REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-04)
Health Savings Accounts
(Reference Committee G)
(June 2004)

EXECUTIVE SUMMARY

In adopting the recommendations in Council on Medical Service Report 3 (I-03), "Health Reimbursement Arrangements," the House of Delegates requested a follow-up study on the implementation of Health Savings Accounts (HSAs). Council on Medical Service Report 6 describes the development of HSAs out of their predecessors, Medical Savings Accounts (MSAs); outlines the legislation and regulations governing HSAs; compares HSAs to MSAs; includes a glossary of key terms; presents available information on HSA market activity; summarizes relevant AMA policy; and highlights the successful implementation of significant AMA policy with the establishment of HSAs.

Like MSAs, HSAs are a form of health insurance coverage that includes a high-deductible insurance plan coupled with a tax-advantaged personal savings account to be used for qualified medical expenses. Under MSAs and HSAs, patients have greater control over health care decision-making, as well as experience the financial consequences of those decisions.

The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) established HSAs effective January 1, 2004, thereby making MSAs permanent, removing previous MSA eligibility restrictions, and loosening MSA benefit design restrictions. Subsequent regulatory guidance issued by the Treasury Department and the Department of Labor addressed numerous details of HSA coverage, eligibility, contributions, expenditures, administration, reporting requirements, and inheritance, with further guidance expected in June 2004, and in 2005. Since the establishment of HSAs there has been a flurry of market activity, with strong interest in HSAs being shown by individuals, employers, insurers, and the financial services industry. As HSA experience accumulates, policy makers and researchers will closely observe enrollment, demographics, and impact on health expenditures.

Extensive, longstanding AMA policy supports the promotion and expansion of MSAs, and by extension, HSAs. The permanent establishment of HSAs represents a substantial victory for the AMA by achieving most of the AMA's legislative objectives for MSAs. Council on Medical Service Report 6 concludes with several recommendations to enhance availability and appeal of HSAs.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - A-04
(June 2004)

Subject: Health Savings Accounts

Presented by: Ardis D. Hoven, MD, Chair

Referred to: Reference Committee G
(Samuel P. Solish, MD, Chair)

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1 At the 2003 Interim Meeting, the House of Delegates adopted as amended the recommendations in
2 Council on Medical Service Report 3, "Health Reimbursement Arrangements." Recommendation
3 4 of the report calls for the AMA to report to the House on the implementation of Health Savings
4 Accounts (HSAs). The Board of Trustees referred the requested study to the Council on Medical
5 Service for a report back at the 2004 Annual Meeting.
6
7 This report describes the development of HSAs out of their predecessors, Medical Savings
8 Accounts (MSAs); outlines the legislation and regulations governing HSAs; compares HSAs to
9 MSAs; includes a glossary of key terms (Appendix A); presents available information on HSA
10 market activity; summarizes relevant AMA policy; highlights the successful implementation of
11 significant AMA policy with the establishment of HSAs; and makes several policy
12 recommendations.
13
14 BACKGROUND
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16 As highlighted in Appendix B, both MSAs and HSAs are a form of health insurance coverage that
17 includes a high-deductible insurance plan coupled with a tax-advantaged personal savings account
18 to be used only for qualified medical expenses. Patients have incentives to utilize health care in a
19 cost-conscious manner because they spend from their own accounts and/or out-of-pocket before
20 meeting the deductible, and because unspent account balances accumulate and accrue interest from
21 year-to-year. High deductibles keep premiums low, making coverage more affordable than
22 traditional insurance and freeing up monies to fund the accounts. Once the deductible has been
23 met, coverage resembles conventional insurance, typically in the form of a preferred provider
24 organization (PPO) with little-to-no cost sharing for in-network services and limits on total out-of-
25 pocket costs. HSAs and MSAs can result in administrative savings to the extent that services
26 utilized before the deductible are not sent through claims processing. Account funds also can
27 finance long-term care with untaxed dollars, and serve as retirement savings for non-medical
28 expenses, though subject to income tax upon withdrawal.
29
30 Although MSAs had been available in some states since the 1980s, the Health Insurance Portability
31 and Accountability Act of 1996 (HIPAA) established a five year national demonstration of MSAs,
32 extending the tax advantages of traditional employment-based health insurance to MSAs. Under
33 HIPAA, MSA account contributions, interest earnings, and account expenditures were not subject
34 to federal income taxation. HIPAA also imposed numerous rigid, complex rules regarding
35 eligibility, benefit design, and account contributions. These constraints hampered enrollment and
36 discouraged insurers and insurance brokers from investing in product development and marketing.

Despite these obstacles, approximately 100,000 households or individuals enrolled in HIPAA-qualified MSAs, with about 25% of enrollees previously uninsured (Internal Revenue Service, 2004). MSAs appear to have saved both enrollees and employers on total premium and out-of-pocket expenditures (Bond et al., 1996).

MSA supporters sought to make MSAs permanent and eliminate restrictions hindering their growth. Legislation passed in 2001 and 2002 renewed the MSA demonstration through the end of 2003. In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) established HSAs effective January 1, 2004, thereby making MSAs permanent and removing most restrictions. Almost immediately after the passage of the Medicare Act of 2003, the Treasury Department issued guidance on the implementation of HSAs, followed by further guidance from the Treasury Department in March 2004, and the Department of Labor in April 2004. The Treasury Department guidance asked the public for input on yet further guidance to be issued by June 2004, and in 2005. Since December 2003, there has been a flurry of activity surrounding HSAs by the insurance industry, employers, consumer-driven health care advocates, the financial services industry, and the media. The Treasury Department has established an e-mail address, voice mailbox, and Website to answer the public's questions about HSAs: hsainfo@do.treas.gov, (202) 622-4HSA, and http://www.treas.gov/offices/public-affairs/hsa.

COMPARISON OF MSAs AND HSAs

The establishment of HSAs is part of an overall trend toward consumer-directed health care, in which patients have greater control over health care decision-making, as well as experience the financial consequences of those decisions. This trend includes MSAs, HSAs, and health reimbursement arrangements (HRAs) – a relatively new form of MSA-style health coverage that has greater flexibility in benefit design and eligibility than MSAs or HSAs. As previously noted, HSAs are essentially MSAs with fewer restrictions. Although no new MSAs can be established, people with previously existing MSA accounts can continue to contribute to them so long as they are enrolled in a qualified high-deductible health plan (HDHP), or they may roll them over into HSAs by filling out a form provided by the account custodian. HSAs and MSAs are the same form of health insurance coverage, yet HSAs have a number of advantages over MSAs. HSAs are now permanent, in contrast to the temporary pilot project status of MSAs. Whereas only employees of small firms or the self-employed were eligible to establish an MSA, anyone can have an HSA, and the 750,000 enrollee limit for MSAs was removed. Under MSA rules, either the employer or the employee could make account contributions, but not both, whereas employers and/or employees may contribute to HSAs.

Under HSAs, the permitted parameters for health plan deductibles, account contributions, and account expenditures have been loosened, and HSAs may be offered in cafeteria plans offered by employers. High-deductible health plans may now have lower minimum deductibles, higher maximum deductibles, and higher out-of-pocket limits. Limits on annual HSA account contributions are up to 100% of the plan deductible, rather than 65% of the deductible for individuals or 75% for families under MSAs. Workers between age 55 and 65 may now make catch-up contributions of an additional $500 per year, with the amount increasing by $100 each year until 2009 when it reaches $1,000. As with MSAs, qualified medical expenses that may be made from HSAs are defined by Section 213(d) of the Internal Revenue Code, and generally exclude health insurance premiums. In contrast to MSAs, HSA regulations permit high-deductible health plans to provide coverage for preventive services before the deductible has been met. HSA

funds can be used to pay for qualified medical expenses of family members who themselves do not have HDHP coverage under less restrictive circumstances than with MSAs. Under MSAs, qualified medical expenditures were subject to federal income tax for those over age 65, whereas HSA medical expenditures are tax-free regardless of age. Finally, whereas non-medical expenditures are still subject to income tax, the penalty for non-medical expenditures for those under age 65 has been reduced from 15% to 10%.

REGULATORY GUIDANCE

Guidance issued by the Treasury Department in December 2003, and March 2004, addressed numerous other details of HSA coverage, eligibility, contributions, expenditures, administration, reporting requirements, inheritance, and definition of preventive care.

HSA-Compatible Benefits and Permitted HDHP Benefit Design

In general, an individual is ineligible for an HSA if the individual has additional coverage through a non-qualifying health plan. Exceptions include coverage for dental care, vision care, and long-term care. Coverage of drug expenses below the deductible is not permitted. However, before the Treasury Department had clarified this point, some employers and individuals offered or enrolled in health plans exempting drugs from the high deductible in the belief that such plans qualified as HSA-compatible HDHPs. In order to allow employers and enrollees time to adapt to HSA benefit requirements, the Treasury Department issued transition relief guidance allowing first-dollar or near first-dollar coverage of drugs alongside HSAs through the end of 2005.

As noted above, HDHP plans are permitted but not required to offer first-dollar coverage of preventive care services. The Treasury Department definition of preventive care for purposes of HSAs supersedes definitions set forth by state law, and includes annual physical exams, immunizations, screening tests, routine prenatal and well-child care, tobacco cessation programs, and obesity weight-loss programs, but not the treatment of existing conditions. Future guidance will clarify whether the definition of preventive care includes additional benefits such as drugs under limited circumstances, employee assistance program services, or employee wellness programs.

Flexible spending account (FSA) funds are prohibited from being rolled over into HSAs. Future guidance also will clarify the exact circumstances under which FSA and HRA coverage is compatible with HSAs. In its June 2004 guidance, the Treasury Department is expected to rule that individuals' FSA and HRA funds cannot be used to pay for covered expenses below the HDHP deductible, although FSA and HRA funds can be used to pay for any post-deductible coinsurance or copayments, as well as for non-covered expenses such as dental or vision care.

For health plans with separate in-network and out-of-network annual deductibles, the in-network deductible is used to determine whether the plan qualifies as an HDHP and the annual contribution limit. As with MSAs, qualified HDHPs issued to families are effectively prohibited from incorporating "embedded" individual deductibles, common in the insurance industry. Embedded individual deductibles – lower, per-person deductibles applied to individual family members – are not permitted unless the embedded deductible is at least as high as the minimum family deductible ($2,000 in 2004), in which case the annual contribution is limited to the amount of the embedded deductible, rather than the full family deductible.

HSA Contributions and Withdrawals

A qualified HSA account custodian can be any insurance company, bank or similar financial institution, or anyone already approved to be an individual retirement account (IRA) or MSA custodian. HSA funds can be invested in virtually the same vehicles as IRAs, including stocks, bonds, and mutual funds, but excluding life insurance policies. As with MSAs, annual contribution limits generally are prorated based on the number of months the enrollee is both enrolled in an HDHP and holding an HSA account. However, because many individuals have had difficulty locating qualified account custodians, transition relief guidance allows extra time to establish HSAs; so long as an otherwise-eligible individual is enrolled in an HDHP, qualified expenses for 2004 may be reimbursed from an HSA even if the account is established as late as April 15, 2005, and the contribution limit is determined by the number of months the individual is enrolled in an HDHP. The Treasury Department guidance puts no limit on the fraction of the maximum annual contribution that can be deposited at any time up until April 15 of the following calendar year. Once someone with an HSA turns 65, or otherwise becomes Medicare eligible, the individual can no longer make account contributions, although he or she may continue to spend account funds (with non-medical expenses subject to income tax but no additional penalty, as noted above).

THE OUTLOOK FOR HSAs

Since the authorization of HSAs in late 2003, employers, insurers, financial institutions, policy makers, and the media have shown intense interest in HSAs. Some observers predict that HSAs will revolutionize the U.S. health care system, restraining health care utilization, exerting competitive pressure on prices, forcing transparency of pricing, cutting the ranks of the uninsured, boosting innovation in benefit design, spurring demand for cost-containing medical technology, reducing managed care interference in treatment decisions, and restoring the patient-physician relationship. The number of HSAs is estimated by some to grow as high as 5 million by 2006 (*Consumer Driven Market Report*, 2004). Other estimates are more conservative, forecasting relatively slow growth and minimal impact of HSAs. The real popularity and effect of HSAs remains to be seen, and will depend largely on the content of further Treasury Department guidance, the fate of legislative proposals to allow tax deductibility of HSA plan premiums, and the ability of HSAs to curb health care spending.

Although the course of the HSA market is still speculative, clearly the incentives to develop, offer, and educate the public about HSAs are far greater than under MSAs. Experience with HRAs demonstrates the ability for insurance markets to respond rapidly to enabling legislation. Less than a year after the IRS ruling establishing HRAs, 1.5 million HRAs were established (*National Journal*, 2004). HRA enrollment has been especially strong in the fully-insured small group market; satisfaction and re-enrollment rates have been high; and preliminary evidence does not suggest adverse selection, while suggesting cost-containment potential (Galen Institute, 2004).

Demand for HSAs Among Individuals

The loosening of eligibility restrictions vastly increases the potential market for HSAs. In the short run, demand for HSAs is limited by lack of availability and public awareness. As noted earlier, however, transition relief guidance allows individuals extra time to establish accounts. Eventually, demand for HSAs is likely to be particularly strong among workers whose employers do not offer health insurance benefits – the group that accounts for the majority of the uninsured. During the

first week of 2004, Assurant Health (formerly Fortis) received over 1,000 applications for HSAs, and during the first six weeks of the year, 30% of their new HSA enrollees were among the previously uninsured. HSAs also have the potential to expand coverage by funding premium payments for workers who lose their jobs (Galen Institute, 2003).

The lowering of required deductibles also makes HSAs appeal to more people, especially given that there is already a trend toward higher deductibles. More than one-third of individual policies and one-quarter of family policies sold through eHealthInsurance.com already have deductible levels consistent with HSAs (Associated Press, January 14, 2004). Many state high-risk insurance pool plans already have deductible levels within HSA parameters (*HSA Insider*, 2004). Given limits on out-of-pocket expenditures, even frequent utilizers of health care services could be attracted to HSAs as a means of wresting control over health care decisions from managed care insurers (Galen Institute, 2003). The fact that HSA health plans are now permitted to exempt a wide array of preventive services from the high-deductible will also make HSAs more attractive to many individuals and families. On the other hand, some analysts worry that families might be deterred from purchasing an HSA because, in contrast with insurance industry norms, plans generally may not apply lower embedded individual deductibles to individual family members (Ginsburg, *Modern Healthcare*, February 2004).

Individuals will be attracted to HSAs both for insurance coverage and as an investment vehicle. Since contributions and interest earnings are not taxed, HSAs have the potential to yield substantially more than ordinary investments (see Appendix C). Even if no HSA funds are rolled over to the following year, the individual reaps a tax advantage by paying for out-of-pocket medical expenses with untaxed dollars. HSA funds used for non-medical retirement expenses are tax-deferred in that they are taxed upon withdrawal, typically at a lower tax rate than applied when the individual contributed the funds. In that respect, an HSA is essentially a traditional IRA with additional tax advantages: not only are contributions untaxed, but certain withdrawals are not taxed, and certain withdrawals may be made without penalty before retirement age, those withdrawals being for qualified medical expenses. The tax advantages of HSAs, although generally greater for those in higher tax brackets, are substantial for anyone earning enough to pay income taxes. As with any investment vehicle, depending on the performance of investment choices, individuals could accumulate significant retirement savings, or see inflation erode the value of their accounts. As with IRAs, individuals own and control the investment choices. In its April 2004 guidance, the Department of Labor clarified that, although employers or plan sponsors may require enrollees to make initial deposits with specified account custodians such as a particular bank or brokerage house, individuals are then free to move HSA funds to any qualified account of their choosing.

Demand for HSAs Among Employers

Employers seeking to rein in rapidly escalating health benefit costs – or simply offer health benefits – will be attracted to HSAs. In a 2003 survey of small business owners conducted by the National Small Business Association, 73% of respondents reported that HSAs would appeal to their employees. A recent survey of large employers indicates rapid growth in the number of firms offering employees a consumer-driven health care plan (Watson Wyatt Worldwide, press release, March 2004). Some employers will prefer HSAs over HRAs because they may be funded wholly or in part by employees. On the other hand, some employers will prefer HRAs since HRA accounts need not be pre-funded and payments are made only as services are used (Galen Institute,

2003). Large firms tend to offer an HSA or HRA alongside conventional health plans, whereas small firms may view such plans as an opportunity to offer affordable health benefits for the first time.

At the time that this report was written, it was expected that the June 2004 Treasury Department guidance would resolve many issues of particular interest to large, self-insured employers new to the HSA market. For example, under what circumstances are FSAs and HRAs compatible with HSAs? Are employee assistance programs, which typically provide short-term support for problems such as drug or alcohol addiction, compatible with qualified high-deductible coverage? Until such issues have been resolved, neither employers nor insurers know the extent to which existing health benefits must be modified to conform to HSA requirements.

In the meantime, employers welcomed the Treasury Department's transition relief guidance permitting coverage of drug expenses below the deductible through the end of 2005. In its April 2004 guidance, the Department of Labor clarified that, although an HDHP for an employment group may be subject to federal Employee Retirement Income Security Act of 1974 (ERISA) regulations, HSA accounts ordinarily are not. This ruling was particularly welcomed by small and medium-sized employers that wish to avoid costly ERISA compliance requirements.

Because of the timing of the HSA regulatory guidance relative to open-enrollment periods, some employers were unable to offer HSAs in 2004, and there could be a large wave of employers offering HSAs in 2005. In April 2004, the federal Office of Personnel Management announced that, starting in 2005, HSAs will be offered to the nearly 9 million federal employees and their dependents covered through the Federal Employees Health Benefits Program. Employers offering HSAs alongside other health plan choices are likely to adjust premiums and benefits in order to mitigate any adverse selection across plans. Because employers will closely monitor HSAs, there will eventually be more complete data with which to evaluate the impact of HSAs on selection, utilization, and costs.

The potential for HSAs to reduce costs may be limited because most health care expenses are generated by the small number of people with expenses far exceeding deductible and out-of-pocket limits. On the other hand, more people exceed deductibles and out-of-pocket limits with conventional insurance than with HSAs. A critical issue will be the extent to which HSAs impact costs not only through utilization, but by containing prices of health care services, particularly through market competition among providers and insurers, stimulation of cost-saving treatment approaches, and incentives to participate in disease management programs.

Supply of HSAs by the Insurance and Financial Services Industries

In early 2004, demand for HSAs on the individual market seemed to outpace supply, with some individuals having difficulty finding knowledgeable, qualified banks or other institutions with which to establish accounts (hence, the aforementioned transition relief guidance allowing extra time to establish HSAs). Some observers believe that large investment firms will show a tepid response until HSA accounts reach thresholds such as $25,000, leaving insurers and smaller financial institutions to establish a niche for smaller accounts (Ramthun, *HSA Insider*, March 2004). Many insurers planning to market HSA accounts along with their insurance plans will start by offering simple accounts, later offering more sophisticated investment options (Financial News Service, 2004). At least one company already plans to issue debit cards for HSA,

1 MSA, and FSA accounts that would verify patient eligibility and track deductibles (*Business Week*,
2 March 2004). Although some insurers are awaiting final regulatory guidance, most industry
3 experts expect the availability of HSA plans and accounts to expand rapidly, as was the case
4 following the liberalization of IRA eligibility restrictions in 1981. Individuals can already connect
5 with HSA insurance and account providers through the Internet. The Website
6 www.HSAInsider.com maintains a growing list of vendors of qualified high-deductible plans and
7 HSA accounts by state and by type of market (individual, small group, and large group).
8
9 In a recent survey of insurers serving employer groups, 42% of respondents reported having an
10 HSA product either ready or under development, with another 25% considering entering the HSA
11 market (Eastbridge Consulting Group, Inc., 2004). With Medicare HSAs authorized under the
12 Medicare Advantage program (formerly Medicare+Choice), 33 companies plan to offer Medicare
13 HSAs and another 30 are considering doing so (America's Health Insurance Plans, 2004). The first
14 insurers offering qualifying high-deductible health plans have been companies already offering
15 MSAs or HRAs, such as Assurant/Fortis, MSAver, Golden Rule, and Destiny, as well as large,
16 national carriers such as Blue Cross/Blue Shield and Aetna (Eastbridge Consulting Group, Inc.,
17 2004). The large carriers tend to offer plans with a wide range of benefit designs, some already
18 complying with HSA requirements. Large carriers were already positioned to serve as HSA
19 account custodians and to educate and mobilize brokers to market HSAs. Large carriers also are
20 reportedly working with large employers to develop sophisticated benefits packages that integrate
21 HSAs with HRAs and/or FSAs, to the extent that future Treasury Department rules permit such
22 arrangements.
23
24 Criticisms of HSAs
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26 The main criticism of HSAs is that they are only for the "healthy and wealthy." Based on the
27 limited available evidence to-date from MSAs and HRAs, this concern has not been borne out.
28 Researchers and policy makers will pay close attention as additional data accumulates on the age,
29 health, and socioeconomic characteristics of HSA takers relative to non-takers. The General
30 Accounting Office had been directed by HIPAA to conduct a comprehensive study by January
31 1999 of the effects of MSAs in the small-group market, including the effect of MSAs on adverse
32 selection. However, low MSA enrollment prevented the GAO from conducting the study. A
33 simulation model developed by the RAND Corporation suggested that MSAs would not
34 disproportionately attract younger, healthier individuals (Goldman, et al., *Health Services*
35 *Research*, April 2000). At a February 2004 Galen Institute forum on consumer-directed health
36 care, six insurers presented data showing that HRA enrollees were older and of slightly lower
37 health status as those opting for other forms of coverage, although the analyses were unable to
38 control for detailed individual characteristics such as prior health conditions or income. Similarly,
39 there is evidence that, despite chronic conditions or high medical expenses, some people are
40 attracted to HRAs because they gain greater control over health care decisions than under
41 conventional managed care plans.
42
43 Calculations conducted by the AMA Division of Socioeconomic Policy Development show that the
44 annual cost of an HSA compared to a PPO depends on health plan premiums, deductibles,
45 coinsurance, and out-of-pocket limits, as well as individual medical expenses and tax bracket. Not
46 surprisingly, individuals with little or no medical expense generally save money with an HSA
47 because of the premium difference. Individuals with moderate to high medical expenses are more
48 likely to find the PPO less expensive. However, two factors in addition to low premiums could

make an HSA more affordable than conventional coverage even for those with higher expenses. First, although generally higher than PPO out-of-pocket limits, the HSA out-of-pocket limit serves as a powerful protection against catastrophic loss. Second, out-of-pocket expenses funded by an HSA are paid for with untaxed dollars. Because of this tax advantage, some individuals may find an HSA less expensive than the PPO regardless of their medical expenses. As noted earlier, although the tax advantages of HSAs are greater the higher an individual's tax bracket, the tax advantages are nonetheless substantial for nearly everyone.

Although policy makers and researchers should monitor HSA data for possible evidence of markedly uneven enrollment based on health status or income, these concerns appear to be overstated. The relevant question is not only whether HSAs benefit some groups more than others but, for a given individual or family, how does an HSA compare to the alternatives? People with high medical expenses will pay attention not only to their overall costs – which could be lower with an HSA than conventional coverage – but also to gaining greater choice and control over physicians and treatment decisions (Scandlen, February 2004), an advantage of HSAs. Because of their low premiums, HSAs are likely to have particular appeal to low-income individuals, putting insurance coverage within reach for the first time for some. As noted earlier, IRS data showed that about 25% of MSA enrollees had been previously uninsured.

RELEVANT AMA POLICY

Extensive, longstanding AMA policy supports the promotion and expansion of MSAs, and by extension, HSAs (Policies H-165.879, H-165.869, H-185.982, H-180.957, H-270.969, and H-165.920[7], AMA Policy Database). Policy H-165.869[3] closely parallels legislative proposals to expand MSAs by seeking to repeal MSA demonstration status, eligibility restrictions, and numerous other legislative constraints on MSAs. Policies H-165.920[7] and H-165.869[1] support legislation allowing the tax-free use of MSA accounts for health care expenses as an integral component of AMA proposal to expand health insurance coverage and choice. In addition to calling for a lifting of MSA eligibility restrictions and enrollment limits, Policy H-165.879 calls for MSA accounts to be available through a wide variety of sources, including banks, brokerage houses, and health insurers.

Along with efforts to liberalize MSA rules, Policy H-165.863 advocates allowing employees to rollover any unexpended funds from an FSA into an MSA. The AMA also supports HRAs (Policy H-165.854), and Policies H-165.869[2] and H-180.957 support efforts to educate patients, employers, and physicians about the advantages of MSAs and HRAs. Policy H-165.869[5] calls for the AMA to continue to promote MSAs being offered to AMA physicians through its own medical insurance programs.

DISCUSSION

The permanent establishment of HSAs by the Medicare Prescription Drug, Improvement, and Modernization Act and subsequent regulatory guidance represents a substantial victory for the AMA by achieving most of the AMA's legislative objectives for MSAs. Specifically, the following elements of AMA policy were achieved:

- Permanently repealing the limit on the number of MSAs (hereafter called HSAs) and removing the demonstration status of the project;

- Expanding eligibility to employees of any size employer and to any individual;

- Allowing both employees and employers to contribute to HSAs;

- Allowing annual HSA deposits up to 100% of the deductible, with no limit on the fraction that can be deposited at any time during the year;

- Reducing the permitted annual minimum deductibles and allowing higher annual maximum deductibles (Policy H-165.869[3e] called for allowing unlimited annual maximum deductibles);

- Allowing HSAs to be offered in cafeteria plans provided by employers;

- Extending a "safe harbor" to high-deductible plans in all states to allow for the coverage of preventive services regardless of whether the deductible has been met; and

- Making HSAs available from a wide variety of sources, including banks, brokerage houses, and health insurers.

One of the few AMA policy objectives for HSAs that remains unrealized is allowing insurers to offer qualified high-deductible health plans that apply lower embedded individual deductibles to individual family members, in conformance with insurance industry norms (Policy H-165.869[3j]). As noted earlier, family HDHP plans may not apply embedded individual deductibles unless they are at least as high as the minimum family deductible of $2,000, rather than the minimum individual deductible of $1,000 (dollar amounts apply to 2004). Because no more than one family member ordinarily has high medical expenses in a given year, a $2,000 deductible for a family represents a higher threshold than a $1,000 deductible for an individual (Ginsburg, *Modern Healthcare*, February 2004), particularly for smaller families. In addition, the annual account contribution is limited to the lower amount of the embedded deductible rather than the full family deductible, so a family enrolled in an HDHP with $2,000 embedded deductibles for each family member and a $5,000 deductible for the whole family could contribute only $2,000 to their HSA despite being responsible for as much as $5,000 in deductibles. It should be noted that incorporating (or prohibiting) embedded deductibles has an ambiguous effect on cost-containment incentives. On the one hand, insurance coverage for a given family member takes effect as soon as that individual's expenses reach the lower threshold, reducing incentives for that person to restrain health care spending. On the other hand, coverage for a given family member is not triggered unless that person reaches the individual threshold him or herself (or unless the sum of family members' below-deductible expenses reaches the level of the family deductible).

The Council on Medical Service believes that HSA high-deductible health plans offered to families should be permitted to include embedded individual deductibles as low as the minimum permitted individual deductible ($1,000 in 2004), and that annual contribution limits should be determined by the plan's family deductible rather than by the lower embedded deductible. While it is unknown what the net effect of embedded deductibles would have on health care spending, how much of a deterrent the restrictions on embedded deductibles present for the adoption of HSAs, or the extent to which HSA insurers and enrollees would choose to offer embedded deductibles, the Council believes that the effective prohibition on embedded deductibles puts HSAs at a competitive

1 disadvantage in the health insurance marketplace. Giving HSA high-deductible health plans the
2 flexibility to conform to insurance industry norms in this respect could broaden the appeal of HSAs
3 without violating the spirit or intent behind them.
4
5 Finally, the AMA has been engaged in active dialog with representatives of the federal government
6 regarding HSAs, expressing appreciation to Congress for authorizing HSAs and to the Treasury
7 Department for timely issuance of regulatory guidance. The AMA has submitted formal comments
8 on both the issued and pending rules, endorsing interpretations of HSA legislation consistent with
9 AMA policy. The Council looks forward to disseminating additional information as the Treasury
10 department issues further guidance and as more data on the HSA market becomes available.
11
12 RECOMMENDATIONS
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14 The Council on Medical Service recommends that the following be adopted and the remainder of
15 the report be filed:
16
17 1. That the American Medical Association (AMA) strongly encourage employers to consider
18 offering Health Savings Accounts as an option for their employees. (Directive to Take
19 Action)
20
21 2. That it is the policy of the AMA that high-deductible health insurance plans issued to families
22 in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person
23 deductibles to individual family members:
24
25 a. with the permitted levels for per-person deductibles being the same as permitted levels for
26 individual deductibles; and
27
28 b. with the annual HSA account contribution limit being determined by the full family
29 deductible or the dollar-limit for family policies. (New HOD Policy).
30
31 3. That the AMA continue to examine alternative means for the financing of health care
32 consistent with AMA policy and sound principles of medical practice. (Directive to Take
33 Action)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Develop communication to and/or meet with employers regarding HSAs at a total estimated cost of $1,657.

APPENDIX A

Glossary of Terms

Consumer-Driven Health Care (CDHC) – An emerging trend in health care coverage and delivery characterized by incentives for individuals to make health care decisions in a cost-conscious manner and by a high degree of individual choice regarding physicians and other health care providers, treatment decisions, and/or health insurance coverage. CDHC encompasses defined contribution (DC) health benefits, medical savings accounts (MSAs), health savings accounts (HSAs), and health reimbursement arrangements (HRAs). Also called Consumer-Directed Health Care.

Defined Contributions (DC) – A form of employee health benefit in which the employer or sponsor contributes a fixed-dollar amount toward the employee's health insurance, and the employee is responsible for paying any difference between the employer contribution and the premium of the chosen plan. Although the employer contribution may be higher for employees choosing family rather than individual coverage, and contributions might vary from year-to-year, at any given point in time, employees receive fixed contributions, creating incentives to choose insurance according to the costs and benefits of available plans. While plan choice can be unrestricted, employers typically restrict choice to a menu of prescreened plans. In some cases, the fixed-dollar amount is applied to a plan that the employee has customized on the basis of cost-sharing requirements and/or provider network. The definition of defined contributions has expanded to include health insurance plans in which the individuals receives or contributes a fixed-dollar amount to a personal health care account (see Health Reimbursement Arrangements).

Embedded Deductibles – In the context of family coverage by a health insurance plan, a deductible applied to individual family members that is lower than the family deductible. The plan reimburses the individual family member's expenses once they have reached the embedded individual deductible, even if the full family deductible has not been met yet. Expenses of other family members are not reimbursed until they have reached the embedded deductibles, or until family members collectively have reached the family deductible. Most family policies include embedded deductibles. Also called Stacked Deductibles or Nested Deductibles.

Flexible Spending Account (FSA) – An employee benefit offered by an employer, typically through a cafeteria plan, that allows employees to have pretax dollars withheld from their salaries to pay for qualified medical expenses as defined by Section 213(d) of the Internal Revenue Code, or dependent-care expenses. Each year, the employee must determine in advance the amount set aside, up to a limit set by the employer. Account balances cannot be carried over to the following year, and any funds remaining at the end of the year are forfeited to the employer. FSAs are governed by Section 125 of the Internal Revenue Code.

Health Reimbursement Arrangement (HRA) – A relatively new form of health care coverage in which the employer agrees to reimburse qualified medical expenses (as defined by Section 213[d] of the Internal Revenue Code) incurred by the employee or the employee's spouse and dependents up to a maximum dollar amount per year. Contributions by employers and reimbursements to employees are not subject to income or employment taxes. The law permits but does not require employers to roll over unused balances to increase the maximum reimbursement amount in subsequent years. Similarly, the employer may or may not allow retirees or departing employees access to unspent balances after they have left the company. HRAs have greater flexibility in benefit design than HSAs and MSAs, and are governed by Sections 105 and 106 of the Internal Revenue Code.

Health Savings Account (HSA) – A form of health insurance coverage that includes a high-deductible insurance plan (HDHP) coupled with a tax-advantaged personal savings account to be used only for qualified medical expenses. Unspent account balances accumulate and accrue interest from year-to-year. High deductibles keep premiums low, making coverage more affordable than traditional insurance. Once the deductible has been met, coverage resembles conventional insurance, typically in the form of a preferred provider organization (PPO) with little-to-no cost sharing for in-network services and limits on total out-of-pocket costs. HSAs were authorized by the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173), effective January 1, 2004, effectively making MSAs permanent, removing MSA eligibility restrictions, and loosening MSA benefit design restrictions. Depending on the context, HSA can refer solely to the account, or to the package of the HDHP plus the account.

High-Deductible Health Plan (HDHP) – A health insurance plan with a deductible that is higher than typical deductibles seen in the insurance market. Plan reimbursement for most or all covered benefits takes effect only after the enrolled individual's or family's medical expenses have reached the deductible. Enrollment in a qualified HDHP is a condition for eligibility to establish a health savings account (HSA) or medical savings account (MSA), and HDHPs often also accompany health reimbursement arrangements (HRAs). Federal regulations establish permitted parameters for deductibles and out-of-pocket limits of HSA- and MSA-qualified HDHPs (see Appendix B).

Individual Retirement Account (IRA) and Roth IRA – A self-funded, tax-advantaged retirement account that allows individuals to make contributions up to a specified annual limit. IRA funds may be placed in bank accounts, or invested in stocks, bonds or mutual funds. Traditional IRA funds are tax-deferred; contributions are deductible from income tax, and withdrawals are subject to income tax, typically at a lower tax rate than applied when the individual contributed the funds. Roth IRA funds are taxed upon contribution but not upon withdrawal, and are available only to individuals below an income cutoff.

Medical Savings Account (MSA) – A form of health insurance coverage that includes a high-deductible insurance plan (HDHP) coupled with a tax-advantaged personal savings account to be used only for qualified medical expenses. Unspent account balances accumulate and accrue interest from year-to-year. High deductibles keep premiums low, making coverage more affordable than traditional insurance. Once the deductible has been met, coverage resembles conventional insurance, typically in the form of a preferred provider organization (PPO) with little-to-no cost sharing for in-network services and limits on total out-of-pocket costs. MSAs were authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on a demonstration basis and subject to numerous rigid, complex rules regarding eligibility, benefit design, and account contributions. Depending on the context, MSA can refer solely to the account, or to the package of the HDHP plus the account.

APPENDIX B

Comparison of Medical Savings Accounts (MSAs) and Health Savings Accounts (HSAs)

	MSAs	HSAs
Program Status	Temporary pilot project	Permanent
Eligibility	Employees of small employers (50 or less), or self-employed, not Medicare-eligible, and with qualified coverage (see below)	Anyone not eligible for Medicare and with qualified coverage (see below)
Enrollment Cap	750,000 people (excluding the previously uninsured)	None
Ownership	Individual	
Carryover of Unused Funds	May be carried over indefinitely	
Portability	Yes	
Tax Treatment of Contributions	Tax-free, including interest earnings.	
Funding Source	Either employer or employee, but not both; or self-employed	Employer and/or employee/individual
Corresponding Health Plan	Must have a qualified high-deductible health plan (HDHP) as defined by HIPAA (MSAs) or MMA (HSAs), and not be covered by any other plan that duplicates benefits in the HDHP.	
Can Offer Thru Cafeteria Plan	No	Yes
Minimum Deductible		
Individual	$1,700	$1,000
Family	$3,450	$2,000
Maximum Deductible		
Individual	$2,600	$5,000 (Replaced by annual
Family	$5,150	$10,000 out-of-pocket limits)
Annual Out-of-Pocket Limit		
Individual	$3,450	$5,000
Family	$6,300	$10,000
Annual Contribution Limit		Lesser of 100% of deductible or
Individual	65% of deductible	$2,600
Family	75% of deductible	$5,150
Catch-up Contributions	No	Yes
Qualifying Medical Expenses	Expenses defined by §213(d) of the Internal Revenue Code. Premiums for long-term care insurance, COBRA, insurance for those receiving unemployment comp., and Medicare Part A & B (but not Medigap).	
	Expenses of family members even if not covered by HDHP, but only in years contributions not made to account.	Expenses of family members even if not covered by HDHP.
First-dollar Coverage of Preventive Care Permitted	No, except in states with mandated first-dollar coverage of preventive services	Yes
Medical Expenditures		
under age 65	Tax-free	Tax-free
over age 65	Taxed	Tax-free
Non-Medical Expenditures		
under age 65	Taxed +15% penalty	Taxed +10% penalty
over age 65	Taxed	Taxed

Note: All dollar figures refer to 2004. Sources: The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; U.S. Treasury Department; Council for Affordable Health Insurance; Galen Institute, and the HSA Coalition.

APPENDIX C

Comparison of Tax Treatment of HSAs and IRAs

<table>
<tr><th colspan="3"></th><th>HSA</th><th>Traditional IRA</th><th>Roth IRA</th></tr>
<tr><td colspan="3">Contributions</td><td>UNTAXED</td><td>UNTAXED</td><td>Taxed</td></tr>
<tr><td colspan="3">Interest</td><td>UNTAXED</td><td>Taxed</td><td>UNTAXED
(Unless withdrawn pre-retirement)</td></tr>
<tr><td rowspan="4">Withdrawals</td><td rowspan="2">Pre-Retirement</td><td>Medical Expenses</td><td>UNTAXED</td><td rowspan="2">Taxed
+ 10% Penalty</td><td rowspan="2">UNTAXED</td></tr>
<tr><td>Non-med Expenses</td><td>Taxed
+ 10% Penalty</td></tr>
<tr><td rowspan="2">Post-Retirement</td><td>Medical Expenses</td><td>UNTAXED</td><td rowspan="2">Taxed</td><td rowspan="2">UNTAXED</td></tr>
<tr><td>Non-med Expenses</td><td>Taxed</td></tr>
</table>

Notes: HSA retirement age is 65. IRA retirement age is 59 ½. Traditional IRA must be fully withdrawn by age 70 ½ or forfeited. Roth IRA has income eligibility cut-off.