

ISSUE BRIEF

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Obamacare's Cost Sharing Is Too High, Even for HSAs

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The Affordable Care Act (ACA, also known as Obamacare) changed the individual insurance market in ways that altered the customer mix significantly, as well as the availability and design of insurance plans.¹ Previously, the primary customers for individual market insurance were Americans who were either self-employed or buying coverage between jobs. They were mainly seeking financial protection for possible future medical expenses. After Obamacare, the primary customers became individuals seeking subsidized insurance to pay for their current medical expenses. That skewed the post-ACA individual market toward a risk pool consisting of older, less-healthy, and costlier-to-insure individuals.

In response to these changing market dynamics, insurers changed the design of their plans, including by charging patients higher deductibles and increasing plan out-of-pocket maximums.² In many cases, insurers increased out-of-pocket limits on plans as high as the maximums allowed by the ACA (\$7,350 for self-only coverage, and \$14,700 for family coverage in 2018).³

These changes are widespread throughout the Obamacare markets. More than half of all plan designs (54.7 percent) in the 39 states using the federally run exchange (Healthcare.gov) set out-of-pocket limits at the maximum allowed by the ACA.

Cost-sharing limits are set at the maximum level allowed in all Catastrophic-level plans; 51 percent of Bronze-level plan designs; 58 percent of Silver-level plan designs, and 41 percent of Gold-level plan designs.

One result: Numerous Obamacare plans now have out-of-pocket limits that are higher than the amount that the federal law allows in order for a plan to be paired with a health savings account (HSA). HSAs allow individuals to set aside money tax-free to pay medical costs. Consumers effectively get a discount on the cost of their medical care whenever they can avoid paying tax on the money used to purchase that care.

Congress specified that for a plan to be HSA-compatible, it must have a deductible that is no lower than the minimum set in law, and a limit on total out-of-pocket costs that is no higher than the maximum set in law. In 2018, the deductible must be at least \$1,350 for self-only coverage or \$2,700 for family coverage, and the annual out-of-pocket limit must not be greater than \$6,650 for self-only coverage or \$13,300 for family coverage.

Most Obamacare Plans' Cost Sharing Is Too High to Be HSA-Compatible. Because Obamacare's maximum out-of-pocket limits are higher than those for HSA-compatible plans, over half (57 percent) of all plan designs now offered on Healthcare.gov have out-of-pocket maximums that are too high for the plan to qualify as HSA-compatible. Only 30 percent of plans sold on the federal Obamacare exchange meet the criteria of having both a high-enough deductible and a low-enough out-of-pocket limit to qualify as HSA-compatible. Of the other, non-HSA-qualified plans, 19 percent do not

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CHART 1

Few Obamacare Plans Are HSA-Compatible

SHARE OF OBAMACARE PLANS IN 2018



SOURCE: Author's calculations based on data from HHS Individual Market Landscape from Healthcare.gov.

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qualify because their deductibles are too low, while 81 percent do not qualify because their out-of-pocket limits are too high.

Most Obamacare HSA Plans' Deductibles Are Higher than the Contribution Limit. Under most of Obamacare's HSA-qualified plan designs, the enrollee cannot make a tax-free contribution to the account that would be large enough to cover the plan's annual deductible. Of the HSA-qualified plan designs offered in the 39 Healthcare.gov states, 52 percent have deductibles for self-only coverage that are higher than the maximum allowable HSA contribution amount of \$3,450, and 61 percent have deductibles for family coverage that are higher than the maximum allowable HSA contribution amount of \$6,900. One-quarter of the HSA-qualified plan designs on Healthcare.gov have deductibles set at, or near, the maximum out-of-pocket limit.⁴

In contrast, annual deductibles for workers with employer-sponsored HSA plans averaged \$2,433 for self-only coverage, and \$4,647 for family coverage in 2017.⁵ So, on average, workers in employer-sponsored

HSA plans can cover their entire deductible with pre-tax contributions to their HSAs.

Under Obamacare, Insurers Are Constraining HSA-Plan Provider Networks. Insurers have also responded to escalating claims costs by narrowing provider networks. During the 2015 plan year, 54 percent of plan offerings had more restrictive networks, and by 2018 that figure has increased to 73 percent.⁶ HSA-qualified plans follow a similar pattern: 73 percent of HSA-qualified plans also have more restrictive networks this year. (See Chart 2.)

This constriction is something of an anomaly. Prior to Obamacare, insurers generally offered—and customers generally expected—a rough trade-off in plan design to provide customers value for their purchase. Typically, plans with higher out-of-pocket costs offered a broader choice of providers, while plans with limited provider choice offered lower out-of-pocket costs. However, Obamacare has managed to force insurers into offering plans characterized by both limited provider choice and high out-of-pocket costs.

1 Obamacare imposed new regulations and benefit mandates on the individual health insurance market, and provided substantial subsidies for low-income individuals to purchase health insurance through new, government-run exchanges.

2 The other significant changes were increased premiums and narrowed provider networks.

3 Centers for Medicare & Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program," *Federal Register*, Vol. 81, No. 246 (December 22, 2016), p. 94140.

4 Specifically, 26 percent of HSA-qualified plan designs carry deductibles for self-only coverage of \$6,000 to \$6,650, and deductibles for family coverage of \$12,000 to \$13,300.

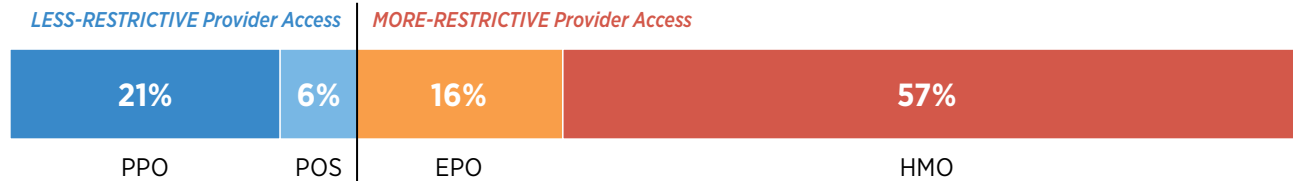
5 Kaiser Family Foundation, "2017 Employer Health Benefits Survey," September 19, 2017, Figure 8.7, <https://www.kff.org/report-section/ehbs-2017-section-8-high-deductible-health-plans-with-savings-option/> (accessed May 31, 2018).

6 Caroline F. Pearson and Elizabeth Carpenter, "Plans with More Restrictive Networks Comprise 73% of Exchange Market," Avalere, November 30, 2017, <http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market> (accessed May 31, 2018).

CHART 2

Most Obamacare Plans Restrict Provider Access

SHARE OF OBAMACARE PLANS IN 2018



PPO—Preferred Provider Organization EPO—Exclusive Provider Organization
POS—Point of Service HMO—Health Maintenance Organization

SOURCE: Author's calculations based on data from HHS Individual Market Landscape from Healthcare.gov.

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Some Obamacare Markets Have No HSA Plans. For the past three years, insurer choice and competition in the Obamacare exchanges have been shrinking—to the point that half of all U.S. counties now have only one insurer that offers exchange coverage.⁷ That diminished choice is also reflected at the plan level. This year, of the 39 states using Healthcare.gov, six have counties in which no HSA-qualified plans are available. (See Table 1.)

Solutions. Obamacare's provisions are driving the disconnects discussed above. As with escalating premiums and narrowing provider networks, higher plan deductibles and out-of-pocket maximums are manifestations of the basic flaws in Obamacare's public policy architecture. The only way to reverse that is for Congress to get back to work on repairing the damage done to the individual insurance market by Obamacare.

As part of that effort, Congress should expand individuals' ability to choose a HSA-qualified plan by changing some statutory requirements. Proposals that might alleviate some of these issues include increasing tax-free contribution limits for HSAs to equal the maximum out-of-pocket limits.⁸ Another idea would be to define compatible coverage in terms of actuarial value instead of minimum deductibles and maximum out-of-pocket limits.⁹ In other words, rather than setting parameters for cost sharing, as

TABLE 1

States with Counties that Do Not Have Any HSA-Compatible Plans on the Exchange

State	Total Counties	Counties without HSA-Compatible Plans	
		Number	Percent
Missouri	115	7	6%
Ohio	88	6	7%
Oklahoma	77	20	26%
Pennsylvania	67	20	30%
Tennessee	95	5	5%
Virginia	134	13	10%

SOURCE: Author's calculations based on data from HHS Individual Market Landscape from Healthcare.gov.

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the law currently does, plans could qualify as HSA-compatible if they covered no more than a specified percentage of the expected medical expenses of a sta-

7 Edmund F. Haislmaier, "2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink," Heritage Foundation *Issue Brief* No. 4813, January 25, 2018, https://www.heritage.org/sites/default/files/2018-01/IB4813_1.pdf.

8 S. 403, "Health Savings Act of 2017," Section 405.

9 Roy Ramthun, "Moving to a More Flexible Standard for HSAs," HSA Consulting Services, 2018, <https://www.aba.com/Advocacy/Issues/Documents/Moving-More-Flexible-Standard-HSAs.pdf> (accessed May 31, 2018).

tistically standard pool of enrollees. For instance, a plan with a 70 percent actuarial value is one that can be expected to pay 70 percent of the cost of covered benefits for a typical enrollee. So, the law could be changed to say that any plan with an actuarial value of, say, 70 percent or less, would qualify to be used with an HSA. Such a change would permit a wider range of plan designs to qualify as HSA-compatible.

Making America's Health Care System Work for Patients

Americans' health insurance choices have been narrowed under Obamacare. Addressing the problems outlined in this *Issue Brief* would be a good, incremental step to improve access to HSA-qualified plans that offer quality coverage. Further changes will be needed to fully empower patients, lower costs, and expand choices.

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