Deloitte.

New York Health Benefit Exchange

Study 6: Health Savings Accounts

Final Report

March 6, 2013

Table of Contents

I. Executive Summary

A. Background

Under the provisions of the Affordable Care Act ("ACA")[1], millions of individuals and small businesses will have access to affordable health care coverage through the Health Benefit Exchanges ("Exchanges"). The Exchanges will offer consumers a choice of health plans and provide information on price, provider network, and level of benefits. Each state, within federal regulations, has the opportunity to determine the structure of the Exchange and the minimum amount of information that will be provided for consumers to evaluate.

New York State was awarded Planning and Establishment Grants from the U.S. Department of Health and Human Services ("HHS") for Exchange planning, conducting background research, evaluating the integration of current programs, and designing the infrastructure and technical considerations of the operation and the enrollment system associated with the Exchange to meet all regulations. In addition, New York State was also chosen as one of the seven Early Innovators ("EI") to design and implement the Exchange and share components with other states.

Among the policy decisions facing the Exchange is whether and to what extent Health Savings Accounts ("HSAs") should be offered through the Exchange. HSAs are savings accounts established by individuals and employers, and used to pay for qualified health care costs. These accounts are owned by the individual and they are thus responsible for maintaining their account balance and determining how to spend their account dollars. HSAs are accounts that can only be used with qualified High Deductible Health Plans ("HDHPs"). In planning the implementation of the Exchange, New York State must decide on the appropriateness of offering HSAs or HSAs and HDHPs on their Exchange given the State's vision, market characteristics, consumer needs, and product considerations. Although this report will focus on the offering of HSAs, HDHPs may also be paired with Health Reimbursement Arrangements ("HRAs") which are employer funded health accounts that can be used for health care expenses.

B. Applicable Regulations

There are two sets of federal legislation affecting how New York State can offer HSAs under an Exchange. The Medicare Modernization Act (MMA) of 2003 authorized HSAs and set out the rules of their use, and the ACA defined what benefits health plans, including HDHPs, must provide in order to qualify as an Exchange offering.

The MMA sets up HSAs to provide tax-advantaged health care savings that could be used to pay for certain qualified health care expenses. However, the MMA restricts the use of HSAs to those linked to qualified HDHPs. Contributions to the HSA as well as the HDHP minimum deductibles and maximum out-of-pocket amounts are determined by the Internal Revenue Service.

There are several provisions established by the ACA that affect HSA-qualified HDHPs offered on an Exchange in 2014. Among the most important are covered services requirements, design limitations, and actuarial value requirements. Whether offered on or off the Exchange, non-grandfathered[2] HSA-qualified HDHPs must provide a defined set of benefits called Essential Health Benefits in 2014. Additionally, the Internal Revenue Service sets a minimum deductible, a maximum out-of-pocket limit, and contribution limits for HDHPs in order for them to be HSA eligible, which may affect their viability in an Exchange. Lastly,

in order to be offered on the Exchange, plans are subject to minimum actuarial value requirements. These concepts are discussed further in the body of this report.

In order to be offered under MMA and ACA, an HSA must be linked to a qualified HDHP and that HDHP must meet the applicable ACA requirements.

C. New York State Options

New York State's decision regarding whether to offer HSAs and/or HSA-qualified HDHPs on the Exchange will depend on a variety of factors. Table 1 presents three options we examined for HSA and HDHPs in the 2014 Exchange environment:

Table 1. New York State Exchange Options regarding HSAs and HDHPs

Options	Exchange Description	Considerations
1. Exchange could potentially offer both HSAs and qualified HDHPs	An individual would first purchase an HDHP (or a small group employer would select it as an option for their employees) and then proceed to establish an HSA on the Exchange.	▪ This option has the greatest potential for administrative and operational complexity for the Exchange, adding complexity to the systems build ▪ Provides consumers a "one stop shop" with increased consumer choice, responsibility for health care decisions and tax benefits ▪ Could increase competiveness of Exchange marketplace ▪ Low income consumers enrolled in an HDHP with or without an HSA may forgo necessary care due to high out-of-pocket expenses ▪ Medical costs could be reduced due to informed and prudent consumer spending
2. Exchange could potentially include HDHPs without HSAs	An individual would purchase an HDHP (or a small group employer would select it as an option for their employees) on the Exchange. If individuals wanted to set up an HSA, they would do so off the Exchange. For example, an individual would select an HSA-qualified HDHP and then would be directed off the Exchange to set-up an HSA.	▪ This option has less administrative and operational complexity for the Exchange than Option 1 ▪ Does not allow for a seamless purchasing experience from the consumer perspective
3. Exchange does not offer HSAs and HSA-qualified HDHPs	An individual or small group employer would both purchase an HSA-qualified HDHP and establish an HSA off the Exchange.	▪ This option has the least administrative and operational complexity for the Exchange compared to Options 1 and 2 ▪ HSAs and HSA-qualified HDHPs will be available outside the Exchange and may cause decreased participation in the Exchange and the potential for anti-selection

D. Findings

The following are key findings resulting from an analysis of New York State's options for offering HSA and HDHPs in an Exchange environment:

1. **HSAs could potentially be offered on the Exchange.** The ACA does not exclude HSAs from Exchanges. Modeling indicates that HSA-qualified HDHPs may fit into bronze or silver level metallic tiers which means they could potentially be sold on the Exchange. However, other Bronze-level plan designs may be created that would not qualify as an HSA-qualified HDHP. For example, products could be created with relatively low deductibles and higher co-insurance amounts, which would exclude them from being eligible for pairing with an HSA.

2. **HSA-qualified HDHPs offered through an Exchange are subject to the Internal Revenue Service restrictions on deductibles, out-of-pocket limits and contribution limits to HSAs.** These restrictions and limits are updated annually and determine which HDHP plans are qualified to be paired with HSAs.

3. **There is growing popularity of HSAs and HDHPs in the market.** Nationally, in January 2012 enrollment was 13.5 million, up 18 percent from 2011 and 35 percent from 2010. In 2011, 18% of all employers nationally offered HSA-qualified HDHPs as a healthcare option and 69% of employees with employer sponsored HSAs receive contributions from their employer. In New York State, the percentage of people covered by HSAs and HDHPs compared to commercial enrollment was 4.6% in 2012 up from 2.7% in 2010[3].

4. **It is not clear based on the ACA whether catastrophic plans will qualify as HSA-qualified HDHPs.** There is uncertainty as to whether a catastrophic plan offered on an Exchange will be HSA-qualified given the differing definitions of preventative services prescribed under the ACA and IRS. Additionally, catastrophic plans will not be viable for a large segment of the population because they are only available in the individual market to people under age 30 and those who have received certification that they are exempt from the coverage mandate by reason of affordability or hardship. Future regulatory guidance will need to address whether catastrophic plans will qualify as HSA-qualified HDHPs.

5. **Uncertainty exists because many ACA provisions have not yet been clarified by HHS.** Modeling based on the most recently released CCIIO actuarial value calculator indicates that HSA-qualified HDHPs may fit into bronze or silver level metallic tiers, but future changes to the actuarial value calculator and further information regarding how HSAs and HDHPs are treated may determine what can be offered on the Exchange.

In the balance of this report, we describe design features of HSAs and HDHPs and present provisions and requirements associated with HSAs and HDHPs. We also describe current market trends for HSAs nationally, in New York State, and in currently established Exchanges. Finally, we present options and considerations for New York State that highlight some of the potential advantages and disadvantages of offering HSAs and HDHPs on the Exchange. An appendix is referenced throughout the report and is provided at the end of the report.

II. Background - Health Savings Accounts and High Deductible Health Plans

One of the objectives of HSAs and HDHPs is to provide the consumer with direct control of their medical expenses while providing choice and flexibility regarding how to manage those expenses. Proponents of these products describe many advantages to the consumer including coverage of qualified medical expenses broader than most traditional plans, continuity of healthcare coverage when changing jobs, during unemployment or disability, and the ability to rollover the balance year to year with interest. HSAs also provide the ability to save on a tax-advantaged basis for healthcare costs during retirement, including Medicare costs such as deductibles, out-of-pocket expenses, copayments and coinsurance. Proponents believe the financial responsibility offered to a consumer will lead to better informed decisions and lower healthcare costs. However, skeptics are concerned that HDHPs and HSAs may cause beneficiaries to forego needed health care. This section describes current characteristics of HSAs including design options, regulations, provisions, and regulations issued from HHS that impacts the implementation of HSAs paired with HDHPs in the Exchange framework.

A. Common Design Features

Introduced as a part of the 2003 Medicare Modernization Act, HSAs allow consumers and employers to deposit money in an account to use for qualified medical expenses. Unlike traditional health plans, money not used for qualified medical expenses within an HSA can be rolled over to build savings in a tax-free, interest earning account. HSAs are a savings account similar to other Consumer-Driven (or Directed) Health Plan ("CDHP") accounts such as Health Reimbursement Arrangements ("HRAs"), Flexible Savings Accounts ("FSAs") and state and federal Archer Medical Savings Accounts ("MSAs"). All of these accounts can be used to pay for medical expenses and differ based on their tax treatment, contributions, account ownership and rollover status. Along with HSAs, consumers and employers have the option to pair HDHPs with an HRA or FSA, which provides additional flexibility to purchase the appropriate level of coverage. Table 2 outlines common HSA design features and compares these features to other types of CDHP accounts.

Table 2. HSA, FSA and HRA Features

Features	HSA	FSA	HRA
Account Owner	Individual/Employee	Employer	Employer
Contributions	Optional for employer, through payroll deferral, and directly from the employee or individual	Optional for employer and through salary reduction Employees typically cannot contribute after-tax	Employer is required to contribute. Payroll deferral and direct employee contribution not allowed
Tax Treatment	Employer: deductible Salary reduction is generally non-taxable Employee/Individual: deductible	Employer: deductible Salary reduction is generally non-taxable	Employer: deductible
Investment Income	Grows tax-free	None	None
Rollover Use	Can use current contributions for future expenses including Medicare expenses	None	May have some roll over but does not move with employee if change in employment status

An HSA is owned by an individual or an employee and the law requires qualified individuals to enroll in an HDHP. Table 3 below lists some design features of an HSA-qualified HDHP and considerations necessary to be eligible for an HSA:

Table 3. HDHP Design Features

Design Option	Considerations
Coverage Type	➢ Self-Only HDHP – covers only one individual ➢ Family HDHP – covers eligible consumer and at least one other individual
Coverage Period	➢ May be calendar year or a 12-month period set up by employer
Deductible/ Out-of-Pocket Limits	➢ Subject to annual minimums and limits depending on self or family coverage ➢ IRS limits change based on the Consumer Price Index ("CPI") ➢ IRS limits apply to only in-network services ➢ If multiple or embedded deductibles are offered, the lowest deductible determines whether plan can be used with HSA ➢ Carry Over Deductibles, includes expenses for a longer term than 12 months, must be scaled to be equal to minimum HDHP requirements for use with HSA
First Dollar Coverage for Preventative Care	➢ Preventative Services (including but not limited to health evaluations, prenatal and well-child care, tobacco cessation programs, weight-loss programs, screening services) must be entirely covered and are not subject to the annual deductible
Network Plans	➢ May have separate out-of-pocket limit for out-of-network expenses. Out-of-network limits are not subject to IRS limits.
Coinsurance/Copayments	➢ There are no regulations on the limits for either coinsurance or copayments except the Out-of-Pocket limit
Prescription Drug Benefits	➢ HDHPs can only cover preventative care medications to be HSA-qualified. Any additional coverage must be in the form of a rider. ➢ If the rider covers non-preventative medications that are not subject to the HDHP deductible, then the HDHP is not HSA-qualified. ➢ Health plans may find it difficult to establish a benefit plan that satisfies the Essential Health Benefit requirements of the ACA and the HSA requirements for an HDHP.
Discount Cards	➢ Discount cards are allowed

B. Internal Revenue Service Regulations

According to regulations from the IRS regarding HSAs, the tax-exempt account must be linked to an HDHP. In addition to enrolling in an HSA, a qualified individual must currently have no other healthcare coverage (with some exceptions for health-related payment plans[4]), must not be enrolled in Medicare, not claimed as a dependent on another individual's tax return, and must be covered by a qualified HDHP on the first day of the month for which eligibility is claimed. The enrollee must have a social security number or tax ID along with proof of HDHP enrollment at time of enrollment for an HSA. The account is sanctioned to be set up by a trustee which can be a bank, insurance company, or someone that is approved by the IRS to be a trustee.

The HSA contribution is tax deductible if an individual contributes to its value or, if contributions are made by an employer, the contributions are excluded from the individual's annual gross income. Contributions to the HSA as well as the HDHP minimum deductibles and maximum out-of-pocket amounts are determined by the IRS. These limits are presented in table 4 below for 2011, 2012 and 2013:

Table 4. IRS requirement for HSAs and HDHPs

		2011	2012	2013
HDHP Minimum Deductible Amount	Individual	$1,200	$1,200	$1,250
	Family	$2,400	$2,400	$2,500
HDHP Maximum Out of Pocket Amount	Individual	$5,950	$6,050	$6,250
	Family	$11,900	$12,100	$12,500
HSA Maximum Contribution Amount	Individual	$3,050	$3,100	$3,250
	Family	$6,150	$6,250	$6,450

C. Affordable Care Act Provisions

Currently the ACA is silent regarding HSAs and does not contain provisions prescribing whether HSAs can be offered on an Exchange. However, if an individual would like to contribute to an HSA, they must first enroll in a qualified HDHP, which is subject to ACA provisions. In addition to contribution, deductible and out-of-pocket limits enacted by the IRS, as part of ACA the format of an HSA with an HDHP will also be impacted beginning in 2011. Table 5 below detailed ACA provisions that affect HDHPs and will consequentially impact HSAs:

Table 5. ACA Provisions that impact HSAs and HDHPs

Effective Year	ACA Provision	Impact to HSA and HDHP
2011	Preventative Care Services required	➢ HDHPs began offering First Dollar Coverage for preventative care services, which increased the cost of an HDHP
	Coverage and Penalty changes	➢ Over-the-counter drugs are no longer an eligible medical expense for HSA-qualified HDHPs ➢ Increase in penalty from 10 to 20% for non-eligible uses of an HSA
2014	Essential Health Benefits Requirement	➢ Non-grandfathered HDHPs will be required to cover them
	Deductible Limits for Small Group Market	➢ Limits deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits[5]. Annual out-of-pocket maximum are set to HSA qualified HDHP limits. These values are indexed annually.
	Actuarial Value	➢ HDHP plans must meet actuarial value limitations or not be offered on the Exchange
2018	Cadillac Tax	➢ HSA employer contributions are subject to tax cap ➢ Once cap is reached, 40% tax applies[6]

D. Bulletin Issued by Health and Human Services

Uncertainty with the Actuarial Value of HDHPs and Exchange Requirements

A provision of the ACA is that qualified health plans[7] must meet a minimum actuarial value requirement of 60 percent to be offered within the metallic tiers. HHS released a bulletin in February of 2012 and issued proposed regulation in November of 2012 regarding the actuarial value calculation for the individual and small group markets. According to the bulletin[8], actuarial value is defined as the "expected health care costs a plan will cover" based on cost-sharing provisions for a set of benefits and is the ratio of health care costs paid for by the plan divided by the total health care costs. The intended goal of the actuarial value calculation is to provide individuals and small businesses a standardized way to compare plans so that the choice of health care coverage is, according to the bulletin, based on "premiums, quality, provider network, and customer service." The actuarial value calculator will be based on a default standard population including summary statistics, such as in continuance tables, which will be provided by HHS. Beginning in 2015, a state-specific data set may be used as the standard population to calculate the actuarial value if the data set is submitted by the state and approved by HHS.

HHS has proposed that the calculator used to determine the actuarial value of an employer health benefit plan would include any current year HSA contributions or amounts newly made available under an HRA for the current year. This calculation will create administrative complexities for both health plans and insurance departments to obtain approval for products required to meet the minimum actuarial value.

Furthermore, HHS proposes to exclude adjustments in the actuarial value for individual contributions, including those made by employees to employer HSAs. Modeling based on the most recently released CCIIO actuarial value calculator indicates that HSA-qualified HDHPs may fit into bronze or silver level metallic tiers, but future changes to the actuarial value calculator and further information regarding how HSAs and HDHPs are treated may determine what can be offered on the Exchange. According to the Kaiser Family Foundation report[9] on Actuarial Values, three consulting firms (Actuarial Research Corporation, Aon Hewitt, and Towers Watson) estimate that it is possible to create an HSA-qualified HDHP within the bronze or silver metallic level and many plans will easily meet the actuarial value requirement.. Additionally, the different basis prescribed by the IRS and ACA for adjusting for inflationary pressures may result in future HSA-qualified HDHPs no longer qualifying for bronze or silver status. IRS regulations rely on inflation-adjusted increases for HSA contributions and HDHP deductibles whereas the ACA indexes increases in cost sharing to the rate of average premium growth. In time, these two different approaches could cause HSA-qualified HDHPs to no longer qualify as a bronze or silver metal level plan.

Uncertainty with the viability of Catastrophic Plan paired with an HSA on an Exchange

A catastrophic plan is permitted only in the individual market and can be offered to only those under the age of 30 before the plan starts or to those who qualify for a financial hardship exemption. This plan design type has an actuarial value under 60 percent and is potentially attractive to those with financial hardship or who cannot afford more costly insurance.

Due to the restrictive eligibility requirements, catastrophic plans will not be viable for a large segment of the population. Furthermore, there is uncertainty if these catastrophic plans will be HSA-qualified. These plans provide catastrophic coverage with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. Future regulatory guidance will need to address whether catastrophic plans will qualify as HSA-qualified HDHPs.

III. Analysis

A. United States Health Savings Account Market Trends

Health Savings Accounts have had growing popularity since the enactment of the Medicare Modernization Act in 2003. Nationwide enrollment reached the million member mark in March of 2005, the 10 million member mark by January of 2010 and was approximately 13.5 million members in January of 2012. The HSA market breaks down into individual, small group and large group enrollees (definition of large group varies by state). Since 2007, the majority of total HSA enrollment is large group employers. Furthermore, large group employers represented over 50 percent of total enrollment in 2010 (50%), 2011 (55%) and 2012 (59%)[3]. Market research on enrollment figures, consumer characteristics, and premiums associated with HSA-qualified HDHPs are presented below:

Table 6. Key Market Trends

Enrollment
➢ The growth rate has slowed from 2005 (43% YOY) to 2011 (14% YOY), but has slightly increased to 18% YOY in 2012 (AHIP Center for Policy and Research, May 2012)
➢ In 2005, 54% of HSA enrollees were individuals, which have dropped since then to 18% in 2012. Small businesses have stabilized at about 25% of the market since 2005 (AHIP Center for Policy and Research, May 2012)
➢ 44% of employees in small businesses chose HSA-HDHP when offered a choice between HSA-qualified HDHP and other types of coverage (America's Health Insurance Plans, July 2011)
Consumer Characteristics
➢ Gender distribution is evenly split (Employee Benefit Research Institute, April 2012)
➢ 46% of HDHP enrollees have median incomes between $25,000 to $50,000, (America's Health Insurance Plans, May 2009)
➢ About half of enrollees in an HSA-eligible plan (including dependent children) are aged 40 and above, and half are below the age of 40. (America's Health Insurance Plans, November 2011)
Premium and Out of Pocket Expense
➢ Average annual premiums for HSA-qualified HDHP Plans were $4,427 for single coverage and $12,655 for family coverage. (America's Health Insurance Plans, November 2011)
➢ In contrast, the average premium for non-savings account plans was $5,565 for single coverage and $15,363 for family coverage. (America's Health Insurance Plans, November 2011)
➢ Average HDHP premiums are about 20 percent lower than non-HDHP from 2008 to 2011 (Kaiser Family Foundation)
➢ The average annual deductible for single/family coverage is $2,190/$4,068 for HSA-qualified HDHPs (Kaiser Family Foundation, 2011)
➢ The average annual out-of-pocket maximum for single/family coverage is $3,725/$7,434 for HSA-qualified HDHPs (Kaiser Family Foundation, 2011)
➢ 69% of employees with employer-sponsored HSA and HDHPs received contributions to the accounts from their employers (Kaiser Family Foundation, 2011)

B. Summary of New York State Market

According to America's Health Insurance Plan's Center of Policy and Research, it estimated that over 270,000 people in New York State are covered by HSA-qualified HDHP in January of 2012 and that 4-6% of lives under age 65 enrolled in commercial health plans were enrolled in HSA-qualified HDHPs in New York State.

Currently in New York, individuals can enroll in HSA-qualified HDHPs only through the Healthy New York ("HNY")[10] program as New York State law prohibits HMO carriers and non-HMO carriers from selling HDHPs to individuals. In addition, the New York State law allows non-HMO carriers, but prohibits HMO carriers from selling HDHPs in the small group market. New York State law also requires that all HMOs within the State offer HNY. HNY's eligibility rules include maximum income level requirements and are offered to resident individuals, sole proprietors, and small businesses (fewer than 50 employees). As of January 2012, this plan is only offered as an HDHP and is HSA qualified. On the HNY website, the State directs enrollees to contact their insurance company or bank to set up an HSA.

There are several HSA-qualified HDHPs in the New York State market currently. Table 7 below shows the range of key benefits offered through the HDHP plans currently offered in the marketplace based on health plan responses to the Section 308 letter submitted by New York State.

Table 7. Common HSA-Qualified HDHP features in New York State (as of August 2012)

Features		HSA-qualified HDHP Ranges
Deductible		
	Individual	$1,300 to $5,500
	Family	$2,600 to $11,000
Out of Pocket Max		
	Individual	$2,500 to $5950
	Family	$4,000 to $11,900
Coinsurance after Deductible (In-Network)[1]		0% to 20%
Coinsurance after Deductible (Out of Network)[2]		0% to 40%
Including Rx		Varies
Separate Deductible for Out of Network		Varies

[1,2] Coinsurance applies to only some benefits and may have annual limits

C. Existing Exchange Offerings

In the 2012 health insurance market there are two notable state-run Exchanges - the Massachusetts Health Connector ("Health Connector") and the Utah Insurance Exchange, with each representing a different vision for a health insurance Exchange. The Health Connector and Utah Exchange offer HSA-qualified HDHPs, but in line with their functional differences, the method to promote HSA-qualified HDHPs differs.

The Health Connector is operated by a semi-independent state agency tasked with helping residents locate health insurance that meets their needs. The Health Connector administers two Exchanges: Commonwealth Care, providing subsidized coverage for individuals below 300% of the federal poverty level and Commonwealth Choice, for those over this threshold to shop for coverage options. According to the Health Connector quarterly report[11], as of July 2012, more than 225,000 individuals (including 2,500 employees through the Business Express program) were enrolled. The Health Connector is a web based Exchange with options to view coverage for individuals, families, young adults, employees, employers, and brokers. Plans fit into Bronze, Silver and Gold plan types (with a low, medium and high level plan design within each plan type) which differ on plan design (rather than actuarial value) and premium level.

The Health Connector offers HDHPs as a part of "low" Bronze level plans with an explanation that all low Bronze level plans (except one) are HSA compatible. There is a section of the website that allows those

considering HSA-qualified HDHP plans to "learn more." By clicking this option, a brief explanation of an HSA with key advantages of having an HSA is provided. There is a prompt to contact the purchaser's bank or health insurer to set up an HSA. If a purchaser simply searched "HSA" in the "Go" box of the website, the first two options are health plans that offer HSAs with their HDHPs.

Contrary to the Health Connector, Utah's Health Exchange has minimum requirements for a plan to be offered on the Exchange and as of July 2012, over 140 plans are offered in the Exchange with varying levels of benefit and premium. Originally offered to all employer sizes, in March of 2011 the Utah Exchange website was limited to small-group employers (less than 50 employees) and not offered to individuals. According to the Utah Exchange Board Meeting minutes[12], as of June 2012 there are 296 employer groups representing 6,942 covered lives on the Exchange.

The Utah Exchange explicitly lists participating Medical and HSA providers, of which there are two bank options for small employers to choose from. When selecting either of the bank options a purchaser would be rerouted to the banks website and a variety of frequently asked questions regarding HSAs, including the advantages and detailed descriptions of the accounts. Both banks also have suggested HDHP carriers that they work with upon enrollment. Accordingly, more small-group employers that visit the Utah Exchange website are prompted to consider the option of an HSA and HDHP benefit design directly.

While the two Exchanges differ in many regards, they both offer HSA-qualified HDHPs as a practical option for health care coverage. The Health Connector offers HDHPs as a bronze level plan and directs purchasers outside of the Exchange for HSAs. Conversely, the Utah Exchange directs purchasers outside of the Exchange for suggested HSA providers and HDHP carriers.

D. New York State Options

We examined three options for HSAs and HDHPs in the 2014 Exchange environment:

I. New York State offers both HSAs and HDHPs on the Exchange.

As discussed earlier, creating a bronze or silver level HSA and HDHP is likely possible, at least initially, given the mandates in benefits, deductibles and out-of-pocket limits. By offering HSAs and HDHPs through the Exchange, New York State would allow both individuals and employers to "one stop shop." Under this option, purchasers are given more clarity regarding what an HDHP is, how it may meet their needs, and are provided the opportunity to shop for an HSA account trustee they prefer. When visiting the Exchange, a purchaser can select an HDHP plan and then be prompted to select an HSA trustee (bank or insurer). Through this process there is no confusion regarding who to contact and how to set up an HSA.

II. New York State offers only HDHPs through the Exchange.

By offering only HSA-qualified HDHPs on the Exchange and directing purchasers off the Exchange for HSA providers, New York State saves the time and resources associated with developing the systems functionality to offer HSAs on the Exchange. This option would work similarly to that of the MA Health Connector. A purchaser would select an HSA-qualified HDHP plan and could be provided a directive message regarding who to contact for an HSA. While this option may cause some confusion for individuals and employers regarding where to set up an HSA, this option has less administrative complexity for the Exchange.

III. New York State's Exchange does not offer HSAs or HSA-qualified HDHPs

New York State may decide that offering HSA and HSA-qualified HDHP options are not necessary for its Exchange. Under this option, consumers would be directed off the Exchange to purchase HSA-qualified HDHPs and HSAs. Of the three options, the exclusion of HSAs or HDHPs on New York State's Exchange provides the least administrative complexities for the Exchange.

E. Exchange Considerations

The potential considerations related to HSAs and qualified HDHPs vary for the various stakeholders involved in the future Exchange marketplace. Following is a list of some of the potential considerations in determining whether to offer HSAs and qualified HDHPs on the Exchange:

Table 9. Exchange Considerations: Advantages and Disadvantages

Exchange Considerations: HSAs and qualified HDHPs offered on Exchange	
Advantages	**Disadvantages**
Meets Consumer Demand: ✓ May promote consumer responsibility for health care decisions ✓ HSA balances can roll over from year to year ✓ Provides individuals, employees and employers with tax benefits ✓ Accumulated HSA account balances can be used for Medicare premium and qualified medical expenses during retirement ✓ Qualified medical benefits are broader than most traditional plans and can allow consumers to purchase services beyond essential health benefits **Increased Volume on the Exchange:** ✓ Provides consumers a "one stop shop" with increased consumer choice ✓ Increased volume on the Exchange will create a broader risk pool, alleviating concerns regarding anti-selection (risk adjustment will help alleviate anti-selection but will not remove its impact entirely) ✓ Increases competiveness of Exchange marketplace and encourages increased carrier participation ✓ HSA/HDHP products provide additional opportunities for carrier innovation and differentiation **Addresses Health Care Cost Issues:** ✓ Medical costs may be reduced due to increased consumerism	**Increased Administrative Complexities:** ✓ HSA/HDHP products are more complex than traditional insurance, which will create additional administrative and operational complexities for the Exchange, carriers, providers and individuals/employers who purchase the products **Increased Financial Risk:** ✓ HSA/HDHP products are more difficult to understand than traditional insurance and additional member education is required ✓ Individuals and families are assuming larger financial risk and may forgo necessary care due to high out-of-pocket expenses resulting in increased medical costs across the healthcare system ✓ Misuse of the funds can result in heavy penalties ✓ Individuals and families who do not expect to incur a tax liability will not receive the tax benefits of HSA/HDHP products **Future Regulatory Issues:** ✓ Uncertainty regarding how future Federal guidance may impact the viability of HSA/HDHP products in the Exchange marketplace **Marketplace Issues:** ✓ HMOs are not currently allowed to offer HSA/HDHP products in New York. However New York has made a policy decision to allow HMOs to write at all metal levels, lifting the restriction if the plan's products meet the AV requirements ✓ Employers may prefer control over account funds available through HRAs or FSAs rather than employee control through an HSA because such funds are owned by the employer rather than the employee

F. Exchange Subsidies

As a part of ACA, Federally funded premium credits and cost-sharing subsidies will be provided for eligible individuals enrolled in Exchange coverage who meet certain income requirements. To qualify for premium credits, an enrollee must have an income level at or below 400 percent of the Federal Poverty Level ("FPL"), which in 2012 equated to an annual salary of $44,680 for an individual or $92,200 for a family of four[13]. Premium credits will be awarded on a sliding scale to limit the amount of income spent on health insurance. Similar to premium credits, cost-sharing subsidies are also awarded based on the income level of a household and will be awarded to those with less than 250 percent FPL. Eligible individuals must be enrolled in a silver level plan to qualify for cost-sharing subsidies. Table 10 details the FPL levels and eligible premium credits and cost-sharing subsidies.

Table 10. Subsidy Requirements

Federal Poverty Level (percent of FPL)	**Premium Credit** (percent of income for premiums)	**Cost-Sharing Subsidy** (maximum enrollee cost share)
100-133 %	2 %	6 %
133-150 %	3 - 4 %	6 %
150-200 %	4 - 6.3 %	13 %
200-250 %	6.4 - 8.05 %	27 %
250-300 %	8.05 – 9.5 %	N/A
300-400 %	9.5 %	N/A

There is a concern that the availability of cost-sharing subsidies for silver level plans may disqualify certain HDHPs from being HSA qualified. Cost sharing subsidies that modify a plan design's cost sharing features may not be consistent with IRS regulations. Therefore, there is the possibility that individuals eligible for cost-sharing subsidies may not be eligible to set up an HSA with a silver level HDHP.

IV. Summary

A. Findings

The following are key findings resulting from an analysis of New York State's options for offering HSA and HDHPs in an Exchange environment:

Key Finding #1	**HSAs can potentially be offered on the Exchange.** The ACA does not exclude HSAs from Exchanges. Modeling indicates that HSA-qualified HDHPs may fit into bronze or silver level metallic tiers which means they could potentially be sold on the Exchange.
Key Finding #2	**HSA-qualified HDHPs offered through an Exchange are subject to the Internal Revenue Service restrictions on deductibles, out-of-pocket limits and contribution limits to HSAs.** These restrictions and limits are updated annually and determine which HDHP plans are qualified to be paired with HSAs. There is a concern that the availability of cost-sharing subsidies for silver level plans may disqualify certain HDHPs from being HSA qualified.
Key Finding #3	**There is growing popularity of HSAs and HDHPs in the market.** January 2012 enrollment was 13.5 million, up 18 percent from 2011 and 35 percent from 2010. In 2011, 18% of employers offer HSA-qualified HDHPs as a healthcare option and 69% of employees with employer sponsored HSAs receive contributions from their employer. Over 270,000 people in New York State are covered by HSA-qualified HDHPs[3].
Key Finding #4	**It is not clear based on the ACA whether catastrophic plans will qualify as HSA-qualified HDHPs.** There is uncertainty as to whether a catastrophic plan offered on an Exchange will be HSA-qualified given the definitions of preventative services prescribed under the ACA and IRS. Additionally, catastrophic plans will not be viable for a large segment of the population as they are only available in the individual market to people under age 30 and those who have received certification that they are exempt from the coverage mandate by reason of affordability or hardship. Future regulatory guidance will need to address whether catastrophic plans will qualify as HSA-qualified HDHPs.
Key Finding #5	**Uncertainty exists because many ACA provisions have not yet been clarified by HHS.** Modeling based on the most recently released CCIIO actuarial value calculator indicates that HSA-qualified HDHPs may fit into bronze or silver level metallic tiers, but future changes to the actuarial value calculator and further information regarding how HSAs and HDHPs are treated may determine what can be offered on the Exchange.

V. Study Methodology

This section of the report provides background on the data, methodology and assumptions used in the analysis.

A. Information

In performing our analysis, we relied on data and other information provided to us by the insurers (through the Department of Financial Services) and available publicly. Examples of resources used for analyzing New York State's options are the ACA, IRS, the Employee Benefit Research Institute (EBRI), The American Academy of Actuaries, Health and Human Services, the Kaiser Family Foundation and Americans Health Insurance Plans (AHIP). A complete list of references is presented in the Appendix.

B. Methodology

In order to summarize the information and analyze HSA and HDHP on and off the Exchange, we:

1. Inventoried internal and external research
2. Analyzed market offerings of existing Exchanges
3. Analyzed New York State HSA and HDHP market offerings and state provided 308 letters
4. Reviewed regulations issued by HHS and the IRS
5. Identified the options to include and exclude HSAs and HDHPs on the Exchange
6. Identified considerations of including and excluding HSAs and HDHPs on the Exchange

C. Assumptions

The ACA is silent on the treatment of HSAs on the Exchange. Also, HSA and HDHP regulatory clarifications and rules continue to evolve and are not yet complete. We have reflected the federal regulations provided in Appendix and collaborated with the Department to make decisions on what to include in the analysis. Future guidance provided by HHS may impact the results of this study.

VI. Appendix

A. References

Federal regulations have been provided in the following documents:

- **The Patient Protection and Affordable Care Act ("ACA")**: Title 1 – Quality, Affordable, Health Care for All Americans; http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
- **CCIIO Bulletin: "**Actuarial Value Bulletin**";** February, 2012; http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf
- **CCIIO Proposed Rule:** "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation"; November, 2012; http://cciio.cms.gov/resources/regulations/index.html#pm
- **Internal Revenue Service:** "Health Savings Accounts and Other Tax-Favored Health Plans"; 2011; http://www.irs.gov/pub/irs-pdf/p969.pdf

Additional information has been provided in the following documents:

- **American Academy of Actuaries;** "Actuarial Value under Affordable Care Act"; July, 2011; http://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf
- **American Academy of Actuaries;** "Re: Actuarial Value and Cost Sharing Reduction Bulletin"; May, 2012; http://www.actuary.org/files/AV_comment_letter_05_16_2012_final.pdf
- **America's Health Insurance Plans Center for Policy and Research;** " Health Savings Accounts and Account –Based Health Plans Research Highlights"; July, 2012; www.ahip.org/HSA**Highlights**Report072012/
- **America's Health Insurance Plans Center for Policy and Research;** "January 2012 Census Shows 13.5 Million People Covered by Health Savings Account/ High-Deductible Health Plans (HSA/HDHPs)"; May, 2012; http://www.ahip.org/HSA2012/
- **America's Health Insurance Plans Center for Policy and Research;** "Health Savings Accounts and Account-Based Health Plans: Research Highlights" November, 2011; www.ahip.org/Workarea/linkit.aspx?ItemID=4294967298
- **Blue Cross Blue Shield Association: "**Detailed Summary of PPACA**";** April, 2010;
- **Employee Benefit Research Institute; "**Characteristics of the Population with Consumer-Driven and High-Deductible Health Plans, 2005-2011"; April 2012; http://www.ebri.org/pdf/notespdf/EBRI_Notes_04_Apr-12.CDHP-EldPovty.pdf
- **Employer Health Benefits; "**High-Deductible Health Plans with Savings Option"; 2011; http://familiesusa2.org/conference/health-action-2012/toolkit/content/pdfs/EHB.pdf

- **Johnson, Whitney R.**; "The Impact of Health Reform on HSAs"; 2011; http://www.ifebp.org/inforequest/0160537.pdf

- **Kaiser Family Foundation;** "Health Savings Accounts and High Deductible Health Plans: Are They an Option for Low-Income Families?"; October, 2006; http://www.kff.org/uninsured/upload/7568.pdf

- **Kaiser Family Foundation: "**Summary of New Health Reform Law"; April, 2011; http://www.kff.org/healthreform/upload/8061.pdf

- **Kaiser Family Foundation;** "What the Actuarial Values in the Affordable Care Act Mean"; April, 2011; http://www.kff.org/healthreform/upload/8177.pdf

- **Kaiser Family Foundation;** "Employer Health Benefits Annual Study"; 2012; http://ehbs.kff.org/pdf/2012/8345.pdf

- **Massachusetts Health Exchange;** https://www.mahealthconnector.org

- **Milliman:** "Measuring the Strength of the Individual Mandate"; March, 2012; http://publications.milliman.com/publications/health-published/pdfs/measuring-strength-individual-mandate.pdf

- **National Health Council:** "Actuarial Analysis to Estimate Costs of Model EHB Package"; August, 2011; http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_ActuarialAnalysis.pdf

- **Neeleman, Stephen D.**: "The Complete HSA Guidebook"; 2011; http://www.healthequity.net/documents/The_Complete_HSA_Guidebook.pdf

- **Utah Health Exchange;** http://www.exchange.utah.gov/

B. Glossary

- **Actuarial Value –** Actuarial value is the percentage of total healthcare costs covered by the plan insurer or carrier. For example, a plan with an actuarial value of 80 percent, the carrier covers 80% of the total costs while the insured is responsible for the remaining 20 percent.

- **Catastrophic Plan –** A catastrophic plan has a high deductible and may cover only certain types of expensive care.

- **Consumer Driven Health Plan (CDHP) –** Consumer Driven or Directed Health Plans allow members to set up personal accounts (HSAs or HRAs) to pay for medical expenses.

- **Consumerism** – Transferring the economic purchasing power—and decision-making—to the hands of members through the supply of information, financial incentives, rewards, and other benefits that encourage personal involvement in healthcare purchasing decisions.
- **Exchange –** An insurance marketplace designed for individuals and small groups providing affordable health benefit plans that meet certain benefits and cost requirements.

- **Flexible Spending Account (FSA) –** An account set up by an employer for their employees to use for out-of-pocket medical costs. An employer limits how much money can be placed in a FSA and there is no roll-over of funds.

- **Federal Poverty Level (FPL) –** A measure of income used to determine eligibility determined annually by Health and Human Services.

- **Health Reimbursement Account (HRA) -** Employer funded health account that can be used for health care expenses. There is roll-over of unused HRA funds however the employer owns this account.

- **Health Savings Account (HSA) –** A medical savings account set up and owned by an individual used for health care expenses. Unused funds are rolled-over at the end of the year.

- **High Deductible Health Plan (HDHP) –** HDHPs offer higher deductibles than traditional health plans and can be combined with HSAs or HRAs to pay for medical expenses.

- **Out-of-Pocket Limit –** The max amount an insured will pay before the insurer covers 100% of medical costs.

- **Rider –** An amendment to an insurance policy for a specific service not covered in the original plan design.

---

[1]Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)

[2] A "grandfather" status is granted to plans in existence prior to March 23, 2010. These plans are exempt from some key provisions of ACA. Particularly, grandfathered plans are not required to offer Essential Health Benefits; http://policyinsights.kff.org/2011/september/grandfathering-explained.aspx

[3] America's Health Insurance Plans Center for Policy and Research; " Health Savings Accounts and Account –Based Health Plans Research Highlights"; July, 2012; www.ahip.org/HSA**Highlights**Report072012/

[4] Other health related coverage includes coverage for accidents, disability, dental care, vision care, and long term care. See section "Other health coverage" http://www.irs.gov/pub/irs-pdf/p969.pdf

[5] Kaiser Family Foundation**: "**Summary Of New Health Reform Law"; April, 2011; http://www.kff.org/healthreform/upload/8061.pdf

[6] An excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage; http://www.kff.org/healthreform/upload/8061.pdf

[7] Section 1301 and its applicable amendments in Section 10104 establish the criteria for any qualified health plan (QHP) to be offered via a state health insurance exchange program, Consumer Operated and Oriented Plan (CO-OP) program, or a multi-state exchange. QHPs must be certified, provide an essential benefits package and be offered by a licensed insurer that agrees to offer one silver- and one gold-level plan and charge the same premium for coverage whether the plan is offered through an exchange, through a CO-OP program, through a multi-state exchange, directly from the issuer or through an agent; http://hcr.amerigroupcorp.com/wp-content/uploads/2011/04/HRI-0120.pdf

[8] Center for Medicare and Medicaid, "Actuarial Value and Cost-Sharing Reductions Bulletin", February 2012; http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf

[9] Kaiser Family Foundation; "What the Actuarial Values in the Affordable Care Act Mean"; April, 2011; http://www.kff.org/healthreform/upload/8177.pdf

[10] See Study #5 Healthy New York and Family Health Plus Employer Buy-In provided by Deloitte Consulting

[11] "Connector Quarterly Program Summary Report"; July 6, 2012; https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2012/2012-07-12/4-QuarterlyReport.pdf

[12] "Defined Contribution Risk Adjuster Board Minutes"; June 2012; http://www.insurance.utah.gov/docs/RAB/RAB-Min6-26-12_Unapproved.pdf

[13] Income level is defined by the Internal Revenue Code as the adjusted gross income as reported on and individual's tax return; http://www.healthcare.gov/law/resources/authorities/section/1004-income-definitions.pdf