Evaluating High-Deductible Health Plans and Health Savings Accounts

Overview

Offering high-deductible health plans (HDHPs) continues to be a popular way for employers to reduce their spending on employee health care coverage. While HDHPs, in the past, have had lower premiums, premium rates for these plans have been increasing at a pace similar to that of lower deductible plans. HDHPs require enrollees to pay very high deductibles and have much greater out-of-pocket (OOP) costs. HDHPs are often coupled with a tax-advantaged health care arrangement such as a health savings account (HSA) or a Health Reimbursement Arrangement (HRA).

This executive summary is intended as a pocket guide for affiliate staff that explains the main features of both HDHPs and HSAs, the HSA contribution and OOP limits, the HDHP strategies to consider, and the questions to ask when evaluating these plans.

Main Features of HDHPs

HDHP enrollees generally experience an increase in OOP costs and health benefit and cost risks. In addition, HDHPs are supposed to provide enrollees with access to provider cost and quality information to help them choose the most appropriate hospital, doctor, pharmacy or other providers. However, health care cost transparency and quality reporting organizations indicate that most plans fail to provide patients with effective information. Furthermore, HDHP proponents argue that since patients are expected to use their HSA money to pay for non-reimbursed medical services prior to reaching the high deductible, they will be more cost conscious. Unfortunately, this has not been the case as patients have little to no control over their medical needs, the services providers order/recommend, and/or the cost and quality of those services.

Main Features of HSAs

A federally-qualified HDHP eligible for an HSA in 2022 must have a minimum annual deductible of $1,400 for self-only coverage and $2,800 for family coverage before covered plan benefits can be reimbursed. The 2022 annual deductibles for an HDHP with an HSA can be as high as $7,050 for self-only coverage and $14,100 for family coverage. In other words, the 2022 annual OOP maximum amounts for an HDHP with an HSA are $7,050 for individual coverage and $14,100 for family coverage.

In addition to having coverage under a federally qualified HDHP, individuals must meet the following requirements in order to contribute to an HSA:

- Have no other health coverage (e.g., a spouse's plan) unless it is limited benefit coverage such as dental, vision, and/or long-term care;
- Not have a general-purpose health flexible spending arrangement (FSA) or an HRA unless it is HSA-compatible (e.g., dental and vision FSA only);
- Not be enrolled in Medicare; and,
- Not be claimed as a dependent on someone else's 2021 tax return.

Individuals who are 55 years of age or older can contribute an additional $1,000 a year to an HSA until they are enrolled in Medicare. While the federal government does not tax employer or employee HSA contributions, the states of California and New Jersey do impose a state tax on employee contributions and HSA capital gains.

HSA contributions are deposited into a tax-free trust or a custodial account with the balance rolling over each year. OOP expenses that are reimbursable under an HSA include deductibles, co-payments, and other qualified medical expenses.

HSA Contribution, Deductibles, and OOP Limits

	2023	2022
HSA Contribution Limit **(Employee and employer amt)**	Self-only: $3,850. Family: $7,750.	Self-only $3,650. Family: $7,300.
HSA catch-up contribution for 55+	$1,000.	$1,000.
HDHP minimum deductibles	Self-only: $1,500. Family: $3,000.	Self-only: $1,400. Family: $2,800.
HDHP maximum OOP limit (includes deductibles, co-payments, etc. but does not include premiums).	Self-only: $7,500. Family: $15,000.	Self-only $7,050. Family: $14,100.

HDHP Strategies to Consider

When reviewing HDHP and HSA options:

- **Plan Ahead.** Be certain you understand your current plan and any proposed health plan(s) in order to make informed comparisons with any proposed changes.

  Obtain plan data. Compile and review cost and utilization data for your plan several months prior to plan renewal and/or bargaining. Request at least the past two years of data.

- **Focus on the cost drivers.** Identify the plans' high-cost areas and discuss HDHP alternatives such as analyzing prescription drug costs and the performance of the current pharmacy benefit manager (PBM). It may be time to re-bid the PBM arrangement for more cost-effective pricing.

- **Coordinate the HDHP with a wellness, disease, and behavioral health management program.**

- **Determine if/how in-network and out-of-network benefits differ.** Cost sharing for out-of-network care should not be so exorbitant that members face the possibility of incurring enormous debt in addition to being faced with a high deductible and other OOP costs. For example, some specialty physicians (e.g., psychiatrists and psychologists) rarely participate in networks.

- **Include financial safeguards.** Employee OOP costs should be capped at a reasonable level to protect patients against catastrophic expenses.

- **Require that the employer "buy the plan"** through higher wages, benefit improvements and/or an employer contribution to a tax-advantaged arrangement that matches the level of the high deductible with the employee and employer contributions not exceeding the legal maximum. Also, propose that the employer contribution be made in full at the start of the year to protect enrollees who may have large medical expenses early in the year. Limit the amount the enrollee will pay in premium for the HDHP and restrict the percentage of increase for each year after that.

Questions to ask when evaluating HDHPs/HSAs

Will the employer pay all the administrative and maintenance fees for setting up and maintaining an HSA?

Does state law limit employer contributions to employee health coverage? If so, how will that influence the employers' HSA contribution level?

What web-based provider quality and cost information will be available to HDHP participants?

What assistance will be provided to lower-income individuals/families facing a high deductible? Will an income ceiling be established for lower-income people faced with a HDHP option so that they can remain in the lowest-deductible plan possible?

Will employee satisfaction be monitored and how often?

What type of surveys will be conducted to ensure that people are not experiencing financial hardship because of the HDHP? Will employees be able to participate in developing the survey? How often will surveys be conducted?

Will patient access to treatment (e.g., emergency room visits, inpatient admission rates, prescription fill rates, and/or readmission rates) be monitored and shared with employee representatives and employees?

How does the HDHP provider network compare to that of the lower-deductible plan?

Will HDHP provider reimbursement rates differ from the current, lower-deductible plan?

How will provider discounts be handled? (Ask the plan sponsor to provide reimbursement rates for the top 25 diagnoses under the plan and patients' OOP costs. Also, determine how many employees use out-of-network providers and what the cost impact will be under an HDHP.)

Compare the current lower deductible plan's service restrictions to those in the HDHP. Even though the ACA prohibits plans from using a lifetime or annual dollar limit on

essential health benefits, health plans may still include severe restrictions on the number of services, visits, etc. in order to limit utilization.

Obtain a list of the medications that will be covered before, after the high deductible is met, and compare it to the medication list of the lower-deductible plan.

For more information

To learn more about HDHPs, contact the NEA Collective Bargaining and Member Advocacy Department at 202-822-7080 or email at collectivebargaining@nea.org.

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