National Association of Benefits and Insurance Professionals

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State Toolkit - HDHP/HSA Eligibility Issue

The Problem

Many prescription-drug manufacturers offer various forms of financial assistance to patients to reduce their out-of-pocket costs, mainly for the most expensive drugs. One form of these assistance programs is the copay accumulator program. Savings from copay accumulator programs are currently excluded from counting toward a health plan enrollee's annual cost-sharing limit (such as a deductible in a high-deductible health plan, or HDHP). It also does not generally count as money spent by enrollees toward their out-of-pocket maximum.

To assist consumers with these costs, bills are being considered by state legislatures across the country that would require this financial assistance to count toward a participant's cost-sharing amount. This would also mean, for example, that the assistance from copay accumulator programs would count toward the deductible for those enrolled in HDHPs.

Unfortunately, these bills – if passed as customarily written – would make any individuals covered by HDHPs who utilize these accumulator programs ineligible to contribute to a health savings account, or HSA. According to the IRS, individuals with an HSA must pay the full amount of their healthcare without discounts until they meet the deductible; this was clarified in Q&A-9 of IRS Notice 2004-50. This means that any state law allowing individuals to use the adjustment program (or any discount cards) towards their deductible is in direct conflict with federal law – and anyone with a HDHP-HSA plan will no longer be eligible to utilize their HSA.

Pennsylvania, Arizona, Arkansas, Connecticut, Georgia, Illinois, Kentucky, Louisiana, Oklahoma, Tennessee, Virginia, and West Virginia have enacted or considered similar legislation.

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The Solution

The National Council of Insurance Legislators (NCOIL), which every state is a member of, released model legislation with amendment language that would ensure that the bill does not apply to those enrolled in HDHP-HSA plans who have not already met their deductibles.

1. When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [CARRIER/INSURER/ISSUER] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person for a prescription drug that is either:
    a. without a generic equivalent; or
    b. with a generic equivalent where the enrollee has obtained access to the prescription drug through any of the following:
        i. prior authorization
        ii. a step therapy protocol
        iii. the health care insurer's exceptions and appeals process.
2. A person that pays any amount on behalf of an enrollee for a covered prescription drug:
    a. must notify the enrollee prior to the acceptance of the financial assistance of the total amount of assistance available and the duration for which it is available; and
    b. may not condition the assistance on enrollment in a specific health plan or type of health plan, to the extent permitted under federal law.
3. If under federal law, application of subsection (A) would result in Health Savings Account ineligibility under section 223 of the federal Internal Revenue Code, this requirement shall apply only, for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of subsection (A) shall apply regardless of whether the minimum deductible under section 223 has been satisfied.