Testimony of J. Kevin A. McKechnie
Executive Director, HSA Council,
American Bankers Association
Washington, DC

Executive Summary

Under current law, roughly 26 million Americans take advantage of the savings benefits of a Health Savings Account (HSA) offered through a qualified High Deductible Health Plan (HDHP). However, it is estimated that each American will need $180,000 in retirement for healthcare expenses alone.[1] In addition, a recent survey conducted by HSA Bank, revealed an alarming 40% of Americans never save money specifically for future healthcare expenses.[2]

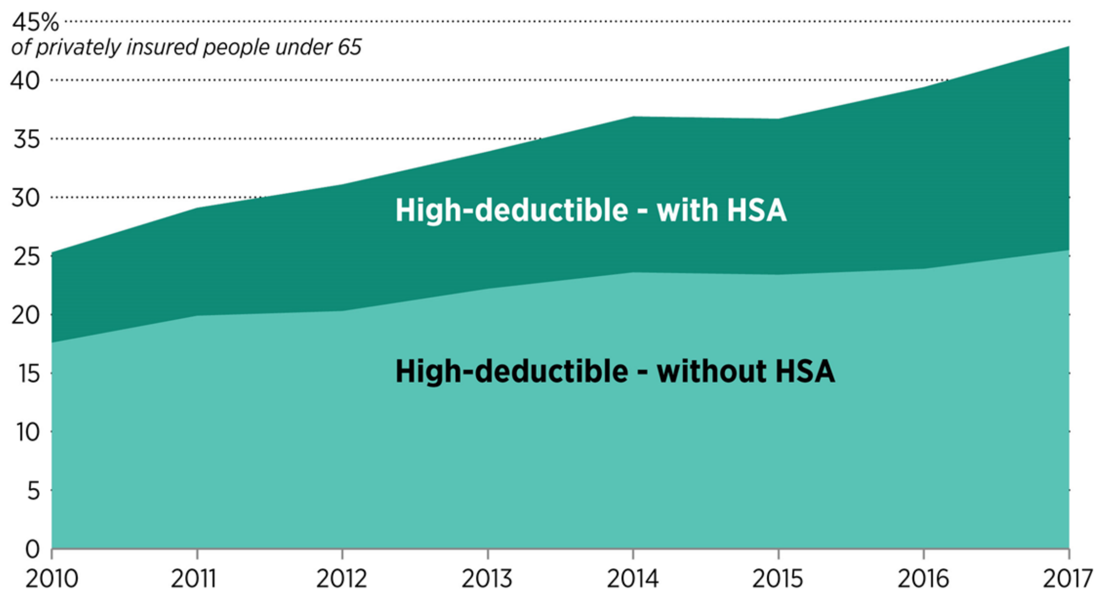
HSAs are the only health account in the United States that allows people to save for future healthcare needs tax-free and pay for current out-of-pocket costs tax-free. Realizing the potential for immediate savings, the National Conference of Insurance Legislators (NCOIL) passed a resolution in 2018 encouraging states to defend state-regulated HDHPs from state legislation at odds with federal HSA regulations. The resolution passed unanimously. Connecticut is a current NCOIL member; its elected officials serve on NCOIL Committees.

We are also encouraged by recent bipartisan legislation that would improve the flexibility of HSA-qualified insurance plans recently approved by the Ways & Means Committee in the U.S. House of Representatives.

Health Savings Accounts in Demand

Signed into law in 2003, Health Savings Accounts (HSAs) were created to help individuals covered under a compatible health plan, often referred to as a High Deductible Health Plan (HDHP), set aside funds on a tax-free basis to pay for certain medical expenses when faced with paying a high deductible. This can significantly reduce the burden of high out-of-pocket costs.

Looking more broadly at American's health insurance coverage throughout the year, the National Business Group on Health shows that enrollment in consumer-driven health plans has grown by about seventy percent (70%) over the past seven years. Enrollment in HSA-qualified plans has also doubled during this same time. Estimates vary, but approximately one-third of employees are now enrolled in consumer-driven health plans. In fact, nine in ten large employers (90%) offered at least one consumer-driven health plan in 2019, and the most common design was the HDHP paired with an HSA for eighty percent (80%) of employers with any type of consumer-driven health plan. Despite this growth, many more Americans are enrolled in other plans with high deductibles that do not make them eligible for an HSA.



Narrowing Gap of Deductible Amounts

The average health plan deductible today qualifies most health plans as a Health Savings Account (HSA) compatible plan. And as such, the requirement for an individual to have coverage under a High Deductible Health Plan (HDHP) has lost its relevancy.

At the beginning of the program in 2004, a HDHP had a deductible of $1,000 for individual coverage. Now, as governed by Internal Revenue Code (IRC) Section 223, the minimum deductible for an HSA-qualifying plan is $1,400 for individual coverage in 2020. The minimum deductibles are adjusted annually for inflation[3] and have clearly increased modestly since 2004. As premiums have risen, employers and insurance carriers have increased deductibles almost annually in an effort to moderate year-over-year premium increases.

With that said, there is a narrowing gap of deductible amounts associated with HDHPs as compared to Preferred Provider Organizational (PPO) plans and almost all other types of health plans. The average deductible for individual plans of all types is currently $1,655. Effectively, this means that the average health plan deductible for all types of plans exceeds the IRS minimum deductible threshold for HDHPs, and has done so for more than five years.

For 2020, the minimum deductible to for an HSA-qualifying plan is $1,400, for individual coverage, and $2,800 for family coverage.

According to the 2019 Kaiser Family Foundation Employee Benefit Survey (KFF), over the past five years, the average annual deductible amongst all covered workers has increased 36%, yet in that same time frame, the average HDHP deductible has risen only 12%.

HSA qualified HDHP deductibles have risen even slower during the same time period. The average deductible for single plans has risen 12% while the average for family plans has risen only 6%. No other type of health insurance can make this claim.

In my opinion, one of the main contributors to the relative stability of HSA-qualified plan deductibles vs. the astonishing rise in deductibles in traditional plans is that the deductibles of traditional plans have increased largely so that plan sponsors can attempt to restrain premium increases at a rate lower than they otherwise would be, if deductibles were static.

The KFF data substantiates this claim - over a 10 year period, the average deductible of HSA qualified health plans increased only 29% for single plans, and 25% for family plans, while the average plan deductible for traditional health plans has more than doubled – an increase in excess of 100%.

Preventative Care Services Covered

Some benefits may be covered before the deductible is met, such as preventive care services.

In 2010, the Affordable Care Act (ACA) borrowed this concept from HSAs and made coverage of preventive care services a requirement for all health plans regardless of deductible, including self-insured employer-sponsored plans. In July 2019, the Internal Revenue Service expanded the definition of "preventive care services" to include coverage of certain medical services or items for individuals with chronic conditions. Although employers and insurance carriers are not required to offer these additional services, the flexibility will allow them to address concerns that individuals with chronic conditions might face higher costs in the long-term by not accessing services that help them maintain their health status and avoid complications or worsening of their conditions.

Annual Limits Required

HSA-qualified plans are required to have an annual limit on out-of-pocket expenses. This better protects Americans from inflation and ultimately more costs.

At the beginning of the program in 2004, the annual limits for HSA-qualified plans were no more than $5,000 for individual coverage. After inflation, these limits have increased modestly since 2004. For 2020, these amounts will rise to $6,900 for individual coverage. In comparison, the out-of-pocket limit for a Marketplace plan is $8,200 for an individual.[4] If a health insurance plan does not limit annual out-of-pocket expenses to these or lower amounts for 2020, it cannot be an HSA-qualified plan.

In 2014, the Affordable Care Act (ACA) out-of-pocket limits were on par with HSA out-of-pocket limits. However, the annual inflation adjustment factor used to adjust the ACA limits is the medical component of the consumer price index (M-CPI), whereas the HSA-qualified plans limits have since been adjusted by general inflation (i.e., CPI, and more recently chained-CPI). Thus, the ACA out-of-

pocket limits have risen much faster than the HSA limits. For example, for 2020 the ACA out-of-pocket limits are $8,150 for individual coverage, which is $1,250 higher than the HSA limits.

This means that HSA-qualified plans provide better protection against high medical expenses than the ACA requires and will continue to do so as these amounts diverge further.

Rising Healthcare Costs Can be Alleviated

The HSA Council believes that bipartisan efforts are needed to address rising out-of-pocket healthcare costs that impact Americans now and into retirement. With the large retirement savings gap in place, we believe Health Savings Accounts (HSAs) are the best solution to help alleviate this concern.

Health View Services estimates that a couple retiring today can expect to pay over $360,000 to cover medical expenses in retirement – including Medicare and long-term care insurance premiums.[1] HSAs are the only triple-tax advanced account in existence, meaning funds are contributed tax free, grow tax-deferred and can be withdrawn tax free to pay for IRS-qualified medical expenses during an individual's working years and in retirement. This is a significant advantage over traditional retirement options, which are subject to income tax when withdrawn.

Continue to Build Positive Change

While small changes are being made to help alleviate current healthcare expenses, there is still more to be done.

In the U.S. House of Representatives, the House Ways & Means Committee recently passed bipartisan legislation to do just that by allowing Health Savings Accounts to work with direct primary care arrangements (H.R. 3708), allowing Health Savings Account funds to be used to pay for the costs of over-the-counter drugs and medicines without a prescription (H.R. 1922), and allow HSA-qualified plans to cover the cost of inhalers and their associated medications without application of the policy deductible (H.R. 4716).

This latter piece of legislation builds on updated guidance by the Internal Revenue Service in July 2019 allowing HSA-qualified plans to cover certain medical services and items below the deductible for individuals with chronic conditions.

This change is expected to be a boon for Americans who suffer from chronic conditions and have a HDHP with an HSA. Although employers and insurance carriers are not required to offer these additional services, the flexibility will allow them to address concerns that individuals with chronic conditions might face higher costs in the long-term by not accessing services that help them maintain their health status and avoid complications or worsening of their conditions.

Additionally, last year the National Conference of Insurance Legislators (NCOIL) passed a resolution calling on states to preserve HSAs and their associated HSA-qualified high deductible health plans by refraining from enacting new mandates that threaten their existence because they conflict with federal rules for Health Savings Accounts.

Proposed CT Senate Bills

Our understanding is that the Connecticut legislature, like many states, is wrestling with how best to address many of the same issues as Congress and has proposed two bills - Senate Bill 28 and Senate Bill 902 – attempting to restrain HDHPs. I have reviewed these proposals and should point out that they do not follow the NCOIL resolution and risk harming the only health plans that help Americans lower their out-of-pocket costs and take control of their retirement savings - Health Savings Accounts.

Senate Bill 28

Although well-intentioned, Senate Bill 28 targets only one insurance product – HSA-qualified high deductible health plans. If the problem is high out-of-pocket costs, clearly non-HSA plans also meet this definition without the advantage of allowing expenses to be paid pre-tax. In addition, the bill would off-load business risk from health care providers to insurance companies for the cost of covered benefits below the policy deductible. I would imagine every business, not just medical practices, would like their state's help to off-load their business risk onto other entities. I don't see how it makes any economic sense to do this for just HSA-qualified high deductible health insurance plans.

Senate Bill 902

Like Senate Bill 28, Senate Bill 902 also targets only one insurance product – HSA-qualified high deductible health plans. It should also be noted that existing guidance from the Internal Revenue Service (IRS Notice 2004-50, Q&A 22-24) already allows HSA-qualified plans to provide credit for costs incurred earlier in the year under a prior plan. If the Connecticut legislature intends to mandate this process, it should not single out HSA-qualified high deductible health plans. In addition, any pro-ration of deductibles must be permitted in such a way that HSA-qualified plans can meet federal rules for Health Savings Accounts.

We interpret subsection (b)(2) (i.e., lines 50-53) to preclude HSA-qualified plans from applying family deductibles where appropriate, thereby needlessly disqualifying HSA-qualified plans from using appropriate deductibles for non-single coverage. Although subsection (c) includes language intended to provide an exemption, we are not convinced that the language in subsection (c) accomplishes this objective.

We review proposals just like this one from many states for compliance with federal HSA rules. We are pleased to provide what counsel the legislature deems appropriate if it would be helpful.

Conclusion

Americans are working longer, saving less, and facing higher out-of-pocket costs than ever before. HSAs are the only health account in the country that provides an opportunity to save tax-free for future healthcare needs. It is also the only health account in the country that allows current out-of-pocket expenses to be paid pre-tax. We strongly encourage states to embrace their potential for providing residents with an immediate savings instead of singling them out, unfairly, as the problem. Bi-partisan legislation in Congress, far from restricting HSAs, is expanding their utility and even proposing to coordinate them with government programs like Medicare, TRICARE, VA benefits and Indian Health

Service programs. Congress is acting to preserve and improve Health Savings Accounts (HSAs) to help millions more Americans benefit from this tax-free health savings vehicle.

[1] "HealthView Services 2019 Retirement Healthcare Costs Data Report." *HealthView Services*. 2019. *HealthView Services.* 9 May 2019. http://www.hvsfinancial.com/2019/09/21/2019-retirement-health-care-costs-data-report/

[2] "HSA Bank Health and Wealth Index[SM]." *HSA Bank.* March 19, 2019. http://www.hsabank.com/hsabank/learning-center/index2019

[3]Initially, the inflation adjustment factor was the consumer price index (CPI) but this has now been changed to chained-CPI as a result of the tax reform law enacted in December 2017.

[4] https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

IRS Notice 2004-50, Q&A 22-24

Q-22. If an employer changes health plans mid-year, does the new health plan fail to satisfy section 223(c)(2)(A) merely because it provides a credit towards the deductible for expenses incurred during the previous health plan's short plan year and not reimbursed?

A-22. No. If the period during which expenses are incurred for purposes of satisfying the deductible is 12 months or less and the plan satisfies the requirements for an HDHP, the new plan's taking into account expenses incurred during the prior plan's short plan year (whether or not the prior plan is an HDHP) and not reimbursed, does not violate the requirements of section 223(c)(2)(A).

Example. An employer with a calendar year health plan switches from a non-HDHP plan to a new plan with the first day of coverage under the new plan of July 1. The annual deductible under the new plan satisfies the minimum annual deductible for an HDHP under section 223(c)(2)(A)(i) and counts expenses incurred under the prior plan during the first six months of the year in determining if the new plan's annual deductible is satisfied. The new plan satisfies the HDHP deductible limit under section 223(c)(2)(A).

Q-23. If an eligible individual changes coverage during the plan year from individual HDHP coverage to family HDHP coverage, does the individual (or any other person covered under the family coverage) fail to be covered by an HDHP merely because the family HDHP coverage takes into account expenses incurred while the individual had individual coverage?

A-23. No.

Example. An eligible individual has individual coverage from January 1 through March 31, marries in March and from April 1 through December 31, has family coverage under a plan otherwise qualifying as an HDHP. The family coverage plan applies expenses incurred by the individual from January through March toward satisfying the family deductible. The individual does not fail to be covered by an HDHP. The family coverage satisfies the deductible limit in section 223(c)(2)(A)(i)(II). The individual's

contribution to an HSA is based on three months of the individual coverage (*i.e.*, 3/12 of the deductible for the individual coverage) and nine months of family coverage (9/12 of the deductible for family coverage).

Q-24. How are the minimum deductible in section 223(c)(2)(A) for an HDHP and the maximum contribution to an HSA in section 223(b) calculated when the period for satisfying a health plan's deductible is longer than 12 months?

A-24. The deductible limits in section 223(c)(2)(A) are based on 12 months. If a plan's deductible may be satisfied over a period longer than 12 months, the minimum annual deductible under section 223(c)(2)(A) must be increased to take into account the longer period in determining if the plan satisfies the HDHP deductible requirements. The adjustment will be done as follows:

(1) Multiply the minimum annual deductible in section 223(c)(2)(A)(i) (as adjusted under section 223(g)) by the number of months allowed to satisfy the deductible.

(2) Divide the amount in (1) above by 12. This is the adjusted deductible for the longer period that is used to test for compliance with section 223(c)(2)(A).

(3) Compare the amount in (2) to the plan's deductible. If the plan's deductible equals or exceeds the amount in (2), the plan satisfies the requirements for the minimum deductible in section 223(c)(2)(A). (Note that the deductible for an HDHP may not exceed the out-of-pocket maximum under section 223(c)(2)(A)(ii).)

If the plan qualifies as an HDHP, an eligible individual's maximum annual HSA contribution will be the lesser of the amounts in (1) or (2) below:

(1) Divide the plan's deductible by the number of months allowed to satisfy the deductible, and multiply this amount by 12;

(2) The statutory amount in section 223(b)(2)(A)(ii) for individual coverage ($2,600 in 2004) or section 223(b)(2)(B)(ii) for family coverage ($5,150 in 2004), as applicable.

Example. For 2004, a health plan takes into account medical expenses incurred in the last three months of 2003 to satisfy its deductible for calendar year 2004. The plan's deductible for individual coverage is $1,500 and covers 15 months (the last three months of 2003 and 12 months of 2004). To determine if the plan's deductible satisfies section 223(c)(2)(A) the following calculations are performed: (1) multiply $1,000, the minimum annual deductible in section 223(c)(2)(A)(i), by 15, the number of months in which expenses incurred are taken into account to satisfy the deductible, = $15,000; (2) divide $15,000 by 12 = $1,250; (3) The HDHP minimum deductible for individual coverage for 15 months must be at least $1,250. Because the plan's deductible, $1,500, exceeds $1,250, the plan's individual coverage satisfies the deductible rule in section 223(c)(2)(A). The maximum annual HSA contribution in 2004 for an eligible individual with individual coverage under these facts is $1,200, the lesser of (1) ($1,500/15) X 12 = $1,200; or (2) $2,600.

Source: https://www.irs.gov/irb/2004-33_IRB#NOT-2004-50)