

December 27, 2019

Ted Doolittle, State Healthcare Advocate
Chairman, High Deductible Health Plan Task Force
Office of the Healthcare Advocate
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By email to Ted.doolittle@ct.gov

Dear Chairman Doolittle:

Thank you for the opportunity to testify before the Task Force in November and thank you for allowing me to clarify and amplify upon my remarks.

Preventive Care

Question #1: "It was asked whether a state mandate for first-dollar coverage of the listed treatments would be compatible with HSA-qualified plans. You answered that it would not because mandating those treatments would make them non-optional and that the IRS guidance specifies that first-dollar coverage of the listed treatments must be optional. We are interested in the analysis that supports that answer. Can you share any work that the ABA has or is aware of which makes clear that this coverage must be optional to the insurer and may not be mandated by a state?"

Let me attempt to clarify what I meant. The HSA statute and IRS guidance ([Notice 2004-23](#) and [Notice 2004-50](#)) created a "safe harbor" for coverage of preventive services without application of a deductible. This means that a health insurance plan will not fail to be treated as an "HSA-qualified" insurance plan merely because it provides first-dollar coverage of preventive services. This is the only exception provided to the general requirement that HSA-qualified plans apply a minimum deductible to all benefits covered by the plan and the source of the theory that preventive services coverage is optional.

Later, the authors of the Affordable Care Act (ACA) borrowed this feature from HSAs and mandated first dollar coverage of preventive services for all health insurance plans in the U.S. (except for grandfathered plans). The ACA further mandated first-dollar coverage for a specific set of preventive services; however, the ACA mandate went beyond the original IRS safe harbor for preventive services for HSA-qualified plans.

Consequently, the IRS clarified that the safe harbor for HSA-qualified plans included the ACA-mandated preventive services.¹

However, it is important to understand that the original IRS guidance (Notice 2004-23) also stated that “preventive care” for HSA-qualified plans did not include “any service or benefit intended to treat an existing illness, injury, or condition.” That changed this past summer when the IRS ([Notice 2019-45](#)) for the first time expanded the preventive care safe harbor for HSA-qualified plans only to include services that treat an existing chronic condition.

This allows, but does not mandate, HSA-qualified plans to cover specific services provided to individuals with specific chronic conditions without application of the policy deductible and, therefore, retain their status as “HSA-qualified” plans. Further, it “does not treat these services and items as preventive care required to be provided without cost sharing for purposes of [Section 2713 of the PHS Act \[the Affordable Care Act\]](#).”

IRS Notice 2019-45 does not address whether coverage of the services listed in the Appendix to the Notice may be mandated by a state. However, IRS Notice 2004-23 explains that “state law requirements do not determine whether health care constitutes preventive care under section 223(c)(2)(C).” This policy was reiterated in [IRS Notice 2018-12](#), which further states that,

“the determination whether a health care benefit that is required by state law to be provided by an HDHP without regard to a deductible is ‘preventive’ for purposes of the exception for preventive care under section 223(c)(2)(C) is based on the standards set forth in guidance issued by the Treasury Department and the IRS, rather than on how that care is characterized by state law.”

Proposal to Force Health Insurers to act as Lenders

Question #2: “Some stakeholders on the Task Force are interested in a proposal to require insurers, rather than providers, to assume the credit risk for services provided before the deductible is met. How this would work is that the insurer would advance the money to the provider and then collect or attempt to collect the deductible from the member/patient. Several members of the task force, on both sides of this issue, asked you about this arrangement, but, perhaps because of how the questions were phrased, the task force did not come away with a clear understanding whether such an arrangement would be compatible with HSA-qualified plans.”

¹ See IRS Notice 2013 - 57

Requiring insurers to also act as lenders – and observe all the relevant regulatory requirements and consumer disclosures inherent in being a lender – seems likely to exacerbate consumer confusion and expense instead of relieving either. The added compliance burden of acting as a lender would inevitably – and perhaps dramatically – increase insurance costs as insurers would have to contend with another layer of regulation in addition to their already comprehensive responsibilities under federal and state law.

Were a state to require health insurers to assume providers' credit risk for the cost of non-preventive medical services provided to consumers before their deductible is met would, in my view, cause a large, unresolvable problem. I believe state mandates of this kind would be viewed as a violation of the HSA statute's requirement that a minimum deductible be applied to all covered benefits (except preventive care). By advancing money to the provider, the insurer could be viewed as providing "coverage" below the minimum deductible, which, were insurers to do so, would risk disqualifying plans of insurance as HSA compatible and by extension, *disqualifying all of the state residents covered by them as eligible to contribute to their HSAs*.

The HSA Council has seen this before, in other states. If it is determined that a previously approved plan of insurance was HSA-qualified, and a subsequent state action invalidates that status, consumers covered by the plan are no longer eligible to contribute to their account; and, consumers may be liable for taxes and penalties on any money contributed in that tax year.

Consumers then usually must find replacement health insurance coverage, which by definition, is more expensive.

As I hope I said many times during my testimony, HSAs offer consumers the chance to pay for medical services tax-free; no other health insurance plan in America offers that benefit.

Question #3: May an insurer extend what is essentially credit to a member for services provided before a deductible is met, in an HSA-compatible plan?

I am unaware of any federal restriction prohibiting an insurer from also being a lender if the insurer so chooses; however, I am also unaware of laws – federal or state - compelling insurers to extend credit to members if they don't want to. It would be highly unusual for a state to compel an insurer to be creditor. Becoming a creditor is universally understood to be a voluntary, not an unwilling, position in a financial transaction.

As I also explained above, I believe mandating credit extensions would be viewed as a violation of the HSA statutory requirement that a minimum deductible be applied to all covered benefits (except preventive care). By advancing the money to the provider, the insurer could be viewed as providing "coverage" below the minimum deductible.

Question #4: Would a member's payment to the insurer, rather than the provider, for services provided before a deductible is met, be a qualifying medical expense that could be paid by an HSA?

While there is no clear guidance from the IRS on this matter, please keep in mind how unusual this requirement would be. For example, when a mechanic fixes your car, your auto insurer doesn't owe the mechanic money, you do. How enthusiastic would auto insurers be to continue doing business in a state that required them to pay mechanics who repaired cars for the drivers they insure without a dramatic increase in premium to offset the expense?

This is the underlying question I addressed in November: is the issue under debate the dynamics of High Deductible Health Plans (HDHPs), which by definition only exist in conjunction with tax-advantaged Health Savings Accounts (HSAs); or, is the issue around the financial dynamics of health plans that have relatively high deductibles, an entirely different matter?

The 2019 Kaiser Family Foundation Employee Benefit Survey (KFF) says that the average deductible for individual plans of all types is currently \$1,655. Accordingly, the average health plan deductible today could qualify most health plans as HSA compatible. At the beginning of the program in 2004, a HDHP had a deductible of \$1,000 for individual coverage.

In 2020, sixteen years later, as governed by Internal Revenue Code (IRC) Section 223, the minimum deductible for an HSA-qualifying plan is \$1,400 for individual coverage and \$2,800 for family coverage.

Over the past five years, the average annual deductible amongst all covered workers has increased 36% while HSA qualified HDHP deductibles have risen much slower; 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.

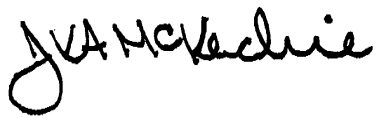
In my opinion, the main contributors to the relative stability of HSA-qualified plan deductibles vs. the astonishing rise in deductibles in traditional plans is that the deductibles of traditional plans have increased largely in order to restrain premium increases.

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 well in excess of 100%. If the Task Force has issues with high deductibles it is to this market segment that I suggest you look.

The value proposition of HSAs is simply this: being able to pay rising out-of-pocket costs tax-free and the ability to save for future medical expenses tax-free as opposed to having to pay state and federal taxes before paying your doctor's bill.

We look forward to assisting the Task Force in its work and remain at your service.

Sincerely,

A handwritten signature in black ink, reading "J. Kevin A. McKechnie". The signature is written in a cursive, flowing style with a large initial "J" and "K".

J. Kevin A. McKechnie
Executive Director