Written Statement of

Roy J. Ramthun
President, HSA Consulting Services, LLC

Before the

Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives

Wednesday, June 6, 2018

Chairman Roskam, Ranking Member Levin and members of the Subcommittee, I would like to thank you for this opportunity to testify before the Subcommittee on Health about how consumer-directed health plans and Health Savings Accounts (HSAs) can help lower costs and expand access to health care. My name is Roy Ramthun, and I am a private consultant residing in the Washington, DC area. My consulting practice focuses primarily on helping financial institutions, HSA administrators, employers, health plans, brokers, and consumers to better understand and take advantage of the benefits offered by consumer-driven health care programs such as HSAs and their associated health insurance plans.

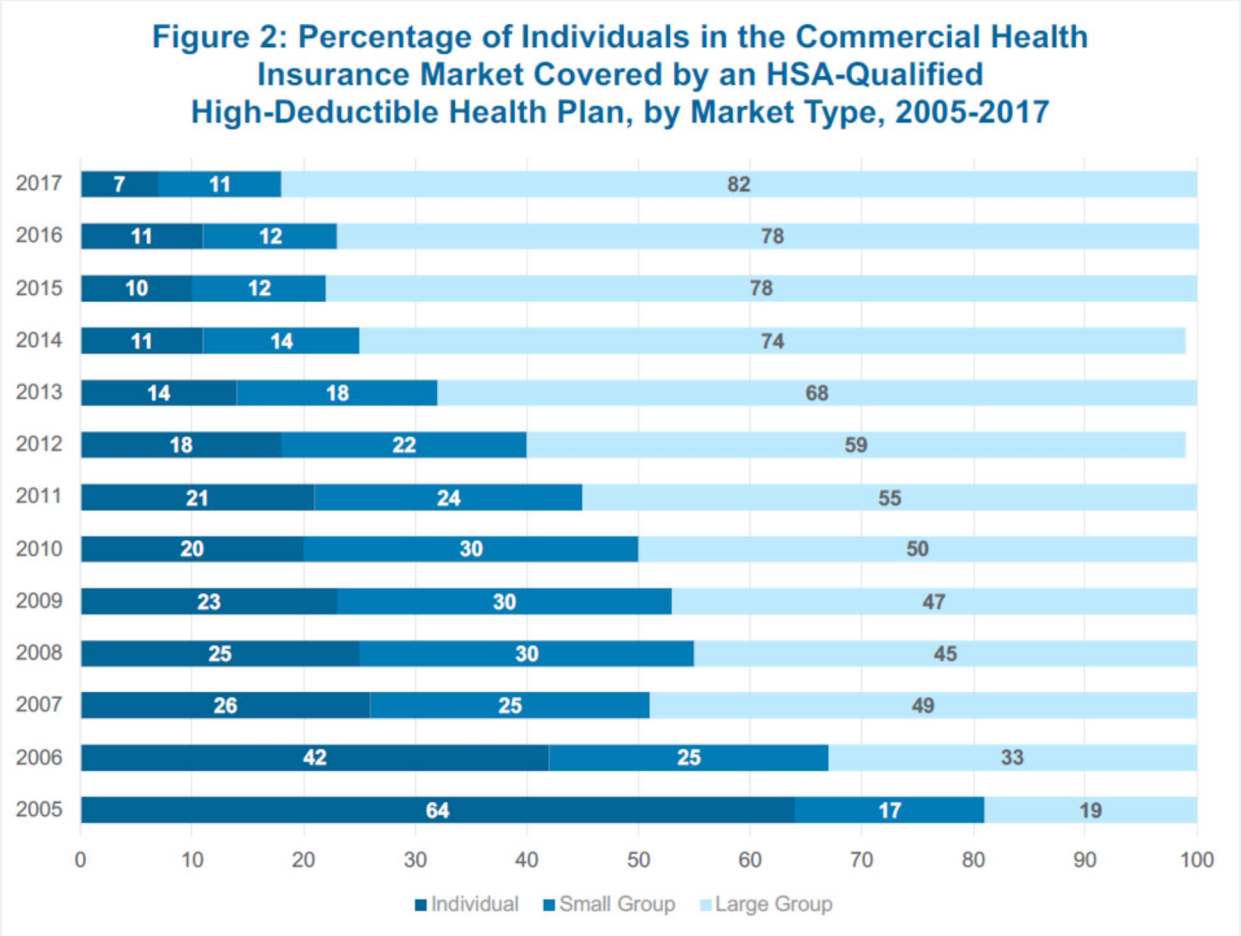
I have had the distinct honor to serve our country in positions at the U.S. Senate Committee on Finance, the White House, the Treasury Department, and the Department of Health and Human Services (HHS). While at the Treasury Department, I led the implementation of the HSA program after its enactment in 2003. I started my own consulting practice after leaving the White House in 2006 to devote my full time and attention to this program and related issues.

Brief History of HSAs

HSAs were officially created in the Medicare Modernization Act of 2003 (P.L.: 108-173), although they can trace their roots to a demonstration program created in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104–191) known as Archer Medical Savings Accounts (MSAs). The basic structure has remained largely unchanged since 2003, with somewhat modest changes having been made in the Health Opportunity Patient Empowerment (HOPE) Act of 2006 (title III of P.L. 109-432) and the Affordable Care Act of 2010 (P.L. 111–148). Starting in 2014, HSA-qualified health insurance plans have been offered on the state health insurance exchanges as well.

Evolution of HSAs Since 2003

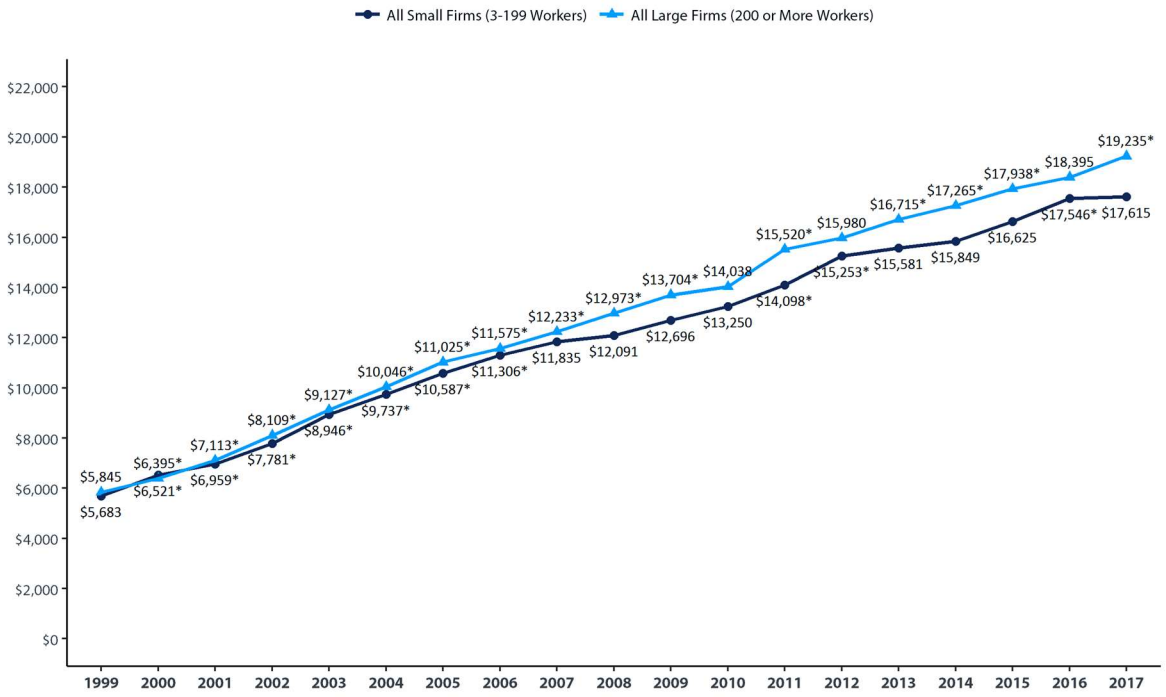
The history of the HSA program is a tale of two markets. In the early days, most of the growth in HSAs came from individuals and small employers. Over time, larger employers have driven most of the growth, according to data from America's Health Insurance Plans (see Fig. 2 below). According to the National Business Group on Health, nine in ten employers (90%) will offer at least one consumer-driven health plan in 2018. In addition, nearly forty percent (40%) of employers will offer a consumer-driven health plan as the only plan option in 2018, compared with thirty-five percent (35%) in 2017. The most common consumer-driven plan design is a high-deductible health plan paired with an HSA, offered by eighty percent (80%) of employers with any type of consumer-driven health plan.



Today, consumer-driven health plans are the fastest growing product in the market for employer-based group health plans. Estimates vary, but approximately thirty percent (30%) of employees are now enrolled in consumer-driven health plans. This percentage has doubled over the past 6 years. What is fueling the growth in consumer-driven health plans? One of the reasons is the dramatic increase in health insurance premiums (see Fig. 1.12 below).

Figure 1.12

Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2017



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Other surveys suggest that costs may be even higher. For example, Milliman Inc. recently reported that health care costs for the typical family of four are projected to reach $28,166 through an employer-sponsored preferred provider organization (PPO) plan this year. The 4.5 percent increase in projected costs for 2018 is the second lowest in the 18-year history of Milliman's Medical Index, just slightly above last year's record low rate of 4.3 percent.

As premiums have risen, employers and insurance carriers have increased deductibles almost annually in an effort to moderate year-over-year premium increases. Fifteen years ago, it was hard to find high deductible plans in the large employer group market. Today, it seems as if every plan is a high deductible plan as deductibles for preferred provider organizations (PPOs) and even health maintenance organizations (HMOs) have risen to levels similar to that for HSAs. Annual deductibles for workers with employer-sponsored HSA plans averaged $2,433 for self-only coverage, and $4,647 for family coverage in 2017.[1]

[1] Kaiser Family Foundation, "2017 Employer Health Benefits Survey," September 19, 2017, Figure 8.7, https://www.kff.org/report-section/ehbs-2017-section-8-high-deductible-health-plans-with-savings-option/.

Issues, Challenges & Opportunities for HSAs

HSA eligibility requires enrollment in a high deductible health insurance plan. But not all plans with high deductibles make individuals eligible for HSAs. This is due to the strict requirements for "HSA-qualified" high deductible plans. At the beginning of the program (2004), this meant a deductible of $1,000 for self-only coverage and $2,000 for family coverage. The minimum deductibles are adjusted annually for inflation[2] and have increased modestly since 2004. For 2018, the minimum deductibles have risen to $1,350 for self-only coverage and $2,700 for family coverage. If a health insurance plan does not meet the minimum deductible for 2018, it cannot be an HSA-qualified plan. While other plans may have deductibles above these amounts, there are other reasons why they are not HSA-qualified.

One of the main features that separates HSA-qualified plans from other health insurance plans with high deductibles is that the HSA-qualified plan deductible must apply to all covered benefits, including prescription drugs, received from in-network providers. Plans that do not apply a deductible or apply a separate lower deductible to prescription drugs cannot be an HSA-qualified plan. The only benefits that may be covered before the deductible is met are preventive care services. In 2010, the Affordable Care Act borrowed this concept from HSAs and made coverage of preventive care services a requirement for all health plans regardless of deductible, including self-insured employer-sponsored plans.

Another key requirement for HSA-qualified plans is an annual limit on out-of-pocket expenses. At the beginning of the program (2004), this meant annual limits of no more than $5,000 for self-only coverage and $10,000 for family coverage. The annual out-of-pocket limits are also adjusted annually for inflation[3] and have increased modestly since 2004. For 2018, these amounts have risen to $6,650 for self-only coverage and $13,300 for family coverage. If a health insurance plan does not limit annual out-of-pocket expenses to these or lower amounts for 2018, it cannot be an HSA-qualified plan.

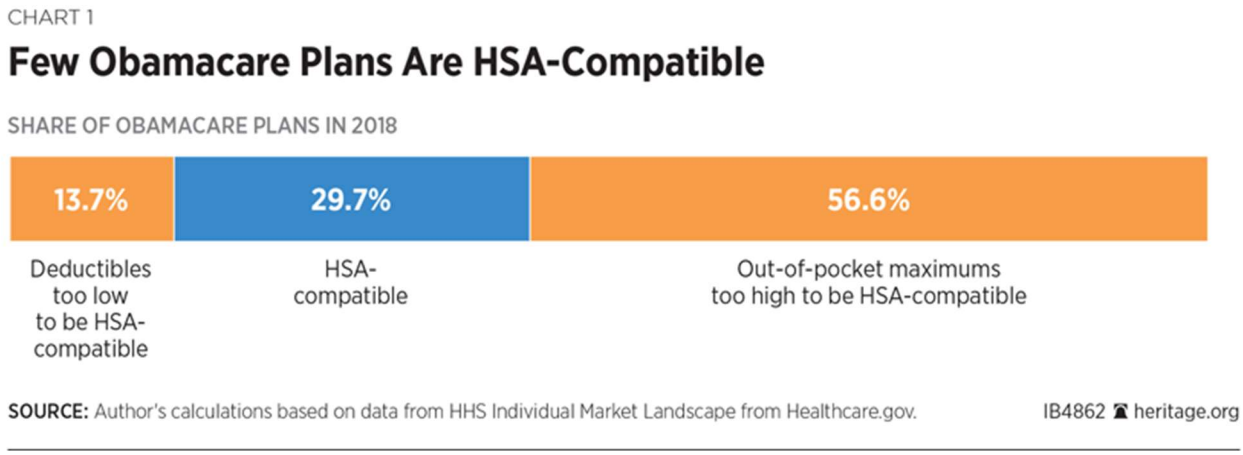
Annual out-of-pocket limits are another feature borrowed from HSAs by the Affordable Care Act (ACA) which made them a requirement for all health plans, including self-insured employer-sponsored plans. In 2014, the ACA out-of-pocket limits started out at the same amounts as the HSA out-of-pocket limits. But the annual inflation adjustment factor used to adjust the ACA limits is the medical component of the consumer price index (M-CPI) whereas the HSA-qualified plans limits have since been adjusted by CPI (now chained-CPI). Thus, the ACA out-of-pocket limits have risen much faster than the HSA limits. For example, for 2018 the ACA out-of-pocket limits are $7,350 for self-only coverage and $14,700 for family coverage, $700 and $1,400 higher than the HSA limits, respectively. This means that HSA-qualified plans provide better protection against high medical expenses than the ACA requires. Further, all plans with annual out-of-pocket limits above the HSA-qualified limits deny their enrollees access to an HSA which could greatly help them pay for their out-of-pocket costs.

[2] Initially, the inflation adjustment factor was the consumer price index (CPI) but this has now been changed to chained-CPI as a result of the tax reform law enacted in December 2017.
[3] Ibid.

There isn't much information regarding how high employers offering self-insured health plans are setting their annual out-of-pocket limits. In the individual market, the picture is clearer. According to an analysis by Ed Haislmaier of the Heritage Foundation, more than half of all plan designs (54.7 percent) in the 39 states using the federally run exchange through Healthcare.gov set out-of-pocket limits at the maximum allowed by the ACA.[4] Cost-sharing limits are set at the maximum level allowed for:

- all Catastrophic-level plans
- 51 percent of Bronze-level plan designs
- 58 percent of Silver-level plan designs
- 41 percent of Gold-level plan designs.

Because the ACA's maximum out-of-pocket limits are higher than those for HSA-qualified plans, over half (57 percent) of all plan designs now offered through the federal exchange have out-of-pocket maximums that are too high for the plan to qualify for an HSA. As shown in Chart 1 below, only 30 percent of plans sold on the federal exchange meet the criteria of having both a deductible high enough and an out-of-pocket limit low enough to qualify for an HSA. Of the plans that are not HSA-qualified, 19 percent fail to qualify because their deductibles are too low, while 81 percent do not qualify because their out-of-pocket limits are too high.[5]



Under most of ACA's HSA-qualified plan designs, annual deductibles exceed the maximum amount that an individual could contribute to their HSA. Of the HSA-qualified plan designs offered in the 39 Healthcare.gov states, 52 percent have deductibles for self-only coverage that are higher than the maximum HSA contribution amount of $3,450, and 61 percent have deductibles for family coverage that are higher than the maximum HSA contribution amount of $6,900. One-quarter of the HSA-qualified plan designs have deductibles set at, or near, the maximum out-of-pocket limit.

[4] "Obamacare's Cost Sharing is Too High, Even for HSAs," https://www.heritage.org/health-care-reform/report/obamacares-cost-sharing-too-high-even-hsas
[5] Ibid.

In the first few years of the state insurance exchanges, HSA-qualified plans were generally available, primarily in the Silver and Bronze metal tiers. But carrier exits and reductions in plan offerings have also impacted HSAs. In 2018, six of the 39 states using the federal exchange have counties in which no HSA-qualified plans are available, including Pennsylvania and Tennessee (see Table 1).[6]

TABLE 1

States with Counties that Do Not Have Any HSA-Compatible Plans on the Exchange

State	Total Counties	Counties without HSA-Compatible Plans: Number	Counties without HSA-Compatible Plans: Percent
Missouri	115	7	6%
Ohio	88	6	7%
Oklahoma	77	20	26%
Pennsylvania	67	20	30%
Tennessee	95	5	5%
Virginia	134	13	10%

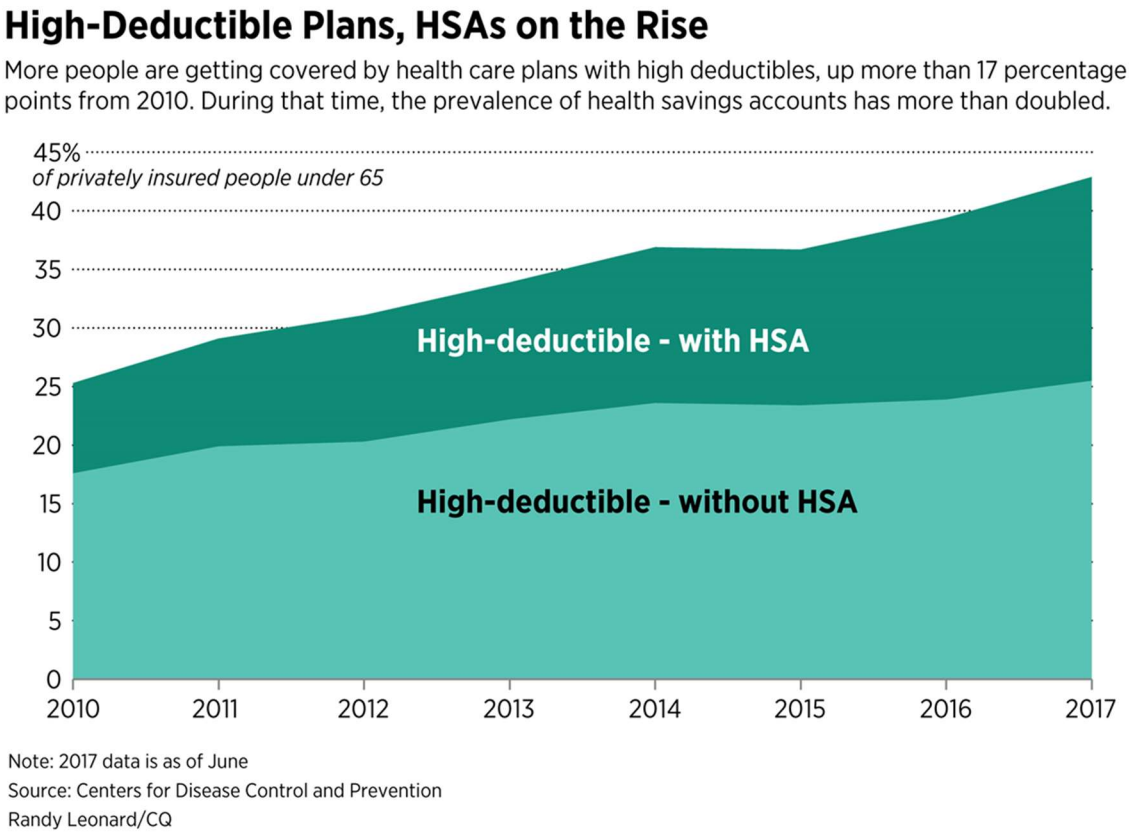
SOURCE: Author's calculations based on data from HHS Individual Market Landscape from Healthcare.gov.

IB4862 ☎ heritage.org

Looking more broadly at American's health insurance coverage throughout the year, recent data from the National Center for Health Statistics indicates that enrollment in consumer-driven health plans has grown by about seventy percent (70%) over the past seven years. Enrollment in HSA-qualified plans has doubled during this same time. Despite this growth, many more

[6] Edmund F. Haislmaier, "2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink," Heritage Foundation Issue Brief No. 4813, January 25, 2018, https://www.heritage.org/sites/default/files/2018-01/IB4813_1.pdf.

Americans are enrolled in other plans with high deductibles that do not make them eligible for an HSA. I will address this disparity later in my testimony.



The Benefits of Consumer-Driven Health Care

There are several benefits of consumer-driven health care, including premium savings for employers and workers, lower year-over-year trend, tax-free contributions by employers to workers' HSAs, and more engaged consumers. I will address each of these benefits below.

- **Premium Savings for Employers**

One of the biggest reasons employers are switching to HSAs is because the premiums are about $2,400 less than traditional plans for family coverage, as can be seen from the table below (Fig.8.8) from the September 2017 report by the Kaiser Family Foundation/Health Research in Education Trust (KFF/HRET).[7] Employers could just pocket their savings, but this report indicates that many of them are sharing their premium savings with their workers in the form of contributions to workers' HSAs. On average this amounts to $1,100 per worker for those with family coverage.

[7] https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/

Figure 8.8

Average Annual Premiums and Contributions to Savings Accounts for Covered Workers In HDHP/HRAs or HSA-Qualified HDHPs, Compared to Non-HDHP/SO Plans, 2017

	Single Coverage			Family Coverage		
	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans
Annual Premium	$6,438*	$5,773*	$6,949	$18,948	$16,821*	$19,225
Worker Contribution to Premium	$1,216	$918*	$1,288	$5,130*	$4,289*	$6,149
Firm Contribution to Premium	$5,222	$4,855*	$5,661	$13,817	$12,532	$13,076
Annual Firm Contribution to the HRA or HSA	$1,351	$608	Not Applicable	$2,444	$1,086	Not Applicable
Total Annual Firm Contribution (Firm Share of Premium Plus Firm Contribution to HRA or HSA)	$6,573*	$5,473	$5,661	$16,261*	$13,608	$13,076
Total Annual Cost (Total Premium Plus Firm Contribution to HRA or HSA)	**$7,789***	**$6,390***	**$6,949**	**$21,391***	**$17,895***	**$19,225**

NOTE: When those firms that do not contribute to the HSA (47% for single coverage and 46% for family coverage) are excluded from the calculation, the average firm contribution to the HSA for covered workers is $795 for single coverage and $1,417 for family coverage. Three percent of covered workers are enrolled in a plan where the firm matches employee HSA contributions. For HDHP/HRAs, we refer to the amount that the employer commits to make available to an HRA as a contribution for ease of discussion. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. Thus, employers may not expend the entire amount that they commit to make available to their employees through an HRA. Covered workers enrolled in a plan where the firm matches any employee contribution to an HSA account are not included in the average contribution (3% for single coverage and 3% for family coverage). Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages.

* Estimate is statistically different from estimate for Non-HDHP/SO Plans ($p < .05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

According to Willis Towers Watson's 22nd annual Best Practices in Health Care Employer Survey,[8] seventy-seven percent (77%) of best performing companies have moved their employees into consumer-driven health plans. Combined with other strategies, this has led to significant savings on their health benefit costs. Best-performing companies achieved a $2,251 per employee per year health care cost advantage over the national average in 2017 ($9,950 compared with $12,201). Other studies have shown similar results. This is hard evidence of "bending the cost curve" that is so elusive for the rest of our nation's health care system.

Why isn't every company offering consumer-driven health plans? They may have to if the ACA's "Cadillac plan" tax ever goes into effect. Companies may have few other options as effective as consumer-driven health plans to keep their costs below the thresholds where the excise tax will affect them.

- **Premium Savings for Employees**

Not only are employers saving money on premiums, workers are too – approximately $1,850 for family coverage (see Fig 8.8 above), according to the 2017 report from KFF/HRET.

- **Employer Contributions to Employees' HSAs**

Employers could just pocket their premium savings, but the 2017 KFF/HRET report indicates that many of them are sharing their premium savings with their workers in the form of contributions to workers' HSAs. On average this amounts to $1,100 per worker for those with

[8] https://www.willistowerswatson.com/en/press/2018/03/best-performing-companies-achieve-significant-health-care-cost-savings

family coverage. Combined with workers' own premium savings of $1,850, almost $3,000 can be deposited in their HSAs without taking money away from their retirement plan, take-home pay or other savings.

- **Lower Overall Spending on Health Care**

The potential for bending the cost curve for national health care spending was confirmed several years ago when researchers at the RAND Corporation published in the journal *Health Affairs* the results of their analysis of the potential impact of consumer-driven health plans on the American health care system.[9] The RAND analysis suggested that if consumer-driven health plans grow to represent half of all employer-sponsored insurance in the United States, health care spending could drop by $57 billion annually—about 4 percent of all health care spending among non-elderly Americans. The study acknowledges that HSAs are far more cost-effective and estimates that if all of the same people were covered by HSA-qualified plans the annual savings would be as high as $73.6 billion. This may be a conservative estimate.

- **More Engaged Consumers**

But consumer-driven health plans are not just about saving money. It's also about *how* the money is saved—by changing how employees think about their health and taking action to improve it. I would like to take a few moments to clear up some common misperceptions about consumer-driven health plans.

First, research is increasingly suggesting that lifestyle behaviors account for approximately three-quarters of health care spending in the U.S. This is likely to only get worse as diet, obesity, lack of exercise, and smoking take its toll on our bodies and our health care system. Fortunately, consumer-driven health plans cover preventive care services without applying a deductible or other out-of-pocket expense. In fact, "free" preventive care was included in the original design of HSAs, long before the ACA made it a requirement of all health plans. Data from Aetna, Cigna, the Employee Benefit Research Institute (EBRI), and others suggests that utilization of preventive care services is higher when individuals are enrolled in consumer-driven health plans. Additional data suggests higher compliance with disease management and treatment regimens for individuals with chronic conditions. While there is always a risk that people will seek less care when spending their own money (several studies have raised this concern), I am not aware of any evidence to suggest that the health status of individuals enrolled in consumer-driven health plans has declined, and in most cases, it appears to be improving. Obviously, this is an issue to monitor for the future.

Second, individuals enrolled in consumer-driven health plans are more engaged in their health care. Several surveys by EBRI suggest that enrollees in consumer-driven health plans are more likely to: (1) check whether their plan would cover their care; (2) talk to their doctor about treatment options and costs; (3) talk to their doctor about prescription drug options and costs; (4) ask for a generic drug; (5) check the price of service before seeking care; (6) use an online cost-

[9] https://www.rand.org/pubs/research_briefs/RB9690z3/index1.html

tracking tool; and (7) develop a budget to manage health care expenses. Similar findings have been reported by insurance carriers.

Third, HSA-qualified consumer-driven health plans provide true catastrophic protection by virtue of their annual limits on out-of-pocket expenses and have been doing so since 2004. These limits apply both to medical and pharmacy expenses and therefore provide an extremely important benefit to people with chronic conditions and/or high annual health care expenses.

Fourth, covered benefits and services are generally identical to traditional plans, not "skimpier" as some critics believe. The ACA does not allow it except for other types of insurance plans which are not generally HSA-qualified. What is different is the amount of covered benefits paid by the consumer-driven health plan. So, while the exact same benefits may be covered by each plan, the consumer-driven health plan may only cover 60 or 70 percent of the cost of covered benefits, whereas a traditional HMO or PPO plan may cover 80 or 90 percent of the cost of covered benefits, on average. However, the difference in out-of-pocket costs for covered benefits is typically offset almost dollar-for-dollar by a difference in premiums. For example, a plan with a higher deductible (by $2,000) will typically have a premium that is $2,000 lower. Many people understand this concept when applied to their auto and homeowner's insurance policies, but the concept is still relatively new to many people for their health insurance.

Fifth, even though individuals enrolled in consumer-driven health plans typically have higher out-of-pocket expenses, they still receive the benefit of the discounted prices for medical services negotiated by their insurance plan. For example, a patient may have an office visit with his or her personal physician. While the physician may charge $150 for each office visit, he/she usually accepts a discounted fee of $70 to $100 depending on the insurance plan. In these cases, the patient would pay only $70 to $100 until their deductible is met, not the full $150 charged by the physician.

Sixth, there is a growing industry of companies providing transparency services to help people manage their medical care and health care finances. Companies like Compass, Medibid, BidRx, ZendyHealth, Healthcare Blue Book, and others are responding to the needs of patients by providing better information about the price and quality of health care services. Another industry is responding to the demand for "wellness" services to help people maintain and improve their health to avoid disease and chronic conditions. These companies would likely not exist without the growing consumer demand for better value for their health care dollar.

Finally, even though individuals enrolled in consumer-driven health plans are typically subject to higher up-front deductibles, most employers are providing a contribution of funds to the associated HSA which helps lessen the sting of the deductible. In addition, workers' premium savings can also be re-directed towards funding their HSAs. With HSAs, unspent funds automatically accumulate each year and are therefore available to meet future health expenses.

Why HSAs Should Be Expanded

Eligibility for HSAs should be expanded so that millions more Americans can take advantage of their protection against high out-of-pocket costs. As deductibles have risen dramatically for all plans since the enactment of the Affordable Care Act, there is a greater need for helping Americans save for their out-of-pocket costs. HSAs could be part of the solution to this problem. HSAs are not limited to workers with the right employment -- anyone that is eligible can establish and contribute to an HSA. In addition, there is no guesswork involved and no reason to fear losing the money that is not spent each year. In fact, most people could save money simply by adding up all their qualified health expenses at the end of the year and reimbursing them through their HSA.

Proposals to Expand/Modify HSAs

Currently, there are numerous legislative proposals to modify HSAs, including some bipartisan legislation. The industry-supported "gold standard" is the Health Savings Act (H.R. 1175) sponsored by Health Subcommittee member Rep. Erik Paulsen (R-MN).

In general, HSA-related bills seek to do one or more of the following:

1. Make more Americans eligible for HSAs;
2. Allow Americans to contribute more money to their HSAs each year;
3. Allow HSAs to be more flexible so funds can be used for additional health-related expenses;
4. Allow HSA assets to be transferred or rolled over tax-free to a child, parent, or grandparent of an account owner (currently limited to spouses); or
5. Protect HSA assets from creditors in personal bankruptcy situations.

I have attached a summary of the bills introduced in the 115th Congress that include provisions addressing each of these areas (see Attachment 1).

Moving to a More Flexible Plan Design for HSAs

After reviewing the existing legislative proposals, I believe the simplest way to allow more Americans to access HSAs is to move to a more flexible health plan design for HSA-eligibility instead of the rigid "high deductible health plan" with all its bells and whistles. Americans don't want to hear why they can't have an HSA. They want to know how they can take advantage of an HSA, too.

I recently wrote a white paper[10] about one approach towards moving to a more flexible plan design based on actuarial value instead of specific deductibles and other requirements. Actuarial value is a numerical value that reflects the generosity of the plan's coverage. For example, a plan with an actuarial value of eighty percent (80%) is designed to cover eighty percent (80%) of

[10] https://www.aba.com/Advocacy/Issues/Documents/Moving-More-Flexible-Standard-HSAs.pdf

the cost of the benefits covered by the plan, on average, leaving 20 percent to be paid out-of-pocket by the individual(s) enrolled in the plan.

Actuarial value reflects the plan design features including deductibles, copays, coinsurance, and annual limits on out-of-pocket expenses. In general, the greater the amount of covered benefits the plan pays (i.e., the less the consumer pays out-of-pocket), the higher the actuarial value. Since deductibles and out-of-pocket limits have the greatest impact on actuarial value, this means that plans with lower deductibles and lower out-of-pocket limits typically have higher actuarial values because the plan pays a larger share of the total benefit costs. Conversely, plans with higher deductibles and higher out-of-pocket limits typically have lower actuarial values because the plan pays a smaller share of the total benefit costs.

Actuarial value is a common calculation in insurance plan design but is not typically known by or disclosed to consumers except for the "metal tier plans" (e.g., Bronze, Silver, etc.) available in the state health insurance exchanges under the ACA. Actuarial value can help consumers compare the cost of premiums relative to their exposure for out-of-pocket costs. Under the ACA, insurance carriers use a standardized methodology (the "AV Calculator") for determining the actuarial value of each plan offered on the state insurance exchanges in a standardized way. This methodology or a similar standard could be used for this purpose.

In my white paper, I propose that future HSA eligibility could be based on a plan's actuarial value instead of specific deductibles and other plan features. I recommend that enrollment in a health plan with an actuarial value below eighty percent (80%) would make consumers eligible for an HSA. I recommend this threshold for actuarial value because HSA-qualified plans can currently be offered in the Gold metal tier on the state insurance exchanges.

Once an AV standard is set for future HSA-qualified plans, insurance carriers should have the flexibility to design plans with vary levels of cost-sharing. All plans with actuarial values below the eighty percent (80%) threshold would make consumers eligible for HSAs. Plans with actuarial values above that standard would not. I hope you will consider this proposal as you contemplate making changes to HSAs.

Conclusion

I support expanding HSAs to more Americans to help them with their growing out-of-pocket costs. I also support expanding contribution limits for HSAs so that everyone has the opportunity to cover their risk of out-of-pocket expenses through their HSA. One never knows when a "really bad year" might be lurking around the corner. If we are lucky enough to keep our job and our health, then the money we save will help us pay for our health care in retirement. With Medicare's finances less than certain and the potential cost of long term care, expanding HSAs is one way of helping us all.

On another Medicare-related note, when I turn 65 I will not have the option to stay off Medicare even if I continue to work as a self-employed individual. I think this should be changed. I would like to continue my HSA eligibility and save taxpayers money by not having Medicare

cover my medical bills until I fully retire. Expanding HSAs to working seniors would eliminate the discrimination for millions of pre-retirees that can and choose to work beyond age 65. Many of us want to and have the incentive to do so because we will not be able to qualify for full Social Security benefits until age 67.

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to provide this testimony today. I look forward to the opportunity to discuss these issues in greater detail with you. I would be pleased to answer any questions you have.

Thank you.

Attachment 1

HSA-Related Legislation Introduced in the 115th Congress

As of June 1, 2018

- **Bills that Would Make More Americans Eligible for HSAs**

  - Deem all Bronze, Silver, and Catastrophic plans sold on the state insurance exchanges as HSA-qualified plans -- H.R. 35 (Burgess)
  - Eliminate the requirement that an HSA-eligible individual be enrolled in an HSA-qualified plan – H.R. 247 (Brat), H.R. 408 (King), H.R. 1072 (Sanford)
  - Clarify that direct primary care services are not "insurance" that would disqualify an individual from HSA eligibility – H.R. 365 (Paulsen), H.R. 1175 (Paulsen), H.R. 1280 (Fortenberry)
  - Allow Medicare beneficiaries to contribute to an HSA – H.R. 408 (King).
  - Allow HSA-eligible seniors enrolled in Medicare Part A only to contribute to HSAs – H.R. 1175 (Paulsen)
  - Allow Native Americans that are otherwise HSA-eligible to contribute to their HSAs regardless of utilization of IHS or tribal medical services – H.R. 1175 (Paulsen), H.R. 1476 (Moolenaar)
  - Allow members of health care sharing ministries to contribute to HSAs – H.R. 1175 (Paulsen), H.R. 2310 (Kelly)
  - Allow HSA-eligible individuals to receive specified health care services at their employer's on-site medical clinic without cancelling their HSA-eligibility – H.R. 1175 (Paulsen)
  - Allow HSA-eligible health plans to use embedded deductibles for family coverage that are as low as the minimum deductible for self-only coverage (i.e., $1,300/person vs. $2,600/person for 2017) – H.R. 1175 (Paulsen)
  - Expand the definition of "preventive care" services to include certain prescription and over-the-counter drugs for chronic conditions – H.R. 1175 (Paulsen)
  - Modify the safe harbor definition of "preventive care" to include care related to the treatment of any medically complex chronic condition – H.R. 4978 (Black/Blumenauer), H.R. 5138 (Kelly)
  - Modify the definition of "permitted insurance" that HSA-eligible individuals may have coverage under without impacting their HSA eligibility to include insurance policies known as "excepted benefits" – H.R. 5138 (Kelly)
  - Allow HSA-eligible workers to access certain medical services provided at on-site employer clinics or retail clinics without impacting their HSA eligibility – H.R. 5138 (Kelly)
  - Allow otherwise HSA-eligible individuals to contribute to their HSA even when their spouse participates in a general health FSA – H.R. 5138 (Kelly)
  - Allow individuals participating in a health FSA or HRA to become HSA-eligible if unused funds in the FSA or HRA are converted to a post-deductible FSA or HRA, a

limited purpose FSA or HRA, a retirement HRA, a suspended HRA, or the remaining FSA or HRA funds are used solely for preventive care – H.R. 5138 (Kelly)
- Allow individuals to disclaim any coverage that would disqualify them from HSA eligibility – H.R. 5138 (Kelly)
- Modify the definition of an HSA-qualified plan to permit coverage of two primary care office visits before the deductible is satisfied (H.R. 5858)

- **Bills that Would Allow Americans to Contribute More Money to Their HSAs**

  - Set the maximum contribution to an HSA at the annual limit for out-of-pocket expenses under an HSA-qualified plan (i.e., $6,650 for singles, $13,300 for families for 2018) – H.R. 35 (Burgess), H.R. 1175 (Paulsen), H.R. 1280 (Fortenberry), H.R. 1628 (Black), H.R. 4200 (Brady)
  - Increase the HSA annual contribution limits to $10,000 singles and $20,000 families – H.R. 408 (King).
  - Remove the maximum annual contribution limit to HSAs (i.e., unlimited contributions to HSAs permitted) – H.R. 1072 (Sanford)
  - Allow an additional tax deduction for amounts contributed to the HSA of a taxpayer's child or grandchild -- H.R. 35 (Burgess)
  - Allow taxpayers to establish HSAs for their minor children and contribute up to $3,000 to each child's HSA (contributions are tax deductible) – H.R. 277 (Roe)
  - Eliminate the need to pro-rate contributions for partial year eligibility – H.R. 408 (King)
  - Change the inflation adjustment for contribution limits to medical CPI – H.R. 408 (King).
  - Add an annual inflation adjustment to the catch-up contribution limit – H.R. 408 (King).
  - Allow both spouses to make catch-up contributions to the same HSA account – H.R. 1175 (Paulsen), H.R. 1628 (Black)
  - Allow unspent funds from employees' FSAs or HRAs to be rolled over to their HSAs – H.R. 1175 (Paulsen)
  - Allow Medicare enrollees to contribute their own money to their Medicare MSAs. – H.R. 1072 (Sanford), H.R. 1175 (Paulsen)

- **Bills that Would Allow HSA Funds to Be Used for Additional Health-Related Expenses**

  - Repeal the prescription requirement for reimbursement of OTC medicines from HSAs – H.R. 247 (Brat), H.R. 394 (Jenkins), H.R. 421 (Love), H.R. 1072 (Sanford), H.R. 1175 (Paulsen), H.R. 1436 (Jordan), H.R. 1628 (Black)
  - Allow HSA funds to be used tax-free to pay for eligible medical expenses incurred by all children under age 27 regardless of tax dependent status – H.R. 1175 (Paulsen), H.R. 5138 (Kelly)
  - Allow HSA funds to be used tax-free to pay for:

    - insurance premiums – H.R. 247 (Brat), H.R. 408 (King), H.R. 1072 (Sanford), H.R. 1175 (Paulsen)
    - direct primary care services or fees – H.R. 247 (Brat), H.R. 365 (Paulsen), H.R. 1072 (Sanford), H.R. 1175 (Paulsen), H.R. 1280 (Fortenberry)
    - dietary and nutritional supplements. – H.R. 1072 (Sanford), H.R. 1175 (Paulsen)

    - fitness and exercise equipment or health coaching, including weight loss programs. – H.R. 1072 (Sanford), H.R. 1175 (Paulsen), H.R. 1280 (Fortenberry)
    - qualified sports and fitness expenses up to $1,000 per year ($2,000 for married couples) – H.R. 1267 (Smith), H.R. 5138 (Kelly)
  - Lower the tax penalty for non-qualified HSA distributions from 20% back to the original 10% – H.R. 247 (Brat), H.R. 1175 (Paulsen), H.R. 1436 (Jordan), H.R. 1628 (Black)
  - Allow HSA-eligible expenses incurred before the date the HSA is established to be reimbursed tax-free if the HSA account is established within 60 days of the date that the account owner's HSA-qualified coverage begins – H.R. 1175 (Paulsen), H.R. 1628 (Black)
  - Allow qualified expenses incurred prior to the date the HSA is established to be reimbursed tax-free from an HSA as long as the account is established prior to the tax filing deadline for the year the account is established – H.R. 1072 (Sanford)
  - Allow unspent FSA or HRA balances to be rolled over into an HSA as long as the amount does not exceed $2,250 for an individual with self-only coverage or $4,500 for an individual with family coverage (amounts adjusted annually for inflation); also eliminates the testing period that follows any rollover – H.R. 5138 (Kelly)

- **Bills that Would Place New Restrictions on Tax-Free Uses of HSA Funds**

  - Exclude elective abortions (except in the case of rape or incest) from tax-free reimbursement with HSA funds – H.R. 2019 (Foxx)

- **Bills that Would Allow HSA Assets to Be Transferred/Rolled Over Tax-Free to Family Members**

  - Allow an account holder's HSA to roll over to a child, parent, or grandparent, in addition to a spouse upon the account owner's death – H.R. 1072 (Sanford)
  - Allow required minimum distributions from retirement accounts to be deposited into HSAs – H.R. 277 (Roe)

- **Bills that Would Protect HSA Assets from Creditors in Personal Bankruptcy Situations**

  - Amend federal bankruptcy law to protect HSA assets from creditors in bankruptcy situations just as IRA assets are protected – H.R. 35 (Burgess), H.R. 1072 (Sanford), H.R. 1175 (Paulsen)

- **Bills that Would Make Other HSA Changes**

  - Rename "high deductible health plans" as "HSA-qualified health plans" – H.R. 1175 (Paulsen)