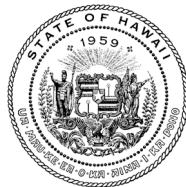


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TESTIMONY OF
GARY S. SUGANUMA, DIRECTOR OF TAXATION

TESTIMONY ON THE FOLLOWING MEASURE:

S.B. No. 2431, S.D.1, Relating to Health Savings Accounts

BEFORE THE:

House Committee on Health

DATE: Wednesday, March 18, 2026
TIME: 9:00 a.m.
LOCATION: State Capitol, Conference Room 329

Chair Takayama, Vice-Chair Keohokapu-Lee Loy, and Members of the Committee:

The Department of Taxation (DOTAX) offers the following comments regarding S.B. 2431, S.D.1, for your consideration.

S.B. 2431, S.D.1, adds a new section under chapter 235, Hawaii Revised Statutes (HRS), to establish a nonrefundable tax credit for insurers offering federally qualified "health savings account-eligible high deductible health plans" in Hawai'i. The bill provides for three credit amounts, which depend on whether the taxpayer has written a qualifying plan for (1) an insured residing in an area of the State that is not medically underserved; (2) an insured residing in a non-rural area of the State that is medically underserved; or (3) an insured residing in a partially rural area of the State that is medically underserved. The credit amounts, which are unspecified, apply to each qualifying plan written on or after January 1, 2026, subject to an annual cap per taxpayer.

Subsection (c) provides that to qualify for the credit, a taxpayer must make a matching contribution up to an unspecified amount of a policyholder's first-time contribution into a health savings account.

Subsection (e) allows a taxpayer to claim the credit within five years following the close of the taxable year for which the credit may be claimed. Subsection (e) also allows a credit to carry forward any excess credit in subsequent years until exhausted.

Subsection (f) requires DOTAX to adopt rules under chapter 91 to require a qualified taxpayer claiming the credit to report the value of benefits provided to those insured under this section.

The bill has a defective effective date of July 1, 2050, and applies to taxable years beginning after December 31, 2025, with a December 31, 2030, sunset date.

First, DOTAX recommends that subsection (e) be amended to require that a taxpayer claim the credit within 12 months following the close of the taxable year, as is customary for other credits in chapter 235, HRS, instead of five years as currently provided in the bill. DOTAX notes that allowing a taxpayer to claim a credit within five years after the close of the taxable year may conflict with the existing three-year statute of limitations. Additionally, DOTAX recommends that a five-year limitation be imposed on the time period that the taxpayer may carry forward the credit. Specifically, DOTAX recommends amending subsection (e) on page 5 to read as follows:

(e) The credit allowed under this section shall be claimed against the net income tax liability for the taxable year. If the tax credit under this section exceeds the taxpayer's net income liability for the original claim year, the excess of credit over liability may be used as a tax credit against the taxpayer's net income tax liability in subsequent years until exhausted; provided that no credit carry forward under this section shall be used as a credit for a taxable year more than five years after the taxable year in which the tax credit is originally claimed. All claims for tax credits under this section, including any amended claims, shall be filed on or before the end of the twelfth month following the close of the taxable year for which the credit may be claimed.

Second, DOTAX notes that it does not have the subject-matter expertise to determine whether a health plan was written by a “qualified taxpayer” in a “non-rural,” “partially rural,” or “rural” area of the State that is “medically underserved.”

Third, DOTAX notes that enforcing the bill’s health savings account matching provision would be administratively challenging, as DOTAX would need to determine a policyholder’s first-time contribution amount, based on account information that is potentially not readily accessible for review and may present privacy concerns, and compare that to a qualified taxpayer’s claimed tax credit amount. It is also not clear what constitutes a “policyholder’s first-time contribution.”

Fourth, DOTAX recommends that if this measure is passed the effective date be amended to apply to taxable years beginning after December 31, 2026, to allow sufficient time to prepare forms, make system changes, necessary rules, and inform taxpayers.

Thank you for the opportunity to provide comments on this measure.



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Mar 18, 2026

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The Honorable Gregg Takayama, Chair

The Honorable Lisa Marten, Chair

House Committee on Health

House Committee on Human Services & Homelessness

The Thirty-Third Legislature

Conference Room 329

State Capitol

State of Hawaii

Honolulu, Hawaii 96813

SUBJECT: SB2431, SD1; Relating to Health Savings Accounts

Chair Takayama, Chair Marten, and Members of the Committee:

Aloha Independent Living Hawaii (AILH) **respectfully offers comments with recommendations** on SB2431 SD1.

AILH is a cross-disability, consumer-controlled Center for Independent Living (CIL) serving people with disabilities across Hawaii. Our mission is to support the right of people with disabilities to live, work, and participate fully in community life—consistent with the Independent Living philosophy that people with disabilities are the best experts on their own needs and must be centered in policies that affect them.

SD2431 SD1 establishes a tiered, nonrefundable income tax credit for qualified insurers offering federally qualified health savings account-eligible high deductible health plans (HDHPs), with enhanced incentives for plans written for residents in rural and medically underserved areas. It also requires insurers to match a portion of a policyholder's first-time health savings account (HSA) contribution. The bill is framed in part as a response to anticipated Medicaid coverage losses and a strategy to promote insurance continuity and portability.



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AILH recognizes the Legislature's intent to address coverage gaps—particularly in Hawaii's neighbor islands and rural communities, where provider shortages and geographic barriers compound access challenges for people with disabilities. We offer the following comments to ensure this bill's implementation does not inadvertently harm the very populations it aims to help.

Preliminary Concern: Incomplete Bill Language

Before addressing substantive policy concerns, AILH notes that SB2431 SD1 contains multiple blank dollar figures throughout the tax credit tiers, the HSA match amount, and the annual insurer cap. The bill also carries an effective date of July 1, 2050—a standard legislative placeholder indicating the measure is not yet in final form.

AILH respectfully requests that the Committee ensure the final credit amounts and match thresholds are publicly disclosed and subject to scrutiny before the bill advances further. The dollar figures are not incidental—they determine whether the incentive is meaningful for rural insurers, and whether the HSA match is accessible to low-income enrollees, including people with disabilities transitioning off Medicaid. A policy framework without those numbers cannot be fully evaluated for equity or fiscal impact.

1. HDHPs Present Structural Barriers for People with Disabilities

This Committee's jurisdiction over health and human services places it in a unique position to ask a question the Senate Ways and Means Committee was not primarily focused on: who will actually be harmed by high deductibles?

People with disabilities—across all disability types—typically have higher, more frequent, and less deferrable healthcare needs than the general population. This includes regular prescriptions, specialist visits, durable medical equipment, therapies (physical, occupational, speech, behavioral), and mental health services. For these individuals, an HDHP's lower premium



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may appear affordable at first glance while concealing significant out-of-pocket exposure before the deductible is met.

The consequences are not abstract. When people with disabilities delay or forgo care due to cost exposure, conditions worsen, hospitalizations increase, and—critically for this committee—the likelihood of homelessness or institutional placement rises. The connection between unmanaged health conditions and housing instability is well-documented, and Hawaii's homeless population reflects this: 55% of Oahu's unhoused residents report one or more disabling conditions.

AILH recommends the Committee request an analysis of anticipated HDHP enrollee demographics, with particular attention to enrollment by people with disabilities and those transitioning from Medicaid, before the bill's credit structure is finalized.

2. HSA Eligibility Excludes Most People with Disabilities

The bill's HSA contribution match is presented as a consumer benefit—but federal law significantly limits who can contribute to an HSA. To be eligible, an individual must be enrolled in a qualifying HDHP and cannot be enrolled in Medicare, Medicaid, TRICARE, or most other coverage. This means the match benefit is structurally unavailable to:

- People with disabilities receiving Medicare (including those under 65 on SSDI);
- People enrolled in Medicaid, including Med-QUEST in Hawaii;
- People with dual Medicare-Medicaid enrollment (among the most vulnerable and highest-need individuals); and
- People transitioning off Medicaid who re-enroll during the same year.

AILH recommends the bill's consumer disclosures—which we address below—explicitly and accessibly explain HSA eligibility restrictions so that



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individuals who cannot benefit from the match are not misled when selecting a plan.

3. Medicaid Transition Tracking Must Include Disability and Homelessness Outcomes

The bill acknowledges that anticipated federal Medicaid changes will cause significant coverage transitions in Hawaii. For people with disabilities, Medicaid is not simply health insurance—it is often the funding mechanism for home and community-based services (HCBS) that enable people to live independently rather than in institutions. Loss of Medicaid, even temporarily, can trigger a cascade: loss of HCBS, inability to manage health conditions, housing destabilization, and in the worst cases, institutionalization or homelessness.

AILH reiterates its recommendation from prior testimony that the bill require tracking of Medicaid transition outcomes, and specifically requests this Committee add a requirement that the Department of Human Services report on:

- The number of individuals with disabilities who transition from Medicaid to qualifying HDHPs;
- Rates of return to Medicaid, including time elapsed and health acuity at re-entry;
- Any correlation between HDHP enrollment, delayed care, and emergency department utilization; and
- Any correlation between loss of Medicaid coverage and housing instability or homelessness entries.

This data would allow both this Committee and the Legislature to evaluate whether the bill's tax incentive reduces long-term public costs or shifts them upstream into emergency care, crisis services, and homelessness programs—all within the jurisdiction of this joint committee.



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4. Consumer Disclosures Must Be Accessible Across Disability Types

AILH previously recommended plain-language, accessible disclosures regarding deductible obligations and HSA match limitations. We wish to be more specific for this Committee: accessibility in disclosure must be understood in cross-disability terms.

This means disclosures should be:

- Available in plain language (for people with cognitive or intellectual disabilities, and for people with limited English proficiency);
- Screen-reader compatible and available in alternative formats (for people who are blind or have low vision);
- Available in ASL-accessible formats or with interpreter access (for people who are Deaf or hard of hearing); and
- Delivered through community-based organizations and centers for independent living, not solely through insurer websites or mail, to reach people in rural and medically underserved areas.

AILH recommends the bill be amended to require that consumer disclosure materials meet accessibility standards consistent with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, and that outreach plans specifically include partnerships with Centers for Independent Living and disability-serving organizations.

5. Expand Reporting to Support Ongoing Oversight

The bill requires insurers to report the value of benefits provided to the Department of Taxation. AILH recommends this reporting also include, at minimum:

- Average and median annual out-of-pocket spending by enrollees;



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- Rates of delayed or foregone care due to cost exposure, disaggregated by rural versus non-rural enrollment;
- Emergency department utilization trends among enrollees;
- Re-enrollment rates into Medicaid following HDHP enrollment; and
- Enrollment data disaggregated by disability status, to the extent permissible under applicable privacy law.

Given that this bill creates a multi-year tax expenditure—and sunsets in 2030—robust outcome data is essential for the Legislature to evaluate whether it should be extended, modified, or allowed to expire.

SB2431 SD1 reflects a genuine effort to expand coverage options and address rural access gaps that directly affect people with disabilities in Hawaii. AILH supports the Legislature's intent while urging this Committee to ensure the final bill includes complete dollar figures for public review, cross-disability accessible disclosures, robust outcome tracking tied to Medicaid transitions and homelessness, and an explicit evaluation of impacts on high-utilization populations. A tax incentive that inadvertently increases underinsurance among people with disabilities would undermine the very goals this bill seeks to advance.

Thank you for the opportunity to provide comments..

Aloha,

Roxanne Bolden

Executive Director

TAX FOUNDATION OF HAWAII

735 Bishop Street, Suite 417

Honolulu, Hawaii 96813 Tel. 536-4587

SUBJECT: NET INCOME, Credit for High Deductible Health Plans and HSAs

BILL NUMBER: SB 2431 SD1

INTRODUCED BY: CPN

EXECUTIVE SUMMARY: For taxable years beginning 1/1/2026, establishes a tiered nonrefundable tax credit for qualified taxpayer insurers that offer one or more federally qualified health savings account-eligible high deductible health plans in the State, under certain conditions, and increasing the tax credit to incentivize more plans being written for residents in rural medically underserved areas of the State. Requires qualified taxpayer insurers to match up to a certain amount of a policyholder's first-time contribution into a health savings account. Sunsets 12/31/2030.

SYNOPSIS: Adds a new section to chapter 235, HRS, to establish a health savings account (HSA)-eligible high deductible health plan tax credit. The credit is, for each federally qualified HSA-eligible health plan that is written by a qualified taxpayer for an insured residing in:

Credit Amount	Health Plan Is Written In
\$ _____	An area of the State that is not a medically underserved area
\$ _____	A non-rural medically underserved area of the State
\$ _____	A partially rural medically underserved area of the State
\$ _____	A rural medically underserved area of the State

In any event, the taxpayer must match all participants' initial contributions to the HSA, up to \$ _____, to be eligible for the credit. The credits are nonrefundable but may be carried forward indefinitely.

All claims for tax credits under this section, including any amended claims, shall be filed within five years following the close of the taxable year for which the credit may be claimed. Failure to comply with the foregoing provision shall constitute a waiver of the right to claim the credit.

The Department of Taxation shall adopt rules pursuant to chapter 91 to administer the credit and report the value of benefits provided to insureds under this section.

Defines "Health savings account" as the same as under section 223(d)(1) of the Internal Revenue Code of 1986, as amended.

Defines “High deductible health plan” means a plan that is: (1) Available as individual coverage through an exchange under section 1311 or 1321 of the Patient Protection and Affordable Care Act; and (2) A bronze plan, as described in section 1302(d)(1)(A) of the Patient Protection and Affordable Care Act, or a catastrophic plan, as described in section 1302(e) of the Patient Protection and Affordable Care Act.

Defines “Medically underserved area” or “population” as a geographic area or population group designated by the United States Department of Health and Human Services as an area with a shortage of primary care health services or a population group experiencing a shortage of primary care health services and facing economic, cultural, or linguistic barriers to access health care.

Defines “Qualified taxpayer” means a taxpayer that: (1) Offers one or more health savings account-eligible high deductible health plans that are in compliance with section 223 of the Internal Revenue Code of 1986, as amended, for residents of the State, including those in rural and medically underserved areas; and (2) Enrolls at least _____ policyholders in one or more federally qualified health savings account-eligible high deductible health plans.

Defines “Rural” as an area that is not delineated as an urbanized area by the US Census Bureau.

EFFECTIVE DATE: July 1, 2050 for taxable years beginning after December 31, 2025.
Repeals on December 31, 2030.

STAFF COMMENTS: The bill includes unspecified credit amounts and otherwise contains blanks for important information. The bill cannot be scored for revenue gain/loss in its current form, and cannot be vetted properly unless numbers are inserted.

We note that the Rules of the House and of the Senate specify that proceedings are to follow Mason’s Manual of Legislative Procedure published by the National Conference of State Legislatures. Mason’s Manual specifies, in section 416-8 of its 2020 edition, that “When proposals containing blanks are introduced, these must be filled before other motions to amend are entertained.”

The current draft of this measure allows claims to be filed within five years of the taxable year in which the credit may be claimed. This conflicts with the normal statute of limitations for income tax returns, section 235-111, HRS, which provides a three-year period within which a claim for refund or credit may be filed.

Digested: 3/4/2026



March 18, 2026

The Honorable Gregg Takayama, Chair
The Honorable Sue Keohokapu-Lee Loy, Vice Chair

House Committee on Health

Re: SB 2431 SD1 – RELATING TO SAVINGS ACCOUNTS

Dear Chair Takayama, Vice Chair Sue Keohokapu-Lee Loy, Members of the Committee:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to provide comments on SB 2431 SD1, which for taxable years beginning 1/1/2026, establishes a tiered nonrefundable tax credit for qualified taxpayer insurers that offer one or more federally qualified health savings account-eligible high deductible health plans in the State, under certain conditions, and increasing the tax credit to incentivize more plans being written for residents in rural medically underserved areas of the State. Requires qualified taxpayer insurers to match up to a certain amount of a policyholder's first-time contribution into a health savings account. Sunsets 12/31/2030.

HMSA appreciates the intent of this measure to improve affordability and support individuals enrolled in high-deductible health plans (HDHPs). However, Health Savings Accounts (HSAs) were never designed to be funded by insurers, and it is not standard practice—either in Hawai‘i or nationally—for insurers to make matching HSA contributions.

Federal HSA rules established by the Internal Revenue Service (IRS) clearly define HSAs as tax-advantaged accounts owned by individuals and funded primarily through employee contributions, employer contributions, or both. The IRS sets annual limits that apply to the combined total of all contributions made by the employer and the employee. There is no category or requirement anywhere in federal law for insurers to make HSA contributions. HSAs are tied to conditions of employment, payroll withholding arrangements, and employer plan design—not to insurance carrier activity.

Given this structure and long-standing federal practice, we respectfully request clarification on whether the proposed tax credit in SB 2431 SD1 is intended to apply **to employers**, who are permitted under IRS rules to make HSA contributions on behalf of employees. If the intent is to direct the tax credit toward insurers, it may conflict with federal HSA design, create compliance questions, and move Hawai‘i far outside national norms.

Thank you for the opportunity to express these concerns with the measure.

Sincerely,

Walden Au
Director of Government Relations



Hawaii Medical Association

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HOUSE COMMITTEE ON HEALTH

Representative Gregg Takayama, Chair

Representative Sue L. Keohokapu-Lee Loy, Vice Chair

Date: March 18, 2026

From: Hawaii Medical Association (HMA)

Elizabeth Ann Ignacio MD - Chair, HMA Public Policy Committee

Christina Marzo MD and Robert Carlisle MD, Vice Chairs, HMA Public Policy Committee

RE SB 2431 SD1 RELATING TO HEALTH SAVINGS ACCOUNTS. Department of Taxation; Health Insurance; Health Savings Account-Eligible High Deductible Health Plan; Bronze Plan; Catastrophic Plan; Tax Credit; Medically Underserved Areas

Position: **Comments**

This measure would, for taxable years beginning 1/1/2026, establish a tiered nonrefundable tax credit for qualified taxpayer insurers that offer one or more federally qualified health savings account-eligible high deductible health plans in the State, under certain conditions, and increasing the tax credit to incentivize more plans being written in rural medically underserved areas of the State; require qualified taxpayer insurers to match up to a certain amount of a policyholder's first-time contribution into a health savings account; sunsets 12/31/2030.

HMA appreciates the amendments of the Senate Committee on Commerce and Consumer Protection. HMA supports the intent of this measure that may provide a geographically targeted incentive to counter decreased enrollment and higher per-member risk in rural and underserved areas of our state, as well as improve affordability and portability for people losing or transitioning coverage.

The debate around expanding higher-deductible health plan (HDHP) options coupled with Health Savings Accounts (HSA) is active. The concerns of the Department of Labor and Industrial Relations are noted that HDHPs do not satisfy employer obligations under Hawai'i's Prepaid Health Care Law. HDHPs can deter needed care and medications for some patients, particularly those with chronic disease or limited savings. Additionally, while requiring a first-time contribution match may help new enrollees fund out-of-pocket exposure in a high-deductible plan, these benefits may skew toward higher-income or more financially "ready" households.

To ensure that these tax credits improve access in rural and medically underserved areas, HMA recommends clear guardrails, including transparent reporting that incentives are passed through to consumers, rural-specific network adequacy standards, and meaningful consumer protections for high-deductible plans. We are grateful that our legislators are exploring pathways to healthcare affordability that can increase patient access without discouraging timely, medically necessary care.

Thank you for allowing the Hawaii Medical Association to provide comments on this measure.

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Linda Rosehill, JD, Government Relations • Marc Alexander, Executive Director

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REFERENCES AND QUICK LINKS

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