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Tax-Favored (Consumer-Driven) Health Plans • January 2011

As health insurance and health care costs continue to rise, both employers and employees are looking for ways to decrease expenses while continuing to provide health insurance. Tax-Favored Health Plans, more commonly known as Consumer-Driven Health Plans (CDHPs), allow consumers to have more flexibility and control over how health care dollars are spent while maintaining catastrophic insurance coverage through high-deductible health insurance plans (HDHPs). Using these two types of plans together has become more common since CDHPs gained federal tax-favored status in 2003 and expanded to provide additional tax savings and other benefits in 2007.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 make some changes to CDHPs beginning January 1, 2011. The goal of these changes is to maintain affordable health insurance options for employers and consumers while limiting tax benefits to decrease federal losses in tax revenues.

TYPES OF CONSUMER-DRIVEN HEALTH PLANS

CDHPs are designed to decrease overall health spending by using a high-deductible “catastrophic” health insurance plan (HDHP) to lower insurance premiums and using those savings to fund a CDHP. A CDHP is a savings or reimbursement account, usually administered by a bank or other financial institution, which gives individuals greater control over and participation in health care spending. The goal is that using this combination of health insurance plans will lead consumers to make more informed and efficient decisions about their health care utilization.

Individuals control their own CDHPs and use them for qualified health expenses, many of which would not be paid for by a traditional insurance plan. For instance, most CDHPs currently allow expenses for provider and hospital co-pays, co-insurance, dental and vision care, everyday medical supplies like band-aids, and non-prescription drugs like cough syrup and aspirin (note: there will be changes to the non-prescription drug benefit beginning on January 1, 2011; see “Changes to CDHPs” on page 8).

Although sometimes known by different names, the IRS defines four types of accounts that are considered to be CDHPs: Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), Flexible Spending Arrangements (FSAs), or Health Reimbursement Arrangements (HRAs). All CDHPs were created under a single premise, but each has its own specific qualifications, plan requirements, contribution guidelines and allowable expenditures.

CDHP Overview

- The term Consumer-Driven Health Plans includes various types of reimbursement accounts, reimbursement arrangements, and savings accounts that can be used to pay health care expenses tax-free
- Usually, CDHPs are used along with high-deductible health insurance plans
- CDHPs are generally administered by financial institutions like banks or insurance companies
- All CDHPs allow spending on over-the-counter medications and drugs, but after January 1, 2011, a prescription will be required to buy them tax-free
- Federal legislation in 2003 gave tax-favored status to CDHPs, and additional legislation increased their flexibility and tax-favored status in 2007

Characteristics of IRS-Defined CDHPs at a Glance

| | HSA | MSA | FSA | HRA |
|---|----------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Who may set up? | Anyone | Small employer or self-employed | Employer, but not self-employed | Employer, but not self-employed |
| Who may contribute? | Anyone, including family members | Employee and employer | Employee and employer | Employer only |
| High-deductible health plan participation required? | Yes | Yes | No | No |
| Insurance premiums are qualified expense? | Generally no | Generally no | No | Yes |
| Money rolls over? | Yes | Yes | Generally no | Yes |
| Portable? | Yes | Yes | Generally no | No |

The savings and financial benefits are also different with each plan, with some plans more financially favorable to employers and some to employees. Depending on the type of plan an employer chooses, employers may save while employees pay more out of pocket. As employers look for more and more ways to decrease their costs, many are requiring that employees pay more for health coverage regardless of the type of plans they use. However, the goal of using any CDHP is that money is spent for health care only when it is actually needed and is not used to pay expensive premiums for insurance with benefits that may never be needed.

Health Savings Accounts

HSAs can be set up by anyone: an employer or a qualified individual, including someone self-employed or unemployed. HSAs may only be used by people who are not eligible to be claimed as a dependent on someone else's tax return (even if they don't take the claim). After death, if a spouse is the named beneficiary, the account will continue as the spouse's HSA; if anyone else is beneficiary, it will no longer be treated as an HSA and will be taxable to the beneficiary at the fair market value.

HSAs are available to people who are not enrolled in Medicare and not already using an HRA or FSA, and whose only other health coverage is a high-deductible plan. For 2010, a high-deductible plan is defined as one with a minimum annual deductible of \$1,200 and maximum out-of-pocket expenses of \$5,950 for single coverage (\$2,400 and \$11,900 respectively for family coverage).¹ Other than the high-deductible plan, they cannot have other health coverage except specific coverage for accidents, disability, dental, vision and long-term care.

Employer contributions must be equal for all comparable HSA participants (same amount or same percentage of the annual deductible limit); a comparable employee is one who has the same type of coverage (self or family) and employment (part-time, full-time, former employee). Non-highly compensated employees are not treated as comparable to highly compensated employees.

| HSA Contributions | HSA Distributions & Qualified Expenses |
|--|--|
| <ul style="list-style-type: none"> • Contributions may be made by anyone: employer, employee or any other person • Employer contributions are not generally subject to employer's employment taxes • Employer contributions cannot be deducted from the employee's taxes and are not included as employee's income • All non-employer contributions, regardless of who made them, may be deducted from the employee's taxes, even if deductions are not itemized • Interest or other earnings on HSA assets are tax free • Contributions must be in cash; stock and property are not allowed • Annual contribution limits depend on type of health coverage, age, dates of eligibility and ineligibility. If eligible for an entire year, with HDHP coverage, the 2010 contribution limits are: <ul style="list-style-type: none"> ○ \$3,050 (\$4,050 if 55+ and not on Medicare) for self-only coverage ○ \$6,150 (\$7,150 if 55+ and not on Medicare) for family coverage • Contributions rolled over from Archer MSAs and other HSAs do not count toward annual limit • Adjustments to limits are made for contributions made to an Archer MSA (see below), two married people contributing, and for partial year eligibility • Contributions can be made until April 15 of the next year (by April 15, 2011, for the 2010 tax year) • Unused amounts roll over from year to year | <ul style="list-style-type: none"> • Distributions/reimbursements from HSAs used for qualified medical expenses are not taxed • Distributions can continue to be taken even if the HSA becomes ineligible for further contributions • Qualified expenses are: <ul style="list-style-type: none"> ○ expenses that would generally qualify for medical or dental deduction (see IRS Publication 502) ○ non-prescription medications, drugs and supplies (beginning January 1, 2011, individuals must have a prescription for most medications and drugs to be considered a qualified expense; see "Changes to CDHPs" on page 8) ○ expenses for an individual, spouse and dependents claimed on tax returns, and sometimes for dependents who could have been claimed but were not (eg, expenses for a noncustodial child) • Insurance premiums are generally NOT qualified expenses, with exceptions for premiums for some long-term care, COBRA, someone receiving unemployment benefits, and non-supplemental Medicare or other health care coverage for an individual or a spouse over age 65 • Prohibited transactions between the individual and an HSA include sale, exchange or lease of property, lending of money, furnishing goods, services or facilities, or transfer or use of any assets • Non-qualified distributions will be included as taxable income and are also subject to an additional 10% tax (20% after January 1, 2011), but there is no additional tax if an individual is disabled, over 65 or after he/she dies |

Medical Savings Accounts: Archer MSAs

Archer MSAs are available to individuals and their spouses who are self-employed or employed by a small business (less than 50 employees in the last two years, with exceptions for new businesses and businesses that grow larger) whose only other health coverage is a high-deductible plan. For 2009, the IRS defined a qualified high-deductible plan for an MSA as one with a minimum annual deductible of \$2,000 and maximum out-of-pocket expenses of \$4,000 for single coverage (\$3,000 and \$7,350 respectively for family coverage).¹ Other than the high-deductible plan, participants cannot have other health coverage except specific coverage for accidents, disability, dental, vision and long-term care.

Employer contributions must be equal for all comparable MSA participants (same amount or same percentage of the annual deductible limit); a comparable employee is one who has the same type of coverage (self or family) and employment (part-time, full-time, former employee). Non-highly compensated employees are not treated as comparable to highly compensated employees.

Archer MSAs may only be used by people who cannot be claimed as a dependent on someone else's tax return (even if the person does not claim them as a dependent) and who are not enrolled in Medicare, even if they may be eligible for a Medicare Advantage MSA (see below). An Archer MSA may be transferred if an employee changes jobs, but new contributions may not be made unless eligibility is met again. After death, if a spouse is the named beneficiary, the account will continue as the spouse's Archer MSA; if anyone else is beneficiary, it will no longer be treated as an Archer MSA and will be taxable to the beneficiary at the fair market value.

| Archer MSA Contributions | Archer MSA Distributions & Qualified Expenses |
|---|--|
| <ul style="list-style-type: none"> • Contributions may be received from an employee or employer, but not both in the same year • Employer contributions are not generally subject to employer's employment taxes • Employer contributions cannot be deducted from the employee's taxes and are not included as employee's income • Individual contributions may be deducted from the employee's taxes, even if deductions are not itemized • Interest or other earnings on MSA assets are tax free • Contributions must be in cash; stock and property are not allowed • Contributions are limited based on the annual deductible of the qualifying HDHP; the contribution: <ul style="list-style-type: none"> ○ can total up to 75% of the annual deductible of a family HDHP if held all year ○ can total up to 65% of the annual deductible of a self-only HDHP if held all year ○ amount decreases if individual has not been covered under the HDHP for the entire year • Contributions are also limited to annual earned income from the employer who opened the HDHP, or to net self-employment income • Contributions rolled over from Archer MSAs to another Archer MSA or an HSA are not taxable if completed within 60 days • Only one rollover contribution can be made each year to an Archer MSA • Unused amounts roll over from year to year, until used for a distribution or qualifying event | <ul style="list-style-type: none"> • Distributions from Archer MSAs used for qualified medical expenses are not taxed • Qualified medical expenses not covered by the HDHP may be reimbursed from the MSA • Distributions can continue to be taken even if the MSA becomes ineligible for further contributions • Qualified expenses are: <ul style="list-style-type: none"> ○ expenses for an individual, spouse and any dependents claimed on tax returns, and sometimes for dependents who could have been claimed but were not (eg, expenses for a noncustodial child) ○ expenses that would generally qualify for medical or dental deduction (see IRS Publication 502) ○ non-prescription medications, drugs and supplies (beginning January 1, 2011, individuals must have a prescription for most medications and drugs to be considered a qualified expense; see "Changes to CDHPs" on page 8) • Insurance premiums are generally NOT qualified expenses, with exceptions for premiums for some long-term care, COBRA, or someone receiving unemployment benefits • Prohibited transactions between the individual and an Archer MSA include sale, exchange or lease of property, lending of money, furnishing goods, services or facilities, or transfer or use of any assets • Non-qualified distributions will be included as income and are also subject to an additional 15% tax (20% after January 1, 2011), but there is no additional tax if an individual is disabled, over 65 or after he/she dies |

Medical Savings Accounts: Medicare Advantage MSAs

A Medicare Advantage MSA is a special type of Archer MSA that is administered by Medicare and used solely to pay expenses for the qualified account holder. Anyone using a Medicare Advantage MSA must meet all of the qualifications of the Archer MSA described above, and also must be enrolled in Medicare and have a high-deductible health plan that meets Medicare guidelines. Contributions to Medicare Advantage MSAs come from Medicare, and the plan is administered through a federal Medicare program instead of through a private financial institution like most other CDHPs. Contributions to Medicare Advantage MSAs are not included in income, and distributions for qualified medical expenses are not taxed.

Flexible Spending Arrangements

An FSA is an employer-established plan, but may not be used by those who are self-employed. Employers have complete flexibility in designing an FSA plan and its benefits, and unlike HSAs and MSAs, an individual does not have to be covered under any other health plan to have an FSA.

FSAs are usually funded through voluntary salary reductions, with the amount up to the employee. There is no legal limit on the amount that can be contributed to an FSA, but the employer must set a maximum contribution amount that may not be changed unless employment or family status changes as provided for in the plan. Employees must budget in advance each year to decide how much money to place in an FSA, and unused money usually does not roll over to the next plan year. If an employee overestimates the amount needed for qualified medical expenses that year, the excess money will be lost by the employee. At the same time, if an employee underestimates the amount needed, the tax advantage is given up for any additional expenses because additional contributions to the FSA may not be made.

| FSA Contributions | FSA Distributions & Qualified Expenses |
|--|--|
| <ul style="list-style-type: none"> • Total contributions in a plan year are not limited for either employee or employer, but the plan must set a maximum amount, either dollar or percentage of employee's compensation (beginning on January 1, 2013, contributions will be limited to \$2,500/year and will be indexed to the Consumer Price Index) • Total contribution amount must be designated at the beginning of a plan year, which will be the maximum amount able to be used tax-free by the employee • No employment or federal income taxes are deducted from contributions • FSAs are usually funded by using voluntary salary reductions from paychecks, which are deducted on a regular schedule • Employer contributions, if made, are excluded from the employee's gross income (employer contributions for long-term care are included as income) • Contributions not used within a plan year are usually forfeited ("use it or lose it" account), with provisions to allow flexibility for an additional 2½ months after the end of the plan year • Under some circumstances, contributions to FSAs may be made by taking distributions from existing HSAs | <ul style="list-style-type: none"> • The maximum amount of funds can be withdrawn at any time during the plan year, even if the total contributions are not yet accrued in the account (funds are replaced by regular payroll deductions) • Distributions from FSAs used for qualified medical expenses are not taxed • Expenses are often paid through a debit or credit card or as reimbursement with proper documentation • Qualified expenses are: <ul style="list-style-type: none"> ○ expenses that would generally qualify for medical or dental deduction (see IRS Publication 502) ○ non-prescription medications, drugs and supplies (beginning January 1, 2011, individuals must have a prescription for most medications and drugs to be considered a qualified expense; see "Changes to CDHPs" on page 8) • Insurance premiums are NOT qualified expenses, including those paid for long-term care • Special rules and limits allow military reservists to take some distributions that are considered qualified distributions |

Health Reimbursement Arrangements

HRAs are employer-established plans that may not be used by those who are self-employed, with additional limitations for highly compensated individuals. Employers have complete flexibility in designing the plan and its benefit combinations. Participants are not required to be covered under any other health plan, but HRAs are allowed to be offered with other health plans, including FSAs.

| HRA Contributions | HRA Distributions & Qualified Expenses |
|--|--|
| <ul style="list-style-type: none"> • Contributions may be made only by the employer (employees may not contribute) • Employer contributions are exempt from employer's employment taxes • Employer contributions are excluded from employee's gross income and are exempt from the employee's federal taxable income • Contributions cannot be paid through salary reduction • No limit is set on the amount of money an employer may contribute • Unused amounts left in account can be rolled over from year to year | <ul style="list-style-type: none"> • Distributions/reimbursements are tax-free if used to pay for qualified expenses • Reimbursements may be made to current and former employees, their spouses and dependents, any person able to be claimed as dependent (even if not actually claimed), and spouses and dependents of deceased employees • Qualified expenses are: <ul style="list-style-type: none"> ○ expenses that would generally qualify for medical or dental deduction (see IRS Publication 502) ○ non-prescription medications, drugs and supplies (beginning January 1, 2011, individuals must have a prescription for most medications and drugs to be considered a qualified expense; see "Changes to CDHPs" on page 8) ○ insurance premiums, including those paid for long-term care ○ Health care expenses not already covered under another health plan • Can transfer out of an HRA to an HSA, with limitations • Non-qualified distributions paid out will be considered as income |

COST SAVINGS AND INCREASED EXPENSES WHEN USING CDHPs

Using a combination of HDHPs and CDHPs may result in two large areas of potential savings: decreases in some health care utilization and lower insurance premium costs. However, there is also a potential for increased health care costs, and issues regarding how those costs would be borne.

Decrease in Health Care Utilization

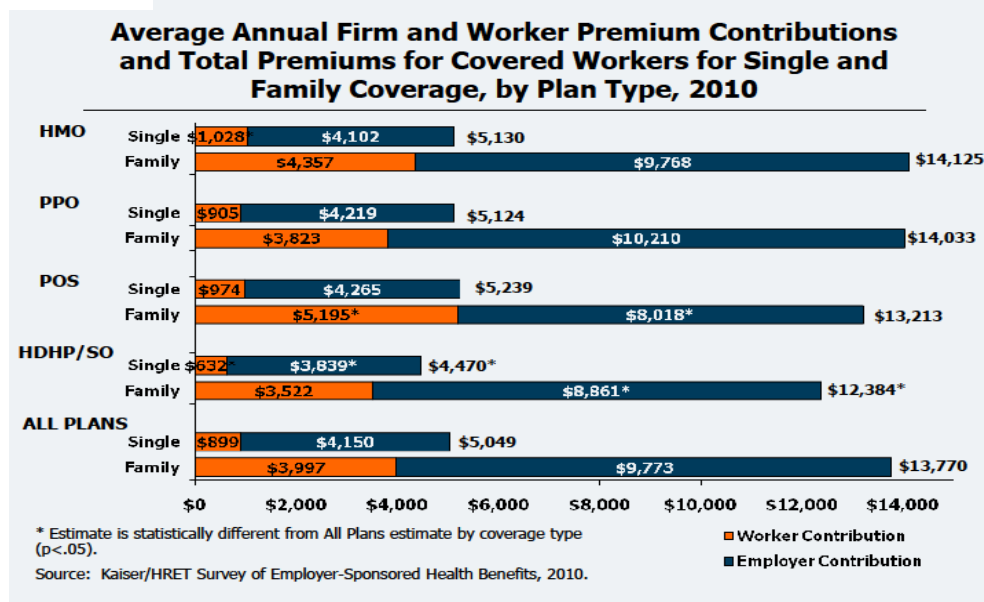
When individuals see health care costs coming more directly out of their pocket rather than being paid through an insurance company, they utilize less health care. Overall, it has been found that people covered under CDHPs say that they are more likely to consider the cost of seeking care and are also less likely to seek out and use health care.² Also, most people enrolled in CDHPs say that they are healthier than those choosing other types of plans,² which may account for lower use of health care services by CDHP enrollees. While it can be a benefit that people consider the cost before seeking care, it can also be a barrier to receiving needed health care prevention and treatment. If consumers are paying more or have the perception that they are paying more than they used to, even if they are not, some may not seek health care when they should.

Lower Premium Costs

Premiums for high-deductible health plans cost much less than premiums for lower-deductible plans, and data from the 2010 Kaiser/HRET Survey of Employer-Sponsored Health Benefits shows significant premium savings when using a HDHP/CDHP combination over more traditional plans³ (see Figure 1). When compared to plan alternatives, the average annual premium savings for using a HDHP along with a CDHP is \$654-\$769³ for individuals and \$829-\$1,741³ for families. The average annual worker contribution is also less than under other plan types, \$273-\$394³ lower for individuals and \$301-\$1,673³ lower for families. The

average employer contribution is less than for every plan except family point of service (POS) plans.³

Figure 1:



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The direct savings seen by using a HDHP and a CDHP is the difference between the amount saved on premiums and the amount spent from the CDHP account. If an employer or individual switches to a HDHP and saves money on premiums, but has no additional health care needs throughout the year, the savings will be the entire difference in the premiums. The amount could be even higher if premiums are allowed to be paid with non-taxed CDHP funds, with savings increasing by the amount of taxes saved.

Who Benefits from Savings?

Saving by using an employer-based combination of HDHPs and CDHPs does not mean that the total savings will be seen solely by employees or only by the employer. Depending on the plan combination chosen, implementation and utilization, all savings may go to the employer or to the employee, or may be divided up somehow. If an individual is using a combination plan, all savings will benefit the individual.

However, costs could increase instead of decrease, and those increases also may be borne solely by the employer, solely by the employee or by a combination of both. For people managing chronic conditions, it may be difficult to estimate how much should be contributed from year to year, especially if they are unable to roll over funds. For individuals who become ill or use a lot of health care services, CDHPs can be more expensive than traditional coverage. Even if someone estimates the exact amount of services used in a year, if an employer contributes less to a HDHP/CDHP plan than to the previous plan, an employee could spend thousands of dollars more out of pocket in a year. While changing to an HDHP/CDHP may help decrease overall health care costs, savings are not a foregone conclusion for everyone.

CHANGES TO CDHPs

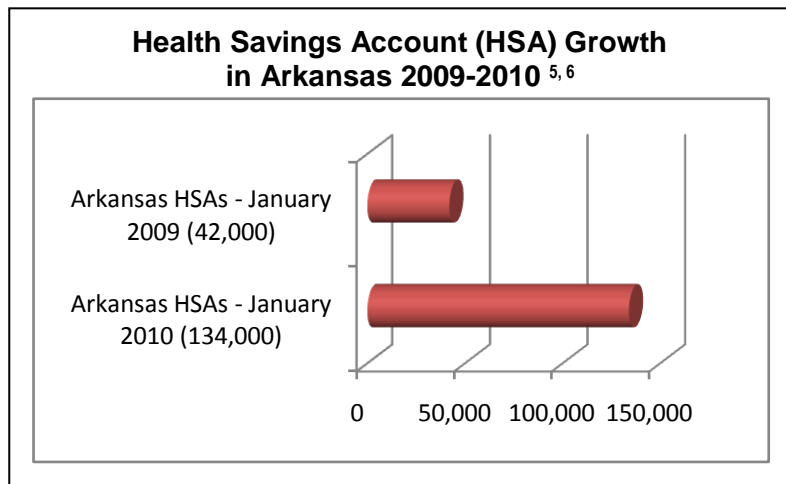
The passage of the Patient Protection and Affordable Care Act will cause some changes to CDHPs.

- 2011 – HSAs, FSAs, HRAs and Archer MSAs will not pay for over-the-counter medicines and drugs without a prescription (insulin, medical devices, glasses, contacts and non-medicine items will be exempt). Currently, most of these items can be purchased tax-free without a prescription.
- 2011 – Non-qualified distributions from HSAs and Archer MSAs will be charged a tax of 20% in addition to counting distributions as income. Currently, the rate is 10% for HSAs and 15% for Archer MSAs.

- 2013 – FSAs will have an annual contribution limit of \$2,500, which will be indexed annually to the Consumer Price Index. Most people contribute less than that now; the average annual contribution to an FSA is \$1,441,⁴ with 18%⁴ contributing more than \$2,500 each year. Those who contribute more generally have annual incomes over \$150,000.⁴

CONCLUSION

The use of CDHPs is on the rise, both in Arkansas and nationally. From 2006 to 2010, the percentage of employer health plans enrolling employees in either an HSA or an HRA jumped from 4% to 13%.^{5,6}



Using CDHPs in combination with high-deductible health plans will likely become an important cost management strategy for many employers, even though tax savings after January 1, 2011 will not be as high as in previous years. The effect on individual consumers will be greatly driven by what types of plans employers choose to offer, and how those plans are designed and implemented. Employer contributions, the ability to roll over or transfer funds, and specific plan design will be important to individual consumers. If used efficiently and effectively, CDHPs may decrease overall health costs as well as costs for individual employers and employees.

Abbreviations Used:

| | |
|--|-----------------------------------|
| CDHP: consumer-driven health plan | HRA: health reimbursement account |
| FSA: flexible spending arrangement | HSA: health savings account |
| HDHP: high-deductible ("catastrophic") health insurance plan | MSA: medical savings account |

Note: Information shared in this overview is based on the law, interim rules and regulations as they are known at this time, and is ACHI's best interpretation of the information. As the law continues to be written into final rules and regulations, it will be further interpreted. Details may change during this process.

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Endnotes

¹ U.S. Department of the Treasury, Internal Revenue Service. "Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans for use in preparing 2009 Returns." [www.irs.gov](http://www.irs.gov/publications/p969/index.html). U.S. Department of the Treasury, Internal Revenue Service, 15 Sept. 2010. Web. 11 Nov. 2010. <<http://www.irs.gov/publications/p969/index.html>>.

² Fronstin, Paul. "What Do We Really Know About Consumer-Driven Health Plans?" *Employee Benefit Research Institute Issue Brief* 345 (2010): 1-28. Web. 15 Nov. 2010. <http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=4612>.

³ The Kaiser Family Foundation and Health Research & Educational Trust. "Employer Health Benefits 2010 Annual Survey." *Kaiser Family Foundation*. Kaiser Family Foundation, Sept. 2010. Web. 11 Nov. 2010. <<http://ehbs.kff.org/>>.

⁴ Hewitt Associates. "The Effects of Health Care Reform on Flexible Spending Accounts." *AON Hewitt*. Hewitt Associates LLC, 2010. Web. 1 Dec. 2010. <<http://www.hewittassociates.com/Intl/NA/en-US/KnowledgeCenter/ArticlesReports/ArticleDetail.aspx?cid=8400&tid=49>>.

⁵ America's Health Insurance Plans Center for Policy and Research. "January 2009 Census Shows 10 Million People Covered by HSA/High-Deductible Health Plans." *www.AHIPResearch.org*. America's Health Insurance Plans Center for Policy and Research, May 2009. Web. 9 Nov. 2010. <<http://www.ahipresearch.org/pdfs/2009hsacensus.pdf>>. (Staff Note: Number rounded to the nearest 1,000.)

⁶ America's Health Insurance Plans Center for Policy and Research. "January 2010 Census Shows 10 Million People Covered by HSA/High-Deductible Health Plans." *www.AHIPResearch.org*. America's Health Insurance Plans Center for Policy and Research, May 2010. Web. 9 Nov. 2010. <<http://www.ahipresearch.org/pdfs/HSA2010.pdf>>. (Staff Note: Number rounded to the nearest 1,000.)

IRS INFORMATION REGARDING CDHPs

Publication 969, Health Savings Accounts and other Tax-Favored Health Plans:

<http://www.irs.gov/publications/p969/index.html>

IR-210-95, IRS Guidance on 2011 Changes to Flexible Spending Arrangements:

<http://www.irs.gov/irs/article/0,,id=227301,00.html>

Revenue Ruling 2010-23: <http://www.irs.gov/pub/irs-drop/rr-10-23.pdf>

Notice 2010-59: <http://www.irs.gov/pub/irs-drop/n-10-59.pdf>

Q&A about OTC Medicines and Drugs: <http://www.irs.gov/newsroom/article/0,,id=227308,00.html>