

# **TAX AND OTHER IMPLICATIONS OF TRADITIONAL HEALTH INSURANCE PLANS VERSUS HIGH-DEDUCTIBLE HEALTH PLANS**

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## **ABSTRACT**

*This paper gives some background on traditional and high-deductible health insurance plans. It also discusses an example of an employer which had been offering a traditional plan to its employees and then added another choice for a high-deductible plan. The discussion will also examine the relevant tax laws relating to flexible spending accounts and health savings accounts. Other implications of the choice between plans will also be addressed.*

## **INTRODUCTION**

For many years, companies providing health insurance to their employees have been faced with quickly increasing medical and insurance costs. Employees have seen large increases to their portion of the premiums; fewer benefits; and higher deductibles, co-payments, and coinsurance percentages. Employers have looked for ways to reduce the increases in costs while still providing adequate health benefits to their employees so they can remain competitive with other employers.

High-deductible health plans (HDHPs) are one option to traditional health plans which employers have considered to respond to the increased costs of health care. These plans supposedly encourage employees to be more careful in their health care consumption because they require a high deductible before the plan begins to pay benefits.

Different health care plans have different tax implications to employees. Traditional plans are often accompanied by the option for a flexible spending account (FSA). High-deductible plans may qualify employers to offer their employees an option of a health savings account (HSA). So in choosing between a traditional plan and a high-deductible plan, an employee should not only consider the premiums and the medical benefits offered, but should also consider the tax implications of that choice.

The next section gives some background on traditional and high-deductible health insurance plans. It also discusses an example of an employer which had been offering a traditional plan to its employees and then added another choice for a high-deductible plan. The following section will discuss tax laws relating to flexible spending accounts and health savings accounts which may be associated with traditional health insurance plans and high-deductible plans. Another section will discuss some other implications of the choice between plans. This section will be followed by the conclusion.

## **HEALTH INSURANCE PLANS**

Many employees have been able to get health insurance plans through their employers over the last several decades. However, improvements in medical technology, increases in malpractice insurance costs, and increasing life spans with the attendant increase in health care needs, have all increased medical care and health insurance costs at a much higher rate than the general inflation

rate. Employers desiring to maintain competitive compensation packages have struggled with the increasing costs of employee health care coverage.

In most cases employers have continued to increase the amounts they are paying for employee health insurance. However, they have also increased the amounts (and perhaps percentages) of the premium portion covered by the employee. They have also had to strategically reduce benefits and increase the required deductible amounts, the co-payment requirements, and the coinsurance percentages.

Traditional health insurance plans may have an annual deductible, perhaps for each individual covered under the plan with a maximum deductible for the family under a family plan. Some services such as doctors' visits may require a co-payment for each visit with the remaining cost covered by the insurance. Other services may require a certain percentage of coinsurance paid by the insured, with the remaining amount covered by the insurance. These plans may also have a maximum coinsurance amount that must be paid by the insured or other maximums that limit the exposed risk to the insured. With the implementation of the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) adjustments may need to be made to these plans to make them consistent with current requirements.

Utah Valley University (UVU) has offered a fairly traditional health insurance plan for many years. Until recent years the premium was covered entirely by the university. However, a change in Utah State law a few years ago requires that employees pay at least 10 percent of the premium, so UVU has had to comply with that requirement. As the plan has had to change to reduce the increase in costs, a deductible has been added to the items subject to coinsurance. The increase of the deductible over time has led to a choice of two competing traditional plans, one with a higher deductible and one with a lower deductible and higher employee premiums. Most of the plan provisions other than the deductible were quite similar. Because these plans are similar, only the basic plan will be discussed here and later compared to the high-deductible plan.

This plan has four major types of services which are covered differently. The first type of service is for preventive items which are covered 100% with no deductible, no co-payment, and no coinsurance. This category includes routine exams (physical, gynecological, family history, well-baby, vision, pap smear and mammogram, and hearing), one per year, covered immunizations, and contraceptives and sterilizations. The second type of service includes physician office visits, both primary care and specialists; after hours/InstaCare visits; and emergency room visits. These services have a required co-payment ranging from \$35 for a primary care doctor visit to \$250 for an emergency room visit. These co-payments are not subject to the medical deductible, but they also do not count toward the coinsurance maximum for the year.

The third type of service includes most other things such as diagnostic tests, x-rays, surgeries, hospital stays, and lab work. These items generally have a 20% coinsurance requirement after the \$1,000 deductible per person (\$2,000 deductible per family) has been met. There is also an annual coinsurance maximum of \$4,000 per person (\$8,000 per family). The fourth category is for prescription medications. Prescriptions have a separate deductible (\$100 per person, \$200 per family) with a separate coinsurance maximum (\$2,000 per person, \$4,000 per family). Brand name prescriptions require a coinsurance of 30% (formulary) or 50% (non-formulary). Generic prescriptions instead have a \$4 (30-day supply) or \$8 (90-day mail order supply) copayment for which the deductible is waived but which also does not count toward the prescription coinsurance maximum.

The details just given assume that a participating provider is used for the service. If a non-participating provider is used, preventive services are not covered, physician visits move to a 40% coinsurance instead of a co-payment, a larger, additional deductible applies, and a larger coinsurance maximum applies. In addition, because these providers have not agreed to accept the insurance company's allowable amount as full payment, the employee may be subject to amounts billed by the provider which were above the maximum allowable by the insurance plan.

High-deductible health plans (HDHPs) are intended to be consumer-driven health plans. Because they have a high deductible before the insurance will pay anything (with the possible exception of some preventive services or other items required by the PPACA which may be covered with no deductible), an argument exists that employees will be more careful in their choice of health care and coverage since they will be paying out of pocket for any amounts up to the deductible. Employees under these plans may be more likely to work toward good preventive measures to reduce the health concerns and might avoid seeking medical care for minor problems since they might have to pay the full cost rather than just a co-payment for an office visit. As would be expected with an HDHP, the premiums are lower. This is a major advantage to the employee.

For the 2013-2014 academic year, UVU added an HDHP as an additional choice. The plan was designed to have no premium for the employee, at least in the first year. Apparently the Utah law passed requiring state employees to pay at least 10% of their insurance premium does not apply to HDHPs. The deductible for this plan depends on whether the employee is covered under single coverage (\$2,000) or family coverage (\$4,000). Other than the preventive services listed above, which are covered 100% with no deductible, the deductible applies to all other services and prescriptions. Once the deductible is met, physician visits are covered with a co-payment (\$25 - \$35 or \$250 for the emergency room), prescriptions have a 30% – 50% coinsurance (except generic prescriptions which have a \$4 co-payment (or \$8 for 90-day mail order prescriptions)), and other services have a 20% coinsurance. However, once the out-of-pocket maximum is met, all other covered services are paid by the insurance at 100%. As before, the out-of-pocket maximum, including the deductible, depends on whether the coverage is single (\$3,000) or family (\$6,000).

Once again, the details provided assume that a participating provider is used. If a non-participating provider is used, an additional, larger deductible applies along with a higher coinsurance percentage, coinsurance in place of most co-payments, and an additional, larger out-of-pocket maximum. Not surprisingly, employees of two types were more likely to seriously consider the HDHP. Those who expected little or no medical costs would prefer the HDHP with no premium. In addition, those expecting very high medical costs such as planned surgeries may prefer the high deductible plan because of no premium combined with lower maximum payments. Employees with expectations of moderate medical costs were then left with more uncertainty and may have looked at what types of medical expenses they expected to incur.

### **RELATED TAX BENEFITS**

Besides considering the premiums and medical benefits of different insurance plans, employees should also consider the tax implications. Typically the portion of any medical insurance premium withheld from employees' compensation can be withheld on a pre-tax basis. In addition, employers may offer other options which can reduce the after-tax cost to employees for the amounts they will need to pay for deductibles, co-payments, and coinsurance. Employers offering traditional health insurance plans can also choose to allow their employees to use a flexible spending account (FSA) to pay for these out-of-pocket costs on a pre-tax basis. Employers offering qualified HDHPs can choose to allow their employees to contribute to an employer-sponsored health savings account (HSA) to achieve tax savings on these costs. Even if

the employer does not sponsor an HDHP, employees may be able to contribute to an HSA with after-tax money and deduct this contribution on their tax returns (IRS Pub. 969).

A medical FSA is an account which can be used in conjunction with a traditional health insurance plan. It allows the employee to elect a certain amount to be deducted from his/her paychecks during the plan year on a pre-tax basis to be used for payment of medical expenses not covered by the insurance plan. Since these amounts are also deducted before employment taxes are calculated, contributions to an FSA reduce income taxes and employment taxes. Since employment taxes are paid by both the employee and the employer, the employer also saves employment taxes on the amounts contributed by its employees to FSAs. Of course there will be a cost associated with managing these accounts. These costs may be incurred directly by the employer if the accounts are self-managed or paid to another entity if the accounts are managed by a third party. However, in many cases, the employment tax savings is more than enough to cover the cost of administering the accounts.

Originally, contributions to these accounts had no limit from the legislation. However, employers were allowed to put a limit on the maximum contribution for an employee (IRS Pub. 969). There was also a practical limit for most employees, as the original law had a use-it-or-lose-it provision. Any amounts contributed to an FSA and not used for qualified medical expenses during the plan year were forfeited back to the employer. Of course this provision increased the risk for employees; they wanted to maximize the tax benefit, but they didn't want to contribute too much and then lose it. Since out-of-pocket medical expenses are very hard to predict in advance when the annual election must be made, employees were perhaps too conservative in the amounts they would elect to be contributed to an FSA. In 2005 a change was made allowing employers to grant a 75-day grace period after the end of the plan year (IRS Notice 2005-42). Employees of employers who adopted this option were allowed to use up amounts elected for the prior plan year as long as the medical costs were incurred within the 75-day grace period. This change essentially allowed employees to use the amount elected over 14½ months rather than 12 months, but any amount not used by the end of the grace period would still be forfeited.

The PPACA (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) legislated a limit to medical FSA contributions for plan years starting after 2012. The new limit is \$2,500 per year with the limit increased over time through indexing (IRS Notice 2012-40). The limit for 2014 is the same \$2,500 as it was for 2013 (IRS Rev. Proc. 2013-35). An employee with two or more unrelated employers can potentially contribute up to \$2,500 through each employer. Employers can choose a more restrictive limit for their plans. With ongoing concern about the use-it-or-lose-it rule and the legislated maximum contribution of \$2,500 which was less than many employers were allowing, another change was announced late in 2013. Employers can now allow employees to use up to \$500 of the amount for an annual election any time in the following plan year (IRS Notice 2013-71). However, employers are not allowed to incorporate both this \$500 carryforward and the 75-day grace period.

Employers that offer HDHPs can also choose to offer their employees the option of an HSA (IRC Section 223). An HSA is an individual-owned savings account which can be funded with pre-tax dollars if contributed through employer withholding. An HSA can also be funded directly by the employee who can then deduct the contributions on his/her tax return. The advantage of contributing through the employer is that contributions made through employer withholding are also exempt from employment taxes.

Legislation allowing HSAs was passed in 2003, effective in 2004 (P.L. 108-173). Some amendments to the law were made late in 2006 (P.L. 109-432). Unlike an FSA, amounts

deposited to an HSA are not lost after a period of time and they are portable if the employee changes to a new employer. Amounts in an HSA may bear interest and can even be invested in different investment accounts through qualified financial institutions. The earnings on these funds are not taxable if they are used for qualified medical expenses.

Amounts from the HSA can be used to pay for qualified medical expenses, either future medical expenses or past medical expenses which were incurred when the HSA was in force. So an employee with an HSA can choose to be reimbursed from the HSA for current medical expenses incurred as soon as the contributions reach the HSA. However, an employee with an HSA can choose to pay for current medical expenses outside of the HSA and then claim reimbursement of those expenses from the HSA in the future, perhaps many years in the future. Whenever qualified medical expenses are reimbursed from the HSA, no federal income tax liability exists on those amounts.

If non-qualified withdrawals are made from an HSA, a 20 percent penalty is applied (was 10% prior to 2011 (P.L. 108-173)) unless these withdrawals are made after the account holder reaches age 65 (P.L. 111-148). Once the account holder is 65, no penalty is applied to non-qualified withdrawals. However, non-qualified withdrawals, whether made before or after age 65, are subject to income taxes. In other words, amounts in an HSA which are not used for qualified medical expenses become, in essence, an additional vehicle for tax-deferred retirement income.

Table 1 shows the statutory limits for HSA contributions. It also shows the minimum deductible and the maximum out-of-pocket expenses for a health insurance plan to qualify as an HDHP for purposes of an HSA. The limits depend on whether the plan is for single coverage only or for family coverage (any coverage other than single coverage). These limits increase over time through an indexing provision of the original legislation. For 2014, an employee with family coverage under an HDHP can contribute up to \$6,550 to an HSA. If the employee is age 55 or older, the contribution can be increased an additional \$1,000. In order for the health coverage for this employee to qualify as an HDHP for purposes of contributing to an HSA, the deductible would have to be at least \$2,500, and the maximum out-of-pocket expenses under the plan could not exceed \$12,700.

## **DISCUSSION**

Several implications follow from the differences in health plans and the related tax benefits. As mentioned earlier, under the traditional health insurance plan offered by UVU, the services are compartmentalized into one of four categories: preventive services covered 100 percent with no deductible, co-payment, or coinsurance; physician office visits which have a co-payment, dependent on what type of visit is made; other services for which a coinsurance percentage is applied after meeting a deductible (with a maximum coinsurance amount); and prescriptions which have a co-pay or coinsurance requirement with a separate deductible and coinsurance maximum. Because these services are all compartmentalized with separate limits and charges for the employee in each different category, the employee's out-of-pocket costs do not depend on the timing of different types of services during the year.

However, for the HDHP plan introduced by UVU for the 2013-14 academic year, because one deductible applies to all of the services except preventive services which are covered 100 percent, the other three types of services are pooled together instead of being compartmentalized. This can mean that the timing of different types of services can affect the total amount paid out of pocket by the employee, at least if the total out-of-pocket costs for the year are between the deductible amount and the out-of-pocket maximum.

Table 1--Health Savings Account (HSA) Limitations							
HSA Annual Contribution Limits				Definition of High Deductible Health Plan			
			Additional Contribution Allowed	Minimum Deductible		Maximum Out-of-Pocket Expenses	
	Single Coverage	Family Coverage	for those 55 or older	Single Coverage	Family Coverage	Single Coverage	Family Coverage
*2004	\$2,250	\$4,500	\$500	\$1,000	\$2,000	\$5,000	\$10,000
*2005	\$2,650	\$5,250	\$600	\$1,000	\$2,000	\$5,100	\$10,200
*2006	\$2,700	\$5,450	\$700	\$1,050	\$2,100	\$5,250	\$10,500
2007	\$2,850	\$5,650	\$800	\$1,100	\$2,200	\$5,500	\$11,000
2008	\$2,900	\$5,800	\$900	\$1,100	\$2,200	\$5,600	\$11,200
2009	\$3,000	\$5,950	\$1,000	\$1,150	\$2,300	\$5,800	\$11,600
2010	\$3,050	\$6,150	\$1,000	\$1,200	\$2,400	\$5,950	\$11,900
2011	\$3,050	\$6,150	\$1,000	\$1,200	\$2,400	\$5,950	\$11,900
2012	\$3,100	\$6,250	\$1,000	\$1,200	\$2,400	\$6,050	\$12,100
2013	\$3,250	\$6,450	\$1,000	\$1,250	\$2,500	\$6,250	\$12,500
2014	\$3,300	\$6,550	\$1,000	\$1,250	\$2,500	\$6,350	\$12,700
* For 2004-2006, the annual HSA contribution was also limited by the health plan deductible							
(P. L. 108-173, P. L. 109-432, IRS Rev. Proc. 2004-71, IRS Rev. Proc. 2005-70, IRS Rev. Proc. 2006-53, IRS Rev. Proc. 2007-36, IRS Rev. Proc. 2008-29, IRS Rev. Proc. 2009-29, IRS Rev. Proc. 2010-22, IRS Rev. Proc. 2011-32, IRS Rev. Proc. 2012-26, IRS Rev. Proc. 2013-25)							

For example, if the last medical service received during the year were an emergency room visit and the costs of this visit caused the employee to exceed the deductible, the employee would have to pay to meet the deductible plus the \$250 co-pay for the emergency room visit (a total for the year of \$4,250--\$4,000 for the deductible plus the \$250 emergency room co-pay). If instead, a generic medication were the last service received for the year and that caused the employee to exceed the deductible, the employee would have to pay to meet the deductible plus the \$4 co-pay for the generic medication (a total for the year of \$4,004--\$4,000 for the deductible plus the \$4 co-pay for the medication). This could be true even if the exact same services were received during the year. Actually, it is not the timing of the services received that would dictate the different payment requirements for the employee. Instead, the payment differences would be a result of when the services were processed by the insurance company, as the date of processing the claims would dictate for which service the deductible was finally met.

Some differences in the characteristics of FSAs and HSAs also need to be presented. An FSA can be set up to coincide with the plan year of the insurance plan. This may not necessarily coincide with the calendar year. For example, the fiscal year for UVU starts on July 1 and ends on June 30, likely fairly typical for educational institutions. Thus, the insurance plan year follows this fiscal year. Thus, UVU's plan year for FSA contributions is consistent with the fiscal year of the institution and the plan year for the insurance plan.

The contribution limits for an HSA follow the tax year, which is the calendar year for most individual taxpayers, regardless of the insurance plan year. Since the UVU HDHP plan started on

July 1, 2013 but the plan year does not coincide with the calendar year, it is possible for an employee to contribute the full 2013 calendar-year maximum contribution in the last half of 2013 once the HDHP plan was in place. However, some complicated implications can result if the employee does not remain on the HDHP plan for at least two plan years after having elected the full 2013 maximum contribution during the last half of 2013. Using some fairly complicated rules beyond the scope of this paper, some of the contribution amount for 2013 would become taxable and would also be subject to a 10 percent additional tax.

The amount to be contributed to an FSA must be elected before the plan year starts. This amount cannot be changed during the year unless the employee has a qualified change in family status. Because the amount to be contributed to the FSA is known in advance, the entire amount becomes available to the employee to pay for qualified medical expenses starting the first day of the plan year even though the amount will be contributed over the plan year. Thus, if a UVU employee had elected an annual FSA contribution of \$2,500 and the employee or his/her dependent had surgery on July 1, 2013, resulting in an out-of-pocket cost equal to or greater than \$2,500, the entire \$2,500 amount could be withdrawn from the FSA even though none of the contribution has yet been deposited into the FSA.

The rules for an HSA are different. An employee can change the amount of contributions to an HSA during the year. Thus, the total that will be contributed for the year is unknown. Therefore, the employee can only withdraw amounts from an HSA after they have been deposited into the account. With the example above of a surgery on July 1, 2013, the employee could not get reimbursed for the out-of-pocket costs until the amounts were actually withheld from his/her paychecks during the year and deposited into his/her HSA.

As mentioned earlier, amounts in an HSA are held in trust for the employee. The account is portable and can be maintained by the employee even if a different job is obtained. These accounts can bear interest and may even have investment options available through the financial institution holding the account. Amounts in an FSA do not bear interest for the employee.

The law that first allowed HSAs (P.L. 108-173) defined individuals for whom the reimbursements from an HSA could be claimed: the individual who had the HSA, his/her spouse, and any tax dependents. Later legislation (P.L. 109-135) relaxed the requirements somewhat and allowed reimbursement for medical expenses for someone who could have been claimed as a dependent except that he/she (1) filed a joint return, (2) had gross income over the exemption amount, or (3) could be claimed as a dependent on another tax return.

The rules for reimbursement from an FSA were the same as those for HSAs. However, after passage of the PPACA (P.L. 111-148) which required “group health plans and health insurance issuers that provide dependent coverage of children to continue to make such coverage available for an adult child until age 26”, the IRS also determined that medical expenses for an adult child under age 27 could be reimbursable from an FSA, regardless of whether the adult child was a tax dependent (IRS Notice 2010-38). While this adjustment was made to FSAs, no similar adjustment was made for reimbursements from HSAs. So if an employee has adult children who are not tax dependents, medical costs paid by the employee for these adult children are not reimbursable from the employee’s HSA. This difference seems to put HSAs at a disadvantage compared to FSAs. However, there are other advantages that HSAs have over FSAs.

## CONCLUSION

Since health care and insurance costs are continually increasing, employers are looking for ways to reduce the increases and provide competitive health insurance and benefit packages for their employees. HDHPs are becoming a more popular alternative to traditional health insurance plans. The costs to the employees for premiums, deductibles, co-payments, and coinsurance vary under these different types of plans. In addition, the tax-favored options for FSAs and HSAs also have differences. This paper has discussed some possible differences between health insurance plans and the related tax benefits. Employees who are considering an HDHP should consider not only the variations in costs and benefits for the specific health insurance plan options, but should also consider the tax benefits available under the different plans.

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