STATEMENT OF

THE AMERICAN BENEFITS COUNCIL

FOR THE RECORD

REGARDING THE MAY 14, 2008

HEARING ENTITLED

"HEALTH SAVINGS ACCOUNTS (HSAS) AND CONSUMER DRIVEN HEALTH CARE: COST CONTAINMENT OR COST-SHIFT"

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

U.S. HOUSE OF REPRESENTATIVES

WAYS AND MEANS COMMITTEE

STATEMENT OF AMERICAN BENEFITS COUNCIL

The American Benefits Council (the "Council") appreciates the opportunity to submit this written statement to the Subcommittee regarding the increasing utilization and effectiveness of health savings accounts ("HSAs") and high deductible health plans ("HDHPs"). The Council is a national trade association representing principally Fortune 500 companies and other organizations that either sponsor or administer health and retirement benefit plans covering more than 100 million Americans.

HSAs are a fairly new health coverage option for American families, having been established by Congress in 2003 as part of the Medicare Modernization Act. Nevertheless, for millions of Americans, HSAs have already become an important tool in securing essential health coverage for themselves and their families. Early data from the Government Accounting Office ("GAO") and other third parties is encouraging, indicating that HSAs are working as intended for the vast majority of Americans who use them. HSA/HDHP arrangements can provide vital "first-dollar" medical coverage for accountholders (and their spouses and qualifying dependents), while utilizing important cost-sharing principles to help lower health coverage costs generally for individuals and employers alike. It is critical that we allow this important new health care option to fully develop and that we permit comprehensive data to be collected on the role it can play in providing quality health care at an affordable price. Any actions to apply new restrictions or burdens on this option would be premature and would risk eliminating a health care tool already being successfully used by millions of Americans.

The following is a summary of our comments:

- Health savings accounts have become an increasingly important tool for millions of Americans in securing lower cost, high quality medical coverage. Recent data compiled by GAO indicates that an estimated 6.1 million Americans were covered by HSA/HDHP arrangements as of January 2008.

- Early data and testimony before the Subcommittee on May 14, 2008, indicate that the vast majority of HSAs include comprehensive "first-dollar" preventive care coverage and that HSAs can succeed in reducing health care costs for American families, while also resulting in increased wellness and quality of care.

- Recent data strongly indicates that participants have sufficient HSA assets to meet actual out-of-pocket expenses under HDHPs, and (i) HSA withdrawals are being used principally for current-year qualified medical expenses, and (ii) HSAs, rather than being used primarily by high-income individuals as a tax shelter, are being used by individuals at a broad range of income levels. For example, one survey found that 45% of all

HSA enrollees in 2005 had annual incomes of $50,000 or less, and there are good reasons to believe that this percentage may be even higher today.

- Current rules regarding HSA substantiation are consistent with the treatment afforded other special purpose accounts and health tax provisions. As discussed below, there are numerous instances under the Internal Revenue Code ("Code") where amounts withdrawn from a special purpose account are not subject to mandatory third party FSA-like substantiation rules. Similarly, the general approach toward health expenditures under federal tax law does not require third party substantiation for an individual to obtain a specific income tax deduction or other tax-favored treatment.

- Imposing third-party substantiation requirements on HSAs is not appropriate, will increase costs for HSA accountholders and limit options for health coverage at a time when such options should be expanded. The Council urges members of the Subcommittee, and members of Congress more generally, to oppose the imposition of third-party substantiation requirements on HSAs, such as the requirements included in H.R. 5719 (the "Taxpayer Assistance and Simplification Act of 2008").

HSAs Are An Increasingly Important Component To Many American Families' Health Coverage.

Recent data compiled by GAO indicates that the number of Americans covered by HSA-eligible plans increased from 438,000 in September 2004 to an estimated 6.1 million in January 2008.[1] This represents a 1,400% increase in their use in just over three years. Moreover, a recent study by America's Health Insurance Plans ("AHIP") found that HSA-usage increased by 35% in the 12-month period from January 2007 to January 2008.[2] American families and workers are indisputably turning to HSAs in increasing numbers to help control their ever-rising health coverage costs.

Early data also indicates that the increased use of HSAs is broad-based. Specifically, recent survey data by AHIP indicates that of those individuals covered by HSAs, 30% were in the small group market, 45% in the large group market, and 25% in the individual market.[3] In addition, it is very significant that the greatest growth in the HSA/HDHP market is in the small plan market, where health care coverage has been a constant public policy challenge.[4]

HSAs Can Reduce Health Costs And Improve Quality Of Care.

In this era of ever-rising health care costs – costs that continue to well outpace general inflation as measured by the Consumer Price Index ("CPI") – American workers and their employers continue to look for ways to help rein in these costs without

negatively affecting health standards and quality of care. As Michael Chernew, Professor of Health Care Policy for Harvard Medical School, testified, cost sharing can reduce excess utilization and health expenditures generally, and HSA/HDHP coverage utilizes certain cost-sharing principles like upfront deductibles and copayments to help reduce excess utilization.[5]

Testimony from Wayne Sensor, CEO of Alegent Health, also provides a first-hand example of how HSA/HDHP coverage can both reduce costs and lead to increased health standards and quality of care. Specifically, Mr. Sensor testified that "there is a significantly higher level of engagement" among those participants [in one of our HSA plans]." He stated that HSA participants "consume more preventive care than any other plan we offer," and that "[m]ore than 45% of HSA participants completed their health risk assessments, compared to just 16% in our PPO plan." On top of all of this, he noted that "[f]rom 2006 to 2007, the cost trend in our two HSA plans declined a full 15%!"[6]

Mr. Sensor's testimony is supported by findings from another study performed by HealthPartners. This study found that the cost of care for participants in HSAs and health reimbursement arrangements ("HRAs") was 4.4% lower than for those individuals with traditional low-deductible coverage.[7] The study also found that the cost savings did not impair the standard of care and that the utilization of preventive care services and medication for chronic illness was equivalent to that of individuals covered under more traditional low-deductible plans.

DATA INDICATES HSA/HDHP COVERAGE UTILIZES IMPORTANT "FIRST DOLLAR" PREVENTIVE CARE COVERAGE.

As Mr. Sensor's first-hand experience at Alegent Health demonstrates, HSA/HDHP coverage, if structured correctly, can achieve its intended result – providing quality care to Americans and their families at reduced costs. One component of successful HSA/HDHP coverage appears to be the inclusion of "first-dollar" preventive care coverage. A survey by AHIP last year showed that recommended preventive care is covered on a "first-dollar" basis by the vast majority of HSA/HDHP products.[8] Overall, the survey found that 84% of HSA/HDHP plans purchased in the group and individual markets provide "first-dollar" coverage for preventive care. Specifically, nearly all HSA plans purchased in the large group market (99%) and small group market (96%) provide "first-dollar" coverage, while 59% of HSA/HDHP policies sold on the individual market include such coverage.[9]

The AHIP survey also found that among those HSA/HDHP policies offering "first-dollar" coverage for preventive care, 100% provide coverage for adult and child immunizations, well-baby and well-child care, mammography, Pap tests, and annual physical exams. Nearly 90% of the policies provide "first-dollar" coverage for prostate screenings and more than 80% offer "first-dollar" coverage for colonoscopies.[10]

EARLY DATA STRONGLY INDICATES THAT PARTICIPANTS HAVE SUFFICIENT HSA ASSETS TO MEET ACTUAL OUT-OF-POCKET EXPENSES UNDER HDHPS.

AHIP's most recent census data indicates that HSA enrollees had an average account balance for 2007 of approximately $1,380 and withdrew on average $1,080 to reimburse qualified medical expenses, including those expenses not otherwise covered under their HDHP.[11] Additionally, early findings indicate that many employers are contributing substantial amounts to their employees' HSAs. Specifically, GAO reports that of those small and large employers that made contributions to HSAs in 2007, the average annual contribution totaled $806.[12]

The Council views these early findings as very encouraging. One criticism of HSAs has been that accountholders cannot contribute a sufficient amount to an HSA on an annual basis to meet their actual out-of-pocket expenses. This is due in large part to the fact that the maximum HSA contribution limit is almost certainly significantly less than the plan's maximum out-of-pocket limit (for example, for 2008, the maximum HSA contribution limit was $2,800 for self-only coverage and $5,900 for family coverage, but the maximum out-of-pocket limit for HDHPs was $5,600 and $11,200, respectively). Notwithstanding this fact, the data indicates that American families have been able to utilize their HSAs to effectively meet their out-of-pocket liability under the HDHP. This is very welcome news as it suggests that HSA/HDHPs meet both the cost and coverage needs of the average American family.

DATA INDICATES THAT HSAS ARE <u>NOT</u> BEING USED AS TAX SHELTERS BY HIGH-INCOME INDIVIDUALS.

The early data from GAO and AHIP is also encouraging for another reason. Contrary to concerns by some that HSAs would be used primarily by high-income individuals as an IRA-like retirement savings vehicle, the data indicates that HSAs are being used by both lower- and higher-income individuals principally to meet current year health costs.

With respect to the specific income levels of those individuals who are currently utilizing HSAs, available data for the 2005 tax year indicates that nearly 50% of all HSA enrollees had annual incomes of less than $60,000. Specifically, the recent GAO report indicates that 41% of HSA tax filers for 2005 had annual incomes below $60,000.[13] Similarly, a survey by eHealthInsurance, an online broker of health insurance policies, found that 45% of all HSA enrollees in 2005 had annual incomes of $50,000 or less.[14] The same survey found that 41% of HSA purchasers were not covered by health insurance during the preceding six months.[15]

Notably, the findings for the 2005 tax year may fail to accurately reflect current trends in HSA usage and may, in fact, understate the percentage of low- and middle-income HSA enrollees. This is because, as part of the Medicare Modernization Act, Congress allowed participants in early HSA-like accounts, called Medical Savings

Accounts ("MSAs"), to convert these accounts into HSAs. Because MSAs generally were only available to self-employed individuals and small business owners – persons who on average would likely have higher incomes than the average American worker – the data for 2005 may well underestimate the number of low- and middle-income individuals who are currently enrolled in HSA/HDHP coverage.

Recent data from AHIP indicates that for 2007, HSA enrollees withdrew on average 80% of their annual contributions to reimburse current-year qualified medical expenses. Moreover, the GAO report states that "average contributions and average withdrawals generally increased with both income and age."[16] Thus, although higher-income individuals on average contributed more to their HSAs in a given year, they also withdrew more contributions during the same year. These early findings, when taken together, are very encouraging because they indicate that that HSAs are <u>not</u> being used primarily by higher-income individuals as a retirement savings vehicle or tax-shelter, but rather are being used by both lower- and higher-income individuals to obtain essential current-year health care coverage.

Lastly, some have pointed to the early data indicating that all HSA account balances are not "spent down" on an annual basis (as is frequently the case with FSAs given the "use-it-or-lose-it" rule) as evidence that HSAs are being used inappropriately as a tax savings vehicle. Such critiques fail to recognize the mechanics of HSA/HDHP coverage in light of the statutory contribution limits and potential out-of-pocket expenses. As noted above, in the vast majority of instances, the HSA participant's potential out-of-pocket exposure under the related HDHP can be as much as 200% of the maximum HSA annual contribution. Thus, to the extent that accountholders do not withdraw all of their HSA contributions in the same year (*i.e.*, as necessary to meet health expenditures), this should be viewed as positive from a public policy perspective. This is because any remaining account balance at year-end will help ensure that accountholders have sufficient HSA assets to meet potential out-of-pocket expenses under the HDHP plan in later years.

AVAILABLE DATA INDICATES THAT HSA MONIES ARE BEING USED FOR QUALIFIED MEDICAL EXPENSES.

The early data, as compiled by GAO, suggests that amounts withdrawn from HSAs are being used by accountholders for qualified medical expenses. The GAO report states that "[o]f the HSA funds that were withdrawn in 2005, about 93 percent were claimed for qualified medical expenses."[17] Moreover, recent statements by a Treasury Department representative before the Ways and Means Committee, indicate that 8.4% of all HSA accountholders list at least some of their HSA distributions as nonqualified taxable distributions.[18]

Under current rules, amounts withdrawn from HSAs that are not used for qualified medical expenses are subject to substantial negative tax consequences. Specifically, such amounts are subject to income tax at the accountholder's marginal tax

rate as well as an additional 10% penalty tax. To the extent that an accountholder fails to accurately report taxable withdrawals, he or she would likely also be subject to various accuracy-related penalties and additions for the underpayment of income tax, as well as related interest.

The early data indicates that accountholders are using their HSAs as intended – primarily to reimburse qualified medical expenses not otherwise covered under the HDHP. Moreover, where amounts are withdrawn and are not used to reimburse qualified medical expenses, the data indicates that accountholders are correctly reporting such amounts as subject to income taxation under the current rules.

CURRENT RULES REGARDING HSA SUBSTANTIATION ARE CONSISTENT WITH OTHER SPECIAL PURPOSE ACCOUNTS AND HEALTH TAX PROVISIONS.

Some persons have suggested that the treatment of HSAs under federal tax law – specifically the lack of a third-party substantiation requirement – is unparalleled and otherwise unique to HSAs. Such assertions are not correct. There are numerous instances under the Code where amounts withdrawn from a special purpose account are not subject to mandatory third party FSA-like substantiation rules, such as with respect to withdrawals from 529 college saving plans or withdrawals from IRAs in connection with a qualifying first-time home purchase.

Under current rules, participants in 529 college savings plans are not required to obtain third party substantiation prior to withdrawing amounts from the 529 plan. However, as with HSAs, the accountholder must report in connection with his or her annual income tax return, the amount of withdrawals that were for qualified educational expenses and, as such, are eligible for tax-free reimbursement. Moreover, as with HSAs, to the extent that withdrawn amounts are not attributable to qualified expenses, such amounts are subject to income and penalty tax.

This is also the case with respect to withdrawals from IRAs in connection with a qualifying first-time home purchase. Under current federal tax rules, IRA owners generally may not make a withdrawal from their IRAs prior to attaining age 59 ½ without otherwise being subject to a 10% penalty for early withdrawals. If, however, the withdrawal is made in connection with the purchase of a qualifying first home, the 10% penalty does not apply. As with HSAs, there is no requirement that the provider or administrator of the IRA first substantiate that the IRA owner has satisfied the requirements necessary to avoid the 10% penalty. Rather, all withdrawn amounts are generally coded by the provider or administrator on the annual information return as being subject to the 10% penalty. When the IRA owner then files his or her annual tax return, he or she then certifies on the return the amount of annual withdrawals that was used for purposes of purchasing a qualifying first home. Thus, no third party substantiation is required.

With respect to the treatment of medical expenses more generally under federal tax law, it is HRAs and FSAs – rather than HSAs – that are in fact the exception to the rule. This is because, as with HSAs, the general approach towards health expenditures under federal tax law does not require that a taxpayer obtain third party substantiation of qualifying medical expenses in order to obtain a specific income tax deduction or other tax-favored treatment.

One example of this can be found under Code section 162(l), which allows self-employed persons to take an above-the-line deduction for qualified medical care. In order to avail oneself of the deduction under this provision, the self-employed individual must certify on his or her annual income tax return the amount that he or she paid for qualified health insurance during the respective tax year. As with HSAs, no third party substantiation is required under federal tax law, although the taxpayer remains subject to accuracy-related penalties and additions under federal tax law.

Another example is section 213(a) of the Code, which permits a taxpayer to deduct qualifying medical expenses in excess of 7.5% of their adjusted gross income. As with HSAs, taxpayers are <u>not</u> required to obtain third party substantiation of such expenses under federal tax law. Taxpayers merely certify on their annual tax return the amount of qualified medical expenses that they incurred that make them otherwise eligible for the deduction. Taxpayers do, however, remain subject to accuracy-related penalties and additions under federal tax law.

Code section 72(t) is another example of the more general rule under federal tax law under which taxpayers are not required to obtain third party substantiation in order to obtain favorable tax treatment. As noted above, in very limited circumstances, pursuant to Code section 72(t), taxpayers are excepted from the 10% penalty tax for early distributions from a qualified retirement plan, including an IRA or employer-sponsored retirement plan. In addition to withdrawals for purposes of a qualifying first-time home purchase, Code section 72(t) also excepts from the penalty withdrawals attributable to certain incurred qualified medical expenses. As with HSAs, Code section 72(t) does not impose third party substantiation requirements. Taxpayers do, however, remain subject to accuracy-related penalties and additions to the extent of mischaracterized or ineligible withdrawals.

IMPOSING THIRD-PARTY SUBSTANTIATION REQUIREMENTS ON HSAS WILL INCREASE COSTS AND LIMIT AMERICANS' OPTIONS FOR HEALTH CARE COVERAGE.

In light of the foregoing, the Council urges members of the Subcommittee, and members of Congress more generally, to oppose the imposition of third-party substantiation requirements on HSAs, such as the requirements included in H.R. 5719 (the "Taxpayer Assistance and Simplification Act of 2008"). The available data indicates that the current regime is working and that substantiation rules like those required with respect to flexible spending arrangements ("FSAs") and health reimbursement arrangements ("HRAs") are not needed at the present time.

At a time when Americans continue to struggle to afford their health care coverage and/or secure appropriate coverage, imposing third party substantiation rules would impose additional costs and burdens on HSA providers and accountholders. These additional costs could operate to limit the attractiveness and efficacy of HSAs.

Americans' options for health coverage need to be expanded at this time, not limited, and imposing third party substantiation could negatively affect the use and/or effectiveness of HSAs. Moreover, given the relative newness of HSAs generally and the encouraging early data indicating that such substantiation is unnecessary, the Council opposes the imposition of third party substantiation rules in connection with HSAs.

CONCLUSION.

HSAs were never intended to be a comprehensive answer to all of America's health care problems. Rather, HSAs were designed to be one important option for Americans families seeking lower-cost but high-quality comprehensive coverage. As the GAO report makes clear, for a significant percentage of American families, HSAs have become an integral part of their health coverage and, thus, should not be curtailed at this time.

More than ever before, Americans need good health coverage options. For a significant segment of American families, HSA/HDHP coverage meets this need by providing lower-cost, high quality coverage. Moreover, as noted above, early data is encouraging and suggests that for the vast majority of HSA participants, HSA/HDHP coverage is operating as intended by Congress. But early data is just that – "early". It is critical, therefore, that we allow this new health care option to develop without additional burdens or restrictions. The Council believes that there is no justification for changes that could curtail the use and/or effectiveness of HSAs. Otherwise, we risk taking away from millions of American families a vital tool in securing affordable, quality health care coverage.

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[1] *Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift? Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (statement of John E. Dicken, Director of Health Care, Government Accountability Office).

[2] *Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift? Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (statement of America's Health Insurance Plans) (hereinafter ("AHIP").

[3] *See* AHIP, *supra*.

[4] *See* Id.

[5] *Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift? Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (statement of Michael E. Chernew, Ph.D., Professor of Health Care Policy, Harvard Medical School).

[6] *Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift? Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (statement of Wayne Sensor, CEO, Alegent Health).

[7] *Consumer Directed Health Plans Analysis*, HealthPartners, October 2007.

[8] *See* AHIP, *supra.*

[9] *See* Id.

[10] *Id.*

[11] *See* Id. *See also Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes*, GAO-08-474R (April 2008), at 8 (stating that in 2005, the average HSA contribution was $2,100, with the average withdrawal being approximately $1,000).

[12] *See* Id at 9 (*citing* Kaiser Family Foundation and Health Research and Educational trust, *Employer Health Benefits: 2007 Annual Survey* (Menlo Park, Calif., and Chicago, Ill.:2007). It should also be noted that in a study conducted by Mercer during the same period which covered only large employers, the average contribution was $626. *Id.* at 9.

[13] *Id.* at 6.

[14] *See* AHIP, *supra* (citing eHealthInsurance survey findings).

[15] *See* Id.

[16] *See* GAO, *supra*, at 8.

[17] *See* Id at 9.

[18] *April 9, 2008 Mark-up of H.R. 5719 by the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong.* (2008) (comment by Thomas Reeder, Benefits Tax Council, Dept. of Treasury) (as reported by Congressional Quarterly).