

HSA contribution. Plus, the lower allowable deductible removes a major hurdle. A large number of individual policies already have deductibles of $1,000.

• The small group market will be slower. Small employers are not benefits innovators. They don't have the time to think much about benefit options. They have had the MSA option available for several years and haven't paid much attention to it. Small employers were very slow to move to managed care, and they are well behind the rest of the market today in increasing employee cost-sharing. They have been more likely to simply not cover dependents at all, and HSAs don't offer much help in that area.

• The fully-insured mid-market is a different story. Companies with 100 to 1,000 employees are more likely to have staff that concentrates on benefits options and has the time to investigate new products. They are also able to keep the conversion cost-neutral – raising deductibles means lowering premiums. The premium savings can be contributed to the HSA, to be supplemented with a worker's own tax-deductible contribution. These companies have been raising cost-sharing requirements anyway, so the prospect of an employee responsibility for funding part of the HSA is less of a stretch in this segment.

• Self-insured large companies will likely stay with Health Reimbursement Arrangements (HRAs). Companies that pay directly for the services consumed are unlikely to be attracted to HSAs, which expect an up-front contribution of money for all employees whether they are using services or not. HRAs have the considerable advantage of not requiring pre-funding. Money is paid out only when a service is incurred, exactly as if the worker were covered by the health plan. On the other hand, the presence of HSAs in the market will put some pressure on HRA employers to allow greater portability of HRA funds. It will be harder to deny employees access to that money when other companies are offering full ownership of an HSA account.

• The uninsured should find it easier to gain coverage. Medical Savings Accounts have already proven their popularity with the uninsured. The IRS reports that 73% of new MSA accounts are set up by people who had been uninsured for six months or more. But MSAs are available only to the selfemployed or employees whose employers set up the program. HSAs will be available to everybody – especially those workers whose employers provide no coverage at all, and who make up the vast majority of the uninsured. Plus, as HSAs gain market share, more and more workers will have a source of funds to pay for coverage when they are laid-off or otherwise lose their jobs. HSAs should have a profound effect on the short-term uninsured.

ANSWERING THE CRITICS

Already some in Congress and organizations like Physicians for a National Health Plan are calling for repeal of Health Savings Accounts. They are worried that wide-spread adoption of HSAs will put an end to their ambitions for a single, government run health financing system. To make their case, they have invented arguments that have no merit in theory or in practice.

These arguments and the responses include the following:

• HSAs will fragment the insurance pool. There is no "insurance pool" in the United States. There are tens of thousands of insurance pools, none of which subsidizes the others. Each individual pool pays only the costs of its own enrollees. HSAs do not change that.

• HSAs will appeal only to the "Healthy and Wealthy." There is not a scintilla of support for this assertion, either in theory or in practice. We have seen no selection problems with MSAs or with HRAs in multiple choice settings, and small wonder — the opportunity to pay less in premiums and save money for the future is far more attractive to lowerincome people than it is to "the wealthy," and high-utilizers are the very people who have rejected managed care because they want more control over their choice of doctor and treatment.

• HSAs will result in traditional coverage

becoming unaffordable. This is often parroted, but it is never explained what is meant by "traditional coverage." If it means major medical indemnity plans, they barely exist anymore. The blame can hardly be put on HSAs (or MSAs), but on managed care. Presumably, the critics do not mean HMOs when they speak of "traditional coverage," since they seem to despise HMOs. And they don't seem to think very highly of PPOs either. If anything, HSAs will offer an alternative that is much closer to "traditional coverage" than anything else currently on the market.

• PPOs have already raised deductibles and cost-sharing, so there won't be much premium savings in switching to a high-deductible plan. That may be true in some cases. But the HSA will provide people with a tax-favored way of paying for the out-of-pocket costs they are already incurring on an after-tax basis. This is a benefit for anyone who currently pays taxes. There will also be a dynamic effect as costs become more visible to consumers, and they begin to force the industry to develop more attractive pricing.

• The individual market discriminates against people with pre-existing conditions. Again, that may be true in some cases, but it is irrelevant to the merits of HSAs. In fact, it would be desirable if high-risk pools also developed HSA products for their enrollees.

• The HSA administration adds another layer of costs in a system that is already wasteful. HSA administration should be as easy and cheap as a checking account at the local bank or a bank card. Certainly this is well below the administrative cost involved in moving the same money through an insurance mechanism, with the 15% - 40% overhead cost incurred by insurance companies. More importantly, the administrative cost for physicians will be close to zero as they simply present a bill to be paid at the time of service.

• Once someone is eligible for Medicare, they can withdraw HSA funds with no penalty, like an IRA. Well, yes, that is true. But this is a good thing, not a bad thing. People will be able to use their

HSA funds to pay for their retiree benefits. And it can help supplement a retiree's income when they are no longer able to work. HSA money is also

available to help pay for long-term care needs, something no other plan is doing anything about.

• HSAs may help control costs at the lowend, but they do nothing about highend expenses where the real problem is. That isn't entirely true, but the point is valid. HSAs will likely create economizing habits that will not disappear once someone breaks through the deductible. But it is true that additional mechanisms are needed to address the high-end costs.

• Other tax-favored savings plans (IRAs, Roth IRAs, 401Ks) provide a tax advantage at one end or the other, but HSAs are tax-free both when the money is put in and when it is withdrawn. But HSAs are not a substitute for retirement accounts, they are a substitute for a portion of health insurance coverage. Most health insurance is also tax free when the premiums are paid, and also when the benefits are received.

PROSPECTS

The market is ready for this. All of the discussion about consumer directed health care in the last few years has sensitized corporate decision makers to the advantage of putting more control in the hands of employees. HSAs provide them with the perfect opportunity to do exactly that. The year 2004 will probably not see massive enrollment because vendors will need to work on developing new products and marketing strategies. But by mid-year there will be an enormous push to gain an early position in this new market and become the recognized "industry leader."

The timing couldn't be better, with an improving economy and widespread gains in the equities markets. Venture capital will be in great demand to get the new products off the ground. Get ready for a twelve-month race to the finish line of 12/31/04 and the first-year enrollment numbers.

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