

Memorandum (March 13, 2018)

To: ERISA Industry Committee
National Retail Federation
US Chamber
American Benefits Council
National Association of Health Underwriters
Sports and Fitness Industry Association
Direct Primary Care Coalition

From: Don Moran

Subject: Analysis of Budgetary Implications of H.R. 5138 & H.R. 365 / S. 1358

You engaged The Moran Company to advise you on the potential budgetary implications of a bill, recently introduced in the House, that would amend the Internal Revenue Code to implement several benefit improvements for persons eligible to receive Health Savings Account contributions coincident with their enrollment in High Deductible Health Plans (HDHPs). Specifically, we were asked to give you our assessment of how the Joint Committee on Taxation (JCT) and the Congressional Budget Office (CBO) might “score” this legislation if offered in a legislative context in which PAYGO rules would apply. Given the time available to complete this analysis, we were not asked to produce a point estimate of a likely score for any of the specific provisions, or for the bill as a whole. Rather, our assignment is to assess how scorekeepers are likely to view the direction and materiality of these provisions, both individually, and taken together.

Our findings are as follows:

- Subject to the caveats presented below, we believe that JCT and CBO may view this legislation as having a lower budgetary impact than they have scored for other HSA reform packages considered by the Congress in this decade.
- The budgetary dynamics of Health Savings Accounts (HSAs) are driven by the number of taxpayers eligible to enroll in an HSA, and the magnitude of the contributions that are made on their behalf. We believe, given the constraints of employee morale and collective bargaining limits, that scorekeepers are unlikely to consider minor changes in HSA regulations as making material changes in the number of employers offering HDHP.

- Holding enrollment and contributions constant, changes to the rules regulating permissible distributions of HSA balances do not necessarily change the revenue effects of HSAs.
- If, however, a policy governing distributions could, over time, increase premiums paid by employers for high deductible health plans, we would expect scorekeepers to take cognizance of the shift in compensation from taxable wages to non-taxable benefits that would result.
- We would expect that a substantial majority of distributions of the type authorized by this legislation would be made on behalf of beneficiaries whose spending is below the HDHP deductible, and hence such spending would not affect HDHP premiums.
- Stakeholders should be prepared for the prospect that scorekeepers will find the bill as a whole to result in some loss of revenue.
- We do not believe that either JCT or CBO would consider future reductions in service use by individuals receiving new preventive benefits as an offset to the revenue effects of the bill.

Our commentary on the individual provisions of the bill is presented in the balance of this memorandum.

Commentary on Specific Provisions

Section 2 Excepted benefits allowed as permitted insurance

This provision would slightly broaden eligibility for HSA participation by individuals purchasing insurance for benefits that are presently deemed to be “excepted benefits” under 223(c) of the IRC. An analysis of this provision shared with us suggested that this provision would increase HSA enrollment by about 25,000 beneficiaries, and would likely result in a reduction in revenues \$85 M over ten years. Having reviewed this estimate, we believe that a score of this magnitude is plausible.

Section 3 Onsite employee clinics and retail clinics

Our analysis of this policy follows our general hypothesis that policies expanding permissible distributions do not necessarily result in reduced revenues unless they would also have the effect of increasing HSA enrollment and/or contributions. Here we believe that while this may, on the margins, cause some number of employers to offer HDHPs and thus make their employees eligible for HSAs, we believe this impact is so modest as to be immaterial to the score, especially given the pressure on HDHP premiums applied by other provisions in this act.

Section 4 Contributions permitted if spouse has a health flexible spending account.

This policy would be scored as expanding contributions, and hence reducing revenues. We cannot render an independent judgment on the magnitude of this score. We note, however, that a provision that authorized catch-up contributions by both spouses was scored in last year’s

analysis of HR 1628 as reducing revenues by less than \$400 million over ten years. While these policies are not exactly congruent, the HR 1628 score may be of comparable magnitude to what scorekeepers might come up with here.

Section 5 Dependents including children up to age 26.

We read this policy as a change to the definition of qualified medical expenses; we do not infer any change in HSA enrollment or contributions. Hence our analysis follows our general hypothesis that policies expanding permissible distributions do not necessarily result in reduced revenues unless the increase in expenditures was large enough to affect HDHP premiums.

Section 6 Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA) interaction with HSAs

Depending on how this provision is read,¹ JCT may assign a significant score if it interprets it as a means for employer plan sponsors to increase contributions to FSAs and HRAs in a manner that effectively increases the overall limits for tax-exempt contributions. Even if the immediate impact on existing arrangements is small, we expect JCT to conclude that creating new categories of FSAs and HRAs that wrap around the existing HSA contribution could motivate plan sponsors to revise their plans over time to take advantage of this expanded benefit. We do not, however, have access to the data sources available to JCT/CBO that would be required to parse the present and potential size of the increase in contributions that could result under this policy.

Section 7 Chronic disease prevention

This policy provides that, as is presently done with respect to preventive services, an insurance arrangement would not be disqualified as a HDHP solely by reason of providing coverage that does not apply a deductible to treatment for medically complex chronic cases. We read this policy to be permissive of innovations in HDPH design, rather than as an attempt to expand HSA eligibility and contributions to a known set of taxpayers who are presently denied coverage because they are enrolled in such plans. It is possible that JCT would score some revenue loss from this provision if it concludes that entry of such plans into the market would increase premiums in the HDHP market.

Section 8 Amounts paid for physical activity, fitness and exercise treated as amounts paid for medical care.

This policy is presently drafted as an amendment to §213(d)(1), which defines medical care for the purposes of all exclusions and deductions in the code—not just for health savings accounts. In July of 2014, JCT assigned a score of \$2.5 billion over 2015 to 2024 to a parallel policy. We understand that stakeholders are advocating narrowing the policy so that is applicable only to §223. Were this provision amended in that way, we believe that the revenue impact would align with our general hypothesis that policies that affected distributions would show a revenue effect

¹ The text of Section 6 makes reference to a clause iv in subsection (B) that does not appear in our copy of §223, which was printed off the Cornell Law Web Site on March 10, 2018.

only if they affected HDHP premiums sufficiently to affect the overall level of Employer Group Health Plan (EGHP) contributions for non-taxable benefits.

In addition to our evaluation of the scoring issues associated with the provisions of H.R. 5138, we were also asked to provide our assessment of the scoring implications of the bill presently numbered H.R. 365 / S.1358, which proposes two substantive changes in policy with respect to so-called “Direct Primary Care” arrangements, under which patients make monthly payments to an organization that affords them open access to primary care services. Those changes would clarify that:

- Participation in such an arrangement would not in and of itself disqualify a taxpayer from establishing an HSA; and that
- Payment made to a direct primary care (DPC) arrangement would be permissible distributions of funds from an HSA.

Based on our evaluation of the budgetary implications of this policy, we agree with the general conclusion reached by stakeholders that enacting these changes would not result in a substantial loss of revenue. We do not read this legislation as breaking the presently-required link between HSA participation and HDHP enrollment. The number of individuals presently barred from HSA participation solely by reason of DPC enrollment is undoubtedly small. Permitting HSA distributions to be made for DPC services would not in and of itself result in an increase in HSA enrollment and/or contributions.

While proponents of various policies in this space advance the argument that revenue losses from the effects of these policies would be offset by cost reductions elsewhere in the system, this sort of offset is typically not recognized by the scorekeeping agencies in estimating federal direct spending and revenues. Hence we doubt that JCT and, if consulted, CBO would conclude that any of the individual policies under consideration would be fully “deficit neutral.”