United States Senate
WASHINGTON, DC 20510

May 26, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Administrator Slavitt:

As health care costs continue to grow, despite the promises made by the Obama Administration to control them under the Affordable Care Act (ACA), health savings accounts (HSAs) offer consumers an opportunity to save tax-free for their health care expenses. These accounts have been widely popular, however; your agency continues to try to suppress these popular plans.

The ACA made a number of changes to HSAs that limit their assistance to consumers and raise taxes, including narrowing the definition of what is considered a qualified medical expense by excluding over-the-counter drugs, and by doubling the penalties on the use of HSA funds for non-qualified medical expenses.

Recently, your agency took another step to potentially limit the utilization of HSA-eligible plans on the federally-facilitated exchanges (FFEs) by developing a "standard option" for the 2017 plan year that imposes additional requirements on plans. For a plan to meet the qualifications of one of the "standard options," it must conform to a uniform set of features related to deductibles, out-of-pocket limits, co-payments and coinsurance levels, and it must have a single provider tier. Furthermore, first-dollar coverage must apply to specific services, and plans must have an actuarial value that complies with each metal level and takes into account cost-sharing subsidies. Under current law, the very requirements to qualify as an HSA will in turn preclude an HSA from meeting the requirements on the new "standard option" and limit consumers' exposure to and choice of popular, consumer-driven health coverage.

According to a memo from the Congressional Research Service (CRS)[1], there are 329 plans that include the term "HSA" in their plan name and meet two of the three requirements of an HSA plan. There are another 1,323 qualified health plans that meet the minimum deductible and out-of-pocket limit requirements to be an HSA, but they do not explicitly include the term in the plan name. CRS clarifies that in order to be considered an "HSA-qualified health plan", individuals must be enrolled in a high-deductible health plan that meets statutory requirements, including the following:

1. A minimum deductible must be met each year. For 2016, the minimum deductible is $1,300 for single coverage and $2,600 for family coverage;

[1] Standard Options and HSA-Qualified Health Plans, Congressional Research Services. May 6, 2016 (attached).

2. The plan must limit out-of-pocket expenses for covered benefits each year. For 2016, the out-of-pocket limit is $6,550 for single coverage and $13,100 for family coverage; and
3. The only benefits that can be covered prior to the deductible being met are for preventive care.

The "standard option" deductible and out-of-pocket limit often contradict the requirements to be considered an HSA, and the requirements of first dollar coverage for non-preventive services eliminates HSAs entirely from this category.

It is clear to see the potential disruption in consumer choice by creating the "standard option" and limiting the types of plans that qualify for it to exclude HSAs, given the likely number of HSA-qualified health plans in the FFEs. Since the ACA was predicated on creating greater access, choice, and reduced health care costs, we request answers to the following questions regarding HSAs and the "standard option:"

1. How many individuals are currently enrolled in an HSA-qualified health plan on the federally-facilitated exchanges?

2. What consideration was given to the statutory requirements for HSAs when debating and discussing the merits of creating a "standard option" to compare plans in the FFEs?

3. Was the Department of Treasury, Internal Revenue Service (IRS) or Office of Chief Counsel for the IRS consulted when developing and finalizing the requirements of the "standard option"? If yes, list the office or offices consulted and the recommendation or recommendations made.

4. Did your agency conduct an analysis or estimate the number and types of plans expected to participate in the "standard option" in 2016, and how many qualified health plans offered on the FFE in 2016, would be excluded from participating based on the new requirements? If yes, provide the estimates and analysis.

Please provide complete responses to the above questions no later than 5:00pm, Monday, June 13, 2016. I
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Sincerely,

Orrin Hatch

Chuck Grassley