HSA COUNCIL

A Partnership of the American Bankers Association and its insurance affiliate, the American Bankers Insurance Association

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June 1, 2009

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

Dear Chairman Baucus and Ranking Member Grassley:

Thank you for the opportunity to comment on the proposed health care reform financing policy options.

In general, members of the HSA Council support the principles established by the Committee and by the President. We are in favor of choice, more affordable coverage, portability of coverage between jobs, and coverage that is universally available to all Americans. We are also in favor of health care security through retirement. We believe Health Savings Accounts (HSAs) play an important role in achieving these goals.

The modifications to HSAs proposed in the Senate Finance Committee's Savings and Revenue Options paper would:

a) limit the annual 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;

b) increase the tax penalty on non-qualified HSA distributions from 10 percent to 20 percent;

c) require employers or third-party administrators to substantiate that all distributions from HSAs are for qualified medical expenses;

d) count HSA contributions against a limit on the exclusion for employer-provided health care coverage were one to be created; and,

e) 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.

These proposals are at odds with the goals stated by the Committee and by the President. More than eight million Americans are now covered by HSA-compatible health insurance plans. We are concerned that the ability of these families and individuals to finance their health care, both current and future, is at risk.

Annual Contribution Limits

Some of the advantages of HSAs are that they allow Americans to save for payment of future medical expenses (including those incurred during periods of unemployment and retirement), to manage their current health care choices directly, and to make better consumer choices. Given the Fidelity Investments data, it would be appropriate for Congress to encourage greater savings rather than limit them.

The Committee's proposal to reduce the amounts Americans can contribute to their HSAs would mean that Americans will have fewer dollars available to pay their retirement health care costs when they become eligible for Medicare and Social Security. For example, in March 26, 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.[1] Impairing the ability of Americans to pay for health care by limiting their ability to contribute funds to their HSAs is counterproductive to managing the costs of health care, especially when the viability of Medicare is itself in question. Stated differently, HSAs can improve the solvency of Medicare by reducing the number of Americans that must rely on it during retirement.

Another 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 costs associated with vision and dental benefits, coinsurance for hospitalizations, prescription drugs and specialty care, all of which can be both substantial and unpredictable; accordingly, the ability to save for them in a HSA is important for many Americans. Restriction of contributions to the account amounts to an impairment of benefits for those who most need them.

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.

[1] Dayton Business Journal, March 26, 2009: Fidelity: retirement health care tops $240K per couple

Increase the non-qualified expense tax penalty to 20%

With respect to increasing the penalty on non-qualified expenses from 10% to 20%, we wish to remind the Committee that the architecture of the HSA statute is based upon the architecture of Individual Retirement Accounts (IRAs). Distributions from a HSA for non-qualified expenses are subject to income taxes and a 10% 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.

Accordingly, the HSA Council recommends that the current penalty of 10% remain in place.

Substantiation of distributions

The Committee also proposed subjecting HSA distributions to prior authorization or substantiation similar to the substantiation protocols required for distributions from employer-owned Flexible Spending Arrangements (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 that use it to pay for their health care, in order to increase compliance by a very small percentage of individuals who may be violating the tax laws.

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 (TPA) into the transaction, by requiring that TPAs substantiate every distribution from an HSA before it is made.

There are significant legal problems with substantiation that the Committee's proposal does not address.

First, the HSA Council is very concerned that there are no instructions to HSA Trustees or Custodians about how to prevent individuals from accessing their own money. Unlike FSAs, HSAs are owned by the individual, not the employer. In an FSA, employees designate pre-tax dollars to be withheld by their employer who has the responsibility to make sure those funds are only spent on qualified medical expenses. The employer typically hires a TPA to "substantiate" the claims of his employees. This process is very inefficient: 90% of all FSA transactions are non-electronic – paper-based – while only 10% are electronic. This costly inefficiency is directly caused by the substantiation requirements inherent in the FSA.

HSAs work much more efficiently; 90% of all HSA transactions are electronic and only 10% 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.

Furthermore, employees electing a FSA must use those funds completely by the end of every year or they are forfeited to the employer, the owner of the money. This also potentially creates overutilization of non-necessary medical care by the employee at the end of the year, in an effort to derive some value from the funds, as opposed to forfeiting them to their employer.

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. Given the amount of information privacy issues in the media, we would expect a negative public response to any unnecessary disclosures of private health care information, especially to employers.

Second, the Committee's proposal does not include instructions to Trustees and Custodians about how to treat the balances already accrued in each account. Would Trustees and Custodians apply the "substantiation" rules to the entire balance of a 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.

Obviously, the HSA Council is strongly opposed to the idea of prior substantiation of HSA distributions but we are willing to consider an alternative. If it is the Committee's intention is to provide a means for the IRS to assess possible fraud, we could support enhanced reporting to the Internal Revenue Service (IRS) on an annual basis, as follows:

Under current law, HSA Custodians or Trustees must report contributions and distributions on IRS Forms 5498-SA and 1099-SA, respectively. Given that the overwhelming majority of HSA transactions are electronic, the technology exists to sort these transactions by Merchant Class Code (MCC). We would be willing

to work with the Committee to define a protocol where HSA Custodians and Trustees made available to the HSA Owner, reports which further detail distributions for each tax year.

The result would be a detailed list of expenditures and cash transactions that would be available for review. For anti-fraud assessments and audits, we judge this approach superior to any pre-expenditure protocol that might be devised.

Lastly, costs associated with substantiation requirements would disproportionately affect community banks and discourage them from offering HSA accounts. Many ABA members are community banks that are still considering whether to offer HSAs to their customers. 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 has also proposed including the cost of HSA plans in the limit on the employer provided health care exclusion. We consider this to be appropriate provided that the exclusion pertains only to the annual cost of the HSA plan, defined as annual contributions to the HSA from all sources plus the annual cost of the qualifying health insurance that must accompany the account.

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. In fact, we are counting on it. 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 less cost.

Eliminating the OTC exclusion

The policy paper provides, as an option, ending the use of money from a health FSA, HRA, or HSA to pay for over-the-counter drugs. 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.

Conclusion

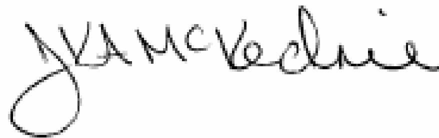
The evidence of the last five years shows that consumer-directed health plans, including HSAs, are reducing or eliminating premium increases, providing health insurance for previously uninsured individuals, and reducing overutilization of unnecessary health care services. The result has been more efficient use of services and increased personal responsibility in the form of more health- and

cost-conscious behavior, all without having a negative effect on health outcomes compared to those covered by traditional plans.

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.

Thank you, again, for the opportunity to comment and we look forward to working with the Committee to achieve the President's goals.

Sincerely,



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