GROOM LAW GROUP

Statement of
William F. Sweetnam, Jr.
Principal, Groom Law Group, Chartered
Before the
Committee on Small Business and Entrepreneurship
United States Senate
Tuesday, February 13, 2007

Chairman Kerry, Senator Snowe and the other members of this Committee, I'd like to thank you for this opportunity to testify before the Committee on Small Business and Entrepreneurship about the problems – and some solutions – to the problem of small businesses and health care. My name is Bill Sweetnam and I'm a principal at the Groom Law Group here in Washington DC, a law firm that practices exclusively employee benefits law. I previously was the Benefits Tax Counsel in the Office of Tax Policy at the Department of the Treasury from 2001 to 2005. I was in charge of the legislative and regulatory issues surrounding employee benefits. One important area that I was involved in was the implementation of the new laws permitting Health Savings Accounts (HSAs). It is for that reason that I have been asked to testify.

As others who will testify here will state, there are problems with small business providing health insurance coverage to their employees. I believe, and statistics will confirm, that the availability of HSAs makes it easier for small employers to provide their employees with affordable health insurance coverage. The purpose of my testimony here is to urge the Congress not to cut back on any of the tax advantages that are afforded to HSAs and to provide additional changes to the HSA rules which will make HSAs more attractive to employers and employees.

Overview of Tax Treatment of Health Insurance

Under current law, if an individual receives health coverage from his employer, the entire amount of that coverage is excluded from income for both income and employment (Social Security/Medicare) tax purposes. An outgrowth of the exclusion for employer-provided health care is the favorable tax treatment of expenses paid from a flexible spending account under a cafeteria plan and the development of health reimbursement arrangements. Self-employed individuals who purchase health insurance are able to deduct the full cost of health insurance for income tax purposes. Those who are employed and purchase their health insurance on their own can only deduct their health care premiums for income tax purposes and only to the extent that they itemize their tax deductions and their health expenses exceed seven and one half percent of adjusted gross income. There is no payroll tax deduction for the purchase of individual health insurance policies; consequently, lower income individuals who purchase insurance on their own may not receive any tax relief on those purchases. Therefore, it is critical to try to get as many individuals covered under employer-provided health coverage as possible.

Importance of Cost of Health Insurance in Small Business Market

Small businesses are very cost sensitive when it comes to providing health insurance to their employees. As the cost of health insurance goes up, small business owners have few choices. One option is to not offer coverage if the cost of health insurance coverage is too large. Other options would be to increase the costs that employees have to bear to continue to have that health coverage. That cost increase can come in different ways. One way would be to increase the premium that the employee pays to participate in the employer's health care plan. This, of course, raises the likelihood that an employee will decide that he or she cannot afford health care coverage and not participate in the employer's health insurance plan. Another method of controlling costs is to increase the amount of the deductible under the health insurance plan or to increase the amount of co-payments for each service or visit to the doctor. This helps keep the monthly premium down, but increases the costs for the individual when using health care services under the plan.

Health Savings Accounts as an Alternative

HSAs provide another way for small businesses to provide health insurance coverage for their employees in a cost effective manner. A HSA is a funded account, similar to an IRA.

Contributions to the HSA may be made within specified limits by individuals who are not yet entitled to Medicare and/or by employers on behalf of such individuals. For 2007, the contribution limits is $2,850 (self-only) or $5,650 (family) coverage. Contributions to the HSA by an eligible individual are fully deductible by the individual making the contribution, regardless of whether the individual is employed.

Amounts in an HSA grow on a tax-free basis and, if used for medical expenses, may be withdrawn on a tax-free basis. Amounts may be distributed for non-medical purposes, but such distributions are subject to income tax and may be subject to a 10 percent additional tax.

In order to contribute to an HSA, an individual must be covered under a "high deductible health plan" ("HDHP") and may not participate in any other non-high deductible health plan, subject to certain exceptions. For 2007, an HDHP is defined as a plan with a minimum annual deductible of $1,100 for self-only or $2,200 for family coverage. The annual out-of pocket cap for the HDHP must not exceed $5,500 for self-only or $11,000 for family coverage. As with other traditional health insurance, premiums that the employer pays for the HDHP are excludible from the employees' income.

The premium for an HDHP is usually much less than the insurance premium for typical heath insurance. With the lower premium, employers have savings that they can contribute to the HSA. In 2004, the first year that HSAs were available, there were many examples of small businesses that purchased HDHPs for their employees and, with the savings due to the lower premiums, made contributions to the HSAs for their employees. For example, Activities Press of Ohio, a small business with 45 employees, switched to an HSA/HDHP arrangement in 2004. [1]

[1] HSA Insider, April 30, 2004.

They contributed $2,000 to an HSA for each employee that had family coverage and $1,000 for employees with individual coverage. Their total savings after the switch to the HSA/HDHP was $56,500. Similarly, Mercury Office Supply with 13 employees had savings of $12,000 in 2004 for switching to an HSA/HDHP arrangement and they made contributions to their employees' HSAs of $2,500 for those with family coverage and $1,200 for those with individual coverage.[2] These are just a few of the stories about small businesses using the HSA/HDHP arrangement as a way to provide health care to employees that I heard about while at the Treasury Department.

Current Market for HSAs

Unfortunately there is little recent government data on how many HSAs have been opened. That information would be derived from a compilation of income tax returns and that information is only available years after the return is filed. Since HSAs have only been available since 2004, there has not been enough time for an adequate determination from government sources of the number of HSAs established.[3] However, industry surveys have shown a growth in enrollment in HSAs from 438,000 in September 2004 to 3.2 million in January 2006.[4] In the small group market[5], the 2006 survey showed that the growth in covered lives under HSA/HDHP arrangements increased from 79,000 in 2004 to 510,000 in 2006, and the total coverage moved from 438,000 covered lives in 2004 to 3,168,000 covered lives in 2006. This survey also found that in the small group market, 33 percent of the small-group policies were purchased by employers that previously offered no health care coverage to their workforce.

A recently released study from UnitedHealth Group[6] provides further information. UnitedHealth Group, though its Definity Health business, is the largest provider of consumer-directed health plans in the country. The study found that, despite fears that the HSAs would only appeal to the wealthy, HSA are utilized by consumers across all income ranges. Most notably, 80 percent of low-income individuals (those earning $25,000 or less annually) open HSA accounts if the employer makes a contribution to an HSA. If the employer does not make a contribution to an HSA, however, lower income individuals are less likely to fund their own HSA accounts. In UnitedHealth's survey, those small employers that do contribute to their employees' HSA make on average a contribution of $1,109 annually.

---

[2] HSA Insider, April 15, 2004.

[3] The Government Accountability Office (GAO) has issued a report in 2006 on HSAs (GAO Report 06-798) that was based on very limited consumer experience with. The report relied on 2004 data and the authors of the report concede that "[m]uch of the data ... cannot be generalized to all HSA-eligible plans and enrollees or HSA account holders." The GAO's analysis of specific employers' experience with HSAs was based on the experience of three employers.

[4] Center for Policy and Research, America's Health Insurance Plans (AHIP) 2006 Study of HSA enrollment. ("AHIP Study")

[5] The small group market in the AHIP survey was generally defined as employers with 50 or fewer employees.

[6] http://www.unitedhealthgroup.com

Congress Should Let the HSA Market Mature

Policy makers should not take from the current data that HSAs are not successful and that they should be curtailed. The AHIP study shows that approximately one third of the individuals that have an HSA/HDHP arrangement did not previously have health insurance coverage. HSAs are a new product and there must be time given to have them more fully accepted in the market place. 401(k) plans were once new and untested, yet no one now believes that the slow early years of 401(k) adoption should have resulted in Congressional action to eliminate the 401(k) plan as an alternative savings provision. HSAs should have the same chance to mature in the marketplace as 401(k) plans did.

Recent Legislative Changes to HSAs

In an effort to continue to promote HSAs and to make the transition to HSAs easier, Congress enacted the Tax Relief and Health Care Act of 2006 (H.R. 6111) (the "Act"). The Act includes several significant provisions that are generally effective in 2007, except where noted otherwise:

Modifies the limit on contributions to HSAs, so that it is not limited to the annual deductible of the high deductible health plan (HDHP); instead, contributions would be limited only by indexed dollar amount ($2,850 self-only; $5,650 family for 2007).

Under current law, HSA eligible individuals may make HSA contributions up to the lesser of (i) 100% of the annual deductible limit of the eligible individual's high deductible health plan ("HDHP") or (ii) $2,850 for self-only and $5,650 for family coverage for 2007 (indexed for inflation). Under this rule, it is unlikely that an individual who incurs any significant medical expenses could accumulate amounts in the HSA from year to year. Under the new provision, eligible individuals will be able to contribute up to $2,850 (self-only) or $5,650 (family) for 2007, regardless of the annual deductible under the individual's HDHP. Allowing an individual to contribute more than the HDHP deductible to his or her HSA increases the likelihood that some amounts in the HSA will carry over from year to year. This makes it easier for a small business to provide an HSA/HDHP arrangement to its employees.

Requires the Secretary of Treasury to announce the cost-of-living adjustments applicable to HSAs by June 1 of each year. This change is effective for tax years beginning after 2007.

Each year, certain key figures relating to the HDHP limits and the amount that an individual can contribute to an HSA are adjusted for inflation. Under current law, the cost-of-living increase is based upon information from the Bureau of Labor and Statistics (BLS)--specifically, the average consumer price index ("CPI") as of the close of the 12-month period ending on August 31. The IRS announces the new limits in a Revenue Procedure that is generally published in November each year, which is widely viewed as providing an inadequate amount of lead time for insurance companies and other HSA providers who are offering HDHP/HSA products and employers who are distributing open enrollment materials for the following year. The new provision changes the dates for which the CPI is measured for HSA purposes to the 12-month period ending on March 31st of the calendar year, allowing the

calculation to be performed earlier in the year. The new provision also requires the Secretary of Treasury to announce the cost-of-living adjustments applicable to HSAs by June 1 of each year. This will make it easier for employers to communicate the details of the HSA/HDHP arrangement earlier in the year.

Allows individuals who become covered by a HDHP after January to contribute up to the full annual limit, even if they were only eligible individuals for a portion of the taxable year.

Under current law, an individual who enrolls in an HDHP mid-year is subject to the minimum annual deductible under the HDHP, but such individual's maximum HSA contribution limit is reduced on a pro-rata basis for each month that the individual did not have HDHP coverage as of the first day of the month. The new provision corrects this disparity and provides that an individual who becomes an HSA-eligible individual in any month after January may make the full HSA contribution for the year (e.g., $2,850 for self-only coverage for 2007). If, however, an individual who becomes an HSA-eligible individual mid-year is no longer an eligible individual (e.g., is no longer covered by an HDHP) at any time during the 13-month period beginning with the last month of that year, the contribution amounts attributable to the months preceding the month in which the individual became HSA-eligible are includible in income and subject to a 10% additional tax. This makes it easier for an employer to change to an HSA/HDHP arrangement mid-year.

Permits an individual to transfer the balance remaining in his or her FSA or HRA account as of September 21, 2006 (or, if less, the balance on the date of the transfer) to an HSA. The transfer must be made before January 1, 2012.

Under current law, no transfer from a flexible spending arrangement ("FSA") or health reimbursement arrangement ("HRA") to any other type of account, including an HSA, is permitted. Making such a transfer would violate sections 106 and 105 of the Internal Revenue Code that apply to FSAs and HRAs, and would result in adverse tax consequences for the participant and the employer. Effective after the date of enactment, this provision allows a one-time transfer from an FSA or HRA to an HSA and specifies that transferred amounts are excludable from wages for income and employment tax purposes. Such amounts are not deductible as HSA contributions and are not subject to the maximum contribution limit (transferred amounts do not count against the maximum contribution limit). If, at any time during the 13-month period beginning with the month of the transfer, an individual is no longer an eligible individual (e.g., is no longer covered by an HDHP), the transferred amounts are includible in income and subject to a 10% additional tax. Employers allowing any employee to make the one-time transfer must make it available to all eligible individuals covered by an HDHP of the employer. This provision will generally be applicable to larger employers that are more likely to sponsor FSAs and HRAs.

Allows coverage under a health FSA during the "2-1/2 Month Grace Period" to be disregarded for eligible individuals who have a zero balance in their HSA at the end of the previous calendar year.

Under current law, an individual covered under an FSA is generally precluded from contributing to an HSA. Pursuant to Notice 2005-42, FSA plan sponsors may allow FSA participants to continue to incur qualifying medical expenses up to March 15th following the close of the plan year (the "2-1/2 month grace period"). According to Notice 2005-86, an individual participating in an FSA that incorporates the 2-1/2 month grace period generally may not contribute to an HSA until the first month following the end of the 2-1/2 month grace period, even if the participant's account balance is "zero." Under the new provision, a participant in an FSA that incorporates the 2-1/2 month grace period may nonetheless contribute to an HSA during the grace period if his or her account balance is "zero" as of the end of the previous plan year. Alternatively, if the FSA participant maintains amounts in his or her account balance at the end of the plan year, the participant may make a one-time transfer of the balance to an HSA (in accordance with rules prescribed by Treasury and the rules discussed above). This provision is effective on date of enactment. Again, this provision will generally be applicable to larger employers that are more likely to maintain FSAs and HRAs for their employees.

Allows employers to make contributions to HSAs on behalf of non-highly compensated employees in higher amounts (or higher percentages of deductibles) than to highly compensated employees without violating the comparable contribution rules.

If employers make contributions to the HSAs of employees, those contributions must generally be either the same amount or the same percentage of the HDHP's deductible for the year. This is known as the comparable contribution rules. These rules do not apply to employer contributions that are made through a cafeteria plan.

The comparable contribution rules generally preclude an employer from making contributions to HSAs on behalf of non-highly compensated employees ("NHCEs") in higher amounts (or higher percentages of deductibles) than to highly compensated employees ("HCEs"). Under the new provision, employers are permitted to make greater HSA contributions on behalf of NHCEs, but must satisfy the comparability rules with respect to contributions to NHCEs.[7]

Allows individuals to make a one-time distribution to rollover amounts from an IRA to an HSA, subject to the HSA contribution limit.

Under current law, no amount may be rolled over from an individual retirement account ("IRA") to an HSA. The new provision allows a one-time rollover from an IRA into an HSA. Such amounts are not includible in income, nor subject to the 10% additional tax applicable to early withdrawals from an IRA. The transfer amount is not deductible and counts against the maximum HSA contribution limit for the year (e.g., $2,850 for self-only and $5,650 for family coverage for 2007). An individual with self-only coverage who transfers amounts from his or her IRA to an HSA may subsequently make an additional transfer if the individual switches to family coverage. The maximum amount of the additional transfer is equal to the difference between the amount transferred while the individual had self-only coverage and the maximum

[7] For these purposes, HCEs are defined under Internal Revenue Code section 414(q). In general, individuals who earn less than $100,000 (for 2007) are considered NHCEs.

deductible limit for family coverage for the year. Similar to the one-time rollover from an FSA or HRA, if, at any time during the 13-month period beginning with the month of the transfer, an individual is no longer an eligible individual, the transferred amounts are includible in income and subject to a 10% additional tax.

Legislative Proposals regarding HSAs

While the provisions regarding HSAs that were part of the Act will be very helpful in further developing the market for HSAs, the Bush Administration did propose other HSA – related legislative changes as part of its fiscal year 2008 budget proposal.

The Administration proposed the following changes:

Expand Qualifying High Deductible Health Plans. To make a contribution to an HSA, the individual must have a qualifying HDHP, which has a deductible of at least $1,100 for self-only coverage and $2,200 for family coverage in 2007 and a maximum out-of-pocket of no more than $5,500 for self-only coverage and $11,000 for family coverage. The proposal would allow plans with 50 percent or more coinsurance and a minimum out-of-pocket exposure to be considered a qualifying high deductible health plan if, under rules established by the IRS and Treasury Department, the resulting policy had the same (or lower) premiums than an already qualifying HDHP would.

Qualifying Medical Expenses. Under current law, qualifying medical expenses can only be paid out of the HSA tax-free if they were expenses incurred after the HSA was established. Under the Administration's proposal, medical expenses that were incurred on or after the first day the individual was eligible to contribute to an HSA (i.e., after the HDHP coverage was obtained) may be reimbursed tax-free as long as the HSA is established before the filing date of the individual's tax return for the year.

Larger Employer Contributions for the Chronically Ill. The comparable contribution rules generally preclude an employer from making contributions to HSAs on behalf of NHCEs in higher amounts (or higher percentages of deductibles) than to HCEs. Under the recently passed Tax Relief and Health Care Act of 2006, employers are permitted to make greater HSA contributions on behalf of NHCEs, but they must satisfy the comparability rules under which each NHCE must get the same dollar amount of contribution from the employer. The Administration's proposal allows contributions to an HSA on account of employees who are chronically ill or who have spouses or dependents who are chronically ill to be excluded from the comparable contribution rules to the extent that these contributions exceed the comparable contributions to other employees.

Deductibles in Family Policies. Under the current law, the HDHP deductible must be reached by the entire family, rather than on a per-family member basis. Plans that have an embedded deductible (where a lesser deductible applies to each family member) are not considered an HDHP for HSA purposes. The Administration's proposal would allow these embedded deductibles as long as the deductible is at least the minimum deductible for individual coverage and the overall family deductible is at least equal to the family HDHP minimum deductible.

Catch-Up Contributions. Individuals who are over age 55 are permitted to make an additional contribution to their HSA annually ($800 in 2007). The Administration's proposal would permit both spouses who are eligible individuals to make catch-up contributions to an HSA owned by just one spouse.

HSA Contributions of Individuals Covered by HRA or FSA. Generally, if an individual is covered by an FSA under a cafeteria plan or under a HRA, that individual is not eligible to make a contribution to an HSA. The Administration's proposal would allow such an individual to make a contribution to an HSA while still covered by the FSA or HRA; however, the allowable HSA contribution would be reduced by the FSA or HRA coverage amount. This should make it easier for an individual to transfer to HDHP/HSA coverage when he or she was previously participating in a FSA or HRA.

Use of Cafeteria Plans in Small Businesses.

As mentioned at the beginning of my testimony, cafeteria plans provide another tax-favored way to pay for health insurance coverage. With a cafeteria plan, an employee can elect to have a portion of his compensation used to pay for qualified medical expenses on a pre-tax basis. Some employers allow their employees to use cafeteria plan elections to pay for their health insurance premiums on a pre-tax basis. Other employers allow employees to establish FSAs where the salary reduction contributions are later used to pay for medical expenses, such as co-pay amounts and other medical expenses that are not covered under the employers' health plan. Because of the nondiscrimination rules regarding the use of cafeteria plans and FSAs, many small businesses are unable to offer them for their employees.

Senator Snowe has recently introduced legislation to make it easier for small businesses to establish a cafeteria plan. The legislation, The SIMPLE Cafeteria Plan Act of 2007, will provide small businesses another way to offer cafeteria plans to their employees by providing that the nondiscrimination rules will be met if the employer provides a matching contribution on behalf of lower paid employees. This will provide one more way for small businesses to provide more tax effective health care coverage to their employees and the Congress should seriously consider its enactment.

* * * *

I thank you for this opportunity to testify before this Committee and I am available to answer any questions that you might have.