COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

ANNUAL REPORT ON HIGH-DEDUCTIBLE HEALTH PLANS PURSUANT TO § 38.2-5601 OF THE CODE OF VIRGINIA

to the
Senate Committee on Finance
Senate Committee on Education and Health
Senate Committee on Commerce and Labor
House Committee on Appropriations
House Committee on Finance
House Committee on Commerce and Labor
House Committee on Health, Welfare and Institutions

December 12, 2018

COMMONWEALTH OF VIRGINIA

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The Honorable Thomas K. Norment, Jr.
The Honorable Emmett W. Hanger, Jr.
Co-chairs, Senate Committee on Finance

The Honorable Stephen D. Newman
Chairman, Senate Committee on Education and Health

The Honorable Frank W. Wagner
Chairman, Senate Committee on Commerce and Labor

The Honorable S. Chris Jones
Chairman, House Committee on Appropriations

The Honorable R. Lee Ware
Chairman, House Finance Committee

The Honorable Terry G. Kilgore
Chairman, House Committee on Commerce and Labor

The Honorable Robert D. Orrock, Sr.
Chairman, House Committee on Health, Welfare and Institutions

Dear Senators and Delegates:

Attached hereto is the report on the availability of high deductible health plans. This report was prepared pursuant to § 38.2-5601 of the Code of Virginia.

Respectfully submitted,

Scott White
Commissioner of Insurance

EXECUTIVE SUMMARY

The Virginia State Corporation Commission ("Commission") submits this updated report in accordance with the Virginia Health Savings Account Plan, §§ 38.2-5601 through 38.2-5604 of the Code of Virginia. Health Savings Accounts ("HSAs") were created by federal legislation and are designed for use with High-Deductible Health Plans ("HDHPs"). By law, the Commission is required to provide information on the availability of HDHPs in Virginia and recommendations for legislation that would increase the attractiveness of HSAs or eliminate barriers to their use.

There is considerable activity in the HSA market in Virginia even though there has been a decrease in HDHP business from the previous year. There are at least 18 companies that offer HDHPs in Virginia, and at least 275,842 Virginians were covered by HDHPs at the end of 2017; this is a decrease from 22 companies and 374,000 covered lives at the end of 2016. No state legislative or regulatory barriers to the sale of HDHPs have been identified that would restrict the attractiveness of HDHPs to Virginians. However, 2017 witnessed changes in federal regulatory rules that caused marketplace disruptions in the individual health insurance market, resulting in decreased HDHP sales as well as a decrease in the number of insurers offering health insurance plans in certain geographical areas in Virginia. The Bureau of Insurance will continue to monitor the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010), and subsequent regulations, as well as other federal legislation and market activity in Virginia. The Bureau of Insurance has no recommendations for legislative changes at this time.

INTRODUCTION

The Virginia Health Savings Account Plan (§§ 38.2-5601 through 38.2-5604 of the Code of Virginia) requires the Virginia State Corporation Commission ("Commission") to make annual updates on the Virginia Health Savings Account Plan to the chairs of the House Committees on Appropriations; Finance; Health, Welfare and Institutions; and Commerce and Labor and the Senate Committees on Finance; Education and Health; and Commerce and Labor on Health Savings Accounts ("HSAs") in Virginia. The Commission is required to provide information on the availability of High-Deductible Health Plans ("HDHPs") in Virginia and recommendations for legislation that would increase the attractiveness of HSAs or eliminate barriers to their use.

HSAs were created by federal legislation included in the Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, which became effective on January 1, 2004. HSAs are tax-exempt trust or custodial accounts. HSAs are owned by individuals, and the contributions in the accounts are used to pay for eligible medical expenses. HSAs are designed for use with HDHPs, health insurance plans that provide health coverage after a pre-determined deductible amount has been reached. HDHPs can be offered by a health maintenance organization, a health services plan, or an insurer.

The minimum deductible amount and annual out-of-pocket limits for an HDHP to qualify for use with HSAs are determined by federal legislation and are indexed annually to adjust for inflation. For 2018 these amounts were:

Minimum Deductible Limits:
$1,350 for a single person (self-only)
$2,700 for family coverage

Annual Out-of-Pocket Limits:
$6,650 for a single person (self-only)
$13,300 for a family

For 2019, the minimum deductible limits are the same as for 2018, but the annual out-of-pocket limits will increase slightly:

Annual Out-of-Pocket Limits:

$6,750 for a single person (self-only)
$13,500 for a family

BACKGROUND

HSAs are similar to the Archer Medical Savings Accounts ("MSAs") that were developed as a way to provide incentives for individuals to become cost conscious in their purchases of medical services. The MSAs were viewed as a tool to provide people with more control over their health care dollars.

MSAs initially were created as a four-year demonstration program as part of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (1996) ("HIPAA"). The program began on January 1, 1997, and limited eligibility to self-employed individuals and employees of businesses with no more than 50 employees. Under the MSA structure, either the employee or the employer, but not both, could contribute to the MSA.

HIPAA authorized a nationwide limit of 375,000 MSAs until April 1997, with allowable increases up to 600,000 by April 1998 and to 750,000 for the total program. With passage of the Community Renewal Tax Relief Act of 2000, Pub. L. No. 106-554, the demonstration program was extended through 2002, and the MSAs were renamed "Archer MSAs" after Congressman Bill Archer, who sponsored the amendment that created them. The Job Creation and Worker Assistance Act of 2002, Pub. L. No. 107-147, further extended Archer MSAs, and thereafter the program was considered an IRS pilot subject to future extensions by the United States Treasury Department.

Under these laws, participants in MSAs made tax-free deposits on a regular basis that were used to cover routine medical care up to the amount of the HDHP deductible. The HDHP then covered the health care expenses above the deductible according to the terms of the policy. Earnings and other interest on MSAs were tax free. Tax deductions could be claimed for contributions even if there was no itemization of deductions. Contributions could remain in MSA accounts from year to year until they were used, and contributions did not have to be made every year.

An individual was only eligible for an Archer MSA if the individual was an active participant for any tax year ending before January 1, 2008, or became an active participant after 2007 by reason of coverage under an HDHP of an Archer MSA participating employer.

The covered individual could not have other health insurance coverage. However, as provided in Internal Revenue Service Publication 969 (October 1997), participants were allowed to have coverage for accidental injuries, disability, dental and vision needs, tort liabilities, ownership or use of property, or a specific disease or illness. Additionally, participants could have long-term care insurance and workers' compensation insurance. They also could have coverage for a fixed amount per day (or other period) of hospitalization.

The MSAs' annual minimum deductible amounts and out-of-pocket maximums were indexed for inflation based on the Consumer Price Index. Initially, annual deductibles were at least $1,500 and not more than $2,250 for individual coverage and at least $3,000 and not more than $4,500 for family coverage. The maximum annual out-of-pocket expenses were set at $3000 for self-only coverage and $5,500 for family coverage.

MEDICAL SAVINGS ACCOUNT EXPERIENCE

The number of MSA plans sold nationally was considerably less than contemplated. The number of Virginians that purchased HDHPs that could be used with MSAs was consistent with national figures, according to information from the Internal Revenue Service. Approximately 65,000 deductions were taken nationwide for MSAs by 2001.

The number of companies that marketed HDHPs for use with MSAs in Virginia decreased over time. In 1999, there were 22 companies that had policies approved for sale that met the federal requirements for use with MSA accounts. At least eight companies were actively marketing HDHPs in Virginia for use with MSAs in 2002. However, four companies that had plans approved for sale never marketed those plans in Virginia, and another two companies merged with other companies that were active in the MSA market.[1] The number of Virginians covered by HDHPs in Virginia in 2002 was estimated to be at least 3,000.

The MSA experience in Virginia was consistent with national experience. The HDHPs that received federal recognition as "qualified plans" under the pilot program were contracts that met requirements for sale in Virginia as major medical contracts prior to the start of the federal program.

HEALTH SAVINGS ACCOUNT EXPERIENCE AND THE AVAILABILITY OF HIGH-DEDUCTIBLE HEALTH PLANS IN VIRGINIA IN 2017

The current level of market activity in Virginia remains consistent with national experience. America's Health Insurance Plans ("AHIP") is a national trade association whose members provide health care benefits to over 200 million Americans through employer-

[1] The information on company activity in the MSA market is based on surveys of licensed accident and sickness insurers, health maintenance organizations, and health services plans operating in Virginia; subsequent computer tracking of forms filings by licensed accident and sickness insurers, health services plans, and HMOs; and direct contact with insurance company personnel.

sponsored coverage, the individual insurance market, and public health programs. According to AHIP's Center for Policy and Research, the number of people covered by HDHPs in March 2005 represented a 100% increase in covered lives compared to the six-month period preceding March 2005. AHIP reported over 1,000,000 people were covered nationally. AHIP annual censuses have reported the following nationwide HSA/HDHP participation in coverage for each January in years after 2005:

Year (January)	Covered Individuals (millions)
2006	3.2
2007	4.5
2008	6.1
2009	8.0
2010	10.0
2011	11.4
2012	13.5
2013	15.5
2014	17.4
2015	19.7
2016	20.2
2017	21.8

The number of companies providing information to AHIP has fluctuated from 99 in 2005 down to 64 by 2015 and 59 by 2016, further declining to 52 by 2017. The number of AHIP reported covered lives also has fluctuated. The 2017 AHIP census report noted that census participation was not received from all health insurers that sell HSA/HDHP insurance coverage or administer HSA/HDHP coverage for self-insured group health plans.

Specifically, in relation to Virginia participation, AHIP has reported the following:

Month/Year	Covered Individuals (VA)	Covered Individuals (National)
January 2015	416,484	19.7 million
January 2016	428,677	20.2 million
January 2017	338,096	21.8 million

In addition to receiving data from AHIP, the Commission's Bureau of Insurance ("Bureau") also conducts its own annual coverage surveys. Information on current activity in the HSA market in Virginia for this report was obtained through surveys to companies who previously indicated they were actively offering or considering offering HDHPs. This information was supplemented by information from electronic tracking of forms filings with the Bureau. Information was also obtained through direct contact with company personnel. Based on this information, the Bureau has concluded that there are at least 18 health insurance companies that offer HDHPs in Virginia that are marketed for use with HSAs. This number is less than the 22 companies that offered HDHPs in 2016.

The following companies are currently offering HDHPs in Virginia:

Aetna Health, Inc.
Aetna Life Insurance Company
Anthem Health Plans of Virginia, Inc.
CareFirst BlueChoice, Inc.
Cigna Health and Life Insurance Company
Federated Mutual Insurance Company
Group Hospitalization and Medical Services, Inc.
Healthkeepers, Inc.
lnnovation Health Insurance Company
Innovation Health Plan Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Optima Health Insurance Company
Optima Health Plan
Optimum Choice Inc.
Piedmont Community HealthCare, Inc.
Piedmont Community HealthCare HMO, Inc.
UnitedHealthcare Insurance Company
UnitedHealthcare of the Mid-Atlantic, Inc.

Based on the combined results from all companies responding to the Bureau's 2018 survey, during 2017 22,000 policies were sold in Virginia covering 148,000 lives. As of year-end 2017, there were 86,000 HDHPs in force covering 276,000 lives on a cumulative basis, including both policies sold in 2017 and other policies remaining in force from prior years.

The following chart compares these survey results with the prior three years:

Year	Policies Sold	Covered Lives	Cumulative Policies in Force at Year End	Cumulative Covered Lives at Year End
2017	22,000	148,000	86,000	276,000
2016	52,000	187,000	133,000	374,000
2015	42,000	121,000	125,000	313,000
2014	51,000	122,000	117,000	274,000

INCREASING THE ATTRACTIVENESS OF HEALTH SAVINGS ACCOUNTS AND ELIMINATING BARRIERS TO USE

In 2018, as in previous years, the Bureau requested, from the companies offering HDHPs or considering offering the plans in Virginia, information on efforts that could be taken to increase the attractiveness of HSAs. No suggestions for changes to Virginia requirements were made. Previous company responses have acknowledged that because HDHPs are tied to HSAs and federal legislation, state actions have limited impact on the attractiveness of the product.

Beginning in 2016, federal rules[2] established that individuals with family coverage cannot be responsible for an annual maximum out-of-pocket expense limit that is greater than the annual maximum out-of-pocket expense limit for self-only coverage under the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010), ("ACA"), which for 2017 was $7,150. Due to this requirement, carriers had to configure HSA-compatible HDHP family plan designs for 2017 so that no individual within the family would be responsible for an amount greater than $7,150, while ensuring that individuals are subject to the family HDHP minimum deductible of $2,600. The effect of this provision is that when an HSA is used in conjunction with an HDHP providing family coverage, the HDHP family annual minimum deductible applies, but the annual maximum out-of-pocket expense limit for any individual covered in the

[2] See 80 Fed. Reg. at 10825.

family must be subject to the annual maximum out-of-pocket expense limit of $7,150, instead of the HDHP family annual maximum out-of-pocket expense limit of $13,300.

The ACA's cost-sharing limits also have implications for qualified health plans classified as catastrophic plans. These plans are available to people under age 30 and to those that qualify for hardship exemptions. Typically, these plans have lower monthly premiums because the deductibles are equal to the ACA's maximum annual out-of-pocket expense limits. Because these cost-sharing limits are higher than the annual maximum out-of-pocket expense limits for HDHPs, catastrophic plans cannot qualify to be used as HDHPs for HSAs. The effect of this change on the Virginia market is not known at this time. Other plans may still qualify for use with HSAs as long as the cost-sharing requirements meet federal guidelines.

At the present time, it is not possible to project the long-term impact that the ACA will have on the use of HSAs and HDHPs nationally or in Virginia.

CONCLUSION

There remains considerable activity in the HSA market in Virginia. There are at least 18 companies that offer HDHPs in Virginia, and at least 276,000 Virginians were covered by HDHPs at the end of 2017. No state legislative or regulatory barriers to the sale of HDHPs have been identified that would restrict the attractiveness of HDHPs to Virginians. The Bureau, on behalf of the Commission, will continue to monitor legislation and associated regulations, as well as market activity in Virginia. The Commission has no recommendations for legislative changes at this time.