

**HEALTH SAVINGS ACCOUNTS:
FEASIBILITY OF OFFERING AN HSA-QUALIFIED HIGH
DEDUCTIBLE HEALTH PLAN TO STATE EMPLOYEES**

SENATE BILL 04-94 REPORT TO THE GENERAL ASSEMBLY
OCTOBER 1, 2004

Colorado Department of Personnel & Administration

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EXECUTIVE SUMMARY

Senate Bill 04-094 requires the director to evaluate the feasibility of offering a high deductible health plan that would qualify state employees to use health savings accounts (HSAs), and to report his findings to the General Assembly no later than October 1, 2004. The report must identify any impediments to such a plan and describe the measures taken by the Department of Personnel and Administration (Department) to implement such a plan. The Department completed its evaluation and has concluded that offering an HSA-qualified high deductible health plan (HDHP) is feasible and that it makes sense to offer such a plan to state employees as part of a coordinated effort to revamp benefits programs on July 1, 2005.

The Department has identified certain impediments that are being addressed as we move forward under evolving federal guidance and market experience. These challenges fall into the following three categories:

- Developing a comprehensive plan design with an HSA-qualified HDHP that avoids adverse selection and the creation of poorer choices for employees not using HSAs;
- Properly tracking satisfaction of deductible limits by obtaining private plan administration that can affordably reintegrate claims processing systems fragmented over time as a result of widespread use of subcontracted pharmacy benefit coverage; and
- Taking full advantage of short-term federal safe-harbors by resolving ambiguities surrounding which prescription drugs expenditures count toward the deductibles (i.e., preventative drugs versus treatment of existing conditions).

The Department has already created an integrated set of plan designs that include an HSA-qualified HDHP while mitigating adverse selection and providing alternative plans for all employees. This comprehensive plan redesign, to be effective July 1, 2005, is the backbone of the Department's recent Request For Proposals (RFP) for medical coverage released in early July 2004. Staff and private consulting actuaries are currently reviewing proposals and hope to make an award sometime in November. Any contract awarded by the State will address the second impediment and properly track deductibles. Finally, the Department will look to continually evolving federal guidance and its own internal and external experts to clarify which prescription drug expenditures count toward meeting deductible limits.

With respect to HSAs, it appears that at least initially individually administered accounts will best maximize choice and minimize costs for employees. A State-administered program does not appear to be in the best interests of employees. However, from the outset the Department will provide employee education and access to information on available HSA providers while continuously reevaluating the costs and benefits of administering a State HSA program.

BACKGROUND

When the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) was signed into law on December 8, 2003, it created, among other things, a new type of tax-favored account—a Health Savings Account—to help eligible individuals with qualifying high deductible health plans¹ save for medical and retiree health expenses. Within weeks of the passage of the MMA, a bill was introduced in the Colorado Senate, SB 04-094, to convert the tax provisions for Medical Savings Accounts (MSAs) to apply to Health Savings Accounts. The final bill was passed by the General Assembly and signed into law by Governor Owens on May 17, 2004. This bill allows carriers authorized to do business in Colorado to offer HDHPs designed to co-exist with an HSA.

Senate Bill 04-094 also contains the following provision with respect to state employee health benefits: *“The director shall evaluate the feasibility of offering a high deductible health plan that would qualify for a health savings account as described in 26 U.S.C. 223, as amended, for state employees. The director shall forward the findings based on such evaluation to the members of the health, environment, and institutions and business affairs and labor committees of the House of Representatives and the Senate no later than October 1, 2004. In the director’s findings, the director shall list any impediments to implementing such high deductible health plans and measures taken to implement such plans for state employees.”* (24-50-605(5) C.R.S.) This provision is the impetus for this report.

HSAs have drawn a great deal of interest, primarily because they are uniquely attractive tax shelters. The tax advantages are significant. Contributions to an HSA are not taxed (subject to limits), HSA earnings are exempt from tax, and HSA balances may be distributed on a tax-free basis to pay qualifying health expenses or accumulated for future health expenses. HSA funds may also be used (on a taxable basis) for non-health purposes, either currently or in the future, although a ten percent tax penalty would apply in addition to the applicable income tax rate.

An individual is eligible to contribute to an HSA, only if on the first of every month, the individual is:

- Covered by an HSA-qualified HDHP
- Not covered by another health plan that is not a HDHP (with certain exceptions)²;
- Ineligible to be claimed as a dependent on another’s tax return; and
- Not enrolled in Medicare.

¹ A qualified High Deductible Health Plan must meet the requirements of Internal Revenue Code §223.

² Permitted coverage includes workers’ compensation, liability insurance, automobile insurance, insurance for a specified disease or illness (e.g., a cancer policy), and insurance that pays a fixed amount per day of hospitalization. Permitted insurance includes coverage for accidents, disability, dental care, vision care or long-term care.

To understand why HSAs are so important and unique, it helps to compare their features to those of other health care reimbursement arrangements: flexible spending arrangements (FSA)³, health reimbursement arrangements (HRA)⁴, and retirement health savings trusts (HST)⁵. A chart comparing and contrasting the features of HSAs, to HRAs and FSAs is appended to this report as Attachment A.

Although an HSA may be funded with employer contributions or a combination of employer and employee contributions, employer contributions are not required. This flexibility in funding is an improvement over health reimbursement arrangements (HRAs), which can only be funded with employer contributions. While health flexible spending arrangements (FSAs) have a use-it-or-lose-it feature that requires employees to forfeit unused funds at the end of the plan year, HSA fund balances carry forward. HSAs are also portable, so an account-holder is not dependent upon a particular employer to enjoy the advantages of having an HSA. If an account-holder changes jobs, the HSA follows. An eligible individual can establish an HSA even if unemployed or retired (not enrolled in Medicare). In both of these instances, however, contributions to the HSA are incumbent upon the employee being enrolled in a qualified HDHP.

As with an individual retirement account (IRA)⁶, the account-holder, not the employer, owns the HSA. An eligible individual may establish an HSA at an early age, make contributions when permissible, and use the account to reimburse medical expenses throughout his or her lifetime. Account-holders may leverage their HSA accounts to fund the purchase of health benefits not offered by their employers, including long-term care⁷ and post-retirement medical insurance benefits.

HSAs are more consumer-friendly for individuals to use to reimburse qualified medical expenses in that distributions from an HSA are not subject to the claims substantiation requirements applicable to health FSAs and HRAs. Although the individual must maintain records sufficient to justify the favorable tax treatment of HSA distributions,

³ A Flexible Spending Arrangement (FSA) is a reimbursement plan that gives employees coverage under which eligible expenses may be reimbursed, subject to certain conditions such as a maximum limit. The most common FSA is one offered through a cafeteria plan, with employees paying the entire premium for coverage through pre-tax dollars. Also called a flexible spending account.

⁴ A Health Reimbursement Arrangement (HRA) is an arrangement under which an employer promises to reimburse eligible employees for certain medical expenses up to a specified maximum amount per year and that meets the safe harbor requirements contained in IRS Notice 2002-45. Also called a health reimbursement account.

⁵ A Retirement Health Savings Trust is a trust arrangement established to receive contributions to be used for future retiree health care expenses.

⁶ An Individual Retirement Account (IRA) is a self-funded retirement plan that allows an individual to contribute a limited yearly sum toward retirement; taxes on the interest earned in the account are deferred.

⁷ Long-Term Care (LTC) is insurance coverage that provides for the maintenance and personal care of ill or disabled persons.

no third-party adjudication of claims is required, which is also simpler for the employer.

Despite their positive features, HSAs may only appeal to a limited number of employees: those with the discretionary income or discipline to adequately fund their accounts.

Unlike funds deposited in a retirement account that are generally not withdrawn until retirement, funds contributed to an HSA may be withdrawn during the accumulation period to pay medical expenses not covered by insurance. To the extent that contributions flow in and right out again, administrative costs may be greater than interest earnings on the funds. Investment opportunities are limited when fund balances are modest and it may take an account-holder several years to accumulate a substantial fund balance.

Since coverage under a qualified high deductible health plan is a prerequisite to the establishment and maintenance of an HSA, it makes sense to concentrate initial efforts on such a plan. This also allows time for the market to develop HSA products.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

As defined in Internal Revenue Code §223, a HDHP is a health plan with an annual deductible of at least \$1000 and a cap of \$5000 on out-of-pocket expenses⁸ for self-only coverage (double for family coverage). The term “HSA-qualified HDHP” is used in this paper to distinguish this Code §223 plan from other high-deductible health care (HDHC) plans. Except for preventive care, no benefit can be paid until the annual deductible has been satisfied. Despite its high deductible, the State’s current PPO plan is not an HSA-qualified HDHP because some services, including prescriptions, are not subject to the deductible.

The amount of the HDHP deductible limits the maximum contribution for which an eligible individual is allowed a tax deduction for contributions to an HSA. For 2004, the maximum deductible HSA contribution for an eligible individual with self-only coverage is the lesser of \$2,600 or 100% of the annual deductible for the individual’s HDHP coverage. The maximum contribution for an individual with family coverage is the lesser of \$5,150 or 100% of the annual deductible for family coverage.⁹

INITIAL CONSIDERATIONS

⁸ In this context, out-of-pocket expense refers to the insured’s share of covered expenses not paid by the HDHP including any deductible, coinsurance, or co-payment. It does not include premiums, expenses in excess of any allowance, or out-of-network expenses.

⁹ Code §223(b)(2)(A-B) (as indexed). Code §223(g) requires that the dollar limits applicable to high deductible health plans be adjusted for inflation.

As health care costs continue to rise each year, the Department continues to look for high-value, cost-effective plan designs to meet the disparate needs of the State's diverse employee population. Although not suitable for every situation, an HSA-qualified HDHP option would support the Department's Consumer Choice Initiative¹⁰ by enabling a true consumer-directed¹¹ health plan. Participating employees would be able to manage much of their own health care through HSA accounts they own and control, yet be protected from catastrophic loss. It is generally believed that employees are more likely to be judicious consumers when spending their own money. Before going forward however, the Department considered the impact a HDHP would have on the cost of any other non-HDHP coverage options that may be offered, particularly fully insured HMOs.

When an employer offers more than one health coverage option, there is a tendency for the healthiest employees to select the plan with the lowest premiums or to forgo coverage altogether while the least healthy tend to select the plan with the lowest co-payments. Since the least healthy naturally utilize more medical services, the relatively "richer" plans (plans with greater coverage) have higher claims costs, which are then reflected in higher premiums at renewal. The higher premiums force more employees to abandon the plan, thus concentrating the risk even more. Employees with ongoing health problems whose need for coverage is the greatest will hang on as long as they can, while those whose need is not so apparent are the first to waive coverage. This effect is called adverse selection and will eventually make the plan selected against untenable.

The Department has experienced this phenomenon first hand in recent years. Since any HDHP (or HDHC) can exacerbate adverse selection against other plans, underwriters of fully insured, non-HDHP coverage are likely to adjust their premiums in consideration of the additional risk, further burdening employees in non-HDHP plans, including traditional HMOs such as Kaiser. Critics of HDHPs charge that this is unfair to the medically disadvantaged who are more likely to need and choose a lower deductible health plan.

Adverse selection can be mitigated to some degree if all plan options offered are part of the same risk pool¹². Within a shared risk pool, the HDHP premiums can be set at a

¹⁰ Consumer Choice Initiative – an integrated initiative designed to inform employees about the direct link between wiser healthcare choices and their bottom line costs.

¹¹ Consumer-directed health care (CDHC) is a strategy for controlling health care costs based upon the belief that by giving employees a financial stake through shifting control of funds allocated to health care and providing information about health care costs and quality, employees will become more cost-conscious buyers of health care services, shopping and thinking about value in the same way they make purchasing choices about other goods and services.

¹² In this context risk pool means the pool of money from which all claims within a given group are paid. A risk pool seeks to define the expected claim liabilities of its given population as well as the required funding to support the claim liability.

higher level than the risk would otherwise require in order to partially subsidize the premiums for the non-HDHP plans. The Request for Proposals (RFP) issued by DPA in July 2004, calls for a set of health plan options, including an HSA-qualified HDHP option, to share a common risk pool. Although the evaluation of proposals is still in process at this writing, the Department expects to implement an HSA-qualified HDHP as one of several options to be offered employees for the plan year beginning July 1, 2005.

TIMING

The Department studied the possibility of offering a qualified HDHP on January 1, 2005, but found it was not feasible. Although HSAs were introduced in December of 2003, the initial guidance issued by the IRS left many questions unanswered and would-be plan sponsors hesitant to move forward. While most major insurance companies are expected to introduce HSA-qualified HDHPs in 2005, only a few plans had been rolled out by mid-year 2004 and none appeared ready to respond to an RFP for a statewide HSA-qualified HDHP by May 1, the date by which an RFP needed to be posted in order to assure a January 1 effective date.

The Department considered offering state employees the opportunity to participate in HSAs through modifications to its current PPO¹³, but was concerned that the changes required to make the PPO qualify as an HSA-qualified HDHP would be very unpopular with employees, especially elimination of the prescription drug card. Since the State currently offers only one PPO, such changes would adversely affect all PPO enrollees (about 9,000 employees) while relatively few would benefit from the HSA advantage, at least initially. In addition, the requisite minimum deductibles and out-of-pocket maximums presume a twelve-month plan year. The Department determined that it made the most sense to provide this opportunity as part of a coordinated approach that includes multiple PPO options for employees and a potential return to self-funding at the next full plan year.

As is often the case with new federal legislation, the initial guidance from the IRS brought more questions than answers. Most would-be plan sponsors held back, waiting for additional guidance that has come in a series of IRS notices and revenue rulings issued in the spring and summer of 2004. As of this writing, the latest, HSAs: Questions and Answers, IRS Notice 2004-50, was issued July 23, 2004, and revised and corrected August 9.

¹³ A Preferred Provider Organization (PPO) is a type of indemnity plan under which health coverage is provided through a specified network of health care providers (e.g., hospitals and physicians). Covered persons who obtain care from providers outside the network generally incur greater costs (e.g., higher deductibles, higher co-insurance, or non-discounted provider charges).

To understand why many insurance carriers have been slow to bring HDHPs to market despite the public's intense interest in HSAs, it helps to understand how HSA-qualified HDHPs differ from the HDHC plans currently available. HDHCs work well with Health Reimbursement Arrangements (HRAs), but are not suited to HSAs.

UNIQUE CHALLENGES PRESENTED BY HDHPs

Virtually all commercial health plans with deductibles offered prior to the introduction of HSAs, including the State's current PPO, begin to pay benefits when any one family member's expenses exceed the individual deductible before the family deductible has been satisfied. However, to qualify as an HSA-qualified HDHP, the minimum individual deductible cannot be embedded in family coverage. This is a fundamental shift in the way deductibles are traditionally applied to family plans. For example, a health plan designed with a \$2000 family deductible is not an HSA-qualified HDHP if it reimburses expenses for any family member before the family incurs at least \$2000 in aggregate claims. This unique requirement means that standard claims processing systems cannot be applied to many HSA-qualified HDHPs. It may take legislative action to ensure that the industry has the ability to resolve the complex claims processing coordination issues presented by HSA-qualified HDHPs.

The widespread use of prescription drug and mental health carve-outs¹⁴ presents another challenge. The application of a common deductible to all covered expenses was once standard practice, but was largely abandoned as insurance carriers found it more cost effective and efficient to outsource or subcontract specialty services such as pharmacy benefit management and mental health care. Although transparent to the insured, one health plan may actually consist of three or more separate specialty plans, with separate claims processing and accounting. These specialty services are usually subject to fixed co-payments that do not count toward the deductible or out-of-pocket maximum.

The introduction of HSA-qualified HDHPs found many large carriers unequipped to lump medical, pharmacy, and mental health benefits together under a common deductible. Because of the short period since the enactment of HSAs, many employers and health insurance providers have been unable to modify the benefits provided under their existing health plans to conform to the statutory requirements of Code §223 for an HDHP.

In April 2004, the IRS offered transitional relief with Notice 2004-22 that provides a temporary safe harbor¹⁵ for prescription carve-out plans, but only to January 1, 2006. Rather than move quickly to develop systems to integrate separate benefits, some

¹⁴ In this context, "carve-out" refers to medical services that are separated from the main body of a contract and paid under a different arrangement or rider, e.g., a prescription drug card.

¹⁵ A "safe harbor" is a set of rules and regulations that will guarantee compliance with the law if followed.

players within the industry continue to push for an extension of the safe harbor. Although further relief is possible, it would be imprudent for an employer to count on such an extension when implementing an HDHP plan. This is another reason the Department felt it was important to coordinate its approach in rolling out an HSA-qualified HDHP along with other plan redesigns that allow for a higher deductible health plan that includes pharmacy benefits.

Another interesting yet challenging aspect of HDHP plan design is ambiguity regarding eligible and ineligible prescription drugs. The latest round of guidance, Notice 2004-50 issued July 23, 2004, which supplements the safe harbor guidance on preventive care published in Notice 2004-23, classifies preventive drugs as any medications taken by a person who has developed risk factors for a disease that is not yet clinically apparent, or those that prevent the recurrence of a disease from which the person has recovered. However, Notice 2004-50 explicitly states that the preventive care safe harbor does not include any service or benefit, including drugs or medications intended to treat an existing illness, injury, or condition. The complicating factor is determining which patients are eligible to receive these drugs and treatments on a preventive basis when the same drug may also be used to treat an existing condition. The following example illustrates the challenge.

Consider two enrollees in an HSA-qualified HDHP that includes first-dollar¹⁶, benefits for preventive services. Both enrollees are taking angiotensin-converting enzyme (ACE) inhibitors.¹⁷ The first patient had a prior heart attack and made a full recovery, and is taking ACE inhibitors to prevent another heart attack. The second patient is taking the medication to treat congestive heart failure, a chronic condition. The first patient could likely receive ACE inhibitors on a first-dollar basis but the second could not. This double-standard could change prescribing patterns for physicians who might be tempted to note that a prescription drug is preventive when it's actually being used to treat a patient's chronic condition so that the drug can be covered by insurance, rather than paid out of the patient's pocket until the deductible is satisfied.

For health insurers, this dilemma will require a heightened level of diligence to make sure drugs and treatments are appropriately classified. Since very few pharmacy benefit management companies currently have access to diagnosis information, it remains to be seen if even second generation HDHPs will offer first-dollar benefits for preventive drug therapy. Some employers and insurers may choose not to because of the complexities of making determinations and administering the benefit.

¹⁶ "First-dollar" in this context means not subject to the deductible.

¹⁷ Angiotensin-converting enzyme or ACE inhibitor is an oral medication that lowers blood pressure and helps slow the progression of heart failure. For people with diabetes, especially those who have protein (albumin) in the urine, it also helps slow down kidney damage. Capoten®, Vasotec®, and Zestril® are commonly used ACE inhibitors.

The safe-harbor guidance for preventive care also calls for more complex claims-processing capabilities for medical procedures. According to Notice 2004-23, treatment that is incidental to a preventive care service or screening, such as the removal of polyps during a diagnostic colonoscopy¹⁸, also falls within the safe harbor for preventive care. However, to take advantage of the safe harbor, the insurer's automated claims-processing system has to be able to code both the colonoscopy and the polyp removal as preventive service, something it likely cannot do now. Although such claims can be manually processed or adjusted, manual adjudication of common medical procedures is not cost effective.

Although the expanded definition of preventive services is good news and supports certain disease management initiatives¹⁹, it will require a change in the way that services are classified, and how laboratory and pharmacy claims are adjudicated.

The lead time required to think through the implications, develop policies, program new systems, establish training programs and communications has contributed to delays in bringing HDHP options to market. With the benefit of time and experience, subsequent generations of HDHP designs are likely to be significantly more sophisticated than first generation plans.

Early guidance also raised concerns about the compatibility of HSAs with wellness, disease management and Employee Assistance Programs (EAPs). The no-other-coverage rule could have meant requiring state employees to choose between the Colorado State Employees Assistance Program (CSEAP) and an HSA. Fortunately, Notice 2004-50 provides reassurance that for HSA purposes, an EAP or wellness or disease management program will not be considered a health plan unless it provides significant medical care benefits.

Another early concern was whether or not employees who wished to contribute to HSAs could use FSAs to cover expenses not covered by the HDHP. Notice 2004-50 confirmed that traditional health FSAs, such as the one currently offered State employees, are considered non-HDHPs and not compatible with HSAs. Although employees who enroll in the State's Health Care FSA may enroll in the HDHP, they will not be eligible to contribute to an HSA if they do.

¹⁸ A diagnostic colonoscopy is a procedure to examine the lining of the large intestine with a rigid or flexible video or fiber optic endoscope to evaluate signs or symptoms of disease. A polyp is a smooth-coated tumor projecting from a mucous membrane that may or may not be cancerous.

¹⁹ Disease management is a system of coordinated health care interventions and communications for populations with chronic medical conditions, such as diabetes, congestive heart failure, and asthma. It emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies.

A third concern still to be addressed is how to develop and disseminate an effective education program to assist employees in understanding HDHPs and HSAs. Although HSAs are similar in purpose to FSAs, they differ in striking ways. It will be very important to clearly explain what eligibility or benefits restrictions apply. In order to choose an appropriate plan option, an employee must understand and weigh a myriad of considerations, including the following:

- How a spouse's plan can keep an employee from being eligible for an HSA;
- Which medical expenses are reimbursable from an HSA, but not an FSA, and vice-versa;
- How substantiation requirements differ between FSAs and HSAs; and,
- The consequences of having impermissible coverage.

An employer who offers an HSA-qualified HDHP is not required to offer an HSA and is not required to monitor compliance. However, the Department recognizes a responsibility to fully inform employees who may enroll in the HDHP in order to qualify for an HSA what compliance entails. The Division of Human Resources continuously monitors the regulatory environment and market to stay fully informed of developments. The Department's long-term strategy for implementing and communicating employee benefits includes taking the experience of other large employers into consideration.

STEPS TAKEN TO IMPLEMENT AN HSA-QUALIFIED HDHP

In January 2004, the Department began to follow the development of HSAs and to investigate and evaluate the effectiveness of HDHPs in the context of the Department's total compensation strategy. In July 2004, the Department issued a medical RFP that calls for a set of health plan options, including an HSA-qualified HDHP, that would be suitable for self-funding and that would share a common risk pool to minimize adverse selection. By carefully measuring utilization of the various plan options once they have been implemented, the Department expects to be able to evaluate the effectiveness of plan design in influencing employees to become judicious health care consumers. The insights gained will inform the Department on the next phase of the total compensation strategy.

Until an HSA-qualified HDHP is offered, there is no way to know for certain how well it will be received by employees, if it will live up to its promise to help control costs, and whether it will be feasible for the State to sponsor an HSA for state employees.

CONSIDERATIONS IN ESTABLISHING A HEALTH SAVINGS ACCOUNT

Administration of Health Savings Accounts raises additional issues not directly tied to offering a High Deductible Health Plan. Although complete analysis of HSA administration is beyond the scope of the SB 04-94 report on the feasibility of HDHPs, a brief discussion of the alternative approaches to HSAs implementation is helpful in understanding the appropriate role for the State in facilitating employee use of HSAs.

At the outset, the State has identified the following considerations related to HSA administration:

- What alternatives are available to employees for establishing HSAs?
- What start-up costs will be incurred before contributions can commence?
- Will administrative costs be subsidized or will the participants bear all costs?
- How much time and what resources will be necessary to design both the initial employee communications and the ongoing employee education and outreach support that will be required for the program to be well received?
- Will additional staff be needed?
- Will the level of participation justify the administrative expense?

As stated previously, a unique aspect of HSAs is that employer involvement is not required. Use of HSA tax advantages is primarily between the IRS and the taxpayer; permitted tax-exempt contributions become a deduction on the individual's tax return and the employee is solely responsible to maintain supporting documentation. Thus, HSAs could be State-sponsored or employee-sponsored. However, State-sponsored HSA administration increases program costs while limiting employee flexibility and choice. As discussed in more detail below, at the outset a State-sponsored HSA program appears to offer no significant advantages to employees.

Similar to Flexible Spending Accounts, a State-sponsored HSA would involve the establishment of an additional cafeteria plan option with pre-tax payroll deductions. With IRS approval, the State could establish a trust and use a private vendor to administer the investment choices for employees, much like one of the defined contribution retirement plans. Entities other than banks and insurance companies must submit a written application to the IRS demonstrating fiduciary experience and competence.

Because the role of trustee involves the handling and investing of funds, there are extensive safeguards involved, such as minimum required net worth, bonding and annual audits. There are also certain requirements that an HSA trustee or custodian must comply with in order to offer qualified HSAs. The IRS has released draft versions of model HSA trust accounts and custodial account forms that provide a good indication of the minimum requirements for a qualifying HSA trust or custodial agreement. However, serving as a financial institution is not the core business of the Department. Since it is unnecessary in order to make HSAs work for employees, serving establishing and administering a trust is not an effective or efficient option for the State.

A State-sponsored trust is also undesirable because of the responsibilities associated with investing money over the long term. Since interest earnings are tax-free and

rolling account balances may grow over time, there will likely be increasing pressure upon the State to offer the type and kind of investment choice and services employees can get through establishing their own IRA-type accounts. Administrative costs to employees for this type of investment flexibility are likely to be greater for an HSA than for a retirement account because (i) more frequent transactions (withdrawals) are anticipated, (ii) fund balances will accumulate more slowly, and (iii) participation is expected to be limited to the higher paid and healthy.

A simpler alternative model for State administration would be for the State to contract with one or more IRS-approved financial institutions to serve as the trustee or custodian for HSA administration at the employee's direction. However, since the State cannot under any circumstances limit where employees can set up HSAs, a State-sponsored HSA must be capable of sending the employee contributions wherever the employee directs. Whether the State is the trustee or merely a conduit for contributions, employees do not have to use State offered HSA investment vehicles. The State cannot maintain contracts with multiple HSA providers to meet every employee's desire and use the payroll system to move the contributions. Given the viable alternatives available to state employees, it is neither cost-effective nor desirable policy to use the payroll system in this manner.

While the State could contract with a single IRS-approved financial institution with a default investment option, from which employees could move their money elsewhere, here again, employees gain nothing they cannot accomplish on their own. Moreover, it makes little sense to add this extra layer of administrative cost and overhead if employees want to move money to their own HSA providers for maximum investment flexibility. In this scenario, as in all State administration arrangements, employees who want to move their money elsewhere pay administrative fees twice. Given the relatively low employee participation rate expected in the early years and the correspondingly high unit costs, the State fees would be relatively high for the users unless subsidized by the benefits program.

In addition, pre-tax payroll deductions actually hurt employees by reducing their Highest Average Salary (HAS) under the PERA defined benefit retirement plan. This adversely affects retirement and disability benefits. Although the General Assembly could legislatively remedy this apparent impediment, it is unnecessary because employees have viable alternatives. They can set up post-tax electronic debits directly from their own bank accounts and achieve whatever HSA management flexibility and cost structure they desire.

Under all of the foregoing options the State becomes responsible to determine HSA eligibility even though pre-tax payroll deductions provide employees only convenience and no income tax advantages. It is true the State would not have the FSA-like administrative burden and risk of monitoring how funds are spent. Further, HSAs are

not subject to the same limitations as FSAs on irrevocability, so employees could be permitted to change contributions more frequently than is the case with FSAs. Yet the State would still be compelled to establish some limitations on employee changes in order to effectively administer the plan and keep costs at a reasonable level. Here again, employee choice is limited without any significant corresponding benefit.

The best option in the near term is for the State to offer an HSA-qualified HDHP and let employees set up and manage their own individual HSAs in accordance with IRS guidelines, just as they would an Individual Retirement Account. Since employer involvement is not required, employees who wish to establish an HSA may do so if they satisfy the eligibility requirements. Low-cost, non-group and small-group HDHPs are already on the market, often sold in combination with an HSA. Stand-alone HSAs are also available from a number of financial institutions. This approach maximizes employee flexibility to select providers they trust and to direct the investment of their money.

State law and recent federal guidance on HSA suggest that the State could provide employees a listing of available HSA providers without incurring fiduciary obligations and associated program costs, so long as the State does not endorse any of them. This service would function much like the State's Work-Life Discount program in the sense that the State merely provides a clearinghouse for employees and vendors (buyer and seller) without assuming liability for the transaction of business between them.

Under individually administered HSAs, employees could make post-tax contributions to their accounts by direct electronic debit from their personal financial institutions. The tax-deductibility of eligible contributions is unaffected by a post-tax approach. Although the State's payroll system could facilitate these transfers, as each employee can presently use up to 5 electronic transfers in addition to the direct deposit of their paychecks, the Department's policy is moving away from expansion of the payroll system for purely private transactions, especially when there is no legal requirement or real advantage to the employee.

The recommended option allows employees to take early advantage of HSAs without adding unnecessary costs and controls. It also provides employees the greatest flexibility in controlling their investment opportunity.

CONCLUSION

An HSA-qualified HDHP is feasible and the Department is moving forward with such a plan as part of revamping its benefits programs for July 1, 2005. Identified impediments are being addressed. However, it seems prudent for the State to leave creation and management of HSAs to individual employees at the outset. This eliminates unnecessary limitations and costs associated with a State-administered program. Since employer involvement is not required in HAS administration, the

recently released RFP includes a qualified HDHP option so it can be offered as soon as possible to those employees who may be interested in establishing an HSA. The Department will continue to evaluate the costs and benefits of adding a State-administered HSA program in the future.

Attachment A

A Summary of Tax and Related Compliance Issues for Health FSAs, HRAs, and HSAs

Plan Design or Compliance Issue	Health Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)	Health Savings Account (HSA)
Internal Revenue Code	Code §125	Rev. Rule 2002-41, Notice 2002-45	Code §223
Who is eligible?	Any employee, subject to employer-designed exclusions.	Any employee, subject to employer-designed exclusions.	Any individual who is covered under a qualified HDHP (as defined in Code § 223), not entitled to Medicare, and not claimed as a tax dependent. With certain exceptions, the individual cannot have any non-HDHP coverage.
Is funding with cafeteria plan salary reductions permitted?	Yes	No. Must be funded by Employer.	Yes
Can unused amounts be carried over to the next year?	No	Yes	Yes
What medical expenses are eligible for reimbursement?	Otherwise unreimbursed Code § 213(d) medical expenses incurred during the coverage period. Cannot reimburse insurance premiums. Cannot reimburse qualified long-term care services.	Otherwise unreimbursed Code 213(d) medical expenses incurred while coverage is in effect, including premiums for eligible health insurance and long-term care insurance, subject to employer-designed limitations.	Otherwise unreimbursed Code § 213(d) medical expenses of account-holder, spouse and dependents incurred after HSA established, including premiums for COBRA insurance, long-term care insurance, health insurance while drawing unemployment compensation; or if 65

A Summary of Tax and Related Compliance Issues for Health FSAs, HRAs, and HSAs

Plan Design or Compliance Issue	Health Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)	Health Savings Account (HSA)
			or older, any health insurance except a Medicare supplemental policy.
Are distributions (or cash-outs) for non-medical expenses permitted?	No	No	Yes, but such amounts are taxable and subject to a 10% excise tax (certain exceptions apply).
Must coverage be elected/provided for a full 12-month period, and are there prohibitions on mid-year changes?	Yes	No	No for HSA, Yes for HDHP offered through cafeteria plan.
Do the uniform coverage rules apply, requiring the annual coverage amount to be available as of the first day of the plan year?	Yes	No	No
Can amounts that are unused at termination of active employment continue to be spent down?	No. Cannot use unused amount to pay for claims incurred after termination.	Yes. HRA can permit unused amounts to be used until depleted to pay for claims incurred after termination.	Yes. HSAs are non-forfeitable and portable.
To be reimbursable, must claims be incurred during a current period of coverage?	Yes	Yes, but claims incurred but not reimbursed due to an insufficient balance can be reimbursed in subsequent years if individual was a participant when the claims were incurred	No. Distributions for qualifying medical expenses will be tax free if incurred at any time after the HSA is established.

		and is still a participant.	
Is expense substantiation required?	Yes	Yes.	Yes. HSA account-holder must retain records.
Is claims adjudication required? That is, must someone other than the covered employee/individual process and approve the claim?	Yes	Yes.	No
Can an individual participate in more than one of these vehicles at the same time?	An employee who is covered by a health FSA may also participate in an HRA.	An employee who is covered by an HRA may also participate in a health FSA.	A traditional, general-purpose health FSA or HRA would make an individual ineligible for an HSA.
Are there ordering rules that apply?	Yes. Generally, health FSAs must be payors of last resort. Cannot reimburse expenses that have been reimbursed elsewhere.	Yes. Generally health FSAs must be payors of last resort. Cannot reimburse expenses that have been reimbursed elsewhere.	No. In general, an HSA-eligible individual cannot have non-HDHP coverage. Certain permitted coverage and permitted insurance is permissible. An HRA or FSA would be impermissible coverage, unless restricted to pay only permitted coverage benefits (e.g., dental, vision) or to pay benefits only after HDHP deductible is met. Cannot reimburse expenses that have been reimbursed elsewhere.
Do Code § 105(h) nondiscrimination	Yes	Yes	Yes for self-insured HDHP. No for HSA,

requirements apply? 20			but if employer makes HSA contributions, Code § 4980E requires comparable contributions to be available for comparable participating employees.
Do Code § 125 nondiscrimination requirements apply? 21	Yes, for health FSAs offered under a cafeteria plan.	No. HRAs cannot be offered under a cafeteria plan.	Yes for HDHP or HSA offered under a cafeteria plan.
Is a trust account required?	No	No	Yes
Are account earnings taxable?	If reimbursements are made directly out of the general assets of the employer and account funds are not set aside in a separate account, there are no earnings to be taxed. If funds are deposited in a VEBA, earnings are generally not taxable.	If reimbursements are made directly out of the general assets of the employer and account funds are not set aside in a separate account, there are no earnings to be taxed. If funds are deposited in a VEBA, earnings are generally not taxable.	No (except unrelated business income will be taxed under Code § 5114).
Is a health plan required?	No.	No.	Yes. A HDHP is required.
Do the privacy provisions or HIPAA apply?	Yes.	Yes.	Yes, for an HDHP and for an employer-sponsored HSA, even if sponsored by governmental entity or church.
Does COBRA apply?	Yes. But there is a special rule for qualifying health	Yes. If HRA falls within the technical definition of health	Not for HSA. Yes for an HDHP.

²⁰ Amounts payable under a §105 self-insured medical reimbursement plan are not excludable from income to the extent that the plan discriminates in favor of highly compensated individuals.

²¹ Contributions under a §125 plan are not excludable from income to the extent that the plan discriminates in favor of highly compensated individuals.

	FSA's.	FSA, the special rule for qualifying FSA's will apply.	
Maximum Annual Contribution	No limit imposed by federal regulation. State of Colorado plan maximum is \$6000	Determined by plan sponsor.	2004 \$2,600 self-only \$5,150 family Plus \$500 catch-up contribution if 55 or older.
Is carry-over permitted?	No.	Yes.	Yes.
Refund of unused contributions permitted?	No. Funds belong to Employer.	No. Funds belong to Employer.	Funds belong to account-holder. Distributions for anything other than eligible medical expense are taxed as income and subject to an additional 10% excise tax.
Employer involvement required?	Yes.	Yes.	No.