Statement of the Massachusetts Bankers Association
Concerning S 698, H 1101, S 789, and H 1312,
Acts Relating to Consumer Deductibles, and
Acts Relating to Insurance Coverage for Doula Services
Joint Committee on Financial Services
April 29, 2025

On behalf of the Massachusetts Bankers Association's (MBA) more than 120 commercial, savings and cooperative banks and federal savings institution members with 72,000 employees located throughout the Commonwealth and New England, we are writing to express our concerns and offer amendments to **S 698 and H 1101** -- Acts relating to consumer deductibles, and **S 789 and H 1312** -- Acts relating to insurance coverage for doula services.

The MBA is affiliated with the American Bankers Association Health Savings Account Council members who collectively administer approximately 90% of the Health Savings Accounts (HSAs) in the nation. Closer to home, according to a recent study by Devenir that was commissioned by the ABA, there were approximately 730,000 HSAs in the Commonwealth in 2023 accounting for 1.18 million affected individuals.

Background on HSAs

An HSA is a trust or custodial account offered in conjunction with a high deductible health insurance plan that meets specific requirements of the Internal Revenue Code. An individual enrolled in a qualifying health plan is able to deduct contributions to an HSA from Federal income taxes and then use contributed funds tax-free to pay for qualified medical expenses. HSA assets automatically roll over from year to year, are portable, and have some features not found with similar products, such as Flexible Spending Accounts (FSAs).

However, consumers cannot benefit from an HSA unless they are enrolled in a health plan that meets the IRS requirements for an "HSA-qualified" high deductible health insurance plan. Specifically, a health plan will fail to be HSA-qualified if a state law requires "first-dollar coverage" of benefits that are not considered "preventive care," as determined by the Internal Revenue Service under Federal law. A state law that causes a plan to be disqualified would prevent a consumer from being able to fund an HSA unless the state law specifically exempts HSA-qualified plans from disqualifying requirements.

HSA-qualified plans are the only health plans that must meet a minimum deductible requirement. For 2025, the minimum deductible is $1,650 for self-only coverage and $3,300 for family coverage (i.e., any coverage that is not self-only coverage). The minimum deductible must apply to all covered benefits received from in-network providers. The only exception is "preventive care" benefits as determined by the IRS.

The IRS definition of "preventive care" follows the definition in the Affordable Care Act (ACA) and in some cases is more expansive. For example, in IRS Notice 2019-45,[1] the IRS said that certain services provided to individuals with specific chronic conditions, such as insulin for diabetics, could also be

[1] IRS Notice 2019-45, https://www.irs.gov/irb/2019-32_IRB#NOT-2019-45

considered "preventive care" for HSA-qualified plans. The IRS definition permits HSA-qualified plans to cover insulin without a deductible and with limited or no cost-sharing.

State Efforts

Accordingly, ABA has been tracking state legislation, including in the Commonwealth, which would prevent a health plan from meeting the requirements of an HSA-qualified plan. The HSA Council is concerned that state legislative efforts to help some consumers – by imposing a well-intentioned benefit coverage mandate on a fully-insured health insurance plan, or by requiring that payments made by or on behalf of an insured or enrollee, could count toward their deductible – could harm consumers by making their high deductible health plan ineligible for the tax benefit provided by a Health Savings Account.

Unfortunately, several bills on the Joint Committee's April 29 hearing agenda could prohibit HSA-qualified plans from being offered to consumers in the future because of conflicts with Federal law that would be created if these bills were enacted. Approximately 1.18 million privately insured Massachusetts residents who are covered by these plans could be adversely impacted by these bills.

Concerning S 789 and H 1312 -- Acts Relating to Insurance Coverage for Doula Services

These bills would disqualify HSA-qualified plans by requiring health insurance coverage of doula services with no patient cost-sharing. This challenge remains despite language in the bill defining doula services as "physical, emotional, and informational support, <u>but not medical care</u>." Because we are not medical experts, we are in no position to opine further on the merits of – for or against – mandatory coverage of doula services without cost-sharing. Likewise, we are also not expert enough to determine whether doula services may be considered "preventive care" by the IRS. Regrettably, it is not clear that the coverage of doula services required by **S 789 and H 1312** meets the IRS definition of "preventive care."

In addition, the IRS stated in Notice 2018-12 that, in the case of HSA-qualified plans, the Federal definition takes precedence over state law:

> "Notice 2004-23 also explains that <u>state law requirements do not determine whether health care constitutes preventive care under section 223(c)(2)(C)</u>. State insurance laws often require health insurance policies and similar arrangements subject to state regulation to provide certain health care benefits without regard to a deductible or on terms no less favorable than other care provided by the health insurance policy or arrangement. However, <u>the determination whether a health care benefit that is required by state law to be provided by an HDHP without regard to a deductible is "preventive" for purposes of the exception for preventive care under section 223(c)(2)(C) is based on the standards set forth in guidance issued by the Treasury Department and the IRS, rather than on how that care is characterized by state law</u>."

In the absence of a clear determination by the IRS that the coverage of doula services required by **S 789 and H 1312** meets the IRS definition of "preventive care," we believe the most prudent action by the Joint Committee would be to take a more cautious approach to avoid doing harm to individuals enrolled in HSA-qualified plans. Such an approach would embrace language included in **Section 2 of S 764** and **Section 2 of H 1309** (both of which are also on the Joint Committee's agenda for the April 29 hearing):

> *"provided, however, that deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on such for these services."*

We urge the committee to amend **S 789 and H 1312**, consistent with the language noted above (or similar language) protecting HSAs where needed throughout the bills. This will provide for clarity and consistency across all of these bills and how they impact HSAs.

Concerning S 698 and H 1101 - Acts Relating to Consumer Deductibles

S 698 and H 1101 would require health insurers to include amounts paid by or on behalf of the insured by another person when calculating an insured's cost sharing responsibility. However, as noted above, HSA-qualified plans must apply the minimum deductible to all covered benefits, except for "preventive care" benefits.

Additional IRS guidance[2] [3] further clarified these requirements regarding amounts paid by or on behalf of an insured by another person. Although the examples provided by the IRS guidance are specific pharmacy benefits, we believe the same principles should apply to all covered benefits.

The IRS reiterated its position again its April 16, 2021 letter to the Illinois Department of Insurance in response to a request for clarification regarding a law which passed the Illinois legislature in 2019 (Public Act 101-0452), which is similar to the law that would be created if either **S 698 or H 1101** are enacted in Massachusetts. This letter has been widely circulated among state regulators and insurance legislators nationwide.

The IRS elaborated further on its previous guidance by providing an example:

> *"The issue raised by your inquiry is what amounts count toward the minimum annual deductible for an HDHP [i.e., HSA-qualified plan]. Notice 2004-50, 2004-33 I.R.B. 196, Q&A-9, provides that an individual covered by an HDHP who also has a discount card for health care services or products, may still contribute to an HSA provided that the individual is required to pay the costs of the covered health care until the minimum annual deductible for the HDHP is satisfied. In other words,* ***the minimum annual deductible may only be satisfied by actual medical expenses the covered individual incurred. For example, if a covered individual is prescribed a drug that costs $1,000, but a discount from the drug manufacturer reduces the cost to the individual to $600, the amount that may be credited towards satisfying the deductible is $600, not $1,000. This same principle also applies to a third-party payment, such as a rebate or coupon, that has the same effect as a discount."*** [emphasis added]

Thus, HSA-qualified plans would lose their status as "HSA-qualified" if they apply, or give credit to, payments made by any other person than the insured towards satisfying the insured's minimum deductible requirement.

We believe the most prudent action by the Joint Committee would be to take a more cautious approach to avoid doing harm to individuals enrolled in HSA-qualified plans. Such an approach would embrace language included in **Section 139 of S 868** and **Section 11 of H 1234** (which have also been referred to the Joint Committee but are not on the agenda for the April 29, 2025 hearing):

> *"If under Federal law, application of this requirement would result in health savings account ineligibility under section 223 of the Federal Internal Revenue Code, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the covered individual has satisfied the minimum deductible under section 223*

[2] IRS Notice 2004-50, https://www.irs.gov/irb/2004-33_IRB#NOT-2004-50
[3] IRS Notice 2008-59, https://www.irs.gov/irb/2008-29_IRB#NOT-2008-59

of the Federal Internal Revenue Code, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the Federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under section 223 has been satisfied."

Other bills before the Joint Committee, including **S 802, S 718, S 714, H 1337, H 1309, H 1234, H 1228, and H 1137**, also include acceptable language. Furthermore, two bills which became law during the prior legislative session – **H 4999 (Chapter 186) and H 4918 (Chapter 231)** – also included acceptable language.

We urge the committee to amend **S 689 and H 1101** consistent with the language noted above (or similar language from other bills or laws, as noted) protecting HSA account owners where needed throughout the bills. This will provide for clarity and consistency across all of these bills and how they impact HSAs.

Finally, it should be noted that we are otherwise agnostic and take no position for or against the other concepts included in these bills. Our only concern is that the imposition of specific requirements included in these bills would disqualify otherwise qualified state residents from funding their HSAs to help manage their out-of-pocket medical costs.

Thank you for your consideration of these matters. We would be happy to respond to any questions that you may have.