



HSA Update



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Welcome to the HSA Update, keeping you up-to-date on the Health Savings Account marketplace with bi-weekly analysis and review of public policy, market innovations, and technology advances in the HSA arena.

■ **HSA Council is Partnering with CDHP Solutions**

The HSA Council is proud to announce that it is partnering with *CDHP Solutions*, the leading health care consumerism magazine, to sponsor the [CDHP Solutions Forum](#).

As part of our partnership, HSA Council members will be given a 20% discount on Sponsorship and attendee fees for the Forum!

About the Forum:

The Forum is "A One-Day Health Care Benefit Forum to help Employers prepare for and manage the new 'Health Care Law' and Give A-to-Z Insight into Consumer-Directed Health Care Solutions."

At the Forum you will:

- Learn about the latest CDHC trends, including new products and technologies
- Network with your peers to share concerns and opportunities around CDHC
- Discover products and services that will help your CDHC implementation succeed

This Forum will be educational for anyone interested in the consumer-driven health care market, including:

- CEOs / Presidents / CFOs
- Banks
- HR and benefits executives
- Health plan administrators
- Benefit consultants
- Third party administrators
- Corporate wellness and medical directors
- Benefit brokers

Please review the [Forum's website](#) and contact [Renee Galbraith](#) if you have any questions about becoming a member of the HSA Council.

■ **Kevin McKechnie's Article in CDHP Solutions**

This article discusses the shuttering of nHealth due to the regulatory uncertainties in the health care reform legislation (PPACA) and also addresses our concerns with the interchange provision in the Senate's financial reform legislation (S. 3217).

Article: The Looming Healthcare Regulatory Chaos

One of the most promising start-up companies in America, a health insurer no less, has decided that while it was able to weather ObamaCare's legislative phase, the ensuing regulatory regime would make it impossible to continue offering High Deductible Health Plans (HDHPs) to employers. nHealth a Richmond, Virginia based company, said in a letter to its broker community that,

"Despite a product that was gaining increasing acceptance among companies throughout the

Commonwealth, the uncertainties in the regulatory climate coupled with new demands imposed by national healthcare reforms have made it challenging to sustain the level of sales required to remain viable over the long run.”

The first casualty of ObamaCare is here and why it happened so fast is instructive. nHealth fell not so much because of an inability to comply with the rules, but because of an inability to attract investment capital in the face of such dramatic uncertainty about what the rules might eventually be. This is the sort of unavoidable market deflection that ensues anytime Congress makes such a broad grant of authority to a bureaucracy. Absent any statutory or other limit on government, how can markets assign capital when the definition of political and regulatory risk changes constantly or is unknown?

This dynamic is usually found outside the United States, and not in some highly technical comparison of Britain’s National Health Service to ours, or in the murky minutiae of some other command economy’s approach to financing health care. Instead, it can be found in the market for political risk insurance, a product most companies purchase when they want to make an investment in a nation where the local constitution is, shall we say, somewhat flexible.

Pouring millions into cell towers in Sudan or fiber optics in Nicaragua can result in very fruitful investments indeed, but for the fact that the local juntas have a habit of nationalizing companies depending upon their need for resources at any one time. The American version of the same experience is having a Department of Health and Human Services (HHS) empowered with so much regulatory discretion that one minute your insurance products are approved and selling and the next they are prohibited and illegal. Either way, the end result is the same; investors are penalized arbitrarily by government instead of for underperformance by markets.

This brings us to ObamaCare’s first and perhaps most onerous regulation: Medical Loss Ratio (MLR) rules for insurers selling in the small and large group markets.

The section of the Patient Protection and Affordable Care Act (PPACA) that may prove the most destructive to the American insurance industry isn’t the command to cover a certain type of person or disease but to do it while losing at least 80 or 85 cents on every dollar collected. Pause for a moment and reflect upon how eager the investor community would be to buy a mutual fund or a stock in a company that by law can’t make a return greater than 15%.

Would you want to give that enterprise your retirement fund?

Probably not, and that’s the first issue: in our world of publicly traded health insurance companies how can a health insurer attract capital when investors know that earnings, by virtue of having mandated losses, are capped? More to the point, how eager will an investor be when it’s clear that one role now entrusted to HHS is to monitor insurer profits and restrict them by defining which operating expenses are medical and which administrative?

In our letter to HHS, the American Bankers Association’s HSA Council discussed this dynamic at length by pointing out that improving access to care by making health insurance more affordable requires more insurers competing against each other to lower prices. But, in a marketplace where health insurers are required to sustain a minimum loss ratio, achieving that affordability through price competition will be difficult at best.

It’s also difficult when health underwriting is no longer permitted. In exchange for insuring all comers, Congress gave the insurance industry a sales guarantee: the PPACA includes a mandate for individuals to purchase health insurance and penalties for companies that do not offer it to their employees. It’s important to note, however, that a mandate to buy insurance doesn’t mean much if there is no affordable insurance to buy. A mandate to offer employee benefits is similarly onerous if the cost of the benefits is too great per employee to avoid the penalty.

Were MLR regulations to shrink the availability of insurers offering HSA-qualified HDHP plans, employers would have no choice but to offer higher-cost plans that would vastly increase the number of small businesses subjected to the penalty. And the math here is staggering: take the number of

employees (for companies of 50 or more, just like nHealth), add the number of hours each part-time employee works in a month and multiply the result by \$3,000.

That's the penalty for not providing qualifying benefits to your employees.

When talking to HHS or to the National Association of Insurance Commissioners (NAIC), the state regulatory group responsible for issuing the MLR rules, one has the feeling that all is going to be well in the end. The PPACA contains explicit prohibitions on writing rules that negatively affect competition, disadvantage small insurers relative to their larger cousins, or prevent new companies, like nHealth, from entering the market. So what went wrong?

nHealth's exit from the market exposed the unhappy truth that you can't legislate investor confidence. Merely creating the perception that the American health insurance industry is under attack has dissuaded all but the most knowledgeable investors from allocating capital to this sector.

These were the known consequences to the health insurance industry Democrats in Congress understood before casting their votes in favor of ObamaCare. The unknown consequences to the industry, arising from legislation reforming the financial sector, are just beginning to be understood.

One provision of S. 3217, the Restoring American Financial Stability Act, passed in the Senate, would impose a cap on the fee (known as the interchange fee) card issuers charge merchants to process transactions. The net effect of handicapping yet another well established financial utility is that so many of the insurance and employee benefit programs that use card technology – HSAs, HRAs, FSAs, state unemployment insurance programs, social security checks etc. – would have to revert to paper-based transactions, thereby shouldering all the additional costs such low tech systems entail.

Unable to offer electronic card solutions at the government's imposed price, insurers and the government itself will not be able to pay doctors or issue benefits through these facilities. Instead, the more expensive, less efficient technology of yesterday will supplant the 21st century systems banks have already developed.

For example, in 2001, electronic payments, including payments processed through card networks, cost about one third as much as a paper transaction. HHS reports a more dramatic disparity: According to HHS' Administration for Children and Families, the cost of sending a paper check is \$1.90; the cost of processing the same transaction electronically was just \$0.14, over 13 times less expensive.

According to the Network Branded Prepaid Card Association, the state of Maryland saved \$400,000 in check printing and mailing costs by dispensing unemployment benefits on prepaid debit cards. In 2008, the Treasury Department reported \$1.17 billion was loaded onto prepaid cards for 450,000 Social Security recipients, at a savings of more than \$0.90 per benefit payment.

The final irony: HHS awards very large grants, billions of taxpayer dollars, to develop electronic medical records. Moving from paper to the electronic world is so important that Dr. David Blumenthal, the Obama administration's National Coordinator for Health Information Technology says, "those who 'get on board' will be paid more by Medicare and Medicaid, beginning in 2011. But in 2016 the subsidies disappear and those still using paper records risk sanctions, including reduced Medicare fees."

Well.

The stated goals of the PPACA included making health care financing more efficient, making health insurance products more affordable and providing American consumers with more choice. It seems clear that forcing health insurers out of business through profit restrictions, and vastly increasing already high administrative costs by mandating paper-based transactions seems a step, maybe even a leap, in the wrong direction.

■ J.P. Morgan Released HSA Usage Report

J.P. Morgan recently released a report that details the usage, spending, and investment habits of its HSA holders. J.P. Morgan currently serves over 500,000 accountholders.

The report is based on 2009 activity. The following is an excerpt of its findings:

- 45% of accounts have balances over \$1,000 as of 12/31/09 compared to 35% at the end of 2008
- Accounts with higher cash balances are becoming more common. The percentage of accounts with balances under \$500 decreased from 50% at the end of 2008 to 42% in 2009. The percentage of accounts with balances over \$2,000 increased from 20% at the end of 2008 to 31% in 2009
- 68% of accountholders contributed more than they spent during each month in 2009
- The average account contribution in 2009 was \$1,816
- Most transactions (70%) are sign for purchase transactions done via a card
- The average spend or distribution per HSA in 2009 was \$1,305, or \$109 per month
- While purchases at drugstores resulted in the highest volume of transactions per account, hospitals and dental expenses had the highest average dollar amount per transaction (\$212 and \$194 respectively)
- Most investment dollars were held in equity mutual funds (52%)

[Read the Full Report: follow link to Report under Related Info on the right hand side.](#)

HSA Update is edited by Kevin McKechnie, ABIA executive director, and Renee Galbraith, health policy manager. Please visit our Web site for daily news updates, in-depth legislative analysis, and resources for implementing HSAs. www.hsacouncil.com

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