

Exhibit Number: 18

The following exhibit is several assorted documents that exceeds the 10-page limit therefore it cannot be scanned. A small portion has been scanned to aid in your research for information. The exhibit is on file at the Montana Historical Society and can be viewed there.

Committee on Public Health, Welfare & Safety

SENATE PUBLIC HEALTH, WELFARE & SAFETY
EXHIBIT NO. <u>19</u>
DATE: <u>2-18-05</u>
BILL NO. <u>SB 467</u>

Testimony on SB 467

Sponsored by Sen. John Esp

Before the Senate Committee on Public Health, Welfare and Safety

February 18, 2005

Mr. Chairman, Members of the Committee:

For the record my name is Connie Welsh. I am Chief of the Employee Benefits Bureau in the Department of Administration. We are here today to testify, very reluctantly, in opposition of SB 467.

Senator Esp has been very gracious in visiting with us on a couple of occasions about this bill and as we understand the objective, we believe at a very high level we have the same goal. In order to provide some accountability to the increase in health care costs we need to engage the consumer in understanding and making decisions about the cost and consumption of health care. Where we differ, I believe, is in how we achieve that goal.

There are two main reasons for our opposition to the bill.

1. First, this bill would legislate very specific plan offerings within the overall package of State Employee Benefits. When the Legislature created the State Employee Benefit pool in 1979, they provided for an advisory council (SEGBAC) to advise the Department on matters pertaining to benefit offerings to the members of the plan. [2-15-1016, MCA] This Council is comprised of 12 members representing employees, retirees, union members (two union rep seats), and a member of the Legislature. In the past, Senator Grimes has served as the Legislator representative on the Council.

The Department consults with the Council in matters related to the benefits offered to plan members. They are able to consider the entire scope of the plan and make decisions about the impact of changes on the entire system and how it impacts plan members as well as the overall cost of the program. By developing and making decisions on plan changes in the context of the overall program, we are able to reduce unwelcome consequences and maximize the performance of the plan. In addition, since the unions are part of the Council, benefits are NOT a subject of collective bargaining.

This model was actually adopted by the State of Wyoming. They had a system that was vulnerable to piecemeal decision making and as a result that state scrapped their system and started over with a system like ours. My predecessor assisted them by providing information about our Council, governance, and administrative structure.

2. The second reason we oppose the bill is because we don't believe this is the best way to achieve engaging employees in consumer health care. In particular, it requires that we offer at least two high-deductible health plans (HDHPs), that they be offered no later than January 1, 2006, and that the Health Savings Account (HSA) platform be the basis for the consumer plan.

I believe you have in front of you a packet. There are three Attachments.

Attachment A is a 14 pg. document comparing three tax vehicles for delivering health care. It really hits the highlights of how HSAs compare to a Health Reimbursement Account or HRA and to a Flexible Spending Account arrangement or FSA. I'm not going to go over this in detail, this is more for your reference and to address questions.

Attachment B is a Time Line of Events involving the Department and Councils actions regarding implementing a consumer plan and authorization of these various tax vehicles.

Finally Attachment C is a picture of our 2005 benefit plans laid alongside a potential consumer plan offering so I can show you why it is important to develop a plan in consideration with the total package of offerings.

If you could please turn to Attachment B, I'd like to take you through this timeline. The State Plan began to develop a plan to offer a consumer driven health plan back in 2002. Let's distinguish a consumer driven health plan from an account such as an HSA or HRA. The plan actually is a combination of the benefit design structure, all of the contracts and supporting services needed to administer it as well as the tax platform it uses. The accounts are the tax platform allowing tax advantaged treatment of those dollars for health care.

=> Go thru highlights of Attachment B.

- discussion of elimination of Basic Plan and actuarial advantage to limiting the number of plan offerings (concern with multiple HDHPs)
- discussion of timeline for offering product (no later than January 1, 2007)

Now if I could ask you to look at Attachment C, I'd like to go over why we think that limiting the plan to an HSA platform may not be the way to go. We currently have four medical plan offerings. If you look at the Provider Network line, you will see that each of our existing medical offerings have a different network. Right above that section I've listed the rates. Now the three plans titled "...MC Plan" have nearly identical benefits. They are three different companies that administer them and use different networks. The variation in the rates is largely due to how much difference there is in the discounts in those networks. We are able to provide a good level of coverage at varying deductible levels by managing those plans. What we want to do with a CD plan is to offer a complementary plan that provides some premium relief, ideally we would be able to make some amount of state share available to the employee or plan member to saving in an accounts (the incentive if you will) and not cause adverse selection in the remaining offerings. Let me give an example. If we were just to add two low premium plans and allow people to take the state share difference and keep it that would be very attractive to our healthy folks who aren't using services. However, if you are facing high cost surgery, you likely would want to be on a lower deductible plan to reduce your out of pocket. This is adverse selection since the healthy folks are not keeping money into the pool to pay the costs of the sick folks. However, the next time a healthy person needs

services, they may look at jumping back into a lower deductible plan to get better up front reimbursement.

The other question is whether we want to use an HSA. An HSA requires that any employer contribution, once made is the property of the employee.

=> example of \$1200 employer contribution to HSA (at beginning of year vs. spread throughout year)

HSA funds cannot be used to pay for health insurance premiums with the exception of our Medicare population. Only out-of-pocket costs for items covered by a FSA.

The infrastructure for HSAs is not very well defined in Montana yet. To my knowledge, Wells Fargo is the only larger bank that is ready to administer qualified trust accounts for HSAs.

A combined HRA/HSA platform may work better. We could allow employees to put their own money in the HSA portion of the account and then put employer funds in the HRA portion of the account. This still allows for accumulation, but protects both parties more fully we believe.

HSA guidance is not yet finalized. Treasury is still issuing regs. I recently attended a conference at the national level on HSAs. The White House had a representative as well as Treasury and a number of national entities concerned with HSAs. Roy Ramthun, Senior Advisor to the Secretary of the Treasury for Health Care spoke. He is responsible for issuing guidance. While we were in the conference, we began to ask him about treatment of various aspects of HSAs, for example catch up provisions for two HSA owners in a household. He didn't have an answer. However, we told him what we wished Treasury would do, he called during break and by that afternoon we were looking at a proposal on catch up provision treatment! This is how fluid and fast this is still going.

Finally, Medicare has just issued regs on the new Part D drug benefit. We do not entirely know how this benefit will work with HSAs. We are meeting with our consultant next week to discuss joining a large employer working group nationwide to advise the Centers for Medicare and Medicaid Services (CMS) on how to value employers who offer Rx coverage to Medicare beneficiaries under an authorized Prescription Drug Plan. However, since two different government agencies are involved, there appear to be inconsistencies.

For all of these reasons, we urge you to not pass SB 467. We are committed to bringing forward a consumer driven plan offering by January 1, 2007. Please let us continue the process we started in 2002 and develop the best plan we can for State Employee Benefit Plan members and for the State of Montana taxpayer.

Thank you.

COMPARISON OF HEALTH SAVINGS ACCOUNTS (HSAs) WITH HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs), AND FLEXIBLE SPENDING ARRANGEMENTS (FSAs)

	HSA	HRA	FSA
I. IN GENERAL			
Definitions and Overview	<p>Effective January 1, 2004, an HSA is a tax-advantaged trust or custodial account created for the benefit of an individual (not limited to employees) who is covered under a high deductible health plan ("HDHP"). The trustee may be a bank, any insurance company (not just a life insurance company), other persons already approved to be trustees or custodians of IRAs or MSAs, or another person (e.g., a third party administrator) approved by the Secretary of Treasury. Contributions may be made by an employer, the individual, or a family member (subject to gift tax). Contributions are deductible if made by an individual and are excludable from income and wages if made by an employer. Earnings grow tax-free and distributions for qualified medical expenses are tax-free. Nonqualified withdrawals are subject to income and penalty taxes. Excess contributions are subject to a 6-percent excise tax. Like an IRA, the HSA is owned by the individual and is portable. Debit or credit cards may be used for reimbursement. HSAs may be established in the same way that individuals establish IRAs or MSAs. IRS permission or employer involvement is not required. The HSA provider need not require proof of HDHP coverage but may desire to do so for purposes of its recordkeeping and reporting. If an employer sets up an HSA for an employee, however, the employer must verify that the employee is enrolled in an HDHP offered by the employer.</p> <p>Code § 223, §4973. Notice 2004-2, Rev. Rul. 2004-45, Rev. Rul. 2004-38, Rev. Proc. 2004-22, Notice 2004-23, Notice 2004-25, and Notice 2004-50.</p>	<p>A health reimbursement arrangement ("HRA") is an arrangement funded solely by the employer. HRAs may be offered to employees or former employees. Amounts must be used for qualified medical expenses and balances may be carried forward. Depending upon the terms of the HRA, coverage may (or may not) continue if the employee terminates service. HRAs are not portable.</p> <p>HRAs are described in administrative guidance. See Notice 2002-45; 2002-2 C.B. 93; Rev. Rul. 2003-43, 2003-21 I.R.B. 935.</p>	<p>A health flexible spending arrangement ("FSA") is an arrangement that may be funded by the employer and/or the employee via salary reduction. Health FSAs may be offered only to employees (self-employed persons are not eligible). Amounts must be used for qualified medical expenses and balances may not carry forward beyond the coverage period. FSAs are not portable.</p> <p>FSAs were codified in Code §106(c) under § 301(c)(2) of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). However, FSAs previously existed through administrative guidance. In 1989, the IRS issued proposed regulations that apply to health FSAs. See Prop. Reg. § 1.125-2, Q&A-7.</p>

HSA		HRA	FSA
II. RULES ON CONTRIBUTIONS			
A. Employer Contributions Generally	<p>Employer contributions are excludable for income and employment tax purposes. Code §§ 106(d), 3306(b)(18) & 3401(a)(22), respectively; Notice 2004-2 Q/A-19.</p> <p>Once an employer makes the contributions to an HSA, an employer cannot require that the HSA distributions be made exclusively for medical expenses or place any other restrictions or limitations on the HSA, including any limitation on rollovers or transfers. See Notice 2004-50 Q/A 59. A requirement that HSA distributions satisfy reasonable administrative rules imposing minimum dollar amounts or limits on the frequency of distributions is allowed. Notice 2004-50 Q/A-80. If an employer makes an excess contribution to an HSA, the employer may not recoup the excess contribution from the HSA itself. Notice 2004-50 Q/A-82. [Note that this situation may occur where an employer funds an HSA on January 1 for the full-year deductible and before the close of the year the employee has a change in status that results in a change from family to individual coverage or in terminating HDHP coverage altogether. The excess contribution may violate the comparability rule, if applicable (discussed at box II.B. below). In addition, the employer will have wage reporting issues for the excess contribution and the employee will have an increased income tax obligation and, if the excess contribution is not timely distributed, an excise tax.]</p>	<p>These arrangements are unfunded. Payments from the employer and coverage under the HRA are excluded from the employee's income under Code §§105, 106.</p>	Same as HIRA
B. Employer Contributions – Comparability	<p>Employer contributions must satisfy either the “comparability” rules or the cafeteria plan nondiscrimination rules, but not both. The cafeteria plan nondiscrimination rules are discussed in box IV.F. below. Employer contributions that are not provided through a cafeteria plan must be provided on a “comparable” basis to all eligible employees in order to avoid a 35-percent excise tax Code §4980G. For these purposes</p>	<p>HRAs are subject to the nondiscrimination tests under Code § 105(h).</p>	Same as HRA.