



**“Lowering Costs and Expanding Access to Health Care
Through Consumer-Directed Health Plans”**

by

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**for the
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Subcommittee on Health**

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Chairman Roskam, Ranking Member Levin and members of the subcommittee, I am Matt Eyles, President and CEO of America's Health Insurance Plans (AHIP). AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

We appreciate the opportunity to testify on consumer-driven health plans and their role in providing more Americans with access to high quality, affordable health care coverage. The innovative products offered by AHIP's members include high-deductible health plans (HDHPs) that can be combined with Health Savings Accounts (HSAs). A growing number of Americans rely on HSA/HDHPs as a valuable health care coverage option.

Our statement focuses on the following areas:

- Background information on Health Savings Accounts (HSAs), including the findings of an annual AHIP survey that has measured strong enrollment growth in HSA-eligible plans over the past 12 years;
- Issues for policymakers to consider while examining the current status and future role of HSA/HDHPs; and
- Proposed solutions for strengthening and improving HSAs and HSA-eligible health plans to better empower consumers and meet their needs.

Background Information and AHIP Survey Findings on the Growing Popularity of HSA/HDHPs

HSAs provide an opportunity for individuals to use tax-free funds to pay current medical expenses while also setting aside money for future health care costs. These accounts offer additional tools to help consumers make affordable health care choices and control their health care dollars.

With HSAs, consumers play an active role in deciding when and how much to contribute to their accounts, how to invest in their accounts, and how to use their health dollars. The funds that individuals withdraw from their HSAs to pay for their health care services and products are not taxed. At the end of the year, any unspent dollars in an HSA can stay in the account and be used to pay for medical expenses in future years. Interest and other earnings on HSA funds accumulate in the fund and are also tax-free. This empowers consumers to make more engaged decisions about their health care while accumulating savings to pay for future health care needs.

HSAs must be combined with an HDHP, which also must meet specific requirements for deductibles and out-of-pocket expenses. For calendar year 2018, an HDHP is defined as a health plan with an annual deductible that is not less than \$1,350 for self-only coverage or \$2,700 for family coverage and annual out-of-pocket expenses (deductibles, co-payments, and other amounts, excluding premiums) that do not exceed \$6,650 for self-only coverage or \$13,300 for family coverage.

Federal law specifically provides that certain preventive care services must be covered by HSA-compatible health plans prior to the deductible being met at zero cost sharing. That means that HDHP enrollees have “first dollar coverage” for a wide range of preventive health care services, including annual physical exams, screening services, immunizations, tobacco cessation programs, and routine prenatal and well-child care.

A significant number of Americans have found HSA/HDHPs to be an appealing option for meeting their health care coverage and treatment needs. Since HSAs were originally authorized by Congress in December 2003,¹ there has been a steady and significant increase in the number of Americans enrolled in HSA-eligible plans.

In April 2018, AHIP released an update to our annual survey showing that enrollment in HSA/HDHPs totaled at least 21.8 million as of January 2017, reflecting a 9.2 percent increase since the previous year.² This survey was based on responses from 52 insurance companies. For context, based on these and other survey results, more individuals are enrolled in HSA/HDHPs than the entire Medicare Advantage program.

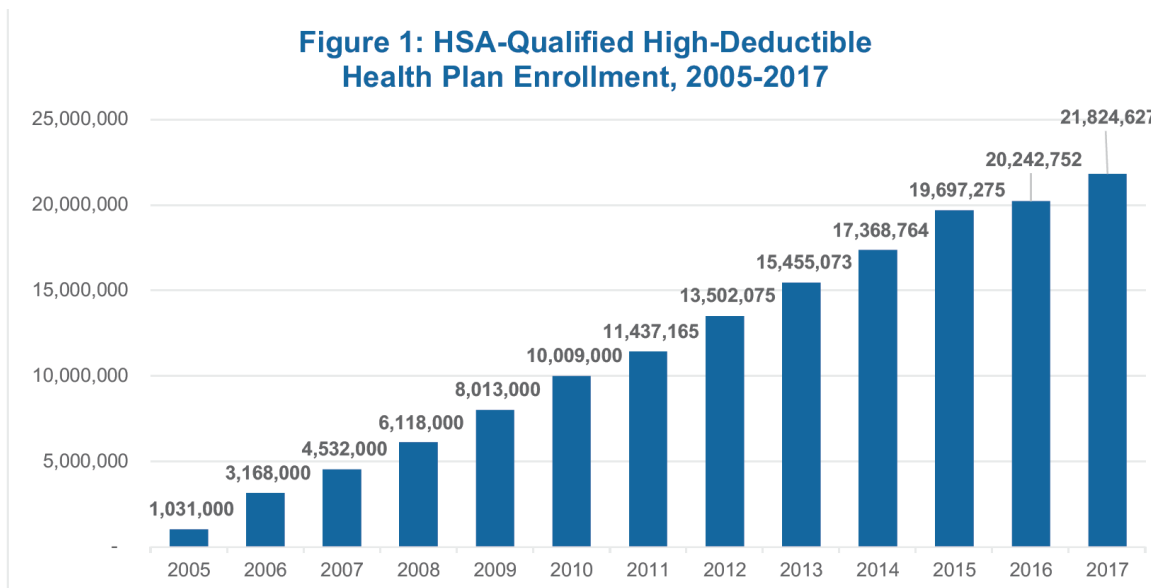
AHIP has conducted an annual HSA/HDHP survey since 2005. The chart below shows that HSA/HDHP enrollment has increased at a steady, robust pace – a cumulative 2,014 percent increase – over the past 12 years. The popularity of these options is also supported by other research, which have shown even higher enrollment in HSA-eligible plans – ranging from 22 million to 31.7 million people or around 12 percent of the non-Medicare population.^{3,4}

¹ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173.

² *Health Savings Accounts and High Deductible Health Plans Grow as Valuable Financial Planning Tools*, AHIP, April 2018. https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf

³ *2017 Year-End Devenir HSA Research Report*, Devenir, February 2018. <http://www.devenir.com/research/2017-year-end-devenir-hsa-research-report/>

⁴ *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017*; National Center for Health Statistics, May 2018. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf>



Our survey also provides data on where individuals access or purchase their HSA/HDHPs and the age distribution of HSA/HDHP enrollees. These data point to other possible areas of reform, particularly for HSAs accessed on the individual and small group markets and for adults who are eligible for coverage on their parents’ employer-sponsored coverage.

Demographic data for HSA/HDHP enrollees, based on AHIP’s survey, show that in January 2017:

- 23 percent were under the age of 18;
- 11 percent were 18-24 years;
- 32 percent were 25-44 years;
- 33 percent were 45-64 years; and
- 1 percent were age 65 and older.

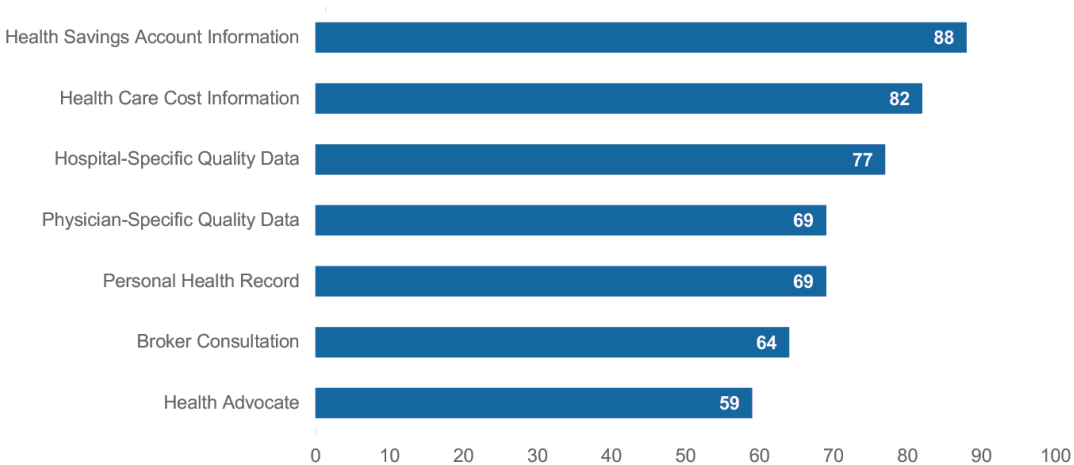
HSAs are a consumer-friendly savings tool that empowers individuals to plan for future health care expenses and gain peace of mind to supplement the security of a health insurance plan. As such, another component of our survey asked sponsors of HSA-eligible plans about the many valuable tools and services they offer to their enrollees.

We found that HDHPs offer consumers a variety of tools, including:

- 98 percent of respondents offer members access to health and wellness resources;
- 88 percent provide members access to information on their health savings account;

- 82 percent offer health care cost information;
- 69 percent supply members with access to their personal health record;
- 69 percent provide physician-specific quality data and 77 percent provide hospital-specific quality data; and
- 64 percent offer enrollees access to broker consultations.

Figure 2: Percentage of Health Insurers Providing Access to Consumer Decision-Support Tools, January 2017



Evidence clearly shows that HSAs have enjoyed consistent and significant growth since they were first offered to consumers in 2005. They provide an attractive option for employers, employees, and individuals seeking an efficient way to cover health care costs. There is still room for improvement to maximize the potential for consumer-directed health plans, however.

Issues for Policymakers to Consider While Examining HSAs and HDHPs

As Congress evaluates the current status and future role of HSAs, it is important to look broadly at the landscape surrounding HSA/HDHPs – focusing not only on the significant value they offer consumers, but also on areas where there are opportunities for improvement.

Following the enactment of the 2003 law, there have been few changes to HSAs, even as other areas of the health care system have experienced vast transformation. These areas include a stronger emphasis on consumer agency and focus, a revolution in health technology, a shift from volume-based to value-based payments, and a growing recognition that covering high-value services can help reduce long-term costs. At the same time, costs have grown substantially for health services and treatments, making it even more imperative that consumers have adequate tools to access

needed care and know their options. Policymakers must account for growing consumer reliance on these plans and their current and future health needs when considering reforms to expand flexibility for consumers, employers, and plans in their use and design of HSA/HDHPs.

- a. Inherent differences between the individual market and group markets should be considered as Congress explores strategies for strengthening HSA/HDHPs.

HSA-eligible plans are available to individual market consumers, but are purchased far less frequently by individuals who buy coverage on their own than by employees who obtain coverage through group markets. Today, only about 7 percent of individuals enrolled in HSA-eligible plans are covered through the individual market. By contrast, 82 percent of enrollees in HSA-eligible plans are covered through the large group market.⁵ AHIP survey data have shown that while overall enrollment in HSA/HDHPs has grown in all markets since 2005, the vast majority of growth has been concentrated in the large group market. This indicates that there are disparities in the advantages of these plans between the markets that need to be addressed to provide consumers with more cost-effective coverage options that meet consumer needs.

Employer-provided plans have distinct advantages in offering HSA-eligible plans and encouraging the use of HSAs. The most significant advantage that HSA participants have through employer-provided coverage is that most employers make direct contributions to their accounts. All contributions by an employer must be equal for all employees, regardless of income level. Thus, even for lower-wage workers who may otherwise have difficulty saving for future expenses, they will have funds in the HSA. This is a significant difference compared to the individual market, where funding the account is entirely the responsibility of the individual.

Data have shown that employers contribute significant funds to HSAs, highlighting the value they and their employees find in the accounts. For example, the Kaiser Family Foundation found that approximately 77 percent of HSA enrollees work for a firm that makes annual contributions to the HSA account.⁶ The average employer contribution to the account is \$608 for single coverage and \$1,086 for family coverage. However, these averages include firms that contribute \$0 to the account. When such firms are removed from the equation, the average contribution is \$795 for single coverage and \$1,417 for family coverage.

⁵ *Health Savings Accounts and High Deductible Health Plans Grow as Valuable Financial Planning Tools*, AHIP, April 2018. https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf

⁶ *Employer Health Benefits: 2017 Annual Survey*, Kaiser Family Foundation, 2017. <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017>

HSAs offered through employer-provided coverage also offer the advantage of providing easier access to resources to advise employees about the benefits and uses of an HSA as well as the potential to use direct payroll deductions for HSA contributions, which make it substantially easier for workers to save money, much as they do for a retirement account.

While the large group market is able to offer additional benefits that make HSA/HDHPs more attractive and practical to consumers compared to the individual and small group markets, these plans still provide an attractive option for many consumers, particularly those that may not have access to other health coverage tax advantages.

While moderate-income individuals and families have access to subsidies that shield them from premium instability in the individual market, millions of middle class Americans are increasingly being priced out of many markets. Expanding flexibility for benefit design and access to HSA-eligible plans can help increase tax-preferred access to health coverage and care for middle class individuals and families.

Currently, it is very difficult to determine whether an individual enrolled in a plan in the individual market is also eligible to enroll in an HSA. As we previously noted, the Internal Revenue Service sets out-of-pocket limits on HDHPs, which are \$6,650 for self-only coverage or \$13,300 for family coverage for 2018. Any health plan that has out-of-pocket limits above these thresholds cannot be coupled with an HSA. These requirements are not aligned with current metal level plan requirements, however. For example, out-of-pocket limits for individual Silver-level plans (historically the most popular coverage option) are \$7,150 for individuals and \$14,300 for families for 2018. Because of the misalignment in thresholds, individuals enrolled in these policies may not have access to tax-preferred mechanisms that can help cover these out-of-pocket costs. Additionally, it is not readily apparent on HealthCare.gov which plans are and are not compatible with HSAs.

b. Patients with chronic conditions face barriers due to restrictions on HSA-eligible plans.

While HSA/HDHPs meet many consumer needs, they are generally considered a less attractive option for consumers with known, ongoing health needs – generally known as chronic conditions. Chronic diseases affect millions of Americans and are a leading driver of rising health costs. At least 60 percent of Americans live with a chronic disease, with at least 42 percent having multiple

chronic conditions.⁷ Moreover, 86 percent of total health care expenditures are for individuals living with chronic health conditions, accounting for \$2.3 trillion annually. In recent years, there has been a growing recognition that lowering financial barriers to essential, high-value services – for example, through value-based insurance design (VBID) – can lead to better patient adherence to treatment, better clinical outcomes, and lower costs from avoiding preventable complications.

Unfortunately, federal law has not evolved to address the needs of the growing number of consumers with chronic conditions who may be enrolled in HSA/HDHPs or may want to enroll in these plans if they provided more benefit flexibility. As stated previously, HSA-eligible plans cover certain preventive services pre-deductible with no cost sharing – just like other comprehensive plans (e.g., HMO and PPO plans). However, current law takes a limited view of “preventive services” and places strict limits on what HSA-eligible plans may cover on a pre-deductible basis.

For example, this means that a diabetic enrolled in an HDHP will have to meet the plan deductible before the plan can cover insulin or test strips even though there is ample evidence showing this type of secondary and tertiary prevention is critical to avoiding debilitating, expensive complications.⁸ Many consumers with chronic conditions or who have dependents with chronic conditions may find it challenging to rely on an HDHP for these reasons.

c. Narrow definitions prevent individuals from realizing the full potential of HSA/HDHPs.

A range of popular and cost-effective services disqualify a health plan from HSA-eligibility, if the plan offers them on a first-dollar coverage or pre-deductible basis. These services include telemedicine, second-opinion services, retail clinics, and on-site medical clinics. While many plans lower or eliminate co-pays for these services as a way of encouraging lower-cost, effective care, current federal regulations disqualify these plans from being paired with an HSA.

Similarly, HSAs cannot be used to pay for certain expenses and products that help support health and financial security. For example, an individual may not use HSA funds to pay for over-the-counter drugs that often cost less than prescription medications. HSA funds also may not be used to pay for coverage that positively impacts physical, mental, and financial health such as dental

⁷ *Multiple Chronic Conditions in the United States*, Christine Buttorff, Teague Ruder, and Melissa Bauman, RAND Corporation, May 2017. https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf

⁸ *Primary, secondary, and tertiary prevention of non-insulin-dependent diabetes*, A. Dornhorst and P. K. Merrin. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2397691/?page=1>

insurance, disability income protection, supplemental health benefits, Medigap coverage, and vision insurance.

While an HSA may be used to pay for Qualified Long-Term Care Insurance (QLTCI), current HSA contribution limits are often too restrictive to allow for QLTCI purchases. This is a significant concern, considering that the Department of Health and Human Services (HHS) estimates that individuals and their families pay for 52 percent of their long-term care costs out of their own pockets.⁹

d. The value of HSAs is restrained by statutory limits on HSA contributions.

Statutory limits on HSA contributions limit the ability of consumers to save for their deductible and future health care expenses. For 2018, the law limits HSA contributions to \$3,450 for individual coverage and \$6,900 for family coverage. However, the maximum out-of-pocket expenditure for an HSA-eligible plan is \$6,650 for individual coverage and \$13,300 for family coverage.

This leaves a significant gap between the annual contribution limit and the maximum-out-of-pocket limit, meaning that an individual or family may have a maximum out-of-pocket amount or deductible amount that is nearly double the amount they may save in their HSA for any given year. Thus, an account intended to provide tax-advantaged funds to help cover out-of-pocket health care expenses cannot, under current law, adequately cover the actual costs a consumer may incur in a calendar year under their specific plan.

Moreover, if an individual has an HSA but no longer has HDHP coverage, he or she cannot contribute additional amounts to the HSA under current law. This restricts a person's ability to continue to save for future expenses, including expensive medications, Medicare premiums, and long-term care.

As a direct result of the current limitations on HSA contributions, many consumers are unable to save enough money for future health care expenses, including the costs they will face in retirement, which are estimated to total \$280,000 for the average couple.¹⁰

⁹ *Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief*, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, July 1, 2015.

<https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>

¹⁰ *Fidelity Investments' 16th annual retiree health care cost estimate*, Fidelity Investments, April 19, 2018.

<https://www.fidelity.com/about-fidelity/employer-services/a-couple-retiring-in-2018-would-need-estimated-280000>

Given these and other restrictions on benefit design and coverage, there are 44.5 million individuals enrolled in HDHPs whose plans fail to qualify for an HSA.¹¹

Valuable Lessons on Improving HSAs and HSA-Eligible Plans Can Be Learned from Both Medicaid and the Employer Markets

States operating under a federal Medicaid waiver have experimented with HSAs for Medicaid enrollees and demonstrated that low-income individuals can effectively use HSAs and have an impact on an enrollee's utilization of health care services.

For example, the Healthy Indiana Plan (HIP) 2.0 pairs an HDHP with an HSA product called a Personal Wellness and Responsibility (POWER) Account. Under the HIP Plus version of this program, beneficiaries must contribute to a personal account. More than 90 percent of these beneficiaries consistently contributed to their POWER accounts. Rates of non-urgent emergency room visits declined for the HIP Plus population, and they used more preventive care than those in a regular HIP plan that did not contribute to a POWER account.¹² This outcome offers helpful lessons on how consumer decision-making is affected by an individual's participation in contributing funds to their HSAs.

For states and health insurers alike, the lessons from Medicaid Managed Care plans are highly instructive in designing plans for individual market consumers that may be more constrained in their ability to contribute to an HSA. More novel approaches can aid the ability of consumers to save through an HSA while also harnessing the positive results of consumer engagement through consumer-driven health products.

Proposed Solutions for Building on the Success of HSAs and HDHPs

We thank committee members for supporting innovative policy solutions to strengthen and improve HSA/HDHPs. Americans value a consumer-oriented approach to making decisions about their health care needs. The enormous growth in enrollment in HSA/HDHPs clearly signals growing popularity and reliance on these plan options. This continued increase in enrollment combined with health trends and current restrictions, mean that while these plans satisfy many consumer needs,

¹¹ *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2017*; National Center for Health Statistics, May 2018. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf>

¹² *Health savings accounts in the individual market*, Deloitte, 2017. <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-health-savings-accounts-in-the-individual-market.pdf>

more changes are warranted to empower consumers and support Americans' physical, mental, and financial health and stability. Below, we outline several policies that would make HSA/HDHPs an even more effective and valuable health care option for the American people, many of which are championed by members of this committee.

a. Allow greater benefit design flexibility for HSA-eligible plans.

As previously discussed, an enrollee in an HSA-qualified plan must meet his or her full deductible before the plan can pay for most services, treatments, or medications. Recognizing that preventive treatment is critical to improving health outcomes and avoiding costly long-term complications, Congress allowed for preventive care to be covered pre-deductible. There is a similar recognition that ensuring consistent access to treatment for those with chronic conditions such as diabetes, heart disease, and substance use disorders can help prevent expensive, debilitating complications.

The Chronic Disease Management Act (H.R. 4978) would provide much-needed flexibility by allowing HSA-qualified plans to cover services that help Americans manage their chronic conditions pre-deductible just as they do for preventive care. This approach improves the value of HSA-qualified plans for consumers and enables patients to more easily access care they need to effectively manage their chronic conditions.

b. Increase flexibility for HSA contributions and use.

HSAs are a valuable tool for consumers to use tax-free dollars for current and future health needs, but added flexibility on how these dollars are contributed would improve their utility for consumers.

Current limits for HSA contributions are not aligned with potential out-of-pocket costs for consumers, limiting the effectiveness and promise of these accounts, which are intended to help consumers better afford present and future medical costs. Policymakers should better align current contribution limits with potential out-of-pocket costs in HDHPs.

AHIP data also show that for the non-Medicare population, individuals aged 18-24 are the least likely to enroll in an HSA/HDHP even though this demographic would logically be well-suited to a plan with lower expected annual health costs and the ability to save funds for future health needs. Unfortunately, the HSA law has not accommodated other changes to insurance coverage. While adults are now able to maintain coverage through their parents' employer-sponsored insurance up until age 26, individuals cannot contribute to or use HSA funds for adult children.

Additionally, individuals are limited in how they can use their HSA funds even for products and services that are critical to the long-term health, quality of life, and financial stability for most Americans such as dental and vision coverage, other supplemental benefits, and over-the-counter medications. Such products and services should qualify as HSA-eligible medical expenses.

Among other policies, the Bipartisan HSA Improvement Act (H.R. 5138), the Restoring Access to Medication Act (H.R. 394), and the Health Savings Act of 2017 (H.R. 35 / H.R. 1175) would all allow for many of these new flexibilities.

c. Improve health care affordability, particularly for middle class consumers and the self-employed, to allow more consumers to fully utilize consumer-directed health products.

Millions of middle-class Americans who have annual incomes above 400 percent of the federal poverty level, but lack access to employer-provided coverage or public programs, find health insurance premiums to be unaffordable due to instability in individual market premiums. While the states and Congress have enacted policies to reduce premiums such as reinsurance funding and temporary relief from the Health Insurance Tax, more is needed.

A significant number of those who purchase health coverage through the individual marketplaces are self-employed. In fact, one in five who purchased coverage during the first year of the ACA marketplaces were either small business owners or self-employed.¹³ These individuals need access to more affordable coverage. Improvements to HSAs may offer new tax advantages and more ways to save money for the self-employed and middle-class consumers.

Aligning thresholds in the individual market, clearly indicating HSA-eligibility for individual market policies, and promoting HSA literacy would improve the ability of middle-class families to choose a health plan that meets their needs and increases access to tax-preferred health coverage mechanisms.

Additionally, policymakers on both the state and federal level should build off of recent successes in many states and explore novel ways to increase access to consumer-driven health products for lower and moderate-income individuals and families.

¹³ *The Rise of Alternative Work Arrangements: Evidence and Implications for Tax Filing and Benefit Coverage*, Office of Tax Analysis Working Paper 114, Department of the Treasury, January 2017. <https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/WP-114.pdf>

Conclusion

With more than 21.8 million consumers covered in HSA-eligible plans, and enrollment expected to continue growing in the coming years, HSAs and HSA-eligible plans represent a vital option to provide Americans with greater control and choice over their health and financial security. Promoting consumer and patient choice in the health care system is important to improving health outcomes and patient satisfaction. HSA-eligible plans are one option among many that health plans strive to offer to provide choice and affordability for consumers.

Thank you for this opportunity to discuss the value of HSA/HDHPs and our recommendations for further strengthening and improving this important and increasingly popular health care option. Recognizing that a growing number of Americans are embracing a consumer-oriented approach to health care, we fully support efforts in Congress to build upon the success of HSA/HDHPs.

We appreciate the support many committee members have demonstrated for HSA/HDHPs and we look forward to continuing to work with you to advance solutions for improving access to high quality, affordable health care.