

Health Savings Accounts:

Back to the Future

by Kathy Klug and Lois Chianese

Health savings accounts (HSAs) have altered the health care landscape in ways no one might have predicted. HSAs have emerged as a valuable tool in the quest to change consumers' health care spending behaviors and better manage health care costs. This article compares and contrasts HSAs to other health care spending accounts, addresses various HSA topics in the context of HSAs' first six years, and speculates on the future of HSAs. The authors identify policy changes that could help expand HSAs, drive further employer savings, make HSAs more user-friendly, impact employee satisfaction and increase adoption rates.

INTRODUCTION

December 8, 2009 marked the sixth anniversary of the passage of legislation authorizing health savings accounts (HSAs), altering the health care landscape in ways no one might have predicted in 2003. Employer and employee acceptance of HSAs, combined with accelerated Internal Revenue Service (IRS) guidance, meaningful legislative enhancements and rapid adoption rates, have positioned HSAs as a valuable tool in the quest to change consumers' health care spending behaviors and better manage health care costs.

ACS/BNY Mellon HSA Solution: Employer Survey, a survey of nearly 200 employers released in 2009 by ACS/BNY Mellon, the largest HSA administrator, showed widespread employer and employee acceptance of HSAs. Eighty-six percent of the employer participants indicated that their health care costs were the same or reduced as a result of their high-deductible health plan (HDHP) offering. More than 60% of participants experienced a cost reduction while 25% stated employer costs remained the same.

In addition, 82% of the 4,000 accountholders responding to the *ACS/BNY Mellon HSA Solution: Ac-*

count Holder Survey, also released in 2009, believe that HDHP/HSA plans meet their family's needs and are affordable. Over 84% of the accountholders said the overall cost of the plan and the ability to personally control health care costs were important or very important reasons for selecting the HDHP/HSA plan. More than half of the accountholders said they now pay closer attention to their medical bills, and nearly half said participation in the HDHP/HSA plan has caused them to more actively monitor health care costs.

This article compares and contrasts HSAs to other health care spending accounts, addresses various HSA topics in the context of HSAs' first six years, and speculates on the future of HSAs.

ALPHABET SOUP

Through passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress authorized the establishment of HSAs, adding Section 223 to the Internal Revenue Code. HSAs joined an already crowded menu of health care spending accounts—flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs)—causing speculation about why another option was needed.

TABLE**HEALTH CARE SPENDING ACCOUNTS COMPARISON OF FEATURES**

	Health Savings Accounts (HSAs)	Flexible Spending Accounts (FSAs)	Health Reimbursement Arrangements (HRAs)
Eligibility			
High-Deductible Health Plan (HDHP)	Required	Not Required	Customary
Portability	Yes	No	Optional
Contributions			
Employee	Permitted	Permitted	Not Permitted
Employer	Permitted	Permitted	Permitted
Investment Earnings	Yes	No	No
Distributions			
For Out-of-Pocket Medical Expenses	Permitted	Permitted	Permitted
For Insurance Premiums	Permitted ¹	Not Permitted	Optional
For Nonmedical Expenses	Permitted	Not Permitted	Not Permitted
Annual Forfeitures	Not Permitted	Required	Not Customary
Claims Substantiation	Individual	Employer	Employer
Compliance			
Subject to ERISA ² and COBRA ³	No	Yes	Yes
Nondiscrimination Requirements	Yes	Yes	Yes

1. At the age of 65, HSA funds can be used to pay premiums for Medicare Parts A, B and D, Medicare HMO coverage and retiree medical insurance.
2. Employee Retirement Income Security Act.
3. Consolidated Omnibus Budget Reconciliation Act.

But, as the table outlines, an HSA is different in some not-so-subtle ways.

HSAs, like individual retirement accounts (IRAs), are tax-exempt trusts or custodial accounts set up by the individual with a qualified trustee or custodian. Unlike FSAs and HRAs, which are generally unfunded notional accounts administered on a pay-as-you-go basis, HSAs must be funded in order to realize their tax advantages.

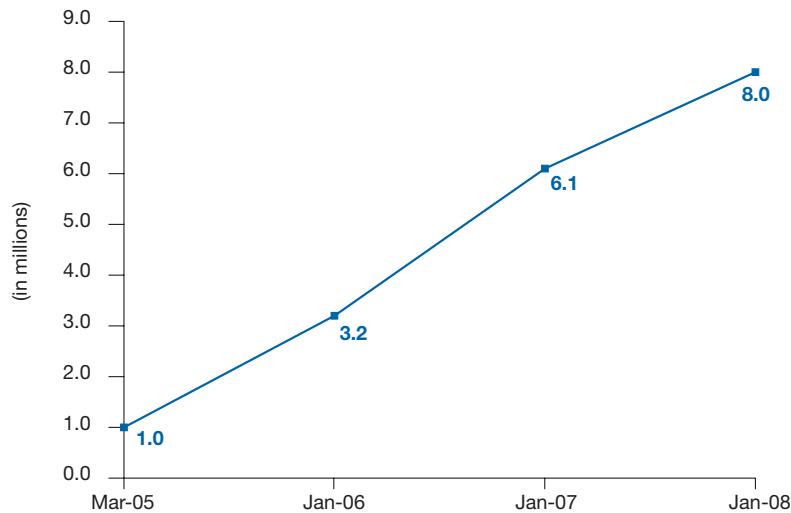
HSAs may be funded with both employer and employee contributions. In fact, anyone can contribute to the HSA of an eligible individual. In comparison, HRA contributions are limited to those made by the employer, and FSAs may accept only employer con-

tributions and employee contributions made on a pretax basis.

Under what is commonly referred to as the “use-it-or-lose-it” rule, FSAs require individuals to use all of the funds allocated to their employer-owned account for qualified expenses by the end of the plan year (plus any applicable grace period). The employee forfeits any amounts not used by the deadline (including the employee’s pretax salary deferrals). On the other hand, the account holder is 100% vested in all HSA contributions, regardless of their source.

Because HSAs are fully vested, funded and individually owned, they are fully portable. HRAs, on the other hand, are not subject to any mandatory vesting

FIGURE 1
INDIVIDUALS COVERED BY HDHPs/HSAs



standards, nor do they have to be funded. In fact, many employers have included a vesting component in their HRA programs to address employee concerns about portability.

Contribution and distribution rules that apply to IRAs also apply to HSAs. For example, contributions to the HSA in excess of the statutory limits are subject to the same excess contribution rules that apply to IRAs. Like IRAs, HSAs are also subject to a voluntary tax reporting process. No claims substantiation like that required for FSAs and HRAs applies to HSAs. As a result, monthly fees for HSA administration are typically 10-20% lower than those for FSAs and HRAs.

YOU'VE COME A LONG WAY, BABY

Depending on whom you ask, the growth of HSAs might best be described as both robust and better than expected, especially when compared to the adoption rates for medical savings accounts (MSAs), a similar account-based health care funding option introduced in 1996, or 401(k) plans, an account-based retirement plan.

According to an America's Health Insurance Plans (AHIP) study released in May 2009, eight million people were covered by HDHPs/HSAs in January 2009 (see Figure 1). This represents an increase of seven million covered individuals since March 2005.

Initial HSA adoption rates were slowed in part due to the short period of time between the enact-

ment of the enabling legislation in December 2003 and the January 1, 2004 effective date of Internal Revenue Code Section 223. Early adopters had to scramble to find vendors willing and able to establish accounts as of the effective date.

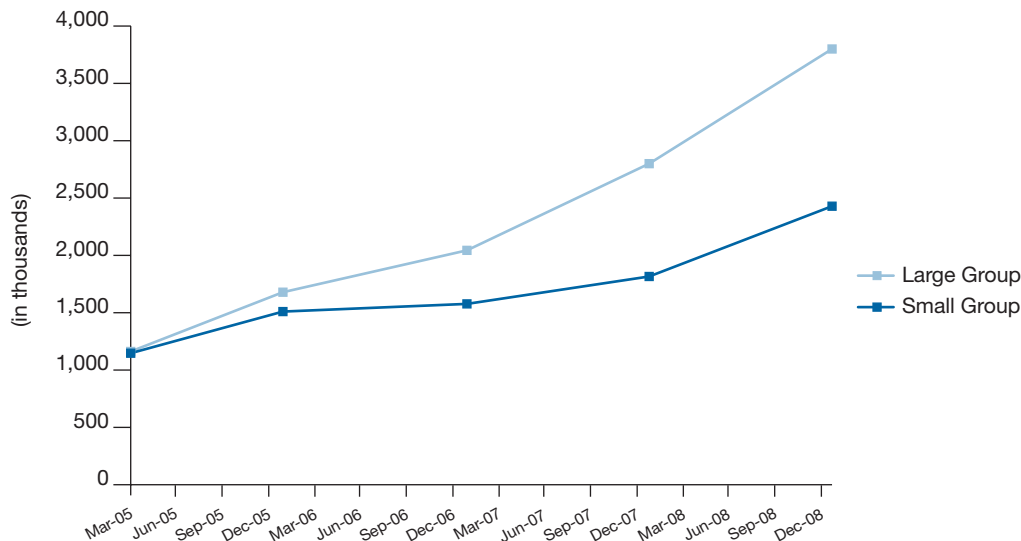
Also, the HSA legislation was off-cycle for employers making health care plan design changes for calendar year 2004, since it came during the very end of open enrollment for that year. And in some cases, it was even too late for employer consideration for calendar year 2005, as many employers finalize plan design changes by the end of the first quarter of the calendar year (e.g., by March 30, 2004 for January 1, 2005 changes).

The AHIP study also reported a 35% increase in HDHP/HSA coverage in the large-group market segment between January 2008 and January 2009, and a 34% increase in HDHP/HSA coverage in the small-group market segment during the same time frame. Generally, *small-group market* was defined as coverage through an employer with 50 or fewer employees (see Figure 2).

Other factors influencing early adoption rates by employers included a lack of guidance on key compliance issues (i.e., the comparable contribution rules), what to do about existing HRA and FSA plan designs, and a "wait and see" attitude permitting the evaluation of early adopter results before taking the plunge.

Factors unique to HSAs may continue to exert a subtle downward pressure on adoption and growth rates. These include the enrollment and account es-

FIGURE 2
LARGE GROUP VS. SMALL GROUP GROWTH



establishment actions required of the individual account holder as compared to employer administration of 401(k) enrollment and account establishment activities. Also, since the primary determinant of HSA contribution amounts is the employee's type of health insurance coverage (i.e., single or family coverage), HSAs have multiple non-age-related maximum contribution levels as compared to the single maximum contribution level for 401(k) plans.

NOT YOUR FATHER'S TAX SHELTER

Individuals who establish HSAs have multiple tax savings opportunities:

- The ability to make pretax contributions to the account
- Tax-free growth of account assets
- Tax-free distributions for amounts used to purchase qualified medical expenses for the account holder and dependents.

Some have advocated that this triple tax savings feature should cause individuals to prioritize HSA contributions over contributions to other tax advantaged accounts like 401(k) plans, especially if the goal is accumulation of savings for postretirement medical expenses. No other retirement savings account, including 401(k) plans or IRAs, provides all three of these tax advantages.

Because of the tax advantages afforded HSAs, many opponents have touted HSAs as another tax

shelter for the wealthy with little or no meaningful benefit for low- or middle-income taxpayers. However, the study released by AHIP in May 2009 regarding the estimated income characteristics of HSA account holders does not support that position.

According to the AHIP study, which used a geo-coding technique to estimate the income levels of over one million HSA account holders, 3% of HSA account holders lived in lower income neighborhoods, which had 1999 median incomes of less than \$25,000, and almost 46% of HSA account holders lived in lower middle-income neighborhoods, which had 1999 median incomes between \$25,000 and \$50,000. Results from the AHIP study also revealed that account holders in higher income ranges (account holders in neighborhoods with median incomes between \$75,000 and \$100,000) made larger contributions but, contrary to the objectives of a tax shelter, also had larger withdrawals.

When account holders were asked why they selected an HSA, 81% of those responding to the *ACS/BNY Mellon HSA Solution: Account Holder Survey* completed in the second quarter of 2009, indicated that the ability to personally control health care costs was an important factor. Forty-four percent of those survey respondents earned less than \$75,000 per year. Thirty-seven percent did not have a four-year college degree, and 55.7% had families. Half of the respondents also indicated accumulation of funds for long-term medical needs as a personal goal.

Analysis by ACS of over half a million account-

HEALTH CARE AND HEALTH CARE-RELATED DEBIT CARD MERCHANT CODES

- Medical services and health practitioners
- Doctors
- Dentists and orthodontists
- Grocery stores and supermarkets (where over-the-counter drugs and other qualified medical expenses may be purchased)
- Hospitals
- Financial institutions—ATM (Withdrawals could be used to reimburse the accountholder for qualified medical expenses previously paid out of pocket with personal funds.)
- Optometrists and ophthalmologists
- Opticians, optical goods and eye glasses
- Chiropractors
- Discount stores (where over-the-counter drugs and other qualified medical expenses may be purchased)
- Medical and dental laboratories

holders and their enrollment, contribution, spending and savings patterns revealed consistently higher male HSA enrollments throughout the decades, peaking with “30-something” and “40-something” accountholders, with over 60% male accountholders in this age range. Over 40% of accountholders are women in their 20s or in their 50s and beyond. This may reflect women’s work patterns, i.e., reduced employment during childbearing years. Despite these identifiable gender differences, both male and female accountholders save more than 33% of their HSA contributions. In aggregate, the savings rate is 33.2% for female accountholders and 35.5% for male accountholders. There is no discernable gender-based difference in the savings percent for accountholders who are aged 40 and above.

NOT YOUR MOTHER’S INDIVIDUAL ACCOUNT PLAN

The term *individual account plan* makes many people think of the accounts offered under an employer-sponsored 401(k) plan. In fact, some employers initially suggested bundling HSA administration services and investment options with those being provided by the employer’s 401(k) vendor. It didn’t take employers (or others) long to figure out that all individual accounts are not created equal.

Like an HSA, a 401(k) plan must be a funded arrangement with the plan assets held in a qualified trust. However, individual 401(k) accounts are really notional accounts in a trust while the individual ac-

countholder, not the trustee or custodian, owns his or her HSA assets. As a result, all actions related to HSA contributions and investments must be initiated and settled by the accountholder. This is a departure from “business as usual” for employers that are used to correcting funding and other administrative errors without any interaction or authorization from employees.

Furthermore, 401(k) plans allow distributions only in the event of disability, retirement, hardship or death. HSAs are highly transactional, covering qualified medical expenses ranging from emergency room visits to the purchase of over-the-counter cold medicine. While 401(k) funds cannot be removed without the trustee’s authorization, HSA funds may be withdrawn by the accountholder at any time (and for any purpose) using an ATM, debit card or check. Transactional-based accounts like HSAs cost more to administer. Yet due to much lower statutory contribution limits, HSA asset accumulation opportunities are much slower than 401(k) plans, making it more difficult for vendors to offset their costs using the asset accumulation revenue model that is so prevalent with 401(k) plans. Faced with this dilemma, traditional 401(k) vendors were not among the first to enter the HSA arena.

Further complicating an already tenuous cost-revenue relationship are accountholder and employer expectations regarding standard features of an HSA administration package. Based on their experiences with 401(k) plans and other health care spending accounts, employers and accountholders want electronic enrollment and funding capabilities, multiple investment options and other first-tier electronic

banking functions, all in the form of a no- or low-fee product configuration.

BIG SCREEN TVs OR BY-PASS SURGERY?

In its enabling legislation, Congress provided HSAs with one of their greatest efficiencies by placing the burden of substantiation related to the use of HSA funds squarely on the individual. This is consistent with the principle tenet of the U.S. tax system (i.e., voluntary compliance).

However, the pros and cons of self-substantiated payments have been debated since the inception of HSAs. Employers have expressed concerns about funding accounts without substantiation or other controls (e.g., debit card merchant codes). Self-serving third-party administrators have stirred the pot by reporting cases where HSA funds were used to purchase exotic vacations and big screen TVs. Even Congress periodically proposes legislation to require substantiation of HSA fund uses. Despite the potential for abuse, custodians and other HSA vendors find that use of debit cards at legitimate health care merchants far exceeds any other use of the cards.

Debit card merchant code data collected in 2008 by ACS for its HSA book of business shows that 94% of debit card transactions during the first quarter of 2008 were conducted with health care or health care-related merchants. (See the sidebar, “Health Care and Health Care-Related Debit Card Merchant Codes.”)

Even though some HSA expenses are not qualified medical expenses, the statute does not prohibit such transactions as long as accountholders accurately report those amounts on their income tax filings and pay any applicable taxes and penalties.

EDUCATION IS KEY

The results of a recently released survey, *Benefits & Behavior: Spotlight on Consumer-Driven Health Plans*, conducted by Guardian Life Insurance Company in December 2008 revealed that while 59% of the 1,000 survey participants knew about HSAs, only half of them had a good understanding of the benefits they provide. For example, 52% of those responding to the survey did not know that HSA contributions are not subject to tax, and 55% thought withdrawals were taxable even if they were used for qualified medical expenses. Sixty percent were unaware that HSAs are portable.

This level of misunderstanding highlights the need for HSA education. But what type of education is needed and who should provide it? How much employer-provided education is too much? Could em-

ployer-provided education raise an employer’s involvement with the HSA to a level that exceeds the “limited involvement” standards described in Department of Labor *Field Assistance Bulletin 2004-01*? If so, would this cause the HSA to become an employer-sponsored employee benefit plan subject to the Employee Retirement Income Security Act (ERISA)? And how much is enough to give employees the knowledge they need to make informed financial decisions about their health care?

Employers are of two schools of thought on account holder education. Some employers leave it to the HSA vendor or HDHP provider, merely directing employees to the vendor or provider’s HSA tools and education materials. Others include an education component (e.g., interactive modeling tools) as part of their employee welfare benefit portals. In some cases, they integrate their portals with the vendor’s and provider’s tools.

Most employers agree that HSA education is necessary and should be part of a comprehensive health care benefit strategy. For those worried about providing too much information, even the basics will help employees understand the potential benefits of HSAs. Employers can take advantage of readily available materials and tools to accomplish this objective.

Employee surveys also can help employers understand what is required for a good HSA experience. Respondents to the *ACS/BNY Mellon HSA Solution: Account Holder Survey* released in 2009 indicated that online selection tools, employee meetings and ongoing communications were the most helpful initiatives offered by employers to help explain HSAs. Of less importance were paper communications, phone support and open enrollment fairs.

INTEGRATION READY (OR NOT!)

Probably no other health care spending account is more closely integrated with a health plan than an HSA. Individuals are not even eligible to set up HSAs unless they are first covered by an HDHP that meets certain statutory requirements with respect to deductibles and out-of-pocket limits. Tracking the individual’s satisfaction of the deductible requirement was the starting point for many of the early integration conversations between HSA vendors and health plans. But it soon became apparent that other integration points would also be needed.

Employers wanted funding integration similar to what they were using for their 401(k) plans, and account holders and health plans using auto adjudication for FSAs and HRAs wanted claims integration. While many health plans demanded integration, their

HSA INTEGRATION CONTINUUM

Level 1—Referral Only

The health plan distributes sales and enrollment materials. The HSA vendor receives all enrollment data directly from the employer and provides all customer service, interactive voice response (IVR) and Web access for HSA inquiries.

Level 2—Enrollment

The health plan collects the HSA enrollment information and transmits an enrollment file to the HSA vendor. The HSA opening process may also be integrated with the HDHP enrollment process. The HSA vendor provides all customer service, IVR and Web access for HSA inquiries.

Level 3—Customer Service

The health plan provides Tier 1 customer service and warm transfer calls¹ to the HSA vendor as needed. Subject to accountholder consent, the health plan may also choose to provide its customer service representatives with access to HSA balance and transaction information via Web services.

Level 4—Web Access

The health plan Web site is a single source for HDHP and HSA information. The HSA information can be displayed on the health plan site via Web services calls or via a single sign-on link to the HSA vendor's Web site.

Level 5—Claims Payment

The health plan claim system automatically submits claims to the HSA for payment. Payment is automatically transferred from the individual HSA to the health plan. Accountholders may turn this functionality on or off at any time.

1. *Warm transfer call* refers to the simultaneous transfer of a telephone call and its associated data from one agent to another.

system and information technology resource limitations made claims integration more of a “nice-to-have-tomorrow” than a “must-have-today” feature.

Differences in HDHP business strategy also influenced the health plan provider's position on integration. Many health plans decided to test the market with a “referral only” model while some health plans, in an attempt to own the member relationship, wanted full integration, which included enrollment, customer service and Web access.

As a result, what has evolved is an HSA integration continuum offering choice at five levels (see the sidebar, “HSA Integration Continuum”). While the model refers to the health plan's role in the integration continuum, large employers that contract directly with the HSA vendor have used a similar integration model.

WE GET BY WITH A LITTLE HELP FROM OUR FRIENDS

On December 22, 2003, just two weeks after Congress passed legislation permitting the establishment

of HSAs, the IRS issued its first HSA guidance in the form of IRS Notice 2004-2. That initial guidance contained 38 questions and answers related to basic HSA issues such as what an HSA is, who can have them, how HSAs can be established, regulations on contributions, distributions and other matters, such as the discrimination rules that apply to HSAs.

Within seven months of issuing that guidance, the IRS issued Notice 2004-50, which contained 88 additional questions and answers expanding the original five categories of questions covered in Notice 2004-2 to 11 categories in Notice 2004-50. In all, the IRS issued seven pieces of HSA guidance between December 2003 and November 2004.

Though the IRS was unable to address every issue, its quick response proved to be very helpful to health plans, custodians, administrators and employers trying to bring HSA products to the marketplace during 2004.

Additional help came just two short years after the introduction of HSAs when Congress passed the Health Opportunity Patient Empowerment (HOPE) Act of 2006, changing the rules for calendar years beginning on or after January 1, 2007. The primary pur-

pose of the HOPE Act was to expand access to HSAs by making them more user-friendly.

One of the changes promoting HSA expansion was the elimination of the *lesser of* contribution rule. Prior to the change, contributions were limited to the lesser of the deductible under the HDHP or the maximum statutory contribution limit (based on single or family coverage). After the change, contributions up to the statutory maximum are permitted without regard to the individual's HDHP deductible amount.

Another change related to expansion permits full-year contributions for individuals who enroll in an HDHP midyear (up to December 1), as long as certain coverage conditions are satisfied during the following year.

The act also added special rollover rules to address the concerns of employers struggling with what to do with existing HRAs and FSAs, and it eliminated the negative impact of a health FSA grace period on HSA eligibility for an FSA participant with a zero balance on the last day of the plan year.

HSA “GRAB-BAG GUIDANCE” COMES UP EMPTY

Although early IRS guidance issued in near record time in 2004 covered many basic HSA issues, it became clear additional guidance was needed as accounts aged and new legislation was enacted. In July 2008, the IRS issued Notice 2008-59. Commonly referred to as *grab-bag guidance*, the notice was a compilation of 42 of the most frequently asked HSA questions on a range of issues for which formal IRS guidance had not previously been issued.

Although appreciated, the grab-bag guidance was disappointing in that much of it merely documented informal IRS positions that the IRS had already shared with custodians, HSA administrators, employers and other stakeholders.

What was not addressed—or addressed at a level that gave the relief many believe is needed to simplify HSA administrative processes and impact administrative costs—was guidance on issues causing uncertainty for all stakeholders.

For example, as an acknowledgement of the unique relationship that exists between employers and HSA accountholders, many stakeholders were looking for some form of “administrator error” exception to the general rule that precludes employers from making adjustments to accounts once funds have been allocated. Instead, what was provided were very limited exceptions that apply to ineligible employees and employees whose HSA contributions exceed statutory limits.

While additional guidance addressing administrative errors is not expected in the near future, it is hoped that the IRS will consider ways to address the realities of the employer/employee relationship inherent in many HSA experiences.

CURTAIN CALL FOR FSAs AND HRAs?

Even before the health care reform debate heated up last summer, employers, taxpayers, lobbyists, legislators and other interested parties were debating the virtues of allowing multiple health care spending accounts to continue to coexist.

When HSAs were introduced, Treasury guidance made it clear that FSAs and HRAs were “other coverage” that would cause an individual to be ineligible to establish an HSA unless they were designed as limited purpose or postdeductible spending accounts. FSAs, with their use-it-or-lose-it rules and 2½-month reimbursement grace periods, presented limited challenges for HSA participants, but HRAs were more troublesome. To the extent HRAs were vested, employees had virtually no options, short of spending down the HRA (or electing to treat the HRA as a suspended or retirement HRA), to enable them to become eligible to fund an HSA.

In response to employer requests for administrative simplification, Congress passed the HOPE Act in 2006, allowing employers to modify their FSA and HRA plan designs. This modification permits certain employees to roll their account balances from those accounts into an HSA, thereby eliminating the other coverage that was making them HSA-ineligible. Some practitioners believed that in addition to solving the immediate coverage problem, the guidance also signaled future changes aimed at eliminating the inefficiencies and confusion created by allowing multiple but similar health care spending accounts.

While additional changes to FSA and HRA rules have not been enacted, it appears everything is on the table when it comes to raising revenue to pay for health care reform.

I WANT IT ALL AND I WANT IT NOW

Although HSAs have been around only since 2004, technologies and services related to electronic banking and 401(k) recordkeeping have been available to the general public much longer. As a result, since day one, employers, accountholders and health plans have demanded a feature-rich HSA product.

- Some of the most requested HSA features include
- Electronic enrollment and banking capabilities

- Multiple investment options (including low- or no-load mutual funds)
- Dedicated customer service support/interest rates above market rates for similar bank accounts (i.e., checking and savings accounts).

Because these features are readily available to 401(k) participants, HSA accountholders assume they should also be readily available to them at no or very low cost. Unfortunately, the HSA revenue model is substantially different because HSAs are different from 401(k) plans in many significant ways.

- The maximum annual contribution limit for a 401(k) plan was \$16,500 (\$22,000 for participants aged 50 and older) in 2009. The 2009 maximum contribution to an HSA was limited to \$5,950 (\$6,950 for accountholders aged 55 and older) for family coverage and \$3,000 (\$4,000 for accountholders aged 55 and older) for individual coverage. As a result, asset accumulation is much slower for HSAs, resulting in smaller revenue-sharing opportunities for administrators and custodians that earn revenue off of the spread on investments.
- The transactional nature of HSAs—as compared to 401(k) accounts where distributions are generally limited to death, disability, retirement and hardship—results in higher transaction costs. When these are combined with the smaller asset accumulation opportunities for HSAs, it is not hard to see that there is less money in the HSA revenue model to offset administrative costs.

Custodians and administrators hear the requests for a no-fee product, and the day may be coming when no-fee accounts are the norm. But until interest rates rebound and asset accumulation reaches critical levels, many of the requested features will continue to have a cost associated with them.

EMPLOYERS GO DIRECT

It is often said that timing is everything—and that holds true for HSAs, especially as it relates to employer design and implementation strategies in the early years. As mentioned earlier, the short time between passage of the HSA legislation and its effective date did not leave employers any time to implement design changes for the 2004 calendar year.

Compounding the timing issue was the hybrid nature of HSAs. While employers had experience with individual account plans like 401(k)s and FSAs, HSAs were not only accounted for on an individual basis, but they were individually owned and required action on the part of the individual to be opened. While HSAs could be funded by the employer through pretax contributions under the employer-

sponsored Section 125 plan, the employer could not make adjustments to correct payroll funding errors without employee authorization. Many potential custodians were good at offering retail banking services to individuals, but they had no experience with supporting employer-sponsored benefit programs or group enrollment processes.

Employers considering the opportunities presented by HSAs were finding it hard to put their arms around just what HSAs were and how best to offer them to employees. Even those employers that were making commitments to offer an HSA-qualified health plan were on the fence about the HSA component. Should the employer allow employees to set up HSAs with a custodian of their choice and, if so, how would a pre-tax payroll process interface with multiple custodians? Would there be enough HSA products available to make employee choice an option? Did the employer's selection of a preferred HSA provider to which it would send payroll deductions cause the HSA to become an employee benefit plan subject to ERISA? Just how much employer involvement with an HSA was too much for ERISA purposes? Were there advantages to contracting directly with the custodian or HSA administrator? Due to the integrated nature of the HSA with the HDHP, did it make more sense to contract for HSA services through the health plan?

As health plans, custodians and HSA administrators were assessing operational capabilities and distribution strategies based on assumptions of how they thought employers would react, two predominant models emerged: the employer direct and the health plan model.

While early adopters—many of whom were small employers—chose the health plan contracting model because of timing and integration issues, many larger employers opted for the employer-direct model because they liked the independence it gave them and it was consistent with the way they contract for other benefit services. Additionally, some employers that originally contracted with the health plan have moved to the employer-direct model. Even though they changed health plans, they like their HSA administrator and don't want to interrupt that relationship. As of now, the health plan contracting model is still the most utilized model, but employers continue to show interest in the employer-direct model.

IF IT LOOKS LIKE A DUCK AND WALKS LIKE A DUCK IT'S PROBABLY A DUCK

By statute, any insurance company, bank or person approved by the IRS to be a trustee or custodian of an

IRA or Archer MSA can serve as an HSA trustee or custodian. Many entities fall within this statutory definition, but some do not. For example, some new business combinations have presented themselves since the HSA legislation was passed in December 2003.

Timing (or lack thereof) drove early HSA business strategies and resulted in both fairly traditional as well as not so traditional business combinations as HDHP providers, banks, third-party administrators and others found themselves rushing to be among the first to offer an HSA product. Calculated guesses were made regarding whether the primary buyer would be the employer or the individual and what the best distribution channel was for reaching each type of buyer. At first glance, HSAs appear to represent clearly different revenue opportunities for different stakeholders, including asset accumulation opportunities, individual and group health plan sales opportunities, and administrative services opportunities, but those lines blur quickly.

Initially, some organizations chose to align themselves with the opportunity closest to their core business. For example, many health plans unable or unwilling to muster the resources or support necessary to establish themselves as the trustee or custodian formed alliances with financial services organizations. Administrative service providers with individual account plan experience also formed alliances with banks because—while they had employer support, account administration and customer service expertise—they were unable to serve as a custodian or trustee because of the statutory requirement. Smaller banks have also entered the fray, but real traction has been hard to come by given the features necessary to compete with the bigger providers.

In addition to forming alliances with financial services institutions, at least one health plan bought a bank with a significant book of MSA business. Another health plan is in the process of launching its own bank, and still others use a subsidiary, like a life insurance subsidiary, to fill the HSA custodian role.

While the dust has yet to settle on much of the custodian/trustee landscape, it looks like the multiple-health-plan-owned bank model will not survive. Blue HealthCare Bank, a federally chartered bank in which 33 “blue” plans have a stake, announced in August 2009 that it was seeking to sell its assets as well as its federal charter. The Blue HealthCare Bank had approximately 6,300 accounts.

Debate also continues regarding whether the custodian must have a household name. Interest rate pressures related to the recession and other global economic conditions, along with a demand for more bells and whistles, may also impact the sustainability

of some revenue models, such as those offering a high interest rate.

ON A CLEAR DAY. . .

Even though an ERISA exception applies to HSAs if the employer limits its involvement consistent with Department of Labor guidance, significant regulatory oversight requiring fee transparency and privacy protections is in place to ensure the quality of the consumers’ overall HSA experience.

Depending on their bank charter, custodians and trustees will be examined for regulatory compliance by at least one federal regulatory body, and they may also be examined by state regulatory bodies. The applicable regulations include but are not limited to

- Truth in Lending, Regulation Z
- Fair Debt Collection Practices Act
- Right to Financial Privacy Act
- Truth in Savings, Regulation DD
- Availability of Funds, Regulation CC
- Equal Credit Opportunity Act, Regulation B
- Fair Credit Reporting Act
- Fair Housing Act
- The Bank Secrecy Act
- The USA Patriot Act of 2001
- Gramm-Leach-Bliley Act, Regulation P.

In addition to regulatory scrutiny, voluntary disclosure of fees and revenue-sharing arrangements by and between health plans, employers, administrators, custodians and accountholders has been common practice. And as new business models emerge, transparency will continue to be an important consideration.

CREAM RISES TO THE TOP

After almost six years of steady expansion, the HSA administrator landscape currently offers a healthy mix of service providers spanning several industry sectors. As pricing and interest rate pressures continue to take their toll, one would expect many of the pretenders to fall by the wayside and the contenders to rise to the top.

In addition to the national banks that introduced their first-generation products in 2004 and 2005, many regional and small banks have entered the arena looking to take advantage of HSA asset accumulation opportunities. Given that these banks offer a low- or no-fee product and pay higher-than-average interest rates, it is yet to be determined how long they can sustain such models.

Certain mutual fund providers are also in the mix, although it does not appear that account volume has

been as easy to come by as would be assumed given the recordkeeping platform and investment integration capabilities they possessed before HSAs were introduced and based on the customer relationships they already had in place with employers that purchase their 401(k) services.

While some health plans have chosen to get into the banking business by acquiring existing banks or starting their own, others like the health plans backing Blue HealthCare Bank have decided to leave banking to the bankers. The exit of Blue HealthCare Bank, though not surprising to insiders, may provide some insight into the future for competitors unable to grow account volumes to the levels needed to support both the initial investments and the future investments that will be required to compete with industry leaders.

Consolidation rather than expansion may be the theme for the next six years. In fact, health care reform could result in accelerated consolidation if HSA-related provisions like claims substantiation make it into some final version of the law.

PRESSURE COOKER

It is to be expected that competition will drive down fees for products and services over time, but HSAs have felt the pressure since their inception and long before the dance card was full. Compared to FSA fees, which at \$3.50 to \$5.50 per month are typically 10-20% higher than HSA fees, the market continues to pressure custodians and administrators to offer low- or no-fee HSA products.

Some factors contributing to price pressure include the current “land grab” by regional banks and credit unions that came late to the HSA party with no distribution partner. Noting that only 6.1 million of the possible 180 million insured individuals have established HSAs, many of these newcomers have been willing to waive fees in an attempt to attract depositors (and deposits). The HSAs offered by these entities are generally interest-bearing checking accounts repurposed as an HSA custodial account. These entities generally do not support employer functions such as group setups, and they offer little or no integration with health plans or investment options.

Bundled pricing techniques may also be used to drive down HSA fees by entities with access to alternative revenue streams from the same customer base. For example, employers contracting directly with the health plan may pay a bundled administrative-services-only (ASO) fee that includes both HDHP administration fees and HSA administration fees. Al-

ternatively, the health plan may just charge an ASO fee and no HSA fee, even though it provides HSA services. The difficulty with these types of arrangements is that it is hard for the customer to determine the extent to which the ASO fees are offsetting the HSA fees, creating a false impression of cost savings rather than a cost-subsidy situation. Another disadvantage of this model is the impact it may have over time on the ability of vendors that do not have access to alternate revenue streams to remain in the market, thus eliminating competition and limiting choice.

In somewhat of a double whammy, increased pressure to reduce or eliminate fees has escalated at the same time interest rates have tanked due to the recession and global economic conditions. Some of the interest rate pressure has come from regional banks and credit unions that have been willing to pay higher-than-average interest rates in exchange for the opportunity to cross-sell other bank services to new account-holders to whom they would not otherwise have access. It has yet to be seen how long the price and interest rate pressure can be sustained if significant increases in account volume do not take place.

HEALTH CARE REFORM (SHOULD I SAVE MY SHOE BOXES?)

Though HSAs have been part of the health care reform debate since the beginning, it's possible that HSAs will emerge from the process unscathed.

If this were to happen, certain policy changes could help expand HSAs, drive further employer savings, make HSAs more user-friendly, impact employee satisfaction and increase adoption rates.

Benjamin Zycher, senior fellow at the Manhattan Institute for Policy Research, concluded in a report he authored in 2009 titled “HSA Health-Insurance Plans After Four Years: What Have We Learned?” that similar to the U.S. experience with retirement plans, “legal and regulatory simplicity combined with looser eligibility standards and more generous limits on the contributions that policyholders can make to their health savings accounts” could increase the popularity of HSA-qualified plans.

Policy changes similar to those discussed in Zycher's report were actually proposed by Senator Orin Hatch in 2008. These user-friendly provisions, which could simplify account administration and have an immediate impact on HSA adoption rates, include

- Allowing accountholders to use HSA funds to pay for any type of health insurance premium
- Allowing HSA funds to be used to reimburse qualified medical expenses incurred after HDHP coverage begins, as long as the account is set up

by April 15 of the following year (i.e., a retroactive account establishment date)

- Expanding coverage for veterans and individuals receiving Medicare Part A
- Allowing catch-up contributions to the same account (rather than requiring spouses to maintain separate accounts, resulting in some cases in duplicate administrative fees)
- Removing FSA grace period restrictions, simplifying transitions from FSA coverage to HSA enrollment
- Expanding the definition of *preventive drugs* to include prescriptions and over-the-counter medicines that prevent the worsening of or complications from chronic conditions
- Allowing health plans with 50% coinsurance to qualify as an HDHP
- Allowing higher employer contribution limits for employees with chronic illnesses.

It is important that HSA vendors and health plan providers continue to explore ways to expand HSAs, a valuable health care funding option for many individuals.

CONCLUSION

No one knows what the next six years hold for HSAs or health care in general, for that matter. More time and data are needed to declare the HSA funding model an unequivocal success, but early findings are encouraging. Maintaining a dialogue with all stakeholders, recognizing administrative efficiencies, and improving upon the current model in ways that are meaningful to the accountholder will be key drivers of expansion and increased cost-savings opportunities. ◀

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