

June 4, 2009

The Honorable Max Baucus  
The Honorable Chuck Grassley  
United States Senate  
Washington, D.C. 20510

VIA E-MAIL

Dear Chairman Baucus and Ranking Member Grassley,

Thank you for the opportunity to comment on the proposed health care reform financing policy options. The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, Health Savings Account (HSA) and senior markets. CAHI's membership includes insurance companies, small businesses, providers, nonprofit associations, actuaries, insurance brokers and individuals. Since 1992, through peer-reviewed research and advocacy efforts in the states and Washington, D.C., CAHI educates lawmakers and regulators about the results, positive or negative, of health care reform measures.

CAHI members support the general principles for health reform established by the Committee and by the President. We believe consumer-driven health plans such as Health Savings Accounts (HSAs) play an important role in achieving these goals. However, we believe that some of the Committee's proposals are at odds with the goals stated by the Committee and by the President. We are concerned that the more than 8 million Americans now covered by HSAs could lose their ability to finance their health care, both current and future, through HSAs.

### **Annual HSA Contribution Limits**

The Committee proposes to limit the annual HSA contribution amount to the lesser of the individual's deductible under his or her qualified high deductible health plan (HDHP) or the maximum allowable contribution set annually by the IRS under current law. However, the provision would penalize Americans with HSAs that have chronic conditions or high health care expenses as well as limit the ability to save for future health care expenses during periods of unemployment or in retirement. Finally, we believe this provision would be unnecessary if there is an annual limit on the tax exclusion for health care benefits (e.g., insurance plus HSA contributions) that can be obtained tax-free through employers.

One reason to permit HSA contributions in amounts greater than the insurance deductible is that there are many qualified medical expenses that are not covered by health insurance, or that may continue once the deductible is satisfied. Examples would include coinsurance for hospitalizations, prescription drugs and specialty care, all of which can be both substantial and unpredictable. The ability to save for them in a HSA is important for

many Americans. This limitation would primarily impact individuals with chronic conditions and higher than average health care expenses.

The ability to put aside additional dollars that are to be used to pay for health care expenses during periods of unemployment is especially important in the current economy. For example, HSA funds can be used to pay premiums for COBRA continuation coverage and other health insurance when receiving federal or state unemployment benefits. People with HSAs may also choose to pay for health care expenses directly instead of purchasing insurance. Currently, with the exception of HSAs, there is no tax relief for insurance or expenses paid outside of one's job unless one qualifies for the new COBRA subsidy and the former employer is still in business.

The Committee's proposal to reduce the amounts Americans can contribute to their HSAs would also mean that Americans will have fewer dollars available to pay their health care costs in retirement when they become eligible for Medicare and Social Security. For example, in March 2009, Fidelity Investments reported that a 65 year-old couple retiring in 2009 would need \$240,000 to pay for retiree health care costs not covered by Medicare. This is up from \$225,000 reported in 2008.

### **Increase the Tax Penalty for Non-Qualified Distributions**

The Committee proposes to increase the tax penalty on non-qualified HSA distributions from 10 percent to 20 percent. Unfortunately, this would make the tax penalty, which is in addition to the required income tax payable on the non-qualified distribution, twice as big as the penalty that applies to Individual Retirement Accounts (IRAs), upon which HSAs are based. Distributions from an HSA for non-qualified expenses are subject to income taxes and a 10 percent penalty under current law, just as they are for non-qualified distributions from an IRA. We believe this penalty has been sufficient to deter non-qualified distributions except perhaps in times of personal emergency, when, as is the case with IRAs, individuals choose to pay the tax penalty to access their funds in times of dire need. We believe the penalty of 10 percent should remain in place.

### **Substantiation of HSA Distributions**

The Committee proposes to require employers or third-party administrators to substantiate that all distributions from HSAs are for qualified medical expenses, similar to the substantiation required for distributions from employer-owned Flexible Spending Accounts (FSAs). Such a requirement would be a dramatic departure from current law and greatly increase the cost of HSA administration, and greatly dilute the benefits Congress granted to those Americans who use their accounts to pay for their health care, in order to increase compliance by a very small percentage of individuals who may be using their HSA funds inappropriately.

Adding a new substantiation requirement runs completely counter to the whole idea of reducing the costs of health care by, among other things, reducing the costs of administration. Substantiation will simply add to the administrative cost and burden of health care financing for employers and consumers, especially for small employers and consumers who set up HSAs in the individual market. Substantiation will make the

accounts more costly and difficult to use since consumers will be forced to pay for many expenses out-of-pocket and then submit a paper receipt to their employer or TPA for approval. This results in the completely unnecessary disclosure of private health care information to employers and administrators from individuals who are paying their own expenses out of their own accounts with their own money.

Currently, HSA owners and HSA Trustees and Custodians must report to the IRS the annual amount of contributions to and distributions from each account. The IRS has the authority to audit these accounts and assess penalties for non-compliance. The proposed law would insert a third party administrator into the transaction, by requiring that TPAs substantiate every distribution from an HSA before it is made. This process is very inefficient: 90 percent of all FSA transactions are non-electronic – paper-based – while only 10 percent are electronic. This costly inefficiency is directly caused by the substantiation requirements inherent in the FSA. HSAs work much more efficiently; 90 percent of all HSA transactions are electronic and only 10 percent are paper-based, the reverse of the FSA marketplace; and, the individual, not the employer, owns the funds in the account regardless of the source of the funds. Where FSAs are largely about moving paper between the medical services provider, the employee, the employer and the TPA, HSAs are usually debit-card based and thus electronic.

The Council is also concerned that there are no instructions to HSA Trustees or Custodians about how to prevent individuals from accessing their own money. Would Trustees and Custodians apply the “substantiation” rules to the entire balance of an HSA or just to funds accumulated post-enactment? This is a threshold question for financial institutions: only pursuant to a court order or through the lien process are financial institutions able to deny individuals access to their private property, which the funds in HSAs clearly are.

Lastly, costs associated with substantiation requirements would disproportionately affect community banks and discourage them from offering HSA accounts. Adding another layer of administrative costs may convince some banks to remain on the sidelines longer than they would otherwise.

### **Employer-provided health care coverage exclusion limits**

The Committee proposes to count HSA contributions against a limit on the exclusion for employer-provided health care coverage were one to be created. Although CAHI would prefer that the exclusion be eliminated in favor of a refundable credit, we are not opposed to placing a limit on the exclusion *as long as it applies equally across the board to all plans and all health care accounts (FSAs, HRAs, and HSAs).*

HSA-compatible health plans are the most affordable plans in every market throughout the nation. We have confidence that the annual cost of any HSA health plan in the United States will be well below the tax-exempt limit the Committee is considering. The great advantage of HSAs is the ability of this financing structure to provide the same or superior benefits as traditional health plans for significantly lower costs. However, individuals choosing HSA plans should be allowed to put the difference between their plan premium and any exclusion amount into their HSA account without any additional

limits, such as the Committee proposes by limiting annual HSA contributions to the lesser of one's deductible or the statutory limit.

### **Eliminating OTC Drugs and Products as “Qualified Medical Expenses”**

The Committee proposes to eliminate the ability to use HSA funds to pay for or reimburse expenses for over-the-counter drugs and products because they would no longer be considered a “qualified medical expense” under Sec. 213(d) of the Internal Revenue Code. This change will raise the cost of many common health care items – such as cold and allergy medications – purchased by consumers. With so many prescription medicines going “off patent” in recent years, there is no reason to force people to rely on more expensive prescription medicines when low cost generics available over the counter will do. If the Committee is truly worried about rising health care costs, this policy sends the opposite message.

### **Actuarial Equivalence Benefit Standards**

Finally, we wish to comment on a proposal by the Committee concerning the benefit packages companies must provide, with actuarial values ranging from 76 percent to 93 percent of the actuarial value of Medicaid. We believe these benefit standards are extremely generous and will therefore make health care coverage extremely costly for most Americans.

First, we note that the actuarial values are derived from analysis by Watson Wyatt. Although the four actuarial equivalence standards are said to be representative of “typical” employer-sponsored plans, we question whether the data adequately includes small employers, which frequently offer much less generous benefits. Therefore we believe the standards may be artificially high because they are based solely on data from large employers. Even the standards for “minimum creditable coverage” in Massachusetts contemplate a broader range of standards, including a minimum standard of 56 percent.

Second, requiring all insurance carriers to provide all four benefit standards would impose an unreasonable requirement on many health plans in the current market. For example, many carriers no longer provide HMO plans and enrollment has been steadily declining for over a decade. On the other end of the spectrum, we question whether the 76 percent standard would allow consumer-driven health plans (CDHPs) to continue to be offered. CDHPs are the fastest growing product on the market, and employers are increasingly turning to them to provide affordable benefits to their employees.

If the 76 percent standard is not lowered, it will be imperative to allow HSA account contributions by employers and employees to be counted when determining the actuarial value of HSA-qualified health plans (technically known as “high deductible health plans” or HDHPs).

Finally, the actuarial values identified in the plan will lead to health benefit plans that are significantly more expensive than plans currently available in the market. In light of the fact that there are exemptions to the mandate for individuals whose premium exceeds 10

percent of income, this could lead to significant number of individuals being exempt from the individual mandate. The resulting adverse selection that would occur could make health insurance coverage in the individual market even more expensive.

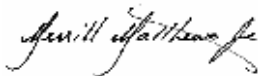
### **Conclusion**

The evidence of the last five years shows that HSAs and other consumer-driven health plans are reducing or eliminating premium increases, providing health insurance for previously uninsured individuals, and reducing overutilization of unnecessary health care services. The result has been more increased personal responsibility and higher engagement in maintaining health and seeking the best value for the health care dollar being spent, all without having a negative effect on health outcomes.

Implementing the suggested policy changes to the HSA would simply cripple one of the few health care reforms that are accomplishing the President's stated goals for health care reform.

We look forward to working with the Committee to achieve the President's goals.

Sincerely,

A handwritten signature in cursive script, appearing to read "Merrill Matthews".

Merrill Matthews  
Executive Director