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THE POTENTIAL FOR HEALTH CARE SAVINGS ACCOUNTS TO ENGAGE PATIENTS AND BEND THE HEALTH CARE COST CURVE

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

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THE POTENTIAL FOR HEALTH CARE SAVINGS ACCOUNTS TO ENGAGE PATIENTS AND BEND THE HEALTH CARE COST CURVE

THURSDAY JUNE 7, 2018

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to call, at 3:00 p.m., in Room 216, Hart Senate Office Building, the Honorable Erik Paulsen, Chairman, presiding.

Representatives present: Paulsen, Handel, and Maloney.

Senators present: Heinrich, Klobuchar, and Hassan.

Staff present: Ted Boll, Colin Brainard, Kim Corbin, Gabrielle Elul, Alaina Flannigan, Connie Foster, Colleen Healy, Alice Lin, and Russ Rhine.

OPENING STATEMENT OF HON. ERIK PAULSEN, CHAIRMAN, A U.S. REPRESENTATIVE FROM MINNESOTA

Chairman Paulsen. We will call the hearing to order. Thanks everyone for being here.

All Americans deserve access to affordable patient-centered health care. Unfortunately, the fight to achieve this worthy goal has become politicized to the point where it is perilous to even acknowledge the shortcomings of our current Byzantine system.

There are bipartisan solutions to this problem, and today we will be discussing one of those. That is why I am excited to convene today's hearing titled "The Potential For Health Care Savings Accounts To Engage Patients and Bend the Health Care Cost Curve."

When does a patient decide that a common cold is not worth the expense of a doctor's visit? Or whether it would be worth saving dollars by going to a general practitioner who could easily treat an ailment rather than a pricey specialist?

Patients would have a hard time answering these questions, because the actual cost of care remains obscured until long after services are rendered. Even after patients receive an explanation of benefits, the true cost is obscured by what providers charged and what the government or insurers decided they would pay for a service.

This lack of transparency has contributed to rising health costs, which ultimately leads to more unaffordable insurance and even less satisfaction with the health care system.

Yet in the current environment consumers and providers alike are divorced from the true cost of care. As the economist Milton

Friedman once said, "Nobody spends somebody else's money as wisely or as frugally as he spends his own." Americans are excellent comparison shoppers—television, direct mail marketing, billboards, and storefronts all appeal to consumers' senses of value for price when making important choices for themselves and their families.

An important part of everyday life is making decisions based on personal preferences, needs, and of course cost. And it is for this reason that competition thrives among auto manufacturers, food producers, and home builders to deliver safe, healthy, and long-lasting products that people can afford.

We all acknowledge that American health care and health insurance are very expensive. And in today's hearing we will investigate how health savings accounts, or HSAs, allow Americans to lower the cost of health care by drawing on an important idea, an area of their expertise, and that's themselves.

HSAs have delivered great benefits, and there may be even more to come if lawmakers strengthen HSAs' hold in the marketplace. I believe they can broaden access to quality medical care, increase patient choice, and improve health for all Americans.

It is for this reason that I joined with the Senate Finance Committee Chairman, Orrin Hatch, to enhance both health savings accounts and flexible spending accounts to give hard-working Americans more choice and control when it comes to their health care decisions.

According to one estimate, if half of employer-sponsored insurance incorporated HSAs, national savings and health care spending could total $57 billion annually. So how do they work?

An HSA is a tax-exempt account that is set up to pay or reimburse certain medical expenses incurred while covering—while covered by the kinds of high-deductive health care plans many Americans have today. Employees and employers contribute these funds pre-tax, and the money that has gone unused can roll over year to year, and consumers continue to have access to the money even if they change employers or leave the workforce. So it is portable.

And since the creation of HSAs in 2003, the number of people who have an HSA has risen dramatically. In 2005, roughly 1 million people were enrolled, and today 22 million people have HSAs. Americans clearly see the benefit of directing their own health dollars towards their own health care needs and expenses.

My own home State of Minnesota has the third-highest enrollment in HSAs in the country, with nearly 1.2 million enrollees. And a 2016 study of large employers that offered consumer-directed health plans, CDHPs, in the form of a high-deductible health plan with HSAs, found significant long-term cost reduction and no evidence of worse health outcomes.

In recent years, the State of Indiana implemented an HSA structure both in its Medicaid program and in insurance offered to State employees. Then-Governor Daniels noted that this consumer-driven approach resulted in savings and customer satisfaction. In 2010, state employees who enrolled were expected to save more than $8 million, compared to their co-workers in the traditional health care alternative.

Ultimately, the HSA is a vital tool that helps improve our health care system even for those who do not have an HSA. By putting consumers directly in charge of their health care, the health care sector becomes more consumer-conscious.

As in many areas of our economy, the answer usually lies in the wisdom of the American people. I look forward to hearing from our distinguished panel of witnesses today how HSAs and the idea of consumer-driven health care can help improve the affordability of health care.

But before I introduce them, I now recognize the Ranking Member, Senator Heinrich, for his opening statement.

[The prepared statement of Chairman Paulsen appears in the Submissions for the Record on page 26.]

OPENING STATEMENT OF HON. MARTIN HEINRICH, RANKING MEMBER, A U.S. SENATOR FROM NEW MEXICO

Senator Heinrich. Thank you, Chairman Paulsen. I am looking forward to today's discussion on health savings accounts. These tax-free accounts play a constructive role for some consumers to cover health care costs. HSAs are particularly helpful for those earning more than $100,000 who are already saving for retirement and have less trouble covering their monthly bills and student loan payments.

But HSAs do little to bend the so-called "Health Care Cost Curve." This is the fundamental problem that we must focus on: How do we provide top-quality care while reducing our overall national health care spending, and lowering consumers' out-of-pocket costs?

But HSAs seem to generate the most savings through cost shifting, not cost savings. Here employers pay less by offering skimpier plans, coupled with an HSA. But employees shoulder a greater share of costs: the financial risks of getting sick, as well as yet another obstacle to navigate between themselves and their actual health care.

And this is happening at the exact time when wages remain stubbornly stagnant, and more and more families are struggling to get ahead. But my chief concern is this:

Part of the reason that we are here today is that our Republican colleagues seem to be gearing up for yet another attempt to repeal the ACA. If the new proposal is anything like the last, we can expect it to gut Medicaid, drop millions from coverage, take away comprehensive coverage, and further hike premiums.

Central to the Republican vision has been to move more and more consumers to high-deductible plans which have lower premiums but ask consumers to pay more for doctor visits and services before the health plan covers care.

If paired with an HSA, a family can put aside up to $6,900 tax-free to use for qualified health expenditures. The investments in the HSAs grow tax-free. The thinking behind the HSAs is that if people put aside their money for their health care, they will spend it more wisely and, on average, spend less.

They will have, as they say, "skin in the game." The problem, though, is that without knowing what we're paying for and how much we're paying, without transparency, consumers simply do not

have the tools that they need to make rational decisions about costs. And HSAs are unable to help with this problem.

What we do know is that HSAs sometimes encourage people to forego needed care, which is the main way that they save money. If you need chemotherapy to treat your breast cancer but you've under-funded your HSA and have a $2,700 deductible, what happens?

If your child gets sick, will you take her to the doctor, or keep her at home, based on how much of your deductible you've paid down?

If you or a loved one is grappling with an opioid addiction, a reality for far too many across the country and in New Mexico, will an HSA cover your treatment?

Can someone battling addiction, or managing a serious mental health issue, make enough money to save into an HSA in the first place?

These are important questions. No matter where you live, what you do for a living, or what party you belong to, these questions are at the heart of our health care conversation.

I am worried that HSAs, an idea that has merit for some well-off consumers, are being twisted into a quick fix that will only exacerbate the challenges in New Mexico such as our ongoing fight against the opioid epidemic.

I am all for working together on real solutions to making needed improvements in our health care system, improvements that will reduce costs on consumers, increase price transparency, so that consumers can make informed decisions and prevent surprise medical bills, as well as reduce the overall cost of health care in our country.

But focusing on HSAs while avoiding an honest conversation about the key drivers of health care costs could have real negative impacts on real people who are simply trying to manage an illness or care for a sick loved one.

We must focus on actions that can actually bend the cost curve, like investing in preventive care, using the government's purchasing power to lower drug prices, and paying for quality of care rather than quantity. And we have to focus on making things simpler for families.

I look forward to our witnesses' testimony today, and to hearing their perspectives on how we can bring down health care costs for families. Thank you.

[The prepared statement of Senator Heinrich appears in the Submissions for the Record on page 27.]

Chairman Paulsen. Thank you, Senator Heinrich.

And with that, we will begin by introducing our witnesses. First we have Dr. Scott W. Atlas, who is the David and Joan Traitel Senior Fellow at Stanford University's Hoover. Dr. Atlas has published more than 120 journal articles. Two recent books include "Restoring Quality Health Care: A Six Point Plan for Comprehensive Reform at Lower Costs." And also "In Excellent Health: Setting the Record Straight on America's Health Care System." Dr. Atlas has been published or interviewed by The Wall Street Journal, Forbes Magazine, CNN, Fox News, the PBS Newshour, and many others. As Professor in Chief of Neuroradiology at Stanford University

Medical Center, he has trained more than 100 neuroradiology fellows. Dr. Atlas received a B.S. degree in Biology from the University of Illinois in Urbana-Champaign, and an M.D. from the University of Chicago School of Medicine.

Also with us is Kevin McKechnie, who joined American Bankers Association back in 2001. He is currently the Executive Director of the HSA Council, and a Senior Vice President. Mr. McKechnie is also a principal in HSA Holdings, which provides health care financing expertise to several governments around the world. Previously he served for four years as government relations representative for Marsh & McClennan. Mr. McKechnie also served as Director of Government Relations for International Financial Services, and Legislative Assistant for former Representative William Dannemeier of California. Mr. McKechnie has a B.A. in History and Political Science from York University in Toronto, Canada, and pursued graduate studies in American History at American University.

Tracy Watts is a Senior Partner in Mercer's Washington, D.C., office and is on the Policy Board of Directors for the American Benefits Council. A consultant with Mercer for 30 years, Ms. Watts specializes in health care cost management, assisting employers in the design, evaluation, and ongoing management of health and group benefit plans for active and retired employees. As a spokesperson for Mercer she has been quoted in The Wall Street Journal, The New York Times, The Washington Post, Money Magazine, USA Today, and many others. Ms. Watts is a graduate of Texas Christian University.

And also with us today is Dr. Kavita Patel, who is a non-resident Fellow at the Brookings Institution, as well as a practicing primary care internist at Johns Hopkins Medicine. Dr. Patel served in the Obama Administration as Director of Policy for the Office of Intergovernmental Affairs and Public Engagement. As a senior aide to Valerie Jarrett, Dr. Patel played a critical role in policy development and evaluation of policy initiatives connected to health reform, financial regulatory reform, and economic recovery issues. Dr. Patel also served and worked as a Deputy Staff Director on Health for the late-Senator Edward Kennedy. Being in this room, as she mentioned to me a little earlier. She earned her medical degree from the University of Texas Health Sciences Center and her Masters in Public Health from the University of California, Los Angeles.

And with that, we will welcome each of you to the hearing today, and we will begin by recognizing you, Dr. Atlas, for five minutes.

STATEMENT OF SCOTT W. ATLAS, M.D., DAVID AND JOAN TRAITEL SENIOR FELLOW, HOOVER INSTITUTION, STANFORD UNIVERSITY, STANFORD, CA

Dr. Atlas. Thank you, Chairman Paulsen, Ranking Member Heinrich, and Members of the Committee. Thank you for the invitation and opportunity to speak today about health care reform, and specifically about the role of health savings accounts.

It is in the context of overall health care reform that I will discuss the importance of HSAs, including the rationale for incentivizing their use, and for strategically reforming them to le-

verage their impact on broadening access to quality medical care, increasing patient choice, and improving health for all Americans.

The critical concept here is that reducing the cost of medical care itself is the most effective pathway to broader access to quality care and lower insurance premiums, and ultimately of course better health.

Instead, the Affordable Care Act, and most post-ACA ideas, continue to stress making insurance more affordable, mainly through refundable tax credits or other subsidies. But insurance premiums are secondary, and historically chiefly reflect two factors: Mainly the cost of medical care accounting for the majority and the regulatory environment. Therefore, strategies that subsidize premiums artificially prop up insurance coverage that typically has minimized out-of-pocket payment. This is directly counter productive because it shields medical care providers from competing on price.

Two key points are essential to clarify from the start:

Number one, the HSA is a vital and highly effective proven tool to broaden access to affordable high-quality health care for all Americans, even those without HSAs. It does so by putting consumers directly in charge of buying their own health care, and better than tax deductions HSAs uniquely incentivize savings. The fundamental purpose of an HSA is not simply to provide a tax-sheltered benefit for individuals in order to cushion the blow of high health care expenses.

Two, the HSA is not an isolated, independent component of the health care system. Reforms to maximize their positive impact for consumers are tied to other reforms. To broaden access to affordable high quality health care for all Americans, there are three fundamental steps that must occur, and all directly relate to HSA reforms.

One, patients must be strongly incentivized to consider medical care prices and simultaneously equipped with the tools to do so. This is accomplished through universally available large, liberalized and transferable HSAs in conjunction with lower-cost, higher-deductible insurance. The key question is: Is it realistic to suggest that patients could even consider price?

Among privately insured adults under 65, almost 60 percent of all health expenditures is for elective outpatient care. Even in the elderly, almost 40 percent of expenses are for outpatient care. Outpatient services dominate America's health care spending, and these are amenable to price-conscious purchasing. To fully leverage the impact of HSAs, it is important to position more patients as paying directly. Despite the ACA's regulatory attempt to shift consumers to more comprehensive, what I call "bloated coverage," a shift toward high-deductible plans with HSAs has continued. Indeed, by increasingly choosing HSAs when given the opportunity, Americans are approving their value.

HSAs with high-deductible coverage have proven to reduce health care prices. Spending reductions average 15 percent per year and increase with the level of deductible and when paired with HSAs. Adding HSAs to high-deductible plans correlates to 50 percent to double the savings of high-deductible plans alone.

Downward pressure on health care prices from doctors competing for patients who pay directly for care has been demonstrated by

procedures originally not covered by insurance, like Lasik Corrective Eye Surgery, or MRNCT and CT screening.

Data from MRI and outpatient surgery-covered care confirms that, when patients are motivated to compare prices, prices come down significantly. And this reduces prices for all health care consumers, not just HSA holders.

The issue is not whether HSAs are effective in making health care more affordable, it is how to maximize their adoption and fully leverage them.

All HSAs should be fully owned and controlled by individuals. Restrictions on full HSA participation by seniors on Medicare should be abolished. Given that seniors are the biggest users of health care, it is critical to have them exerting downward pressure on health care prices.

HSA limits should be expanded and uses should be eased, including for the expenses of the HSA account holder's elderly parents. And the list of allowable services and products should be expanded. They should be delinked from specific insurance deductibles. HSAs have also been a valuable vehicle for effective wellness programs. The ACA limited the financial incentives from employers, including deposits into HSAs. That should be abolished.

The second big point is introduce the right incentives into the Tax Code to maximize the use and benefit of HSAs. And my belief is the Tax Code should cap the amounts of deductions or income exclusions if they're maintained, but it should limit those deductions or exclusions to two categories of expenses: HSA contributions and the amount of premiums for catastrophic coverage. To have tax deductions for all health care expending is counterproductive. It gives an incentive to spend more on health care.

Three, strategically increase the supply of medical care to stimulate competition and increase choices. In large part, this means removing archaic, anti-consumer barriers to competition among doctors, other medical care providers, health care technology, and drugs.

In conclusion, in other countries governments hold down health care costs mainly by limiting the use of medical care, drugs, and technology through its power over patients and doctors often as single payer. And those countries get the expected results when looking at the actual data: long waits and worse medical outcomes than the United States, particularly for their poor citizens who are the only ones unable to circumvent those systems.

We should consider a different approach: creating appropriate incentives, and eliminating harmful regulations so that prices of care come down and high-quality care is affordable for everyone. Thank you.

[The prepared statement of Dr. Atlas appears in the Submissions for the Record on page 29.]

Chairman Paulsen. Thank you. Mr. McKechnie, you are recognized for five minutes.

STATEMENT OF MR. J. KEVIN McKECHNIE, EXECUTIVE DIRECTOR, HSA COUNCIL AND SENIOR VICE PRESIDENT, AMERICAN BANKERS ASSOCIATION, WASHINGTON, DC

Mr. McKechnie. Thank you, Mr. Chairman, Ranking Member Heinrich, Members of the Committee:

I appreciate you having this hearing today. Mr. Chairman, I would like to request that my written testimony appear in the record as if read, if that's alright?

I founded the Council in 2004 with the hope of accelerating adoption velocity of HSAs and the qualified insurance that goes with them, and we've succeeded. According to Devenir Research of Minneapolis, there are now more than 22 million accounts containing about $54 billion to pay for the future health care needs of about 30 million Americans. We think that is the number as of about January of this year in 2018. And that is an extrapolation, to be entirely candid.

Let me start with an observation from some of your former colleagues. So far, most of the proposals before Congress attempt to deal with access but do not adequately address the more important factor, cost control.

"We have introduced legislation that would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their own money." So says United States Senators Sam Nunn, John Breaux, Tom Daschel, David Boren, Richard Lugar, and Dan Coates on September 18th, 1992. A bipartisan group, they were obviously ahead of their time and I suggest onto something. HSAs are the only health insurance plans in America that allow their owners to save for the future. Every other plan, even the ones a lot of health advocates call "good insurance" start their participants off at the beginning of the year with nothing in the bank to satisfy out-of-pocket expenses.

HSAs allow their owners to pay for routine care with tax-exempt dollars, rather than after-tax dollars. And the Kaiser Family Foundation says the average deductible for single coverage in a small firm last year was $2,120. An important consumer question is how to satisfy that deductible. With pre-tax dollars from your HSA? Or after-tax dollars from your wallet?

Fidelity Investments reports that a 65-year-old couple would need $275,000 just to pay for the health expenses Medicare doesn't cover in retirement. I'm quite sure none of you are under the impression that our pension system is over-funded. HSAs can be a useful public policy tool to address that problem, too.

My good friend Jody Dietel, Chief Compliance Officer for Wage Works, testified yesterday before your colleagues on the House Ways and Means Committee that the median household income for an HSA account holder, according to their data, is only $57,060. Our anecdotal data of six companies just like Wage Works lowers that to $53,000.

Additionally, most HSA owners, 77 percent in fact, were born after 1965. Only 22 percent are Baby Boomers, which is to say people at the height of their income potential. Devenir says the average HSA balance is a little more than $2,000, and that 78 percent of account holders have less than that in their account.

Accordingly, I conclude these accounts are used for their intended purpose, which is paying for routine health care expenses by Americans of mostly modest income, comprised mostly of the three generations that followed the Baby Boomers, Generation Z, Millenials, and Gen Xers.

I am here today on their behalf to ask for your help. While HSAs are one important tool for managing costs, they need improvement. You can't have an HSA and be enrolled in Medicare or a traditional health plan, and you can't take Social Security benefits because that automatically enrolls you in Part A. You can't have access to Tricare, or Indian Health Services, or Veterans Administration benefits. You can't be covered by a medical FSA, and you can't have access to retail medical clinics or telemedicine at no cost.

Accordingly, HSA owners would like more flexibility. HSAs should be able to cover more value-based services like direct primary care, expenses associated with chronic disease management, and telemedicine services.

There are bipartisan bills in both Houses of Congress, several supported by you and your colleagues, Mr. Chairman, that would allow these services in a HSA, and the H3A Council strongly supports all of them.

We also support allowing plans with an actuarial value of up to 80 percent to be considered HSA-qualified, so we don't have to come and petition Congress or the IRS to achieve plan flexibility. As long as you had a plan that was below 80 percent, you'd be able to offer whatever services made that bucket full.

We agree that HSAs should be more flexible. We further suggest allowing an increase in allowable contributions, up to the out-of-pocket maximum, in order to help people pay for these additional services, or at least have the potential to cover their entire out-of-pocket risk with tax-exempt funds.

We also want to allow seniors who choose to keep working and are covered by an employer-sponsored HSA plan to enroll in Medicare and still be HSA-eligible. The President has gone further and proposed allowing HSAs in the Medicare Advantage Program. We agree with him. We agree with him and in any event know that this subject merits further discussion. Medicaid should be broadened so that the example of Indiana's HIP2.0 program can be expanded if a State so chooses. Vice President Pence, then Governor Pence, accomplished by Federal waiver what we think states should have a right to do if they want. Now I don't think HSAs can solve every problem—to your point, Ranking Member Heinrich—but at least they have all the incentives in the right place. They let people save for the future. It's very important. They promote transparency in pricing, exerting downward pressure on costs, and they respect well-known and proven insurance principles.

I think more Americans should have access to HSAs, and recommend that legislative proposals pending before Congress be quickly enacted.

Mr. Chairman, thank you for holding this hearing, and I look forward to any questions.

[The prepared statement of Mr. McKechnie appears in the Submissions for the Record on page 42.]

Chairman Paulsen. Thank you. Ms. Watts, you are recognized for five minutes, as well.

STATEMENT OF MS. TRACY WATTS, SENIOR PARTNER, MERCER; AND POLICY BOARD OF DIRECTORS, AMERICAN BENEFITS COUNCIL, WASHINGTON, DC

Ms. Watts. Chairman Paulsen, Ranking Member Heinrich, and Members of the Committee:

Thank you for this opportunity to meet with you to discuss the critical role of health savings accounts and making health care more affordable.

My name is Tracy Watts. I'm a Senior Partner at Mercer, and I am testifying today on behalf of Mercer and the American Benefits Council where I serve on their Policy Board of Directors.

I have more than 30 years of experience helping Fortune 500 employers develop innovative strategies to control their health care costs.

Mercer is a business unit of Marsh & McClennan Companies. The businesses of MMC include Mercer, Oliver Wyman, and Marsha & McClennan Agency. We employ 25,000 colleagues in the U.S., including more than 350 in your District, Chairman Paulsen.

The American Benefits Council is a public policy organization that represents Fortune 500 companies and collectively the Council's members either sponsor directly or provide services to retirement and health plans covering more than 100 million Americans.

So I would like to begin my testimony by highlighting some relevant findings from Mercer's National Survey of Employer-Sponsored Health Plans. The survey includes responses from 2,500 employers, and it is the oldest, longest, and most comprehensive survey of its kind. The results can be projected to any size employer population in the U.S.

Our survey shows that an increasing number of American workers and their families enrolled in consumer-directed plans, or CDHPs. And on page 3 of the PowerPoint attachment to my written testimony you will see about 34 percent of American workers employed by large companies, those with 500 or more employees, enrolled in a CDHP.

Since 2009, the enrollment in CDHP plans has increased an astounding 325 percent. In addition to increased reliance on consumer-directed plans by American workers, if you turn to page 4 you will see that HSA-eligible plans cost 20 percent less than PPO plans in general, and they are 6 percent less costly than PPO plans with deductibles over $1,000. It is important to note that the success of HSA-eligible plans in reducing plan costs is one of the few strategies proven to help bend the curve, and in turn help manage premium costs for employees.

A driving force behind growth into HSA-eligible plans is the threat of the 40 percent Cadillac tax, now delayed to 2022, and we thank you for that. And thank you, Senator Heinrich, for your leadership in working to repeal the tax.

Next I would like to share an example of how we help clients analyze and evaluate their health plan performance. This particular example shows the positive impact of HSA-eligible plans on both cost and health risk.

In this example, the employer has sponsored an HSA-eligible CDHP plan alongside a PPO plan for more than three years. And on page 8 you will see that we matched enrollees in the PPO plan to enrollees in the CDHP option who shared the same demographic and risk profiles at the start of the three-year comparative period.

There were approximately 13,000 plan members in each of the comparison groups. So it is a good sample size. When we looked at how the participants in each plan option used their medical services over the three-year period, it was quite similar across the two groups. There was basically no difference in the use of preventive screenings and annual physicals.

The CDHP plan did have lower utilization of the emergency room, of office visits, and prescriptions. However, the day supply for the prescriptions was actually higher for CDHP members, which could mean better utilization of mail-order benefits, and better compliance with their prescribed therapies.

The most interesting finding, though, from this study is shown on page 12, where we look at health risks over the three-year period. The PPO plan had a significant decline in the low-risk category, and an increase in the high-risk category while the risk structure for the CDHP plan was virtually unchanged.

We valued the change in the PPO risk at approximately an 8 percent increase in the risk of the PPO members. This suggests that the CDHP plan may have been more effective at helping participants manage existing or new medical conditions or health risks.

As for costs, the data were clear that the HSA-eligible plan ended up costing on average 15 percent less per capita than the PPO plan over the three-year period. We've performed this analysis for other employer clients with very similar results.

We thank you for holding this hearing today to highlight how HSAs can indeed engage patients and bend the cost curve. I appreciate the opportunity to share these findings with the Committee, and I am pleased to answer your questions.

[The prepared statement of Ms. Watts appears in the Submissions for the Record on page 75.]

Chairman Paulsen. Thank you, Ms. Watts.

Dr. Patel, you are recognized for five minutes.

STATEMENT OF KAVITA PATEL, M.D., M.S., PRIMARY CARE PHYSICIAN, JOHNS HOPKINS MEDICINE, AND FELLOW, BROOKINGS INSTITUTION, WASHINGTON, DC

Dr. Patel. Thank you very much. Thank you, Chairman Paulsen, Ranking Member Heinrich, and other Members of the Committee:

This is a great honor for me to be here on this side of the dais. I am a former Senate staffer and career in health policy, but I am coming here today kind of bringing all of those worlds together, and perhaps most importantly as someone who delivers care to over 1,000 patients as part of a regular community-based primary care practice. And so that is actually where I start from.

The one thing I would ask you on this very important topic about bending the cost curve is to really consider what I would say

should be all of our north star. That is, how do we make care better and less costly for all Americans? So that is where I come from.

The majority of my patients are primarily insured by either Medicare or Medicaid, and do have commercial insurance as well. So I take care of kind of all gamuts. And I want to tell you about one specific patient, just because she will ring true probably to all of you on some level.

A 47-year-old female—I did get her permission, not her name, but I am going to share her story—a 47-year-old female who actually works for the Federal Government, has a high-deductible health plan, and a health savings account, three children. Average income is about $63,000. And so she is right in that ballpark. She was unfortunately diagnosed with a very complex kidney cancer that fortunately has a very advanced immunotherapy that can actually target her cells, but costs about $150,000 per treatment.

No question that this is something that I think American innovation has brought to her doorstep, but she will regularly use this very advanced medical device with me, one of her 14 doctors, to try to understand what tests does she really need? What is it that she can actually get on a weekly basis in order to make sure she can afford the very expensive drug that she absolutely must take. But then she will sit and bargain with me over which lab test does she need? Which doctor's visits does she need to go to? And these questions are exacerbated at the end of the month when she is looking to next month to think about paying for her rent, thinking about putting food on the table. And this is something with a health savings account.

When I asked her, when I talked to her in preparing for this hearing, how does that HSA help you? And she said probably the most profound thing that I want all of you to take home. She said:

It really doesn't matter whether I have an HSA or not. She said, I have to think about the money that I have to spend in that moment, and what I have to do or not do in order to make that work for my finances.

So I want everybody to kind of take a broader view and think about the growing cost of care, and also what people do. They don't hear "HSA" or a pre-deductible, they just think about the money that is being asked of them when they get the call from their pharmacy, or when the person in my front office desk asks them for their payment at the time of service. And all of us have been to the doctor where we see that sign that says "payment requested at the time of service."

And that $20 adds up when you're dealing with these types of illnesses. So I come to you in that context. And I think that the conversation around bending the cost curve is absolutely the right one to have. I just want to make three points about the drivers of those costs:

Number one, hospitals. Hospitals, one of whom I work for, hospitals have, year-over-year, had double-digit cost increases. And these increases have been held constant, no matter who your payer is.

Number two, ambulatory services. Costs in ambulatory services, physician offices, have increased 71 percent. As a primary care doctor, I would tell you that's a good thing. We should be spending

way more money in high-value services, but we're not. We're spending them across the board.

The third is prescription drugs. Prescription drugs from a recent Office of the Inspector General Report have grown out of proportion—and I'll just give one statistic that I'll actually read to you because it's startling—total reimbursement for all brand name drugs in Part D increased 77 percent from 2011 to 2015, despite a 17 percent decrease in the number of prescriptions for these drugs.

So less actual prescriptions; higher actual reimbursement in Part D. These are not facts to be ignored. So these are three huge cost drivers. I have included some—Senator Kennedy's time taught me that graphs are always wonderful to have, so I've got some graphs in my written testimony that illustrate some of this in I hope a very clear way.

Those are three huge cost drivers. That is not to say that health savings accounts can't play an important role. Absolutely. Innovative services like direct primary care, having access to chronic management services, pre-deductibles so that you don't even have to think about whether you need to spend an HSA on kind of higher value services, work that the University of Michigan has done to identify what's high value. Opioid treatment, for example, should not apply to your deductible. I don't care what you're doing. These are things that just make sense for everyday Americans, and we need to do more of that.

We started some of that by making preventive services covered before deductibles in the Affordable Care Act. That was not enough.

So in closing, I just want to—I know that we will get into, hopefully, an extensive kind of debate about health savings accounts and what fixes. Think about all of this as kind of a large balloon, and think about the real people and the real voices, particularly of patients as well as the doctors who are taking care of those patients, who are just as frustrated. And I hope that we can have a more productive conversation. Thank you.

[The prepared statement of Dr. Patel appears in the Submissions for the Record on page 100.]

Chairman Paulsen. Thank you, Dr. Patel, and thanks for sharing the perspective of a physician and an actual patient that you deal with.

I remind all members we will keep our questioning period time to five minutes, and I will just begin. We have really enjoyed the testimony. And I certainly by no means would recommend or say that health care savings accounts would be a silver bullet or an answer to these challenging problems that we have across the board for the health care spending here in the United States, or for a lot of patients.

But it is being proven to be widely utilized and widely appreciated when you have the average income of folks that use these health care savings accounts of about $57,000, and they are becoming more popular. But I am more interested in how they actually affect bending the cost curve a little bit.

I know that one of the challenges we have in health care today is that health care payments are ending up being made essentially by a third party and not by the patients. So often physicians, often

patients don't know what the cost is when they're not able to compare, or they're not aware in terms of utilizing what health care services to use.

So you have got somebody spending other—somebody else spending money, and they may not spend it as wisely as they would spend their own, for instance. So these consumer-directed health care accounts have successfully addressed some of those challenges.

So maybe, Dr. Atlas, I will just start with you. Can you elaborate maybe a little bit on how—or maybe explain to us some of the ways in which these consumer-directed health care plans have allowed consumers with their own skin in the game essentially a little bit to help put more in the driver's seat and make the right informed consumer choices? And how has that helped to bend the cost curve a little bit?

Dr. Atlas. Yeah, I mean I think you can look at—we at Hoover, and I am trying to be part of what the person who down the hall from me had his office, which was Milton Friedman, spoke quite a bit from evidence. And when you look at the evidence in the published literature on people who have the information necessary to make decisions, and have a health savings account and a high-deductible type plan, the price of care comes down significantly.

When you look at published studies, I mentioned them very quickly on MRI, and on Outpatient Ambulatory Surgery, these are in the literature. And we see that the prices came down 18, 19 percent per year. Of course it is very true what Ranking Minority Member Mr. Heinrich said, which is that the information has to be there. And so in these studies, patients had visibility of price.

The question really is, is there legislation necessary to do that because we really don't do that in other goods and services? You don't have to say to the computer store, you know, you better show your prices.

The fact is that the most compelling reason for doctors and hospitals to post their prices would be knowing that they're competing for patients' money. When patients care what they're spending, they are going to save money. And this is not an assertion that's proven in the literature.

We can also look back at things that weren't covered at all by insurance. So here I'm talking about MRI, whole-body CT, whole-body MRI screening. And I'm a neuroradiologist, so I am very familiar with what happened. When that came out, it was $1,500 to $2,000 in the shopping mall. And within a year or two, the prices came down to $300.

Now that is not the only reason that prices came down, but that's a critical part. There's a value-seeking behavior that is completely missing from the equation here.

So it is factually proven that, when the prices are visible and when signs of quality are visible—which they would be, once you have a competitive environment—the prices come down significantly.

And the key point here is, it's not just the prices for the people who have the health savings accounts. We want health savings accounts as a vehicle to reduce the prices of medical care for everyone, while avoiding the way other countries do this, which is by limiting access to care. This way it is really "consumer driven," to

use the phrase that you're using, and that is the way to get prices down without impacting quality negatively.

Chairman Paulsen. Maybe, Ms. Watts, you can explain a little bit, or follow up on that from the employer's side of the equation, who have a lot of employees who may utilize these accounts. I mean, what have you seen in terms of employers benefiting from these types of consumer-driven plans themselves in terms of costs.

Ms. Watts. Access to tools and resources is key to the success of these programs, and even the one that I talked about. So you've got your design and the incentive, if you will, to have the skin in the game. But it is true, consumers feel very ill-equipped to be able to shop for their health care.

And so, tools exist that provide transparency information. But the truth is, right now only about 30 percent of your medical care that you would be seeking is "shoppable," where you could find out the price, do comparative research for what the prices are.

For everything else, it's too complex. There's too many parties involved to be able to know exactly what something is going to cost. And so one of the things that employers have done is to add advocates for the consumer. The advocate might be within the health plan, or it may be a third party that helps that patient navigate the health care delivery system.

Someone gets this diagnosis and they are a little scared and asking themselves, should I be getting another opinion somewhere else? Is this the type of thing that maybe we want to send this off to a panel of doctors to take a look at, because it's a little bit more complicated?

And, because there's this challenge of knowing what the price is, and shopping based on price, but also knowing, what is the quality of the provider that you're going to be going to? Are they best equipped to be able to help you get the outcome that you're looking for the fastest?

Chairman Paulsen. Thank you. Alright, Senator Heinrich, you are recognized for five minutes.

Senator Heinrich. Thank you, Chairman.

Dr. Patel, it is evident from this hearing, and I have experienced this in the past, that policymakers love high-deductible insurance plans. I can assure you, my constituents do not.

The other feedback I get from them is that high-deductible plans cause them to forego treatment at times. Is that something you've seen in your practice?

Dr. Patel. Yes, Senator. So it's very routine. Go to any kind of community-based, or even hospital-based practice where you have a high volume of patients. We all know the phenomenon of having people try to seek care, or plan out their year to try to understand when and how they will hit their deductible. And it is a very common phenomenon to have patients actually space out services that they need. And many of my patients, I can tell when the fall cycle hits, or when we get into the new year and they're more susceptible to that annual deductible, they will not come in.

And so there is a very conscious decision. And I think it speaks to something that I have seen over a decade of practicing. We talk about wage growth? I have not seen, and I can say I have now treated—I tried to tally—I've taken care of about 22,000 patients

of all types, and I have yet to hear somebody say, you know, I got into a high-deductible health plan, and I'm making more money as a result of it.

Senator Heinrich. Yeah, I am waiting for that constituent.

Dr. Patel. I am, too. I am waiting for that patient to tell me that. Now that is not to say that that is happening, but my experience has been that—and in the data that we are seeing, is showing that people are foregoing that care.

My former employer, the Rand Corporation, ran something called The Rand Health Insurance Experiment, which actually illustrated that, depending on where you put that deductible, people will forego necessary care. And that is exactly where I think, as stewards of the American economy, we need to be careful.

Senator Heinrich. Absolutely. We do not want people running to the doctor every time they have a cold, but we sure want them running to the doctor when they have indications of serious illness.

The first chart in your written testimony shows the cost of prescription drugs growing dramatically faster than other health care costs. The very steep line here in your chart. And frankly I hear more about that than anything else in health care, no questions asked.

What policy should Congress be looking at to lower the skyrocketing costs of prescription drugs?

Dr. Patel. Absolutely. And it is certainly not simple. I was in the Senate when we were launching and designing the Part D Program. I would argue that the Part D Program in 2006 did not reflect the innovation in American medicine that can be made available in the Part D Program in 2018.

So one essential—and I would hope that it is a bipartisan, this is not a partisan issue, it is a bipartisan issue—is to modernize the Medicare Part D Program in order to bring the very innovations that we have in Medicare Parts A and Parts B, to actually do that in Part D.

Right now we have no ability for plans to bring any of the innovative tools, or things that we've done to manage services in other parts of the program. That's one.

Number two, better access to generics and biosimilars. You are hearing that not only does the Trump Administration kind of agree with that, but many health policy experts also feel like that is doable.

Number three is a very direct conversation. It's what Dr. Atlas had referred to about kind of a direct conversation about transparency. And that is transparency in all the levels between the manufacturer, the pharmaceutical benefit manager, the pharmacy, and the person who it really impacts, the consumer at the end.

Senator Heinrich. I think that is an area of commonality here, that I hear, that transparency is key to people making good decisions.

And, Dr. Atlas, you said this very eloquently. You said when the prices are visible. And it seems to me that is one of the challenges here. And we seem to agree that transparency is a good thing. And when people are given more information, they make better choices. It is really hard—myself included, and almost anyone I talk to—that is not the lay of the land in our health care system today.

Dr. Atlas, how do we make that change and require more transparency in the system?

Dr. Atlas. I think this is really a critical point, and I think we do all agree that this transparency is necessary.

First I want to talk about drugs and price transparency because this is the biggest offender of all. Because, you know, recent data shows that there were $179 billion in these very complicated arrangements with pharmacy benefit managers. Patients have no idea what the real price of their drug is.

But the real reason they have no idea is because, just like me when I get my high cholesterol drug, I personally pay $2. I don't care what the price is if I'm only paying $2. And this is the problem—when you have an insurance model, or any program that minimizes to near zero, or to relatively speaking near zero, what you, the patient, pays out-of-pocket for something.

In fact I'm sure that everybody here is aware of the study that came out very recently that in over 20 percent of patient co-pays for drugs, when they're using insurance, their co-pay is larger than if they paid for the entire drug out of pocket because there are contractual agreements that muzzle pharmacists from revealing to patients the prices of the drug if patients would pay out of their pocket.

This is unconscionable and scandalous, but this is an example of the perversion of the system when patients don't know what things cost. So the question really is: How do you get that to occur, and have them care what it costs? It's not just the visibility. Because if the prices were visible but they really didn't care—they didn't get a reward for paying less, okay, fine, I know the price. So they need to be able to get a positive incentive to pay less, because it's not necessarily the same.

When you say someone foregoes medical care, the question isn't that. The more relevant question is about necessary medical care. And when you really look at the data in the literature, and Haviland is the author of one of the studies, she showed that the patients did forego medical care, but they did not get harmful health effects by foregoing that medical care.

So you have to look at the data and be careful not to mix up the kind of activity here. It's a very difficult problem, particularly with drugs, because it's so complicated to get prices there. But as one of my colleagues told me, if you just mandate and legislate that prices have to be posted, it could be like hotel rooms where on the back of the door you see the price, and the price is meaningless. No one even looks at it, no one cares. You have to be far more thoughtful about how you get the prices visible, and I think it's by demand from patients who care what they spend.

Chairman Paulsen. Representative Handel, you are recognized for five minutes.

Representative Handel. Thank you very much, Mr. Chairman, and thank you to all of our witnesses today. I appreciate it. It has been a very good dialogue.

I want to stay on the topic of transparency and come to you, Mr. McKechnie. The HSAs are designed to encourage consumers, patients, to shop around for health services. And we have heard a lot of conversation about whether that is easy to do, or hard to do.

There are some new services companies out there, Meta-bids, Vendi-Health, Health Care Blue Book, that are working very hard to make it easier. In fact, I have availed myself of one of those—I will not say which one, obviously—to check the prices of a mammogram. And it is stunning, the broad array of pricing on it. But no one would know that unless they actually picked up the phone and called each of those and said, "If I come in and pay cash, how much would it be?"

So can you speak to the services that these companies offer, and whether you think that is a good way to go? Or do we need legislation to really drive and foster transparency?

Mr. McKechnie. We think, obviously—thank you for your question, first of all. We think, obviously, the reason there is a request for legislation is because perhaps some of the other methodologies have yet to work. And they will be working whether or not legislation is passed in the first place. That is the nature of consumerism.

They tend to work best, as Ms. Watts said, in that 30 percent where visibility tends to be around nonemergency services, which is why the companies you described can tell you where and when you can get an MRI, and for how much money. They are very good at that kind of diagnostic centric price transparency function.

And when you look at a bank's HSA platform and their web representation of that service, you can see that all of those things are plugged in to help people do exactly what we have been describing here today, which is to take their dollars, find their treatment choice or the one that has been prescribed to them by their doctor, and then where is the most efficient way to spend their scarce resources in the time that is important to them. And I think that is one of those qualitative questions that you miss frequently, which is not just that you need a service or it has been insured and therefore it is inefficient, which is very important and I agree with, but also it needs to be available to you, the essence of consumerism. When do you want to do it? And with whom do you want to do it? And that choice is yours to make. And the services you describe make them easier.

Transparency would be achievable more easily with legislation, since you would have to do it. And so we support that. It is a shame, though, because the point of the story is everything should be transparent and it is not.

Representative Handel. That is right. Thank you very much.

Dr. Atlas, you mentioned briefly in your testimony that policy priorities over the past few years have really been focused more on, I think you called it, the insurance model, or lowering the cost of health insurance, rather than focusing more on lowering the actual cost of health care.

Can you just expand on that a little bit more? Because I think that is a very important differentiation there, and a very important point.

Dr. Atlas. Right. Thank you. When you subsidize insurance premiums, which is what the Affordable Care Act essentially did, or when you give refundable tax credits, which is essentially cash to people like a lot of the Republican proposals were proposing, all you are doing is literally propping up the price of the good. In this case, the good is insurance. And when you do that, you are forget-

ting about the fact that the driver of the cost of insurance, the main driver, is the payout for medical services. At least historically it's been roughly 80/20, 20 being administrative or other things.

And there are some good actuarial estimates that say that the price, as you know, of an insurance premium has went significantly higher under the Affordable Care Act. And it is estimated that about 90 percent of the increase is due to regulations, not the cost of medical care.

So that is sort of an outlier in this. So the key here is to understand what is really the driver of insurance premiums. It is the cost of care. That is the root problem. And the way to solve that, as we are all discussing—or at least I think the gist of this is—is to have exposure in, I don't like to use "skin in the game," but I just like to say "caring about the cost of what you are buying." Medical care is the only good or service that you don't know what it costs until after you've used it. Okay? And even when you get the bill, it is indecipherable, particularly in Medicare.

I want to make one additional point about the idea about the idea that higher deductibles and HSAs—first of all, it is not a panacea. It is not for everyone. And I don't think anyone is saying that. But the reality is that everyone benefits from other people having them, even the people who don't have HSAs themselves.

And if you look at what happened—which I have a chart in what I submitted in my written document here—under the Affordable Care Act it is true that all insurance prices went up. But the fact is that high-deductible premiums selectively went up faster than everything else, even though people still buy them more than they did in the past. And so the economist friends of mine at Hoover said, well how could that be? If your data shows that the prices selectively went up faster for high-deductible care—premiums, why would more people buy? It's because it is still cheaper, okay?

But the problem is that it was selectively punished. It's the exact opposite outcome of what you would want to legislate. People are voting by their actions for the value of HSAs and high-deductible plans.

You look at the curves. There are record numbers, 22 to 30 some million, depending upon what estimate, of people who have HSAs, and increasingly employers are offering them, and people want them. Even in the models where there are multiple companies that have formed so-called exchanges, people when they were given a defined amount of money to use on health benefits, they opted more for high-deductible plans and HSAs. It is not true that people don't want them, they do.

Representative Handel. Sorry to interrupt. I'm out of time. Thank you so much. I yield back.

Chairman Paulsen. Thank you. And, Mr. McKechnie, let me ask you this question, because Indiana has been cited as a model in many respects, particularly because of their State employees. But can you talk a little bit more about the success we've seen in Indiana, or what changes, if any, there have been in Indiana's success since 2010? Can you comment on any lessons that have been learned from other states' approaches in implementing HSAs?

Mr. McKechnie. Sure. I think it is important to understand the landscape here, which is that in 2008 in that Presidential election

Medicaid covered slightly more than 50 million people. And by the time we got to election 2016, Medicaid covered slightly less than 75 million people, 74 million people.

And so the Affordable Care Act is largely responsible for that growth, but of course it left the states with the question of how do you want to expand? And Indiana took up the Affordable Care Act's challenge and said, yes, we want to expand but we want to expand by having an account-based system where it made sense to do so.

And so their system had traditional Medicaid of course, but it also allowed for what they call Indiana Power Accounts, which is called the HIP2.0 Program. And of course most of your current officials at CMS were former Indiana officials, so they know exactly what they are talking about and can enhance whatever answer you might need on this question. But it goes like this:

The marketing for Medicaid 2.0 was—HIP2.0, was so successful the program had to be closed. And that enrollment shut down in that first year because people, it turns out, at the lower end of the economic spectrum aren't illiterate when it comes to finance, did want to have money in an account, did want to see portability, were happy to trade preventative care services for getting $1,100 in their account again next year.

And we think that's a very salutary benefit for teaching people how to use financial instruments. We spent a lot of money at the American Bankers Association trying to promote financial literacy. The Governor actually did it in Medicaid and should be congratulated for it. It doesn't exist too many places.

So it is going well. There are some problems, however. Obviously nothing is perfect. And one of the imperfections is that as people move in and out of jobs, and in and out of Medicaid, that is a very significant complexity to have to manage. This is not Medicare where you age into it and you're there forever.

This is the kind of thing where you earn out of Medicaid eligibility, and you may fall back into the program. And there are integration problems with what happens at that moment.

So they're working on it, trying to make that more seamless, but that is one of the issues, sir.

Chairman Paulsen. Okay. Let me ask a question, and anyone can answer it, but, you know, you have got a lot of different consumer-directed health plans. You have got HSAs. You have got Flexible Spending Accounts. You have got Health Reimbursement Accounts. I mean, any thoughts on which of those might be best that are showing track record of actually helping lower costs, or what might be best for average Americans? I mean it is always individualized for individual folks, but any thoughts?

Ms. Watts. I will share one of Mercer's survey data points with you. Of the consumer-directed plans, the account-based plans, about 77 percent of them are HSA plans. The remaining are HRA plans. And those HRA plans are really more legacy plans, because that is what we had first. Employers put in consumer-directed plans to begin with an HRA, and then we got the Health Savings Accounts. And so for most employers today, their consumer-directed plan is an HSA-based plan.

Chairman Paulsen. Got it.

Dr. Atlas. I would just add, I think it is very important that all of these accounts are shifted into ones that people actually own, rather than are dependent on their employer, and that they don't have this use-it-or-lose-it phenomenon at the end, which of course HSAs do not. This is really critical. In fact, it should be easier—and I have this chart——

Chairman Paulsen. Flexible Spending Accounts would, right?

Dr. Atlas. Yes, but the reality is I'm not sure why there is a need for different types, because they all should be liberalized in their uses, and rules, and things like that. And I think that really there are certain incentives necessary to institute for all HSAs. There is incentive to save if you do not lose it. There is also an incentive to save if you are going to be able to pass it on in a tax-sheltered way, as opposed to just your spouse, which is now one of the rules. Or, use it for your elderly parents, or someone else, even if it is an individual account. There's a lot of things to be done that make HSAs more attractive and more valuable to you.

Chairman Paulsen. Dr. Patel, have you seen other patients experience, you know, they have to use it or lose it, on a Flexible Spending Account versus maybe an HSA?

Dr. Patel. Oh, absolutely, yes. And I do think that the everyday American does not actually understand HSAs and FSAs as well. I think they are offered these choices during the enrollment period, and then they just kind of pick. And they are not necessarily at the time of enrollment kind of savvy about what they are doing.

And I would add one more category, Mr. Chairman: Pre-deductible coverage. Think about how much we spend on tax dollars to allow employers to offer kind of these benefits. Think about just really kind of honing in on kind of what's, you know, necessary care and thinking about pre-deductible coverage.

And I'll just make one little comment about the healthy Indiana plan, because I think it is important to level set. I go back to my days as a health services researcher. There were over 500,000 people that were eligible; 55 percent of the people for the Power Accounts either missed a payment, or never made the first payment; and 14 percent of those eligible never enrolled; 9 in 10 of those people that were actually in those Power Accounts actually ended up falling to that lower tier.

So while people talk about it as a success, and some might say it's a failure, the truth is that there's a lot more work to be done before you think about HSAs and Medicaid.

Chairman Paulsen. Senator Heinrich, you are recognized for five minutes.

Senator Heinrich. For every time I hear about HSAs, I hear ten times about premium inflation, obviously, and premiums are projected to increase by about 15 percent next year, at least according to CBO.

Dr. Patel, do you have an opinion on how the Trump Administration's actions with regard to undermining the individual markets affect those premiums over time?

Dr. Patel. Well I think the critical—yes, I do have an opinion. I think that premium costs, unfortunately, in the current Administration there has been an interpretation that this is all just benefit inflation that's driving the premium costs, and therefore if we re-

lease people from kind of these requirements around kind of essential health benefits, et cetera, that somehow magically we'll offer these better value plans, and therefore they will be cheaper, and that will bring down premiums.

Unfortunately, by changing some of the rules around what plans must, or the way they can offer benefits, you are actually creating kind of a two-tiered system where if people know that they are going to have to deal with chronic illnesses like the patient I talked about, there is no universe where she is going to try to get one of these less generous plans. That is just simple math.

So the critical question is: How are we, without getting into—I realize the word "mandate," and all these things are just toxic politically—but what we really need to do is have an honest conversation about what are the services and valuable benefits within the care delivery system that we must have coverage for? And then, what are the things that we really need to have people drive away from?

And that is the places where you—I know that she had to leave, but when you talk about the cost of mammograms, I can go within one mile and find a mammogram that is ten times the cost, and I can find something that is a couple hundred dollars.

So how do we get at that issue? And that is certainly not being addressed in the current Administration.

Senator Heinrich. HSAs are premised on a consumer's ability to shop around for the best value. And certainly, you know, I have found that for my upper-income constituents in New Mexico, who tend to be on the lower end of the overall curve, but for people making over $100,000 a year, they have a lot of value. But my rural constituents oftentimes do not have any ability to shop around. I mean, they are really captive of whatever infrastructure is left in rural America.

Is there—what is the HSA value for them? Is it just primarily the fact that you might receive the tax benefit? But do you lose the ability to impact the overall system when you cannot choose between providers, really for any of you?

Mr. McKechnie.

Mr. McKechnie. I would be happy to try and answer. I am not sure that is a HSA-specific question. I know the country is going through a discussion about the availability of providers by county, and insurers by county, and so leaving aside the question of HSAs for a moment, I can understand, and I have had the privilege of working with some of the members of the New Mexico State Legislature, Carol Lovell particularly, in this topic area. As we come to the HSA question, a gentleman actually responded I believe to—from our Board, addressing that exact issue, which is not necessarily where you live in the State, but where are you on the economic spectrum?

Because the question of how do you satisfy that first thousand dollars of obligation is a very important one, and not everybody has a thousand dollars, and we recognize that, too. But if you are going to pay a thousand dollars, and the tax rates vary between 15 and 40 percent for income, is it $1,150 that you owe? Is it $1,400 that you owe? And how are those any better than owing simply $1,000?

And so on that issue I imagine we can just leave that aside now, the point having been made. But I think you are right. If there is nobody around the corner from you to go and get treated, I am not sure that is an insurance question. I think that is probably something much more difficult to answer.

Ms. Watts. Could I comment?

Senator Heinrich. Ms. Watts.

Ms. Watts. We co-authored a paper, Mercer, with the American Benefits Council on employer innovations in health care. And I believe one of the case studies in there is one of our ABC member companies that is a rural company in the coal industry. And they have access issues for their employees. And they have actually done direct contracting with some providers, and some of the care that they provide is virtual health care because people don't have access. And somebody previously said this isn't just an HSA issue. The HSA is really just more of a funding vehicle, and it does get people to have skin in the game.

The question you are asking about is access. But thanks to technology we are on the verge of having much more of an open door to access, no matter where you are. And having people understand the value and being able to make better decisions——

Senator Heinrich. I would agree with you wholeheartedly, with the exception of one issue. To have that world exist, we actually have to have the infrastructure to be able to access telemedicine and virtual medicine in those rural areas. And I will tell you that there are vast areas in this country where the broadband access, the infrastructure to make that happen, which I think you would find Republicans and Democrats both agree, is a great change to our health care system, does not actually exist.

Dr. Atlas. Could I add one quick comment on telemedicine, which is there is another anticompetitive problem in the M.D. world, which is that states have their own licensure of doctors, and that prevents, in addition to other rules, prevents active telemedicine, and actually limits competition. And this is a problem.

Chairman Paulsen. I want to thank everyone for taking the time to testify today. This has been great. We unfortunately had some Members who were confined to some other important hearings and issues, particularly on the House side.

So we will—I want to make sure that we know that Members who wish to submit questions for the record, the hearing record will remain open for three business days. And you may anticipate some opportunity to respond in writing, as well, from some of those Members who were unable to attend.

Thank you, again. And with that, the Committee is adjourned.

[Whereupon, at 4:14 p.m., Thursday, June 7, 2018, the hearing in the above-entitled matter was adjourned.]

SUBMISSIONS FOR THE RECORD

I call this hearing to order.

All Americans deserve access to affordable, patient-centered health care.

Unfortunately, the fight to achieve this worthy goal has become politicized to the point where it's perilous to even acknowledge the shortcomings of our current Byzantine system.

There are bipartisan solutions to this problem, and today we will be discussing one.

That is why I am excited to convene today's hearing, titled "The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve."

When does a patient decide that a common cold isn't worth the expense of a doctor's visit? Or whether it would be worth saving dollars by going to a general practitioner who could easily treat an ailment rather than a pricey specialist?

Patients would have a hard time answering these questions, because the actual cost of care remains obscured until long after services are rendered.

Even after patients receive an explanation of benefits, the true cost is obscured by what providers charged and what the government or insurers decided they would pay for a service.

This lack of transparency has contributed to rising health costs, which ultimately leads to more unaffordable insurance and even less satisfaction with the health care system.

Yet, in the current environment, consumers and providers alike are divorced from the true cost of care.

As the economist Milton Friedman once said, nobody spends somebody else's money as wisely or as frugally as he spends his own.

Americans are excellent comparison shoppers—television, direct mail marketing, billboards, and storefronts all appeal to consumers' senses of value for price when making important choices for themselves and their families.

An important part of everyday life is making decisions based on personal preferences, needs, and, of course, cost, and it is for this reason that competition thrives among auto manufacturers, food producers, and home builders to deliver safe, healthy, and long-lasting products that people can afford.

We all acknowledge that American health care and health insurance are very expensive. In today's hearing, we will investigate how health savings accounts, or HSAs, allow Americans to lower the cost of health care by drawing on an important area of their expertise: themselves.

HSAs have delivered great benefits, and there may be even more to come if lawmakers strengthen HSA's hold in the marketplace.

I believe they can broaden access to quality medical care, increase patient choice, and improve health for all Americans.

It is for this reason that I joined with Senate Finance Committee Chairman Orrin Hatch to enhance both Health Savings Accounts and Flexible Spending Accounts to give hard-working Americans more choice and control when it comes to their health care decisions.

According to one estimate, if half of employer-sponsored insurance incorporated HSAs, national savings in health care spending could total $57 billion annually.

So how do they work? An HSA is a tax-exempt account set up to pay or reimburse certain medical expenses incurred while covered by the kinds of high-deductible health care plans many Americans have today.

Employees and employers contribute funds pre-tax. Money that has gone unused can roll over year to year, and consumers continue to have access to the money even if they change employers or leave the workforce.

Since the creation of HSAs in 2003, the number of people who have an HSA has risen dramatically.

In 2005, roughly one million people were enrolled.

Today, 22 million people have HSAs. Americans clearly see the benefit of directing their own health dollars towards their own health care needs and expenses.

My own thrifty State of Minnesota has the third-highest enrollment in HSAs in the country, with nearly 1.2 million enrollees.

A 2016 study of large employers that offered consumer-directed health plans (CDHPs) in the form of high-deductible health plans with HSAs found significant long-term cost reduction and no evidence of worse health outcomes.

In recent years, the State of Indiana implemented an HSA structure both in its Medicaid program and in insurance offered to State employees. Then-Governor Daniels noted that this consumer-driven approach resulted in savings and customer satisfaction.

In 2010, State employees who enrolled were expected to save more than $8 million compared to their coworkers in the traditional health care alternative.

Ultimately, the HSA is a vital tool that helps improve our health care system, even for those who don't have an HSA. By putting consumers directly in charge of their health care, the health care sector becomes more consumer conscious.

As in many areas of our economy, the answer usually lies in the wisdom of the American people.

I look forward to hearing from our distinguished panel of witnesses today how HSAs and the idea of consumer-driven health care can improve the affordability of health care.

Before I introduce them, I now recognize our Ranking Member, Senator Heinrich, for his opening statement.

PREPARED STATEMENT OF HON. MARTIN HEINRICH, RANKING MEMBER, JOINT ECONOMIC COMMITTEE

Thank you Mr. Chairman.

I'm looking forward to today's discussion on Health Savings Accounts.

These tax-free savings accounts play a role for some consumers to cover health care costs.

HSAs are particularly helpful for those earning more than $100,000 who are already saving for retirement, and have less trouble covering their monthly bills and student loan payments.

But HSAs do little to bend the so-called health care cost curve.

This is the problem we must focus on—how do we provide top-quality care while reducing our overall national health care spending AND lowering consumers' out of pocket costs.

But HSAs seem to generate the most savings through cost shifting, not cost saving.

Here, employers pay less by offering skimpier plans coupled with an HSA.

But, employees shoulder a greater share of costs, the financial risks of getting sick, as well as yet another obstacle to navigate between themselves and their health care.

And this is happening at the exact time when wages remain stubbornly stagnant, and more and more families are struggling to get ahead.

But my chief concern is this: part of the reason we are here today is that our Republican colleagues seem to be gearing up for yet another attempt to repeal the ACA.

If the new proposal is anything like the last, we can expect it to gut Medicaid, drop millions from coverage, take away comprehensive coverage, and further hike premiums.

Central to the Republican vision has been to move more and more consumers to high-deductible plans, which have lower premiums but ask consumers to pay more for doctor visits and services before the health plan covers care.

If paired with an HSA, a family can put aside up to $6,900 tax free to use for qualified health expenditures. The investments in the HSAs grow tax free.

The thinking behind HSAs is that if people set aside money for their health care, they will spend it more wisely, and, on average, spend less. They will have some "skin in the game."

The problem, though, is that without knowing what we're paying for and how much we're paying, consumers simply do not have the tools they need to make rational decisions about cost.

And HSAs are unable to help with this problem.

What we do know is that HSAs sometimes encourage people to forego needed care, which is the main way they save money.

If you need chemotherapy to treat your breast cancer, but you've underfunded your HSA and have a $2,700 deductible, what happens?

If your child gets sick, will you take her to the doctor or keep her at home based on how much of your deductible you've paid down?

If you or a loved one is grappling with an opioid addiction—a reality for far too many across the country and in New Mexico—will an HSA cover your treatment?

Can someone battling addiction or managing a serious mental health issue make enough money to save into an HSA?

These are important questions.

No matter where you live, what you do for a living, or what party you belong to, these questions are at the heart of our health care conversation.

I'm worried that HSAs—an idea that I agree works for some consumers—are being twisted into a quick-fix that will only exacerbate the challenges in New Mexico, such as our ongoing fight against the opioid epidemic.

I am all for working together on real solutions to make needed improvements to our health care system.

Improvements that will reduce costs on consumers, increase price transparency so consumers can make informed decisions, prevent surprise medical bills, as well as reduce the overall cost of health care in America.

But focusing on HSAs, while avoiding an honest conversation about the key drivers of health care costs, could have real negative impacts on real people who are simply trying to manage an illness or care for a sick loved one.

We must focus on actions that can bend the cost curve, like investing in preventive care, using the government's purchasing power to lower drug prices, and paying for quality of care, rather than quantity.

And we have to focus on making things simpler for families.

I look forward to our witnesses' testimony and to hearing their perspectives on how we can bring down health care costs for families.

Expanding and Incentivizing Health Savings Accounts:

A Critical Reform For Broadly Available, High Quality Health Care

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The overall goal of US health care reform is to broaden access for Americans to high quality medical care. Over decades, the improper expectation has developed that health insurance will subsidize the entire gamut of medical services, including routine care, with little out-of-pocket payment. Through a series of regulations, including coverage mandates, copayment limits, and restrictions on medical savings accounts, the Affordable Care Act (ACA) counterproductively doubled down on that longstanding misapplication of health insurance and pushed health care reform in the wrong direction. Fundamentally, insurance is about reducing risk, and in health care, the risk is incurring large and unanticipated medical expenses. Instead, the ACA's broad coverage requirements and misguided subsidies encouraged more widespread adoption of bloated insurance and furthered the inappropriate construct that insurance should minimize out-of-pocket payment for all medical care. Patients in such plans do not perceive themselves as paying for these services, and neither do physicians and other providers. With patients having little incentive to consider value, prices and doctor qualifications remain invisible, and providers don't need to compete on price. The natural results are overuse of health care services and unrestrained costs.

It is in the context of overall health care reform that I will discuss the importance of health savings accounts (HSAs), including the rationale for incentivizing their use and for strategically reforming them to leverage their impact on broadening access to quality medical care, increasing patient choice, and improving health for all Americans.

The critical concept is that *reducing the cost of medical care itself* is the most effective pathway to broader access to quality care, lower insurance premiums, and ultimately better health. Instead, most post-ACA ideas continue to stress making *insurance* more affordable, mainly through cash to consumers in refundable tax credits or other subsidies. Insurance premiums are secondary, though, and historically chiefly reflect two factors: 1) the cost of medical care, accounting for about 80 percent of insurance premiums; and 2) the regulatory environment, accounting for most of the rest. Prior and anticipated payouts for medical services are by far the single largest component of health insurance premiums. When the cost of health care services increases, insurance premiums rise. Other factors do have some impact on private insurance premiums, including government regulations, in particular mandated coverage; characteristics of the insured individual (for example, age and certain behaviors); and cost shifting caused by underpayment by public insurance. By overlooking the main factor – the cost of medical care itself - strategies to subsidize premiums artificially prop up insurance coverage that typically minimizes out-of-pocket payment. This is directly counterproductive, because it shields medical

care providers from competing on price. While a number of recent proposals rightfully strip back some of the ACA's harmful regulations and taxes that directly increased insurance premiums, more emphasis is urgently needed on reducing medical care prices, the core cause of high insurance costs and the chief barrier to wide access to care.

Lowering the cost of medical care itself, though, is fraught with peril. It must be achieved without harming patient care. That means without jeopardizing quality, restricting access, or inhibiting critical innovation of American medical care that - based on peer-reviewed data throughout the leading medical journals - is the standard of excellence for the world. Cost reduction can be accomplished *without* restricting health care use or creating obstacles to future innovation, i.e., avoiding the way that other governments regulate costs in their centralized, single-payer systems. Decreasing the cost of care for everyone requires creating conditions long proven to bring down prices while improving quality: incentivizing empowered consumers to seek value, increasing the supply of medical care, and stimulating competition for consumers.

Two key points are essential to clarify from the start, in order to fully understand the role and importance of HSAs in US health care reform:

1) the HSA is a vital and highly effective tool to broaden access to affordable, high quality health care for all Americans, even those without HSAs. It does so by putting consumers directly in charge of buying their own health care. The fundamental purpose of an HSA is NOT simply to provide a tax-sheltered benefit for individuals, in order to cushion the blow of high health care expenses for account holders;

2) the HSA is NOT an isolated, independent component of the health care system. Rather, it is intimately related to other aspects of the health care system, including insurance structure and regulation and tax policy. Reforms to maximize the positive impact of HSAs for consumers are therefore tied to other regulations and reforms.

To broaden access to affordable, high quality health care for all Americans, three fundamental steps must occur, and all directly relate to HSA reforms:

1) Patients must be strongly incentivized to consider medical care prices *and* simultaneously equipped with the tools optimized to do so. This is accomplished through universally available, large, liberalized, and transferable HSAs, in conjunction with lower cost, higher deductible insurance coverage.

For consumers to incorporate price into decisions to buy health care and then leverage that consideration to pressure prices downward for everyone, they must have clear personal gain from paying less, and they must pay directly for more of their own care. Conscious value-seeking by incentivized consumers is the essential lever to force competition among sellers, in this case the health care providers, which translates into lower prices and better value.

But is it realistic to suggest that patients could seriously consider price and value? Critics often claim this is unworkable: how can you shop around from the back of the ambulance? But emergency care

represents only six percent of health spending[1]. Among privately insured adults under age 65[2], almost 60 percent of all health expenditures is for elective outpatient care; only 20 percent is spent on inpatient care and 21 percent on medications. Of the top one percent of spenders[3], the group responsible for more than one quarter of all health spending at an average of $100,000 per person per year, a full 45 percent of spending is also outpatient. Likewise, 60 percent of Medicaid money is spent for outpatient care. Even in the elderly, almost 40 percent of expenses are for outpatient care[4]. Outpatient services dominate America's health spending, and these are amenable to price-conscious purchasing.

Better than tax deductions or income exclusions for health expenses, health savings accounts (HSAs) introduce something unique and powerful into health care decisions. Instead of simply introducing incentives that subsidize health care spending relative to other spending, they also incentivize saving. HSAs allow individuals to set aside money tax-free for uncovered health expenses, including routine care. These tax-sheltered accounts grow by contribution or investment. Note that widespread HSAs, when paired with high deductible plans, could pay for the bulk of medical care events, since most health care experiences involve smaller, non-catastrophic expenses. Since they reward saving, HSAs are highly effective in motivating patients to consider price and value.

To fully leverage the impact of HSAs, it is important to position more patients as direct payers for health care. One key vehicle to position patients as direct payers for a higher proportion of their medical care is widely available, higher deductible insurance plans (HDHPs) with fewer coverage mandates and cheaper premiums. Higher deductibles force direct patient payment for care up to the deductible. Such catastrophic coverage would restore the essential purpose of insurance - to reduce the risk of incurring large, unanticipated medical expenses. Because patients would pay for most medical care directly at the point-of-care, they would be newly exposed to most health care prices and, consequently, newly concerned with value. Provider prices would become more visible and align with what consumers value, rather than being set artificially or generated via obscure, complex third-party payer arrangements. While the visibility of information that patients require for assessing value must be radically improved, we may not even need legislation to force price transparency. The most compelling motivation for doctors and hospitals to post prices and signals of quality would be their understanding that they are suddenly competing for price-conscious patients who control the money.

Despite the ACA's attempt to shift consumers to bloated coverage, a shift toward high deductible plans with HSAs has continued. In the decade-and-a-half since the tracking of this type of coverage, employers have increasingly offered such plans, and consumers have increasingly selected high-deductible plans. Among those enrollees, a shift toward higher deductibles has continued.[5] Since the introduction of HSAs in 2004, the number of accounts has skyrocketed to over 22 million as of the end of 2017 (see Figs. 1, 2

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[1] Owning the Cost of Emergency Medicine: Beyond 2%; Lee MH, Schuur JD, Zink BJ; Annals Emerg Med 2013;62:498
[2] IMS Institute for Healthcare Informatics. Healthcare spending among privately insured individuals under age 65. February 2012
[3] ibid
[4] What Contributes Most to High Health Care Costs? Health Care Spending in High Resource Patients. D Pritchard, A Petrilla, S Hallinan, DH Taylor Jr., VF Schabert, and RW Dubois; *Journal of Managed Care & Specialty Pharmacy* 2016 22:102-109
[5] Kaiser Family Foundation, "Employee Health Benefits Annual Surveys, 2007–2014," http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

below). Indeed, by increasingly choosing HSAs when given the opportunity, American consumers are approving their value.

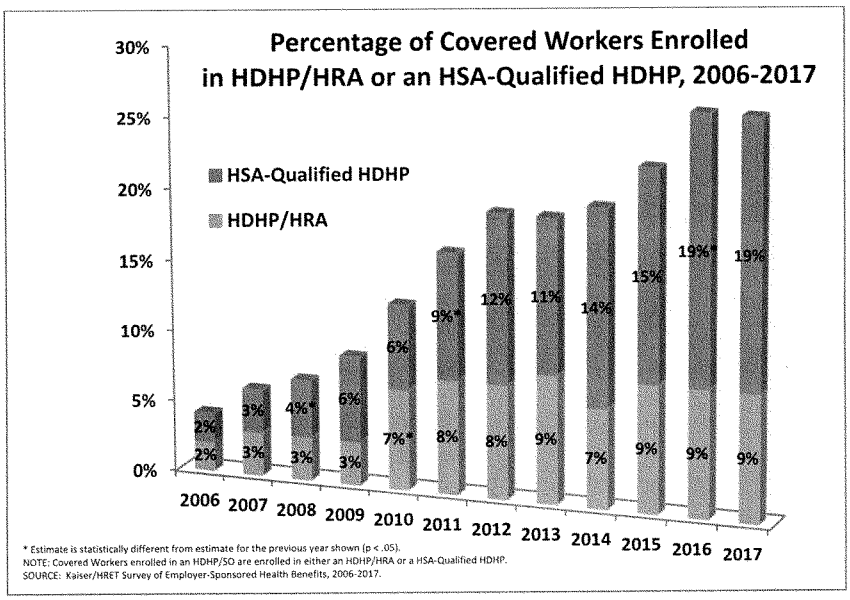

Fig. 1. Percentage of covered employees into HSA-qualified coverage has steadily increased since their introduction.

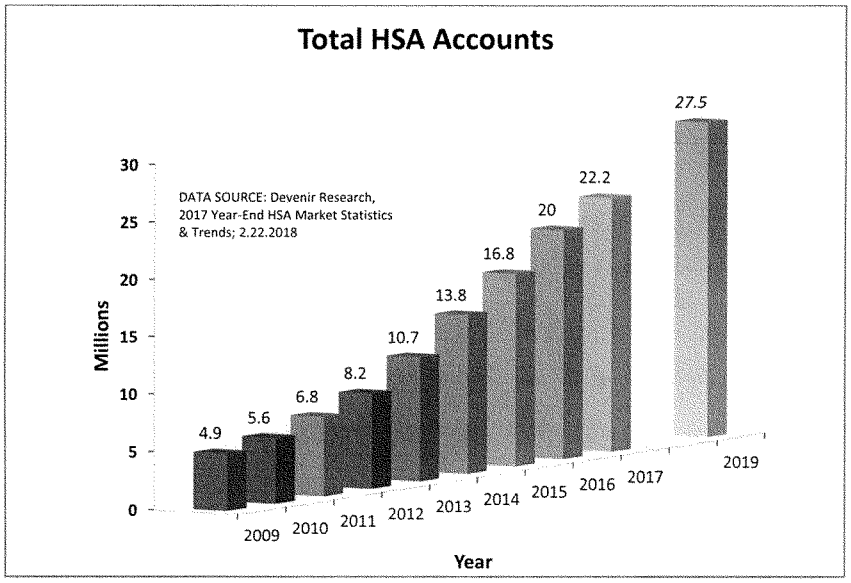

Fig. 2. Enrollment into HSAs has steadily increased since their introduction (2019 is Devenir projection).

HSAs with high deductible coverage have already proven to be a highly effective instrument to reduce health care prices and help individuals buy affordable insurance. A March, 2015 study confirmed previous strong evidence that health spending is significantly reduced for those in such plans. Spending reductions averaged 15% annually[6] and increased with the level of the deductible and when paired with HSAs. In Haviland's 2011 study, adding HSAs to high-deductible plans correlated to an increased savings of from 5.5 percent to 14.1 percent, or 50 percent to more than double the savings of high-deductible plans alone. More than one-third of the savings by enrollees in that study reflected lower costs per health care event, i.e. value-based decision-making by consumers[7]. In other words, prices mattered. These reductions in health care spending occurred without harmful impacts, like increases in emergency room visits or hospitalizations, and without any greater impact on economically vulnerable families[8].

[6] Do "Consumer-Directed" Health Plans Bend the Cost Curve Over Time?; A Haviland et al, NBER Working Paper No. 21031, March 2015; http://www.nber.org/papers/w21031

[7] Haviland AM, Sood N, McDevitt RD, and Marquis MS. The effects of consumer-directed health plans on episodes of health care. Forum for Health Economics and Policy, 2011;14(2):1-27; http://www.rand.org/pubs/external_publications/EP201100208.html

[8] Haviland, A., N. Sood, R. McDevitt, and S.M. Marquis 2011. "How Do Consumer Directed Health Plans Affect Vulnerable Populations." Forum for Health Economics & Policy. 2011;14(2) (Online): 1558-9544.

When people have savings to protect in HSAs, the cost of care comes down without harmful impact on health.

Consumer-empowering shifts toward widespread HSAs and higher deductible coverage reduce prices and broaden access to quality care - the main goal of health system reforms in the first place – and these shifts should be accelerated. Downward pressure on health care prices from competing for patients who pay directly for care has been clearly demonstrated by medical procedures originally not covered by insurance. For instance, prices rapidly and dramatically decreased when patients paid out-of-pocket for LASIK corrective vision surgery and MRI or CT screening. Published evidence from MRI[9] and outpatient surgery[10] confirms that when patients are motivated to compare prices, prices come down by almost twenty percent. While price reductions are particularly visible to high deductible plan holders with HSAs, the downward pressure on prices from these instruments *reduces prices for all health care consumers*. Annual health expenditures would fall by an estimated $57 billion if only half of those Americans with employer-sponsored insurance enrolled in such consumer-directed plans[11]. Savings would increase further if deductibles were truly high, rather than simply meeting the outdated definition of $1,000 used in those estimates, and if high deductible plans were freed from excessive, costly mandates. Total annual savings from these reforms could approach $200 billion.

Note that premiums of high-deductible catastrophic coverage are lower than premiums of so-called comprehensive coverage because of the anticipated lower costs of covering the medical care under the plan. However, my analysis of Employer Health Benefits Annual Survey data[12] (see Fig. 2 below) shows that premiums for HDHPs rose from two to five times faster than premium increases of any other type of coverage after ACA passage.

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[9] S-J Wu, G Sylwestrzak, C Shah and A DeVries; Price transparency for MRIs increased use of less costly providers and triggered provider competition; Health Affairs 2014;33:1391-1398; http://content.healthaffairs.org/content/33/8/1391.abstract

[10] JC Robinson, T Brown and C Whaley; Reference-Based Benefit Design Changes Consumers' Choices And Employers' Payments For Ambulatory Surgery; Health Affairs 2015;34:415-422, http://content.healthaffairs.org/content/34/3/415.abstract

[11] Haviland, A., M.S. Marquis, R.D. McDevitt, and N. Sood. 2012. "Growth of Consumer Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save $57 billion Annually." Health Affairs 31(5): 1009-15 (http://content.healthaffairs.org/content/31/5/1009.full)

[12] Kaiser Family Foundation Employer Health Benefits Annual Survey Archives; https://www.kff.org/health-costs/report/employer-health-benefits-annual-survey-archives/

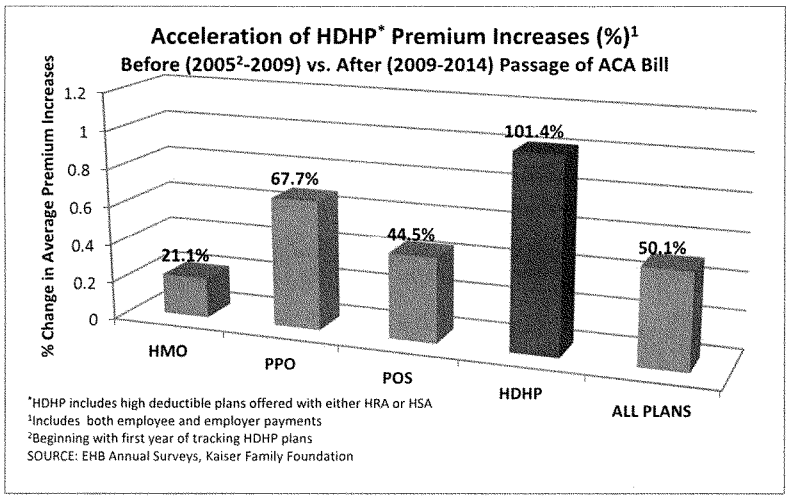

Fig. 2. ACA regulations have accelerated the increase in premiums of high deductible plans more than any other type of coverage.

The factors by which the ACA contributed to rising premiums in high deductible plans must be eliminated. Excess mandated coverage that made HDHP insurance more expensive should be rolled back, including the ACA's "essential benefits" that increased premiums by 10 percent[13] and the 2,270 state coverage mandates for everything from acupuncture to marriage therapy. To make HDHPs even more affordable, we should remove the ACA's 3:1 age rating that raised premiums for younger enrollees by 19 percent to 35 percent,[14] many of whom would buy lower premium coverage.

The issue is not whether HSAs are effective in making health care more affordable for everyone; it is how to maximize their adoption and fully leverage their power.

It is essential that HSAs are made available to all Americans, perhaps even automatically opened for every citizen with a social security number or at birth. All HSAs should be fully owned and controlled by individuals, eliminating more restrictive variants that are tied to specific employers. To maximize

[13] EF Haislmaier and D Gonshorowski, "Responding to *King v. Burwell*: Congress's First Step Should Be to Remove Costly Mandates Driving Up Premiums" (Heritage Foundation Issue Brief 4400, May 2015), http://www.heritage.org/research/reports/2015/05/responding-to-king-v-burwell-congresss-first-step-should-be-to-remove-costly-mandates-driving-up-premiums.

[14] JT O'Connor, "Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014," *Milliman Reports*, April 25, 2013, http://ahip.org/MillimanReportACA2013/.

consumer leverage on prices and thereby broaden access to affordable, quality care for everyone, the current ban on full HSA participation by all seniors on Medicare should be abolished. Given that seniors are the biggest users of health care, motivating them to seek value is a crucial part of exerting downward pressure on health care prices. Nearly 4 million Americans reach age 65 every year and live 25% longer now than in 1972[15]. Today's seniors need to save money for decades, not years, of future health care. The expected tripling of health expenses for a 65-year-old by 2030 makes HSAs even more important[16]. Presently, HSA participation is quite restricted for seniors. Seniors who have applied for or accepted Social Security cannot contribute to an HSA. Restricted accounts called "Medicare Advantage MSAs" are currently available but require enrollment in a high-deductible MA health plan. Among other restrictions, deposits into these MSAs are prohibited except from Medicare itself and are limited in amount to typically less than half of the required deductible of the accompanying coverage.

HSA limits should be expanded by liberalizing maximum allowable contributions (and catch-up contributions for persons in their 50s) to, for example, equal those of total annual out-of-pocket limits for ACA Marketplace plans (for 2018, $7,350 for individuals and $14,700 for families). Restrictions on HSA uses should be eased, most importantly for the expenses of the HSA holder's elderly parents. And the list of allowable health care services and products that can be purchased with HSA funds should be expanded to include, for instance, over-the-counter drugs without need for doctor's prescription, and home health care devices.

Beyond broadening their maximums and their uses, several other reforms are important in order to achieve the desired impact of HSAs on health care availability and quality for everyone. This means ensuring stronger incentives are in place to motivate value-seeking by patients. HSAs should never expire or be forfeited due to an arbitrary "use it or lose it" deadline. On the death of the owner, HSAs are currently deemed taxable unless the beneficiary is the spouse. This should change, so that tax-sheltered rollovers would be allowed to all surviving family members, not just spouses.

HSAs should be de-linked from specific insurance deductible requirements (i.e., in defining "HSA-qualified plans"). The requirement of owning coverage with government-specified deductibles in order to open an HSA is counterproductive, as it limits the use, and therefore the power, of HSAs. It also eliminates the possibility of HSAs with other, more tailored plans that could cover necessary care subject to a lower deductible, especially for chronically ill people. We should modify the insurance exchange regulations to allow everyone, regardless of age or employer, the option of high deductible plans with the same liberalized rules on HSAs. The only requirement for making contributions to the reformed HSA should be that the enrollee at least has active catastrophic insurance coverage, without any specified deductible. Eliminating those requirements would help more families save for out-of-pocket expenses and broaden consumer power.

HSAs have also been a valuable vehicle through which a growing number of employers offer wellness programs and medical screenings, including such tests as blood pressure, body mass index, and

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[15] JM Ortman, VA Velkoff, and H Hogan; An Aging Nation: The Older Population in the United States: Population Estimates and Projection; Current Population Reports; May 2014 P25-1140

[16] Actuarial data from HealthView using historical claim data and projections, June 2011

cholesterol. In 2015, 96.7 percent of employers offered lifestyle programs,[17] increasing from 73 percent in 2011 and 57 percent in 2009. More than one-third of firms offering wellness programs include financial incentives to participants, including lower insurance premiums, reduced cost sharing, and higher employer contributions to individual HSAs.[18] Consumers have demonstrated the efficacy of smoking cessation and obesity interventions, including cash financial incentives. Significant gains in productivity, marked reductions in health claims, improvement of chronic illnesses, and major cost savings have resulted and have benefited both participant employees and their employers.[19] Medical costs and absentee day costs fall by about three to six dollars for every dollar spent on wellness programs.[20] The ACA limits the financial incentives from employers, including cash deposits into employee HSAs, to 30 percent of the cost of that employee's health coverage. Abolishing that limit would expand these powerful motivators for employees, encouraging employees to participate in more wellness programs already proven to improve health and reduce health costs.

HSAs could also transform Medicaid into a bridge program geared toward enrolling beneficiaries into affordable private insurance, with equal access to doctors, specialists, treatments, and medical technology as the general population, instead of shunting poor Americans into a parallel second-class system with worse health outcomes and far less access to care. A reformed Medicaid would establish and seed fund HSAs and provide an option for limited-mandate, high deductible private insurance with currently budgeted federal dollars. States should not only be encouraged to allow Medicaid enrollees to opt for HSA contributions; federal funding could be contingent on states meeting certain enrollment thresholds into limited-mandate coverage and HSAs. It would give control of the health care dollar to low-income families to foster provider competition for that money. HSAs would provide new incentives for lower-income families to seek good health through wellness programs and healthy behavior in order to save and protect their new, growing financial assets. These reforms would change the purpose and culture of Medicaid agency offices from running special government-administered Medicaid plans to establishing HSAs and finding private, low cost health plans for beneficiaries.

Below is a summary table comparing the proposed expanded, liberalized HSA to current HSAs:

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[17] National Business Group on Health, "Taking Action to Improve Employee Health: Results from the Sixth Annual Employer-Sponsored Health and Well-being Survey," March 25, 2015, https://www.businessgrouphealth.org/pub/29d50202-782b-cb6e-2763-a29a9426f589.

[18] Kaiser Foundation and Heath Research and Educational Trust, "2014 Employer Health Benefits Survey, Section 12: Wellness Programs and Risk Assessments," September 2014, http://kff.org/report-section/ehbs-2014-section-twelve-wellness-programs-and-health-risk-assessments/.

[19] L. L. Berry et al., "What's the Hard Return on Employee Wellness Programs?" *Harvard Business Review*, December 2010, https://hbr.org/2010/12/whats-the-hard-return-on-employee-wellness-programs.

[20] K. Baicker et al., "Workplace Wellness Programs Can Generate Savings," *Health Affairs* 29 (2010): 304–11.

Criterion	Current HSA	New HSA
General eligibility	Must meet specific requirements	Universal for all citizens; automatically opened at birth
Insurance requirement to contribute to HSA	High deductible coverage (deductible level specified by federal government)	Catastrophic coverage (no other specific requirement; no specified deductible range)
Limits on maximum contribution per year (e.g., 2018)	$3,450 (individual) $6,900 (family)	$7,350 (individual) $14,700 (family)
Uses of HSA funds	Not for non-prescription drugs other than insulin	• OTC drugs, home health products are eligible without need for MD Rx • Usable for elderly parents
Tax deductibility	Contributions and withdrawals deductible	Contributions and withdrawals deductible
Eligibility if enrolled in Medicaid	Not eligible without exemption	Eligible
Eligibility if enrolled in Medicare	Not eligible	Eligible
Eligibility if receiving Social Security?	Not eligible	Eligible
Special Medicare Advantage MSAs	List of restrictions limiting contribution levels, contribution sources, others	Full conversion to standard HSA; no special limits or restrictions
Penalty for ineligible withdrawals	20% penalty (plus taxation)	50% penalty (plus taxation)
Uses for insurance premiums (seniors only)	Can reimburse for money withheld from SS to pay Medicare Part B (e.g. $104.90/mo for 2015); Can make tax-free HSA withdrawals for Medicare Part D, MA premiums (not medigap).	Allowed for all premiums
Seniors and ineligible withdrawals	After age 65, taxation	After age 70, 20% penalty
Transfers into HSAs from retirement accounts	Not allowed	Allowed without penalty for seniors
Tax treatment to beneficiary on death of HSA holder	If spouse, tax-free rollover into HSA; otherwise, taxable income	If any family member, tax-free rollover into HSA

2) Introduce the right incentives into the tax code to maximize the use and benefit of HSAs.

The tax code plays an important role in realigning consumer incentives to fund HSAs and leverage downward pressure on health care prices. Beyond the numbers ($275 billion in 2016, according to CBO[21]), the unlimited income exclusion for health expenses created harmful, counterproductive incentives. It encouraged higher demand for care, regardless of cost, while distorting insurance into

[21] From Options for Reducing the Deficit: Reduce Tax Preferences for Employment-Based Health Insurance; Congressional Budget Office. https://www.cbo.gov/budget-options/2016/52246

covering almost all services. Similarly, insurance premium subsidies in the ACA and the tax credits proposed by the GOP artificially prop up high insurance premiums for bloated coverage that minimizes out-of-pocket payment. This prevents patients from caring about price, eliminating the incentives for doctors and hospitals to compete on price.

Presuming that health care deductions or income exclusions are maintained, the tax code should cap amounts, and it should also limit eligibility for deductions or exclusions to two categories of health-related expenses: 1) HSA contributions, and 2) catastrophic coverage premiums (*note*: the definition of "high deductible, catastrophic coverage" is based on 75 percent of the new maximum allowable HSA contribution. For example, to qualify as a high deductible plan for 2018, during which the allowable HSA contribution will be $7,350, the definition of high deductible would equal $5,512.50. This linkage ensures that the HSA contribution maximum will always be higher than covering just the deductible). It would be counterproductive to allow a tax preference for "comprehensive" insurance, because low deductible, heavily mandated plans hide the costs of covered care—that is a fundamental cause of lack of access and rising costs for everyone. Tax deductions for all health care spending are also counterproductive, because they give an incentive to spend more money on health care; in other words, there is an opportunity cost if you spend money on something other than health care because the money is worth more when spent on health care. This tax reform would eliminate that misincentive. Instead, the new incentive is to put money into an HSA and then seek value when buying health care; the opportunity cost is when it is spent, because it could be saved and then grow by investment (or later be bequeathed to the account owner's survivors). The tax revenue decrease from the anticipated HSA expansion would be offset by the new limits on income exclusions.

Note that the tax exclusion or deduction for significantly expanded HSA contributions will increase everyone's savings, including the middle class and the poor, by lower priced medical care and more affordable insurance coverage. And while limiting the health expense exclusion/deduction would reduce the employer benefit, the truth is that to a large extent employees pay for their benefits by receiving lower wages than they would have otherwise been paid. Employment benefits, including health care benefits, replace wages. Over time, employees will instead receive higher wages and more take-home pay as employers are forced to compete with higher wages to attract labor. Ultimately, the cost of insurance premiums and medical care will be reduced by this plan more than the tax benefit for health spending that has distorted the market for health care.

3) Strategically increase the supply of medical care to stimulate competition and increase choices for value-seeking patients.

The supply of medical care must be significantly yet strategically increased, so patients have more options to seek out the best value for their money. In large part, this means removing archaic anti-consumer barriers to competition among medical care providers, health care technology, and drugs.

To improve access to affordable, quality primary care, we need to simplify the credentialing requirements and remove outmoded scope-of-practice limits on qualified nurse practitioners and physician assistants. Private clinics staffed by NPs and PAs can provide cheaper primary care, including

vaccinations, blood pressure monitoring, treating simple infections, and dispensing common drugs. In a 2011 review, 88% of visits to retail clinics involved simple care[22]; care was 30–40% cheaper[23] than at physician offices and about 80% cheaper than at emergency departments; and patients reported high levels of satisfaction[24].

Medical school graduation numbers have stagnated for almost 40 years, despite widely recognized doctor shortages. Increasing specialist supply is also critical, since almost two-thirds of the 2025 projected doctor shortage of 124,000 will be in specialists[25]. We should eliminate archaic non-reciprocal licensing by states in favor of national MD licensing. This unnecessarily limits specialist competition, especially as telemedicine proliferates. Severe specialist and subspecialist training program restrictions have been in place for decades. These anti-consumer practices need to be open to public scrutiny and abolished.

We should also eradicate archaic barriers to medical technology and prescription drugs that impede competition and raise prices. Although originally intended to "restrain health care facility costs", the certificate-of-need (CON) requirements[26] are another example of overregulation with unintended consequences, and are still in place in 34 states, Puerto Rico, and the District of Columbia. High drug prices are a conundrum: the same policies that are associated with the lower prices seen in other countries—price regulation and weaker patent rights—are also those that are generally associated with delayed launches and reduced access to drugs[27]. But we also see an extraordinary lack of price transparency for drugs, fueled by complex behind-the-scenes rebates[28] totaling $179 billion in 2016 from companies to pharmacy benefit managers (PBM), the government, and insurance that prevents any possible price consideration by patients. Worse, many PBMs contractually prohibit pharmacists from volunteering that a medication may be less expensive if purchased at the cash price with contractual gag clauses, according to a 2016 survey[29] of over 600 community pharmacies. And newly published data[30] revealed that well over 20% of patient co-pays (while using insurance) exceeded actual total drug costs if patients paid by cash without insurance. The hidden truth is that prices vary tremendously between drug stores for the same exact drug, yet patients are not sufficiently incentivized

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[22] Ashwood JS, Reid RO, Setodji CM, Weber E, Gaynor M, Mehrotra A. Trends in Retail Clinic Use Among The Commercially Insured. *The American journal of managed care*. 2011;17(11):e443-e448.
[23] Mehrotra A, Liu H, Adams J, et al. The Costs and Quality of Care for Three Common Illnesses at Retail Clinics as Compared to Other Medical Settings. *Annals of internal medicine*. 2009;151(5):321-328.
[24] Weinick, Robin M., Craig Pollack, Michael P. Fisher, Emily M. Gillen, and Ateev Mehrotra, Policy Implications of the Use of Retail Clinics. Santa Monica, CA: RAND Corporation, 2010. https://www.rand.org/pubs/technical_reports/TR810.html.
[25] The Complexities of Physician Supply and Demand: Projections Through 2025 Michael J. Dill and Edward S. Salsberg Center for Workforce Studies November 2008; AAMC
[26] CON-Certificate of Need State Laws - 8/25/2016; National Conference of State Legislatures, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx
[27] Cockburn I, Lanjouw JO and Schankerman M (2016) Patents and the global diffusion of new drugs. American Economic Review, 106 (01). pp. 136-164.
[28] Credit Suisse, 18 April 2017 Americas/United States/Europe Equity Research Pharmaceuticals & Biotechnology, "Global Pharma and Biotech"
[29] National Community Pharmacists Association News Release, Pharmacists Survey: Prescription Drug Costs Skewed by Fees on Pharmacies, Patients, Jun 28, 2016
[30] Van Nuys K, Joyce G, Ribero R, Goldman DP. Frequency and Magnitude of Co-payments Exceeding Prescription Drug Costs. *JAMA* 2018;319(10):1045–1047. doi:10.1001/jama.2018.0102

to alter buying patterns. In a December 2017 Consumer Reports study[31], the national average price for a one-month supply of five common generics ranged by a *factor of 20* between different retailers for a given drug. Even in a single city, the 30-day supply price showed a *10-fold to 17-fold* variation per drug. For the nearly 40 million seniors taking five or more medications daily, the savings from price comparison shopping could be many hundreds of dollars per month. Eliminating excess regulatory barriers to the supply of drugs, coupled with expanded HSAs empowering patients to compare prices, would reduce prices by competition. That pathway would help optimize value without hampering the unique access to drug treatment enjoyed by American patients.

Conclusions

From the evidence, we can conclude that expanded, liberalized, and transferable HSAs represent a key instrument in an overall strategy of broadening access to affordable, high quality health care for everyone. If appropriately designed, HSAs represent a strong incentive to consider price and value for those seeking medical care. HSAs offer more effective incentives than tax deductions for health expenses. HSAs have been proven to reduce the cost of medical care for individuals, and also to improve health by increasing the use of validated wellness programs. While expanded HSAs alone are not necessarily a panacea, they are a critically important and effective step.

In other countries, governments hold down health care costs mainly by limiting the use of medical care, drugs, and technology, through its power over patients and doctors as the single payer. And those countries get the expected results: long waits and worse medical outcomes, particularly for the poor, who are unable to circumvent those systems.

We should consider a different approach[32] – creating appropriate incentives and eliminating harmful regulations to reduce prices, so that high quality care is affordable for everyone. Broadly available options for cheaper, limited mandate, high deductible coverage; markedly expanded HSAs; and targeted tax incentives to leverage consumer power are keys to injecting price sensitivity for health care. Coupling those with strategic increases in the supply of medical care would generate competition and reduce the price of health care, expanding access to quality care for everyone.

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[31] "Shop Around for Lower Drug Prices", Consumer Reports, April 5, 2018; https://www.consumerreports.org/drug-prices/shop-around-for-better-drug-prices/

[32] *Restoring Quality Health Care: A Six-Point Plan for Comprehensive Reform at Lower Cost*, By Scott W. Atlas, Hoover Institution Press, Stanford, 2016; https://www.hoover.org/research/restoring-quality-health-care

June 7, 2018

Testimony of

J. Kevin A. McKechnie

On behalf of the

American Bankers Association's HSA Council

before the

Joint Economic Committee
United States Congress

June 7, 2018

Chairman Paulsen, Ranking Member Heinrich, and members of the Committee, thank you for the opportunity to discuss with you the many benefits and immense future promise of Health Savings Accounts (HSAs).

I am Kevin McKechnie. Since 2004 I have had the honor to serve as Executive Director and founder of the American Bankers Association's HSA Council, an organization of banks, insurers, administrators, and technology partners that represents about 94 percent of the HSAs in the United States.

HSAs are the only health insurance plans in America that allow their owners to save for the future. Every other health plan, even the ones a lot of health advocates call "good insurance," start their participants off at the beginning of the year with nothing in the bank to satisfy out of pocket expenses. Facing the future with nothing is one reason Americans are so worried about their health insurance and the relentlessly rising costs of their health care. HSAs are part of the solution.

In this presentation, I will try to give you an overview of HSAs, their history and how they work, and what makes them effective and beneficial. I'll also try to give you a taste of their amazing promise, concluding with some specific recommendations that can help you bring that promise to life.

About the ABA's HSA Council

The HSA Council is part of the American Bankers Association (ABA), the voice of the nation's $17 trillion banking industry, which is composed of small, regional, and large banks that together employ more than 2 million people, safeguard $13 trillion in deposits, and extend over $9 trillion in loans.

The Council is dedicated to advancing policies that preserve and expand banks' ability to offer Health Savings Accounts. We represent our members before Congress, the White House, and the courts, in order to preserve the ability of Americans to pay for health care using an HSA. Our job is to work every day to improve, strengthen, and expand access to account-based health care solutions for all Americans.

The chairman of our board of directors is Jim Gandalfo, a senior executive of PNC Financial Services Group. To our knowledge, ours is the only national trade association that advocates exclusively for the interests of America's rapidly expanding HSA community. We are humbled and inspired by this mission. We believe HSAs are a blessing in the lives of millions of American families, and help improve the overall quality and efficiency of health

care in America.

Back in 2004 we founded the Council with the hope that we could accelerate the adoption of HSAs and their accompanying, high-quality health insurance. And I'm pleased to report our hope has been realized—and then some.

Today, according to Devenir Research, there are more than 22 million HSAs nationwide, and they make no less than $54 billion available to help pay for the future health care needs of, we estimate, 30 to 35 million Americans. And this rapid adoption is still in its early years. We've only just started to scratch the surface.

In fourteen years, we've gone from zero HSAs to 22 million, and from nobody benefitting from an HSA to one out of every ten Americans benefiting directly from an HSA. And the other nine in ten Americans are benefitting indirectly.

The potential for future expansion of HSA ownership is immense. So is the potential for helping reduce health care costs and reducing the number of the uninsured.

This is why we believe expanding and strengthening HSAs is and must be an integral part of any serious plan to improve health care in America.

History of HSAs

Why do HSAs exist? Before I go into the details of what an HSA is and how it works, I want to take a moment to explain where the concept came from. It sprung fully grown from the mind of J. Patrick Rooney, founder and president of Golden Rule Insurance, sometime in the latter 1980s. Rooney's idea was to allow people to pair a high-deductible health insurance policy with a federally tax-advantaged savings account. (The deductible is the amount of money you have to spend before your insurance kicks in.) With this combination, Rooney reasoned, a number of good things will happen. People who sign up for the insurance will enjoy lower than normal premiums, thanks to the high deductible. And yet their coverage will not be substandard. It will be high-quality. And it will effectively be first-dollar coverage, thanks to the accompanying account, which enables the patient to cover all of his expenses up to the deductible. And this combination will save money, because any money the consumer doesn't spend, he can save and accumulate for his own future health care expenses. That will encourage him to be prudent with his purchases and shop smarter, because he'll have skin in the game. He'll spend his own money, and spend it more wisely. And that will benefit everyone. The ultimate result? Cheaper health insurance and lower health care costs for all. More people covered. More people cared for. That's Pat

Rooney's original vision for HSAs: that they can help all of us get the health care we need, when we need it, at a price we can afford.

This appealing idea was quickly picked up by smart health economists looking for ways to alleviate the nation's excessive health care cost inflation—which back then, as now, was ravaging public and private budgets.

One of the first serious legislative proposals for health savings accounts was introduced in the United States Senate 26 years ago. Importantly, the bill was bipartisan. On September 8, 1992, Democratic Senators Sam Nunn, John Breaux, Tom Daschle, and David Boren, and Republican Senators Richard Lugar and Dan Coats announced a new bill they had written, to establish what they called medical savings accounts. At the time, Congress was still in the early stages of what would become a decades-long national debate over how to help the uninsured. These Senators felt that more creativity was needed than just spending more government money to expand the number of people with health insurance. "So far," they wrote, "most of the proposals before Congress attempt to deal with access [to health care] but do not adequately address the more important factor—cost control. We have introduced legislation . . . that would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their 'own' money."

In 1996 Congress gave the new bipartisan concept a try, enacting a limited pilot-test under the name of Medical Savings Accounts. Seven years later, in late 2003, Congress took the idea national. The name was changed to Health Savings Accounts, a number of changes and improvements were made to the accounts' structure, and they were made available to some, but not all, Americans.

From the beginning, the mission of the HSA opportunity has been to help bend the cost curve downward—to reduce health care costs generally, and government health expenditures in particular—by giving consumers more skin in the game and more control over their personal medical decisions.

In this mission, HSAs have succeeded admirably.

About HSAs

What exactly is an HSA? A Health Savings Account is a tax-advantaged personal savings account that helps people pay for the cost of medical expenses, such as doctor bills and prescription drugs. The money in the account belongs to the account owner, and is not taxed so long as it is used for legitimate health care expenses. Money deposited but not spent can grow over time and thus become a nest egg for medical expenses in retirement or

be left to one's loved ones after death. Deposits can be received from other people, including your employer. There are limits on how much can be contributed to an HSA each year. In order to be able to open and contribute to an HSA, the account owner must also participate in a qualified high-deductible health plan (HDHP), more commonly known as an HSA-qualified plan. Congress has defined certain rules and protections affecting HSA-qualified plans, described in more detail below. All HSA-qualified plans must be HDHPs, but not all HDHPs are HSA-qualified.

Tax advantages. HSAs save their owners money for current health care needs by allowing them to pay for routine care with tax-exempt dollars rather than after-tax dollars. This means a big savings for the consumer. Depending on your tax bracket, using your HSA can save you an additional 15 to 40 percent on your out-of-pocket health care purchases. Only individuals with an HSA can enjoy these additional tax savings.

Specifically, as set forth in the HSA statute, which is section 223 of the federal tax code, contributions to an HSA are deductible from the HSA owner's income, any financial gain realized through interest or investments is not subject to income taxes, and funds spent from your HSA on qualified medical expenses are exempt from income taxes for the remainder of your life, meaning now and throughout retirement. Alternatively, HSA funds may be used as retirement income after age 64 without penalty, if the HSA owner pays income taxes on the distributions.

Contribution limits. Congress has limited the amount of money that may be deposited in an HSA each year. The amount grows with inflation. Back in 2004 the maximum contribution was $2,500 for an individual and $5,000 for a family. The comparable figures for 2018 are $3,450 for an individual and $6,900 for a family.

Deductible limits. A deductible is the amount of money you must pay for health care services by yourself before your health insurance kicks in. Back in 2004 the minimum deductible permitted with an HSA-qualified plan was $1,000 for an individual and $2,000 for a family. The comparable figures for 2018 are $1,350 for an individual and $2,700 for a family.

Out-of-Pocket limits. To help protect families from excessive medical costs, Congress has required that an HSA-qualified health plan must limit the amount that the individual is required to pay out-of-pocket for covered expenses. This is usually called the maximum out-of-pocket limit or OOP max. In 2004, it was set at $5,000 for an individual and $10,000 for a family. The comparable figures for 2018 are $6,650 for an individual and $13,300 for a family.

Tracking and reporting. Account owners are responsible for ensuring their HSA money is spent properly and must report their account activity on their personal income tax returns.

What can an HSA be used for? With certain exceptions, HSA funds may be used for any qualified medical expense that is deductible under section 213 of the federal tax code. While HSA funds may not be used to pay the premiums on an employer-provided health insurance plan, they may be used for premiums on COBRA continuation coverage and qualified long term care insurance. In retirement, HSA funds may be used, not only for qualified medical expenses, but also to pay premiums on Medicare Parts B and D coverage and long term care insurance. HSA funds may not be used for Medigap premiums. Under current law, once you enroll in Medicare you may no longer contribute to your HSA.

To summarize, HSAs allow people to save, tax-free, for out-of-pocket health care expenses and certain kinds of premiums during their working years, and to save for health care expenses in retirement. Those benefits distinguish it from all other kinds of tax-advantaged accounts.

When an HSA is offered as an employee benefit, it differs in a couple of important ways from other consumer-directed health products, namely, Flexible Spending Arrangements (FSAs) and Health Reimbursement Arrangements (HRAs). First, the funds in the HSA account are the property of the employee, and accumulate from year to year. Second, because the HSA is owned by the individual, not the employer, the funds in the account do not revert to the employer if unused. There is no "use it or lose it" rule (and that feature of FSAs has been modified). When you leave the company, you will keep the money in your HSA, but you will have to forfeit any money left in your FSA or HRA except in certain cases.

Most employers who offer HSA-qualified plans also contribute funds to an employee's HSA, which helps lessen the sting of the deductible.

Who can have an HSA? Many Americans are permitted to have to an HSA, but there are exceptions. People who do not have an HSA-qualified health plan are not allowed to contribute to their HSA. Nor are people who are enrolled in a government-run health insurance program such as Medicare or Medicaid.

HSA Enrollment Trends

How many HSAs are there? Devenir Research believes there are at least 22 million HSA accounts in existence and somewhere between 30 and 35 million individuals enjoying

the benefits of a Health Savings Account (approximately one-tenth of the U.S. population).

Who has an HSA? In terms of age, three out of every four current HSA owners is under the age of 50, one in four is over 50.

In terms of gender, about 57 percent of HSA owners are male, 43 percent female.

In terms of household income, WageWorks data suggests that two-thirds of this group earn less than $75,000 a year. Half make less than $60,000 a year. A little over 8 percent earn more than $100,000 a year. And just four-one-hundredths of one percent earn above $200,000. HSA owners have average incomes below $75,000 in every state in the Union except Connecticut, Maryland, Massachusetts, and New Jersey (and the District of Columbia).

What is the trend in HDHP/HSA enrollment? According to the Centers for Disease Control and Prevention (CDC), which tracks health insurance enrollment figures for the U.S. Department of Health and Human Services (HHS):

- Nearly 43 percent of non-elderly Americans—about 119 million people—are enrolled in an HDHP (both HSA-qualified and not).

That number has grown by nearly 20 percentage points since 2010.

- By 2020, just 18 months from now, 50 percent of the U.S. workforce are projected to be enrolled in an HDHP that is also HSA-qualified according to the Center for Disease Control (CDC)

- The share of the total under-65 population that has an HSA account has more than doubled in just the past eight years, rising from about 8 percent in 2010 to more than 18 percent last year.

Enrollment in HDHPs is rising rapidly, and with it potential future HSA enrollment.

Alas, one area where HSAs appear to be receding is in the Affordable Care Act exchanges. According to a paper published by the Heritage Foundation on June 1 of this year, "Numerous Obamacare plans now have out-of-pocket limits that are higher than the amount that the federal law allows in order for a plan to be paired with a health savings account. . . . Because Obamacare's maximum out-of-pocket limits are higher than those for HSA-compatible plans, over half (57 percent) of all plan designs now offered on Healthcare.gov have out-of-pocket maximums that are too high for the plan to qualify as HSA-compatible." As a result, "Only 30 percent of plans sold on the federal Obamacare

exchange meet the criteria of having both a high-enough deductible and a low-enough out-of-pocket limit to qualify as HSA-compatible." But the good news is this problem can be addressed by making HSA-qualified plan designs more flexible, as I'll explain below.

Where are HSAs growing fastest? In the employer market. Account-based health plans—health insurance plans paired with HSAs and HRAs—are the fastest growing health benefits in the employer market and now account for more than 15 percent of all employer-provided coverage. More than 70 percent of employers offer account-based health plans. A growing share of employers offer only such plans. This rapid adoption rate is fueled by the relentless rise of health care costs.

Benefits of HSAs

Do HSAs work? HSA-qualified health plans are now in their 15th benefit cycle. We have 14 years of data with which to assess and judge the value of this important tool. The results are in, and the benefits are clear: HSAs work, and work well, for millions, and not, incidentally, just for the healthy and the wealthy.

Do HSAs help reduce health care costs? Yes. Companies with at least half of their workers enrolled in an account-based health plan report that their per-employee costs are over $1,000 lower than companies without an account-based health plan, according to Towers Watson and the National Business Group on Health. As former Treasury and White House economist Roy Ramthun has observed, "This is strong evidence that putting consumers in charge of their own health care dollars does in fact bend the cost curve downward."

The professional Actuaries at the Centers for Medicare and Medicaid Services (CMS) have credited HDHPs with reducing national health expenditures by 0.9 percent.

Back in 2012, researchers at the RAND Corporation published an analysis in the journal *Health Affairs*, regarding the potential impact of account-based health plans on the American health system, which suggests that if account-based health plans grow to represent half of all employer-sponsored insurance in the United States, health care spending could drop by $57 billion annually—about 4 percent of all health care spending among non-elderly Americans. The study found HSAs more cost-effective than other kinds of health plans, and estimated that if every employee were to be placed in an HSA plan, the annual savings would be as high as $73.6 billion. We think that figure greatly understates the potential savings.

Aetna reported in 2011 that employers who switched to account-based health plans

as their only plan option had saved $21.8 million per 10,000 members over the previous five years. Aetna found that employers who offered an account-based health plan alongside other traditional plan options (e.g., PPO, HMO) also had realized savings, but not as significant—only $8 million per 10,000 members over five years.

Cigna published a study in 2012 concluding that employers can save an average of $9,700 per employee over five years by switching to account-based health plans. The Cigna report concludes that if the share of Americans enrolled in account-based health plans rose to 50 percent and achieved the same results as in its study, the United States could save $350 billion over 10 years and the level of patient care would improve.

The academic evidence is strong for the existence of a positive "HSA effect," a tendency in people to spend less when using a consumer-driven, account-based approach, such as with an HSA.

Let's look closer at that evidence.

A 2009 literature review by the American Academy of Actuaries cites several industry-led studies, all of which find a measurable HSA effect when estimating the year-over-year spending reduction due to switching from a traditional health plan to a CDHP:

- CIGNA Choice Fund 2008 (4 percent spending reduction)
- Aetna HealthFund 2008 (10 percent spending reduction)
- Uniprise 2008 (15 percent spending reduction)

Importantly, all three of these studies found higher rates of preventative care use.

A literature review by RAND Corp. cites, among other studies:

- Nichols Moon and Wall 1996 (if all workers switched to a CDHP, national health expenditures could be reduced by 4 to 6 percent).
- Keeler et al 1996 (if all non-elderly insured were to enroll in a CDHP, health care spending would decline by 0 to 13 percent).
- Hahn 2005 [Humana 2005] (after switch from a PPO plan, CDHP spending was lower than expected by 25 to 35 percent).

- Baicker Dow and Wolfson 2006 (a hypothetical switch from a PPO to a CDHP would reduce individual health spending by 5 percent in short run).

- Burke and Pipich (Milliman) 2008 (CDHP plans produce 1.5 percent in savings beyond non-CDHPs).

A case study by Trumbower and West (Health Equity) 2016 finds that two Pennsylvania school districts that switched to a CDHP reduced their health spending by an adjusted net of 17.46 percent in total claims, compared to districts that continued with the previous, traditional health plan.

The only studies we've encountered that show CDHPs leading to *higher* costs in some (but not all) provider settings are by Parente, Feldman, and Christiansen, circa 2004-2007. Of these, the RAND literature review cautions: "Some of the variation in results of these studies may stem from the heterogeneous benefit designs of both the HDHPs and the conventional plans studied."

The above list is non-exhaustive, but the cumulative weight is clear. Even the least favorable study, Burke and Pipich (Milliman) 2008, shows a 1.5 percent savings from switching to a CDHP. The other studies show even higher savings.

What all this academic data tells us is that the HSA effect is real. For the record, I hereby submit a list of studies in support of this fact.

HSA Effect Studies (Select List)

American Academy of Actuaries. "Emerging Data on Consumer-Driven Health Plans: A Public Policy Monograph." May 2009. URL: https://www.actuary.org/pdf/health/cdhp_may09.pdf.

Aetna HealthFund. "Making an Impact: Seventh Annual Aetna HealthFund Study." 2008. URL: http://www.aetna.com/aetna-press/document-library/Aetna_HealthFund_2009_Study_Results_NA_Sell_Sheet.pdf

CIGNA Choice Fund. "Two Year Experience Study, 2005-2006." March 2008. [Referenced in AAA, above.]

Uniprise. "CDHP Results Discussion." March 2008. [Referenced in AAA, above.]

Baicker K, Dow WH, Wolfson J. "Health Savings Accounts: Implications for Health

Spending." National Tax Journal. Vol. 59, No. 3. September 2006.

Burke J, Pipich R. "Consumer Driven Impact Study." Seattle, Washington. Milliman Inc. April 2008. URL: http://www.hsacoalition.org/wp-content/uploads/2008/04/consumer-driven-impact-studyrr-04-01-08.pdf.

Effros R. "Increase Cost-Participation by Employees (e.g., Through High-Deductible Health Plans)." Rand Technical Report TR-562/4. Santa Monica, California. RAND Corporation. 2009. URL: https://www.rand.org/pubs/technical_reports/TR562z4.html.

Hahn P. "Health Care Consumers: Passive or Active? A Three-Year Report on Humana's Consumer Solution." Louisville, Kentucky. Humana, Inc. June 2005.

Keeler EB, Malkin JD, Goldman DP, Buchanan JL. "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association,* Vol. 275, No. 21. 5 June 1996.

Nichols L, Moon M, Wall SW. "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers." Washington, D.C. The Urban Institute. 1996.

Trumbower B, West W. "Making the HSA Switch: Changing to an HSA-Qualified Health Plan Resulted in Significant 1st-Year Savings in Two Pennsylvania School Districts." Health Equity, Inc. 2016.

Do HSAs help people pay for health care in retirement? Yes. In fact, HSAs are the *only* tax-advantaged savings vehicle that allow Americans to save for health care costs in retirement. FSAs and HRAs do not, because the money belongs to the employer and remains with the employer after the employee leaves. Non-HSA-qualified plans (PPO, HMO, and indemnity) do not, because they have no savings component and the participant has to renew the policy annually. HSAs also differ from traditional IRAs and 401(k)s in one important respect: funds withdrawn from an HSA that are spent on health care expenses are not taxed. Thus HSAs are unique and in these critical ways superior to other account-based approaches. Indeed, one could argue that HSAs are the most attractive and consumer-friendly form of health coverage currently available in the United States today.

To understand how beneficial an HSA can be in retirement, consider the following illustration. Today about 30 to 35 percent of retirees' living expenses are health-related. But Medicare only covers about 60 percentof the average retiree's medical costs. As a

result, the average couple retiring this year, according to Fidelity Investments, will face an estimated $275,000 in health care expenses not covered by Medicare. Due to the tax laws, this couple, forced to use post-tax dollars, will have to spend $334,000 to $380,000, just to cover those $275,000 in uncovered health care costs. But retirees with an HSA will face a much lower hurdle, for two reasons. First, they are allowed to use their HSA funds to pay for health care costs not covered by Medicare. Second, HSA withdrawals are not taxed. (Funds withdrawn from a traditional IRA or 401(k) are taxed.) So our illustrative couple, if they maintain an HSA before retiring, will get to reduce their total health care expenses during their golden years by $59,000 to $105,000—thanks to their HSA.

Do HSAs give patients more control over their health care? Yes. Having an HSA tends to induce consumers to take a more active role in managing their own care, because they have skin in the game. A 2012 survey by the independent Employee Benefits Research Institute (EBRI) suggested that enrollees in account-based health plans were more likely to check whether their plan would cover their care, talk to their doctor about treatment options and costs, talk to their doctor about prescription drug options and costs, ask for a generic drug, check the price of service before seeking care, use an online cost-tracking tool, and develop a budget to manage health care expenses. Insurers have reported similar findings.

HSAs fuel price transparency, consumer empowerment. As a result of the rapid spread of HSAs and other account-based health plans, there has been an information revolution, alongside the HSA revolution. People with account-based health plans are demanding better information about the price and quality of their health care options, and the market is responding. Dozens of new companies have appeared, with names like MediBid, ZendyHealth, and Healthcare Blue Book, which offer consumer-reports style information and online comparison tools to help patients make smart choices among medical providers and treatments.

Criticisms of HSAs

Are HSAs are only for the healthy? The evidence to support this idea is thin. Intuitively, it makes little sense, since HSA coverage is effectively first-dollar coverage, and as I'll explain below, the account can be particularly helpful to people with chronic medical conditions.

Are HSAs only for the wealthy? No. In terms of income, HSA owners are average. Median household income in the United States is currently about $59,000. The median household income for an HSA account holder, according to WageWorks, is $57,060. In terms of age, three out of every four current HSA owners is under the age of 50, one in four

is over 50. That tells us most HSA owners are still in the boost phase of their earning years, while a minority are in their high-earning years. Two-thirds of this group earn less than $75,000 a year, half make less than $60,000 a year, a little over 8 percent earn more than $100,000 a year, and just four-one-hundredths of one percent earn above $200,000. That confirms that HSA owners are far from being Monopoly Men in silk top hats.

In our view, most criticisms of HSAs are really just criticisms of non-HSA-qualified HDHPs. The account is an innocent bystander. An HSA is a tax-advantaged account that helps you pay your deductibles. If policy makers are concerned about high deductibles being unaffordable for some patients, then we think the appropriate response would be to make HSA-qualified plans more flexible. We suggest some ways to do that, below.

Are HSAs really just a disguised investment vehicle? No. According to the experts at Devenir, the average HSA balance is a little more than $2,000 and 78 percent of HSA account holders have less than that amount in their account. This indicates the accounts are being used for their intended purpose: to pay for routine health care expenses.

Are HSA holders vulnerable to excessive charges? No. Just like everyone else with insurance, individuals enrolled in HSA-qualified plans receive the benefit of discounted prices for medical services negotiated by their health plan. Choosing an HSA in no way denies you the benefits of group purchasing and negotiated discounts.

Do HSAs hurt Americans with chronic diseases? Just the opposite. HSAs are especially helpful to people with medically complex chronic conditions, for a couple of reasons. First, having an HSA enables the patient to purchase prescription medications with tax-advantaged dollars rather than with after-tax dollars. Second, HSA-qualified health plans provide true catastrophic protection, by virtue of their annual limits on out-of-pocket expenses, which apply to both medical and pharmacy expenses. Protection against excessive out-of-pocket spending has been a feature of HSAs from the beginning.

Do HSAs offer "skimpier" coverage than traditional insurance? No. Covered benefits and services in an HSA-qualified plan are generally identical to those in a traditional plan, not "skimpier" as some critics believe. What *is* different is the share of the covered benefits paid for by the plan as opposed to the patient. For example, an HSA-qualified plan might cover 60 or 70 percent of the cost of covered benefits, whereas a traditional HMO or PPO plan might cover 80 or 90 percent. But on the other hand, the traditional HMO or PPO may have a higher premium than the HSA-qualified plan, and might also have a skimpier network of doctors and hospitals. We can't really call one or another plan "skimpier" without comparing all the various features and costs of both. As a general matter, HSA-qualified plans resemble other kinds of insurance in every respect except the deductible—

and even that distinction is fading as deductibles continue to rise everywhere.

Do HSA holders go bankrupt due to high out-of-pocket costs? No more so than other Americans, and probably less so. As we've mentioned, every HSA-qualified plan comes with built-in out-of-protection expense protection. And the HSA protection kicks in at lower limits than under non-HSA plans.

Ways to Improve HSAs

Can HSAs be improved? Yes. HSAs work well, but they need some improvements. Currently HSA plans are discriminated against, compared to other co-pay plans. Under current rules, you are not allowed to contribute to an HSA and also:

1. Be enrolled in Medicare.
2. Receive Social Security benefits.
3. Be enrolled in a traditional health plan.
4. Have access to TRICARE or the Indian Health Service or the VA.
5. Be covered by a health care FSA.

Additionally, with today's HSAs you are not allowed to:

6. Have access to employer or retail medical clinics at no cost.
7. Have access to telemedicine at no cost.
8. Have access to high-value chronic disease management at no cost.

To address these weaknesses, and make HSAs even better, Congress should make them available to more people, and make their basic plan design more flexible.

Expanding the usefulness of HSAs to a larger audience will be good for everyone, because it will accelerate adoption and thus accelerate cost reduction.

Expanding flexibility is also important. HSA owners want, deserve, and in many cases need more flexibility. Certainly HSAs should be able to cover value-based services like direct primary care, expenses associated with chronic care management, and telemedicine services. Flexibility and choice are vital to the HSA concept. Every patient is different. As HSAs become more popular, their flexibility must grow.

HSAs and Chronic Disease

Can HSAs be improved for people with chronic diseases? Yes. There is one important weakness in the current HSA model: people with chronic diseases have higher prescription and health care costs and tend to meet their deductible quickly due to prescriptions. In one sense, that's not a problem, because their insurance kicks in as soon as they've met the deductible. But in another respect, it's a big problem, because their comparatively rapid and frequent depletion of their account means these vulnerable Americans have no good way to save tax-free for health care costs in retirement. To make matters worse, current law actually prohibits an HSA-qualified plan from covering chronic disease below the deductible. Any plan that offers such pre-deductible coverage is disqualified from being paired with an HSA and the individual who purchases such a plan is prohibited from contributing to his or her HSA.

> *Policy Recommendation*: *Pass the Chronic Disease Management Act.* To address this problem, and help Americans with chronic illnesses, the ABA's HSA Council supports enactment of the Chronic Disease Management Act, introduced as S.2410 by Senators John Thune (R-South Dakota) and Tom Carper (D-Delaware) and as H.R.4978 by Representatives Diane Black (R-Tennessee) and Earl Blumenauer (D-Oregon). This bipartisan legislation would allow HSA-qualified plans to cover high-value health care services and medications associated with chronic disease management without a deductible. Importantly, it would do so in a voluntary rather than a mandatory way.

HSAs and Medicare, Medicaid

Should HSAs be an option for people on Medicare and Medicaid? Yes. Currently the 138 million people—roughly four in ten Americans—who are enrolled in Medicare or Medicaid (59 million of them in Medicare, 79 million in Medicaid) are barred by law from contributing to an HSA. We can see no good policy reason for this form of discrimination against the poor, the elderly, and the disabled.

Why should Medicare seniors have access to HSAs? Because allowing Medicare seniors to have an HSA would not only benefit vulnerable elderly and disabled patients and their medical providers, but also, importantly, would benefit taxpayers, because, as we've seen, HSAs are a powerful tool for helping to bend the cost curve downward without bureaucratic rationing.

Policy Recommendation: Permit Medicare HSAs for Working Seniors. The ABA's HSA

Council has proposed, and President Trump (in his FY 2019 budget) and several Members of Congress have endorsed, the idea of allowing employed seniors who reach Medicare enrollment age to continue participating in their employer's HSA-qualified health plan, and thus continue contributing to their HSA, while enrolled in Medicare. Importantly, seniors who voluntarily participate in the option would not be allowed to rely on Medigap supplemental coverage, and Medicare would not cover any of their health care costs below the deductible. When the senior leaves the employer plan, he or she will switch to normal Medicare without penalty. At firms with greater than 20 employees, Medicare secondary payer rules would apply, with respect to HSA-qualified coverage. (Employers with fewer than 20 employees are currently exempt from those rules.) Thanks to these strong safeguards, the proposal would certainly reduce federal expenditures—or at the very least, it would not increase them. An analysis by benefits firm Benefit Strategies finds that in every scenario, regardless of firm size, for each individual who opts in, the Treasury is likely to receive a net gain of $8,000 compared to current law. Only in one rare scenario, in which a Medicare-eligible person is working for a firm with fewer than 20 employees but is not receiving Social Security benefits, will the net savings to the Treasury be less than $8,000—in that case, it will most likely be a wash. A budgetary cost estimate by the policy consultancy Adams Auld LLC projects a net savings to the Treasury of $72.3 billion over ten years.

Policy Recommendation: Permit HSAs in original (fee-for-service) Medicare and Medicare Advantage. We believe every Medicare beneficiary should have the option of an HSA. To make this possible, Congress could take any of a number of possible approaches. Perhaps the simplest is to declare traditional fee-for-service Medicare coverage and Medicare Advantage plans to be HSA-qualified (that is, not prohibited coverage). If a person is enrolled in Medicare or an MA plan, he or she is automatically eligible to make and receive contributions to an HSA. There are other possible approaches, more complex than this. But the goal and basic effect would be the same. Most likely, Congress would want to prohibit Medigap supplemental coverage for those Medicare beneficiaries who have an HSA, since the savings account would cover the deductibles, copays, etc., and having Medigap coverage would dissipate the beneficial behavioral effects of having an HSA. Also, a Medicare senior could save money by not having to pay Medigap premiums, and could instead deposit that money into the account. Meanwhile, the government could also make contributions to the account. It might, for example, calculate the dollar savings that would result from reduced utilization (thanks in part to the absence of Medigap) and then use some of all of that savings to make a contribution to the HSA. This proposal can be structured to be budget neutral.

Should low-income Americans have access to HSAs via Medicaid? Yes. Currently, HSAs are not offered in Medicaid, and Medicaid enrollees are not allowed to contribute to an HSA. There is a model, however, for an accounts-based approach in Medicaid, pioneered in the state of Indiana. The Indiana experiment, known as HIP 2.0, is distinguished by three main features, relative to conventional Medicaid. It offers: 1) a more modern benefit design, featuring choice of health plans, and a HSA-like savings account, which is managed by the patient (with rollover rewards to encourage prudent account management); 2) more sensible cost-sharing rules that help reduce waste; and 3) more generous reimbursement rates for doctors and hospitals, which increases patient access to care. Indiana Medicaid officials report that HIP 2.0 has reduced overall program expenditures by 6 percent, on average, while increasing patients' access to care, along with their satisfaction and happiness. Remarkably, these savings are occurring despite a significant boost in provider reimbursement rates. In Indiana, increasing the reimbursements has so far enabled the state to add more than 6,700 new providers to serve Medicaid enrollees, including those who are not participating in HIP 2.0. Almost 30 percent of providers surveyed report a decline in bad debt, and nearly 40 percent have seen a reduction in charity care. Indiana's experiment shows a "better Medicaid" is possible—better for patients, providers, and taxpayers.

Policy recommendation: Permit HSAs in Medicaid, by statute. The ABA's HSA Council has proposed, and drafted legislation, to create a new HSA option within Medicaid. We commissioned a study by the respected Milliman firm to help us gauge the likely financial effects of our Medicaid HSA proposal. Milliman reported: "Full replacement of current Medicaid with a Medicaid HSA would save an average state 6% of their Medicaid budget." Using this assumption, and refining the proposal per our guidance, the policy consultancy Adams Auld LLC found that, if Medicaid HSAs as we propose to structure them became the default approach in 20 states, in adult, non-disabled populations, the likely federal savings would be on the order of $25 billion over a decade. The new statutory option would differ from HIP 2.0 in some ways. Unlike in Indiana, where the money in the account ultimately belongs to the government, the money in a Medicaid HSA would be the account owner's property, regardless of who contributed the money. And of course it would have to be paired with a high-quality, HSA-qualified high-deductible health plan (HDHP). In our draft legislation, the deductible is set at $2,500 in 2019 and is adjusted annually to rise with medical inflation. The full amount of the deductible is deposited in the account each year, with a small portion of this amount coming from the individual, but most of it from the state. For example, the state might contribute $2,350 and the individual $150. Any expenses above the deductible would be paid for by the state, with no further cost-sharing payments required from the individual. (Most people do not reach their deductible, in a given year.) The system would promote

prevention. Similar to a traditional HSA, preventive services, such as annual examinations, recommended mammograms, and smoking cessation programs, are covered without charge to the participant and are not counted against the deductible amount of $2,500. Once the participant meets the deductible by way of the account, all further benefits are fully covered without cost-sharing. When a Medicaid HSA owner leaves the Medicaid rolls, he or she retains the money in the HSA, which can be rolled over into a traditional HSA or, alternatively, cashed out and spent (after payment of any applicable taxes and penalties). Importantly, doctors and hospitals serving Medicaid HSA owners would receive more generous reimbursement for their services, and the pleasure of serving patients who care more about their health care decisions because they have more "skin in the game." The successful Indiana model is a proven way to increase patient participation and engagement in their care and reduce wasteful expenditures in Medicaid while improving patient care. It should be replicated nationally.

Conclusion

HSAs are a success. They work, and work well. While they can't solve every problem, they have all the incentives in the right place. They let people save for the future. They promote transparent pricing. They respect individual responsibility, the hallmark of every financial transaction. HSAs follow well known and proven insurance principles. They save money and help get more people covered.

But they could be even better. Dozens of good HSA-improvement bills, many of them bipartisan, have been introduced in the current Congress. By our count, there are at least 30 such bills in the House and 15 in the Senate. We support virtually all of them. But the following proposals top our priority list, for a number of reasons. These ideas are vetted, bipartisan, and affordable. Some would actually save taxpayer money. Individually and together, they can dramatically strengthen the proven, successful HSA model.

1. Enact the Paulsen-Hatch Health Savings Act (H.R.1175, S. 403).

   Paulsen-Hatch, the flagship HSA expansion bill of the current Congress, would improve and strengthen HSAs in a host of ways. Among other things, it would allow several new classes of Americans to have an HSA, including Medicare seniors, Indian Health Service enrollees, health care sharing ministry members, subscribers to direct primary care practices, and people who use on-site workplace medical clinics. It would also allow HSAs to be used for over-the-counter medications, and not just for prescription drugs as under current law.

2. Enact the Kelly-Blumenauer Bipartisan HSA Improvement Act (H.R.5138).

   Kelly-Blumenauer would improve HSAs in several ways. It would harmonize HSAs with current rules regarding health insurance options for adult children up to age 26, and improve coordination between HSAs, FSAs, and HRAs. It would also permit excepted insurance benefits to be included in an HSA-qualified plan. And it would extend tax deductibility to certain amounts spent on sports and physical fitness activities, thus making these health-promoting activities permissible uses of HSA funds.

3. Enact the Thune-Carper-Black-Blumenauer Chronic Disease Management Act (S.2410, H.R.4978).

   As described above, this compassionate bipartisan measure would allow an HSA-qualified health plan to cover care for medically complex chronic conditions, with no deductible.

4. Create an additional method of determining HSA-qualification using the more flexible actuarial value (AV) approach.

   Earlier, we noted the problem of HSA-qualified plans becoming squeezed out of the ACA exchanges by the rapid rise of health costs. Here's a way to slow or reverse that trend. In addition to the current-law approach to deductibles, which fixes the minimum deductible at, say, $3,450, why not allow a consumer to have whatever level of deductible he or she wants, consistent with an overall health plan actuarial value of say, 80 percent? This would make it much easier for health plans offered on the ACA exchanges to be HSA-qualified. And it also would improve the availability of such plans outside the exchanges as well as in the employer-sponsored group market. The higher the threshold, the greater the number of plans that will qualify for an HSA. At 70 percent, the number of plans that count as HSA-qualified would basically double from its current level. At 80 percent, that number would roughly quadruple. This simple reform would increase the HSA holder's freedom of choice, allowing him to find a personally satisfying combination of deductibles, premiums, and cost-sharing.

5. Increase HSA contribution limits to match the statutory limit on out-of-pocket expenses for HSA-qualified plans.

Making HSAs more flexible requires an increase in allowable contributions, up to the out-of-pocket maximum, currently $6,650 for individuals and $13,300 for families, in order to help pay for these additional services.

6. End the discrimination against HSAs in Medicare and allow Medicare HSAs for working seniors.

   See our detailed description and explanation above.

7. Allow HSA options in Medicare and Medicaid programs like the Trump Administration's Medicare Advantage MSA proposal.

   We support the Administration's suggested improvements to the existing Medicare Advantage MSA option. Under this proposal, people could roll their HSA funds over into an MA-MSA and contribute to it—things that are currently not permitted.

HSAs help tens of millions of Americans afford good-quality health care. They're a truly powerful tool for improving the quality of care while driving down its cost. With a few sensible improvements, they can help Americans access better care now while saving for their future.

Thank you for this opportunity to testify.

John Breaux
Louisiana

Committees:
Commerce, Science, and Transportation
Finance
Special Committee on Aging

United States Senate
WASHINGTON, DC 20510-1803

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September 8, 1992

Dear Colleague:

The United States is faced with a crisis in health care on two fronts: access and cost control. So far, most of the proposals before Congress attempt to deal with access but do not adequately address the more important factor--cost control. We have introduced legislation that will begin to get medical spending under control by giving individual consumers a larger stake in spending decisions.

We have introduced a bill, the Medical Cost Containment Act of 1992 (S. 2873), which would allow employers to provide their employees with an annual allowance in a "Medical Care Savings Account" to pay for routine health care needs. This allowance would not be subject to income tax if used for qualified medical expenses. Any money not spent out of a given year's allowance could be kept by the employee in an account for future medical needs during times of unemployment or for long term care. In order to protect employees and their families from catastrophic health care expenses above the amount in the Medical Care Savings Account, an employer would be required to purchase a high-deductible catastrophic insurance policy.

Unlike many standard third party health care coverage plans, Medical Care Savings Accounts would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their "own" money. That is, money that they would otherwise be able to save in their account for future needs.

Once a Medical Care Savings Account is established for an employee, it is fully portable. Money in the account can be used to continue insurance while an employee is between jobs or on strike. Recent studies show that at least 50% of the uninsured are uninsured for four months or less.

Today, even commonly required small dollar deductibles (typically $250 to $500) create a hardship for the financially stressed individual or family seeking regular, preventive care services. With Medical Care Savings Accounts, however, that same individual or family would have this critical money in their account to pay for the needed services.

Figure 7.3

Medical Cost Containment Act (S. 2873)
Page 2

We feel that, while the Medical Care Savings Account concept does not provide the total solution to the crisis in health care access, it does begin to address the critical aspects of increasing costs and utilization by consumers.

We hope that you will join us as cosponsors of this legislation. If you have any questions please contact us or have your staff contact Laird Burnett of Senator Breaux's staff at 4-4623.

Sincerely,

John Breaux

Richard Lugar

David Boren

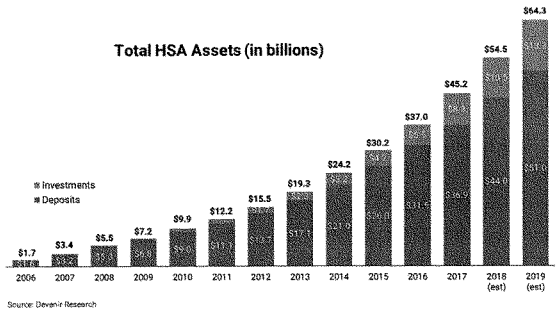
Dan Coats

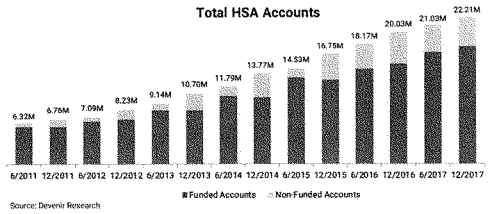
Tom Daschle

Sam Nunn

Figure 7.3a

Devenir Research
2017 Year-End HSA Market Statistics & Trends
DEVENIR


Total HSA Assets (in billions)
Investments
Deposits
$1.7
$3.4
$5.5
$7.2
$9.9
$12.2
$15.5
$19.3
$24.2
$30.2
$37.0
$45.2
$54.5
$64.3
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018 (est)
2019 (est)
Source: Devenir Research



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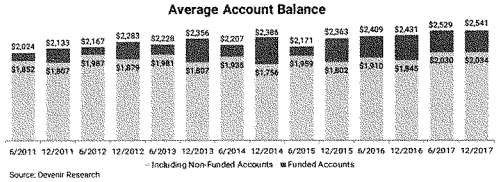

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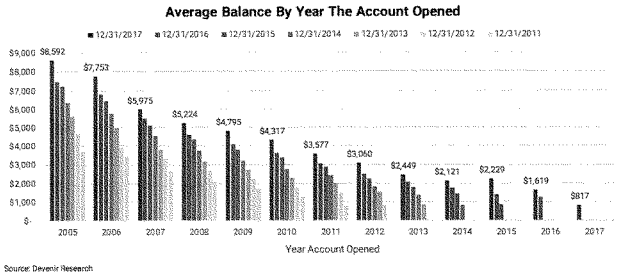

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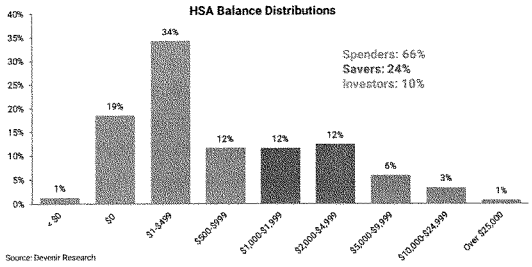
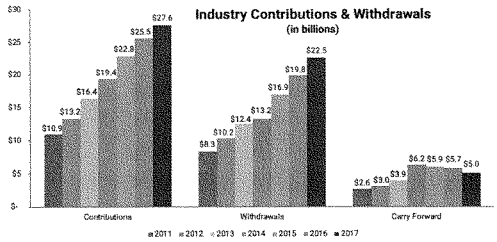

HSA Balance Distributions
40%
35%
30%
25%
20%
15%
10%
5%
0%
1%
19%
34%
12%
12%
12%
6%
3%
1%
Spenders: 66%
Savers: 24%
Investors: 10%
< $0
$0
$1-$499
$500-$999
$1,000-$1,999
$2,000-$4,999
$5,000-$9,999
$10,000-$24,999
Over $25,000
Source: Devenir Research



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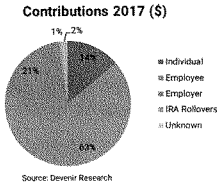
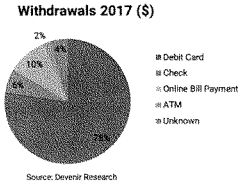
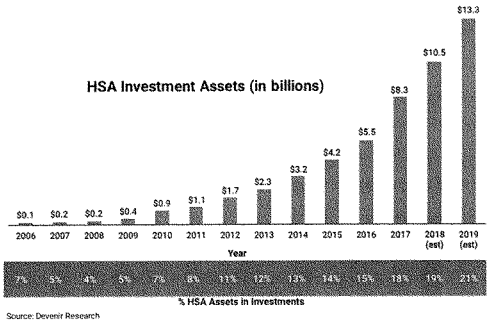

Contributions 2017 ($)
1%
2%
14%
21%
63%
Individual
Employee
Employer
IRA Rollovers
Unknown
Source: Devenir Research


Withdrawals 2017 ($)
2%
4%
10%
6%
78%
Debit Card
Check
Online Bill Payment
ATM
Unknown
Source: Devenir Research



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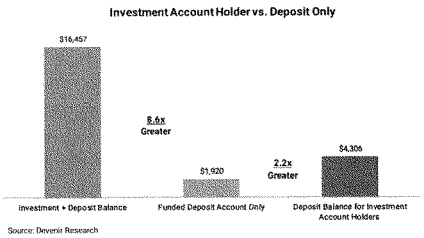
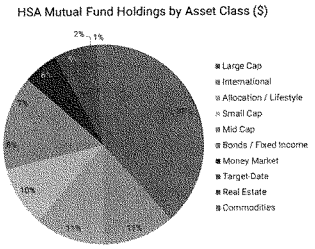

Investment Account Holder vs. Deposit Only
$16,457
8.6x
Greater
$1,920
2.2x
Greater
$4,306
Investment + Deposit Balance
Funded Deposit Account Only
Deposit Balance for Investment Account Holders
Source: Devenir Research



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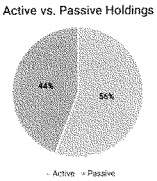

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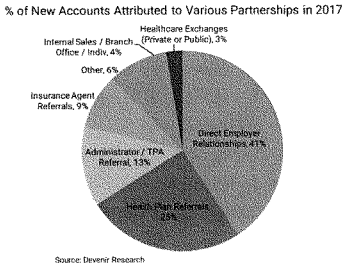
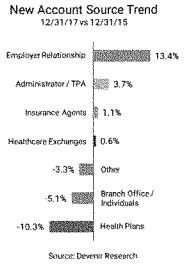

% of New Accounts Attributed to Various Partnerships in 2017
Healthcare Exchanges (Private or Public), 3%
Internal Sales / Branch Office / Indiv, 4%
Other, 6%
Insurance Agent Referrals, 9%
Direct Employer Relationships, 41%
Administrator / TPA Referral, 13%
Health Plan Referrals, 25%
Source: Devenir Research


New Account Source Trend
12/31/17 vs 12/31/15
Employer Relationship
13.4%
Administrator / TPA
3.7%
Insurance Agents
1.1%
Healthcare Exchanges
0.6%
-3.3%
Other
-5.1%
Branch Office / Individuals
-10.3%
Health Plans
Source: Devenir Research

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Statement of
Tracy Watts
Senior Partner
Mercer

On Behalf of the
American Benefits Council and Mercer

Before the Joint Economic Committee
Hearing on
"The Potential for Health Care Savings Accounts to Engage Patients
and
Bend the Health Care Cost Curve"

June 7, 2018

Chairman Paulsen, Ranking Member Heinrich, and Members of the Committee, thank you for this opportunity to meet with you to discuss the critical role health savings accounts are playing to help make health care more affordable.

My name is Tracy Watts, and I am a Senior Partner and US Healthcare Reform Leader at Mercer. I am testifying today on behalf of Mercer and the American Benefits Council, where I serve on their Policy Board of Directors. I have more than 30 years of experience in helping Fortune 500 companies design, finance and administer their health care programs and develop innovative plan designs to control costs and improve the quality of care.

Mercer is a business unit of Marsh & McLennan Companies (MMC), a US-based leading professional services firm with a global network of more than 65,000 experts in risk, strategy, and people. The businesses of MMC, including Mercer, Oliver Wyman, and Marsh & McLennan Agency, collaborate with our clients to navigate the increasingly complex healthcare marketplace to help individuals, families and employees stay healthy and productive, enable innovation, and lower costs.

Our company employs nearly 25,000 colleagues in the US, including more than more than 350 in your district, Chairman Paulsen.

The Council and Mercer appreciate the opportunity to participate in today's timely and critical hearing. The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

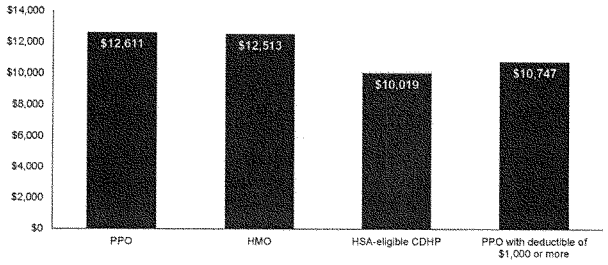
I would like to begin my testimony today by highlighting some important and very relevant findings from Mercer's most recent National Survey of Employer-Sponsored Health Care Plans. The survey, which includes responses from more than 2,500 employers, is the oldest, largest and most comprehensive survey of its kind with results that are statistically valid and projectable for any size employer population in the US. I'll then describe some employer case studies and Mercer analyses that suggest employees enrolled in an HSA-eligible health plan get the care they need, have lower health care costs, and — most importantly — do a good job maintaining their health.

The findings from our survey indicate that an increasing number of American workers and their families are enrolled in consumer-directed health plans ("CDHPs"), also known as account-based plans. Approximately 34% of covered employees working for large employers (those with 500 or more employees) were enrolled in a CDHP in 2017, which represents a rather astounding 325% increase since 2009.

In addition to demonstrating the increased reliance on CDHPs by the American worker, the results from our nationwide survey indicate that HSA-eligible plans save about 20% on plan costs when compared to PPO plans and are 6% less costly than PPO plans with deductibles over $1,000. I would note for the Committee that the success of HSA-eligible plans in reducing plan costs is one of the few strategies proven to help "bend the cost curve" and, in turn, help manage premium costs for employees.

HSA-ELIGIBLE CDHPs COST 20% LESS THAN OTHER MEDICAL PLANS

AVERAGE MEDICAL PLAN COST PER EMPLOYEE, AMONG LARGE EMPLOYERS



MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS 2

When we look at what has been happening with PPO deductibles for small employers, those with less than 500 employees, the average deductible has crept up to almost $2,000 for an individual. For larger employers it is now around $1,000 for an individual. By contrast, the median deductible for an HSA-eligible plan is $1,750 for an individual but participants also have the benefit of an HSA. According to our survey, 77% of employers contribute to their employees' HSA accounts.

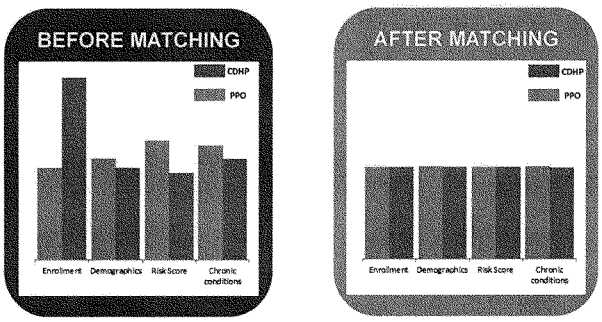
While this trend of employers shifting more responsibility for cost to employees has been underway for some time, the need to avoid the 40% "Cadillac Tax" accelerated the process. We've seen that the average PPO deductible has risen faster than the overall medical plan cost for the past few years, and employees have been moving out of PPOs and into CDHPs with even higher deductibles. While some employers may still have room to raise employee cost-share, there's a growing sense that we need additional strategies to slow cost growth that don't involve shifting more cost or responsibility to employees.

In addition to performing our nationwide survey, we also help clients evaluate the performance of their medical plans – not only from a cost perspective, but also from a care and coverage perspective.

As part of my testimony today, I would like to share with the Committee an example of an analysis that we have done for some clients that best shows the actual positive effects of HSA-eligible plans on both cost and care.

In this case study, the employer had sponsored an HSA-eligible plan alongside a PPO plan for three years. We conducted a match analysis to compare and contrast the overall experience of approximately 26,000 individuals who were covered under either the employer's PPO or the HSA-eligible plan. To control for variances in health risks that could otherwise influence an individual's choice of plan option, we matched 13,000 individuals in the PPO with 13,000 enrollees in the HSA-eligible option who shared the same demographic and risk profiles at the start of the 3-year comparative period.

FIRST, WE MADE SURE THE POPULATIONS WE WERE COMPARING LOOKED THE SAME



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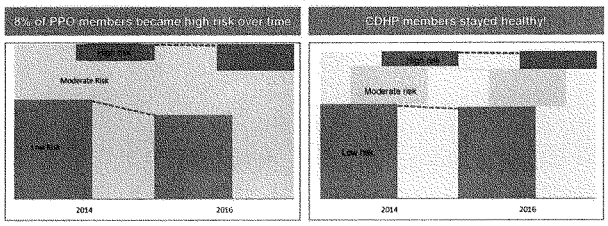
When we looked at how the participants in each of the plan options used their medical benefits, the data showed us that the utilization of health care was quite similar across the two groups. And while the HSA-eligible plan participants used slightly less care – with on average fewer emergency room visits and office visits – the HSA-eligible plan participants showed a slightly higher utilization of prescription medicines, which could actually mean they were more compliant with their prescribed therapies. As for preventive care, we also saw little difference between the two groups in their use of such care.

As mentioned, we sought to only compare individuals with similar demographic and risk characteristics across the two plans. One really interesting finding from this case study was that when we looked at the two groups over the three-year period, the HSA-eligible plan participants maintained their health status, while those in the PPO plan saw [on average] an 8% increase in identified health risks. This fact alone would seem to suggest that the HSA-eligible plan may have been more effective at helping participants mitigate the exacerbation of existing, or onset of new, medical conditions or health risks.

THE CDHP PLAN WAS MOST EFFECTIVE AT "KEEPING MEMBERS IN THEIR SWIM LANES"



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And, as for cost, the data was clear. The HSA-eligible plan ended up costing 15% less than the PPO plan over the 3-year period.

We performed similar analyses for several of our other employer clients and the results from these additional studies are very similar to those that I am sharing with you today.

Providing employees with the tools and resources to move toward consumer-directed health plans is a critical component. For employers that want to continue to provide employees with medical plan choices but would like to see greater enrollment in their high-deductible plans, enrollment results from our own Mercer Marketplace 365 benefit platform support the notion that more employees will choose to move into a high-deductible plan if they have the tools and resources to help them feel comfortable making that decision.

Finally, I want to note that in addition to the use of HSA-eligible plans, as well as other plans and coverage options, employers along with their consultants and advisors (such as Mercer) are developing innovative strategies to address some of the biggest cost drivers in the US healthcare system, including misplaced incentives, waste, uneven quality of care, and the lack of pricing and cost transparency.

Some strategies employers are pursing include implementing Centers of Excellence programs, creating on-site and near site health clinics so employees have easier access to care, implementing programs to better manage chronic conditions, and increased use of telemedicine. Unfortunately, many of these innovations are hamstrung by the HSA statute and regulations. For example, a patient with diabetes that is enrolled in an HSA-eligible HDHP must meet their entire deductible before the plan can cover an eye exam, foot exam, or diabetes medications.

Yet, the evidence is clear that patients with diabetes benefit from annual eye and foot exams and anti-diabetes medicines. Bipartisan bills have been introduced that change this. Additionally, employers can't waive cost-sharing for telemedicine, onsite clinics, Centers of Excellence, or second opinion services for employees that are enrolled in HSA-eligible HDHPs. These reforms would inject Value-Based Insurance Design into this very popular plan design.

Many of the innovations to date outlined in Mercer and the Council's report "Leading the Way: Employer Innovations in Health Coverage" have met with huge success and – if expanded and encouraged – have the potential to fundamentally improve health care for all Americans. Mercer and the Council have developed additional suggestions for enhancing HSAs and making other policy improvements to help build on these successes that we would be glad to share with you.

More survey data and information on the case study can be found in the appendix to this testimony.

We thank you for holding this hearing today. We hope that the hearing serves to help build on these successes by highlighting how HSAs can, indeed, engage patients and bend the cost curve

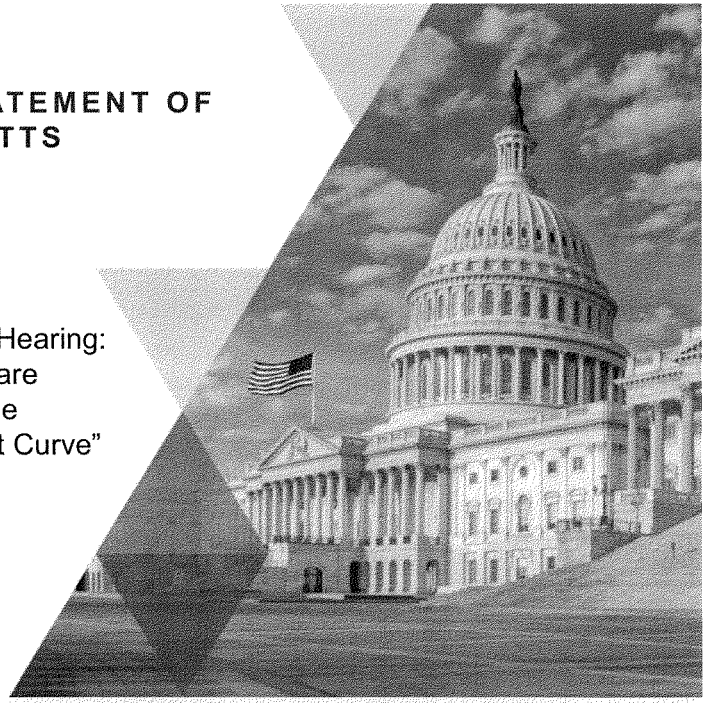
Thank you again for the opportunity to share these findings with the Committee. I'll be pleased to answer your questions.

HEALTH WEALTH CAREER

ADDENDUM TO STATEMENT OF TRACY WATTS

Joint Economic Committee Hearing:
"The Potential For Health Care Savings Accounts To Engage Patients and Bend The Cost Curve"

June 7, 2018



AMERICAN BENEFITS COUNCIL
YOUR ADVOCATE FOR EMPLOYER-SPONSORED BENEFITS SINCE 1967

MAKE TOMORROW, TODAY MERCER

ABOUT MERCER'S NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

Oldest
Marking 32 years of measuring health plan trends

Largest
2,481 employers participated in 2017

Most comprehensive
Extensive questionnaire covers a full range of health benefit issues and strategies

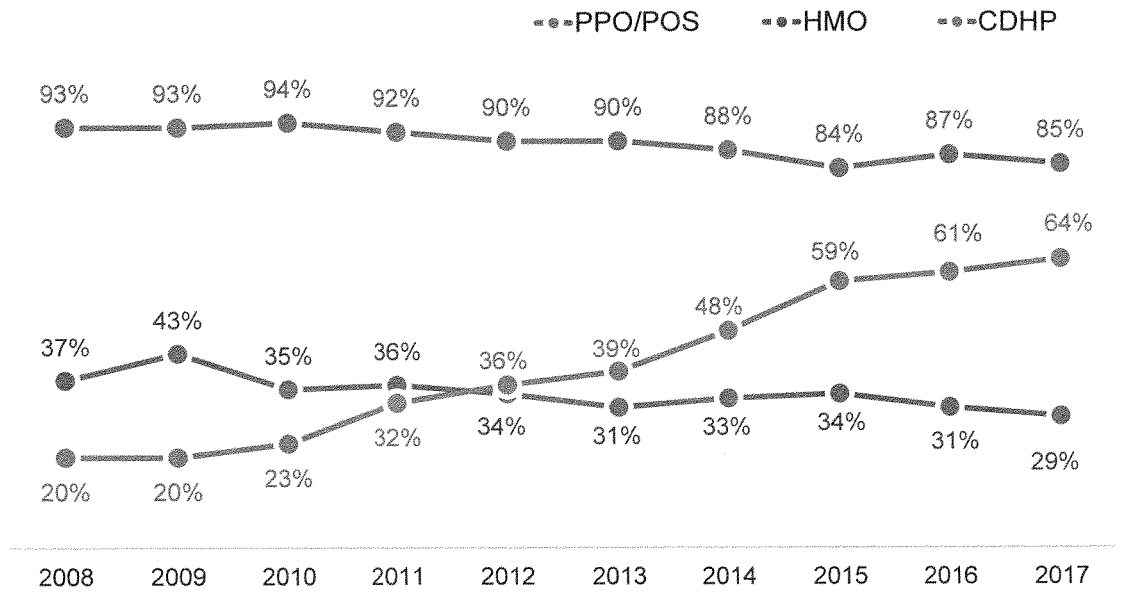
Statistically valid
Based on a probability sample of private and public employers for reliable results

Includes employers of all sizes, all industries, all regions
Results project to all US employers with 10 or more employees

Employer size groups in presentation
Small: 10–499 employees/Large: 500+ employees/Jumbo: 20,000+ employees

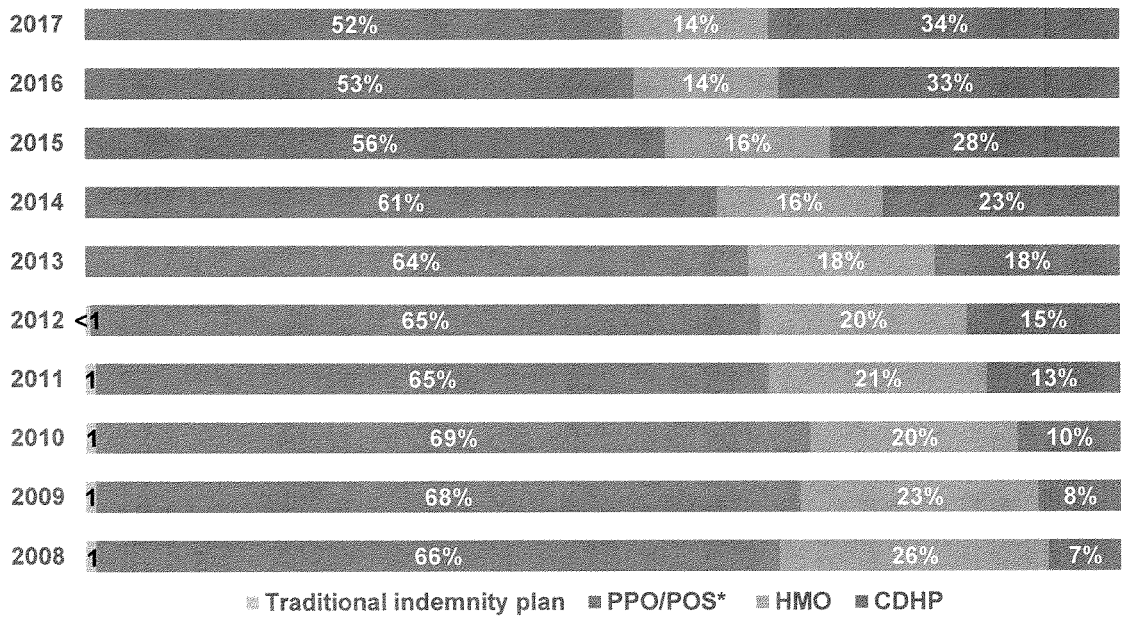
OFFERINGS OF CONSUMER-DIRECTED HEALTH PLANS HAVE MORE THAN TRIPLED SINCE 2009

Large employers



ENROLLMENT IN EMPLOYER SPONSORED MEDICAL PLANS

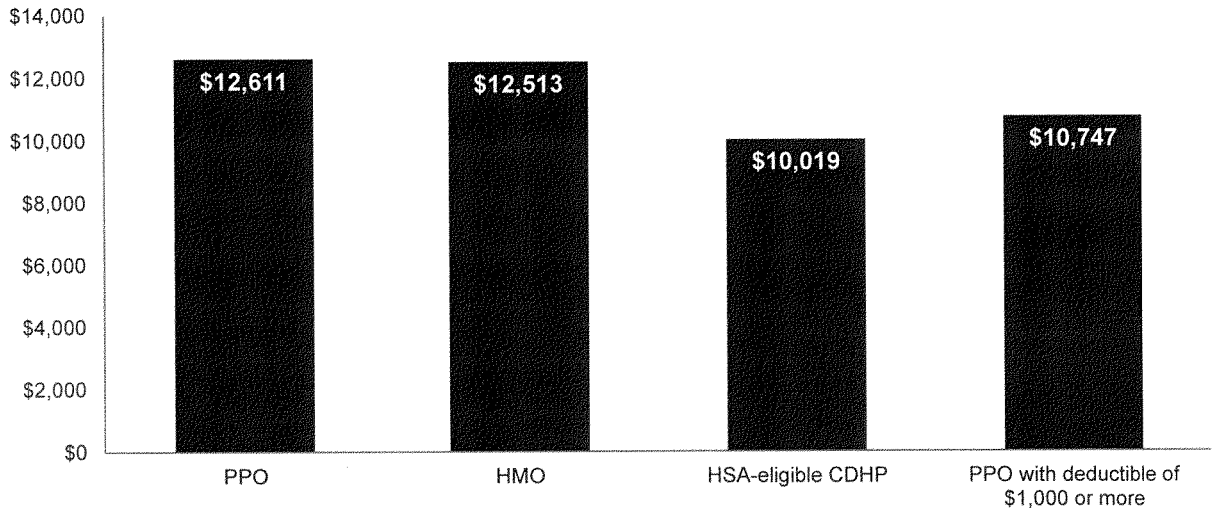
PERCENTAGE OF COVERED EMPLOYEES ENROLLED IN EACH PLAN TYPE, AMONG LARGE EMPLOYERS



*Includes traditional indemnity plans beginning in 2013.

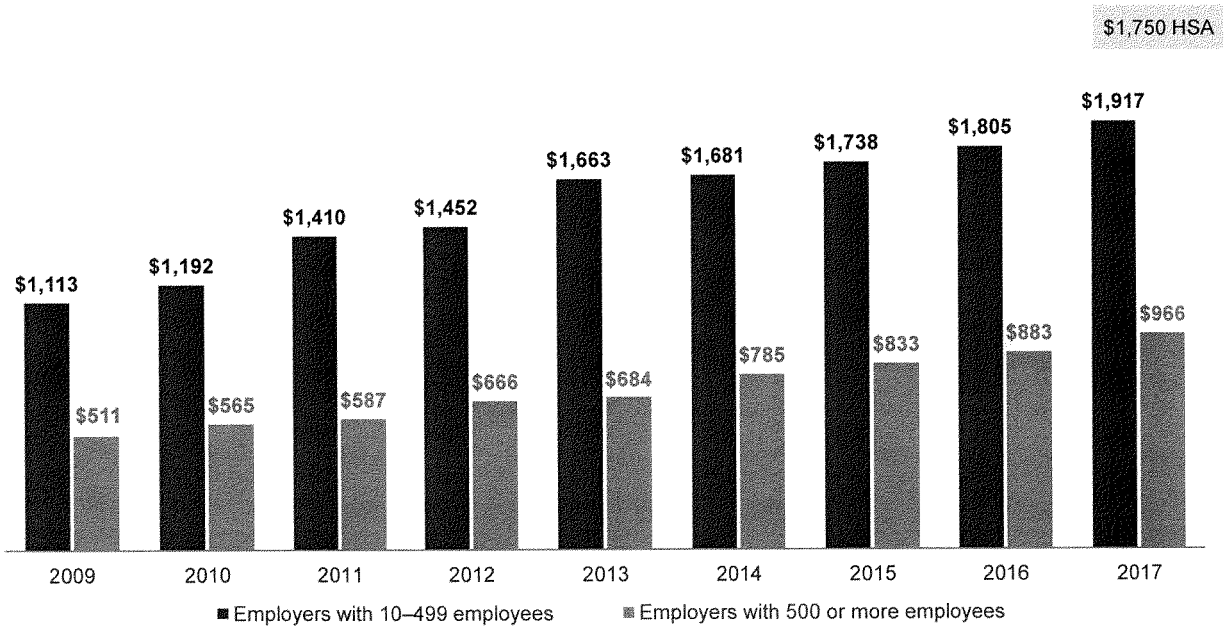
HSA-ELIGIBLE CDHPs COST 20% LESS THAN OTHER MEDICAL PLANS

AVERAGE MEDICAL PLAN COST PER EMPLOYEE, AMONG LARGE EMPLOYERS



PPO DEDUCTIBLES HAVE OUT-PACED COST GROWTH

AVERAGE IN-NETWORK INDIVIDUAL DEDUCTIBLE



PPO VS. HDHP EFFECTIVENESS ANALYSIS

CASE STUDY

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CLIENT CASE STUDY
STRONG INCENTIVES DROVE MEMBERS TO CDHP

2014 — **TODAY**

Client introduces CDHP
with strong incentives

70%

of population is
enrolled in the plan

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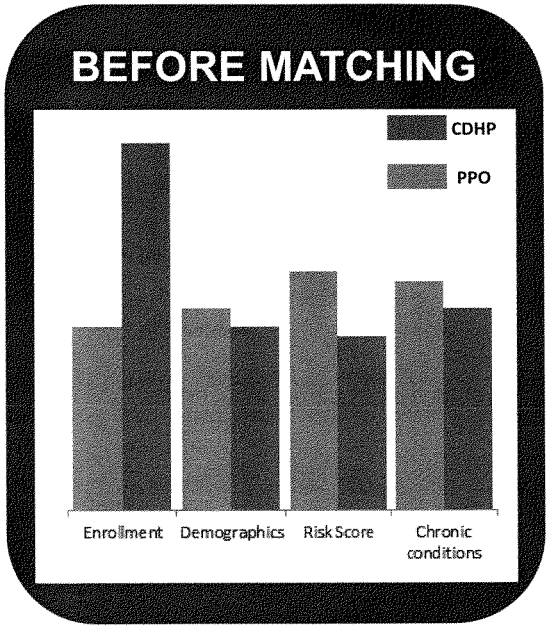
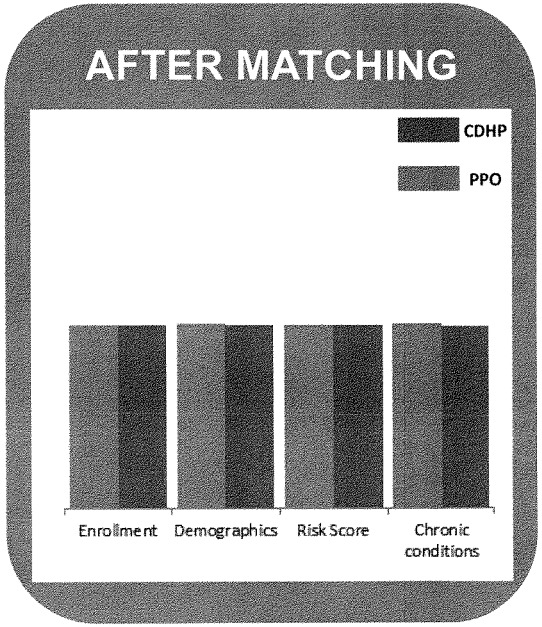
FIRST, WE MADE SURE THE POPULATIONS WE WERE COMPARING LOOKED THE SAME





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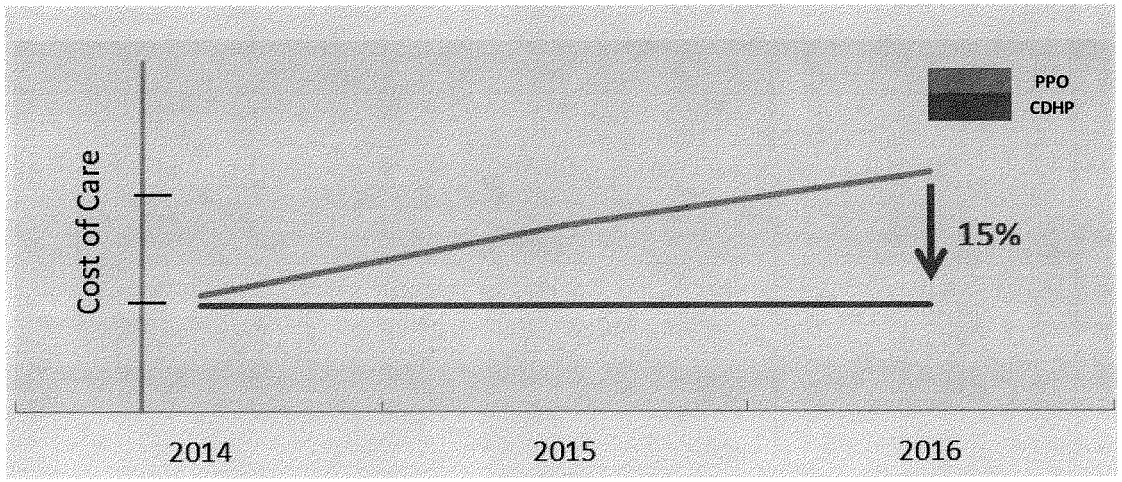
MEMBERS IN THE CDHP COST 15% LESS THAN THE PPO OVER TIME



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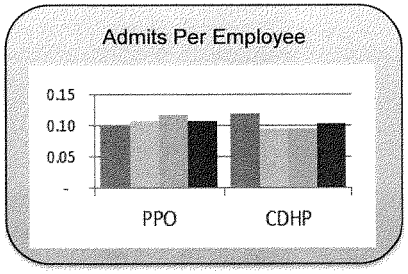
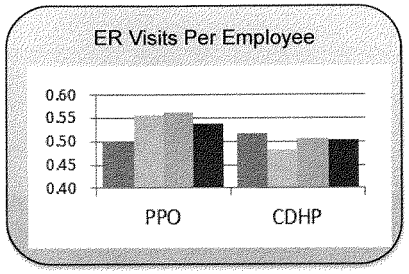
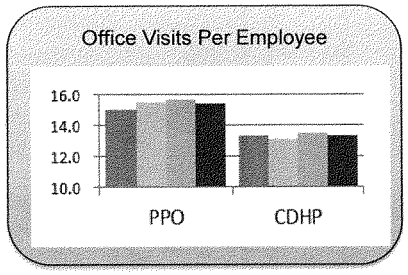
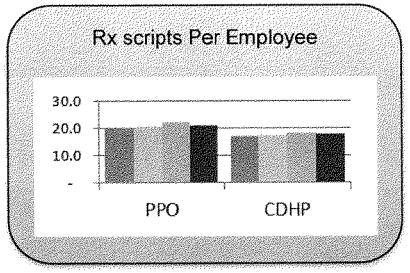
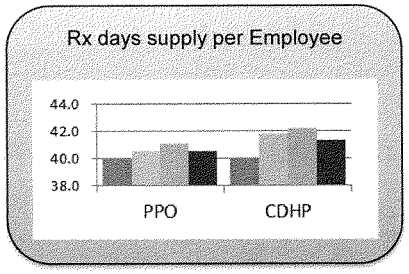
CDHP MEMBERS USED A LITTLE LESS CARE THAN PPO MEMBERS…BUT NOT BY MUCH











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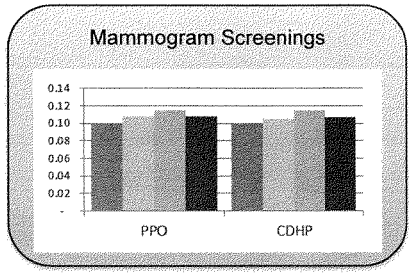
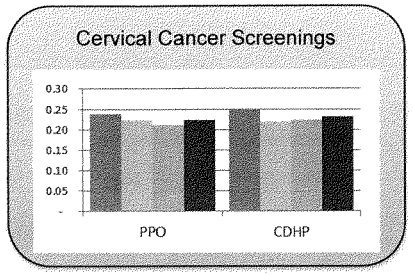
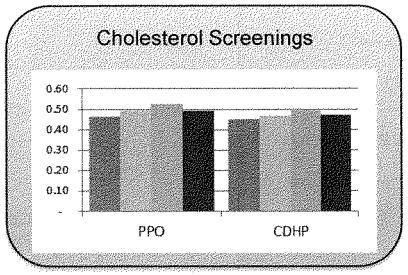
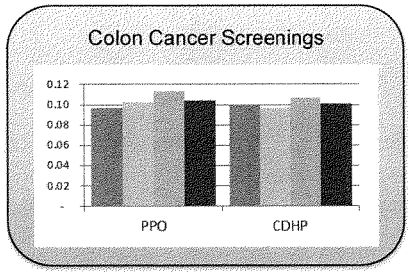
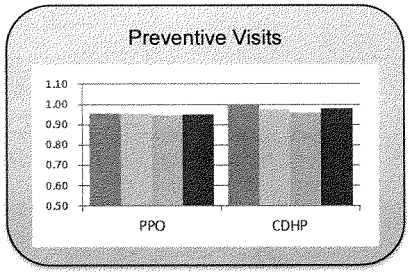
WHAT ABOUT PREVENTIVE CARE?
MEMBERS ACTED SIMILARLY IN BOTH PLANS











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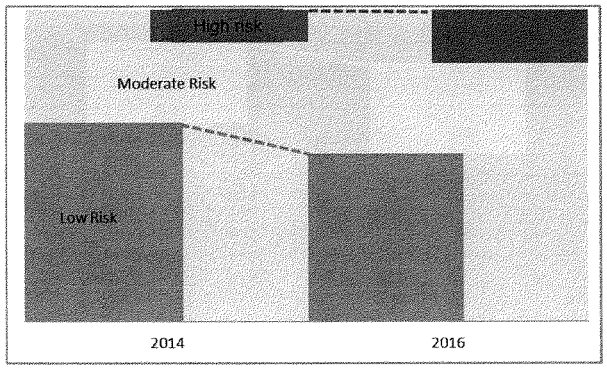
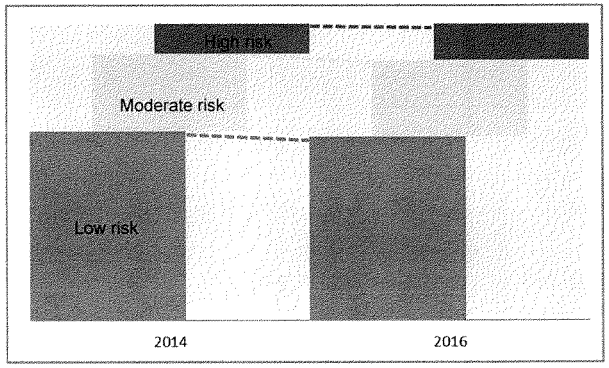
THE CDHP PLAN WAS MOST EFFECTIVE AT "KEEPING MEMBERS IN THEIR SWIM LANES"

8% of PPO members became high risk over time



CDHP members stayed healthy!



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APPENDIX: MORE ON HDHP PLANS

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HSA-ELIGIBLE CDHP ENROLLEE PROFILE, COMPARED TO PPO AND HMO ENROLLEES

Large employers (500+ employees)

	EMPLOYEES ENROLLED IN:		
	HSA-ELIGIBLE CDHP	PPO	HMO
Average age	42	44	43
% of employees electing dependent coverage	58%	56%	56%

ACCOUNT CONTRIBUTIONS, DEDUCTIBLES AND OOP MAXIMUMS

Large HSA sponsors

	% OF SPONSORS MAKING ACCOUNT CONTRIBUTION	EMPLOYER CONTRIBUTION AMOUNT* (MEDIAN)	DEDUCTIBLE (MEDIAN)	OUT-OF-POCKET MAXIMUM (MEDIAN)
In-network				
Employee-only	77%	$500	$1,750	$3,500
Family	77%	$1,000	$3,600	$7,000
Out-of-network				
Employee-only	--	--	$3,000	$6,350
Family	--	--	$6,000	$13,000

*Among employers that contribute to the account

EMPLOYEE CONTRIBUTIONS FOR HSA-ELIGIBLE COVERAGE SIGNIFICANTLY LOWER THAN FOR PPO AND HMO COVERAGE

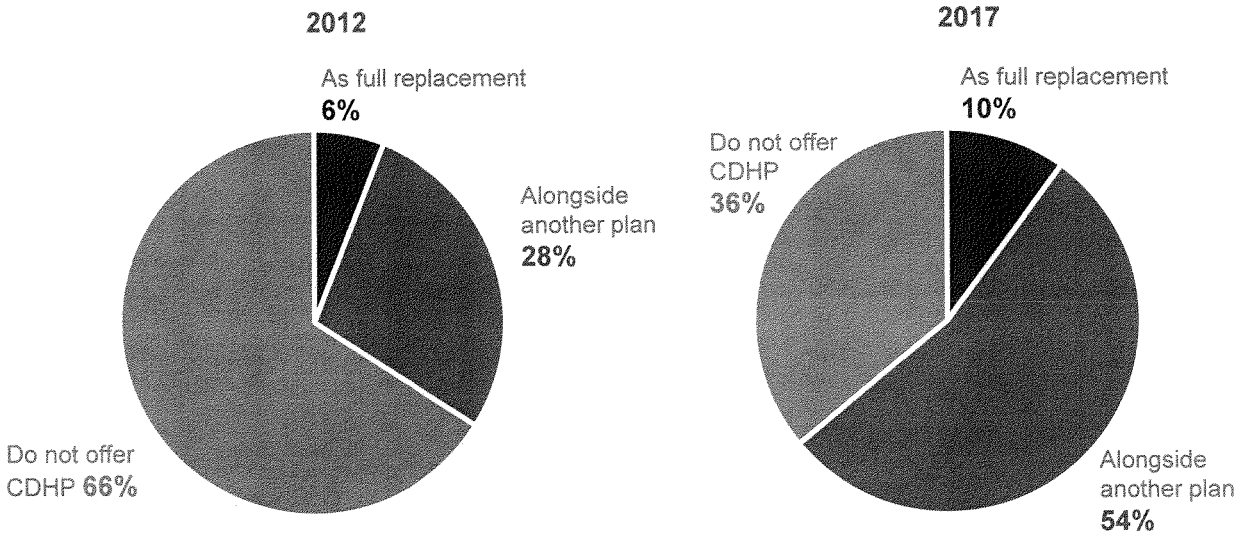
Large employers

	NO CONTRIBUTION REQUIRED	AVERAGE MONTHLY DOLLAR AMOUNT	AVERAGE CONTRIBUTION AS A % OF PREMIUM
HSA-eligible CDHP			
Employee-only	11%	$83	18%
Family	5%	$318	25%
PPO			
Employee-only	6%	$140	24%
Family	4%	$470	31%
HMO			
Employee-only	10%	$128	23%
Family	7%	$484	32%

CDHPS ARE STILL TYPICALLY OFFERED AS AN OPTION – BECAUSE MOST EMPLOYERS WANT TO PROVIDE A CHOICE

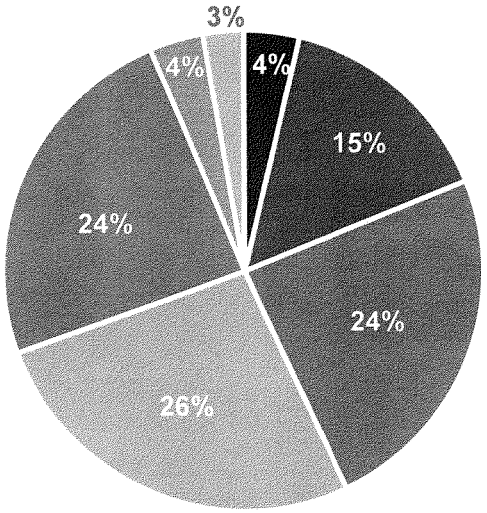
LARGE EMPLOYERS

AT THE LARGEST WORKSITE, OFFER CDHP…



WITH THE RIGHT SUPPORT, EMPLOYEES ARE MORE LIKELY TO ELECT HIGH-DEDUCTIBLE PLANS

2017 ENROLLMENT DATA FROM MERCER MARKETPLACE 365



More than half of enrollees chose a plan with a deductible of $1,850 or higher

- $0 Deductible
- $400 Deductible
- $900 Deductible
- $1,850 Deductible
- $2,850 Deductible
- $4,500 Deductible
- $6,550 Deductible

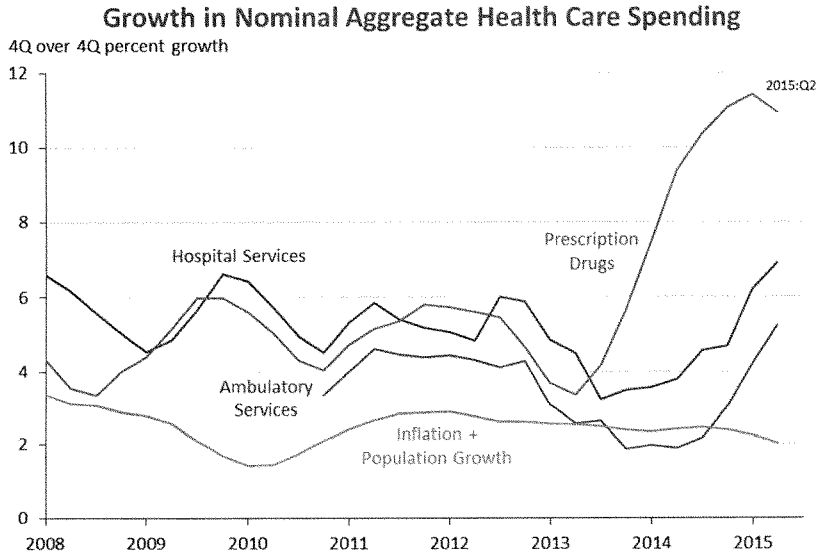
Source: 2017 Mercer Marketplace 365 Enrollment Results; Standard Deductible Options Only

A Hearing of the Joint Economic Committee of the U.S. Congress
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve"
June 7, 2018

Statement of Kavita Patel, MD, MS
Primary Care Physician, Johns Hopkins Medicine
Non Resident Fellow, The Brookings Institution

"Bending the Cost Curve: Health Savings Accounts are a Placebo for the Real Diagnosis"

Thank you Chairman Paulsen, Ranking Member Heinrich and other esteemed committee members for inviting me to speak on the important topic of health care. I am here today as health policy scholar and a practicing primary care physician in Washington D.C. I care for over a thousand patients and it is their stories that have inspired this testimony as well as my basic message to please consider that while health care may seem complicated, the fundamental "North Star" for any economic policy or legislative effort should be the following: "What more can we do to make care better and less expensive for all Americans?" Answering this question will help to guide efforts when there seem to be many distractions. The topic of today's hearing is Health Savings Accounts and while there are certainly opportunities to improve the current program which are highlighted below, it is also important to have a broad overview for why programs such as Health Savings Accounts, Flexible Spending Accounts and High Deductible Health Plans exist in the first place- that is aggregate cost growth in key health sectors above the rate of inflation and population growth as illustrated by the chart below:



Source: Census Bureau, Quarterly Services Survey (hospital services & ambulatory services); Bureau of Economic Analysis National Income and Product Accounts (prescription drugs, population, GDP price index).

Growth in the 3 sectors identified above in descending order (prescription drugs, hospital services, and ambulatory services) can also be summarized as a problem around cost (distinct from price which often doesn't reflect what a patient pays) and resource utilization. Cost and resource utilization vary wildly depending on where you live in the country; below are publicly available costs for the same

procedure on similar patients in the state of Maryland. These costs differ significantly yet patients will still receive care in the higher cost setting, illustrating that health care defies traditional notions that patient engagement or transparency alone can have a significant impact as well as the notion that policy interventions should aim to curb costs and resource utilization. In many cases, despite publicly available information as well as robust employer- based programs, patients are still left with very little demand side economics when there is such great variation in cost and in many cases, patients are often subject to the hospital relationships of individual providers. Additionally, there is very little transparency or ability to calculate costs associated with complications which can lead to tremendous costs.

Actual Costs for Hip Replacement on the Same Patient, Same Procedure, in Different Hospitals

Cost Type	Amount
Inpatient	$34,840
Outpatient	$60
Professional Services	$5,531
Prescription Cost	$799
Potentially Avoidable Complications	$801
Total	**$42,030**

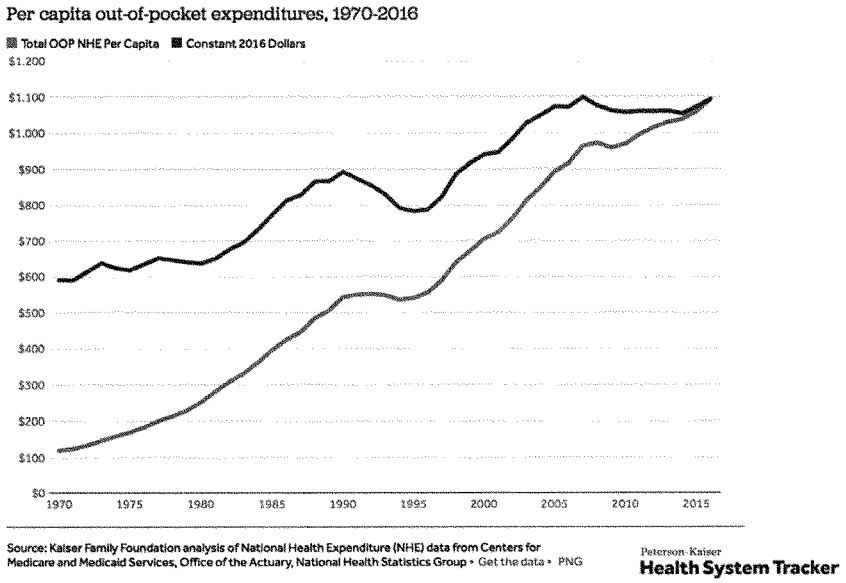
Cost Type	Amount
Inpatient	$19,347
Outpatient	$80
Professional Services	$4,092
Prescription Cost	$718
Potentially Avoidable Complications	$373
Total	**$24,611**

Source: Wearethecost.org

Costs of Care: Additional Drivers

Drivers of cost, in addition to hospital costs illustrated above, include services provided by providers in offices as well as other goods, such as prescription drugs. Office- based services can differ by site of service with Hospital-Based outpatient facilities generally more expensive than those that are independent or freestanding. Prescription drugs, particularly drugs which have few alternatives or represent a breakthrough treatment (such as Hepatitis C, Non-Small Cell Lung Cancer treatment, etc) can often be priced quite high with little ability for market competition or savings opportunities. Opacity around rebates etc, make consumer power even more challenging. Out of pocket costs are also going up in medicine as illustrated in the figure below. Interestingly, out of pocket costs for services can generally be divided into 2 main categories: high and low value services. High value services are things that have a great degree of evidence to support their use- diagnosis and treatment of depression, follow up care from a hospital visit and visits to care for diabetes. Low value services are those which have very poor evidence- consider imaging in back pain, knee arthroscopy for knee pain, opioids for treatment of chronic pain or antibiotics for the common cold. Yet the copayments for all these services (copayments which would be covered by a HSA) are all equal. Certainly as out of pocket costs increase, patients tend to look for

ways to decrease their financial burden (HSAs, etc) but the RAND Health Insurance experiment found that increased costs can also deter patients from seeking important services; this was a finding that has been reinforced in many other class health services research studies, agnostic of payer or patient characteristics.[i]



Resource Utilization: The Care We Receive

In terms of resource utilization, look no further, than the fact that our utilization of services in health care is not evenly distributed; according to the Agency for Health Care Research and Quality[ii] 5% of the population accounts for 50% of overall healthcare spending, with an annual mean expenditure of $43,058. In contrast the lower 50% had an annual mean of $8,384 accounting for only 2.8% of total costs. These patients can see 13 different doctors, fill over 50 different prescriptions in a year and are 8 times more likely to be admitted to the hospital. A health savings account, no matter how large, will do very little to change this trajectory. Yet given how much this small number consumes the time and resources of a large system, it should be a high priority for Medicare and other payers to target programs which can address the disproportionate needs of this population. Targeted approaches which have been proven to be effective in these higher risk populations include:

- Team based care- still a difficult concept in current siloed, Fee for Service (FFS) care
- Targeted care coordination programs with patient based navigators
- Telehealth and remote monitoring services
- Aggressive primary care
- Addressing patients' behavioral health and social determinants needs
- Early introduction of palliative care

There are additional factors that lead to increased resource utilization including provider practice patterns, cost sharing or cost shifting to patients (also reinforced by the RAND Health Insurance Experiment) as well as complex provider networks that often leave patients with out of network charges that were unknown to the patient.

Improvements to Current HSAs

In addition to Health Savings Accounts, a growing number consumers are in High-deductible health plans that are also paired with a tax-free health savings account (HSA-HDHP), which represent a growing percentage of plans offered on the individual and group market. HDHPs have defined minimum deductibles and maximum out-of-pocket limits[iii]. As of 2016, 20.2 million Americans were enrolled in such plans, which represents a 16% increase from 2014.[iv] Employers, in particular, are increasingly offering HSA-eligible HDHPs as a way to expand coverage options, lower their health care spending, and promote proactive consumer engagement.

Guided by the Internal Revenue Service (IRS) safe harbor under section 223(c)(2)(C), HSA-eligible HDHPs may provide select preventive care benefits prior to satisfaction of the plan deductible.[v] Primary prevention, while important, is a small component of overall health spending. By contrast, spending on chronic disease encompasses a substantial majority of total U.S. health care expenditures. Under this guidance, until the deductible is met, coverage does not include "any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications." Thus, HSA-HDHP enrollees with existing conditions are required to pay out-of-pocket for necessary services prior to meeting the plan deductible, resulting in lower utilization of care, and potentially resulting in poorer health outcomes and higher costs. The University of Michigan Center on Value- Based Insurance Design (VBID) led by Dr. Mark Fendrick has been an important voice in highlighting high and low services, particularly with respect to health savings accounts and opportunities to promote better care for all Americans.

High deductible plans should adopt a more flexible benefit design offering more protection for certain medical services through a value-based insurance design plan structure. A targeted strategy exploring coverage for certain high-value, clinically-indicated health services prior to meeting the deductible will produce more value than current plans.

Expanding the IRS "safe harbor" would increase the attractiveness and clinical effectiveness of HSA-HDHPs and would better align consumer engagement with provider payment reform initiatives. Given how entrenched HDHPs are in the American healthcare landscape, the current policy that imposes high deductibles on all chronic disease services – independent of clinical value – to control spending has imparted a clinical and economic toll on Americans with chronic medical conditions. It is critical that regulations that prevent health plans from innovating be amended, such that plan designs that better meet the clinical and financial needs of millions of Americans may be made available. Policies which allow HDHPs the flexibility to provide pre-deductible coverage of high value services that treat chronic diseases is at a minimum, a necessity to move forward with any discussion of benefits of pre-tax dollar savings accounts. Recent research reported demonstrate that generous enhancements in HDHP prescription drug coverage for several chronic conditions would lower consumer out of pocket costs and result in only modes impact on premiums (<2%) or deductibles. Expanding the IRS "safe harbor" to permit coverage of high value prescription drugs prior to meeting the plan's deductible would increase the clinical effectiveness of HSA-HDHPs.

Conclusion

Healthcare spending consumes one in every six dollars of the American economy. If the goal to decreased spending is universal and nonpartisan, a critical look at the drivers of cost must be paired with policy prescriptions that can meaningfully tackle these factors. Below is a simplified table that illustrates the drivers discussed along with key policy solutions which can optimize engagement from patients and providers.

Factors Affecting Cost	Policy Intervention	Relevance of HSAs
Provider market power	Effective payment incentives such as partial capitation or global payment models	Low
Health Plan market power	Aggressive rate review and incentives for new entrants in markets with limited competition	Low
Prescription drugs	Price negotiation and regulation of yearly increases	**possible particularly if changes can be made to include costs prior to meeting deductible
Site of Service	Site neutrality in payments	**possible depending on how HSAs engage consumers

Factors Affecting Utilization	Policy Intervention	Relevance of HSAs

Health Risk Factors/Status	Robust risk adjustment, Payment reforms	Low particularly if HSAs can't cover high value services
Provider practice patterns	Payment reforms which migrate volume to value; Data Sharing and regulatory reforms that promote flexibility	Low
Patient Cost Sharing	Eliminate cost sharing for high value clinical services	**possible depending on degree of health literacy as well change to current statute
Provider Network Development	Prohibit balance billing	Low- in fact many HSAs may shift costs to consumers

In conclusion, it is important to keep in mind that while Health Savings Accounts certainly have merits, there are much larger cost drivers in health care that must be dealt with; our country, as reflected in the recent Medicare Trustees Report, simply does not have the luxury of spending more for worse care. Thank you for this opportunity to share insights from practice and policy.

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April 18, 2018

Hon. Erik Paulsen
Chairman
Joint Economic Committee
G-01 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Paulsen,

I am writing to request a hearing of the U.S. Congress Joint Economic Committee to investigate anti-competitive practices in the prescription drug market. There is evidence that anti-competitive behavior substantially drives up prices and that it may cost Americans billions of dollars a year.

A recent lawsuit by the Attorneys General of 45 states and the U.S. Department of Justice alleges price-fixing by 18 generic drug manufacturers[1]. It asserts that those companies systematically colluded to drive up prices and profits by forming agreements to divvy up markets and set prices. The plaintiffs name 15 generic drugs, including those for high blood pressure, diabetes, liver disease, epilepsy, asthma, glaucoma, fungal infection and other diseases. According to the complaint, "these agreements had the effect of artificially maintaining high prices for a large number of generic drugs and creating an atmosphere of competition when in fact no existed."[2]

In theory, generic drugs should increase competition and reduce prices. However, an investigation by House Oversight and Government Reform Committee Ranking Member Elijah Cummings and Senator Bernie Sanders found that between July 2014 and December 2014, the prices for certain generic drugs rose dramatically, in some cases by more than 1,000 percent.[3] The details of the recent lawsuit suggest that collusive behavior in the generic drug industry may be taking place on a massive scale.

According to the Organisation for Economic Cooperation and Development (OECD), the United States pays more than $1,000 per person on prescription drugs, which is the highest per-capita cost in the world.[4] In 2016, Americans spent $341 billion in prescription drugs overall and more than $75 billion on generic prescription drugs alone.[5] Generic drugs make up almost 90 percent of the total number of prescriptions dispensed on an annual basis.[6]

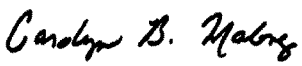
There is evidence that there also are anti-competitive aspects to the market for brand name prescription drugs. One tactic used by manufacturers of brand name drugs is to pay a potential generic competitor to delay introduction of a generic equivalent – "pay for delay" – effectively extending the length of the patent and maintaining high prices.[7] Researchers have found that the prices of competing brand drugs produced by different companies often also rise in lockstep. Ranking Member Cummings, Congressman Peter Welch, and Senator Sanders have raised concerns about this phenomenon in the multiple sclerosis and diabetes drug markets.[8]

The high cost of prescription drugs should be a high-priority, nonpartisan issue. A March 2018 poll by the Kaiser Family Foundation found that 80 percent of Americans think that prescription drug prices are "unreasonable."[9] The same survey also found that 83 percent say that Republicans "are not doing enough" on the issue and that 82 percent say the same about Democrats.

The U.S. Congress Joint Economic Committee can play a role in helping to shed light on the economic impact of anti-competitive behavior in the market for brand name and generic prescription drugs. Moreover, it can take advantage of a broader opportunity to study other anti-competitive aspects of our economy, which stifle innovation and increase costs on consumers. When "free markets" aren't truly free, Americans pay the price.

Thank you for your consideration of my request.

Sincerely,



CAROLYN B. MALONEY
Senior House Democrat, Joint Economic Committee

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Joint Economic Committee Hearing
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve" June 7, 2018
Questions for the Record for Dr. Atlas
Senator Ben Sasse
June 21, 2018

1. Using health care savings accounts to increase competition and drive down prices can only happen in coordination with more transparency in pricing. In your view, what role should the federal government play in enhancing this transparency?
    a. Have you seen any evidence of expanding price transparency so far?

2. In your view, what is not considered a qualified medical expense but should be?
    a. What would be the impact of allowing funds in health care savings accounts to be used for premium payments?

3. If the financial trade off were between keeping annual contribution limits at their current level but expanding HSA eligibility to all plans regardless of deductible status versus keeping the current tie to high deductible plans but increasing annual contribution limits, which would you favor and why?

4. As the health care industry increasingly moves towards value-based care and away from a fee-for-service model, how should HSAs adapt accordingly?
    a. How should qualified medical expenses be adjusted to account for the fact that medical care is less likely to be a fixed fee?

5. Is it possible to see the large-scale expansion of HSAs necessary to enhance competition and drive down costs if insurance continues to be largely employer-sponsored and if HSAs are unavailable for most Americans with high-deductible plans?
    a. What needs to change to drive up participation?

6. As more Americans move away from traditional health insurance and into alternative models like direct primary care and health sharing ministries, how can health care savings accounts adapt?
    a. In your view, should HSAs be used for these expenses?

7. What does the data indicate about the average consumer of these plans and the trends in age, health history, and income level?
    a. Where are their gaps in the data?
    b. Is risk segmentation decreasing as a result of HSA expansion?
    c. Are private employers offering high deductible health plans at higher rates?

Joint Economic Committee Hearing; June 7, 2018
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve"
Answers for the Record by Dr. Scott W. Atlas to Questions by Senator Ben Sasse; June 21, 2018

1) Price transparency is absolutely essential for value-seeking consumers to force competition among sellers, in this case the health care providers, which translates into lower prices and better value.

A growing number of tools are definitely becoming available to compare prices. Several states have put forth laws to require price transparency in health care[1], and insurers, employers, and even providers increasingly offer price transparency tools[2]. Some physician specialties have recognized the need themselves; for example, several web-based resources have been developed to improve price transparency in oncology[3]. According to the Health Care Incentives Institute, "a very strong and thorough body of research demonstrates that consumers will seek lower-priced, high-quality providers when given the right information in the right format"[1]. However, results are mixed. Reasons behind the inconsistent or less-than-dramatic cost reductions include the low percentage of patients who use these tools (partly due to complexity of presentation), and two more fundamental problems: 1) price transparency from the perspective of providers or policy makers does not necessarily lead to transparency in the type of "price" most relevant to patients—the out-of-pocket costs; and 2) insurance structuring reduces motivation to care about price. It seems unlikely that more federal laws will simplify price information or clearly sort out out-of-pocket prices from overall price. Regardless, given the current predominant insurance that minimizes out-of-pocket payment, mandated price visibility without other reforms would not be very effective, because third party payers would have different, opaque arrangements with providers. This is particularly true in prescription drugs, where the extraordinary lack of price transparency is fueled by complex behind-the-scenes rebates (totaling $179 billion in 2016)[4] from companies to pharmacy benefit managers (PBM), the government, and insurers that pervert incentives and prevent any possible price consideration by patients. Worse, many PBMs contractually prohibit pharmacists from volunteering that a medication may be less expensive if purchased at the cash price with contractual gag clauses, according to a 2016 survey of over 600 community pharmacies[5]. Of course, these anti-consumer agreements should be outlawed.

We may not need specific legislation to force price transparency. Indeed, no other good or service requires such governmental legislation. Uniquely in health care, government regulations themselves have undermined price visibility, by pushing people toward insurance that minimizes out-of-pocket payments so that patients perceive "someone else is paying". Along with misguided tax incentives, regulations have prevented consumers from caring much about medical care prices, consequently

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[4] Source: Credit Suisse research, Global Pharma and Biotech, April 18, 2017
[5] NCPA Pharmacists Survey: Prescription Drug Costs Skewed by Fees on Pharmacies, Patients; June 28, 2016

shielding care providers from competing on price. The key is to equip patients with the incentives to consider price and the vehicles to gain from doing so.

Note that most health care involves smaller, non-catastrophic expenses, so widespread and reformed HSAs, when paired with high deductible plans, would pay for the bulk of all medical care events. That means provider prices would immediately become demanded for most medical care, and those prices would naturally align with what consumers value, rather than being set artificially or generated via obscure, complex third-party payer arrangements. *Ultimately, the most compelling motivation for doctors and hospitals to post prices and signals of quality would be their understanding that they are suddenly competing for price-conscious patients who control the money.*

Perhaps the most important point is this - *price transparency is essential, but it is not sufficient.* First, patients must directly gain from paying less. That direct personal gain is generated through larger, liberalized, and transferable HSAs that significantly reward saving with assets that stay with the patient and family. Second, patients must pay directly for more of their own care. If I only pay $1.50 per month out-of-pocket for my cholesterol drug (because the cost is nearly totally covered by insurance), why would I care if prices varied by 20-fold, as shown in a December, 2017 Consumer Reports study[6]? To position patients as direct payers for a higher proportion of their medical care, higher deductible insurance plans (HDHPs) must become available to everyone, rather than limited, and must be permitted to include fewer coverage mandates to make them cheaper. Although not necessarily appropriate for everyone, when given the opportunity, patients increasingly opt for lower cost, higher deductible insurance[7], and these plans put patients directly position to pay for care. *Again, direct payment by patients with strong personal incentives to seek value is the most powerful lever to reducing costs of care.*

2) The list of a "qualified medical expense" (i.e. an expense allowable for tax-free payment from an HSA) should be expanded to include, for instance, over-the-counter drugs without need for doctor's prescription, and home health care devices. But far more importantly, eligible expenses of expanded HSAs should also include payments for the HSA holder's elderly parents. This is especially important, given today's ban on full HSA participation by all seniors on Medicare (this, too, should be abolished immediately – see my submitted written testimony for details and chart of new HSA structure). Given that seniors are the biggest users of health care, motivating them (or those who pay for their expenses) to seek value is a crucial part of exerting downward pressure on health care prices.

HSAs should not be usable for health insurance premiums. It would be counterproductive to allow any tax preference, whether a deduction, an income exclusion, or an HSA expense, for "comprehensive" insurance, because low deductible, heavily mandated plans hide the costs of covered care—that coverage is a fundamental cause of lack of access and rising costs for everyone. Presuming that health care deductions or income exclusions are maintained, I propose that the tax code should cap total amounts, and it should also limit eligibility for deductions or exclusions to only two categories of health-related expenses: 1) HSA contributions, and 2) high deductible, catastrophic coverage premiums (*note*:

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[6] Shop Around for Lower Drug Prices, LL Gill, Consumer Reports, April 05, 2018
[7] EHB Annual Surveys, Kaiser Family Foundation

the definition of "high deductible, catastrophic coverage" is based on 75 percent of the new maximum allowable HSA contribution. If people want to buy insurance that minimizes out-of-pocket payment, that's fine, but it should not be incentivized and subsidized by other taxpayers.

3) There should not be any "financial trade-off" between keeping annual contribution limits at their current level but expanding HSA eligibility to all plans regardless of deductible status versus keeping the current tie to high deductible plans but increasing annual contribution limits. The idea of the hypothetical "trade-off" presumably rests in the anticipated revenue decrease from expanding HSA size. However, as mentioned in my testimony, revenues would actually increase or stay the same on net because of the new tax cap on income exclusion for employer health benefits. Remember, the unlimited income exclusion for health expenses created harmful, counterproductive incentives. It encouraged higher demand for care, regardless of cost, while distorting insurance into covering almost all services. Tax deductions for all health care spending are also counterproductive, because they give an incentive to spend more money on health care. This tax reform to cap amounts, and to limit eligibility for deductions or exclusions to HSA contributions and catastrophic coverage premiums would eliminate that misincentive.

The second point is that expanding HSA eligibility to all plans regardless of deductible status and increasing annual contribution limits are both important to maximize downward pressure on prices of medical care and secondarily on insurance premiums – even for those without HSAs. The more people are positioned to pay directly for more of their care, the more downward pressure on prices will occur through providers competing for cost-conscious patients. Patients must also see the reward for saving their money and seeking value, and that is through reformed, larger, transferable, and more useful HSAs. Today's counterproductive limitations and insurance regulations, however, have dramatically limited the potential benefits of HSAs to everyone who uses medical care. Remember, today's high price of medical care and the regulatory burden of ObamaCare forcing the purchase of expensive insurance filled with mandates has left the consumer with far less money for funding HSAs. Meanwhile, ObamaCare subsidies for insurance that minimizes out-of-pocket payment have prevented consumers from caring much about medical care prices and have consequently shielded doctors from competing on price. Unpressured prices on medical care plus ObamaCare's regulatory burden equals markedly higher insurance premiums (doubled from 2013 to 2017, even with significantly higher deductibles, per eHealth) – and *that means less money for HSA contributions*.

4) The health care industry may or may not move to different models of payment for care. Much of that depends on whether or not more people are empowered to pay directly for their own care via reformed HSAs, or alternatively if patients are shielded even more from decision-making and direct payment. Regardless of those changes to come, qualified medical expenses should first and foremost be broad, for two reasons: 1) so that patients find HSAs highly valuable, and 2) so as much of medical care as possible is purchased via HSAs. That is the way to maximize their impact on prices and ultimately on better access to quality care for everyone, including those without HSAs.

5) Employer-sponsorship of health benefits and insurance is perhaps the best working model of US health insurance, and as more companies compete for employees, benefits will undoubtedly become

even better – that's not the problem. The fact is that employers are *increasingly* offering HSAs and higher deductible coverage as options for their employees (see figures in my written testimony), despite the fact that that premiums for HDHPs rose from two to five times faster than premium increases of any other type of coverage after ACA passage (see figure in my written testimony).
To drive up HSA participation and maximize its use, Congress should first eliminate regulations that limit HSAs and high deductible, low premium coverage. Excess mandated coverage that made HDHP insurance more expensive should be rolled back, including the ACA's "essential benefits" that increased premiums by 10 percent[8] and the 2,270 state coverage mandates for everything from acupuncture to marriage therapy. To make HDHPs even more affordable, we should remove the ACA's 3:1 age rating that raised premiums for younger enrollees by 19 percent to 35 percent,[9] many of whom would buy lower premium coverage.

Second, patients must see the reward for saving their money and seeking value, and that is through reformed, larger, transferable, and more useful HSAs. Congress should make HSAs more valued by consumers – this is critical - by liberalizing their uses, expanding their availability, and incentivizing their importance via tax reforms, *as follows*:

Congress should make HSAs available to all Americans, perhaps even automatically opened for every citizen with a social security number or at birth. All HSAs should be fully owned by individuals, not tied to specific employers. To maximize consumer leverage on prices, the current ban on full HSA participation by all seniors on Medicare should be abolished. Given that seniors are the biggest users of health care, motivating them to seek value is a crucial part of exerting downward pressure on health care prices.

HSA limits should be expanded by liberalizing maximum allowable contributions (and catch-up contributions for persons in their 50s) to, for example, equal those of total annual out-of-pocket limits for ACA Marketplace plans (for 2018, $7,350 for individuals and $14,700 for families). Restrictions on HSA uses should be eased, most importantly for the expenses of the HSA holder's elderly parents. And the list of allowable health care services and products that can be purchased with HSA funds should be expanded to include, for instance, over-the-counter drugs without need for doctor's prescription, and home health care devices.

HSAs should never expire or be forfeited due to an arbitrary "use it or lose it" deadline. On the death of the owner, HSAs are currently deemed taxable unless the beneficiary is the spouse. This should change, so that tax-sheltered rollovers would be allowed to all surviving family members, not just spouses.

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[8] EF Haislmaier and D Gonshorowski, "Responding to *King v. Burwell*: Congress's First Step Should Be to Remove Costly Mandates Driving Up Premiums" (Heritage Foundation Issue Brief 4400, May 2015), http://www.heritage.org/research/reports/2015/05/responding-to-king-v-burwell-congresss-first-step-should-be-to-remove-costly-mandates-driving-up-premiums.

[9] JT O'Connor, "Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014," *Milliman Reports*, April 25, 2013, http://ahip.org/MillimanReportACA2013/.

HSAs should be de-linked from specific insurance deductible requirements (i.e., in defining "HSA-qualified plans"). The requirement of government-specified deductibles in order to open an HSA is counterproductive. It also eliminates the possibility of HSAs with other, more tailored plans that could cover necessary care subject to a lower deductible, especially for chronically ill people. Congress should modify the insurance exchange regulations to allow everyone, regardless of age or employer, the option of high deductible plans with the same liberalized rules on HSAs. The only requirement for making tax-free contributions to the reformed HSA should be that the enrollee at least has active catastrophic insurance coverage, without any specified deductible.

The ACA limits the financial incentives from employers, including cash deposits into employee HSAs, to 30 percent of the cost of that employee's health coverage. Abolishing that limit would expand these powerful motivators for employees, encouraging employees to participate in more wellness programs already proven to improve health and reduce health costs.

HSAs could also transform Medicaid into a bridge program geared toward enrolling beneficiaries into affordable private insurance, with equal access to doctors, specialists, treatments, and medical technology as the general population, instead of shunting poor Americans into a parallel second-class system with worse health outcomes and far less access to care. A reformed Medicaid would establish and seed fund HSAs and provide an option for limited-mandate, high deductible private insurance with currently budgeted federal dollars. Federal funding could be contingent on states meeting certain enrollment thresholds into limited-mandate coverage and HSAs. HSAs would provide new incentives for lower-income families to seek good health through wellness programs and healthy behavior in order to save and protect their new, growing financial assets.

Specific tax reforms are also part of incentivizing HSA adoption (*see my written testimony for complete details*).

Finally, the supply of medical care must be significantly yet strategically increased, so patients have enough competing choices to seek out the best value for their money. In large part, this means removing archaic anti-consumer barriers to competition among medical care providers, health care technology, and drugs (*see my written testimony for complete details*).

6) HSAs should absolutely be usable for direct primary care payment and other innovative health care payment strategies and coverage. The fundamental goal is to maximize HSA adoption and fully leverage their power. Widespread adoption of HSAs and more value-seeking by patients is the best pathway to broaden access to affordable, high quality health care for all Americans, even those without HSAs.

7) (These questions are more fully answered in the written testimonies; see figures there)

Despite the ACA's attempt to shift consumers to bloated coverage, a shift toward high deductible plans with HSAs has continued. In the decade-and-a-half since the tracking of this type of coverage, employers have increasingly offered such plans, and consumers have increasingly selected high-deductible plans.

Among those enrollees, a shift toward higher deductibles has continued.[10] Since the introduction of HSAs in 2004, HSAs have skyrocketed to between 22 and 34 million as of the end of 2017[11]. Note that this is not a tax benefit for "the rich" - median household income for HSA holders is $57,060; two-thirds earn less than $75,000 a year[12]. By increasingly choosing HSAs when given the opportunity, American consumers are approving their value.

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[10] Kaiser Family Foundation, "Employee Health Benefits Annual Surveys, 2007–2014," http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

[11] http://www.devenir.com/research/2017-year-end-devenir-hsa-research-report/, and https://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3547

[12] Testimony Before the Subcommittee on Health of the Ways and Means Committee of the House of Representatives Hearing on Lowering Costs and Expanding Access to Health Care Consumer-Directed Health Plans Submitted by Jody L. Dietel, ACFCI, CAS Chief Compliance Officer for WageWorks, Inc. June 6, 2018

Joint Economic Committee Hearing
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve" June 7, 2018
Questions for the Record for Dr. Atlas
Submitted by Representative Carolyn B. Maloney
June 21, 2018

1) In general, do HSAs mitigate differences in health outcomes for individuals across income strata? In what ways do they succeed or fail?

2) The current limit on HSA contributions is $3,450 for an individual and $6,900 per family. What percentage of HSA contributors max out?

3) One recent bill doubles the amount that can be contributed to an HSA. Given that a small percentage of taxpayers reach the current maximum contribution, what is the rationale for doubling the amount that can be contributed to an HSA? Who would benefit?

Joint Economic Committee Hearing; June 7, 2018
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve"
Answers for the Record by Dr. Scott W. Atlas to Questions by Representative Carolyn B. Maloney; June 21, 2018

1) HSAs improve access to affordable, quality health care for people at all levels of income, but particularly represent the most effective pathway to quality health care for the middle class and poor.

First, the fundamental impact of HSAs is to reduce the prices of health care for everyone, rich or poor, and whether or not they have an HSA. With larger and improved HSAs, patients become sensitive to price because they are rewarded by saving money. Doctors and hospitals would compete for patients who would now pay directly for care and would be newly sensitive to price and value. When people have savings to protect in HSAs, the cost of care comes down[1] without harmful impact on health, like increases in emergency room visits or hospitalizations, and without any greater impact on economically vulnerable families[2]. That reduced price makes care more available for *everyone*, including people without HSAs and including the poor. Moreover, costs of all insurance would be significantly less, including government insurance programs like Medicaid and Medicare. Note that 60 percent of Medicaid money is spent for outpatient care[3], and outpatient non-emergency care is amenable to patient choice. This broadens options and access to care for *everyone* – including people without HSAs, and regardless of source of payment.

Second, HSA reform necessarily goes hand-in-hand with eliminating anti-consumer regulations that limit competition among doctors and hospitals – this is essential to give empowered patients choices for spending their HSA money. *Of particular importance to lower income groups* is increasing the available supply of cheaper and more convenient neighborhood primary care. We know that neighborhood retail clinics staffed by nurse practitioners and physician assistants can provide high quality but cheaper primary care, including vaccinations, blood pressure monitoring, infection treatment, and dispensing common drugs. In a 2011 review, 88% of visits to retail clinics involved simple care[4], 30–40% cheaper than at physician offices[5] and about 80% cheaper than at emergency departments, and with high levels of quality and patient satisfaction[6]. To maximize this, Congress should push to simplify the credentialing requirements and remove outmoded scope-of-practice limits on qualified nurse practitioners and physician assistants.

Third, HSAs represent one of the best vehicles for offering effective wellness programs and screening tests. This is highly beneficial to working class people, because these programs improve chronic illnesses

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[1] AM Haviland et al; Do "Consumer-Directed" Health Plans Bend the Cost Curve Over Time?;, NBER Working Paper No. 21031, March 2015; http://www.nber.org/papers/w21031
[2] Haviland, A., N. Sood, R. McDevitt, and S.M. Marquis 2011. "How Do Consumer Directed Health Plans Affect Vulnerable Populations." Forum for Health Economics & Policy. 2011;14(2) (Online): 1558-9544
[3] D Pritchard, A Petrilla, S Hallinan, DH Taylor Jr., VF Schabert, and RW Dubois; What Contributes Most to High Health Care Costs? Health Care Spending in High Resource Patients.; *Journal of Managed Care & Specialty Pharmacy* 2016 22:102-109
[4] Ashwood JS, Reid RO, Setodji CM, Weber E, Gaynor M, Mehrotra A. Trends in Retail Clinic Use Among The Commercially Insured. *The American journal of managed care*. 2011;17(11):e443-e448.
[5] Mehrotra A, Liu H, Adams J, et al. The Costs and Quality of Care for Three Common Illnesses at Retail Clinics as Compared to Other Medical Settings. *Annals of internal medicine*. 2009;151(5):321-328.
[6] Weinick, Robin M., Craig Pollack, Michael P. Fisher, Emily M. Gillen, and Ateev Mehrotra, Policy Implications of the Use of Retail Clinics. Santa Monica, CA: RAND Corporation, 2010. https://www.rand.org/pubs/technical_reports/TR810.html.

and save money[7] for both the employee and the employer[8]. Yet ObamaCare limits financial incentives from employers, like deposits into employee HSAs. Congress should abolish this rule.

Fourth, we know the harsh reality of today's Medicaid, the current program for the poor that ObamaCare expanded at great cost: 55 percent of doctors in major metropolitan areas already refuse new Medicaid patients[9]. Even of those providers signed up with Medicaid, 56 percent of primary care doctors and 43 percent of specialists are not available to new patients, according to HHS[10]. Moreover, the quality of medical care is inferior under Medicaid, according to peer-reviewed medical journals. Lower quality means more in-hospital deaths, more complications from surgery, shorter survival after treatment, and longer hospital stays than similar patients with private insurance[11]. Instead, with HSAs, Medicaid could be a bridge toward affordable private insurance to eliminate today's substandard, parallel health care system for the poor. New Medicaid should establish and seed-fund HSAs with current federal dollars, empowering beneficiaries and incentivizing healthy lifestyles to protect those new assets. With these reforms, doctors and hospitals would receive payments from the same insurance as from non-Medicaid patients; the limits in access and treatment options would be eliminated.

2) The number of accounts has skyrocketed to between 22 and 35 million[12] since HSA introduction in 2004. For both individual and employer contributions, contribution levels have been increasing. Individual contributions in 2016 were higher the longer the holder had the account; for those holding an account since 2005, the 2016 contribution averaged $3,658, while for those opening new accounts in 2016, the contribution averaged $1,290[13]. Today's counterproductive limitations and insurance regulations, however, have dramatically limited the potential benefits of HSAs to everyone who uses medical care. Remember, today's high price of medical care and the regulatory burden of ObamaCare forcing the purchase of expensive insurance filled with mandates has left the consumer with far less money for funding HSAs. Meanwhile, ObamaCare subsidies for insurance that minimizes out-of-pocket payment have prevented consumers from caring much about medical care prices and have consequently shielded doctors from competing on price. Unpressured prices on medical care plus ObamaCare's regulatory burden equals markedly higher insurance premiums (doubled from 2013 to 2017, even with significantly higher deductibles, per eHealth) – and *that means less money for HSA contributions.*

3) The rationale for doubling the current maximum contribution to HSAs is quite clear. Widespread HSAs, when paired with cheaper high deductible plans, could pay for the bulk of all medical care events,

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[7] K. Baicker et al., "Workplace Wellness Programs Can Generate Savings," *Health Affairs* 29 (2010): 304–11.
[8] L. L. Berry et al., "What's the Hard Return on Employee Wellness Programs?" *Harvard Business Review*, December 2010, https://hbr.org/2010/12/whats-the-hard-return-on-employee-wellness-programs.
[9] Merritt Hawkins, "Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates, 2014 Annual Survey," http://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Surveys/mha2014waitsurvPDF.pdf.
[10] Department of Health and Human Services, "Access to Care: Provider Availability in Medicaid Managed Care," Report OEI-02-13-00670 (December 2014), http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.
[11] See, for example, Michael A. Gaglia, "Effect of Insurance Type on Adverse Cardiac Events after Percutaneous Coronary Intervention," *American Journal of Cardiology* 107 (2011): 675–80; D. J. LaPar et al., "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery* 252 (2010): 544–51; J. Kwok et al., "The Impact of Health Insurance Status on the Survival of Patients with Head and Neck Cancer," *Cancer* 116 (2010): 476–85; R. R. Kelz et al., "Morbidity and Mortality of Colorectal Carcinoma Differs by Insurance Status," *Cancer* 101 (2004): 2187–94; J. G. Allen et al., "Insurance Status Is an Independent Predictor of Long-Term Survival after Lung Transplantation in the United States," *Journal of Heart and Lung Transplantation* 30 (2011): 45–53.
[12] http://www.devenir.com/research/2017-year-end-devenir-hsa-research-report/, and https://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3547
[13] https://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3468

since most health care involves smaller, non-catastrophic expenses. The more people are positioned to pay directly for more of their care, the more downward pressure on prices will occur through providers competing for cost-conscious patients. Patients must be strongly incentivized to care about medical care prices and simultaneously equipped with the tools to do so. Patients must see the reward for saving their money and seeking value, and that is through reformed, larger, transferable, and more useful HSAs. Even in their current form with current regulatory burdens and unnecessarily high costs of ObamaCare insurance, HSAs with high deductible coverage have proven to be a highly effective instrument to reduce health care prices and help individuals buy more affordable insurance. As prices come down due to more value-seeking consumers with larger HSAs, quality health care becomes cheaper and more available to everyone, including patients without HSAs.

Joint Economic Committee Hearing

The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve

June 7, 2018

Questions for the Record for Mr. McKechnie
Senator Ben Sasse

June 26, 2018

1. Using health care savings accounts to increase competition and drive down prices can only happen in coordination with more transparency in pricing. In your view, what role should the federal government play in enhancing this transparency?

   KM Answer: On food labels, at gas stations, even in coffee houses, consumers have more information about products they are about to purchase than in health care. Even before the advent of consumer driven accounts like HSAs, the lack of basic pricing data should have been an outrage to the employers footing the bill. Now that deductibles in non-HSA-qualified plans are rising quickly, and the portion of consumers covered by HSA accounts is rising commensurately, the idea that health care providers can keep their pricing secret, or at least opaque, or at worst unknown, is harmful and should no longer be tolerated. Consumers will likely be effective at forcing transparency simply through provider choice – show me prices or I'll go elsewhere. But, the federal government can and should compel pricing disclosure on the most popular outpatient services. There are several laboratories for testing the efficacy of this practice from Medicare to the Federal Employees Health Benefit Program. I would also argue that the authority to compel pricing disclosure likely exists in existing law currently – it's a mystery to me why various federal administrators have resisted disclosure absent congressional authorization.

   a. Have you seen any evidence of expanding price transparency so far?
      KM Answer: The best example so far is in diagnostics, where consumers in non-emergency situations have the chance to explore different treatment options and different pricing schemes. Almost 60% of all health expenditures for privately insured adults under 65 and almost 40% of the elderly's expenses are for outpatient care, according to a 2012 report from the IMS Institute for Healthcare Informatics as detailed by Dr. Scott Atlas in his June 19 editorial in the Wall Street Journal. Transparency tools listing the prices for outpatient care are increasingly part of health benefit product offerings, which is a benefit to consumers and plan sponsors alike.

2. In your view, what is not considered a qualified medical expense but should be?

   KM Answer: One approach that has elicited bills from several Senators is to identify additional expenses and amend the Internal Revenue Code such that certain high-value services may be

covered pre-deductible. Direct Primary Care services, expenses associated with managing chronic conditions and services like Telemedicine would be appropriate candidates for HSA-qualified status or pre-deductible coverage.

a. What would be the impact of allowing funds in health care savings accounts to be used for premium payments?

KM Answer: The HSA Council has commented several times concerning our opposition to this feature of HSA expansion. We believe it is more important to keep funds available for routine care than pay for insurance benefits, which may require satisfaction of a deductible before becoming available; more importantly, paying premiums reduces the balance of the account thus reducing the funds available to pay for routine care.

3. If the financial trade off were between keeping annual contribution limits at their current level but expanding HSA eligibility to all plans regardless of deductible status versus keeping the current tie to high deductible plans but increasing annual contribution limits, which would you favor and why?

KM Answer: The HSA Council has supported increasing contributions to an amount equal to the statutory out-of-pocket-maximum for an HSA-qualified plan so that HSA owners can cover their entire out-of-pocket risk with tax preferred funds should the need arise. There is currently a gap between the maximum contribution and out-of-pocket maximum limits. Individuals can contribute $3,450 and families $6,900 in 2018; however, their respective out-of-pocket risks are $6,650 and $13,300. In addition, Fidelity Investments says that a retiring couple would need approximately $270,000 to pay for the things Medicare doesn't. Accordingly, the need is for savings tied to medical care, while keeping premiums low. Traditional plans are more expensive than HSAs and have no savings feature.

4. As the health care industry increasingly moves towards value-based care and away from a fee-for-service model, how should HSAs adapt accordingly?

a. How should qualified medical expenses be adjusted to account for the fact that medical care is less likely to be a fixed fee?

KM Answer: IRS guidance needs to be updated to reflect new payment models in health care. We note that increasingly health care services are being bundled and paid under fixed fee arrangements rather than fees for every individual service. It is not clear whether HSA funds may be used tax-free to pay for these care bundles. Some of these payments are being made in advance of care being provided but do not constitute "insurance." Instead, they amount to pre-paid health care. Additionally, because 86 cents of every health care dollar is spent to manage chronic conditions, it makes financial and policy sense to allow more plan design flexibility such that HSA qualified plans have the option to provide chronic disease prevention drugs and services on a pre-deductible basis.

5. Is it possible to see the large-scale expansion of HSAs necessary to enhance competition and drive down costs if insurance continues to be largely employer-sponsored and if HSAs are unavailable for most Americans with high-deductible plans?

   KM Answer: Yes. We believe employers are in the best position to drive change and innovation in the current market.

   a. What needs to change to drive up participation?
      KM Answer: Encouraging more flexible plan designs and greater employer contributions will have the biggest impact. Regarding the latter, removing employer/employee contributions from the calculation of the Cadillac tax – absent its outright repeal - is KEY to employer groups continuing to support and promote change through increased HSA participation.

6. As more Americans move away from traditional health insurance and into alternative models like direct primary care and health sharing ministries, how can health care savings accounts adapt?

   KM Answer: The law should be changed to permit these arrangements to be compatible with HSAs.

   a. In your view, should HSAs be used for these expenses?
      KM Answer: Yes. Consumers should have the choice to spend their own money as they see fit.

7. What does the data indicate about the average consumer of these plans and the trends in age, health history, and income level?

   KM Answer: Senator, I would commend to you the testimony of Jody Dietel, Chief Compliance Officer for WageWorks, before the House Ways & Means Committee on June 6, 2018. I will include the testimony as an attachment and suggest it be made part of the record. WageWorks has been the most generous of the HSA Council's member companies in compiling and sharing data. According to them, "the median household income for an HSA accountholder is $57,060;" "nearly 77% of participants contributing to an HSA were born in 1965 or after, belonging to the Gen Z, Millennial and Gen X demographic. Only about 22% of [WageWorks'] participants are Baby Boomers."

   As to the other issues, I unfortunately do not know where the data gaps are, except to say that we need more of it if we want a more accurate picture of the "HSA Effect" which I describe in my testimony.

   As to the increasing use of HSAs by employers, Mercer, in its 2017 Employer Survey, says that the number of employers offering HSAs as their only option grew from 6% in 2012 to 10% in 2017 but that the proportion of employers adding HSAs as an option went from 28% to 54% during the same time frame. Industry observers suggest these metrics are evidence of either explosive growth or lower than expected growth.

a. Where are their gaps in the data?
b. Is risk segmentation decreasing as a result of HSA expansion?
c. Are private employers offering high deductible health plans at higher rates?

Joint Economic Committee Hearing
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June 7, 2018
Questions for the Record for Mr. McKechnie
Submitted by Representative Carolyn B. Maloney
July 26, 2018

1) The marginal federal tax rate for the lowest earners that pay taxes is 10 percent and that the marginal rate for the highest earners is about 40 percent. How does this benefit how the benefits of HSAs are distributed across the income spectrum?

   KM Answer: The best way to answer is to pose the question from the perspective of a consumer from any income bracket: assuming the consumer has an average deductible, which I cited as $2,120 last year for single coverage in a small firm according to Kaiser Family Foundation, the range of pre-tax earnings required to satisfy that deductible would be $2,332 for income tax filers at the 10% marginal tax rate and $2,968 for income tax filers at the 40% marginal tax rate. Alternatively, income tax filers of all brackets would need to earn $2,120 to satisfy a $2,120 deductible, if they had an HSA, a savings of $212 and $848 respectively. Over a 60-month period, assuming both filers had spent up to their deductible each year, that the HSA-owners had saved the entire difference between the pre- and post-tax amounts, and assuming just a 3% compound interest rate, HSA owners who were 10% marginal income tax filers would enjoy a $1,371.52 benefit, and 40% marginal tax income tax filers would enjoy a $5,485.42 benefit compared to an individual with just traditional PPO coverage.

   In addition, HSA owners searching for coverage in the individual market the Affordable Care Act (ACA) sought to reform would save an additional 7.65% on FICA tax through pre-tax payroll contributions, assuming that feature is not already built into your definition of "marginal tax rate." If the FICA savings are already considered then this should simply be noted as an additional benefit.

2) Savings rates also vary widely by income. How do differences in savings rates by income quintiles affect the distributional effects of HSAs?

   KM Answer: Savings rates tend to decline as income declines so it's important to understand the relevance of employer contributions to modest income HSA owners, which are the vast majority of HSA-owners. Kaiser Family Foundation, in their 2017 Employer Health Benefits Survey, says that the average employer contribution to people covered by HSA-qualified plans was $1,417. I would commend to you the testimony of Jody Dietel, Chief Compliance Officer for WageWorks, before the House Ways & Means

Committee on June 6, 2018. I will include the testimony as an attachment and suggest it be made part of the record. WageWorks has been the most generous of the HSA Council's member companies in compiling and sharing data. According to them, "the median household income for an HSA accountholder is $57,060."Obviously, an employer contribution of $1,417 is more valuable as a proportion of income to an HSA-owner earning household income at or below the WageWorks median level than above it. We include employer contributions as "Suggested Industry Guidance" in all of our publications.

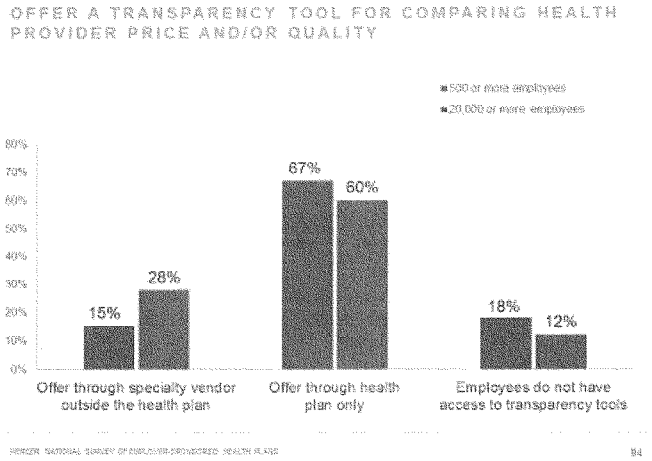
Joint Economic Committee Hearing
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve" June 7, 2018
Questions for the Record for Ms. Watts
Senator Ben Sasse
July 26, 2018

1. **Using health care savings accounts to increase competition and drive down prices can only happen in coordination with more transparency in pricing. In your view, what role should the federal government play in enhancing this transparency?**

   Employers have been working to increase health care quality and transparency through innovative strategies such as providing new and enhanced transparency tools, incentives to use the tools, and reference based pricing. The ability to achieve large-scale success, however, exponentially increases when private sector employers are working hand in glove with public payers to implement similar policies measured in standardized ways.

   a. **Have you seen any evidence of expanding price transparency so far?**

      More than 80% of large (500 or more employees) employers who offer their employees health coverage provide access to a transparency tool – 67% through their health plan and an additional 15% through a specialty vendor.



As I mentioned during the hearing, Mercer and the American Benefits Council co-authored a white paper, Leading the Way – Employer Innovations in Health Coverage. In one of the examples, AT&T committed to consumerism by offering a range of high-deductible HSA-eligible plans. To help employees find the right level of coverage for their health needs and financial situation, their platform includes a cost-comparison tool that uses the employees' claims data as well as a questionnaire to help employees evaluate the financial implications of their plan choices. Enrollment has risen 30% in the lowest-cost plan, and medical trend is below average.

2. **In your view, what is not considered a qualified medical expense but should be?**

Some best practice efforts to promote quality, cost efficiency and better health outcomes are hamstrung by the HSA statute and regulations. For example, a patient with diabetes that is enrolled in an HSA-eligible HDHP must meet their entire deductible before the plan can cover an eye exam, foot exam, or diabetes medications. Yet, the evidence is clear that patients with diabetes benefit from annual eye and foot exams and anti-diabetes medicines. Additionally, employers can't waive or limit cost-sharing for telemedicine, use of an onsite clinic, Centers of Excellence, or second opinion services for employees that are enrolled in HSA-eligible HDHPs. All of which drive efficiency and better outcomes.

a. **What would be the impact of allowing funds in health care savings accounts to be used for premium payments?**

Under current law, insurance premiums are considered qualified medical expenses when used to pay for health care continuation coverage (e.g. COBRA), Medicare and other select coverages. Allowing HSA funds to be used for premiums for employer-sponsored pre-65 early retiree plans has merit and would be equitable with current law.

3. **If the financial trade off were between keeping annual contribution limits at their current level but expanding HSA eligibility to all plans regardless of deductible status versus keeping the current tie to high deductible plans but increasing annual contribution limits, which would you favor and why?**

We would need to consider the details and goals of each option carefully before responding. Deductibles and other cost sharing features are critical to driving the desired consumerist behavior.

4. **As the health care industry increasingly moves towards value-based care and away from a fee-for-service model, how should HSAs adapt accordingly?**

   As our health care system transitions from one that rewards volume to one that rewards value, it would be helpful if HSAs were also afforded more flexibility to transition – for example, value-based care is centered around the idea of providing the right care at the right time in the right setting. Plan benefit designs are structured to promote this concept. One example relates to telemedicine, a plan might want to encourage greater use of telemedicine by eliminating all cost-sharing (including the deductible), charging a $25 copay to visit a Minute Clinic, a $75 copay to go an urgent care facility, and a $250 copay to go to the emergency room. Currently, plans must charge fair market value to anyone in an HSA that utilizes telemedicine before they have met their deductible. This makes it harder for the plan or employer to incentivize the telemedicine services. Additionally, plans and employers who want to encourage greater use of centers of excellence programs, second opinion services, and onsite and near site clinics are all hamstrung by these same rules requiring application of the deductible even when enrollees want to utilize these high value sites of care.

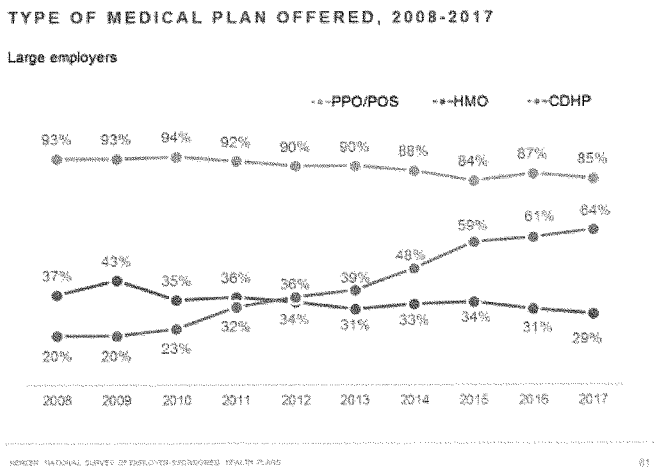
   Additionally, guidance from the U.S. Department of Treasury and the Internal Revenue Service prohibits HSA plans from covering chronic disease prevention pre-deductible. Because nearly half of all Americans have at least one chronic condition and about $0.86 of every health care dollar is spent on managing chronic disease, it makes good policy sense to allow these plans to cover chronic disease prevention pre-deductible. This policy would be very beneficial to patients, employers, and payers alike, including improved health, enhanced workplace productivity, and the avoidance of unnecessary emergency care visits and hospitalizations.

   a. **How should qualified medical expenses be adjusted to account for the fact that medical care is less likely to be a fixed fee?**

      Affording more flexibility is a critical part of encouraging continued innovation in value-based care. For example, consider how legislation can accommodate direct primary care or new and emerging models for high quality, efficient care delivery.

5. **Is it possible to see the large-scale expansion of HSAs necessary to enhance competition and drive down costs if insurance continues to be largely employer-sponsored and if HSAs are unavailable for most Americans with high-deductible plans?**

According to Mercer survey data, 64% of employers with more than 500 employees offered a consumer directed health plan option (account based plan) in 2017 – double the amount six years ago.



Employers are highly motivated to reduce healthcare costs and improve quality, indeed, employers are at the forefront of improving America's health care system through innovative strategies and value-based solutions. HSAs have been used to help make health coverage more affordable and encourage wiser consumption of health services. However, outdated laws and regulations make it difficult for employers to include innovative reforms in HSA-eligible high-deductible plans such as certain disease management programs. These laws and regulations should be updated to better align HSAs with innovative delivery systems reforms. Data belies the assumption that HSAs are unavailable for most Americans with high-deductible plans. Indeed, according to data from WageWorks, the median household income for an HSA accountholder is $57,060.

a. **What needs to change to drive up participation?**

Flexibility on the plan design (as mentioned in #2 above) would be well received and timely to continue to encourage enrollment in HDHPs. As I noted in my testimony, providing employees with the tools and resources to move toward consumer-directed health plans is a critical component. This is evidenced by the enrollment results from our own Mercer Marketplace 365 benefit platform, which indicate that

more employees will choose to move into a high-deductible plan if they have the tools and resources to help them feel comfortable making that decision.

6. **As more Americans move away from traditional health insurance and into alternative models like direct primary care and health sharing ministries, how can health care savings accounts adapt?**

   a. **In your view, should HSAs be used for these expenses?**

   As noted above, outdated laws and regulations make it difficult for employers to include innovative reforms in HSA-eligible high-deductible plans. These laws and regulations should be updated to better align HSAs with innovative delivery systems reforms.

7. **What does the data indicate about the average consumer of these plans and the trends in age, health history, and income level?**

Generally speaking, older employees are more likely to elect lower deductible (richer) options. Once employee salaries exceed $30k, salary appears to have less influence on an employee's decision. Below $30k, employees are much more likely to take the lowest cost option made available

ENROLLMENT BY AGE						
Plan	Less than 30	30 - 39	40 - 49	50 - 59	60+	All Ages
$0 Deductible	2%	2%	3%	2%	3%	2%
$400 Deductible	8%	12%	14%	15%	17%	13%
$900 Deductible	18%	21%	23%	27%	32%	24%
$1,850 Deductible	23%	26%	28%	29%	27%	27%
$2,850 Deductible	33%	26%	22%	19%	15%	23%
$4,500 Deductible	12%	9%	7%	5%	4%	7%
$6,550 Deductible	5%	4%	4%	3%	2%	4%
% CDHP	72%	65%	60%	55%	48%	61%

ENROLLMENT BY SALARY						
Salary	$10 - $30k	$30 - $50k	$50 - $70k	$70 - $110k	$110k+	All Salaries*
$0 Deductible	1%	4%	2%	2%	2%	2%
$400 Deductible	5%	11%	14%	18%	20%	13%
$900 Deductible	27%	26%	25%	23%	18%	24%
$1,850 Deductible	19%	24%	27%	29%	35%	27%
$2,850 Deductible	27%	22%	22%	21%	22%	23%
$4,500 Deductible	16%	9%	5%	4%	3%	7%
$6,550 Deductible	5%	4%	4%	3%	1%	4%
% CDHP	67%	59%	59%	58%	60%	61%

Source: 2018 Mercer Marketplace 365 enrollment results; standard deductible options only

   a. **Where are their gaps in the data?**

b. Is risk segmentation decreasing as a result of HSA expansion?

Using Mercer 2017 survey data, the average age of plan members is very close when comparing HSA (42) eligible plan to PPO (44) and HMO (43). There is a slightly higher percentage of employees electing dependent coverage in the HSA eligible plan.

HSA-ELIGIBLE CDHP ENROLLEE PROFILE, COMPARED TO PPO AND HMO ENROLLEES

Large employers

	EMPLOYEES ENROLLED IN		
	HSA-ELIGIBLE CDHP	PPO	HMO
Average age	42	44	43
% of employees electing dependent coverage	58%	56%	56%

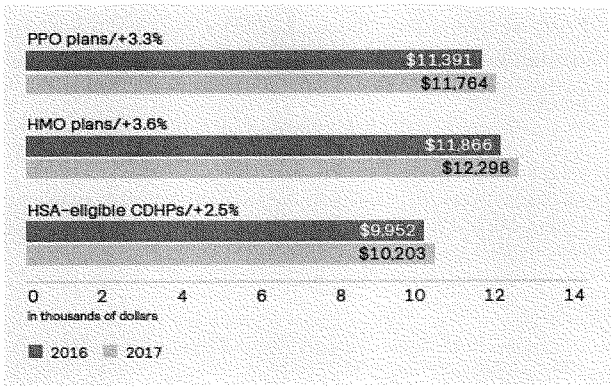
c. Are private employers offering high deductible health plans at higher rates?

There was continued, though modest, growth in employer offerings of CDHPs in 2017. Among employers with 10–499 employees, CDHP offerings rose from 25 percent to 29 percent, while among employers with 500 or more employees, offerings rose from 61 percent to 64 percent. It is important to note that larger employers tend to offer their employees several health plan options while smaller employers typically offer one health plan option – most often a high deductible PPO (over $1,000) that does not qualify for an HSA because it includes a co-pay for a physician office visit (pre-deductible).

The least expensive medical plan type is the high-deductible CDHP that is eligible for a tax-advantaged HSA; the average cost of coverage in this plan is $10,203 per employee. HMO coverage remains the most costly of the three medical plan types, averaging $12,298 per employee, followed by PPO coverage, at $11,764.

Medical plan cost per employee, by plan type

All employers



Does not include dental cost.

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2017

From an employee perspective, the HSA eligible plan contribution requirements are much more affordable than PPO and HMO options. Employee only coverage for $83/month and family coverage for $318/month compared to $140 for employee only and $470 for family coverage for PPO coverage.

EMPLOYEE CONTRIBUTIONS FOR HSA-ELIGIBLE COVERAGE SIGNIFICANTLY LOWER THAN FOR PPO AND HMO COVERAGE

Large employers

	NO CONTRIBUTION REQUIRED	AVERAGE MONTHLY DOLLAR AMOUNT	AVERAGE CONTRIBUTION AS A % OF PREMIUM
HSA-eligible CDHP			
Employee-only	11%	$83	18%
Family	5%	$318	25%
PPO			
Employee-only	6%	$140	24%
Family	4%	$470	31%
HMO			
Employee-only	10%	$128	23%
Family	7%	$484	32%

Joint Economic Committee Hearing
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve" June 7, 2018
Questions for the Record for Dr. Patel
Senator Ben Sasse
July 26, 2018

1. Using health care savings accounts to increase competition and drive down prices can only happen in coordination with more transparency in pricing. In your view, what role should the federal government play in enhancing this transparency?
    a. Have you seen any evidence of expanding price transparency so far?

Pricing Transparency has been an oft-invoked topic or solution but very little practical examples that have also driven down pricing; the federal government can play an essential role in promoting greater pricing transparency by facilitating full disclosures around rebates, for example in pharmaceuticals. There is some evidence of expanding price transparency through private sector efforts supported by companies such as Castlight, etc, but they are limited. There are also interesting, provocative examples of individual providers/physicians who have become concierge style doctors, offering a transparent listing of prices as well as offering medications and labs on a cost basis, in a transparent manner, often cheaper than through pharmacies, lab companies etc. Unfortunately many Americans simply can't take advantage of concierge models nor should that be where transparency is only highlighted.

2. In your view, what is not considered a qualified medical expense but should be?
    a. What would be the impact of allowing funds in health care savings accounts to be used for premium payments?

Right now, care for chronic conditions are subject to copayments in commercial plans and Medicare; this care is important and we want to encourage this work and I would strongly advocate for this care to be a qualified medical expense. The impact financially would be minimal.

3. If the financial trade off were between keeping annual contribution limits at their current level but expanding HSA eligibility to all plans regardless of deductible status versus keeping the current tie to high deductible plans but increasing annual contribution limits, which would you favor and why?

Given the financial burden that such an expansion would pose on the federal government and the urgent need to reduce costs for all Americans, I would reconsider expanding HSA eligibility and start first with reforms that I referred to in my written testimony to encourage pre-deductible inclusion of high value clinical services for consideration in current Health Savings Accounts.[i]

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[i] https://www.healthaffairs.org/do/10.1377/hblog20140403.038296/full/

Joint Economic Committee Hearing
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve" June 7, 2018
Questions for the Record for Dr. Patel
Submitted by Representative Carolyn B. Maloney
July 26, 2018

1) There has been research suggesting that health outcomes are correlated with income and wealth. Could you describe that correlation? Has that correlation changed over time and what is the prognosis for the future?

   Thank you for this important question; yes there have been some important studies that have highlighted the strong relationship between income, wealth and important outcomes such as mortality. In the United States between 2001 and 2014, higher income was associated with greater longevity, and differences in life expectancy across income groups increased.[i] This correlation hasn't changed and in terms of prognosis, unlikely to change in the future. What might change are the effects of other important variables such as geography (where you live might be a stronger predictor of outcomes) as well as certain elements of access to health care which might be a stronger predictor (such as the presence or absence of regular health care insurance).

2) In general, do HSAs mitigate differences in health outcomes for individuals across income strata? Do provisions of the Affordable Care Act mitigate these differences?

   I am not personally aware of any evidence regarding mitigation of health outcomes for individuals across income strata. Provisions of the Affordable Care Act such as the standardization of benefits attempt to mitigate these differences.

3) It has been argued that HSAs will constrain medical costs by giving individuals with high-deductible health plans incentives to take control of their health care. They will shop more wisely and thus induce providers to reduce prices. As a practicing physician, are you confident that most patients can make such decisions?

   The patients I treat come from all walks of life- they are people with limited incomes as well as high powered executives with high deductible health plans that have health savings accounts; almost all of these patients feel helpless however when so many decisions regarding where a patient might receive a procedure or get their blood drawn etc are really driven by the doctor as well as the referral patterns that dominate. This is why I have emphasized the need to also move high value clinical services predeductible so that we can allow for as many Americans with CDHPs (Consumer Directed Health Plans) to benefit from the pre-tax dollars for important services.

4) In your testimony you reference "opacity" in pricing as critical to driving down costs of prescription drugs. Could you explain how drug prices are not opaque? Is the market for prescription drugs competitive?

   Drug pricing in its current form is extremely opaque; my apologies if the opposite message was unintentionally conveyed; currently manufacturers set prices but then an opaque (opaque to the consumer or purchaser of health care) process of rebates and discounts takes place between the manufacturers and number of intermediaries such as Prescription benefit managers (PBMs) and GPOs (Group Purchasing Organizations).

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[i] Chetty, R., Stepner, M., Abraham, S., Lin, S., Scuderi, B., Turner, N., ... Cutler, D. (2016). The Association Between Income and Life Expectancy in the United States, 2001–2014: Association Between Income and Life Expectancy in the United States. *JAMA*, *315*(16), 1750–1766. http://doi.org/10.1001/jama.2016.4226

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