MAINE BANKERS Association

January 11, 2021

Senator Sanborn, Senate Chair
Representative Tepler, House Chair
Members of the Health Coverage, Insurance and Financial Services Committee
Sent via Legislative Testimony Submission Service

Re: ***LD 1783 An Act to Require Health Insurance Carriers and Pharmacy Benefits Managers to Appropriately Account for Cost-sharing Amounts Paid on Behalf of Insureds*** **and** ***LD 1822 An Act to Improve Access to Behavioral Health Services by Prohibiting Cost Sharing by Insurers***

Dear Senator Sanborn and Representative Tepler,

I write to you on behalf of the Maine Bankers Association (MBA) in a neither-for-nor-against position regarding the above-referenced bills, but with concerns about unintended consequences. The Maine Bankers Association consists of 30 member banks that collectively employ over 9,000 Mainers, providing good careers and benefits to Maine citizens.

These bills are well intended from a consumer protection standpoint. However, if these bills are passed as currently drafted, they could cause other consumer protection issues by putting at risk 140,000 Maine Health Savings Accounts (HSAs) representing 270,000 Maine covered lives. Owners of HSAs depend on these accounts to manage their current and future medical care expenses. (See Exhibit 1 Regarding HSAs)

To mandate that a plan provide coverage for behavioral health services before the annual deductible is met or to provide deductible credit for prescription drug costs not actually incurred by the individual would disqualify the consumer's health insurance plan from being a high deductible health plan (HDHP) and, therefore, make the consumer ineligible to contribute to their Health Savings Account. Any

contributions made to the account could be subject to taxes and penalties and the consumer may have to find alternative coverage.

I have attached a letter (Exhibit II) from the Internal Revenue Service (IRS) to the Illinois Department of Insurance. The IRS letter informs the Illinois Department of Insurance that laws like LD 1783 and LD 1822 will disqualify HSA owners from contributing to their accounts, absent any exception for the HSA-qualified high deductible health plans. We want to propose the following amended language for LD 1783 if the Committee decides to move forward with the bill.

LD 1783 Proposed Amendment National Council of Insurance Legislators (NCOIL) Model Language:

Sec. 2. Application. The requirements of this Act apply to prescription drug benefits provided pursuant to a contract or policy of insurance by a carrier or a pharmacy benefits manager on behalf of a carrier on or after January 1, 2023.

> **Except, if under federal law, the application of section 1 (enacting 24-A MRSA §4349, sub-§ 6) would result in Health Savings Account ineligibility under section 223 of the federal Internal Revenue Code, this requirement shall apply only, for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223, except with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of section 1 shall apply regardless of whether the minimum deductible under section 223 has been satisfied.**

LD 1822 also appears problematic for HSAs because the IRS only allows zero cost-sharing for services or treatments that are deemed “preventive care” under federal rules. It is our understanding that other [?] behavioral health services are not "preventive care" under IRS guidance (Section 223 of the Internal Revenue Code) for HSA qualified plans. We want to propose the following amended language for LD 1822 if the Committee decides to move forward with the bill.

LD 1822 Proposed Amendment

Any of the highlighted blue language would work for section 2 of LD 1822, which reads as follows:

Sec. 2. Application. The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2023. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

"except in the case of a 'high-deductible health plan' as implemented and interpreted by the U.S. Department of the Treasury under 26 U.S.C. 223"

"except to the extent that coverage of this service without cost-sharing would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to title 26 United States Code section 223"

"Section 1 shall not apply to a state-regulated high-deductible health plan to the extent it results in the plan's failure to qualify as a high-deductible health plan pursuant to section 223 of the Internal Revenue Code."

"If the application of the requirements of section 1 would cause a health benefit plan's failure to qualify as a Health Savings Account-qualified High Deductible Health Plan under 26 U.S.C. sec. 223, as amended, then the requirements of section 1 shall not apply to that health benefit plan until the minimum deductible under 26 U.S.C. sec. 223, as amended, is satisfied."

We ask you to consider our proposed amended language for these two bills if the committee decides to move forward with the proposals. The goal of the proposed amended language to these bills is to ensure that 140,000 HSA accounts representing 270,000 covered Maine lives are protected. Thank you for the opportunity to allow the Maine Bankers Association to submit comments on LD 1783 and LD 1822. If you have any question or would like to discuss this further, please do not hesitate to contact me at 207.791.8401 or jroche@mainebankers.com. Kathy Keneborus plans to attend the work session for these two bills.

Sincerely,

Jim Roche
President
Maine Bankers Association
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Maine Bankers Association Letter for LD 1783 and LD 1822

Health Savings Account Overview

In everyday language, we refer to some health insurance programs as HSA plans, but there are really two components. First, a person must have a qualified high deductible health plan (HDHP) which is not simply a plan that has a high deductible, but a plan defined in federal law as one with a certain minimum annual deductible and maximum annual out-of-pocket cost. In addition, a qualifying HDHP is prohibited from providing coverage for any services other than preventive care (behavioral health is not considered preventative by the IRS) before the minimum annual deductible is met. Preventive care may include coverage for treatment of individuals with certain chronic conditions.

Second, a person with an HDHP is eligible to make contributions to a health savings account (HSA) on a tax-favored basis to allow them to pay for deductibles, coinsurance, or copays that they may incur for qualified medical expenses (which include dental and vision care).

Healthcare.gov provides some benefits of the HDHPs with HSAs.

- HDHPs may have lower monthly premiums than non-HDHPs.
- A person may deduct the amount deposited into an HSA from the income they pay state and federal income tax on. (Further, a person making payroll deductions to an HSA also does not pay FICA on those deposits.)
- Withdrawals to pay eligible medical expenses are tax-free.
- Unspent HSA funds roll over from year to year allowing one to build tax-free savings to pay for medical care in later years including into retirement.

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

OFFICE OF THE CHIEF COUNSEL

April 16, 2021

Dana Popish Severinghaus
Acting Director
Illinois Department of Insurance
122 S. Michigan Avenue, 19th Floor
Chicago, IL 60603

Attention: KC Stralka

Dear Ms. Popish Severinghaus:

I am responding to your inquiry dated March 8, 2021, about the interaction of copay accumulator rules and the ability of a health plan to qualify as a high deductible health plan (HDHP) that permits an individual to contribute to a health savings account (HSA). You also asked about the benefits that may be provided by an HDHP before the minimum annual deductible is satisfied.

Section 223 of the Internal Revenue Code allows eligible individuals to deduct contributions to HSAs. Among the requirements for an individual to qualify as an eligible individual under Section 223(c)(1), an individual must be covered by an HDHP and have no disqualifying health coverage. Under Section 223(c)(2), an HDHP is a health plan that satisfies certain requirements, including requirements related to minimum deductibles and maximum out-of-pocket expenses.

Generally, under Section 223(c)(2)(A), an HDHP may not provide benefits for any year until the minimum deductible for that year is satisfied. However, Section 223(c)(2)(C) provides that "[a] plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1861 of the Social Security Act, except as otherwise provided by the Secretary)." Therefore, an HDHP may provide benefits defined as preventive care for purposes of Section 223 without a deductible, or with a deductible below the minimum annual deductible otherwise required by Section 223(c)(2)(A).

The issue raised by your inquiry is what amounts count toward the minimum annual deductible for an HDHP. Notice 2004-50, 2004-33 I.R.B. 196, Q&A-9, provides that an individual covered by an HDHP who also has a discount card for health care services or products, may still contribute to an HSA provided that the individual is required to pay the costs of the covered health care until the minimum annual deductible for the HDHP is satisfied. In other words, the minimum annual deductible may only be satisfied by actual medical expenses the covered individual incurred. For example, if a covered

individual is prescribed a drug that costs $1,000, but a discount from the drug manufacturer reduces the cost to the individual to $600, the amount that may be credited towards satisfying the deductible is $600, not $1,000. This same principle also applies to a third-party payment, such as a rebate or coupon, that has the same effect as a discount.

As noted above, an HDHP may provide benefits defined as preventive care for purposes of Section 223 without a deductible, or with a deductible below the minimum annual deductible otherwise required by Section 223(c)(2)(A). A state statute requiring a plan to provide benefits other than preventive care before the minimum annual deductible is satisfied does not change this outcome. Notice 2004-23, 2004-15 I.R.B. 725, explains that state law requirements do not determine if health care is preventive care under Section 223(c)(2)(C). For example, Notice 2018-12, 2018-12 I.R.B. 441, clarifies that male contraception and sterilization services are not preventive care for purposes of Section 223(c). Therefore, a health plan that provides benefits for these services without a deductible or with a deductible below the minimum annual deductible for an HDHP is not an HDHP, even if coverage is required by state statute.

I hope this information is helpful. If you have additional questions, please contact me or Kari DiCecco at 202-317-5500.

Sincerely,

Denise Trujillo
Branch Chief, Health and Welfare
Office of Associate Chief Counsel
(Employee Benefits, Exempt Organizations,
and Employment Taxes)